ADULT SOCIAL CARE CABINET COMMITTEE

Thursday, 20th July, 2017

1.30 pm*

Darent Room, Sessions House, County Hall, Maidstone

please note earlier start time

Kent County Council
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AGENDA

ADULT SOCIAL CARE CABINET COMMITTEE

Thursday, 20 July 2017 at 1.30 pm
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 (14)

Conservative (11): Mrs P T Cole (Chairman), Ms D Marsh (Vice-Chairman), Mr G K Gibbens, Mrs A D Allen, MBE, Mrs P M Beresford, Mrs S Chandler, Miss E Dawson, Mr K Gregory, Mr P J Homewood, Mr P W A Lake, Mr D D Monk, Mr R A Pascoe, Mrs P A V Stockell and Mr M J Horwood

Liberal Democrat (2): Mr S J G Koowaree, Ida Linfield and Mr R H Bird

Labour (1) Mr B H Lewis

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)

1 Introduction/Webcasting Announcement

2 Apologies and Substitutes

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

3 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.

4 Minutes of the meeting held on 9 June 2017 (Pages 7 - 14)

To consider and approve the minutes as a correct record.

5 Verbal updates by Cabinet Member and Director (Pages 15 - 16)

To receive a verbal update from the Cabinet Member and Director on the issues listed.

6 17/00062 - Older People and People Living with Dementia Wellbeing Core Offer (Pages 17 - 24)

To receive a report from the Cabinet Member for Adult Social Care and the Corporate Director of Social Care, Health and Wellbeing about proposals regarding the commissioning of a new community wellbeing service for Older People and People living with Dementia, and notice of a future key decision.

7 16/00137 - Proposed changes to funding arrangements of Housing-Related Support and Community Alarms in Sheltered Housing (Pages 25 - 50)

To receive a report from the Cabinet Member for Adult Social Care and the Corporate Director of Social Care, Health and Wellbeing and to consider and either endorse or make a recommendation to the Cabinet Member on the proposed decision to work in collaboration with current providers to explore and secure alternative funding models, enabling the gradual withdrawal or reduction of the Council's contribution towards housing related support and community alarms in sheltered housing by the end of March 2018.

8 Implications of the Policing and Crime Act 2017 for Adult Social Care (Pages 51 - 58)

To receive a report from the Cabinet Member for Adult Social Care and the Corporate Director of Social Care, Health and Wellbeing on the key measures of the 2017 Act which may have a direct impact on councils with adult social care responsibilities, in particular duties under the Mental Health Act 1983, and relevant service provision.

9 Approach for Social Care New Monies (Pages 59 - 66)

To receive a report from the Cabinet Member for Adult Social Care and the Corporate Director of Social Care, Health and Wellbeing on actions taken in relation to the plan for the Social Care New Monies, as announced in the Spring Budget in March 2017.

10 17/00073 - Approach for Social Care New Monies – Progressing High Impact Change 4 – Nurse Led Community Services (Pages 67 - 80)

To receive a report from the Cabinet Member for Adult Social Care and the Corporate Director of Social Care, Health and Wellbeing and to consider and either endorse or make a recommendation to the Cabinet Member on the proposed decision to formalise existing arrangements in the short-term and enter into an agreement to cover specification and procurement of a nurse-led community service in the medium and long-term.

11 Adult Social Care - Social Value Framework (Pages 81 - 114)

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

Corporate Director of Social Care, Health and Wellbeing on the new framework and the process for producing it.

12 Adult Social Care Annual Complaints Report (2016 - 2017) (Pages 115 - 136)

To receive a report from the Cabinet Member for Adult Social Care and the Corporate Director of Social Care, Health and Wellbeing on the operation of the Adult Social Care Complaints and Representations procedure between 1 April 2016 and 31 March 2017.

13 Adult Social Care Performance Dashboard (Pages 137 - 156)

To receive a report from the Cabinet Member for Adult Social Care and the Corporate Director of Social Care, Health and Wellbeing on progress against targets set for key performance and activity indicators for May 2017 for Adult Social Care.

14 Work Programme 2017/18 (Pages 157 - 160)

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

15 Motion to Exclude the Press and Public for Exempt Item

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

EXEMPT ITEMS

(At the time of preparing the agenda there was an exempt appendix relating to item 10. During this and any such items which may arise the meeting is likely NOT to be open to the public)

John Lynch,
Head of Democratic Services
03000 410466

Wednesday, 12 July 2017

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

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KENT COUNTY COUNCIL

ADULT SOCIAL CARE CABINET COMMITTEE

MINUTES of A meeting of the Adult Social Care Cabinet Committee held at Darent Room, Sessions House, County Hall, Maidstone on Friday, 9th June, 2017.

PRESENT: Mrs P T Cole (Chairman), Mrs A D Allen, MBE, Mrs P M Beresford, Mrs S Chandler, Mr G Cooke (Substitute for Mr D D Monk), Mr D S Daley (Substitute for Ida Linfield), Miss E Dawson, Mr K Gregory, Mr P J Homewood, Mr S J G Koowaree, Mr P W A Lake, Mr B H Lewis, Ms D Marsh and Mr R A Pascoe

OTHER MEMBERS: Graham Gibbens and Catherine Rankin

OFFICERS: Andrew Ireland (Corporate Director Social Care, Health and Wellbeing), Mark Lobban (Director of Commissioning), Penny Southern (Director, Learning Disability and Mental Health), Anne Tidmarsh (Director, Older People and Physical Disability), Theresa Grayell (Democratic Services Officer) and Emma West (Democratic Services Officer)

UNRESTRICTED ITEMS

2. Apologies and Substitutes.
(Item. 2)

1. Apologies for absence had been received from Mr D D Monk and Ida Linfield.

2. Mr G Cooke was present as a substitute for Mr Monk and Mr D S Daley was present as a substitute for Ida Linfield.

3. Election of Vice-Chairman.
(Item. 3)

1. Mr K Gregory proposed and Mrs A D Allen seconded that Ms D Marsh be elected Vice-Chairman of the Committee. There were no other nominations.

Agreed without a vote.

2. Ms D Marsh was duly elected Vice-Chairman of the Committee.

4. Declarations of Interest by Members in items on the Agenda.
(Item. 4)

1. Mrs A D Allen made a general declaration of interest as the Co-Chairman of her local Partnership Group for People with Learning Disabilities.

2. Mr S J G Koowaree made a general declaration of interest as his grandson was looked after by the County Council.

3. Mr R A Pascoe made a general declaration of interest as his granddaughter was severely disabled.

5. Minutes of the final meeting of the former Adult Social Care and Health Cabinet Committee held on 14 March 2017 and the first meeting of this committee held on 25 May 2017.
(Item. 5)

RESOLVED that, subject to the deletion of a question mark in the second italic bullet point in paragraph 4 of minute 4 of the 14 March minutes, the minutes of the final meeting of the former Adult Social Care and Health Cabinet Committee held on 14 March 2017 and the first meeting of this committee held on 25 May 2017 be approved as a correct record. There were no matters arising.

6. Chairman's and Cabinet Member's Announcements.

1. The Chairman welcomed the new Members who had recently joined the County Council and welcomed all Members to the first meeting of the new Adult Social Care Cabinet Committee.

2. The Cabinet Member, Mr G K Gibbens, advised the committee that a Government consultation on the core offer of services for older people living with Dementia had started on 9 June and would continue until 21 July. He added that any Member wishing to speak to him about the consultation would be most welcome to come to his office at any time.

7. Agenda items 6 and 7 - considering exempt information.

The Chairman asked Members if, in debating these items, they wished to refer to the exempt appendices which accompanied agenda items 6 and 7, and if they wished to pass a motion to exclude the press and public. Members confirmed that they did not wish to refer to the exempt information and discussion of the two items was thus able to take place in open session.

8. 17/00030 (b) - Community Support Services - Homecare contract continuation or variation through mutual negotiation.
(Item. 6)

1. Mr Lobban introduced the report and explained that, although the two services covered in this and the next agenda item were parts of a larger programme of community service delivery, the proposed treatment of the two services would require separate key decisions. He set out the main issues affecting the delivery of home care services nationally, including workforce issues (staff terms and conditions, travel to clients and competition from other local employers), and the need to integrate and align social care and NHS services. These issues had prompted a review of the way in which the services were to be delivered. The current proposals were part of phase three of the County Council's transformation programme, and would be helped by the additional funding made available nationally to support social care services. It was proposed that the County Council continue to contract with its current providers until May 2019, at which time the re-modelled services would be ready to re-tender. This delay would allow time to tackle the workforce issues.

2. Mr Lobban, Mr Ireland and Mrs Tidmarsh then responded to comments and questions from Members, including the following:-

a) a view was expressed that, as part of a sustainable employment market, zero-hour contracts were a welcome choice for some workers, and so should be offered as an option, alongside full-time and permanent contracts. Mr Lobban reiterated that the current plans allowed for workforce issues to be examined as a whole. This would present a challenge but would bring long-term benefits;

b) in response to a question about how the home care market could tackle the issue of many older people being lonely rather than being in need of any specific care services, Mr Lobban explained that this could be addressed when reviewing the provision of Domiciliary Care as part of the service re-model. Applying national trends, it had been estimated that, in Kent, some 30,000 older people were isolated from neighbours and family, and establishing initiatives to help them keep in touch was an important area of work. Mr Ireland added that the Care Act of 2014 had broadened the definition of 'eligible needs' to include emotional as well as practical needs;

c) the need to achieve consistency of care was emphasised, so an older person would know whom to expect to arrive at their home and would be able to build a rapport with that person;

d) the extent of work invested in innovating and finding the best model of care provision was acknowledged, but concern expressed that the delay in finalising NHS Sustainability Transformation Plans (STPs) would mean they would not be as helpful as they could be in supporting this agenda;

e) in response to a question about the danger of contractors being unable to fulfil their contractual obligations, and what would happen in this instance, Mr Ireland explained that the ultimate responsibility to provide services for those who needed them rested with the County Council, and if a contractor were to default on a contract or go out of business, it would fall to the County Council to provide suitable services. Mr Lobban added that current providers had worked with the County Council for many years, and had a good understanding of needs and a good working relationship with the Council. However, the capacity of providers to meet increasing demand could sometimes be a problem, and it might be necessary from time to time to supplement contracts by spot-purchasing. Mrs Tidmarsh added that the County Council was working with the Kent Integrated Care Alliance and Skills For Care, and liaising with local colleges, to address the workforce issues;

f) in response to a question about a pilot scheme currently running in Canterbury, Mr Lobban explained that this would be of multi-disciplinary teams and would involve 100 service users, and would look at how best to integrate health and social care services; and

g) it was suggested that a way to raise the profile of caring as a profession would be to instigate an 'employee of the month' scheme. Mr Lobban confirmed that such a scheme had been discussed at a recent Kent Integrated Care Alliance conference, and that the Cabinet Member for Adult Social Care had agreed that the County Council could sponsor an award.

3. RESOLVED that the decision proposed to be taken by the Cabinet Member for Adult Social Care, to:-

a) agree to continue, for some contracted providers, service provision on the existing terms and conditions through to 31 May 2019, and, for other contracted providers, where mutual negotiation can be agreed, to award varied interim contracts through to 31 May 2019;

b) delegate authority to the Corporate Director of Social Care, Health and Wellbeing, or other nominated officer, to undertake the necessary actions to implement the decision; and

c) authorise officers to commence market engagement in readiness for the full procurement process, where required,

be endorsed.

9. 17/00030 (c) - Community Support Services - Supporting Independence Service contract continuation or variation through mutual negotiation.
(Item. 7)

1. Mr Lobban introduced the item and explained that this proposed continuation was also part of phase three of the transformation agenda, and was being presented for the same reasons as the Homecare service. The Supporting Independence Service was also affected by the same workforce issues as set out in the previous item. It was proposed that the County Council continue to contract with its current providers until May 2019, at which time the remodelled services would be ready to re-tender. This delay would allow time to tackle the workforce issues. This issue was also the subject of a pilot scheme currently running in Canterbury, working with service users to help them identify and set achievable goals and to monitor their progress, and to look at how services could best be integrated with those of the NHS. Mr Lobban explained that the use of Canterbury for both pilot schemes was coincidental and that projects were not area-specific. When required, a pilot would be allocated to whichever of the four transformation teams was able to run it, and the Canterbury team happened to be doing the two mentioned.

2. RESOLVED that the decision proposed to be taken by the Cabinet Member for Adult Social Care, to:-

a) agree to continue service provision on the existing, or varied, terms and conditions through to 31 May 2019, and, for other contracted providers, where mutual negotiation can be agreed, to award varied interim contracts through to 31 May 2019;

b) delegate authority to the Corporate Director of Social Care, Health and Wellbeing, or other nominated officer, to undertake the necessary actions to implement the decision; and

b) authorise officers to commence market engagement in readiness for the full procurement process, where required,

be endorsed.

10. 17/00053 - Direction of future provision of social care and support to adults with mental health needs.
(Item. 8)

Mrs C Fenton, Head of Mental Health, was in attendance for this item.

1. Ms Southern introduced the report and outlined the background to the proposed adoption of the Partnership Principles, Kent's Forward View for Mental Health 2016 – 2021, on which the committee was being invited to comment. The new partnership principles were the culmination of a series of transformations made in recent years to services for people with mental health issues.

2. Ms Southern, Mrs Fenton and Mr Ireland responded to comments and questions from Members, including the following:-

a) it was confirmed that no new or additional government or NHS funding was available to support the new arrangements and it was vital therefore that existing funding was spent very carefully to support good-quality, integrated service provision;

b) it was vital also that the transition from children's to adults' services was as smooth as possible;

c) the recruitment and retention of community psychiatric care professionals had been a challenge as far back as the 1970s, when large institutions were closing down, and the importance of good recruitment and retention was still important. Ms Southern explained that such recruitment was undertaken by the NHS rather than the County Council and Mrs Fenton added that Kent had not experienced the shortage apparent in other areas of the country;

d) in response to a question about monitoring of the outcomes of 'Live it Well', Ms Southern explained that this had been closely monitored and the outcomes had fed into the new partnership principles;

e) in response to a concern expressed that delivery of CAMHS should not be at risk during the transition to the new directorate structure, Ms Southern explained that it was her responsibility to oversee delivery of CAMHS. Mr Ireland added that commissioning of services for people with mental health needs was undertaken by the NHS and that the work of the County Council's Specialist Children's Services team and the NHS were now more integrated than at any time before;

f) in response to a concern about services for older people living in isolation, Ms Southern explained that services for these people were now much more joined up than they had previously been and were being delivered through strategic partnerships, needing only one referral, to provide a service which covered all aspects of an older person's life;

g) the integration of services under the new partnership arrangements was generally welcomed but concern was expressed that those delivering

services in the community must be suitably trained to prevent needs reaching crisis point. Ms Southern explained that work to upskill the workforce had been going on for three years. Mrs Fenton added that the new partnership arrangement would ensure that both referral to and discharge from secondary care would be as timely as possible;

h) in response to a question about whether or not the number of places available in Kent for adults with mental health needs was sufficient, Ms Southern explained that admissions were commissioned by CCGs or NHS England and that social care staff had no control of or influence over this. Asked what percentage of Kent people were admitted to beds within Kent, Ms Southern advised that this information was held by CCGs;

i) Mr Ireland added that, for children with the most severe mental health needs, there were insufficient beds in Kent and, as a result, some children with severe or highly specialised needs might have to be placed in other parts of the UK. However, in terms of adults and children combined, the number placed in Kent was far greater than the number placed out of county, and Kent was thus a net importer of social care clients; and

j) in response to a question about how older people's medication would be reviewed to ensure that it was right, and was manageable, Ms Southern explained that social care staff worked closely with public health colleagues to identify any negative effects of medication on an older person's physical and mental health.

3. RESOLVED that the decision proposed to be taken by the Cabinet Member for Adult Social Care, to:

a) approve the adoption of the Partnership Principles, Kent's Forward View for Mental Health 2016 – 2021;

b) approve the overarching intentions plan for adults with mental health needs; and

c) delegate authority to the Corporate Director of Social Care, Health and Wellbeing, or other nominated officer, to undertake the necessary actions to implement the decision,

be endorsed.

11. Adult Social Care and Health - Annual Equality and Diversity Report 2016/2017.

(Item. 9)

Mr M Thomas-Sam, Head of Strategy and Business Support, and Ms A Agyepong, Corporate Lead, Equality and Diversity, were in attendance for this item.

1. Mr Thomas-Sam introduced the report and he and Ms Agyepong responded to comments and questions from Members, including the following:-

a) data relating to religion and sexual orientation listed in the report included a high proportion 'unknown/not recorded', and Ms Agyepong explained that, although the aim was to gather the fullest information possible, this would rely on respondents being comfortable and willing to share information. Most respondents were aware that they were under no obligation to supply such information. It was always important that data provided be protected and treated with caution. Information requested from people must be relevant and proportionate to the intended aim. For example, in planning end-of-life work, a person's religious beliefs, if any, would play a role in the service provided for them in their final days;

b) the information listed in the report referred to County Council employees, and it would be useful to be able to compare this with the proportion of the Kent population as a whole. Ms Agyepong undertook to provide this information to the questioner outside the meeting; and

c) the report stated that there had been no financial implications in producing it, and Ms Agyepong explained that gathering and reporting such data was a core activity for the Equality and Diversity team and hence did not require any additional cost, beyond the usual everyday resources. Future reports could refer to there being 'limited' financial implications rather than 'none'.

2. RESOLVED that:-

a) current performance and proposed priorities be noted;

b) it be ensured that equality governance continue to be observed in relation to decision making; and

c) the approach for delivering against the new equality objectives, and annual reporting to the committee, be agreed, the latter in order to comply with the Public Sector Equality Duty (PSED), and ensure progress against the Council's objectives.

12. Work Programme 2017/18.
(Item. 10)

RESOLVED that the committee's work programme for 2017/18 be noted.

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

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

To: Adult Social Care Cabinet Committee – 20 July 2017

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

Classification: Unrestricted

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

Cabinet Member for Adult Social Care – Mr G K Gibbens

19 June 2017 – Local Government Association Community Wellbeing
20 June 2017 – County Councils Network & KPMG & Social Care Integration Seminar
28 June 2017 – Spires, Tenterden opening – Graham Gibbens
5 July 2017 – Beeches opening – Diane Marsh
11 July 2017 – Autism Strategy Launch

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

1. Delayed Transfer of Care / Improved Better Care Fund
2. Care Quality Commission
3. Association of Directors of Adult Social Services
4. Transformation Phase 3.

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From:	Graham Gibbens, Cabinet Member for Adult Social Care Andrew Ireland, Corporate Director of Social Care, Health and Wellbeing
To:	Adult Social Care Cabinet Committee – 20 July 2017
Decision Number:	**17/00062**
Subject:	**OLDER PEOPLE AND PEOPLE LIVING WITH DEMENTIA WELLBEING CORE OFFER**
Classification:	Unrestricted
Past Pathway of Paper:	Adult Social Care Portfolio Board – 26 April and 28 June 2017 Strategic Commissioning Board – 18 May and 5 July 2017 Commissioning Advisory Board – 14 July 2017
Future Pathway of Paper:	Cabinet Member decision
Electoral Division:	All

Summary: This paper sets out the proposals regarding the commissioning of a new community wellbeing service for Older People and People living with Dementia. It is proposed that current funding arrangements end and the new services are commissioned through an outcome focused contract. The new contract will improve outcomes for people whilst making best use of resources. It will also help shape the voluntary and community sector services ensuring organisations are brought together as a delivery network(s) and can consistently evidence the impact they are having in improving people's lives.

Recommendation: The Adult Social Care Cabinet Committee is asked to:
a) **COMMENT** on the consultation;
b) **NOTE** the further opportunity for committee members to comment on the recommendations once this report is published; and
c) **AGREE** the Cabinet Member will take the Executive Decision at the end of August 2017 and this is reported as a "for information" item at the Adult Social Care Cabinet Committee meeting on 29 September 2017.

1. Introduction

1.1 This paper sets out proposals regarding the commissioning of a core offer of community based wellbeing services for Older People and People living with Dementia and is intended to provide members of the Adult Social Care Cabinet Committee with an opportunity to engage in the consultation process.

1.2 Services are currently funded through a range of historic annual grants to voluntary and community sector organisations.

1.3 Commissioners have identified the opportunity to improve outcomes for people, and support better demand management in order to reduce spend in other areas of adult social care through the more effective use of these community based services.

1.4 Following an extensive period of engagement and co-production with providers of services (current and new), Older People, People living with Dementia and their carers, this report sets out a proposal to end the current annual funding arrangements and commission wellbeing services through a new outcome focused contract.

1.5 Public consultation on the proposal started on 12 June 2017 and is due to close on 23 July 2017.

2. Financial Implications

2.1 The Older Person and Physical Disability (OPPD) Division currently invests a total of £5,131,459 in grants for Older People and People living with Dementia (£4,328,215 for Older People and £803,244 for People living with Dementia).

2.2 This allocation of funding is historic and is distributed through a range of different grants which have been used to fund a range of different services across the county. There is a lack of equity of funding which does not reflect what is known about the profile of communities or the demand for support.

2.3 Under this proposal, funding will be re-allocated across geographic lots using a funding formula which takes into account the number of Older People and People living with Dementia, levels of deprivation as well as other economic factors related to delivering services. This means that, in comparison to current spend, funding in some areas will decrease while in others it will increase. This will lead to greater equity in spend for wellbeing services across the county.

2.4 It is proposed that funding be allocated within geographic lots and the budget will be split in order to:

- Fund strategic Partner/s to manage the contract, provider infrastructure and support their Delivery Network
- Fund the Delivery Network for the achievement of the required outcomes within the contract
- Fund a separate pot to incentivise the achievement of specified outcomes and/or reward exceptional performance
- Allocate a further amount to grant funding of new innovative projects to help further develop services.

3. Policy Framework

3.1 The Care Act (2014) emphasises that "The core purpose of adult care and support is to help people to achieve the outcomes that matter to them in their life". It places a duty on local authorities to:

- Promote wellbeing
- Prevent, reduce or delay needs
- Provide information and advice
- Shape the market

3.2 Increasing Opportunities, Improving Outcomes: Kent County Council's Strategic Statement 2015-2020, Strategic Outcome of "Older and vulnerable residents being safe and supported with choices to live independently."

3.3 Your life your well-being is the Council's Strategy for Adult Social Care (2016-2021) and sets out the vision "To help people to improve or maintain their wellbeing and to live as independently as possible."

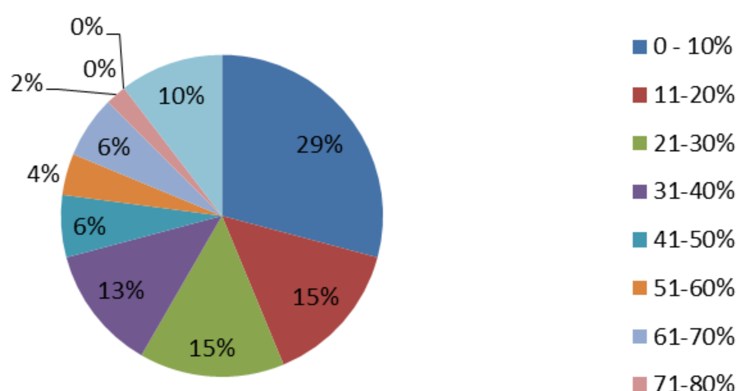
3.4 Kent County Council's Voluntary and Community Sector policy describes the Council's relationship with the voluntary sector, including detailing a consistent approach to grant funding across the organisation. This includes specific guidance that "grant funding is not used for the delivery of services that should be provided under contract." The OPPD division has been directed to end historic grant funding arrangements in order to comply with this policy.

4. The Report

4.1 The OPPD division currently invests £5,131,459 in grants for Older People and People living with Dementia.

4.2 This funding is currently distributed across 48 voluntary and community sector organisations who deliver a range of services to Older People and/or People living with Dementia. Funding is historic and some organisations have received funding for in excess of ten years via rolling grants.

4.3 Organisations receiving grants vary in size and the grants that they receive contribute towards their overall income to different degrees.



4.4 Services currently provided using this funding include: day services, care navigators, befriending, voluntary transport schemes, dementia cafes and peer support groups and bathing services.

4.5 Commissioners have worked with the market, Older People and People with Dementia as well as colleagues from health and understand that more people could benefit from these services, but that there are some issues which prevent this. These include the following:

- Services are not consistently networked together which means that people might need to approach a number of different organisations before finding the support that is right for them.

- It is difficult for health and social care professionals to refer people to the voluntary sector for support as they are required to have a broad knowledge and understanding of what is available at a local level.

- The grants are historic arrangements that were set up on a district basis. Spend is not linked to demography, levels of need, type of need or demand. This has created gaps in the market.

- Grants, unlike contracts, do not enable the Council to monitor and ensure that the outcomes of grants are met or that the investment delivers value for money.

- The grants are awarded annually, which means that organisations find it difficult to plan or invest in developing services with funding provided on an annual basis.

4.6 Extensive engagement has helped commissioners identify the outcomes that matter most for people which the new service must meet and how this service should be commissioned.

4.7 To date, there have been thirteen engagement workshops which have been attended by over a hundred people representing both current and potential providers. Providers have been asked to comment and feedback on a range of issues including;

- outcomes of the proposed contract
- options for future funding of services
- different contracting models

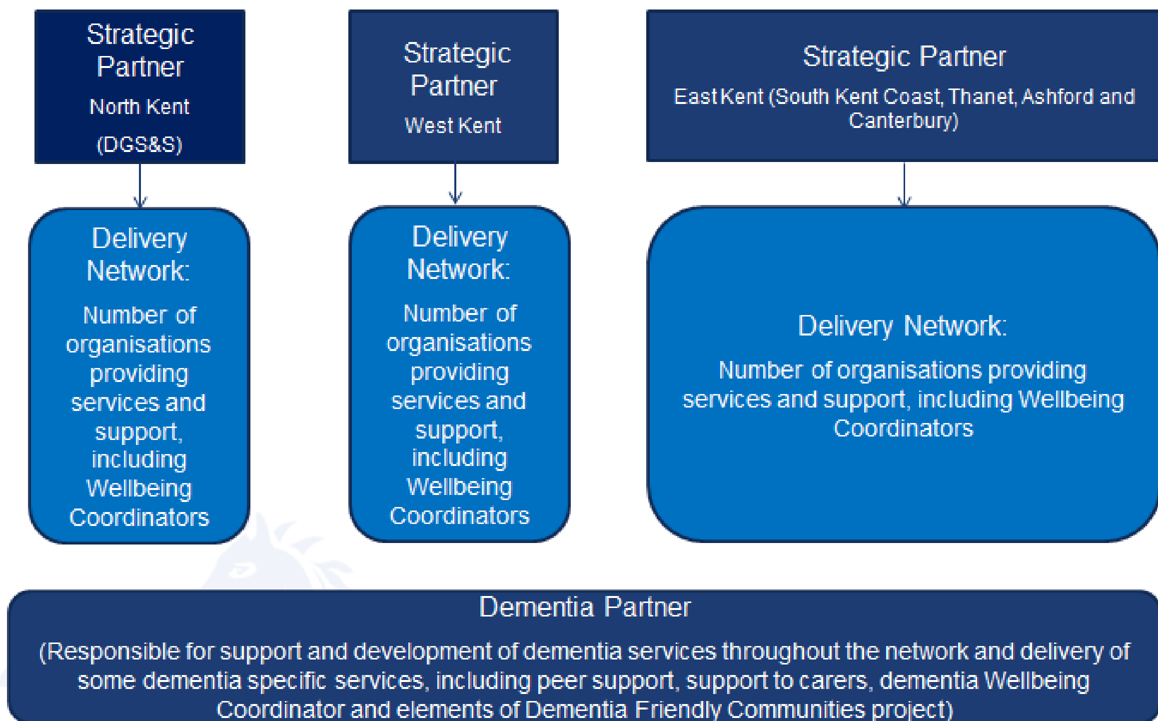
4.8 Commissioners have also spoken to over two hundred Older People, People living with dementia and their carers to understand what is important to them.

4.9 Based on this feedback, it has been clear that people want a range of community based services which support their independence. Therefore the outcomes of the contract will focus on connecting people to their communities and using community based assets to support people, rather than purely a service driven model.

4.10 It is important however to recognise that a portion of people with higher levels of need may require and prefer traditional models of care and there will need to be a place for these within the new contract.

4.11 The engagement process has also recognised the role of the Care Navigator in enabling people to maximise benefits and identify services, resources and activities that meet their needs. Following a design process the Care Navigator role has been expanded to include the development of community based assets as well as supporting people to access the services and support that will help them continue to live independently. The new name for this role will be Wellbeing Coordinators and this will be a specified service within the contract, recognising the value of this role in enabling people to find the right support for themselves in their community.

4.12 Following on from this engagement, the final proposal is to have a contract which is let across three geographic areas and compromises of three lots. This is illustrated below:



4.13 In this model, a Strategic Partner will hold a contract with the Council and be responsible for the delivery of the outcomes and services identified within the service specification. They will sub-contract, grant fund or spot purchase from a range of organisations within the Delivery Network in order to deliver services. Contracts will be awarded following a competitive process and providers can apply for, and potentially be awarded up to, all three lots.

4.14 The proposal to have three geographic lots has been informed by discussions with Clinical Commissioning Groups (CCG) and reflects the future alignment of Accountable Care Organisations. This has resulted in combining Ashford and Canterbury with South Kent Coast and Thanet areas. However, market engagement is being undertaken to ensure that there are organisations within the market that are able to undertake the Strategic Partner role across an area of this size.

4.15 The Delivery Network will consist of a range of organisations that will be funded to deliver services and support to individuals. Organisations will participate in a tendering process which will enable the Council to ensure that any provider delivering direct services to individuals' meet a set quality standard and ensure that there is a fair and transparent process for how the Strategic Partner recruits its Delivery Network. This is a key feature in ensuring that small and medium sized organisations have a place within the contract.

4.16 Feedback from the market highlighted that people living with Dementia (including younger people with Dementia) often require specialist support. Recognising this, the proposal is that there will a separate lot for the more specialist Dementia services across the county. In addition to providing some services, this partner will advise other providers within the network on how to

ensure that their services are 'Dementia Friendly' and develop best practice across the network for people with Dementia.

5. Equality Implications

5.1 An Equality Impact Assessment has been completed in relation to the proposal to end current grants and re-commission community based wellbeing services through a new contract. This identified a potential high adverse impact on older people due to the ending of current funding, but a potential high positive impact from the re-design of services and the longer term investment in providers that the contract would bring.

6. Legal Implications

6.1 TUPE may apply and legal advice will be sought as appropriate

7. Next Steps

7.1 The outcomes and procurement model for the proposed contract are currently out for public consultation and this is due to close on 23 July 2017.

7.2 Due to two purdah periods happening in close proximity, consultation was unavoidably delayed. As the Adult Social Care Cabinet Committee has fallen during the consultation period, this paper is intended to provide members of the Adult Social Care Cabinet Committee with an opportunity to engage in the consultation process.

7.3 In order to allow sufficient time for full and due consideration of the findings of the consultation process it is proposed that the Cabinet Member take an Executive Decision at the end of August and the outcome of this will be reported to the September meeting of the Adult Social Care Cabinet Committee.

7.4 So as to ensure an appropriate amount of time to mobilise the new contract, whilst ensuring continuity of services, it is proposed that grants will be awarded, to the existing organisations receiving KCC funding, for a three month period from 1 April 2018 to 30 June 2018 with the new contract coming into effect on 1 July 2018.

8. Conclusions

8.1 The OPPD division currently invests a total of £5,131,459 in grants for Older People and People living with Dementia.

8.2 Whilst services delivered with this funding provide valuable support to Older People, People living with Dementia and their carers, there are barriers which prevent more people benefitting from these services.

8.3 It is proposed that current funding arrangements are ended and that community based wellbeing services for Older People and People living with Dementia are commissioned through a new outcome focused contract.

8.4 The new contract will be delivered by Strategic Partner/s working with and through a Delivery Network and alongside a Specialist Dementia Partner.

8.5 As a result, more people will be able to access support which enables them to have ***"a life, not a service"***, promoting wellbeing, increasing resilience and improving outcomes.

8.6 Services will focus on connecting people to the services and support that best meets their needs, connecting people to their communities and developing community based resources.

8.7 The new contract will result in longer term funding enabling organisations to invest in developing and modernising services, as well as being able to successfully retain a skilled workforce, including volunteers.

8.8 This proposal places at its heart the principle of wellbeing which is detailed in the Care Act (2014) and Your life your well-being, a vision and strategy for adult social care.

9. Recommendation(s)

9.1 Recommendation: The Adult Social Care Cabinet Committee is asked to:
a) **COMMENT** on the consultation;
b) **NOTE** the further opportunity for committee members to comment on the recommendations once this report is published; and
c). **AGREE** the Cabinet Member will take the Executive Decision at the end of August 2017 and this is reported as a "for information" item at the Adult Social Care Cabinet Committee meeting on 29 September 2017.

10. Background Documents

Older Persons and People Living with Dementia Wellbeing Core Offer consultation
http://consultations.kent.gov.uk/consult.ti/OPCoreOffer/consultationHome

11. Report Author

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From: Graham Gibbens, Cabinet Member for Adult Social Care

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

To: Adult Social Care Cabinet Committee – 20 July 2017

Decision No: **16/00137**

Subject: **PROPOSED CHANGES TO FUNDING ARRANGEMENTS OF HOUSING RELATED SUPPORT AND COMMUNITY ALARMS IN SHELTERED HOUSING.**

Classification: Unrestricted

Past Pathway of Paper: Social Care, Health and Wellbeing DMT (28 September 2016 and 1 March 2017)

Future Pathway of Paper: Cabinet Member decision

Electoral Division: All

Summary: The government's consultation on 'Funding for supported housing' ended in February 2017. This consultation is the first step towards creation of a new funding mechanism for supported housing based on integration of health and social care on a regional basis, encompassing a broad spectrum ranging from some housing management activities to elements of healthcare. Aspects of Housing Benefit will be devolved to local level from 2019/20, amounting to £2.12bn, predominantly to fund these activities. This fund will be ring-fenced and set on the basis of current projections of future need.

In preparation for the proposed changes, during 2017/18 Kent County Council intends to work collaboratively with current providers to explore alternative funding models. In tandem, the County Council will gradually withdraw its contribution to these services by end of March 2018. This will ensure funding for supported housing can continue on a secure footing.

Separately, the County Council will continue to meet its Care Act obligations to the residents of sheltered housing and this will be unaffected by the changes.

Recommendation(s): The Adult Social Care Cabinet Committee is asked to **CONSIDER** and **ENDORSE** or make a **RECOMMENDATION** to the Cabinet Member on the proposed decision (attached as Appendix A) to:
a) **WORK** in collaboration with current providers to explore and secure alternative funding models, enabling the gradual withdrawal or reduction of the Council's contribution towards housing related support and community alarms in sheltered housing by the end of March 2018 and;

b) **DELEGATE** authority to the Corporate Director of Social Care, Health and Wellbeing or other nominated officer, to undertake the necessary actions to implement the decision.

1. Introduction

1.1 Kent County Council currently provides funding to a number of sheltered housing schemes across the county. The funding is a partial contribution towards the posts of scheme managers. The remainder is funded via rents and service charges, reflecting the housing management role of these managers. The Council's contribution does not provide personal care, or any form of health or social care.

1.2 A community alarm service is also funded, most of which are hardwired within sheltered housing schemes.

1.3 Both elements are universally available to those residents in receipt of Housing Benefit in the schemes, regardless of their needs. The Council's contributions towards these services are due to expire on 31 March 2018.

1.4 In light of the government's housing and welfare reform plans, the Council proposes to cease its contribution towards housing related support and community alarms in sheltered housing by April 2018.

1.5 A range of briefings and events is in place to discuss the proposed changes.

2. Rationale

2.1 The government's consultation on 'Funding for supported housing' ended in February 2017. This consultation is the first step towards creation of a new funding mechanism for supported housing based on integration of health and social care on a regional basis, encompassing a broad spectrum ranging from some housing management activities to elements of healthcare. Aspects of Housing Benefit will be devolved to local level from 2019/20, amounting to £2.12bn, predominantly to fund these activities. This fund will be ring-fenced and set on the basis of current projections of future need.

2.2 It is clear that over recent years, both locally and nationally new ways of shaping and funding sheltered housing are already emerging in response to the changing need and funding streams available. The transitional arrangements must take place in tandem with withdrawal of the Council's contribution to these services to avoid duplication.

2.3 In order to deliver cost efficient services to the residents of Kent, which are fit for purpose, it must be ensured that all revenue is spent appropriately, targeting resources at priority and vulnerable groups, promoting independent living, facilitating social inclusion and keeping people safe and secure.

2.4 At present, the activities delivered within sheltered housing and community alarm services overlap with a number of other community services, designed to help older people remain independent.

2.5 The level of support provided through these services often exceeds what is required through the housing related support contract.

2.6 The demographic within sheltered housing is changing; many residents require no support, and ceasing to contribute will not affect those individuals. For residents who have identified support needs, these needs can be readily mitigated with alternative means of more person-centred alternative provisions that are already available within the community.

2.7 Where a resident of sheltered housing has additional needs that require enhanced housing management, which is not personal care or general social care, the landlord or an agent on its behalf can deliver additional support if required. This can be provided through intensive housing management activities eligible under housing benefit. Households not in receipt of housing benefit will be unaffected. Individuals with apparent social care needs will be offered an assessment as a routine.

3. KCC's Strategic Statement and Policy Framework

3.1 The proposed decision aligns with the Council's policy framework, in its Strategic Statement 2015 – 2020 'Increasing Opportunities, Improving Outcomes' which sets out the Council's vision for improving lives by ensuring every pound spent in Kent is delivering better outcomes for Kent's residents, communities and businesses.

3.2 The proposed decision supports the Council's strategic outcome for older and vulnerable residents to be safe and supported with choices to live independently.

3.3 The Council's strategic direction clearly dictates a move towards ending generalised support in favour of needs-based, person-centred services. For a number of reasons, including duplication of service, through the same provision being offered elsewhere, and lack of assessed need, the service approach currently offered is outdated, and therefore no longer offers best value.

4. Options Considered

4.1 **Option 1** - Do nothing, i.e. continue with existing contracts for housing related support and community alarms. The main risks of this approach are;

- The County Council, Kent residents and contracted providers will be disadvantaged when the new national funding arrangements for supported housing comes into effect in 2019/20.
- Procurement rules require re-tendering of contracts, after April 2018.
- Overlap with a number of other community services
- Universally available generic services and not needs-led

- Due to the changing demographic within sheltered housing, many residents require no support
- The support provided is eligible under Housing Benefit and can be funded via intensive housing management costs

4.2 **Option 2** – Rationalise all services by a uniform percentage, thereby maintaining a level of housing related support and community alarms to all, regardless of need. The main risks of this approach are:

- All the risks identified above, plus
- There is no rationale to continue to provide a service that is not needs led.
- There is no rationale to fund services that are potentially duplicated, not needed or should be appropriately funded via alternative funding sources, at the detriment of the Council, targeting funding away from statutory services for the most vulnerable individuals and families in Kent.

4.3 **Option 3** – Undertake an assessment of each organisation and their readiness to transition across to the new Housing Benefit funding of these services. Subsequently to this to then:

- Enhance Housing Benefit entitlements through provision of intensive housing management services.
- Withdraw the Council's contribution to housing related support and community alarms by end of March 2018.
- Undertake close liaison and extensive stakeholder engagement, to mitigate potential impact to residents and disruption to service provision.

4.4 Option 3 is the recommended option as it aligns with the government's proposal on welfare reform and devolved funding. The transition of appropriate costs to Housing Benefit is the only way to ensure that the devolved funding is considered appropriately and that future funding of supported housing in Kent continues to be sustainable.

5. Financial Implications

5.1 The financial impact associated with the proposed decision will be set out in detail in the recommendation report which supports the Executive Decision and this will be subject to the outcomes of a stakeholder engagement exercise.

5.2 The implementation of this decision will help to deliver the Council's Medium Term Financial Plan 2017-20.

6. Legal Implications

6.1 There are no legal implications of the suggested action, subject to the standard termination clauses within the specified contracts.

6.2 The Council will continue to meet its obligations under the Care Act, namely to ensure that every resident over the age of 18 can have a social care assessment and that any assessed, eligible need will be met.

7. Equality Implications

7.1 An Equalities Impact Assessment has been undertaken and is attached as Appendix 1. The impact on groups affected will be minimal, and will be carefully managed and mitigated.

8. Conclusion

8.1 The way that sheltered housing is used and provided is changing nationally. At the same time, new national arrangements for the funding of all supported housing, including sheltered housing, is imminent.

8.2 A provider market briefing will have been held on 19 July, facilitated by an independent consultancy organisation. This will inform, engage and support providers to prepare for the transitional arrangements via housing benefit..

8.3 It is essential that the Council continues to works collaboratively with providers to ensure a smooth transition from housing related support to the new arrangements via housing benefit. This will maximise this new opportunity and ensure that people's needs are met in the best possible way. This will also ensure funding for supported housing can continue on a secure footing.

8.4 Separately, the County Council will continue to meet its Care Act obligations to the residents of sheltered housing and this will be unaffected by the changes.

9. Recommendation(s)

9.1 Recommendation(s): The Adult Social Care Cabinet Committee is asked to **CONSIDER** and **ENDORSE** or make a **RECOMMENDATION** to the Cabinet Member on the proposed decision (attached as Appendix A) to:
a) **WORK** in collaboration with current providers to explore and secure alternative funding models, enabling the gradual withdrawal or reduction of the Council's contribution towards housing related support and community alarms in sheltered housing by end of March 2018 and;
b) **DELEGATE** authority to the Corporate Director of Social Care, Health and Wellbeing, or other nominated officer, to undertake the necessary actions to implement the decision.

10. Background Documents

Budget Book 2017/18
http://www.kent.gov.uk/__data/assets/pdf_file/0006/66534/budget-book-2017-18.pdf

Kent Social Care Accommodation Strategy, Better Homes: Greater Choices
http://www.kent.gov.uk/__data/assets/pdf_file/0018/14634/Kent-social-care-Accommodation-Strategy.pdf

Social Care, Health and Wellbeing Community Support Market Position 2016

http://www.kent.gov.uk/__data/assets/pdf_file/0004/60475/The-Social-Care,-Health-and-Wellbeing-Community-Support-Market-Position-Statement-FULL-statement.pdf

Strategic Statement 2015-2020, 'Increasing Opportunities Improving Outcomes' http://www.kent.gov.uk/about-the-council/strategies-and-policies/corporate-policies/increasing-opportunities-improving-outcomes

11 Contact details

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Appendix A

KENT COUNTY COUNCIL – PROPOSED RECORD OF DECISION

DECISION TO BE TAKEN BY:	DECISION NO:
Cabinet Member for Adult Social Care	16/00137

For publication

Key decision
Affects more than 2 Electoral Divisions, and savings of more than £1m

Subject: Changes to funding arrangements of housing related support and community alarms in sheltered housing.

Decision: As Cabinet Member for Adult Social Care, I propose to:
a) **WORK** in collaboration with current providers to explore and secure alternative funding models, enabling the gradual withdrawal or reduction of the council's contribution towards housing related support and community alarms in sheltered housing by end of March 2018; and
b) **DELEGATE** authority to the Corporate Director of Social Care, Health and Wellbeing, or other nominated officer, to undertake the actions necessary to implement the decision.

Reason(s) for decision:
The government's consultation on 'Funding for supported housing' ended in February 2017. This consultation is the first step towards creation of a new funding mechanism for supported housing based on integration of health and social care on a regional basis, encompassing a broad spectrum ranging from some housing management activities to elements of healthcare. Aspects of Housing Benefit will be devolved to local level from 2019/20, amounting to £2.12bn, predominantly to fund these activities. This fund will be ring-fenced and set on the basis of current projections of future need.

In preparation for the proposed changes, the necessary devolution of funding needs to be met. Many of the activities in sheltered housing can be funded in this way. The transitional funding arrangements must take place in tandem with withdrawal of KCC's contribution to these services to avoid duplication.

The transition of appropriate costs to Housing Benefit is the only way to ensure that the devolved funding is considered appropriately and that future funding of supported housing in Kent continues to be sustainable.

Financial Implications
The financial impact associated with the proposed decision will be set out in detail in the recommendation report which supports the executive decision and this will be subject to the outcomes of a stakeholder engagement exercise.

The implementation of this decision will help to deliver the council's Medium Term Financial Plan 2017-20.

Equality Implications
An Equalities Impact Assessment has been undertaken. The impact on groups affected will be minimal, and will be carefully managed and mitigated.

Legal Implications
There are no legal implications of the suggested action, subject to standard termination clauses within the specified contracts.

Cabinet Committee recommendations and other consultation:
The proposed decision will be discussed at the Adult Social Care Cabinet Committee on 20 July 2017 and the outcome included in the paperwork which the Cabinet Member will be asked to sign.

Any alternatives considered:
N/A

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

....
signed

....
date

KENT COUNTY COUNCIL
EQUALITY ANALYSIS / IMPACT ASSESSMENT (EqIA)

Directorate: Social Care, Health and Wellbeing - KCC

Name of policy, procedure, project or service
Community Alarms and Housing related support in Sheltered Accommodation for Older Persons

What is being assessed?
Plans to reduce and end Community Alarms and Housing related support in Sheltered Accommodation for Older Persons by April 2018

Responsible Owner/ Senior Officer
Mark Lobban, Director of Commissioning

Date of Initial Screening:
June 2016

Date of Full EqIA :

Update each revised version below and in the saved document name.

Version	Author	Date	Comment
1	Sholeh Soleimanifar	25 October 2016	First draft
2	Sholeh Soleimanifar Paul Stephen	24 November 2016	Second draft
3	A Agyepong	28 November 2016	AA Review
4	Sholeh Soleimanifar Paul Stephen	07 December 2016	V4
5	Sholeh Soleimanifar	15 December 2016	V5
6	A Agyepong	16 December 2016	AA Comment and review
7	Paul Stephen	23 December 2017	V7
8	Sholeh Soleimanifar	07 March 2017	V8
9	Sholeh Soleimanifar	08 May 2017	V9

Characteristic	Could this policy, procedure, project or service, or any proposed changes to it, affect this group less favourably than others in Kent? YES/NO If yes how?	Assessment of potential impact MEDIUM		Provide details: a) Is internal action required? If yes what? b) Is further assessment required? If yes, why?	Could this policy, procedure, project or service promote equal opportunities for this group? YES/NO - Explain how good practice can promote equal opportunities
		Positive	Negative	Internal action must be included in Action Plan	If yes you must provide detail
Age	Yes - the project could lead to the removal of funding for housing related support in sheltered housing for older people, though mitigating actions will ensure that those who have an assessed need for support will have access to it through other pathways.	Medium	Medium	a) Yes – KCC Social Care Health and Wellbeing will need to take mitigating action to quantify and reduce the impact; this includes continuing a dialogue with providers and stakeholders, such as the districts and borough housing authorities, to identify those who have an assessed need for eligible support. b) Yes there is a need to collect data from the providers about the needs of those currently receiving the service. We are planning a number of 'deep dives' to a random selection of providers of varying sizes and locations (Large, Medium, Small and one where the HRS is provided by a district or borough Council). The move to rationalise funding will eradicate duplication and end blanket funding of housing related support to those who do not need it.	Yes – the project could lead to greater equality in access to resources for older people. Currently, housing related support is concentrated on delivery to people on the basis of where they live. The proposed changes will introduce choice for those individuals who live in sheltered housing on whether or not to have the service if they do not wish it or more importantly need it. Currently the service is provided regardless of need. As the profile of the way sheltered housing is used has changed, as have aspiration and demographics of people over 55 living in them. .(See Accommodation Strategy)

Disability	Yes - there are some people who are living in sheltered housing on the basis of disability rather than age. Those people will be affected by any changes precipitated by the project, though mitigating actions will ensure that those who have an assessed need for this type of support will receive it.	Medium	Medium	a) Yes – KCC Social Care Health and Wellbeing will need to take mitigating action to quantify and reduce the impact; this includes continue a dialogue with providers and stakeholders, such as the districts and borough housing authorities, to identify those who have an assessed need for eligible support. b) Yes there is a need to collect data from the providers about the needs of those currently receiving the service. We are planning a number of 'deep dives' to a random selection of providers of varying sizes and locations (Large, Medium, Small and one where the HRS is provided by a district or borough Council). The move to rationalise funding will eradicate duplication and end blanket funding of housing related support to those who do not want, need or value it.	Yes – the project could lead to greater equality in access to resources for people with disabilities. Currently, housing related support is concentrated on delivery to people on the basis of where they live. The proposed changes will introduce choice for those individuals who live in sheltered housing on whether or not to have the service if they do not wish it or more importantly need it. Currently the service is provided regardless of need. As the profile of the way sheltered housing is used has changed, as have aspiration and demographics of people over 55 living in them. .(See Accommodation Strategy)

Gender	Yes - we know that there are more older women than men in Kent and that could mean that more women are affected	Medium	Medium	a) Yes – KCC Social Care Health and Wellbeing will need to take mitigating action to quantify and reduce the impact; this includes continuing a dialogue with providers and stakeholders, such as the districts and borough housing authorities, to identify those who have an assessed need for eligible support. b) Yes there is a need to collect data from the providers about the needs of those currently receiving the service. We are planning a number of 'deep dives' to a random selection of providers of varying sizes and locations (Large, Medium, Small and one where the HRS is provided by a district or borough Council). The move to rationalise funding will eradicate duplication and end blanket funding of housing related support to those who do not want, need or value it.	Yes – the project could lead to greater equality in access to resources for people with disabilities. Currently, housing related support is concentrated on delivery to people on the basis of where they live. The proposed changes will introduce choice for those individuals who live in sheltered housing on whether or not to have the service if they do not wish it or more importantly need it. Currently the service is provided regardless of need. As the profile of the way sheltered housing is used has changed, as have aspiration and demographics of people over 55 living in them. .(See Accommodation Strategy)
Gender identity	Unknown	None	None	a) There is no qualitative or quantitative data to suggest that the project will have an adverse effect on the customer base on account of their gender identity.	
Race	Unknown	None	None	a) There is no qualitative or quantitative data to suggest that the project will have an effect on the customer base on account of their race.	

Religion or belief	No	None	None	a) There is no qualitative or quantitative data to suggest that the project will have an effect on the customer base on account of their religion or belief.	
Sexual orientation	Unknown	None	None	a) There is no qualitative or quantitative data to suggest that the project will have an effect on the customer base on account of their sexual orientation.	
Pregnancy and maternity	No	None	None	a) There is no qualitative or quantitative data to suggest that the project will have an effect on the customer base on account of their pregnancy and maternity.	
Marriage and Civil Partnerships	No	None	None	a) There is no qualitative or quantitative data to suggest that the project will have an effect on the customer base on account of their marriage or civil partner status.	
Carer's responsibilities	Yes - we know that many older people have caring responsibilities in Kent and that could mean that more carers are affected.	Medium	Medium	a) Yes – KCC Social Care Health and Wellbeing will need to take mitigating action to quantify and reduce the impact; this includes continuing a dialogue with providers and stakeholders, such as the districts and borough housing authorities, to identify those who have an assessed need for eligible support. b) Yes there is a need to collect data from the providers about the needs of those currently receiving the service. We are planning a number of 'deep dives' to a random selection of providers of varying sizes and locations (Large, Medium, Small and one where the HRS is provided by a district or borough Council). The move to rationalise funding will eradicate duplication and end blanket funding of housing related support to those who do not want, need or value it.	Yes – the project could lead to greater equality in access to resources for carers. Currently, housing related support is concentrated on delivery to people on the basis of where they live. The proposed changes will introduce choice for those individuals who live in sheltered housing on whether or not to have the service if they do not wish it or more importantly need it. Currently the service is provided regardless of need. As the profile of the way sheltered housing is used has changed, as have aspiration and demographics of people over 55 living in them. .(See Accommodation Strategy)

INITIAL SCREENING

Proportionality - Based on the answers in the above screening grid what RISK weighting would you ascribe to this function – see Risk Matrix

Low (1-7)	**Medium** (8-15)	**High** (16-25)
Low relevance or Insufficient information/evidence to make a judgement.	Medium relevance or Insufficient information/evidence to make a Judgement.	High relevance to equality, /likely to have adverse impact on protected groups

The risk rating for the initial screening is LOW.

1. Introduction

This Equality Impact Assessment covers the proposed reduction and withdrawal of the council's contribution towards Housing related support (HRS) services and community alarms in sheltered housing for older persons.

This phased withdrawal of funding is in response to the government's impending proposed devolution of funding for supported housing based on integration of health and social care on a regional basis. The government's consultation on 'Funding for supported housing' ended in February 2017.

All HRS services in sheltered accommodation for Older Persons will be affected countywide, with the exception of Extra Care housing and Home Improvement Agencies.

2. Background

Kent County Council (KCC) provides housing related support funding to a number of sheltered housing schemes across the county. Sheltered housing schemes usually consist of houses, flats or bungalows grouped together. Residents have their own front door and living space, which may have adaptations to make life easier and safer, and there are normally communal areas such as lounges, gardens and laundry rooms for socialising. The majority of schemes have a scheme manager on site, for a set number of hours per week, overseeing the scheme and ensuring the safety of residents. However, they do not provide personal care or help with medication.

KCC also funds a community alarm service, most of which is hardwired within sheletered housing schemes. The alarms allow users to call for help in an emergency.

It is proposed that KCC funding for HRS in sheltered accommodation and all hard-wired community alarms is ended by April 2018.

3. Current Situation / Context

KCC needs to continue to deliver cost efficient services to the residents of Kent, which are fit for purpose, and must ensure that all revenue is spent appropriately, targeting resources at priority and vulnerable groups, through commissioning of services which promote independent living, facilitate social inclusion and keep people safe and secure.

Traditionally, many sheltered schemes have had resident caretakers, providing a scheme

manager function; this is no longer the case, with very few, if any, remaining. Most scheme managers are now responsible for a number of schemes, splitting their time between those facilities. Kent County Council contributes to funding of the scheme manager positions, to provide Housing related support to those in receipt of Housing Benefit.

4. **Rationale for change and suggested approach**

Government's consultation on 'Funding for supported housing' ended in February 2017. This consultation is the first step towards creation of a new funding mechanism for supported housing based on integration of health and social care on a regional basis, encompassing a broad spectrum ranging from some housing management activities to elements of healthcare. Aspects of Housing Benefit will be devolved to local level from 2019/20, amounting to £2.12bn, predominantly to fund these activities. This fund will be ring-fenced and set on the basis of current projections of future need.

In preparation for the proposed changes, the necessary devolution of funding needs to be met. Many of the activities in sheltered housing can be funded in this way. The transitional funding arrangements must take place in tandem with withdrawal of KCC's contribution to these services to avoid duplication.

At present, both HRS and community alarm services duplicate a number of other community services, such as Home Care, Telecare and services commissioned from the voluntary and community sector, such as Information, Advice and Advocacy. The level of provision in these services exceed that provided through the housing related support contract, and can be accessed by anyone deemed eligible following a care needs assessment.

KCC's strategic direction clearly dictates a move towards ending generalised support in favour of needs-based, person-centred services. As it is currently configured, the support offer within sheltered housing is outdated, duplicated and therefore no longer offers best value. It is proposed that following close work with providers to ensure residents' needs are met, the contracts are allowed to end naturally at end of March 2017.

The withdrawal of council's contribution will be based on assessment of risk for each organisation and their readiness to transition across to funding of these services by enhancing their Housing Benefit entitlement through provision of intensive housing management services to people with additional needs. This requires close liaison and extensive stakeholder engagement, to mitigate potential risks to residents and disruption to service provision. This is the only way to ensure that the devolved funding is considered appropriately and that future funding of supported housing in Kent continues to be sustainable.

This proposal mirrors those already implemented in other similar peer authorities and is reflective of the changing role of sheltered housing nationally. Providers and district councils have been advised of the council's intentions regarding the extension and the need to deliver differently in future.

Moving Forward:
The council plans to work closely with providers and stakeholders regarding these proposals and will maintain comprehensive risk logs in order to ensure that risks are appropriately mitigated and managed. The council will also work with all providers to ensure a smooth transition period and transfer of undertakings to other support services, wherever necessary.

5. **Aligning Principles**

Government's consultation on *Funding for supported housing*, which sets out proposals for creation of a new funding mechanism for supported housing based on integration of health and social care on a regional basis, encompassing a broad spectrum ranging from some housing management activities to elements of healthcare.

The *Care Act 2014* sets out in one place, local authorities' duties in relation to assessing people's needs and their eligibility for publicly funded care and support. Under the Care Act, local authorities must carry out an assessment of anyone who appears to require care and support, regardless of their likely eligibility for state-funded care. The focus of that assessment is on the person's individual needs and how they impact on their wellbeing, and the outcomes they want to achieve. The individual is involved in the assessment, as is someone they nominate, such as carer, and they also have access to an independent advocate to support their involvement, if required.

KCC's *Strategic Statement 2015-2020, Improving Outcomes*, stated a focus on improving lives by ensuring that every pound spent in Kent is delivering better outcomes for Kent's residents, communities and businesses. One of KCC's strategic aims within the statement is to ensure that 'older and vulnerable residents are safe and supported with choices to live independently', with a supported outcome being that 'residents have greater choice and control over the health and social care services they receive'. The approach to achieving these outcomes points to a need to 'maximise the value of the Kent tax pound', and to 'recognise that no one size fits all'; it stresses the importance of 'tailoring solutions to need'.

Within the *Kent Social Care Accommodation Strategy, Better Homes: Greater Choices 2014*, it was acknowledged that in order 'to meet the objectives of this Accommodation Strategy and to support the vision of KCC in terms of social care provision, the approach to access and delivery of housing and care support services has to radically change'. It stated that the role of commissioning services for all adult social care clients is 'to respond to the increasing demand upon all services not only as a result of an ageing population but due to the multiple or complex needs of clients' and to 'manage reducing budgets as a result of a reduction in central government funding'. Once again, within this role description is the need to 'achieve best value'.

The strategy points towards the personalisation agenda as one of the most significant shifts in the transformation of social care and support, with the core principles of providing services based upon the needs of an individual, for services to be of a high standard and with recognition that the levels and types of services will vary significantly between individuals within defined adult social care client groups.

The strategy states that 'KCC commissioners and providers will have to consider the impact of the personalisation agenda upon their business models with increased choice and control over purchasing by individuals. This means that people will be able to choose who delivers their services and whether, particularly for extra care housing and supported accommodation, they will buy in to the services offered on site'.

In conclusion, the strategy states that KCC wants to see 'responsible, flexible and integrated commissioning of services to respond to current and future need' and 'more people residing in accommodation that meets their individual accommodation and care and support needs, evidenced by cross agency needs assessments'.

The *Social Care, Health and Wellbeing Community Support Market Position 2016*, stated that 'good commissioning is person-centred and focuses on the outcomes that people say matter

most to them. It empowers people to have choice and control in their lives and over their care and support'. The 'key messages to the market' states that 'demographic change will significantly increase demand for care and support over the coming years but will not be matched by increases in public funding'; it pledged an increased investment in information and advice, preventative services, assistive technologies to support independent living, and a move away from time and task home care, but instead developing more person-centred models of support that are outcome focussed.

Within the *County Council Autumn Budget Statement 2016*, reference is made towards how major savings within the medium term plan are based upon the Adults Transformation programmes, with the council expecting to see further savings coming through from phases two and three. In addition to this, the statement notes how other key savings are based upon 'more targeted and efficient commissioning in areas such as Housing related support'.

With all this in mind, an end to the funding for generalised support offered by scheme managers in sheltered housing schemes clearly aligns with KCC's strategic direction and necessary efficiency savings needs. For a number of reasons, including duplication of service, through the same provision being offered elsewhere, and lack of assessed need, the service approach currently offered is outdated, and therefore no longer offers best value. Also, many of these services will be included in a 'core offer' for older people, which is currently in development.

6. Alternative services

Due to the changing demographic within sheltered housing, some residents require no support, so these proposed changes will not affect those individuals. For residents who have identified support needs, any risk related to these proposals can be readily mitigated with alternative means of help. Dependant on the specifics of the assessed need, alternative provisions, which are more person-centred, can be utilised, that are already available within the community.

Where a tenant has additional needs that require enhanced housing management, which cannot be defined as personal care or general social care, then the landlord or an agent on its behalf can provide and fund the enhanced support using Intensive Housing Management of Housing Benefit, unless the tenant is self-funding, in which case the Housing related support service does not apply. Those older individuals who are believed to require extra care should be offered a Care Needs assessment, if it is thought they may have a need that meets social care eligibility criteria.

Home Care services seek to support people and thereby avoid, prevent or delay entry into social care and or health services, as outlined in the Care Act 2014. The support offered includes social opportunities, befriending, voluntary transport schemes, falls prevention, bathing, meal delivery services, care navigation, information and advice, and advocacy. This level of care goes far beyond what is provided through the housing related support contract, and can be accessed by anyone deemed eligible following a care needs assessment.

KCC is responsible for providing community prevention and early intervention, as well as statutory services for mental health. Preventative services are universal and help prevent entry into formal social care and health systems, reduce suicide and prevent negative health outcomes associated with poor mental health. Earlier this year, KCC ended a range of differing contracts and grants to develop a new *Community Mental Health and Wellbeing Service*. This new service is outcome focussed and designed to reduce stigma, promote good mental health and wellbeing, preventing issues escalating and enabling people to find the right support at the right time. Throughout the commissioning process it was

acknowledged that ensuring a good range of housing options and services are developed, that support people to find housing and/or maintain their tenure, is critically important. As the new service embeds it will be looking for opportunities to work more closely with housing providers to create opportunities for a mixture of supported housing options that promote independence and reduce reliance on care home placements.

Your Life, Your Home is a key Adult Social Care transformation project, which aims to increase the options for independent living available to adults with learning disabilities and reduce the number of residential placements. In Kent, there are currently over 1200 adults with a learning disability living in residential care. Many people's support needs can be met in alternative settings, other than residential care, which will allow them to lead more independent lives. The project team are involved in ensuring sufficient alternative accommodation is made available for people that choose to move on from residential care, and that a range of community based services that continue to support their independence are in place. Community based services for adults with a learning disability are provided through both an internal provision and commissioned services.

The *Integrated Community Equipment Service* plays a crucial role in helping the most vulnerable people in Kent remain in their own home. Through the provision of equipment, people are enabled to carry out everyday activities, maximise their independence, or to be supported to be cared for at home. Equipment can reduce the likelihood of hospital admission and can assist in timely discharge from hospital. The service is available for citizens of Kent, of all ages, with health needs, physical and sensory impairments.

7. Demographics Profile

Kent has an ageing population with people generally living longer and remaining healthy, fit and active for longer than previous generations. This increasing trend is and will continue to place demands upon housing and care and the support services available.

The number of people aged over 55 is set to increase dramatically over the next twenty years - an estimated population increase of nearly 50% from 490,000 in 2008 to 720,000 by 2031. There has been a huge rise in the number of over 55's who are owner occupiers and this number is set to grow, with three out of four people aged over 55 being a homeowner by 2031. The majority of people aged over 55 in Kent are likely to be in generally good health, economically active and in some form of paid employment.

In line with the general population, the demographic of people using sheltered housing has changed; there are a greater proportion of people using sheltered housing who are of working age, many have no support needs and do not want or need the support on offer.

8. Deep Dives

A deep dive questionnaire was circulated in December 2016 to a select group of small, medium and large sheltered housing providers to gather more insight into the type and level of support provided at each site, in order to inform discussions around the current nature of their services. This questionnaire focused on the specifics of the service currently being provided as part of the HRS contract in sheltered accommodation and hard-wired alarms, compared to what is offered to all residents at the same schemes.

Face-to-face meetings then took place with those providers, where the current service practices and use were discussed, as well as what the future of their services would be. The narrative of these discussions differed by provider; some stated that regardless of the future

of funding, the current service would remain, others stated that client numbers had decreased, as they had plans to use the units for other means, while others stated that the current service would not remain without continued funding. Providers stated that they have been expecting funding levels for these services to be reviewed, and most likely decrease, for some time. All narratives involved an acknowledgement of there being a housing problem, not a care/support problem.

Following feedback and analysis of findings, the questionnaire is being revised to be circulated to all remaining providers, to gather further information about the current offer to people in sheltered accommodation, and a profile of who is receiving them.

The eligibility criteria for most sheltered housing means that any decisions made will have a disproportionate impact on older people, as they must be, in most instances, 55+ to be placed there. Older people are more likely to have limited mobility and disability due to frailty; therefore, those with a disability are more likely to be impacted by these proposals also. We also know that many older people in Kent have caring responsibilities, which could mean that more carers are affected also.

Although we information regarding those currently accommodated, based on the eligibility criteria. More information about these individuals is needed in order to fully realise the potential impact on other protected characteristics. Further information from all providers will be requested.

9. Engagement with Stakeholders

The public consultation, 'KCC Draft Budget proposals 2017/18', was open from 13 October 2016 until 27 November 2016. The high-level draft budget for 2017/18 proposes considerable budget savings for Adults and Older People's Services, which includes the savings associated with housing related support for sheltered housing and hard-wired community alarms.

Engagement with landlords, provider organisations and district/ borough councils will be ongoing until the end of March 2018. This engagement has been, and will be, in the form of formal and informal discussions, questionnaires, a workshop, face-to-face meetings and written communications.

10. Potential Impact

Overall, as the withdrawal of KCC's contribution will happen in tandem with the replacement of the devolved funding through the intensive housing management element of housing benefit, the potential impact for residents should be negligible.

For those affected, the impact will vary according to the circumstances of the individual. For those with an assessed need, the service can be replaced with a more person centred approach, in accordance with their assessed needs from statutory services, or other interventions and services available in the community.

In order to try to mitigate the impacts on these groups the following actions are proposed:

- Older People to be offered Care Needs assessment if it is thought they may have a need that meets social care eligibility criteria;
- For older people who do not meet the eligibility criteria for care or support service,

providers to signpost older people with low level support needs and disabilities to generic support services/networks in the community;
- People with enhanced housing related support needs to be supported using Intensive Housing Management services to intervene at times of crisis;
- Providers to identify where people have existing care packages and inform their care managers of changes to their former Supporting People services;
- Telecare service may replace some of the community alarm services that will be decommissioned for people who meet the eligibility criteria. Other people will be encouraged to seek alternative services, which will include self-funding their own alarm service.

There will be no impact on the level of service received by people living in Extra Care housing schemes.

It cannot be determined whether these proposals will have a disproportionate impact on people on the grounds of race, sexual orientation, gender reassignment, marital status or religion. This is due to data not being available and not having received any complaints comments or feedback from service users or providers about these characteristics. Collation of statistics regarding protected characteristics is now a requirement for all commissioned service.

Mitigation:
Where a tenant has additional needs that require enhanced housing management, which cannot be defined as personal care or general social care, then the landlord or an agent on its behalf can provide and fund the enhanced support using Intensive Housing Management of Housing Benefit, unless the tenant is self-funding, in which case the Housing Related Support service does not apply.

Enhanced housing management includes:

- Assistance to tenants to resolve or prevent housing debts that impinge on their ability to pay for their housing
- Assistance to claim and manage housing benefits
- Advice and assistance in relation to fulfilling tenancy conditions
- Advice and assistance to tenants on how to use equipment in their own home
- Advice and assistance to tenants in relation to their own personal safety and the safety and security of their accommodation
- Advice and assistance to tenants in relation to organising repairs or improvements to their home (property or contents)
- Mediation in tenants' neighbour disputes
- Issuing and enforcing occupancy agreements
- Collection of and accounting for rent
- Organising and repair of properties or their contents
- DIY services
- Monitoring the performance of any additional generals social care and personal care services provided by a third party provider care services

The council is planning a provider briefing/workshop in June, where the focus will be on explaining what elements of the current HRS service are eligible for funding through enhanced housing benefit, and how organisations can assist those they accommodate, who are eligible, to apply for this enhanced benefit. This has been successfully achieved in other local authority areas.

Positive Impact:

Identified benefits of change include the opportunity to refocus and to prioritise resources to areas that have the greatest impact in meeting greatest need.

The above will ensure that in the future services for older persons will:

a) Be responsive, personalised and flexible
b) Provide improved quality of service provision
c) Provide improved outcomes for older persons
d) Provide part of an older persons' pathway, effectively linking adult services with the voluntary sector services engaged in the older persons' wellbeing strategy

The proposal could lead to greater access to resources for older people and lead to equality in outcomes between those who do/do not live in sheltered housing e.g. in private rented accommodation/homeowners or other social housing. Currently, HRS is concentrated on delivery to people on the basis of where they live, rather than any assessed need. Reviewing this service would allow opportunity to introduce a needs-based service.

Greater monitoring of eligibility will allow the council to be more accountable with regards to spending and ensure Value for Money is achieved.

JUDGEMENT

Option 1 – Screening Sufficient YES

Following this initial screening our judgement is that no further action is required.

Justification:

The transition of appropriate costs to Housing Benefit is the only way to ensure that the devolved funding is considered appropriately and that future funding of supported housing in Kent continues to be sustainable.

Option 2 – Internal Action Required NO

There is potential for adverse impact on particular groups and we have found scope to improve the proposal

(Complete the Action Plan at the end of this document)

Option 3 – Full Impact Assessment NO

Monitoring and Review

This Assessment will be reviewed monthly during the period of implementation.

Sign Off

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

Senior Officer

Signed: Name: Mel Anthony

Date: 08/05/17 Job Title: Commissioning Manager

DMT Member

Signed: Name: Mark Lobban

Date: Job Title: Director of Commissioning

Please forward a final signed electronic copy to the Equality Team by emailing

diversityinfo@kent.gov.uk

The original signed hard copy and electronic copy should be kept with your team for audit purposes.

Equality Impact Assessment Action Plan

Protected Characteris	Issues identified	Action to be taken	Expected outcomes	Owner	Timescale	Cost implications
Gender	There are older women than men in Kent and that could mean that more women are affected by the proposed change.	• KCC will work with providers to identify those who may be impacted • KCC will carry out needs assessment where required • KCC will host a workshop in Jan/ Feb to support providers during transition.	• Clearer picture of the protected characteristics of those affected by the proposal. • Clearer pathway to alternative provision where required. • Smooth transition to new arrangements. • Impact of proposal minimised. • All those who have an assessed need will receive	Mel Anthony	Jan – March 2018	
Age	Sheltered housing is for people who are 50 years and older (although there are a few under this age). Therefore the proposals will impact older people	• KCC will work with providers to identify those who may be impacted • KCC will carry out needs assessment where required • KCC will host a workshop in Jan/ Feb to support providers during transition.	• Clearer picture of the protected characteristics of those affected by the proposal. • Clearer pathway to alternative provision where required. • Smooth transition to new arrangements. • Impact of proposal minimised. • All those who have an assessed need will receive	Mel Anthony	Jan – March 2018	

Disability	Older people are more likely to have limited mobility and disability due to frailty. Therefore this characteristic is more likely to be impacted by the proposals.	• KCC will work with providers to identify those who may be impacted • KCC will carry out needs assessment where required • KCC will host a workshop in Jan/ Feb to support providers during transition.	• Clearer picture of the protected characteristics of those affected by the proposal. • Clearer pathway to alternative provision where required. • Smooth transition to new arrangements. • Impact of proposal minimised. • All those who have an assessed need will receive	Mel Anthony	Jan – March 2018	

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From: Graham Gibbens, Cabinet Member for Adult Social Care

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

To: Adult Social Care Cabinet Committee - 20 July 2017

Subject: **IMPLICATIONS OF THE POLICING AND CRIME ACT 2017 FOR ADULT SOCIAL CARE**

Classification: Unrestricted

Past Pathway of Paper: Social Care, Health and Wellbeing Directorate Management Team - 28 June 2017

Future Pathway of Paper: None

Electoral Division: All

Summary: The policy objective of the Policing and Crime Act 2017 (the 2017 Act) is to improve the democratic accountability of police forces and fire and rescue services, improve the efficiency and effectiveness of emergency services through closer cooperation and building public confidence in the criminal justice system.

This report focuses on the key measures of the 2017 Act that may have a direct impact on councils with adult social care responsibilities, in particular duties under the Mental Health Act 1983 and relevant service provision.

Recommendations: The Adult Social Care Cabinet Committee is asked to **CONSIDER** and **COMMENT** on the key issues set out in this report.

1. INTRODUCTION

1.1 The Policing and Crime Bill was introduced in the House of Commons on 10 February 2016 and the legislation completed its passage through Parliament on 19 December 2016. The Bill received Royal Assent on 31 January 2017.

1.2 The chapter on policing powers (Sections 52 to 120) has the most impact on local authorities, in so far as the duties placed on councils flowing from the Mental Health 1983 Act (the 1983 Act) are concerned.

1.3 The Policing and Crime Act 2017, Sections 80 to 83 have had the effect of amending Sections 135 and 136 of the Mental Health 1983 Act. Section 135 gives the police powers to remove a person who appears to be experiencing a mental health crisis from a private dwelling and under Section 136, from a public place. Additionally, the 1983 Act enables the police force to subsequently take the individual to a “place of safety” so that a mental health assessment could be undertaken and where appropriate, arrangements made

for their ongoing care and/or treatment. The Mental Health 1983 Act (the 1983 Act) also provides for the police to temporarily detain a person in a mental health crisis in order to protect their health and safety, which do not require the consent of the individual to be detained.

1.4 The purpose of presenting this report is to inform the Adult Social Care Cabinet Committee about the key changes which affect Local Authority duties for the Approved Mental Health Practitioner (AMHP) Service and have been introduced by the 2017 Act and also to set out the implications for Adult Social Care in Kent and, more importantly, to describe the steps being taking to manage the associated risks.

2. POLICY CONTEXT

2.1 The mental health policy landscape is influenced by a number of government policy objectives outlined in amongst other publications; the Government's mandate to NHS England 2017-18, in which "24/7 access to mental health crisis care in both community and A&E settings" is a core objective. Similarly, there are delivery objectives for 2017-18 under the Mental Health Five Year Forward View implementation plan.

2.2 The Mental Health Crisis Care Concordat (MHCCC), which was published in February 2014, is also shaping developments in this area. The Concordat is a national agreement between services and agencies involved in the care and support of people in crisis. There is no additional or dedicated MHCCC budget identified in the national Crisis Care Concordat.

2.3 The four main areas of focus for the Concordat are:

1. Access to support before crisis point
2. Urgent and emergency access to crisis care
3. Quality of treatment and care when in crisis
4. Recovery and staying well.

2.4 The Crisis Care Concordat is mirrored in Kent through a multiagency collaborative partnership through the MHCCC. This is the strategic concordat group supported by three geographical based local concordat groups across Kent and Medway to drive the programme forward. A number of Kent County Council's and Kent Clinical Commissioning Group's service plans and intentions for 2017/18 have been developed which align with the MHCCC requirements and policy objectives.

2.5 It should be noted that the aims and objectives of the 'Your life, your well-being, a new vision and strategy for adult social care 2016 – 2021' as well as some features of mental health in the Kent and Medway Sustainability and Transformation Plan (STP) are wholly in line with the national objectives described above. The Joint Health and Wellbeing Strategy for Kent also has strategic focus on mental health through its theme 4 which, aims to improve physical and mental health and wellbeing for people. The existing and planned mental health service developments being spear headed by Adult Social Care, together with key health partners, demonstrate the determination to make

changes which make a difference to people's lives about which the policy objectives have a bearing.

3. HEADLINE PROVISIONS OF THE 2017 ACT

3.1 The 2017 Act is comprised of nine parts which are divided into a number of chapters. In addition, there are 19 Schedules to the 2017 Act. Below is a list of the chapter headings and the corresponding Sections

Part 1: Emergency services collaboration (Sections 1-12)
Part 2: Police discipline, complaints and inspection (Sections 13 - 37)
Part 3: Police workforce and representative institutions (Sections 38 - 51)
Part 4: Police powers (Sections 52 – 120)
Part 5: Police and Crime Commissioners and police areas (Sections 121 – 124)
Part 6: Firearms and pyrotechnics refreshments articles (Sections 125 – 134)
Part 7: Alcohol and late night refreshment (Sections 135 – 142)
Part 8: Financial sanctions (Sections 143 – 156)
Part 9: Miscellaneous and general (Sections 157 – 184)

3.2 The following paragraphs now turn to Sections 80 to 83 of the provisions of the 2017 Act, which are of most interest to Adult Social Care because they have direct impact on the AMHPS service and associated provision.

3.3 Widening the definition of "place of safety" so that any place may be considered a "place of safety" if it is appropriate and safe to do so (Section 80 subsections (2) and (3).

3.3.1 This section widens the definition of a "place of safety" in the 1983 Act so that anywhere the police consider to be suitable can be a "place of safety". This may include community centres and multiple use buildings in addition to police stations, local authority residential accommodation, hospital settings or care homes for people with mental health needs, (which were already designated as "places of safety" in the 1983 Act).

3.3.2 It is the Government's expectation that broadening the list of "places of safety" will assist the identification of additional "places of safety", facilitating local premises to be used on an ad hoc or contingency basis, in turn enabling the person in crisis to be assessed without delay (whilst simultaneously preventing the need to transport the individual to a different "place of safety").

3.4 Enabling, in certain circumstances, a mental health assessment for an individual detained under Section 135 to take place either in the person's own home or until a suitable hospital bed is identified. (Section 80 subsection 4).

3.4.1 The 2017 Act makes provision for a mental health assessment to take place in the individual's own home provided that the police considers it appropriate to do so, and the person in crisis agrees that the place where they are living can be used as a "place of safety" (if there is more than one occupier, the consent of

the other occupiers is also required). This reduces the need for a person to be transferred to an alternative “place of safety”.

3.5 Requiring whenever practicable that under Section 136 detentions, the police seek advice from a health professional prior to taking or keeping a person in a “place of safety” (Section 80 subsection 5).

3.5.1 This section introduces a statutory requirement on the police to consult a health professional such as a registered medical practitioner, a registered nurse or an approved mental health professional prior to taking or keeping a person at a “place of safety” (unless in the Police officer’s professional judgment it would not be practicable to do so).

3.6 Restricting the circumstances in which police cells can be used as “places of safety” for adults aged 18 years or over (Section 81).

3.6.1 The 2017 Act confers on the Secretary of State the power to make regulations when police cells may be used as a “place of safety” for adults, and to make provision for their treatment whilst detained, including provision for the review of their detention.

3.7 Reducing the permitted period of detention in a “place of safety” from 72 to 24 hours with the provision of an extension of time on the basis of clinical need (Section 82).

3.7.1 The new requirement ensures that the individual’s fundamental rights are not restricted beyond the 24 hour period with the new detention time period aligning with the detention timeframe for those detained for a suspected criminal offence.

3.7.2 This is of particular significance since an individual detained under the 1983 Act has not committed a criminal offence (where previously the 1983 Act allowed a person detained under Sections 135 and 136 to be held pending mental assessment for up to 72 hours, including being held in a police cell).

3.7.3 Additionally, the 2017 Act makes provision for an extension beyond the 24 hour period applicable only, when due to the condition of the individual it is felt that the assessment would not be achieved in the first 24 hours, for example in cases where the person may be intoxicated or requiring physical health treatment.

3.7.4 At the end of the 24 hour period, a 12 hour maximum extension can be authorised by the registered medical practitioner responsible for assessing the detained person. Where both the “place of safety” at which the detainee is being held and the intended place of assessment is a police station, authorisation to extend the permitted period of detention will also require the approval of a police officer of the rank of Superintendent or above. This brings the maximum period of detention under Sections 135 and 136 of the 1983 Act into line with that which can be authorised by a Superintendent under the Police and Criminal Evidence Act 1984 (PACE).

3.8 The application of Section 136 powers without a warrant now extends to private property, enabling Section 136 detentions to apply anywhere apart from domestic dwellings (Section 83).

3.8.1 The application of Section 136 powers now extends to private property where under preceding provisions a warrant would be necessary to detain the individual presenting in crisis. In this context private property may include workplaces with restricted access.

4. IMPLICATIONS FOR ADULT SOCIAL CARE

4.1 The Council through its Adult Social Care function has the lead role in the provision of the Approved Mental Health Practitioner (AMHP) Service. An Approved Mental Health Practitioner is an officer of the Council who is warranted, or authorised, to make certain legal decisions and applications under the Mental Health Act 1983. Usually, the officer will be a Social Worker who has undertaken additional training to be warranted. In 2007 the law was changed to allow other mental health professionals to undertake this role. As a result it is now possible for psychiatric nurses, occupational therapists or psychologists to become AMHPs.

4.2 The Council's statutory responsibilities for the AMHP Service is delegated and delivered as part of the Section 75 partnership agreement between Kent County Council and the Kent and Medway NHS and Social Care Partnership Trust (KMPT). The Service is provided around the clock and has seen a gradual increase in demand over the last three years.

4.3 The very fact that the 2017 Act restricts the use of police cells as a "place of safety" (for detainees under the age of 18 and subject to regulations, restrict the circumstances in which police cells may be used as a "place of safety" for adults 18 years or over), would put further pressure on the Council's mental health services. The need for the Police, Health and the Council to work together to find a better way to address this pressure, forms an essential part of the work of the MHCCC mentioned in paragraph 2.2 above.

4.4 The fact the period of detention has been reduced from 72 hours to 24 hours (even though provision exists for extensions under certain criteria), will impact on the AMHP Service as the window within which to carry out statutory assessment has been reduced. In certain circumstances it may not be possible especially when the condition of the individual is such that assessment would not be possible to be completed in the first 24 hours, for example in cases where the person may be intoxicated or requiring physical health treatment. There is a direct resource impact which the Council has had to address.

4.5 The Council's initial response to meeting this new requirement has had to be managed within current resources and as an interim arrangement two additional posts have been made available to the 24/7 dedicated service in order to meet current, and potentially new demand. This will allow KMPT and the Council work through what these new arrangements will have on the service response

time and if necessary additional resources to meet this pressure will need to be found. It is also important to find different ways to provide for individuals who are assessed under Section 136 Mental Health Act 1983 but are not subsequently detained under the Mental Health. Work is in progress in looking into how a new service could be put in place in partnership with Mental Health Matters. This forms a key part of the how to address the pressures brought about by the changes in the 2017 Act. As well as looking at increased administration and back up support for AMHP.

5. LEGAL IMPLICATIONS

5.1 The Policing and Crime Act 2017 has made consequential changes to Sections 135 and 136 of the Mental Health Act 1983. Sections 135 and 136 give Police powers to detain and remove persons who appear to be suffering from a mental disorder and take them to a designated "place of safety" for their mental health needs to be assessed. The changes carry a number of implications as outlined in the previous section above.

6. CONCLUSION

6.1 Councils with Adult Social Care responsibilities are required to operate within certain legislation, secondary regulations and statutory guidance. These are duties and obligation from which the Council must not depart. In other words, the Council is compelled to follow them. The changes to Sections 135 and 136 of the Mental Health Act 1983, introduced by the Policing and Crime Act 2017 has extended the Council's legal duties which impact on resources, practice, commissioning and partnership working, with a lasting effect.

7. RECOMMENDATIONS

7.1 Recommendations: The Adult Social Care Cabinet Committee is asked to **CONSIDER** and **COMMENT** on the key issues set out in this report.

8. BACKGROUND DOCUMENTS

Policing and Crime Act 2017 (Get in on the Act) -
https://www.local.gov.uk/policing-and-crime-act-2017-get-act

Five Year Forward View for Mental Health
https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf

Kent and Medway Sustainability and Transformation Plan
http://kentandmedway.nhs.uk/stp/

Joint Health and Wellbeing Strategy 2014-2017
http://www.kent.gov.uk/about-the-council/strategies-and-policies/health-policies/joint-health-and-wellbeing-strategy

Kent and Medway Mental Health Crisis Concordat Report 2016/17
https://democracy.kent.gov.uk/documents/s70091/Item%206%20Kent%20HWBB%20Concordat%20July%202016.pdf

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From:	Graham Gibbens, Cabinet Member for Adult Social Care Andrew Ireland, Corporate Director of Social Care, Health and Wellbeing
To:	Adult Social Care Cabinet Committee - 20 July 2017
Subject:	**APPROACH FOR SOCIAL CARE NEW MONIES**
Classification:	Unrestricted
Past Pathway of Paper:	County Council – 25 May 2017 Kent Health and Wellbeing Board – 14 June 2017
Future Pathway of Paper:	None
Electoral Division:	All

Summary: This report is provided to inform the Adult Social Care Cabinet Committee of the actions in relation to the plan for the Social Care New Monies as announced in the Spring Budget in March 2017.

Recommendation(s)**:** The Adult Social Care Cabinet Committee is asked to **CONSIDER** and **COMMENT** on the proposals in relation to the plan for the Social Care New Monies

1 Introduction

1.1 This report sets out the approach to the Social Care New Monies as announced in the Spring Budget in March 2017 (£52m over three years for Kent) along with the original allocation of £6.8m in the budget agreed at the County Council meeting in February 2017 (£20.4m over three years).

1.2 At its meeting on 25 May 2017 the County Council received a report on the additional Social Care monies which constituted a material change to the County Council's budget and a revised budget was approved, together with the overarching strategy for using the new money and the market sustainability fund within the original approved budget for 2017-18.

1.3 The allocation of the Social Care new monies is accompanied by draft guidance and conditions. These conditions are:

1. It must only be spent for the purposes of meeting adult social care needs
2. It must be used to reduce the pressures on the NHS including supporting more people to be discharged from hospital when they are ready
3. It must be used to stabilise the social care provider market.

1.4 The grant will be pooled into the local Better Care Fund and a plan must be developed with Clinical Commissioning Groups (CCG) and providers to meet National Condition 4 (Managing Transfers of Care) in the Integration and Better Care Fund Policy Framework and Planning Requirements 2017-19. However, final decisions regarding the use of the new Social Care monies will still be made by the County Council/Cabinet Member.

1.5 The first quarterly report is due to be submitted on 21 July 2017. The first measurement of impact will be the Delayed Transfers of Care (DTOC) figures for September 2017 and reported in November 2017.

1.6 The funding allocation for Kent is a reducing amount as follows:

- 2017/18 - £26.1m
- 2018/19 - £17.5m
- 2019/20 - £8.7m

1.7 Through the development of the intervention plan, it was agreed that there could be an option to smooth the funding across the three years, should that be sensible, and that this would mean £17.4m available per year recurring. The additional investment from the council of £6.8m would mean that there is £24.2m available for 2017/18, however progressing this in the first year will see some delays which presents an opportunity to re-phase the monies into later years.

2 Consultation and Engagement

2.1 The following table shows the engagement to date and planned:

Date	Event
22 March 2017	Meeting with the Kent Integrated Care Alliance
5 April 2017	CCG Accountable Officers and Adult Social Care and Health Directorate Management Team
	Letter from Accountable Officers
	Letter from NHS Providers
28 April 2017	Home Care Provider Event
3 May 2017	CCG Accountable Officers and Adult Social Care and Health Directorate Management Team
8 May 2017	Care Home Provider Event
12 May 2017	NHS Provider Meeting
25 May 2017	County Council
14 June 2017	Health and Wellbeing Board
15 June 2017, 28 June 2017, 14 July 2017, 16 July 2017	NHS A&E Delivery Boards

3 Kent County Council's approach

3.1 Officers from the Council's Strategic Commissioning, Older Persons and Physical Disability, Learning Disability and Mental Health, Engagement,

Organisation Design and Development and Finance Divisions have been focusing on how the Council should approach priorities for the new monies. This has been regularly reported through the Adult Social Care and Health Directorate Management Team with progress through Strategic Commissioning Board and with the NHS.

3.2 The work to date has focused on two distinct areas; High Impact Changes (HIC) to reduce the pressures on the NHS and DTOC and Social Care market sustainability.

3.3 Furthermore, the areas of spend has been analysed to make sure there is evidence to support the investment in the right areas along with appropriate measures for outcomes. This has also resulted in identifying priorities that need an Executive Decision.

3.4 Additional DTOC pressures in 2017/18 have emerged due to the NHS and LA Transforming Care Programme. To date 43 people have been successfully discharged as part of this programme. In 2017/18 it is anticipated a further cohort of people will be discharged from NHS acute services. The individuals being discharged from acute settings will meet the S117 criteria for aftercare funding from both health and social care services, at an estimated social care cost of £1.4m to the County Council, rising to £2.5m in a full year

3.5 Additionally, the budget for social care approved at the County Council meeting in February 2017 was based upon a combination of funding additional spending pressures e.g. price increases and demographic growth, along with a programme of transformation and efficiency savings necessary to balance the budget within the resources available from central government and council tax. These planned savings are undergoing a review in light of the revised financial climate with the additional grant, especially where these would now be entirely counter-productive to the aims sought to achieve.

4 High Impact Changes (HIC)

4.1 The NHS, working with local systems, identified a number of HIC that can support local health and care systems reduce DTOC. This can be summarised for Social Care as follows:

HIC	Action	17/18 '000	Full Year '000	Key Decision?
HIC 1 "Early Discharge Planning"	Additional staffing to support social care activity in all hospitals at the front door for admission avoidance/integrated urgent care models and other staffing. Improving pathways	308.0	450.0	No
HIC 2 "Systems to Monitor Patient	Development of integrated dashboard and supporting panel processes	27.5	10.0	No

Flow"				
HIC 3 "Integrated Discharge Team"	Additional staffing to support IDT, pathway three and OT/physio support	270.0	360.0	No
HIC 4 "Home First/Discharge to Assess"	Additional investment in pathway one, service commissioning to integrate the wider workforce and utilise opportunities from Phase 3 transformation, additional recruitment for enablement, technicians for adaptations/equipment across sector	3,240.3	4,320.4	Part (service commissioning only)
HIC 5 "Seven day service"	Single Point of Access to develop in line with IDT/HomeFirst pathways – additional professional mental health workers	155.9	207.8	No
HIC 6 "Trusted Assessors"	To be developed in line with HIC 4		£0	No
HIC 7 "Focus on Choice"	Working with Live Well Kent, link Peer Support workers to do early engagement and link with individual in crisis to support them through admission and return home		£0	No
HIC 8 "Enhancing Health in Care Homes"	KMPT support to care homes, OT support to care homes, dementia assessment beds and focus on short term beds including pharmacy support	1,016.4	1,355.2	No
Total		**5,018.1**	**6,703.4**	

Key:

Pathway Zero – people who go home with no extra support
Pathway One = people who go home with an enabling/assessment/short term service
Pathway Two = people who go to a community hospital/short term rehab bed
Pathway Three = people who are discharged to a care home for complex assessment
IDT = Integrated Discharge Team
OT = Occupational Therapist
KMPT = Kent and Medway Partnership Trust

5 Social Care market sustainability

5.1 A range of engagement events have taken place with the provider sector. Members of the Adult Social Care Cabinet Committee will recall the report on Homecare and Supporting Independence Service at the previous meeting on 9 June 2017 and an executive decision was taken on 15 June 2017 by the Cabinet Member for Adult Social Care (17/00030b and 17/00030c).

5.2 Some of the areas of intervention are further developed than others and evidence is required to make sure that the investment will either address market sustainability or reduce the pressure on the NHS.

5.3 The broad areas of investment are as follows:

Area	Action	17/18 '000	Full Year '000	Key Decision?
Care Homes	Opportunities identified include wrap around support to the care homes, leadership support, addressing shortfalls in workforce, increasing capacity, identifying priority areas at risk of exiting the market, collectively working to improve quality across all client groups, access to loan equipment to support hospital discharge	4,599.9	7,000.2	Yes for activity direct to care home providers – longer term plan in development
Community Support	Investment in homecare improving terms and conditions to the worker and ensuring increase in wage direct to worker Investment in other community support activity, voluntary sector support,	7,510.6	9,578.3	Yes (17/00030b taken £5m annual spend (Homecare)) Further needed
Resources/Training	Training for whole sector – needs planned development to progress – need to target areas with service gaps. Additional staff resource to progress activity to manage new money activity, plan and fund new monies events	901.9	1,003.9	No
Total		**13,012.4**	**17,582.5**	

6 Legal Implications

6.1 There will be legal implications in relation to commissioning activity which will be considered under each action necessary. For instance, where an executive decision is required, the necessary consideration will be shared.

7 Equalities Impact Assessments

7.1 An Equalities Impact Assessment will be completed for the new service design as part of the Transformation Programme. For this arrangement, service users would receive continuity in service provision, pending any planned activity for review.

8 Summary

8.1 The total new monies available for the three years is as follows:

	Year One	Year Two	Year Three	Total
New Monies	£26.1m	£17.5m	£8.7m	£52.3m
KCC	£6.8m	£6.8m	£6.8m	£20.4m
Total	£32.9m	£24.3m	£15.5m	£72.7m

8.2 However, the Social Care Health and Wellbeing Directorate Management Team has agreed that this funding should be smoothed over the three years, as follows:

	Year One	Year Two	Year Three	Total
New Monies	£17.4m	£17.4m	£17.5m	£52.3m
KCC	£6.8m	£6.8m	£6.8m	£20.4m
Total	£24.1m	£24.1m	£24.2m	£72.7m

8.3 Until all plans are fully developed, it is not possible to confirm whether there will be any surplus that can still be utilised.

8.4 There are some savings originally planned in the Adult Social Care budget which in light of the purpose of the new monies would now be counter-productive. Consequently some of the new monies will be used to compensate for not proceeding with these original plans.

9 Next Steps

9.1 The final guidance is awaited on how the impact will need to be reported. On each of the items listed in the intervention plan, impact measures will need to be identified and agreed.

9.2 Executive Decisions will be required, particularly in relation to progressing HIC 4 and care home sustainability, and a plan is in development on how this can be progressed to target resource at the areas most needed.

9.3 All other activity reported will be taken forward with direction from the Corporate Director for Adult Social Care and Health and the Strategic Commissioner.

10. Recommendation

10.1 Recommendation(s)**:** The Adult Social Care Cabinet Committee is asked to **CONSIDER** and **COMMENT** on the proposals in relation to the plan for the Social Care New Monies

11. Background Documents

County Council budget report 25 May 2017
https://democracy.kent.gov.uk/documents/b18097/Item%2012%20-%20Revised%20Budget%20201718%20and%20Medium%20Term%20Financial%20Plan%202017%20-20%2025th-May-2017%2010.00%20Count.pdf?T=9

Integration and Better Care Fund Policy Framework 2017-2019
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/607754/Integration_and_BCF_policy_framework_2017-19.pdf

Decision 17/000030b and 17/000030c
https://democracy.kent.gov.uk/ieDecisionDetails.aspx?ID=2063

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From:	Graham Gibbens, Cabinet Member for Adult Social Care Andrew Ireland, Corporate Director of Social Care, Health and Wellbeing
To:	Adult Social Care Cabinet Committee - 20 July 2017
Decision No:	**17/00066**
Subject:	**APPROACH FOR SOCIAL CARE NEW MONIES – PROGRESSING HIGH IMPACT CHANGE 4 - NURSE LED COMMUNITY SERVICE**
Classification:	Unrestricted - Exempt appendix
Past Pathway of Paper:	County Council – 25 May 2017 Kent Health and Wellbeing Board – 14 June 2017
Future Pathway of Paper:	Cabinet Member decision
Electoral Division:	All

Summary: This report is provided to inform the Committee of the implications of establishing contracts for a nurse led community service, currently delivered in some parts of the county by 'Hilton Nursing Partners' as an interim measure pending full market procurement process into the future delivery of community support services (in line with the Your life, your well-being Strategy) and ultimately achieving full integration with the NHS by 2020 (in line with the NHS 5 Year Forward View.)

Recommendation(s)**:** The Adult Social Care Cabinet Committee is asked to **CONSIDER** and **ENDORSE** or make a **RECOMMENDATION** to the Cabinet Member on the proposed decision (Attached as Appendix A) to:
a) **AGREE** to formalise existing arrangements with Hilton Nurse Partners in the short term, procured through a KCC single sourced contract;
b) **AGREE** to enter into an adaptable framework agreement to cover the specification and procurement of a nurse led community service in the medium and longer term, alongside Homecare and Supporting Independence Service, from September 2017;
c) **DELEGATE** authority to the Corporate Director of Social Care, Health and Wellbeing, or other nominated officer, to undertake the necessary actions to implement the decision; and
d) **AUTHORISE** Officers to commence market engagement in readiness for the full procurement process, where required.

1 Introduction

1.1 The Adult Social Care Cabinet Committee received a report on 20 July 2017 which presented the approach to the social care new monies. One of the proposals for the High Impact Changes (HIC) was to progress a Nurse Led Community Service to support the Home First/Discharge to Assess (HIC4).

1.2 The NHS, working with local systems, identified a number of HICs that can support local health and care systems reduce Delayed Transfers of Care (DTOC).

1.3 In relation to HIC 4, the actions proposed by Officers is:
1. For additional investment in Pathway One (which is for people who are in hospital and go home with no extra support)
2. To invest in service commissioning to integrate the wider workforce (community support services such as home care and nurse led services)
3. Utilise opportunities from Phase 3 transformation with additional recruitment for enablement, technicians for adaptations/equipment across sector

1.4 As part of this an executive decision is needed to progress commissioning activity to support HIC 4.

2 Background

2.1 The former Adult Social Care and Health Cabinet Committee endorsed the Adult Social Care Strategy, Your life, your well-being in December 2016. The Strategy is based on the Care Act 2014. Under this Act not only is there a responsibility towards adults with care and support needs and their carers, but also a broader responsibility to promote the wellbeing of adults living in the area. This should help prevent some needs arising in the first place and delay their development.

2.2 The Council is already working with partners in developing new ways of doing things, with the aim of breaking down the barriers between organisations when they get in the way of better care and support. This includes the NHS, and the Your life, your well-being Strategy is part of the broader process of joining up health and social care under the NHS Five Year Forward View.

2.3 The Your life, your well-being Strategy provides the best opportunity to establish the right pathways and develop new ways of working to deliver a sustainable service, whilst keeping people at the heart of everything we do. It also allows us to align activities and services for full integration with the NHS by 2020.

2.4 To enable the delivery of Your life, your well-being, a range of community based services need to be completely redesigned along with a thorough review of what the Local Authority can do and what can be delegated to bring efficiency and better outcomes to people in need of social care services and support.

2.5 There are a number of synergies between all community support services and commissioning intentions through Transformational design that the requirement of an executive decision seeks to continue, through regularising contractual activity with the service provider of the Discharge to Assess service, under HIC 4. Furthermore, a full competitive tender will be required in due course to make sure that services are integrated and offer best value for the Kent taxpayer.

3 Current position

3.1 A nurse led community service was set up initially as a pilot in East Kent to see whether it could positively impact the numbers of DTOC attributed to social care. The service was set up in response to a crisis in hospitals and a letter received from the Director General of Social Care for Local Government and Care Partnerships, providing Kent with a ring-fenced pot of £520k.

3.2 The ‘specification’ for the service was initially developed as a proposal received from an invitation to deliver services to support reduction of DTOC from the ‘John Rouse’ monies in January 2015. Following initial discussions with the Councils Procurement division, it was agreed that the emergency procedures could be used to establish a response to the monies in order to enable the rapid provision of new services. To this end an email was sent to all home care providers and, for East Kent, only one response was received, from “Hilton Nursing Partners” (Hilton). Hilton developed a proposal to take forward the challenge to reduce DTOCs and worked with the Council to establish the service. The arrangements have not been formalised since this exercise.

3.3 Homecare contracts, when tendered, were for one year plus two further one year extensions which were extended in one go at the time due to certainty needed to attempt to address the significant issues experienced by the sector. In order to align these services to Adult Social Care transformational activity, the Cabinet Member for Adult Social Care took an executive decision to extend the existing arrangements, with some key variations and the ability for mini competitions where needed with the end date of this arrangement as 31 May 2019. Extensive discussions took place with providers at the time and the feedback was generally that:

- Many providers would be unlikely to tender for such a short period due to costs incurred during the tender with no guarantee of business.
- Service users would have to transfer to new provider(s) with the potential of having to transfer again within a short period of time.

3.4 This is less relevant for the nurse led ‘Hilton’ service as it is a short term service designed for people to either move home from hospital without ongoing support, re-start any existing care arrangement or start a new longer term service, however the risks in destabilising the service at the point where the measures for the eligibility of the additional social care monies are considerable and as such, this report seeks to award, via single source, proper and effective contractual arrangements with the ‘Hilton’ service and run alongside a procurement plan to establish a service that has been competitively tendered.

3.5 The significance of referencing the Homecare work is that, through Transformation, the pilots and design work are testing the capacity and capability of the market to deliver professionally led, integrated services, of which this is one. Additionally, the provider engagement activity will be with a whole range of providers, many are known Homecare providers, who could also be interested in this opportunity.

3.6 The Care Act 2014 provides greater flexibility for the Local Authority to delegate tasks to others to carry out on behalf of the Local Authority and this is being considered as part of the Design Phase alongside the greater focus on wellbeing and prevention. This lends itself to being able to break down barriers between services and focus on competences to create a more effective, integrated workforce across a range of organisations. Only by changing the views on the workforce will the current staff challenges be addressed and capacity created to deliver better outcomes.

3.7 Commissioners have reflected on the recent and ongoing conversations with stakeholders and the need to target the new monies for market sustainability and HIC and propose:

1. To continue to use existing arrangements with Hilton Nurse Partners in the short term, procured through a formalised KCC single sourced contract,
2. To enter into an adaptable framework agreement to cover the specification and procurement of a nurse led community service in the medium and longer term, alongside Homecare and Supporting Independence Service (SIS) from September 2017; and,
3. Undertake market analysis and engagement to ensure sufficient capacity is available against this framework from October 2017 and embed the service activity with Phase 3 transformation for Outcome Based Care.

4. Financial Implications

4.1 The financial implications of this decision are still being finalised. Total spend to date from Kent County Council to Hilton Nurse Partners is £950k. It is estimated that the increased activity in a nurse led community service across the whole county will be £3.3m per annum, however to establish contracting arrangements in the interim period, this could be between £825k and £1,650k (3-6 months pending discussions with the agency), which might be below the threshold for an executive decision. However, there may need to be some flexibility to this so as to not destabilise service provision in the short term and preparations are being made for this to be an executive decision.

4.2 The most significant legal risk to the establishment of these contracts is that the Council is likely to be operating outside of the procurement regulations. This is because there is a risk that the continuation of the arrangement should have been the subject of competitive tenders. As such the continuation could be open to a range of challenges from providers and service users. Should these challenges be successful, the continuation of the contracts may be set aside or shortened and compensation may be payable to aggrieved parties. Appendix one (exempt) provides further information. Although not obviating the risk

entirely, it is believed that this risk may be mitigated through partial reliance on provisions within the procurement regulations, clear communication and sharing more widely of the opportunity to work with the Council and its NHS partners in developing and designing a new approach. This will be very transparent and market engagement events, due to commence in line with full procurement to October 2017, will be very open to make sure that all questions are answered so the new service delivery and contractual requirements are fully understood.

4.3 If, in implementing this decision it becomes apparent that elements of this may need re-phasing or amending, the Corporate Director will do this in consultation with the Cabinet Member.

4.4 Withdrawal of these services would compromise all statutory duties under the Care Act 2014 and eligibility of the new monies in reducing the DTOC figures across the county.

5 Legal Implications

5.1 There are significant inherent legal implications from this approach. Legal advice has been sought which is legally privileged and therefore attached as an exempt appendix (Appendix 1) to this report.

6 Equalities Impact Assessments

6.1 An Equalities Impact Assessment will be completed for the new service design as part of the Transformation Programme. For this arrangement, service users would receive continuity in service provision, pending any planned activity for review.

7 Recommendation

7.1 Recommendation(s)**:** The Adult Social Care Cabinet Committee is asked to **CONSIDER** and **ENDORSE** or make a **RECOMMENDATION** to the Cabinet Member on the proposed decision (Attached as Appendix A) to:
a) **AGREE** to formalise existing arrangements with Hilton Nurse Partners in the short term, procured through a KCC single sourced contract;
b) **AGREE** to enter into an adaptable framework agreement to cover the specification and procurement of a nurse led community service in the medium and longer term, alongside Homecare and Supporting Independence Service, from September 2017;
c) **DELEGATE** authority to the Corporate Director of Social Care, Health and Wellbeing, or other nominated officer, to undertake the necessary actions to implement the decision; and
d) **AUTHORISE** Officers to commence market engagement in readiness for the full procurement process, where required.

8. Background Documents

County Council budget report 25 May 2017
https://democracy.kent.gov.uk/documents/b18097/Item%2012%20-%20Revised%20Budget%20201718%20and%20Medium%20Term%20Financial%20Plan%202017%20-20%2025th-May-2017%2010.00%20Count.pdf?T=9

Integration and Better Care Fund Policy Framework 2017-2019
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/607754/Integration_and_BCF_policy_framework_2017-19.pdf

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Appendix A

KENT COUNTY COUNCIL – PROPOSED RECORD OF DECISION

DECISION TO BE TAKEN BY: **Graham Gibbens** **Cabinet Member for Adult Social Care**	DECISION NO: 17/00066

For publication

Key decision
Affects more than 2 Electoral Divisions and expenditure of more than £1m

Subject: Approach for Social Care Monies – Progressing High Impact Change 4 – Nurse Led Community Service

Decision: As Cabinet Member for Adult Social Care, I propose to:
a) AGREE to formalise existing arrangements with Hilton Nurse Partners in the short term, procured through a KCC single sourced contract, and;
b) AGREE to enter into an adaptable framework agreement to cover the specification and procurement of a nurse led community service in the medium and longer term, alongside Homecare and Supporting Independence Service, from September 2017.
c) DELEGATE authority to the Corporate Director of Adult Social Care and Health, or other nominated officer, to undertake the necessary actions to implement the decision.
d) AUTHORISE Officers to commence market engagement in readiness for the full procurement process, where required

Reason(s) for decision: The proposed decision supports Kent County Council's vision to:

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

And supports the three themes set out in Your life, your well-being a vision and strategy for adult social care 2016-2012 to:

- Promote well-being
- Promote independence
- Support independence

Financial Implications
The financial implications of this decision are still being finalised. Total spend to date from Kent County Council to Hilton Nurse Partners is £950k. It is estimated that the increased activity in a nurse led community service across the whole county will be £3.3m per annum, however to establish contracting arrangements in the interim period, this could be between £825k and £1,650k (3-6 months pending discussions with the agency), which might be below the threshold for an executive decision. However, there may need to be some flexibility to this so as to not destabilise service provision in the short term and preparations are being made for this to be an executive decision.

Equality Implications
An Equalities Impact Assessment will be completed for the new service design as part of the Transformation Programme. For this arrangement, service users would receive continuity in service

provision, pending any planned activity for review.

Legal Implications

There are significant inherent legal implications from this approach. Legal advice has been sought which is legally privileged and therefore attached as an exempt appendix to recommendation report.

Cabinet Committee recommendations and other consultation:

The proposed decision will be discussed at the Adult Social Care Cabinet Committee on 20 July 2017 and the outcome included in the paperwork which the Cabinet Member will be asked to sign.

Any alternatives considered:

None

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

....

Signed date

By virtue of paragraph(s) 3 of Part 1 of Schedule 12A
of the Local Government Act 1972.

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From: Graham Gibbens, Cabinet Member for Adult Social Care

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

To: Adult Social Care Cabinet Committee – 20 July 2017

Subject: **ADULT SOCIAL CARE – SOCIAL VALUE FRAMEWORK**

Classification: Unrestricted

Past Pathway of Paper: None

Future Pathway of Paper: None

Electoral Division: All

Summary: This paper presents the Adult Social Care – Social Value Act Framework to the Adult Social Care Cabinet Committee

Recommendation: The Adult Social Care Cabinet Committee is asked to **NOTE** the co-productive approach taken to develop the Adult Social Care – Social Value Framework and **ENDORSE** its use in all commissioning activity.

1 Introduction

1.1 The Public Services (Social Value) Act came into force on 31 January 2013. It requires people who commission public services to think about how they can also secure wider social, economic and environmental benefits.

1.2 The Act states that before they start the procurement process, commissioners should think about whether the services they are going to buy, or the way they are going to buy them, could secure these benefits for their area or stakeholders.

1.3 The Act is a tool to help commissioners get more value for money out of procurement. It also encourages commissioners to talk to their local provider market or community to design better services, often finding new and innovative solutions to difficult problems.

1.4 To support implementation of the Social Value Act and help embed the Act within commissioning authorities practice the Cabinet Office announced a small fund for Social Value Act - Implementation and Measurement Projects. The Strategic Commissioning Division along with the Skillnet Group put in a joint bid to this fund with the emphasis of co-producing guidance for commissioning staff to use.

1.5 The bid was successful, one of only eight sites chosen nationally, the feedback received was one of the reasons the bid was successful was because it was 'sector-specific' in focusing solely on adult social care.

2 Policy Context

2.1 KCC strategic Statement, ***Increasing Opportunity, Improving Outcomes*** states the need to maximise social value from the services commissioned: KCC services have a social purpose and therefore the Council must become smarter at determining social value through the commissioning process, especially where it is seeking to leverage social value through the commissioning of services from external providers (for example, in the form of requiring providers to take on apprentices).

2.2 Principle 9 of KCC Commissioning Framework is ***We Will Maximise Social Value.*** That we will plan how to maximise the community benefits through any commissioning activity that is being undertaken. The same considerations of social value will apply to all commissioning that undertaken, the focus will be on social value priorities that are most relevant to the Council and from the earliest possible stage, as a standard part of designing and specifying any KCC service, social value outcomes will be incorporated and consideration given as to how equality can be advanced, where relevant and in a proportionate way.

2.3 Although only required to comply with the Social Value Act when procuring services above the threshold value, the Council's commitment to maximising the community benefits of its expenditure means the same considerations will apply to all commissioning undertaken, for goods and services. The way these considerations apply will differ from case to case, however the commitment to improve the economic, social and environmental well-being of Kent will be consistent.

3 Key Issues

3.1 Although as evidenced above utilising the Social Value Act in commissioning activities is central to KCC Strategic intent and commissioning approach, there was no formal guidance on how to use the act to full effect. Commissioners were using social value but often as, an add on, the last question in a tender; "tell us what you will do to add social value". Commissioners need to be more creative and really think how they can use the act to create wider outcomes in all commissioning activity.

3.2 As part of our Care Act market shaping responsibilities the Council has a duty to help shape care and support markets across Kent. Taking a co-productive approach to developing a framework for the social value act is the most appropriate approach to understand from both providers and end users what social value means to them and how we might best work together to create the best added value through our commissioning endeavours.

3.3 The framework (attached as Appendix 1) is based around the commissioning cycle with guidance about how to consider and maximise social value throughout all commissioning activities.

3.4 The work was supported from within strategic commissioning with support from procurement and strategic and corporate services, with Clare Maynard, Procurement Category Manager, Craig Merchant, Procurement Manager, and Felicity Adams, Business Manager, being part of the core development team.

3.5 The framework was completed and agreed fit for purpose and use by the Social Care Health and Wellbeing Directorate Management Team in November 2016. Commissioning staff have been using the framework since then. Following discussions with senior officers and the Cabinet Member this is being presented to the Adult Social Care Cabinet Committee for their information.

4 Recommendations

4.1 Recommendations: The Adult Social Care Cabinet Committee is asked to **NOTE** the co-productive approach taken to develop the Adult Social Care – Social Value Framework and **ENDORSE** its use in all commissioning activity.

5. Background Documents

None

6. Lead Officer

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TOGETHER FOR SOCIAL VALUE

A SOCIAL VALUE FRAMEWORK FOR ADULT SOCIAL CARE

FOREWORD

I am delighted to introduce 'Together for Social Value', a framework for Social Value in Adult Social Care. This will be a key document for our commissioners, supporting them to use the Social Value Act to achieve the best possible outcomes for the people of Kent, as defined in our Strategic Statement: *Increasing Opportunities, Improving Outcomes*.

Back in 2012, the findings of the County Council Select Committee looking into commissioning was published: *Better Outcomes, Changing Lives, Adding Social Value*. It recognised how important the Social Value Act was in achieving better outcomes and also ensuring that the added value of local voluntary and community organisations and small businesses was not lost as services were commissioned.

Kent County Council (KCC) has shown its commitment to commissioning for Social Value at a strategic level by applying Social Value criteria to all our contracts, not just those above the EU Procurement Threshold. We did this because we see the Act as one of the primary means by which we can support and work in partnership with local providers.

I recognise we still have a way to go to fully utilise the Act's potential, and that there are a number of barriers to overcome. We need to raise awareness and understanding. Commissioners must know how and what to ask for. In response, providers must know how to evidence and articulate the Social Value they already provide and how they could lever more into their provision. This document will be central to establishing that shared understanding. I am sure it will be a cornerstone for great things.

I would like to take this opportunity to thank all those who took part in the co-production work that underpinned the development of this framework, particularly Matt Clifton from Skillnet Group CIC who co-ordinated the project and the Cabinet Office who funded the project.

Graham Gibbens
Cabinet Member for Adult Social Care

INTRODUCTION

'Together for Social Value' expresses the shared goal of commissioners, providers and people who receive care and support to make as much of a difference as possible through the money KCC spends to achieve Adult Social Care outcomes. This goal calls us all to think creatively, beyond primary outcomes for people who receive care, about using all of our resources to achieve other kinds of positive changes for people and places in Kent.

To give a straightforward example, a primary social care outcome may be greater well-being for older people with dementia. The Council could simply buy a service to deliver this. However, a provider may also be able to give jobs, work experience and volunteering in their service to disadvantaged young people, making a difference to their lives too. This extra benefit, or demonstrable Social Value, can often be added by resourceful providers at no extra cost to the public purse. In some cases, added Social Value might even be worth paying extra for, if it maximises the impact public spending can achieve.

There is no limit to the creative ways in which Social Value can be achieved, for example:

- A service delivering hot meals might add Social Value by delivering library books or checking smoke alarms at the same time.

- KCC's Homecare contract is now delivered in small geographical lots instead of through a large County-wide service. This means more local providers are used, reducing the travel distance to reach clients and incentivising travel by foot or bicycle. This adds Social Value by benefitting local employment, the environment and health. Reducing car travel reduces air pollution, estimated to have caused 1050 early deaths in Kent and Medway during 2011.

This framework is intended to inspire and equip commissioners, providers and people who receive care and support to work together as equals to think firstly about outcomes for people who need adult social care, and then imagine added outcomes, or Social Value, that could be achieved for those same adults, or other people and their communities - benefitting Kent economically, socially and environmentally. Working

together as equals is captured in the term co-production. We will maximise Social Value when the insights of all three groups contribute to what is commissioned.

DOCUMENTS THE FRAMEWORK RELATES TO

Since Social Value is about better outcomes for Kent, the framework serves the outcomes defined in the Strategic Statement: *Increasing Opportunities, Improving Outcomes*.

With Adult Social Care situated within all of KCC's commissioning activity, this framework advances principle 9 of the Commissioning Framework: "We will maximise Social Value."

Commissioners should use KCC's FAQ for commissioners: Using Social Value for more detailed guidance alongside this framework, especially when thinking about Social Value throughout the Commissioning Cycle.

HOW THE FRAMEWORK WAS DEVELOPED

Strategic Commissioning in Adult Social Care and Skillnet Group CIC successfully bid for funding from the Cabinet Office to carry out this work, as one of eight Social Value Implementation and Measurement projects across the UK.

This framework has been co-produced by adult social care commissioners, providers and people who receive care, in a process led by Skillnet Group CIC, a social care provider. The centrepiece of the framework's development was a high profile multi-stakeholder workshop held in February 2016.

At this workshop 90 delegates gathered, representing providers across the private and voluntary, community and social enterprise (VCSE) sectors, covering older people, learning disability, physical disability, mental health and physical health, and included VCSE infrastructure support organisations and freelance consultants. Through providers inviting guests, there was strong representation from people who receive care across those same sectors. Delegates received a draft outline framework in advance of the workshop, which meant their input on the day, and in subsequent feedback, was deeply influential on the final text.

WHO THE FRAMEWORK IS FOR

Adult Social Care Commissioners and Procurement Officers should use this framework as a guide to embed Social Value throughout the commissioning cycle. While its immediate application is commissioned services, the framework's approach should extend beyond contracts to grant funding and aspects all partnership working. Social Value outcomes can be achieved by supporting services funded from other sources or contracted by other organisations.

Adult Social Care Providers should use this framework to guide their identification of the Social Value they already achieve, and their imaginative use of resources to create more Social Value. Providers who are deeply committed to maximising Social Value should feel valued by this framework. It will guide providers as they engage with commissioning and respond to opportunities. The framework embraces providers across the public sector (provision by Kent County Council), private sector and VCSE sector.

People who receive care and support are also encouraged to use this framework to influence what kind of differences providers make. When people who receive care, and other beneficiaries such as volunteers, are given a voice as Trustees, Directors or representatives in advisory forums, this supports social wellbeing and confidence, which has Social Value benefits and providers gain stronger insights into what kind of care works. An easy read version of this framework is available to support this.

Providers and people who receive care alike should see this framework as a means to

> ***"hold all services to account for the delivery of KCC's strategic outcomes"***

(Principle 6 of the Commissioning Framework), including maximising Social Value.
KCC Members will also be interested know about the Framework and importantly in understanding the part it can play in the decisions-making process of the council, given that the Framework relates well with significant policy documents of the authority such as the KCC Strategic Statement and Commissioning Framework.

THE PUBLIC SERVICES (SOCIAL VALUE) ACT 2012

The vision to make as much of a difference as possible when buying public services is reinforced by the Public Services (Social Value) Act, which became law at the end of February 2012. Under Subsection 3, KCC must consider:

(a) how what is proposed to be procured might improve the economic, social and environmental well-being of the relevant area, and
(b) how in conducting the process of procurement, it might act with a view to securing that improvement.

As brief examples, economic well-being could include creating jobs; social well-being could mean reducing social isolation; environmental well-being could be advanced by using less and cleaner energy. These categories are deliberately broad; there is no definitive list of Social Value benefits. This gives commissioners and providers freedom to respond innovatively to local needs.

"Relevant area" means the geographical area KCC is responsible for, so Social Value must mean outcomes for Kent. A provider may have impressive corporate social responsibility commitments, for example donating old IT equipment to a developing country, but if they do not serve Kent, they cannot be counted as Social Value under the Act.

Social Value must be ***relevant*** **and** ***proportionate*** to the core public service being procured (Subsection 6). In the Introduction's simple opening example, a contractor caring for older people with dementia is also creating opportunity for disadvantaged young people. Because those opportunities relate to the care service, they are relevant Social Value outcomes. They are also proportionate, because it is reasonable to expect a provider to create such opportunities within their service. On the other hand, it would be irrelevant and disproportionate, for example, for a small care service in West Kent to be expected to add Social Value by creating opportunities in Thanet, far away from their work and local connections.

The Act requires KCC to consider Social Value only when the contract value is higher than the threshold at which it must be advertised in The Official Journal of the European Union (OJEU). However, to make as much of a difference as possible, in its Commissioning Framework, KCC has committed to considering Social Value for all commissioning (see principle 9: "We will maximise Social Value").

WHAT SOCIAL VALUE MEANS WHEN ADULT SOCIAL CARE IS COMMISSIONED

'A LIFE NOT A SERVICE' - TRANSFORMATION IN ADULT SOCIAL CARE

Adult Social Care in Kent is undergoing transformation, on the basis that people should be supported to live full and active lives in their own communities, and that community-based support for well-being will help them maintain their independence at home.

The strapline of this transformation is **'a life not a service'**. Support needs to be more personalised to enable people to achieve the outcomes that matter most to them. Whereas historically, Adult Social Care has commissioned 'a service', Adult Social Care is now on a journey to commission for **'outcomes'**.

This illustration shows the approach, which puts the individual at the centre of all care, looking for ways to support their lifestyle and keep them engaged and connected to the things that matter to them:

This reflects a new requirement that the Care Act 2014 has placed on local authorities to ensure services are available to people which prevent, reduce or delay entry into social care. People using services and their carers have high expectations and rightly want to lead full and rewarding lives, but we know poor health and social isolation are factors that lead people to require on-going services. Adult Social Care will work with individuals, their families and providers to consider not only the support people need for a particular life-stage, but how their needs might change throughout the course of their life, so that support is more responsive to emerging needs.

At the same time, untapped power and strength lies within the communities that people live in. As well as empowering individuals to take more responsibility for their own health and well-being, Adult Social Care is seeking to empower and build capacity

within communities to support social action. This means the development of networks of relationships for mutual support, utilising community-owned facilities and harnessing the goodwill, resilience and drive of people in communities to enable the most vulnerable among them.

A DEFINITION OF SOCIAL VALUE OUTCOMES IN ADULT SOCIAL CARE

In the context of adult social care commissioning for outcomes for people who need care and support, Social Value outcomes can be broken down into four categories:

1. **Outcomes for adults receiving social care *over and above* their outcomes from core delivery**

   An example of this could be a beneficiary of mental health services moving into a provider's workforce, using their first-hand experience to support others and train colleagues. It could mean a beneficiary being supported to become a Non-Executive Director or Trustee of the provider organisation. Such roles and opportunities are likely to increase well-being for those beneficiaries, as well as bringing expertise by experience to a provider's team or governance.

   If these outcomes are innovations that are currently the exception, not the norm, they may be suited to becoming standard good practice in future, moving from Social Value outcomes in this commissioning cycle to Core Delivery outcomes in the next, as a result of the Review phase (see CO-PRODUCING SOCIAL VALUE OUTCOMES THROUGHOUT THE COMMISSIONING CYCLE below).

2. **Outcomes for other people who benefit from engaging with adults receiving social care**

   The introduction contained an example of this kind of Social Value outcome, in which disadvantaged young people benefit from the chance to support older people with dementia. A contract reserving places for apprentices who are looked-after children or interns with learning disabilities in its care workforce would be another example. Unpaid volunteers typically benefit in this way, especially if the chance to volunteer reduces social isolation. This kind of benefit should be sought by

commissioners and measured by providers, not crudely as simple numbers of volunteers or the salary cost equivalent if they were paid (outputs), but in the changes that take place for them through volunteering (outcomes).

3. **Outcomes for other people and communities in Kent beyond those who engage regularly with the social care service**

   Some providers and the people they support find powerful ways of working together to achieve wider impacts on their communities. For example, a learning disability day service might organise regular visits to schools to educate pupils on what it means to have a learning disability, and how people want to be treated. As well as serving strong core outcomes in confidence and skills for people with learning disabilities, the schoolchildren's learning is an added Social Value outcome.

4. **Outcomes for Kent's environment and economy**

   Wider environmental and economic benefits can also enhance core outcomes for people. For example, a service supporting people to live independently in their own homes is likely to reach people living in fuel poverty, unable to afford to heat their homes adequately. If this service arranges a retrofit of insulation to those homes, this achieves the double impact of reducing fuel poverty and reducing CO_2 emissions, which is added environmental Social Value.

HOW SOCIAL VALUE OUTCOMES WILL BE DEVELOPED

PRINCIPLES FOR DEVELOPING SOCIAL VALUE OUTCOMES

The Social Value Act is deliberately flexible, giving public bodies like KCC freedom to determine what best suits local needs and providers the opportunity to innovate.

When commissioners, providers and people who receive care came together in the Social Value workshop and thought about how Social Value should be co-designed in the pre-procurement phase, the following principles emerged from the discussion:

1. **The goal of achieving Social Value outcomes must never compromise the quality of core delivery of a service.**

   This principle recognises that the quality of the core service is paramount. Social Value goals could be ambitious in a way that compromises this. For example, excessive dependency on volunteers or apprentices could mean a reduction in delivery by a skilled, qualified workforce. When shaping Social Value outcomes, commissioners should ask providers if they will risk compromising quality.

2. **Expectations of Social Value should be ambitious, but also tempered by awareness of the capacity of providers and the pressures they are under.**

   Some providers already feel they are expected to do more with less, increasing pressure and weakening their organisation. The best kind of Social Value recognises that resources are limited and thinks imaginatively about how to make the most of them to change lives. During market engagement, providers should feel they are encouraged to raise concerns about the potential of Social Value goals to overstretch their resources.

3. **Expectations of Social Value should be attentive to the socio-economic landscape providers operate in**.

   For example, the hope of vulnerable adults achieving paid work will be influenced by local jobs markets. This may mean there are fewer opportunities in some areas of Kent.

4. **Social Value outcomes should not be so prescriptive and narrow as to inhibit innovation from providers.**

   The key to getting the balance right between prescribing Social Value strategically and promoting innovation lies in the careful use of both specified requirements and open questions in the evaluation of bids. These ensure providers are able to demonstrate how their service goes beyond the specification into the delivery of Social Value. See the next section for guidance. As with core delivery, commissioning for Social Value should seek measurable outcomes, not outputs, and take care not to prescribe rigidly the means of achieving outcomes.

5. **Relationships are essential to strong Social Value outcomes, which means providers must have the ability to connect people with each other, with their local communities and with the opportunities other organisations offer.**

   Social Value outcomes should promote partnership-working and collaboration, acknowledging that competitive markets can divide providers from each other.

6. **In larger contracts with supply chains, Social Value outcomes should promote equal access for small and medium-sized organisations (SMEs).**

   As a benchmark, in August 2015, central government set a target that, by 2020, a third of government spending will be with SMEs, directly or through the supply chain. For example, the subdivision of a large service into small geographical lots supports small providers who are rooted in their local community, with access to local knowledge and resources. This strengthens local economies and local employment, leading to Social Value outcomes. Indeed, under the Public Contracts Regulations 2015, Regulation 46(2), KCC is required to explain why any decision was taken not to subdivide a contract into lots to encourage access for SMEs. See below on 'Market Shaping' under the Care Act 2014.

SPECIFIED REQUIREMENTS AND OPEN QUESTIONS

Before commencing the procurement process and issuing tender documentation, commissioners will engage providers and people who receive care to co-design the Social Value outcomes that will be sought alongside core social care outcomes.

Market engagement events are good opportunities to think together about Social Value. At the same time, providers will have their own ideas and methods, and may not want to disclose these before they tender. This suggests the need for two ways of asking bidders in the tender documentation about the Social Value they will deliver:

1. **Specified Requirements**

   The award criteria questions will specify the co-designed Social Value outcomes required by the service, asking bidders how they will deliver them.

   The **advantages** of using specified requirements are that they:

   - Have been co-designed beforehand, and have therefore been shaped by a wide range of insights.
   - Achieve a consistency of response in tenders. This ensures transparency and equity in the evaluation, making it more objective and structured.
   - Are easier to explain to providers who are unfamiliar with Social Value.
   - Are more likely to be delivered, according to the experience of authorities experienced in implementing the Social Value Act.

   The **disadvantages** of using specified requirements are that they:

   - Are less likely to challenge bidders to exceed Social Value targets and deliver over and above those requirements if they are too prescriptive.
   - May lead to seeking outputs, not outcomes, when providers may have more effective ways of securing the outcomes sought.
   - May inhibit innovation from providers who have a Social Value offer not revealed or anticipated during the co-design process.

   An example specified requirement question:

As added Social Value, the authority wishes to see at least three young people who face disadvantage achieve the outcome of high quality, sustained, paid work. Describe the steps that will be taken to ensure that at least three new social care apprenticeships or sustainable job starts (minimum six months) will be created during the lifetime of this contract.

Commissioners should use their understanding of the provider market to ensure that prescribed and specified Social Value outcomes do not inadvertently exclude high quality providers who may struggle to fulfil them, or inhibit innovation from providers who have a unique Social Value offer.

2. Open Questions

The award questions outline the broad areas in which KCC is seeking Social Value, inviting bidders to respond by specifying their own outcomes and how they would achieve them. An open question should ask the provider how Kent's people and communities have been involved in determining their proposed outcomes and methods.

The **advantages** of using open questions are that they:

- Promote outcomes, not outputs, allowing providers to present their own methods for achieving them.
- Give opportunity to providers to use their creativity and expertise to offer outcomes and solutions that were not anticipated before inviting them to tender.
- Allow VCSEs to champion the Social Value they bring to their communities, which may not match specified requirements.
- Can encourage providers to deliver 'above and beyond' for Social Value, creating a greater and potentially more diverse range of benefits.

The **disadvantages** of using open questions are that they:

- Are likely to lead to different kinds of Social Value offers in competing tenders. These are very difficult to assess comparatively, meaning evaluations will be more subjective and less structured.
- May lead to Social Value offers that are not as closely aligned with KCC's strategic priorities as specified requirements, because they were not co-designed with commissioners.

- Invite outcomes that may not have been co-designed with beneficiaries, which is why it is important to ask about this in the open question.

An example open question:

Describe how KCC's priority of Local Employment will be advanced through added Social Value. This means the creation of local employment and training opportunities. The answer should define the local employment outcomes you will achieve, supported by detail of how and when they will be delivered, and how they will be measured and evidenced. Please also explain how Kent's people and communities have been involved in determining your outcomes and methods.

Given the advantages and disadvantages of each kind of question, the best outcomes are likely to be secured by using both. Co-designed specified requirements could be listed first, inviting a response, followed by a standard open question inviting additional innovation from providers. Based on the judged importance of specified requirements, the scoring of answers could be weighted in the evaluation of tenders, for example assigning 60% of the score to specified requirements, and the remaining 40% to additional outcomes offered in response to an open question.

EVALUATING SOCIAL VALUE IN TENDERS

It is important to note that any specified Social Value required from providers can only contribute to the scoring of a tender if it is relevant, i.e. related to the core outcomes sought by the contract.

This means required Social Value outcomes should arise directly from the same delivery that achieves core outcomes. For example, a contract to supply equipment to enable adults with disabilities to live independently would struggle to establish the relevance of requiring apprenticeships. Another example is a requirement to pay the Living Wage calculated by the Living Wage Foundation. It brings demonstrable social benefits, but it would be difficult to argue that it relates to the core outcomes of any contract. If a commissioner wants any kind of required Social Value to be taken into account in an evaluation, it must be supported by outcomes documented in KCC's strategic priorities and policies, central to which is the Strategic Statement: *Increasing Opportunities, Improving Outcomes*. On the other hand, Social Value offered in response to an open question can be scored, which is the approach KCC has usually taken.

KCC may ask a provider to deliver additional social benefits that are not considered or scored as part of a tender evaluation, but which are included as requirements of a contract and will be monitored by the commissioner. These are known as ‘performance indicators or key performance indicators (KPIs)’, and will be detailed in the contract management schedule of the tender documentation. Any such performance obligations need to have been co-designed with providers and people who receive care in the stages leading up to the final tender submission.

KCC’s Procurement team have developed a standard evaluation template giving a menu of options to best fit an Invitation to Tender. This offers the choice to score Social Value separately once a bid has met a minimum quality and price threshold, which helps ensure Social Value comes within the commission’s budget. Alternatively, Social Value can be embedded into the questions asked about the quality and price of core social care outcomes, and contribute to the scores given to answers to those questions.

For more guidance on the best approach to evaluating Social Value, commissioners should refer to Question 5 of the FAQ for commissioners: Using Social Value and consult their procurement Category Manager.

As a guideline, a survey of leading local authorities on Social Value such as Croydon, Bristol and Knowsley suggests that added Social Value typically accounts for 10% of the total score, with the remainder apportioned as normal between quality and price.

CO-DESIGNING SOCIAL VALUE OUTCOMES

While Social Value outcomes will vary from service to service in adult social care, they should be influenced by the following sources:

KENT'S FIVE SOCIAL VALUE PRIORITIES

KCC has set five priorities for Social Value across all its commissioning activity. These are set out in principle 9 of the Commissioning Framework. Delegates at the Social Value workshop outlined what matters most within these priorities when commissioning Adult Social Care:

Local Employment: *the creation of local employment and training opportunities.*

Delegates highlighted that employment and work experience for people who receive care is very significant for well-being, and should be central to Social Value outcomes wherever possible.

Buy Kent First: *buying locally where possible to reduce unemployment and raise local skills (within the funding available and whilst minimising risk to KCC).*

Delegates suggested that a commitment to buy from Kent businesses and social enterprises that employ disadvantaged people could be a means to benefit other people who receive care beyond the core beneficiaries of a service.

Community Development: *the development of resilient local community and community support organisations, especially in those areas and communities with the greatest need.*

Delegates valued approaches that feature co-production, placing people who receive care as equals and leaders in the services that support them. Commissioned services should enable people to build the confidence and experience to influence decision-making in provider organisations, support their peers and contribute to their communities. Commissioning should also enable communities to be more resilient: able, for example, to recover quickly from severe weather.

Good Employer: *support for staff development and welfare within providers' own organisations and within their supply chain.*

Commissioners should expect policies and practices that support the well-being of the workforce, with investments in skills, training and supportive supervision and appraisal. Sometimes employees are also unpaid carers of relatives or other vulnerable people, through fostering for example. The provider should use policies that affirm and support such commitments outside work. The Invitation to Tender can ask for these policies to be summarised or submitted in full. Delegates also proposed that raising the literacy and numeracy of care staff should be a Social Value priority, especially where employees were ill-served during their education.

Green and Sustainable: *protecting the environment, minimising waste and energy consumption and using other resources efficiently, within providers' own organisations and within their supply chain.*

To promote green and sustainable outcomes, commissioners will now expect providers to have achieved, or be working towards, Steps To Environmental Management (STEM) accreditation, or an equivalent.

Delegates suggested Social Value could mean supporting vulnerable adults to be energy-efficient to save money on energy and create warmer, healthier homes. It might also mean minimising the travel time between domiciliary care visits. Providers should also focus on efficiency savings by reducing their use of natural resources such as the energy used in buildings and vehicles, and water. Providers should also minimise waste, especially if it is non-recyclable.

Social Value outcomes within these priorities should be tailored to the specific needs of the Kent local communities in which outcomes are delivered. Providers should demonstrate knowledge of these local needs in their tenders, either through their own experience in those communities or through that of local partners.

THE STRATEGIC STATEMENT: ***INCREASING OPPORTUNITIES, IMPROVING OUTCOMES***

Because the Statement lists the high level outcomes for everything KCC does, it should be a central resource for planning Social Value that achieves or supports those outcomes. See also MEASURING AND REPORTING SOCIAL VALUE below. Of the three top-level strategic outcomes, the third describes what Adult Social Care seeks through core delivery:

- **Older and vulnerable residents are safe with choices to live independently.**

  As explained above in the definition of Social Value in Adult Social Care, this outcome can be enhanced through Social Value, for the same, or other, vulnerable people that a service supports.

Social Value also has the potential to serve the first two strategic outcomes:

- **Children and young people in Kent get the best start in life.**

  For example, a provider may form partnerships with schools, or offer work experience to young people.

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

  For example, a provider may commit to raising skills within their workforce, or take initiatives to protect Kent's natural environment.

The Statement details supporting outcomes under these three themes, with suggested measures for monitoring progress. These lend themselves for use by commissioners and providers to develop and measure Social Value. See also the last section of the framework: MEASURING AND REPORTING SOCIAL VALUE.

CO-PRODUCTION WITH PROVIDERS AND PEOPLE WHO RECEIVE CARE AND SUPPORT

Social Value outcomes should be developed in close collaboration with providers and people who receive care and support. Market engagement events and other initiatives to work together should therefore be accessible to the relevant vulnerable adults. For example, this might mean ensuring convenient access by public transport, or arranging

an easy read agenda for people with learning disabilities. As an example of doing this in practice, a representative group of people who receive care gathered during the Social Value workshop to discuss what kind of differences mean the most to them. Three main themes from their discussion should guide thinking on what kind of Social Value to commission. People value:

- **The chance to “give something back”.**

  Where possible, Social Value outcomes should mean people who are supported are enabled to contribute to their communities, or even become supporters themselves, for example as peer-mentors.

- **Influencing services as ‘experts by experience’.**

  People who receive care have first-hand experience of what does and does not work, often accompanied by an energetic passion to help improve services. Social value outcomes should feature opportunities for people who receive care as advisors, in monitoring quality, and even as Trustees or Directors.

- **Being employed.**

  Where it is achievable for people who receive care, paid work has powerful beneficial effects on independence, a sense of belonging and contributing, and on mental health.

It should be recognised that our ‘experts by experience’ at the workshop were all people whose degree of frailty and vulnerability did not present a barrier to attending and taking part. Their perspective therefore reflects the mild to moderate range of social care needs. There are many people with more acute needs for whom employment, for example, is out of the question – yet employment is an emphasis in the themes above. This highlights a limitation to the framework’s breadth of co-production. As far as possible, bearing in mind the implications for time and resources, co-production with providers should seek and include equally the perspective of the most vulnerable, hard-to-reach groups.

THE CARE ACT 2014

Social Value has the potential to advance the spirit of the Care Act. In particular, the development of Social Value outcomes should consider opportunities to promote:

- **Wellbeing**, which means people are enabled to build friendships and connections with others in their community. For example, a provider may create opportunities for disadvantaged, isolated people to volunteer within their commissioned service.

- **Prevention**, which means reducing the need for care and support of adults, and support of carers. For example, a service offering supported internships to young people with learning disabilities could help prevent the need for lifelong social care by enabling independence through employment at a young age.

- **Market Shaping**, advanced by facilitating a vibrant, diverse and sustainable market for high quality care and support, regardless of how the services are funded. For example, a lead strategic partner may commit to subcontracting a percentage of provision to small and medium-sized providers across the private and third sectors, and offer free or discounted training to those small partners.

OTHER SOURCES

As well as the above sources, commissioners also intend to work with providers to develop a 'suite of options' for Social Value outcomes, measures and financial proxies tailored for Adult Social Care, which can then be built into specifications. For a basic explanation of what is meant by 'financial proxy', see PRINCIPLES FOR MEASURING AND REPORTING SOCIAL VALUE OUTCOMES, principle 12, below.

It may be possible to achieve adult social care outcomes through Social Value commissioned in other KCC contracts. This would be the case for any KCC contract that creates opportunities for vulnerable adults. Conversely, adult social care could pursue Social Value in its contracts that serves the core outcomes sought elsewhere in KCC's commissioning activity. A requirement for social care apprenticeships would be an obvious example, especially if this serves KCC targets to reduce the number of young people not in education, employment or training (NEET). This potential calls commissioners to network across Directorates, championing the outcomes they are seeking and building awareness of commissioning across the Council. Directorate Business Plans include a requirement to list all commissioning activity planned for the

year ahead, offering a useful resource to identify potential links. For more guidance, see Question 9 of the FAQ for commissioners: Using Social Value.

CO-PRODUCING SOCIAL VALUE OUTCOMES THROUGHOUT THE COMMISSIONING CYCLE

KCC's Commissioning Framework explains the commissioning cycle in the course of outlining principle 2: 'A consistent commissioning approach to planning, designing and evaluating services.' Principle 3 commits to involving 'the right people' at 'the right stage' of commissioning. When commissioning adult social care, Social Value outcomes will be co-produced by commissioners, providers and people who receive care, as commissioners aim to ask the right questions at the right times during the cycle through means such as market engagement events and consultations. The outline cycle below highlights the key questions to ask.

High quality co-production, especially with vulnerable people, takes time. For example, an engagement event which is inclusive of people with learning disabilities may need more time than usual for each agenda item, and plenty of notice beforehand so arrangements can be made to support attendance. The analyse and plan stages in particular need careful advance planning with generous timescales so co-production is not rushed and compromised.

THE ANALYSE STAGE

KEY QUESTIONS FOR PROVIDERS AND PEOPLE WHO RECEIVE CARE AND SUPPORT:

"As we think about how to achieve the best outcomes for people who need care and support, what added differences can we make for them, other people, communities, the environment and economy at the same time?"

"Are there added differences this service has made that should now become standard practice for all providers of this care and support?"
This question is asked on the grounds that what begins as innovation has the potential to become standard good practice.

"Are there added differences currently being made that we risk disrupting or losing through recommissioning?"
The potential impact of disrupting or losing Social Value outcomes through recommissioning should be assessed within a co-productive approach to the analyse stage. For example, given that 'Good Employer' is one of KCC's five priorities for Social Value, will recommissioning adversely affect a workforce currently providing a service? Another example might be a new mentoring or buddy scheme that was created as added Social Value. Did it become a highly valued and needed service? If so, how can it be sustained? Should it now become a core requirement?

Responses to these questions will be included in the diagnostic report.

Commissioners will also analyse the potential for core outcomes to be achieved through Social Value in other commissioning activity and partnership working elsewhere in KCC.

THE PLAN STAGE

Potential Social Value outcomes from the diagnostic report will become provisional Social Value outcomes in the commissioning plan.

KEY QUESTIONS FOR PROVIDERS AND PEOPLE WHO RECEIVE CARE AND SUPPORT:

"How should the added differences we want to make be defined as specific Social Value requirements in this contract?"

"How should those requirements be measured and evidenced?"

Responses to these questions will be included in the service specification. They contribute to award criteria if they relate to the service.

During the plan stage, it is very important to think through potential risks arising from specifying required Social Value:

"Do these Social Value requirements risk compromising the quality of core delivery?"

"Do these Social Value requirements risk excluding any high quality providers from tendering?"

Responses to these questions may lead to modification of Social Value requirements.

Within overall consideration of contract length, commissioners should consider the potential of a longer contract to achieve strong, more sustained Social Value outcomes. In longer contracts, stronger and adaptable performance management may be needed to ensure Social Value is sustained throughout lifetime of the contract.

The award criteria will typically use both specified requirements and open questions (explained above in HOW SOCIAL VALUE OUTCOMES WILL BE DEVELOPED):

- Specified requirements already co-produced, and informed by other sources, to deliver strategic Social Value outcomes.

- Open questions to encourage additional innovation. Providers may prefer not to disclose their Social Value ideas and methods before tendering.

THE DO STAGE

CONTRACT MANAGEMENT

However strong the commitment is from commissioners and providers alike to achieving Social Value, there is always a risk that actual delivery falls short of the ambition expressed in a tender. Effective contract management using monitoring and review is essential to making it happen.

All Social Value outcomes and measurements need to be included in the contract. A distinction should be made between those required by the specification and those offered as additional Social Value by the provider in their tender. Where Social Value is a commitment from the provider in response to an open question, careful thought needs to be given to how this commitment will be measured and managed during the contract. Bidders should be asked to propose in their tender how this will be done.

In keeping with the principles for measuring and reporting Social Value outcomes, detailed below, key performance indicators (KPIs) should be drafted and agreed. They should reflect the importance of Social Value within the overall provision, be achievable, and as light-touch as possible in data collection requirements.

KEY QUESTION FOR THE CONTRACTED PROVIDER(S) AND PEOPLE WHO RECEIVE CARE AND SUPPORT:

"Are the Social Value outcomes in this contract still relevant? Should they be revised?"

The contract will integrate periodic Social Value reviews, encouraging compliance and recognising that needs and possibilities may change during the lifetime of the contract. Commissioners may include the requirement for an annual Social Value statement. Social Value reviews should contribute to a culture of ongoing partnership and co-production.

THE REVIEW STAGE

KEY QUESTIONS FOR THE CONTRACTED PROVIDER(S) AND PEOPLE WHO RECEIVE CARE AND SUPPORT:

"Are there added differences this service has made that should now become standard practice for all providers of this care and support?"

This precedes the same question to be asked more widely during the next analyse phase. Innovative Social Value promised and then proven during the contract will potentially multiply in impact if it can become standard practice, required in the next contract specification.

MEASURING AND REPORTING SOCIAL VALUE

As soon as work began developing the framework, it was clear there is no consensus in Kent among providers, and even among commissioners, on the best methods and tools for measuring social outcomes. As Kent's Voluntary and Community Sector Policy remarks in its section on Social Value:

> "KCC must become more sophisticated at determining the outcomes we wish to achieve and our priorities in relation to social value. But equally, providers must also get better at proving their social value contribution. The VCS and social enterprises are well placed to deliver social value, but articulating this presents a challenge. However, over time measures will mature as good practice is shared."

This reflects the fragmented picture across the UK. Lord Young's 2015 review of the Social Value Act remarked that "social value measurement lacks generally accepted techniques, standards (i.e. so that people know what to measure and when), and clarity around what commissioners want to see."

Given this difficulty, the Strategic Statement: *Increasing Opportunities, Improving Outcomes* offers a strong foundation for guiding approaches to measurement which are tailored for Kent. As outlined above in CO-DESIGNING SOCIAL VALUE OUTCOMES, the Statement presents three over-arching outcomes:

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

Each of these is amplified by several supporting outcomes, each in turn reflected in several suggested measures to track progress. These offer off-the-shelf Social Value indicators. For example, the primary outcome of economic growth has a supporting outcome of business growth through a well-skilled workforce. One of six measures suggested for tracking this is an increase in the number of working age people with vocational qualifications. This could be translated into Social Value through a requirement to upskill the provider's workforce through social care qualifications. This could be defined as a set number of employees achieving a qualification per set amount

of spending on social care within the contract, e.g. one qualification achieved for every £250,000 spent.

When analysing their existing Social Value and thinking about new possibilities, providers should use this statement as a reference if they are interested in tendering to deliver public services. Their presentation of Social Value in tenders should be aligned to the statement's outcomes and indicators.

Notwithstanding this foundation for measuring outcomes, even within adult social care, the variety of outcomes sought through commissioning calls for flexibility in how measures are designed. In the course of co-producing the framework, thirteen principles emerged to guide the development of measures and reporting that will be specific to a contract. They reflect a dialogue between commissioners and providers about respective needs, and apply as much to core delivery as to Social Value. They also seek to be attentive to the benefits and risks inherent in measuring outcomes.

PRINCIPLES FOR MEASURING AND REPORTING SOCIAL VALUE OUTCOMES

1. **Measures will be planned together with providers before they are specified.**

   This is a commitment to co-production and the insights it captures.

2. **Measures will be meaningful, which means they are directly related to the outcomes sought. We will value and measure the things that matter, not just the things that are easy to measure.**

   For example, measuring the number of apprenticeships created through a contract is easy. There are also methods and resources for estimating the financial savings to the public sector of an apprenticeship. However, the increase in well-being of those apprentices is the outcome that matters most. This is harder to measure, but there are proven methods to do it through asking careful questions about well-being before and after the apprenticeship. In the same vein, volunteering is often presented as added value through a total number of hours worked, perhaps with an associated financial value calculated using the minimum or living wage. But what did those volunteers do, and what difference did this make to themselves and others? It takes more effort to capture those outcomes, but they are the measures that really matter.

When thinking about potential Social Value and its measures, commissioners and providers should bear in mind that Social Value may take forms that simply defy quantifying. How do we measure, for example, the impact on the very young and very old when a pre-school nursery visits a care home for adults with dementia every month? To any observer, the impact is profound and beautiful, but defies measurement. The development and presentation of required Social Value in tender documentation should take care not to devalue and marginalise this kind of life-changing innovation. This difficulty can be overcome by the use of narrative, photographic, audio or video accounts of outcomes, complementing numeric and economic measures - see principle 13.

3. **Measurement must not devalue lifelong care given to people whose conditions mean there is limited potential for a measurable reduction in care.**

   This principle recognises that measurement in social care can steer commissioners and providers towards prioritising people with the greatest potential to evidence savings in the cost of care. The planning of measures should be attentive to the equal interests of the most vulnerable, whose need for substantial, expensive care packages may be permanent. This means placing equal importance on progression in confidence and skills, and planning measures to reflect this emphasis.

4. **Measures and reporting will be proportionate and as light-touch as possible.**

   Measurement is intended to serve delivery and not distract from it. In the same vein, reporting will be as brief and infrequent as possible without compromising quality and rigour.

5. **Measures should be simple enough to not require skills and resources that are unachievable for small providers.**

   As an example, social return on investment (SROI) is an established and credible methodology for measuring Social Value. However, it calls for skills, resources and monitoring budgets that may be beyond the reach of SMEs, and disproportionate to the size of their work. Favouring the use of such in-depth methodologies may disadvantage smaller providers.

6. **Planning for measurement should avoid duplication with other statutory bodies monitoring the same provision.**

For example, the Care Quality Commission or Ofsted may already be capturing the same measures with care providers, especially those delivering education in the context of day care.

7. **While measures must be meaningful for everyone who benefits from a service, Social Value outcomes that are unique to individuals will also be sought and valued.**

   This is a commitment to personalisation, recognising that generic measures may do an injustice to changes that are unique to an individual, or individuals. For example, among several apprenticeships achieved as Social Value in a contract, one young person may achieve added outcomes in better mental health because of employment, with reduced admissions to mental health support services. This kind of individual outcome should be captured, presented and valued. If it is possible to anticipate unique individual outcomes in a tender, they should likewise contribute to the scoring of the response to an open question on Social Value.

8. **Commissioners will expect providers to be transparent about how they measure outcomes and not over-claim.**

   Providers should only claim the value they are responsible for creating. It is a natural temptation for providers to take the credit for outcomes that were not entirely a result of their work. When reviewing Social Value reports, it is good practice to ask questions such as “Was this outcome a direct result of the work you did, or did another service bring about the outcome as a whole or in part?”; “Is it likely this outcome would have happened anyway, without your intervention?”

9. **Commissioners will arrange independent verification of measurement if resources allow.**

   This is an ideal in the interests of rigour, and it may be disproportionate in cost to arrange this. If it can be arranged, any independent verifier must bring the necessary experience and skills, and carry legitimacy with commissioners and providers alike.

10. **Measurement will use providers’ existing systems wherever possible**.

Providers will typically use systems they have already invested in and are comfortable using for monitoring and reporting outcomes, sometimes across multiple contracts with several authorities. To support providers to administer contracts efficiently, commissioners should accept the reporting output of these systems if they are fit for purpose, or minimise the impact of migrating to a different system if this is unavoidable.

11. **Commissioners will work with providers towards using common outcomes frameworks for different sectors.**

This co-productive process should include developing an agreed set of social value measures and financial proxies for those measures.

12. **Financial proxies will be considered as a means to evidence savings and value for money, but never allowed to compromise the best outcomes for social well-being.**

A financial proxy means attaching a financial value to a numeric measure. For example, one person moving into paid work achieves financial savings through ending work-related benefits, and financial gains through new income tax and national insurance payments. There are clear benefits to using such proxies to measure Social Value and evidence value for money in procurement. At the same time, this approach risks steering commissioners and providers alike into focusing on outcomes with the highest financial values, or outcomes that lend themselves to financial proxies over those that do not.

To illustrate the risk, imagine two adults, both of whom need social care. Both are supported to achieve outcomes which substantially increase their well-being, the first by moving into paid work, and the second by moving into volunteering. We measure the change in well-being, and find a greater difference has been made for the second person. But the financial value of the outcome is greater for the first person, because paid work achieves greater savings and gains. If providers are incentivised to maximise their financial Social Value, as will happen in contracts with a goal to secure a minimum percentage of Social Value relative to the total contract value, they will gravitate towards outcomes that deliver the most financial Social Value, even if these diminish social well-being outcomes. Social Value goals should therefore always be expressed in terms of outcomes for people and places, not as goals for financial savings.

Ordinarily, in commissioning and procurement, we decide the outcomes we want, and then procure to deliver them with maximum value for money. Financial proxies in Social Value risk reversing this order, if we decide to maximise financial Social Value, and then choose the outcomes that achieve the greatest financial savings and gains. Financial proxies are therefore useful to evidence value for money, but should never be allowed to steer decisions about which Social Value outcomes are sought.

13. **Commissioners will seek and value qualitative 'stories' of outcomes as well as quantitative data.**

Numeric and economic indicators are limited in their ability to describe the value of changes to people and communities. The illustration used in principle 2 on meaningful measures is an example of this limitation, which can be overcome by the use of narrative, photographic, audio or video accounts of outcomes. These accounts should support providers to make the most of their reporting, for example using the same stories in publicity and press releases. Whenever possible, they should feature first-hand accounts from people who receive care and support.

COMMITMENTS TO INFORM AND EQUIP PROVIDERS

KCC is committed to on-going support for providers to understand, plan, achieve and maximise Social Value, through its contract for VCSE infrastructure support, and initiatives such as the STAMP programme.
KCC is also committed to outlining Social Value intentions in the Market Position Statement for Adult Social Care.

SELECTED CASE STUDIES

NCVO's Social Value and Commissioning Toolkit highlights several short case studies, including the Warmer Homes programme led by the Knowsley Third Sector Consortium. In addition to core outcomes in reducing illness and improving mental health for vulnerable residents, the programme achieved quantified Social Value in peer-

education, skills, volunteering, reducing waste and reducing social isolation. These outcomes were innovations in response to an open question on Social Value in the Invitation to Tender.

Six Degrees CIC in Salford uses the Mental Health Recovery Star to understand the value of recovery for people they support as well as their wider Social Value.

The Supporting Leicester Families Programme sought to confront the problem that, despite significant investment in services, many families still experience the same problems from one generation to another. As an example of a meaningful approach to measurement, a thorough research exercise identified 25 common issues, which were then measured across a sample of families accessing services. This allowed the programme to identify the changes that mean the most to families and also achieve significant savings for the public sector.

Croydon Council's toolkit: *Inspiring and Creating Social Value in Croydon* features 10 exceptionally well-presented case studies from across the UK. While they are not examples of Adult Social Care contracts or strategies, they exemplify the visionary, creative potential of Social Value which needs to drive our work together to change lives and places here in Kent.

From:	Graham Gibbens, Cabinet Member for Adult Social Care Andrew Ireland, Corporate Director of Social Care, Health and Wellbeing
To:	Adult Social Care Cabinet Committee – 20 July 2017
Subject:	**ADULT SOCIAL CARE ANNUAL COMPLAINTS REPORT (2016-2017)**
Classification:	Unrestricted
Previous Pathway of Paper:	Social Care, Health and Wellbeing Directorate Management Team
Future Pathway of Paper:	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 2016 and 31 March 2017.

Recommendation: The Adult Social Care Cabinet Committee is asked to **CONSIDER** and **COMMENT** on the content of this report.

1. Introduction

1.1 This report is the Annual Report for the Adult Social Care complaints procedure and provides an overview of the operation of the procedure in 2016/17. It includes summary data on the 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 “Local Authority Social Services and National Health Service Complaints (England) Regulations 2009” placed a duty on Local Authorities and NHS organisations to have arrangements in place for dealing with complaints. One of the reasons for the new Regulations was to bring about greater consistency in how health and social care complaints are dealt with. Some aspects of the Regulations were quite prescriptive, for example setting out who can make complaints:

"A person who receives or has received services from a responsible body; or person who is affected or likely to be affected, by the action, omission or decision of the responsible body which is the subject of the complaint".

2.2 The Regulations were also prescriptive in terms of what can be complained about: including Local Authority Social Services functions and any function discharged under specific partnership arrangements between the Local Authority and an NHS body.

2.3 The Regulations set out a duty to cooperate where there are joint complaints that include an element of health and social care. They also set out some constraints on the procedure – for example setting a 12 month limit of complaints except in certain circumstances.

2.4 Associated with the Regulations, guidance was issues which outlined the key principles of the procedure. The three main principles were **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.

2.5 The Regulations and the guidance underpin the Council's Adult Social Care Complaints Procedures. The general approach taken is to be receptive and open to complaints and to try to resolve the complaint but also to learn any lessons where the service has not been to an acceptable standard.

2.6 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. The protocol was revised and updated in 2016/17.

2.8 For Adult Social Care the complaint response needs to be proportionate to the issues raised. The only timescale in the process relates to the acknowledgment of the complaint which is within three days from receipt. Thereafter the response time is agreed with the complainant and reflects the circumstances and complexity of the complaint. In most cases a 20 working day time scale is agreed however there are cases, such as when an independent investigator is completing the investigation into the complaint or when a joint response with another agency is planned, when a longer time frame is usually agreed.

2.9 Complainants are informed that if they remain dissatisfied after the complaint has been considered and responded to by the Local Authority, then they are entitled to contact the Local Government Ombudsman. The Ombudsman provides the final stage in the process.

2.10 The Regulations require Local Authorities to produce an Annual Report with information about the number and type of complaints received for the 12 months ending on 31 March.

3. Total Representations received by Adult Social Care

3.1 Appendix 1 contains information about the number and type of complaints received in 2016/17.

3.2 The figures show a slight decrease in the number of complaints received in 2016/17 compared with the previous year (649 complaints in 2016/17 compared with 662 in 2015/16). The number of complaints however remains relatively high compared to the numbers that were being received several years ago (538 in 2014/15 and 398 in 2013/14). This is a reflection on the increased demand and pressures on services during a time of transformation, change and financial constraint.

3.3 The 649 statutory complaints received need to be seen in the context of the large number of people accessing the service. There were 38,577 open adult social care cases at the start of 2016-17 and a further 32,105 new referrals were received during the course of the year relating to clients previously not known to the service. The percentage of people who made a complaint was about 0.9%.

3.4 There was a decrease in the number of Enquiries. Where correspondence is received from an MP or Member on behalf of a constituent or about an aspect of the services then it is logged as an Enquiry. Enquiries can also include instances where someone does not want to make a complaint but does want to formally raise an issue. In 2016/17, there were 362 enquiries compared with 403 the previous year.

3.5 In 2016/17, 430 compliments (or merits) were logged. This was a decrease from the 523 received in the previous year. The compliments provide useful feedback where people have written to Adult Social Care with positive comments about their experience of using the service.

4. Performance against timeframes

4.1 The average response time for statutory complaints is set within a complaint plan time frame 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 generally negotiated with the complainant.

4.2 90% of **complaints** were acknowledged within the statutory timescale of three working days and approximately 68% of complaints were responded to within the 20 day timescale agreed with the complainant. For **enquiries**, 92% were acknowledged in three working days and 71% were responded to in 20 working days.

4.3 The response times on complaints dipped slightly compared with the previous year (69% in 2015/16) however the response times for Enquiries improved (61% in

2015/16). Meeting the time scales has proved challenging particularly in some of the Older People/Physical Disability (OPPD) teams where the service average dropped from 66% to 65% and managers have had to balance the competing demands. An Assistant Director has been given a lead role for Quality and Practice Assurance in OPPD and a focus on complaints and improving response times in 2016/17 is part of this role.

4.4 If a complaint response is likely to be delayed and outside the agreed time scale then a holding letter is sent to the complainant to explain that there will be a delay. A weekly report is also issued to remind staff of any complaints that are pending or overdue.

5. Themes identified arising from complaints

5.1 The increase in complaints over the past two or three years is a general increase rather than attributable to any one factor. It reflects the pressures on the service and the wider social care market and the increased complexity of case management.

5.2 A disputed decision remains a key theme in many complaints. Examples include where people consider they require more support than has been agreed or where the support has been decreased following a review of care needs or where someone is unhappy about the level of charging. In 2015/16 there was a significant increase in the number of complaints received as a result of disputed decisions (281 in 2015/16 compared to 185 in 2014/15). The number of complaints about disputed decisions remained constant in 2016/17 with 281 complaints.

5.3 The number of complaints specifically about charging however decreased from 114 in 2015/16 to 102 in 2016/17.

5.4 Although it remains a feature of many complaints, there was a decrease in the number of complaints about communication. This includes people who said they had not been given sufficient information. In the previous year, following the introduction of new telephony arrangements, there were a significant number of people who complained about not getting a response to their telephone calls. Workshops were provided for staff and the number of complaints about this specific issue reduced in 2016/17 by almost 50%.

5.5 The number of complaints about delays, decreased from 181 in 2015/16 to 119 in 2016/17. Examples of the complaints about delays included where there were delays with adaptations to property being completed and delays in services being arranged.

5.6 In a number of complaints (75), the main complaint issue was reference to the behaviour or attitude of the member of staff that the service user was in contact with. Where a complaint investigation has found that the individual member of staff

was at fault or where their practice was not to the required standard, then this is addressed by the manager through supervision with the member of staff.

5.7 The Local Authority also logs complaints about contracted care providers where the service has been commissioned for an individual. For example, this includes complaints where an individual has been placed in a residential or nursing home or is in receipt of home care arranged by the Council. 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. There were 100 complaints with Quality of Care as the main issue in 2016/17 compared with 90 in the previous year.

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 199 complaints were upheld; 198 were partially upheld and 181 were not upheld. There were 33 complaints withdrawn and others were resolved through a meeting or following initial consideration were passed to another process, such as safeguarding. The number of upheld and partially upheld complaints is a reflection on the open and transparent approach to complaints and the willingness to learn from customer feedback.

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 provides valuable insights that can be used to improve service performance. A complaints procedure is only as good as the culture in which it operates it is therefore important to maintain an open and learning culture that is receptive to feedback from customers.

7.2 Complaints reports are presented to both the Directorate and Divisional Management Teams and to the Quality and Good Practice Group meetings. 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 representatives to attend the meetings and feedback issues and lessons at a local level.

7.3 Some of the lessons/issues arising in 2016/17 and discussed at the Quality and Good Practice Group included:

- The difficulties some services users experienced in communication with the service. There was a reminder of the need to keep the service user, and where appropriate the relatives/family members, informed of any key changes in the case, for example following a review or a re-assessment. There were a number of complaints relating to safeguarding where families did not feel they were kept sufficiently informed. The national Making Safeguarding Personal initiative has helped to address this along with the production of Kent specific information leaflets for individuals affected by Safeguarding.
- Several complaints highlighted the need for closer inter-agency working where a number of agencies are involved in a case. At the Quality and Good Practice Group meetings, there was a reminder of the benefits of joint working particularly in relation to individuals who might have a range of needs and be in contact with several agencies.
- Another issue identified through complaints was a gap in service delivery when members of staff take 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. Many teams have reviewed their arrangements and put processes in place for cover if someone goes on unexpected leave.
- There have been some complaints where it has been unclear how a decision was arrived at where an individual lacked capacity and so this was raised at the Quality and Good Practice Group meetings. Where a person lacks mental capacity then a Best Interests Meeting may need to be convened to assist in making a Best Interests Decision.
- In the meetings there has been a reminder of the need to ensure information is provided to the service user/family where there is likely to be a charge for services. There is also need for clarity where there is a “Third Party Top Up”. The Third Party Top Ups occur when the service user has chosen a care home where the fees are higher than the Council would expect to pay and a third party has agreed to pay the difference. The introduction of the County Placement Service has helped to ensure there is more consistent provision of information including information about services and charging.
- A “protection of property” related complaint led to a review and revision of the protection of property policy and changes to the e-learning training on this subject. Protection of Property is relevant when a service user moves into accommodation such as a care home and they are unable to protect or deal with their own property and there is no one else able to do it on their behalf.
- Complaints also flagged up the need for timely re-assessments or reviews where it is brought to the attention of the service that someone has a significant change of needs and may require an updated care and support plan.

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 six 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. Where an independent investigator has been appointed it provides some reassurance to the complainant that there is independent consideration of the complaint.

9. Financial

9.1 In 2016/17, £25,006 was paid in financial settlements. This included cases where the Local Government Ombudsman (LGO) had 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 the time and trouble to pursue a complaint. Most of the 19 settlements and nine LGO cases were for under £1,000 but one settlement was for £9,907. The settlement related to the payment of invoices to a care provider where there had been an increase in costs.

9.2 During the same time frame 45 financial adjustments were made to accounts, or are in the process of being made, totalling £91,996. 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. There was one case where an incorrect invoice had been issued to a service user for £39,427. The account had to be adjusted to reflect the invoice had been sent in error. In another case an adjustment of £8,409 was made where back dated charges had been applied to a service user with learning disability but there was no evidence that the service user or his family had been notified of the charge and so it was decided to charge only from the date that they had been advised that he would have to pay for his care. In a third case it has been proposed that £16,056 should be waivered in case where there was a delay in the completion of a financial assessment leading to a substantial invoice being sent to the service user but this is still subject to confirmation. There are therefore three cases which form a significant part of the adjustments for the year.

10. Complaints via the Local Government Ombudsman (LGO)

10.1 There were a total of 42 “referrals” about KCC Adult Social Care made to the LGO during 2016/17 where the LGO contacted the service. Additional cases were carried forward from the previous year and settled during the reporting year however these are not included in the 2016/17 figures for this report. There was a slight decrease from the previous year when 45 new referrals were made to the Ombudsman.

10.2 At the time of writing the LGO has arrived at a decision on 29 cases. In the other 13 cases the LGO’s decision is still awaited or still to be confirmed. Information about the decisions is included in Appendix 1 and a summary of the cases where the LGO found fault with injustice is included in Appendix 2.

10.3 Each year the LGO publishes a report with a “Review of Adult Social Care Complaints”. The most recent report was produced in November 2016 and provides information about the national picture in terms of the complaints and enquiries they received in 2015/16.

10.4 At a national level the LGO reported that they had received 2,969 complaints and Enquiries. There was a 6% increase in the complaints and Enquiries they received and a 19% increase in the complaints about care providers. The number of complaints they had received about Home Care increased by 25% which is much higher than any other area of social care.

10.5 It is not always possible to make useful comparisons with other Local Authorities regarding the number of complaints received. Although there are national regulations on complaints management there can still be differences in definitions of what is considered to be a complaint or varying arrangements for ensuring all complaints are logged. The LGO’s office however does maintain a record of the number of complaints received at the Ombudsman’s office about Adult Social Care per 100,000 of the general population. In the LGO report for 2015/16, Kent compares quite well with neighbouring Local Authorities: Kent (4.2), Surrey (6.1), East Sussex (9.7), West Sussex (5.3); Medway (6.1); and Essex (3.7)

11. Compliments (or merits)

11.1 The Directorate continues to log compliments or merits, with 430 received in 2016/17. 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 A few examples are provided below:

- “Thank you simply isn’t enough to say how much we appreciate the care and kindness you have shown our mum”.

- “I am writing to thank you for the dedicated care your team gave mum when she was desperately ill recently. The care your team gave our mum was just incredible; we do not believe she would have survived and be alive today without your teams”.

- “Mr and Mrs M: we would like to thank everyone for their assistance and great service.

- “I am completely satisfied with the support and help that we got from the direct payment worker. She is very good at her job, is very knowledgeable about helping and knows how to put you at ease”.

- “Just wanted to pass on a message from Mark (grandson of the client). They are extremely pleased with the grab rail and half step completed yesterday, not only by the quality of the work but also with the short time frame in which the work was completed”.

12. Complaints Operations

12.1 In April 2016, the Children Services and the Adult Services complaints teams came together to form one complaints team although they have retained their specialisms in terms of working to the different legislation and regulations which underpin the procedures. Closer working has proved beneficial in responding to complaints and enquiries about transition and in ensuring a consistent approach to complaints about the new Lifespan Pathway services which bridge the gap between children’s and adult’s services.

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

12.3 In the past the Directorate has used the Respond database to log complaints, Enquiries, compliments and formal advocacy referrals. The system has proved to be an invaluable resource to register the contact and to manage the workflow and produce management reports. In 2016/17, following a tender process, the decision was taken to procure a different KCC customer feedback system. Work is currently in progress to configure and test the new database. It is important that the new system is configured to meet the business need and enable the Directorate to meet all its statutory requirements in terms of complaints handling and reporting.

12.4 In September 2016, the complaints team delivered an Effective Complaint Handling training event for managers and senior practitioners. The training covered the complaints processes, investigating complaints and learning the lessons from complaints.

12.5 The Adult Social Care Customer Care and Operations Manager chairs the Kent and Medway Complaints Officers Network meetings which involve the Complaints Managers for health and social care services in the county. During the course of the year the meetings have proved productive in promoting joint working. The Parliamentary and Health Services Ombudsman's liaison officer attended one meeting to give a comprehensive presentation on the work of the Health Ombudsman. The group has reviewed and reissued the protocols for handling inter-agency complaints. The complaints team has also worked closely with the Kent and Medway Partnership Trust (KMPT) Patient Experience team to ensure effective joint working on complaints about secondary mental health services.

13 Actions Planned in 2017/18

13.1 One of the key actions for the complaints team in 2017/18 is to manage a smooth transfer to the new complaints database. The database is a key resource for logging, monitoring and reporting on complaints, enquiries and merits and the intention is to manage the transfer to the new system with minimal disruption.

13.2 Another action for 2017/18 is to seek feedback from complainants and others on their experience of using the complaints procedure. In the past, the nature of the feedback has tended to reflect whether or not the individual was satisfied with the outcome of the complaint, nevertheless it could be useful to hear people's views on the service.

13.3 The service will continue to use complaints, along with other feedback, to identify opportunities to learn any lessons for the wider service.

13.4 The complaints team will need to adjust its processes and procedures to reflect wider organisational changes such as a move to a centralised commissioning service and the introduction of the Lifespan Pathway Service to streamline the transition from children's to adult services.

13.5 The service will continue to seek improvements to the complaints response times. Managers dealing with complaints are often balancing a number of priorities however it is important that complaints are responded to within timescales as any delays to complaints can lead to further dissatisfaction. The appointment of an Assistant Director in OPPD to a Quality and Practice Assurance role should improve the turnaround of complaints responses. The introduction of a new database should also improve the speed of communications and allow continued detailed performance monitoring and reporting

14. Report Conclusion

14.1 In 2016/17 the Directorate continued to operate a robust and effective complaints procedure to meet its obligations under the statutory regulations. The complaints team has logged, administered and managed complaints, enquiries and

compliments. The team has also managed the communication with the LGO to ensure the Directorate is effectively represented.

14.2 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. I t is also about learning the lessons from complaints to prevent similar complaints from arising again. Complaints are taken seriously by the senior management teams who receive regular reports as well as taking an active role in complaints resolution.

14.3 It has been, and continues to be, a time of significant change in Adult Social Care including the transformation of services, the development of Lifespan Pathway Services and working towards greater integration with health. It has also been a time of severe budgetary pressure on services. The number of complaints and enquiries received remained quite high although slightly lower than in the previous year. Managers continue to focus on delivering a high standard of service and dealing effectively with complaints and other customer feedback is a key part of this.

15. Recommendations

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

16. Background Documents

None

17. Report Author

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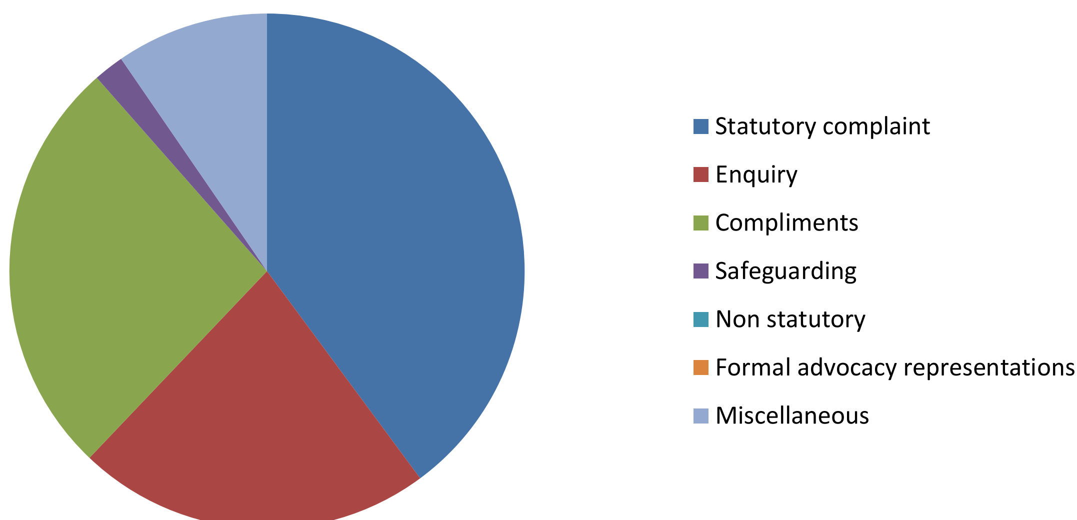
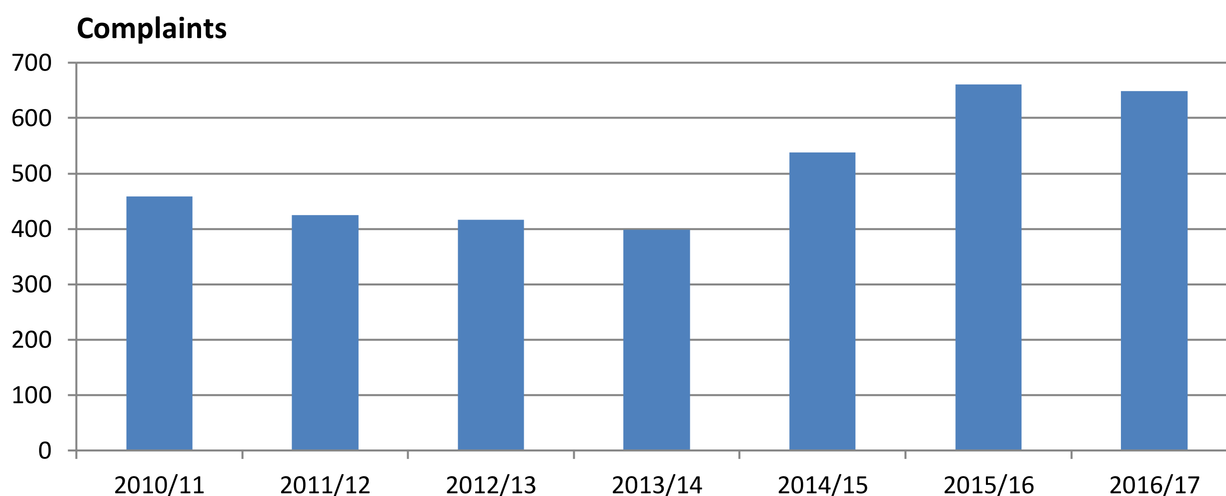
Complaints and enquiries received 1.4.16 to 31.3.17

1. Number of complaints received

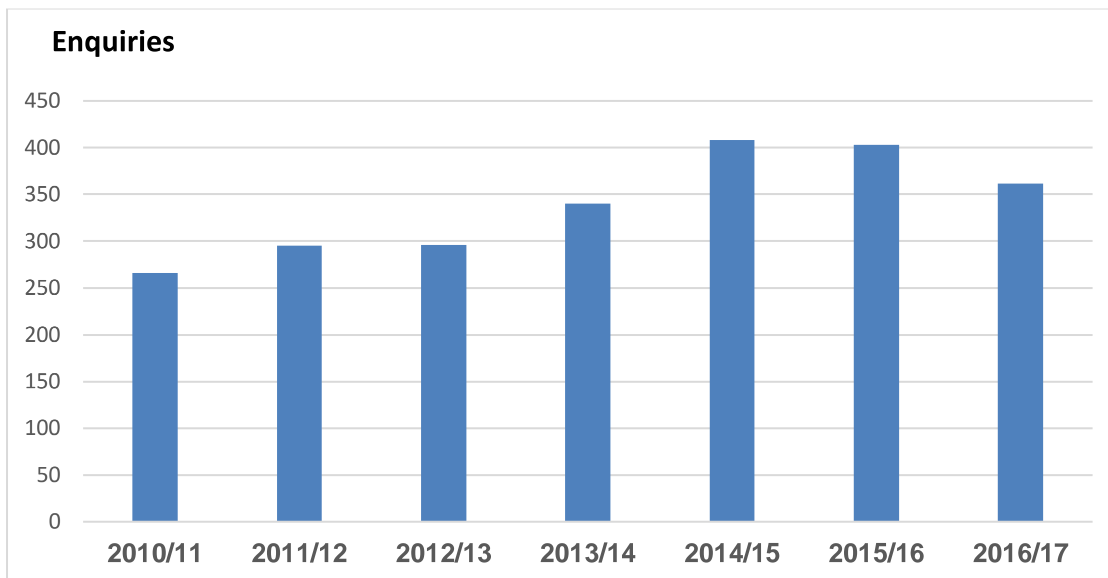


Statutory complaint	649
Enquiry	362
Compliments	430
Safeguarding	31
Non statutory	0
Formal advocacy representations	0
Miscellaneous	156

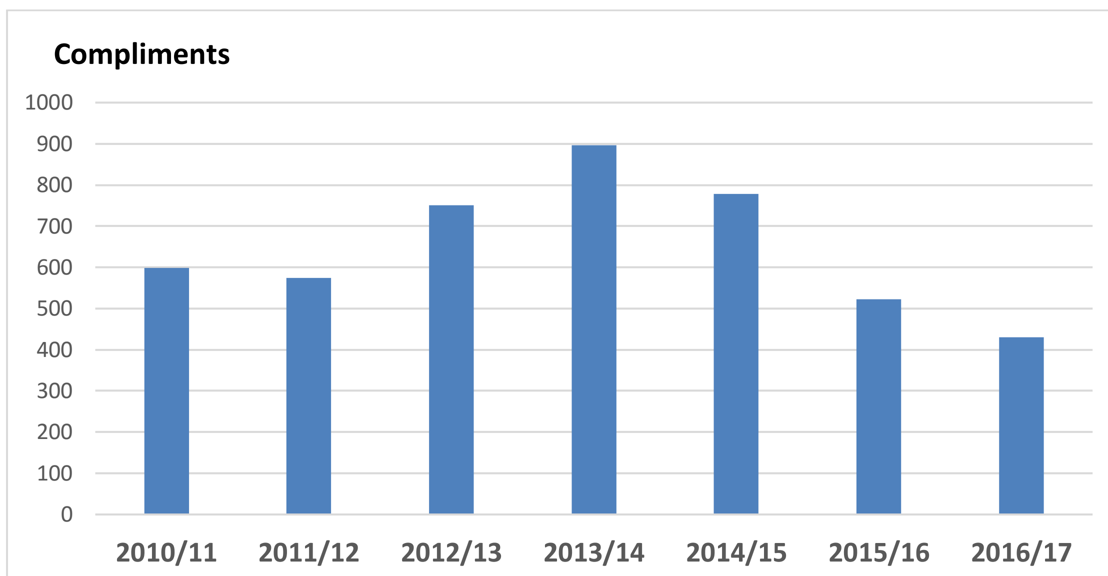
2. Comparisons with previous years



	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17
Complaints	459	425	417	398	538	662	649

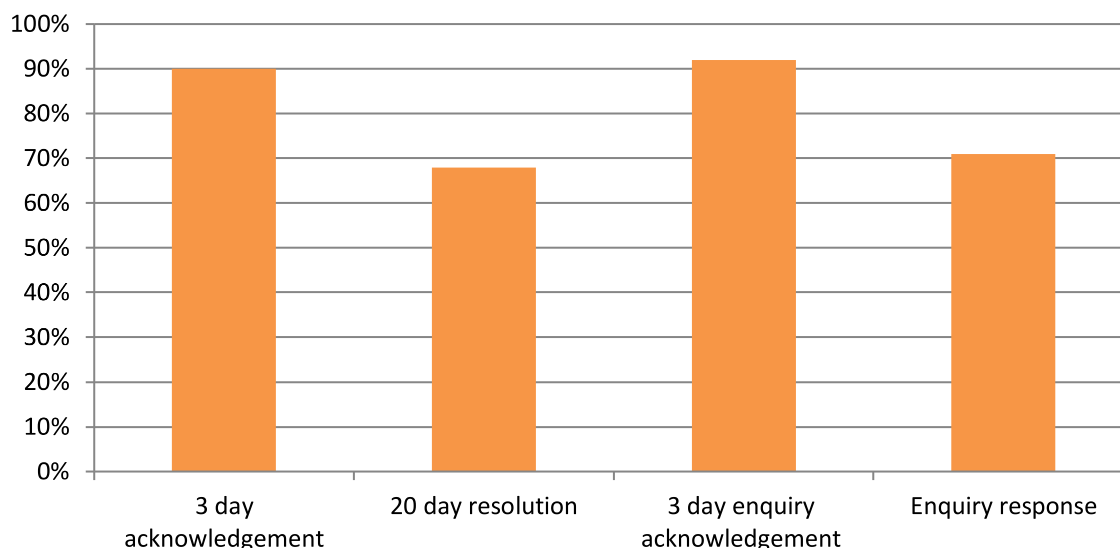


	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17
Enquiries	266	295	296	340	408	403	362



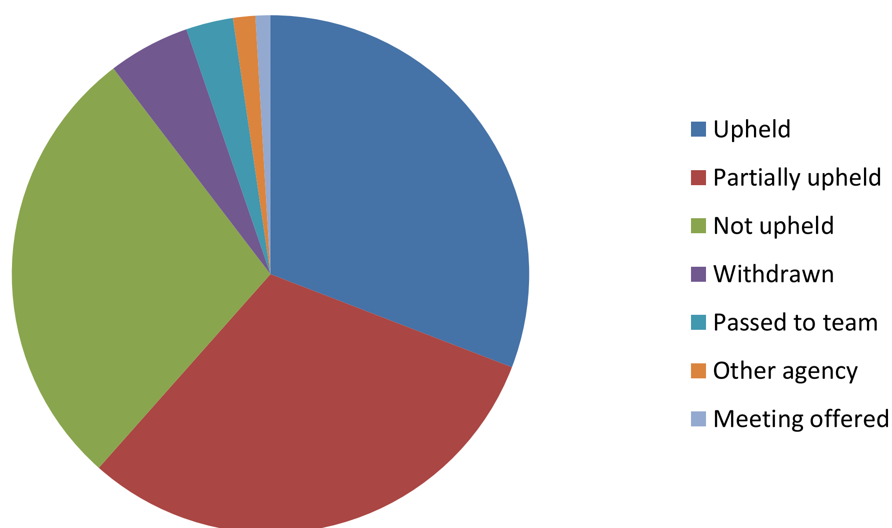
	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17
Compliments	598	575	750	896	778	523	430

3. Timescale for responding to complaints and enquiries



3 day acknowledgement	90%
20 day resolution	68%
3 day enquiry acknowledgement	92%
Enquiry response	71%

4. Complaints outcomes



Complaints outcome	
Upheld	199
Partially upheld	198
Not upheld	181
Withdrawn	33
Passed to team	19
Other agency	9
Meeting offered	6

5. Subject of complaint

Subject	Complaint	Enquiry
Communication	345	48
Disputed decision	281	118
Behaviour	233	25
Delay	119	75
Charging dispute	102	20
Quality of care	100	23
Information request	66	87
Service not meeting needs	42	20
Request for service	33	81
Data protection	15	1
Safeguarding process	11	6
Claim for compensation	9	0
Service reduced	9	5
Eligibility not met	8	4
Lack of provision external service	8	17
Backdate charging dispute	4	2
Funding (organisations)	4	19
Lack of cover for absence	4	0
Change of service	3	0
Failure to deliver service	2	3
Closure	1	3

(complaints and enquiries may have more than one subject)

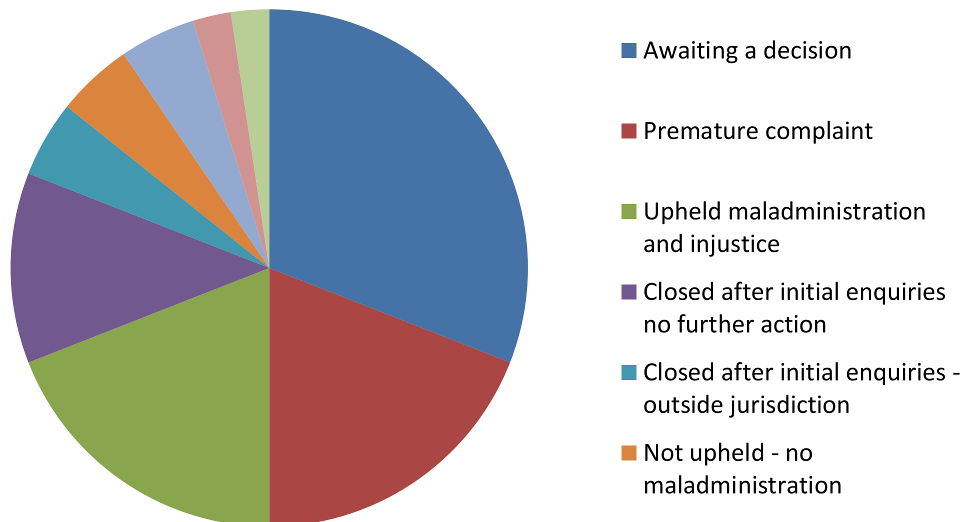
6. Service involved in Complaint and Enquiry

	Complaint	Enquiry
Access to services	7	14
ARMS	4	5
Assessment	91	61
Autistic Spectrum Condition	2	1
Benefits Team	1	0
Best Interests	9	0
Blue Badges	10	12
Carers Assessments	3	0
Case/care management	219	45
Central Duty Team	1	
CFAO	2	0
Charging	85	20
Continuing Health Care	10	4
County Placements Service	9	4
Debt Recovery	10	2
Direct Payments	23	7
DOLS and MCA	5	0

Eligibility	3	1
Equipment and Adaptations	33	29
External Providers	147	81
Financial Assessment	34	18
Hospital Discharge	19	11
Housing	6	18
In House Day Care	13	5
In House Residential	8	8
Information, Advice ,Guidance	7	23
Integrated Care Centre	12	1
Kent Enablement at Home	36	6
Kent Pathways Service	2	0
Kent Supported Assistance Service	1	3
Out of Hours	3	0
Payments (to providers)	9	5
Policy	0	6
Protection of Property	2	0
Respite Care	10	1
Review	3	0
Safeguarding	16	7
Sensory/KAB/Hi Kent	0	2
Shared Lives	1	2
Supported Living	3	1
Supporting People	0	2
Telecare	1	0
Tendering	1	0
Transition	4	2
Transport	3	3
Total	**868**	**410**

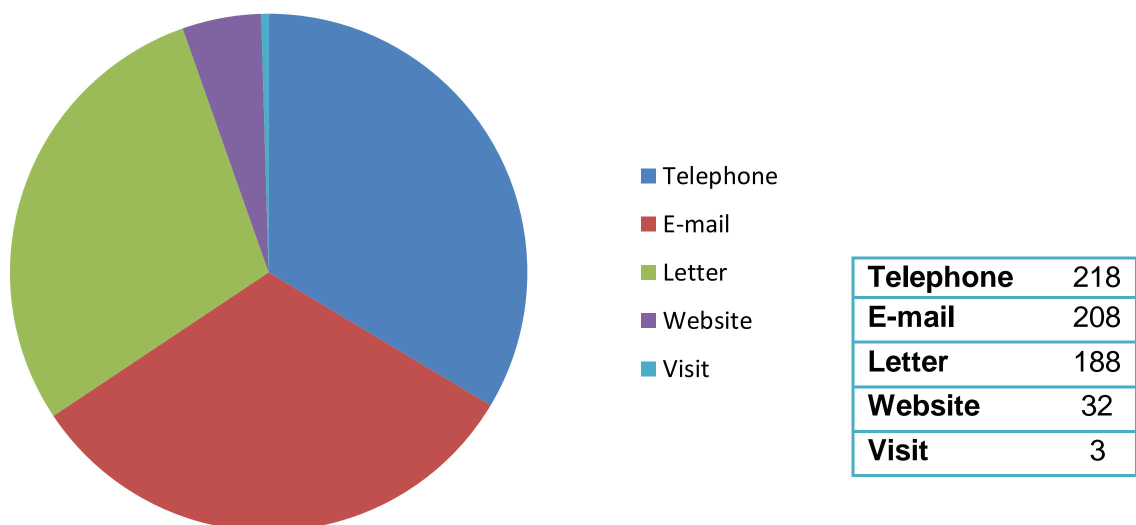
(complaints and enquiries may relate to more than one service)

6. Referrals to Local Government Ombudsman



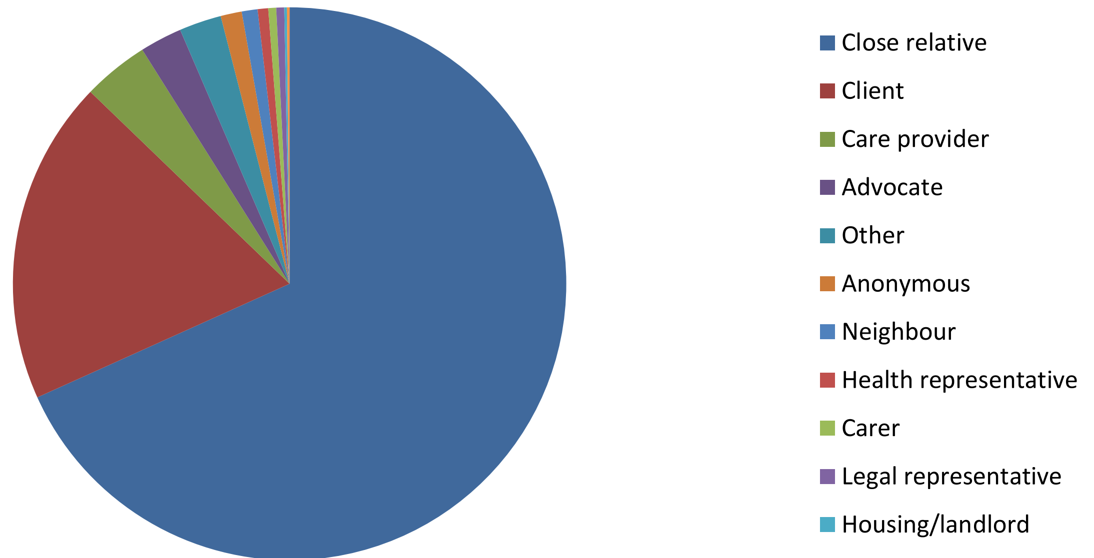
Referrals to Local Government Ombudsman	
Awaiting a decision	13
Premature complaint	8
Upheld maladministration and injustice	8
Closed after initial enquiries no further action	5
Closed after initial enquiries - outside jurisdiction	2
Not upheld - no maladministration	2
Upheld - no further action	2
Not upheld - no further action	1
Upheld maladministration no injustice	1

7. Complaints contact method



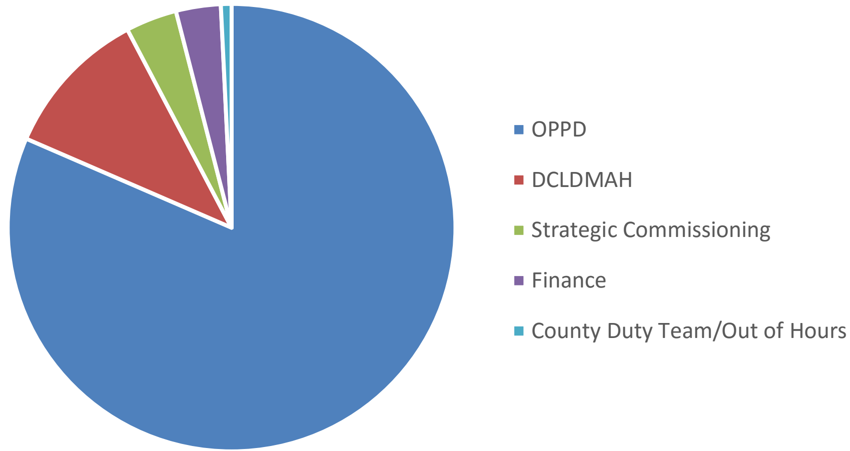
Telephone	218
E-mail	208
Letter	188
Website	32
Visit	3

8. Originators of complaints



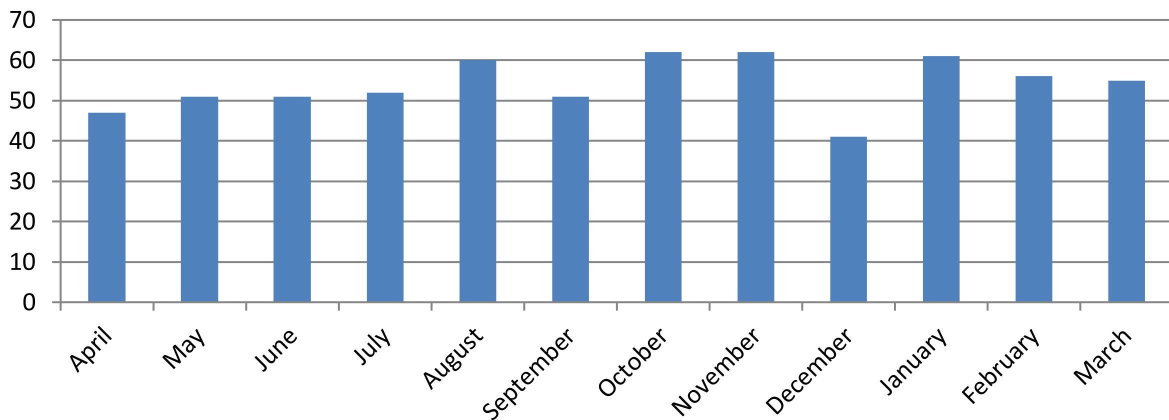
Originators of complaints	
Close relative	443
Client	123
Care provider	25
Advocate	16
Other	16
Anonymous	8
Neighbour	6
Health representative	4
Carer	3
Legal representative	3
Housing/landlord	1
Other local authority	1

9. **Division**



OPPD	529	Strategic Commissioning	24	County Duty/Out of Hours	5
DCLDMAH	70	Finance	21		

10. Complaints received by month



April	47
May	51
June	51
July	52
August	60
September	51
October	62
November	62
December	41
January	61
February	56
March	55

Cases in 2016/17 Where the Local Government Ombudsman Found Maladministration and Injustice.

- Ms V complained that the Council failed to deal properly with charges for her son's residential care. The Council had written to Ms V's son to say that there would be a nil charge for services but this decision was later changed and he had accrued a debt. The Ombudsman found fault with the Council

- Ms P complained that the Council had failed to provide her with information about the potential care providers it had approached. Also the Council was unable to evidence that Ms P had refused care over a period of 16 months and had not arranged care during this period. The Ombudsman found the Council to be at fault.

- The Council failed to put in place robust contingency plans for meeting Mrs Y's needs when her husband went into hospital. The Ombudsman criticised the Council for not putting plans in place.

- The Council failed to deal properly with the respite care needs for a disabled adult to give her parent a break from caring.

- The Council was at fault when it failed to assess the risk to Mrs Y and put in place care plans in place on her admission to a respite unit. She required additional support with moving and handling whilst in respite care.

- Mr B complained about the Council not funding his day care and about the charges for the services he had received. The LGO considered the Council had not dealt properly with Mr B's charges.

- Mrs F complained that the Council failed to assess her needs properly resulting in a significant cut in her personal budget. The Ombudsman found Mrs F's Care and Support plan did not explain how her personal budget was enough to meet her eligible care needs.

- Ms B complained that the Council had failed to update her about a safeguarding review of the care of her mother and had not sent her a copy of the minutes of the meeting. The Ombudsman agreed there had been a delay in providing the complainant with information about the safeguarding review.

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From:	Graham Gibbens, Cabinet Member for Adult Social Care Andrew Ireland, Corporate Director of Social Care, Health and Wellbeing
To:	Adult Social Care Cabinet Committee – 20 July 2017
Subject:	**ADULT SOCIAL CARE PERFORMANCE DASHBOARD**
Classification:	Unrestricted
Previous Pathway of Paper:	Social Care, Health and Wellbeing Directorate Management Team
Future Pathway of Paper:	None
Electoral Division:	All

Summary: The performance dashboard provides Members with progress against targets set for key performance and activity indicators for May 2017 for Adult Social Care.

Recommendation: The Adult Social Care Cabinet Committee is asked to **CONSIDER** the Adult Social Care Performance Dashboard and **AGREE** whether an Informal Member Performance Workshop would be useful.

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 Performance Dashboard which includes a description of the indicator and the latest available results for the key performance and activity indicators

2.2 The Adult Social Care Performance Dashboard is a subset of the detailed monthly performance report that is used at team, Divisional Management Team (DivMT) and Directorate Management Team (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 Performance Dashboard will evolve for Adult Social Care as the transformation programme is shaped.

2.3 The monthly performance monitoring is based on data that is derived from the client system (SWIFT/ AIS). This system captures the assessment, needs, services, costs and review data from every service user that we support.

2.4 The operational teams have the responsibility for updating the system and have a wide range of reports available to them to be able to manage their own performance, including supervision with staff.

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

2.6 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. If it would be helpful to Cabinet Committee, an informal Member Workshop could be put in place to explain the performance management framework, Key Performance Indicators and processes within Adult Social Care.

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

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

2.9 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. Summary of Performance

3.1 There are 13 measures within the Adult Social Care Performance Dashboard which have a RAG (Red, Amber, Green) rating applied.

3.2 For May 2017, eight performance indicators are rated as Green, four as Amber and one as Red.

3.3 In respect of the one performance indicator which has been rated as Red (ASCO3 - Referrals to Enablement) it is thought that three main reasons for this are:

(1) lower than expected referrals to enablement
(2) some increase in the number of new cases which are not be suitable for enablement (for example increasing number of people with

complex dementia needs) thereby reduce the number of new referrals to the service and,
(3) on occasion there may not be capacity to accept new referrals because Kent Enablement at Home (KEaH) steps in when the market is not able to provide support and also where KEaH prioritises hospital discharges which helps with the management of Delayed Transfer of Care.

3.3.1 It should be noted, however, that although current performance is 2,514 (against a target figure of 2,821) Referrals to Enablement have increased from the figure of 2,358, which was reported in the last Performance Dashboard.

4. Recommendations

4.1 Recommendation: The Adult Social Care Cabinet Committee is asked to **CONSIDER** the Adult Social Care Performance Dashboard and **AGREE** whether an Informal Member Performance Workshop would be useful.

5. Background Documents

None

6. Report Author

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steph.smith@kent.gov.uk

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APPENDIX A

Adult Social Care Dashboard

May 2017

APPENDIX A

Key to RAG (Red/ Amber/ Green) ratings applied to KPIs	
GREEN	Target has been achieved or exceeded
AMBER	Performance is behind target but within acceptable limits
RED	Performance is significantly behind target and is below an acceptable pre-defined minimum *

* 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.

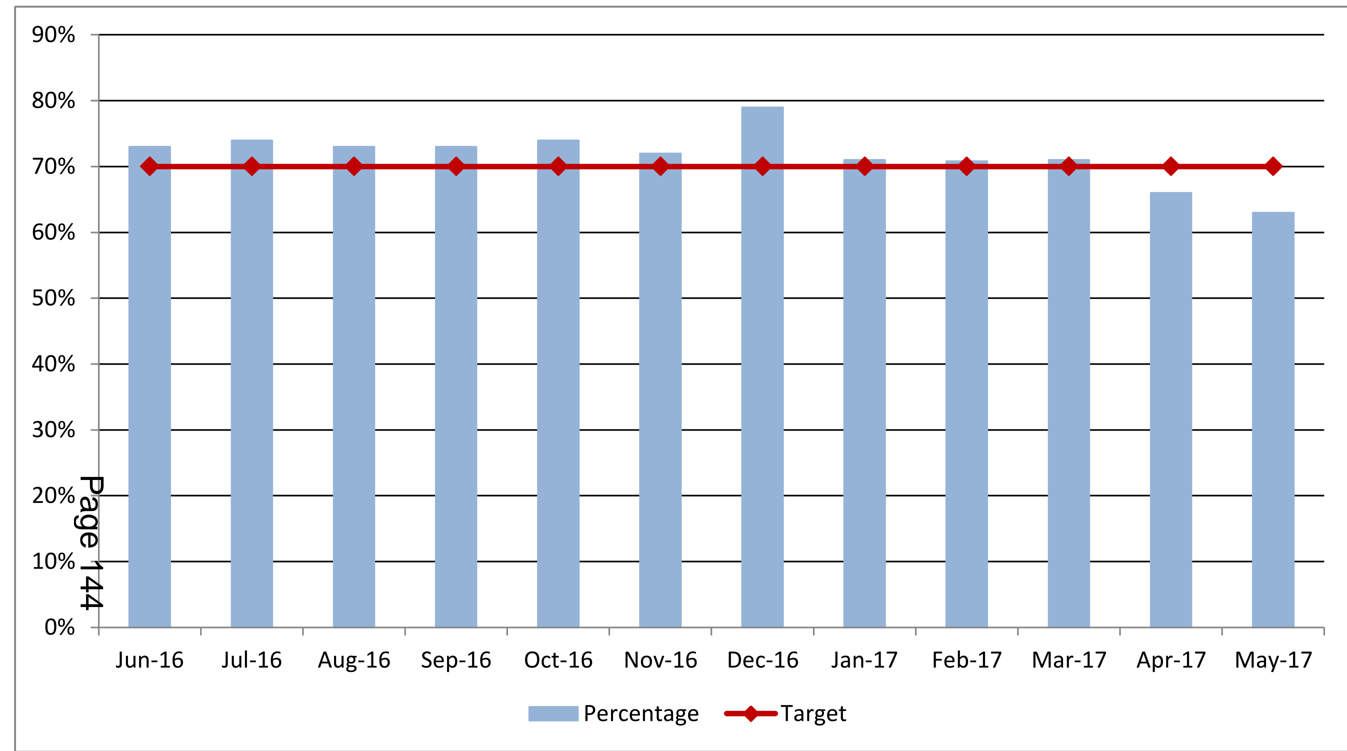
All information is as at the latest month wherever possible.

APPENDIX A

Indicator Description		MoS	SCHW SPS	QPR	2016-17 Outturn	Current 2016-17 Target	Current Position	Data Period	RAG
1)	Percentage of contacts resolved at source (ASC01)	Y	Y	Y	71%	70%	**63%**	Month	**AMBER**
2)	Number of adult social care clients receiving a Telecare service (ASC02)		Y	Y	6,345	6,331	**6,331**	Cumulative	**GREEN**
3)	Referrals to Enablement (ASC03)	Y	Y	Y	786	1,020	**911**	Month	**RED**
4)	Delayed Transfers of Care				26.3% full year effect	30%	**29.2%**	12M	**GREEN**
5)	Admissions to permanent residential or nursing care for people aged 65+	Y		Y	148	151	**102**	Month	**AMBER**
6)	Number of people aged 65+ in permanent residential care (AS01)	Y	Y	Y	2,330	2,241	**2,262**	Snapshot	**AMBER**
7)	Number of people aged 65+ in permanent nursing care (AS02)	Y	Y	Y	1,108	1,107	**1,110**	Snapshot	**AMBER**
8)	Number of people receiving homecare (AS03)	Y	Y	Y	3,995	4,060	**3,983**	Snapshot	**GREEN**
9)	Number of people receiving direct payments	Y			2,143	2,138	**2,058**	Snapshot	**GREEN**
10)	Number of people with a learning disability in residential/nursing care (AS04)		Y	Y	1,118	N/A	**1,107**	Snapshot	**GREEN**
11)	Number of people with a learning disability receiving a community service				1,372	N/A	**1,391**	Snapshot	**GREEN**
12)	Percentage of adults in contact with secondary mental health in settled accommodation				83.7%	75%	**83.1%**	Month	**GREEN**
13)	Percentage of adults with mental health needs in employment				13.5%	13%	**13.3%**	Month	**GREEN**

APPENDIX A

1) Percentage of Contacts resolved at source (ASC01)			AMBER
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

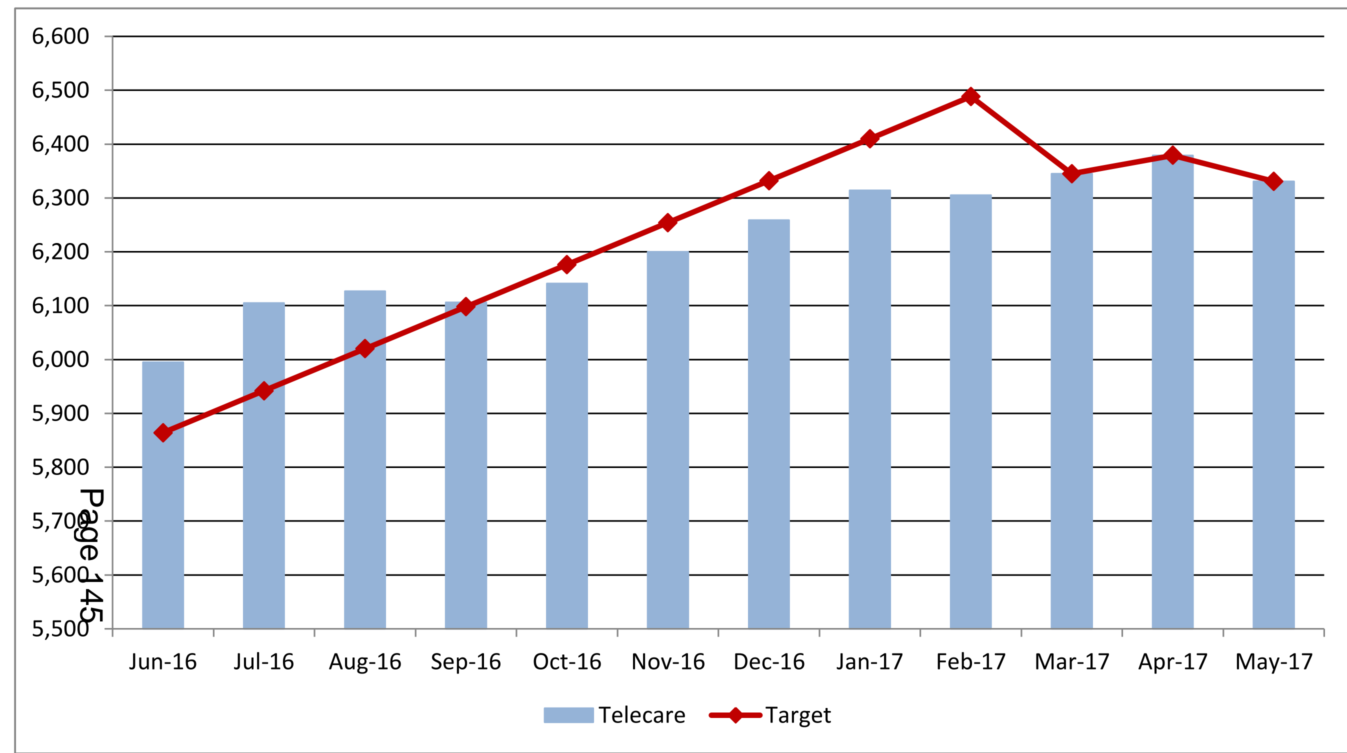
	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17
Target	**70%**	**70%**	**70%**	**70%**	**70%**	**70%**	**70%**	**70%**	**70%**	**70%**	**70%**	**70%**
Percentage	73%	74%	73%	73%	74%	72%	79%	71%	71%	71%	66%	63%
RAG Rating	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN	AMBER	AMBER

Commentary

This is the percentage of people who's needs are met at the point of contacting Social Care through information, advice, guidance or small pieces of equipment. 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.

APPENDIX A

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

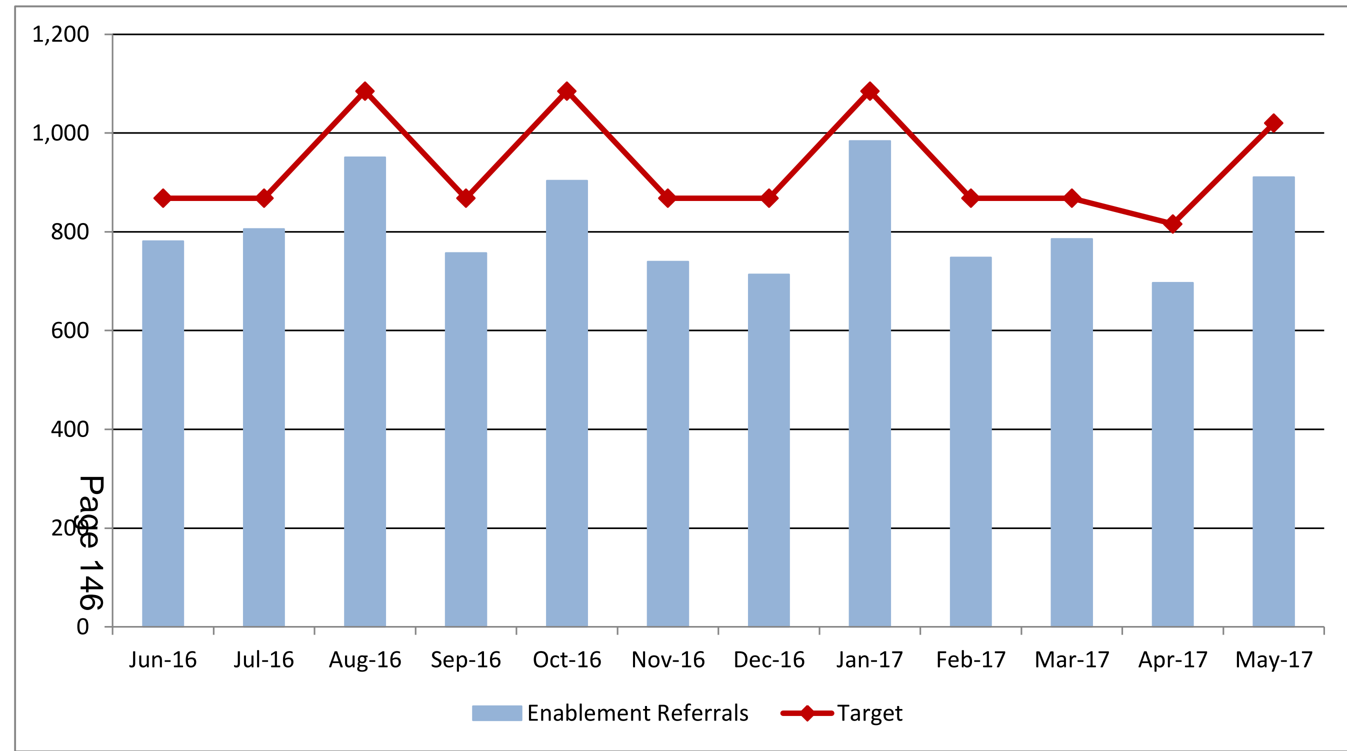
	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17
Target	**5,864**	**5,942**	**6,020**	**6,098**	**6,176**	**6,254**	**6,332**	**6,410**	**6,488**	**6,345**	**6,379**	**6,331**
Telecare	5,995	6,105	6,127	6,106	6,141	6,200	6,259	6,314	6,305	6,345	6,379	6,331
RAG Rating	GREEN	GREEN	GREEN	GREEN	AMBER	AMBER	AMBER	AMBER	AMBER	GREEN	GREEN	GREEN

Commentary

This is the number of people who receive a telecare service. A telecare service reduces the need for support through other services such as homecare and residential care and promotes independence. Revised targets have been agreed to achieve 8,000 people in receipt of Telecare by the end of March 2018.

APPENDIX A

3) Referrals to Enablement (ASC03)			RED
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

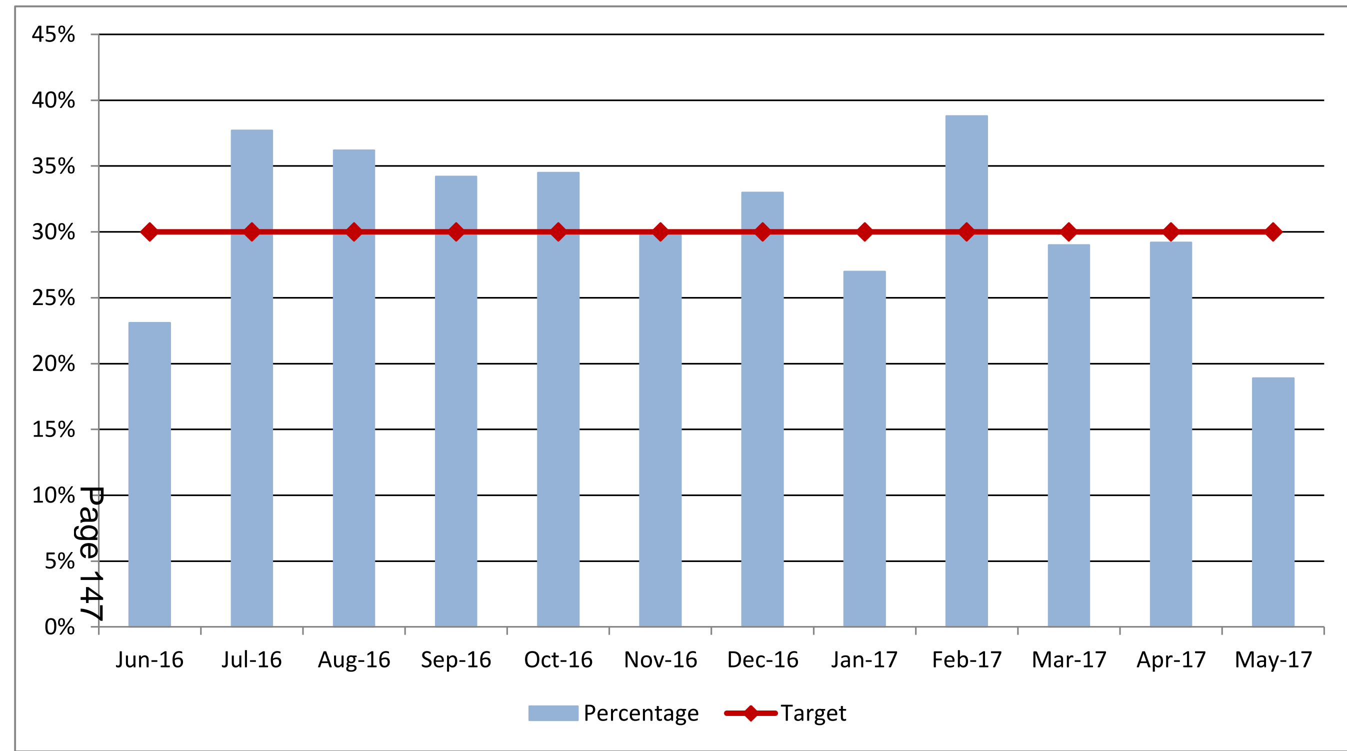
	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17
Target	**868**	**868**	**1,085**	**868**	**1,085**	**868**	**868**	**1,085**	**868**	**868**	**816**	**1,020**
Enablement Referrals	781	806	951	757	904	740	714	984	748	786	697	911
RAG Rating	RED	AMBER	RED	RED	RED	RED	RED	AMBER	RED	AMBER	RED	RED

Commentary

This the number of referrals to our enablement service which is a specialist service to enable people to live independently and undertake daily tasks without support. Additional capacity in KEAH Enablement service has been created which has led to an adjustment in the target with 204 starts per week in Quarter 1 rising to 217 starts per week by the end of 2017-18. This will result in more people utilising the enablement service to aid clients to achieve independence and/or a lesser care package following enablement. Current performance is below target, thought to be caused in part by a high level of clients receiving extended enablement resulting in a lack of capacity to take on new Enablement clients.

APPENDIX A

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.

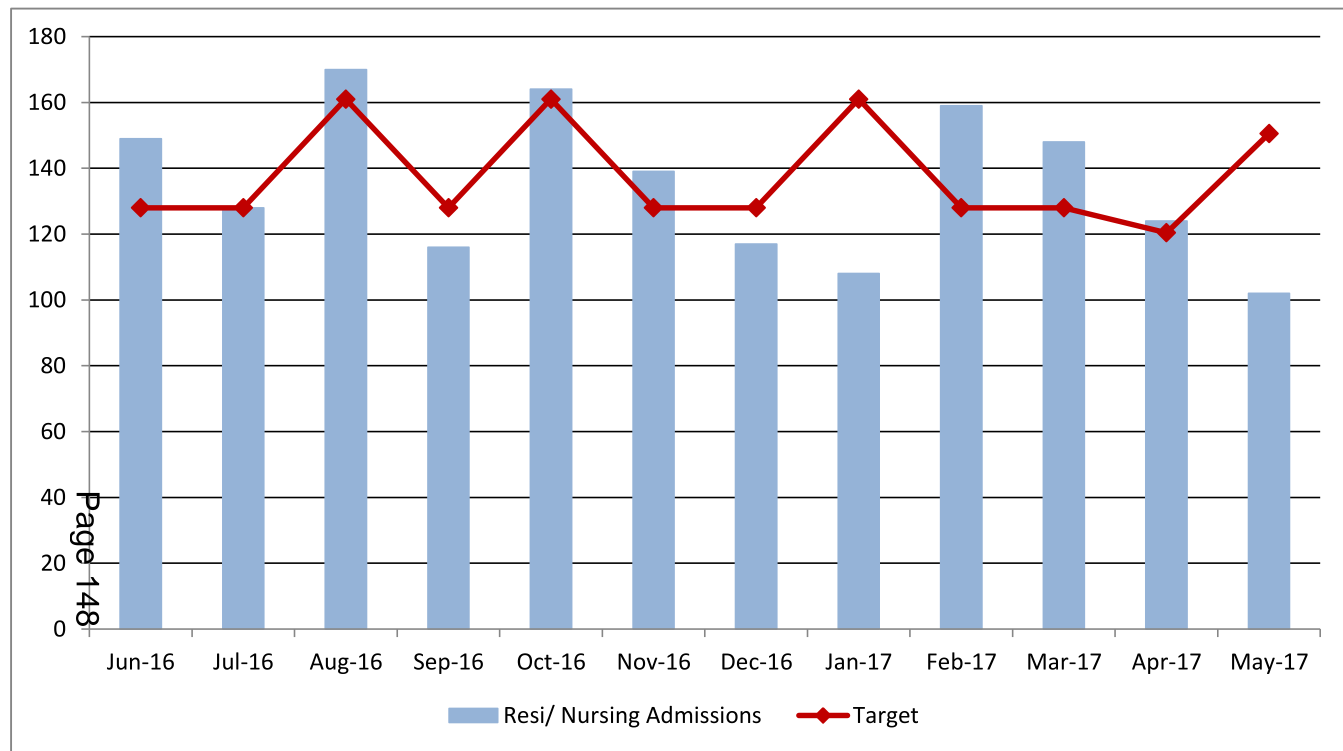
	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17
Target	**30%**	**30%**	**30%**	**30%**	**30%**	**30%**	**30%**	**30%**	**30%**	**30%**	**30%**	**30%**
Percentage	23%	38%	36%	34%	35%	30%	33%	27%	39%	29%	29%	19%
RAG Rating	GREEN	AMBER	AMBER	AMBER	AMBER	GREEN	AMBER	GREEN	AMBER	GREEN	GREEN	GREEN

Commentary

This is the proportion of delays to discharge from hospital that are the responsibility of social care. 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. As of May 2017, 18.9% of delays are attributable in whole or part to Adult Social Care. For Social Care delayed discharges, the three main reasons were: awaiting nursing home placement (43), awaiting domiciliary care package (22), and awaiting residential placement (22).

APPENDIX A

5) Admissions to permanent residential or nursing care for people aged 65+			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: Older people placed into Permanent Residential and Nursing Care per month

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

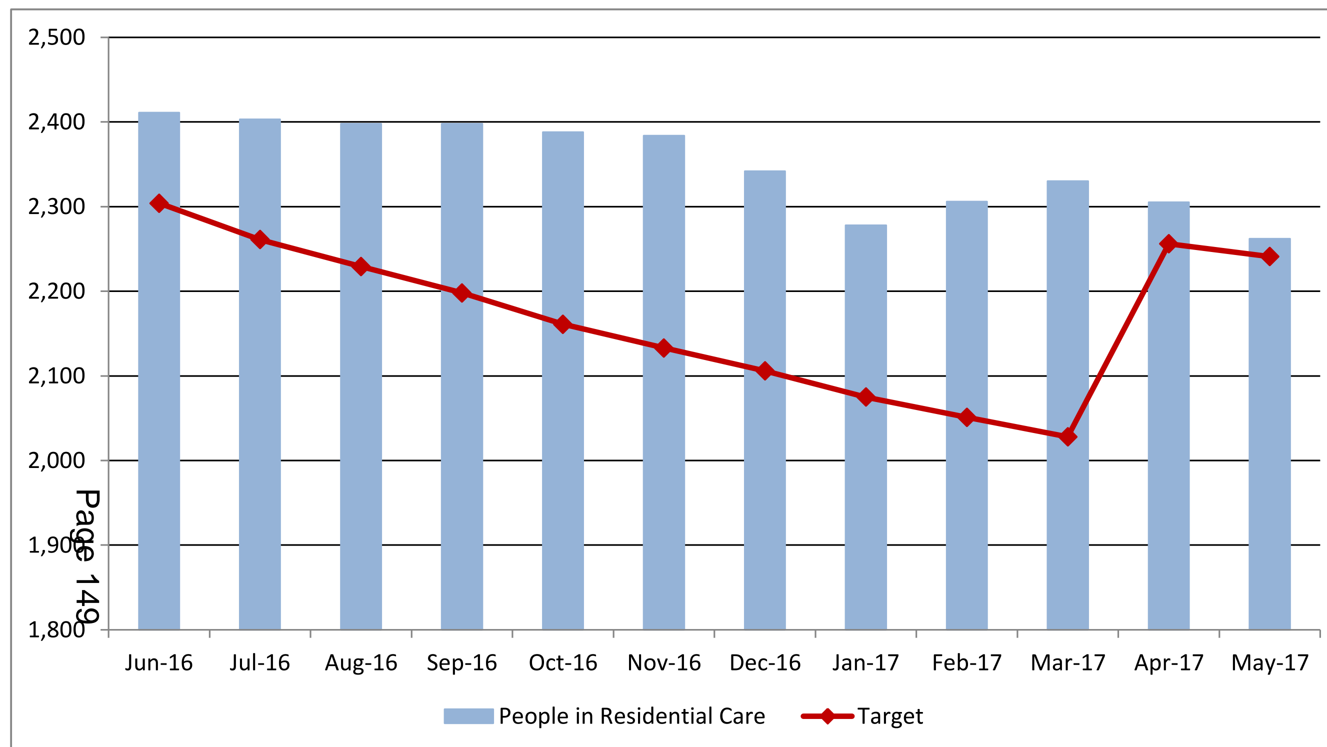
	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17
Target	**128**	**128**	**161**	**128**	**161**	**128**	**128**	**161**	**128**	**128**	**120**	**151**
Resi/ Nursing Admissions	149	128	170	116	164	139	117	108	159	148	124	102
RAG Rating	RED	GREEN	AMBER	GREEN	AMBER	AMBER	GREEN	GREEN	RED	RED	AMBER	GREEN

Commentary

This is the number of older people newly placed in a permanent residential/ nursing care home. Please note that figures for the most recent month are likely to increase due to legitimate delays in inputting whilst placement and funding arrangements are agreed. Reducing admissions to permanent residential or nursing care is a clear objective for the Directorate. Many admissions are linked to hospital discharges, specific circumstances or health conditions, breakdown in carer support, falls, incontinence and dementia. Admissions are examined to understand exactly why they have happened on a monthly basis. 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. As of April 2017 the monthly target is for no more than 30.1 permanent admissions per week for the over 65s to Residential or Nursing Care.

APPENDIX A

6) Number of people aged 65+ in permanent residential care (AS01)			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: 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

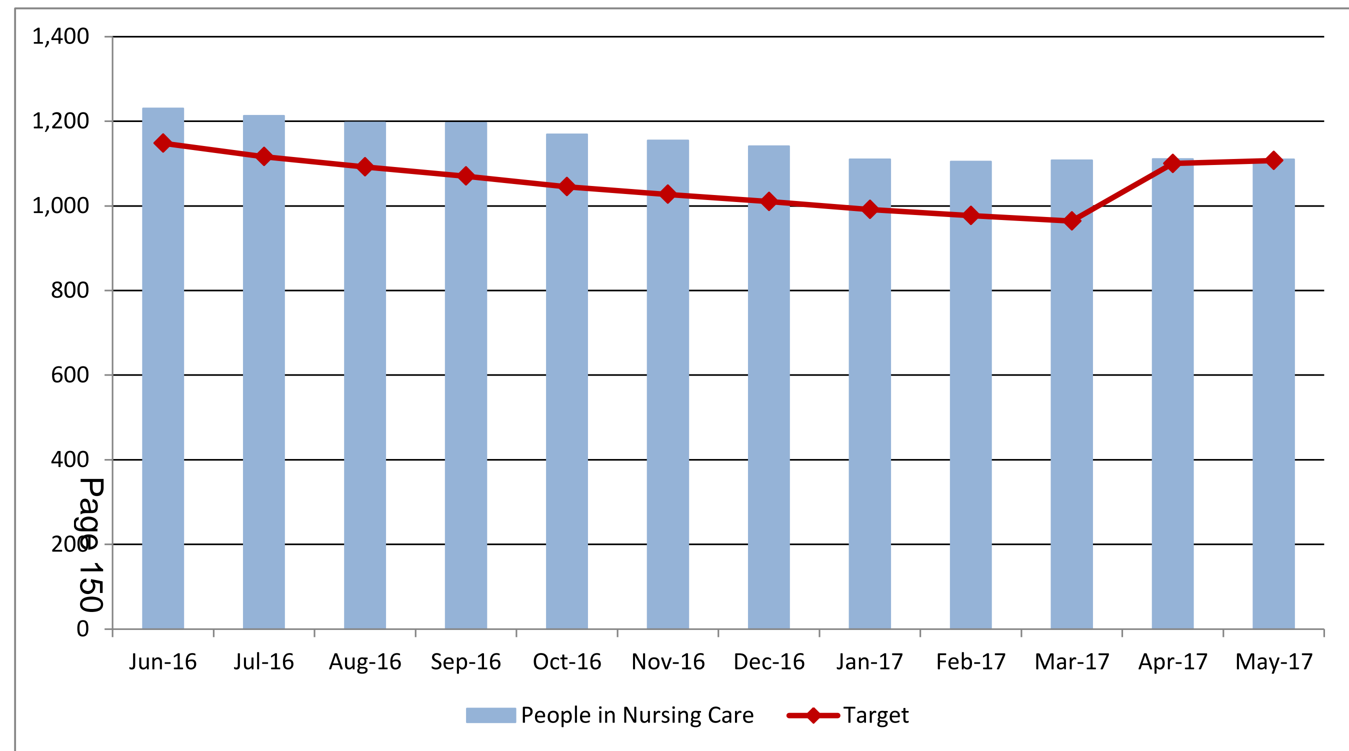
	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17
Target	**2,304**	**2,261**	**2,229**	**2,198**	**2,161**	**2,133**	**2,106**	**2,075**	**2,051**	**2,028**	**2,256**	**2,241**
People in Residential Care	2,411	2,403	2,398	2,398	2,388	2,384	2,342	2,278	2,306	2,330	2,305	2,262
RAG Rating	AMBER	AMBER	AMBER	AMBER	RED	RED	RED	AMBER	RED	RED	AMBER	AMBER

Commentary

This is the number of people in permanent residential care at the end of the month. The number of people aged 65+ in permanent residential care has declined by 149 people in the past 12 months (6.14%) but was above the target level by 21 (0.9%) in May 2017. There is an end of year target of 2,149 people or fewer to be in permanent residential care by 31st March 2018.

APPENDIX A

7) Number of people aged 65+ in permanent nursing care (AS02)			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: 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

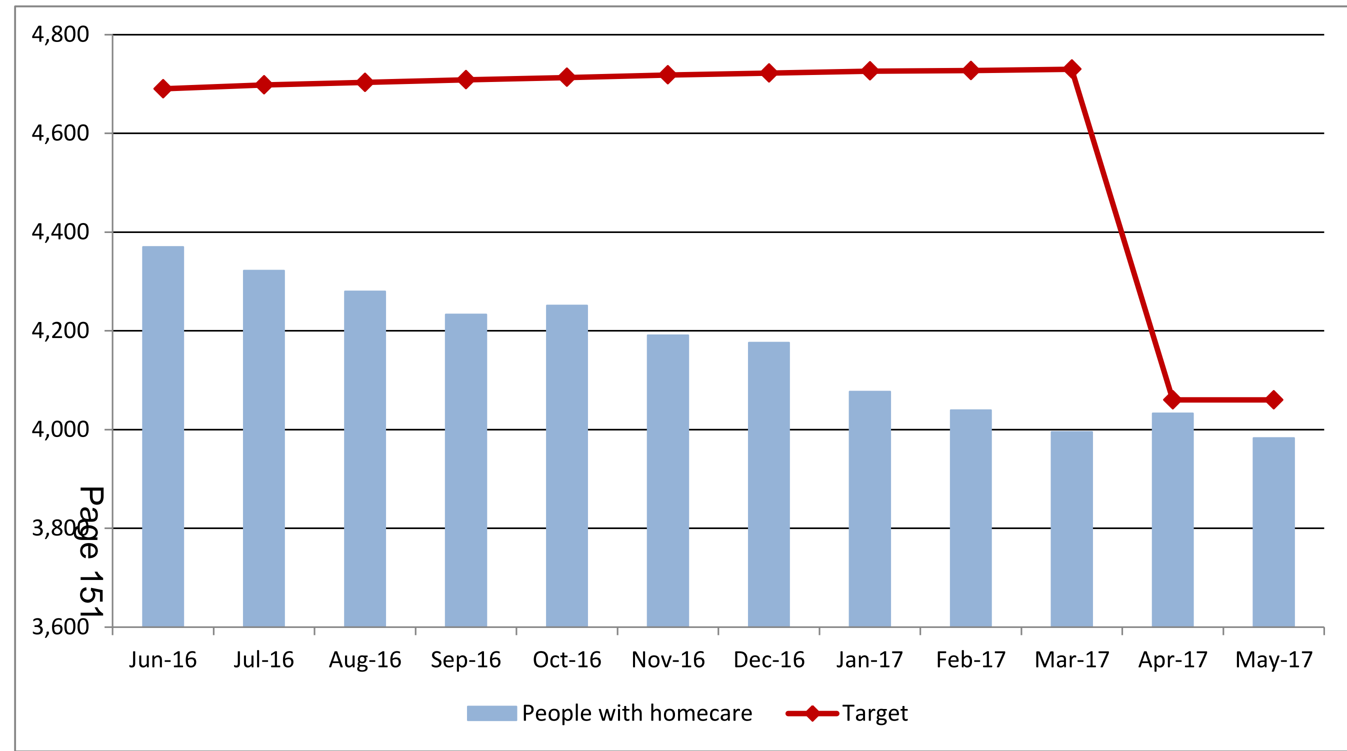
	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17
Target	**1,148**	**1,116**	**1,092**	**1,070**	**1,045**	**1,027**	**1,010**	**991**	**977**	**964**	**1,100**	**1,107**
People in Nursing Care	1,230	1,213	1,197	1,196	1,169	1,155	1,141	1,110	1,105	1,108	1,111	1,110
RAG Rating	AMBER	AMBER	AMBER	RED	RED	RED	RED	RED	RED	RED	AMBER	AMBER

Commentary

This is the number of people in permanent nursing care at the end of the month. The number of people aged 65+ in permanent Nursing Care had been decreasing across Kent (down 120 in the past 12 months) and by May was above the target by 3 clients. There is a target of 1,004 people or fewer in Nursing care by 31 March 2018.

APPENDIX A

8) Number of people receiving homecare (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 homecare

Data Source: Measures of Success - MoS 10

Quarterly Performance Report Indicator

	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17
Target	**4,690**	**4,698**	**4,703**	**4,708**	**4,713**	**4,718**	**4,722**	**4,726**	**4,727**	**4,730**	**4,060**	**4,060**
People with homecare	4,370	4,322	4,280	4,233	4,251	4,191	4,176	4,077	4,039	3,995	4,033	3,983
RAG Rating	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN

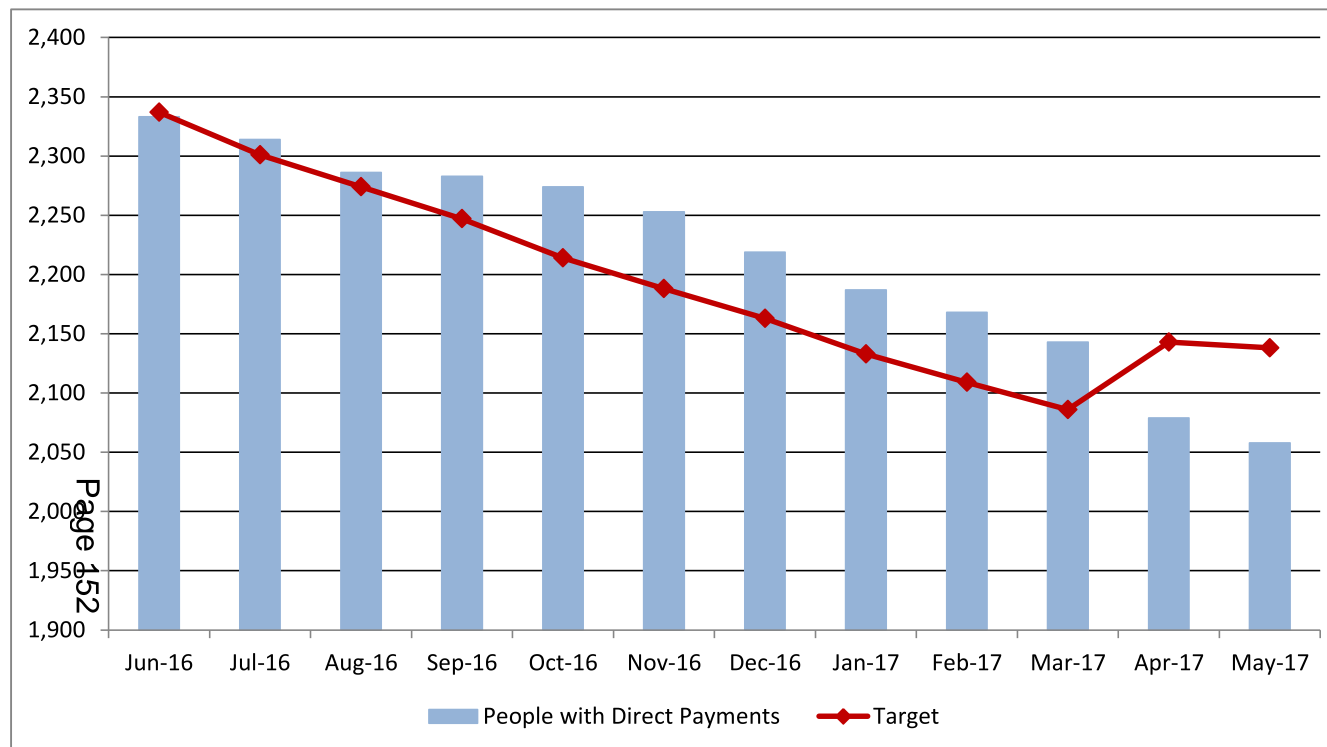
Commentary

This is the total number of people receiving homecare and has remained fairly stable. The 2017-18 target threshold has been lowered significantly to a static target of 4,060, but overall figures remain below target. Homecare is largely delivered to people over the age of 65, with 3,347 people aged 65+ receiving services at the start of May and 636 people aged 18-64 in receipt of a homecare service.

The average hours per older person per week remains slightly below the 2017-18 target of 10 hours or less per person at 9.95 average hours. The 2017-18 target average hours per person aged 18-64 is 11.25, and current performance is 11.44.

APPENDIX A

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

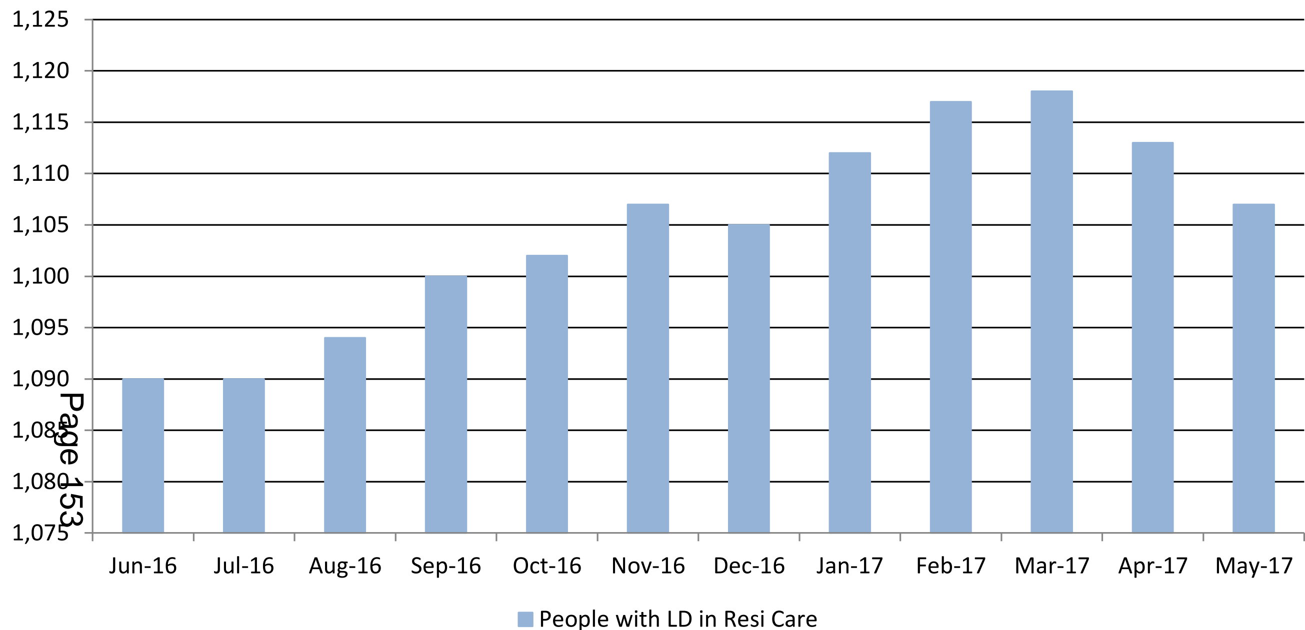
	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17
Target	**2,337**	**2,301**	**2,274**	**2,247**	**2,214**	**2,188**	**2,163**	**2,133**	**2,109**	**2,086**	**2,143**	**2,138**
People with Direct Payments	2,333	2,314	2,286	2,283	2,274	2,253	2,219	2,187	2,168	2,143	2,079	2,058
RAG Rating	GREEN	AMBER	AMBER	AMBER	AMBER	AMBER	AMBER	AMBER	AMBER	AMBER	GREEN	GREEN

Commentary

This the total number of people who have a direct payment and purchase their own care. The total number of people receiving direct payments has been reducing since 2014 when a large number of homecare clients opted for a direct payment when the homecare contract was retendered. 1,095 people aged 18-64 are in receipt of an ongoing Direct Payment, whilst a further 963 ongoing Direct Payments are being made to people over 65.

APPENDIX A

10) Number of people with a learning disability in residential/nursing 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 or nursing care as at month end.

Data Source: MCR Summary

Quarterly Performance Report Indicator

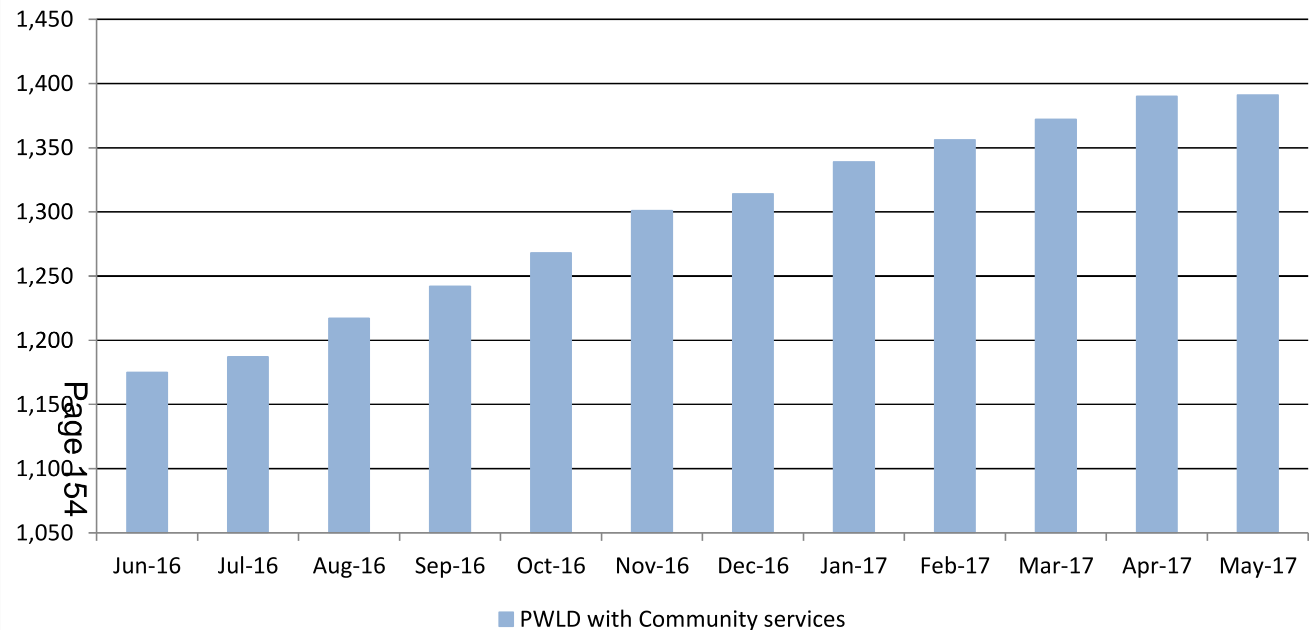
	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17
People with LD in Resi Care	1,090	1,090	1,094	1,100	1,102	1,107	1,105	1,112	1,117	1,118	1,113	1,107
RAG Rating	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN

Commentary

This it the number of people with a learning disability in permanent residential care. 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 as a part of *Your Life, Your Home* 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.

APPENDIX A

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

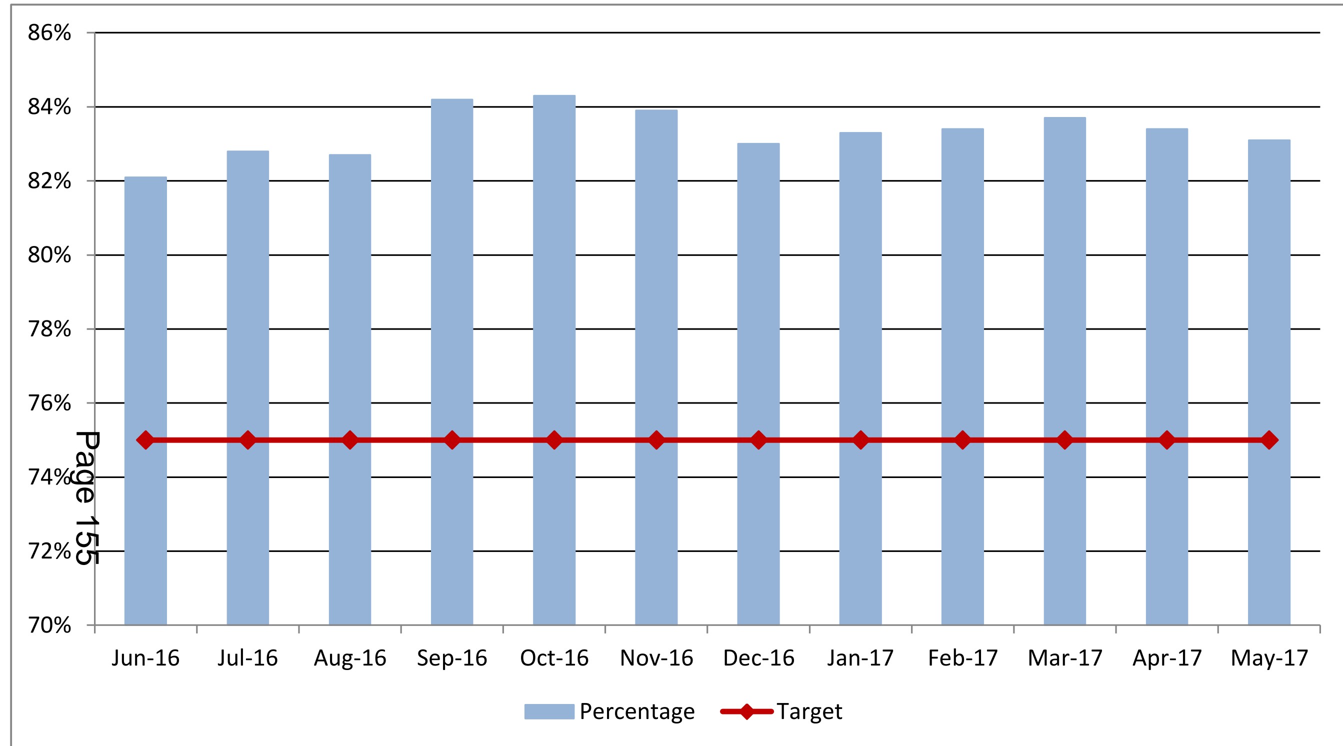
	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17
PWLD with Community services	1,175	1,187	1,217	1,242	1,268	1,301	1,314	1,339	1,356	1,372	1,390	1,391
RAG Rating	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN

Commentary

This is the number of people with a learning disability that are supported in the community. The net number of people with a learning disability receiving a community service (shared lives, supported living and Supporting Independence Service) remains stable and is gradually increasing, with the success of Your Life Your Home contributing to this increase.

APPENDIX A

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

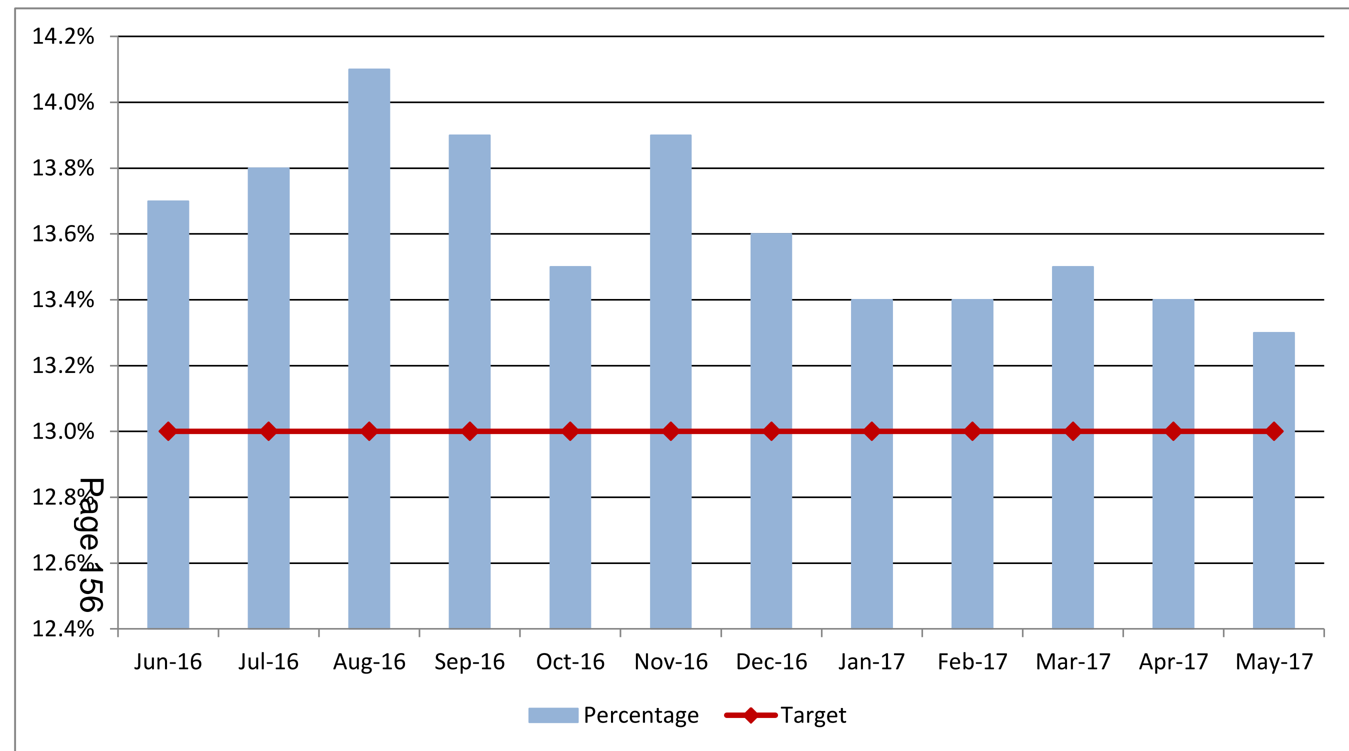
	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17
Target	**75%**	**75%**	**75%**	**75%**	**75%**	**75%**	**75%**	**75%**	**75%**	**75%**	**75%**	**75%**
Percentage	82%	83%	83%	84%	84%	84%	83%	83%	83%	84%	83%	83%
RAG Rating	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN

Commentary

This the percentage of people with a mental health need that are supported to live within the community. This data is provided directly from KMPT and remains above target.

APPENDIX A

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

	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17
Target	**13%**	**13%**	**13%**	**13%**	**13%**	**13%**	**13%**	**13%**	**13%**	**13%**	**13%**	**13%**
Percentage	13.7%	13.8%	14.1%	13.9%	13.5%	13.9%	13.6%	13.4%	13.4%	13.5%	13.4%	13.3%
RAG Rating	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN

Commentary

This the percentage of people with mental health needs that are supported in employment. This data is provided directly from KMPT and remains above target.

From: John Lynch, Head of Democratic Services

To: Adult Social Care Cabinet Committee – 20 July 2017

Subject: **Work Programme 2017/18**

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 Cabinet Committee.

Recommendation: The Adult Social Care Cabinet Committee is asked to consider and note its work programme for 2017/18.

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".*

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 2017/18

3.1 An agenda setting meeting was held on 9 June 2017, 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 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 Cabinet Committee is asked to consider and note its work programme for 2017/18.

6. Background Documents

None.

7. Contact details

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Head of Democratic Services
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Last updated on: 10 July 2017

ADULT SOCIAL CARE CABINET COMMITTEE – WORK PROGRAMME 2017/18

Agenda Section	Items
20 JULY 2017 – 1.30 pm	
	• **Implications of the Policing and Crime Act 2017 for Adult Social Care.** • **Enablement service: to cover demographics, offer, in terms of physical and mental health, performance, integration and links with partners, make up and role of team, outcomes.** (requested by Ms Marsh 1/5/17) • **Dementia offer – similar content to above *(if not covered in recent report to ASCH)*** (requested by Ms Marsh 1/5/17) • **Adult Social Care Performance Dashboards** to alternate meetings • **Annual Complaints Report – Adult Social Care** • **Verbal updates by the Cabinet Member and Corporate Director** • **Work Programme 2017/18** • **Commissioning Options for £20m Government money given to Kent for Adult Social Care provision** • **Domiciliary Care – temporary extension of contract** • **Social Value Framework**
29 SEPTEMBER 2017 – 10.00 am	
	• **Local Account Annual report** – Final version for Members' comment prior to publication • **Transformation Update** (six-monthly) – incl **enablement service** (demographics, offer, performance, links, org, outcomes), **ASC social value framework/Social Value Act, community agents, social prescribing** • **Adult Social Care – Government green paper** • **CQC inspection of local authority commissioning function** • **Peer Reviews** • **End of Life Action Plan** • **SWIFT Replacement** (added by LS, email 10 7 17) • **Budget Monitoring report** (requested by Leader's Group 12 6 17 as regular item) • **Verbal updates by the Cabinet Member and Corporate Director** • **Work Programme 2017/18**
23 NOVEMBER 2017 – 10.00 am	
	• **Adult Social Care Performance Dashboards** to alternate meetings • **Adult Safeguarding** *– as a separate item or as part of a transformation update? (GG and MTS to discuss)* • **Budget Monitoring report** (requested by Leader's Group 12 6 17 as regular item) • **Verbal updates by the Cabinet Member and Corporate Director** • **Work Programme 2017/18** • **Social Impact Bonds** (added by LS, email 6 7 17)
19 JANUARY 2018 – 10.00 am	
	• **Update on Progress against British Deaf Association Charter of British Sign Language pledges** (action from the time limited motion debate at County Council on 8 December 2016) • **Verbal updates by the Cabinet Member and Corporate Director** • **Budget Monitoring report** (requested by Leader's Group 12 6 17 as regular item) • **Work Programme 2018**
9 MARCH 2018 – 10.00 am	

Last updated on: 10 July 2017

- **Draft Directorate Business Plan**
- **Risk Management report** (with RAG ratings)
- **Transformation Update** (six-monthly)
- **Verbal updates by the Cabinet Member and Corporate Director**
- **Budget Monitoring report** (requested by Leader's Group 12 6 17 as regular item)
- **Work Programme 2018**