ADULT SOCIAL CARE CABINET COMMITTEE

Thursday, 27th September, 2018

10.00 am

Kent County Council
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AGENDA

ADULT SOCIAL CARE CABINET COMMITTEE

Thursday, 27 September 2018 at 10.00 am

Ask for: **Emma West**
Telephone: **03000 412421**

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), Mrs A D Allen, MBE, Mrs C Bell, Mrs P M Beresford, Mrs S Chandler, Miss E Dawson, Ms S Hamilton, Mr P J Homewood, Mr D D Monk and Mr R A Pascoe

Liberal Democrat (2): Mr S J G Koowaree and Ida Linfield

Labour (1) Mr B H Lewis

Webcasting Notice

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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 Membership

3 Apologies and Substitutes

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

4 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.

5 Minutes of the meeting held on 4 July 2018 (Pages 5 - 12)

To consider and approve the minutes as a correct record.

6 Verbal Updates by Cabinet Member and Corporate Director

To receive verbal updates from the Cabinet Member for Adult Social Care and the Corporate Director of Adult Social Care and Health.

7 18/00055 - Direct Payment Support Service (Pages 13 - 20)

To receive a report which sets out information relating to the decision to procure a new Direct Payment Support Service to ensure support continues.

8 18/00041 - Community Navigation Service (Care Navigation and Social Prescribing) (Pages 21 - 70)

To receive a report which recommends a decision to approve the commencement of a tender process for the provision of Care Navigation and Social Prescribing services.

9 18/00042 - Local Account for Kent Adult Social Care (April 2017 - March 2018) (Pages 71 - 138)

To receive a report which provides an update on the development of the Local Account for Adult Social Care (April 2017 – March 2018).

10 18/00050 - Shared Supported Living and 24-Hour Care and Support Element of the Supporting Independence Service (Pages 139 - 174)

To receive a report which sets out the rationale behind requesting an extension of the Shared Supported Living Services and 24-Hour Care and Support under the Supporting Independence Services Contract for 11 months in order to enable the Council to fully analyse the service and develop solutions.

11 Integrated Adult Learning Disability Commissioning Section 75 Agreement (Pages 175 - 210)

To receive a report which provides an update regarding the Learning Disability Section 75 Agreement which was established to host integrated commissioning arrangements between Kent County Council and the seven Kent Clinical Commissioning Groups.

12 Development of the Future Provision of Social Care and Support for Adults with Mental Health Needs (Pages 211 - 218)

This report provides an update on the progress in achieving the roadmap for the future provision of social care and support for adults with mental health needs.

13 Care and Support in the Home Services (Pages 219 - 294)

To receive a report which sets out the progress of the Care and Support in the Home Services tender, including provider engagement and market feedback on the specification.

14 Adult Social Care Annual Complaints Report (2017-2018) (Pages 295 - 312)

To receive a report which provides Members with information about the operation of the Adult Social Care Complaints and Representations Procedure between 1 April 2017 and 31 March 2018.

15 Work Programme 2018/19 (Pages 313 - 316)

To receive a report from General Counsel on the committee's work programme.

EXEMPT ITEMS

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

Benjamin Watts
General Counsel
03000 416814

Wednesday, 19 September 2018

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

KENT COUNTY COUNCIL

ADULT SOCIAL CARE CABINET COMMITTEE

MINUTES of A meeting of the Adult Social Care Cabinet Committee held at on Wednesday, 4th July, 2018.

PRESENT: Mrs P T Cole (Chairman), Mrs A D Allen, MBE, Mrs P M Beresford, Mrs S Chandler, Mr I S Chittenden (Substitute for Mr S J G Koowaree), Ms S Hamilton, Mr P J Homewood, Mr P W A Lake, Mr B H Lewis, Ida Linfield, Mr D D Monk and Mr R A Pascoe

OTHER MEMBERS: Graham Gibbens

OFFICERS: Akua Agyepong (Corporate Lead - Equalities and Diversity), Emma Hanson (Head of Strategic Commissioning Adult Community Support), Clare Maynard (Head of Commissioning Portfolio - Outcome 2 and 3), Jack Moss (Procurement Manager), Steph Smith (Performance Monitoring Manager), Penny Southern (Corporate Director, Adult Social Care and Health), Michael Thomas-Sam (Head of Strategy and Business Support), Anne Tidmarsh (Director, Older People and Physical Disability), Paula Watson (Senior Commissioner) and Emma West (Democratic Services Officer)

UNRESTRICTED ITEMS

88. Apologies and Substitutes
(Item 2)

Apologies for absence were received from Mrs C Bell, Miss E Dawson, Mr G Koowaree and Ms D Marsh.

Mr I Chittenden attended as a substitute for Mr G Koowaree.

89. Declarations of Interest by Members in items on the agenda
(Item 3)

Mr B H Lewis declared an interest as his wife was employed by Kent County Council.

90. Minutes of the meeting held on 18 May 2018
(Item 4)

RESOLVED that the minutes of the meeting held on 18 May 2018 are correctly recorded and that they be signed by the Chairman.

91. Verbal Updates by Cabinet Member and Corporate Director
(Item 5)

1. Graham Gibbens (Cabinet Member for Adult Social Care) gave a verbal update on the following issues:

Appointment of Corporate Director of Adult Social Care and Health

Mr Gibbens welcomed the new Corporate Director of Adult Social Care and Health, Penny Southern.

Update on Progress on Pledge 2 of the British Deaf Association Charter

The Kent County Council website met current accessibility standards in line with legal requirements and had been independently verified by the Society of Information Technology Management (SOCITM) and received a 4-star rating. Kent County Council was one of only 6 County Councils to achieve the rating for 2017-18 and had consistently achieved this high rating in previous 4 years. The website was compatible with sight impairment equipment such as Job Access with Speech (JAWS). A series of short British Sign Language (BSL) clips were being produced and put onto the website and information to be put into BSL was being identified by the Deaf Community Worker, this would be extended over time to build up a library of clips. Kent County Council videos would all have subtitles and newsletters updating the Deaf Community on developments would be put into BSL on the Sensory Services Facebook page. The BSL interpreting contract was currently being recommissioned and as part of the work Video Interpreting was being explored. The aim was for deaf people to be able to access all KCC services through a 'front door' on the website. 'Hi Kent' have offered to undertake Deaf Awareness training of reception staff, this would be followed up by Beryl Palmer (Manager of Sensory Disabilities). Wider Deaf Awareness and BSL training would be considered with Workforce Development colleagues as part of the implementation of the Sensory Strategy. Sensory Services staff were continuing to maximise on new digital technology such as Skype to communicate with Deaf people. Kent County Council were working with local Deaf people to help them make most use of new technology developments such as New Generation Text (NGT) which could be used by Deaf people to contact KCC.

2. The Corporate Director of Adult Social Care and Health, Penny Southern, thanked the Committee and staff within Kent County Council for congratulating and welcoming her into her new role and said that she was looking forward to leading Adult Social Care and Health. She then gave a verbal update on the following issues:

Learning Disability Week 2018

Learning Disability Week 2018 was from 18th to 24th June 2018. Penny Southern and Graham Gibbens worked with the Partnership Board who had campaigned with Kent County Council to bring a change into place in Sessions House. She said that many people with learning disabilities had also been campaigning and a new changing place would be opened on 20th July 2018. On 20th July a Craft fair would be taking place in Sessions house to celebrate the opening of the new changing place, this would be a very important day for all of the campaigners and Ms Southern invited Members of the Adult Social Care Cabinet Committee to attend if they were able to. Ms Southern said that during Learning Disability week, she visited Windchimes and Bluebells Short Breaks Services which both had excellent ofsted ratings and offered invaluable respite support.

Equality and Diversity

Ms Southern said that she was delighted to see the LGBT flag raised at Sessions House and to see how supportive KCC staff and Members were to have had the flag raised and how much it meant to the Adult Social Care workforce.

a) Ms Southern received Members' congratulations on her new role.

3. RESOLVED that the verbal updates be noted.

92. 18/00029 - Positive Behavioural Support Service
(Item 6)

Emma Hanson (Senior Commissioner) and Clare Maynard (Head of Commissioning Portfolio – Outcome 2 and 3) were in attendance for this item

1. Clare Maynard introduced the report which set out the Kent and Medway Transforming Care Partnership which sought to develop bespoke and personalised care and support for individuals aged 14 years and over who could move from specialist/secure in-patient services to a community setting for the delivery of their care.

a) In response to a question, Emma Hanson said that overnight care was provided to patients where appropriate.

b) In response to a question, Emma Hanson said the staff that were being recruited for the new service needed to be very experienced care workers. She said that work had been undertaken with providers to ensure that the service did not have a negative impact on other services. Penny Southern said that 43 people had been discharged from the Transforming Care programme to specialist services within Kent. She said that Adult Social Care had recently undertaken work with the University of Kent to ensure that people were appropriately trained and supported to work with people in care.

c) In response to a question, Emma Hanson said that the number of people with Autism Spectrum Disorder (ASD) had increased. She said that Adult Social Care worked closely with the Children, Young People and Education department to ensure that intervention was in place for young people living with ASD and to ensure that they were supported. Anne Tidmarsh said that Adult Social Care had also worked closely with the NHS to develop a joint service. She said that by using enablement, the demand and need of services can be reduced and people would experience a much more fulfilled life in the community.

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

a) undertake a procurement exercise for the provision of a Positive Behavioural Support Service which will commence from September 2018; and

b) 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,

be endorsed.

93. 18/00030 - Care in Home Service
(Item 7)

Clare Maynard (Head of Commissioning Portfolio – Outcome 2 and 3) and Jack Moss (Procurement Manager) were in attendance for this item

1. Clare Maynard introduced the report which set out Care in Home service which was designed to provide care and support for people in order that they can safely reside in their own homes or in supported living accommodation.

   a) In response to a question, Clare Maynard said that the approach to the new service would be consistent and at the highest level, whilst still retaining the ability to innovate. She said that it was important to build upon best practice, understand where changes were needed and drive improvement continuously to allow the whole county to benefit from services.

   b) In response to a question, Jack Moss said that in some cases, older people required overnight care and therefore the service would continue to be commissioned. He said that the service was based on the needs of the service users. Anne Tidmarsh said that budget and resources were also considered with regards to overnight care. Penny Southern said that she would investigate inconsistencies regarding practice and would look at whether policies had been applied correctly around individuals to ensure that the approach was consistent. She said that although overnight care could not be delivered for every service user, a thorough assessment would be undertaken to determine whether the service user would qualify for overnight care services. Mr Gibbens (Cabinet Member for Adult Social Care) said that everyone was entitled to an assessment and assessed needs would be met. He reassured Members of the Committee that they could contact him directly if there was an issue relating to specifically to their local area.

   c) In response to a question, Mr Gibbens said that the funding of Adult Social Care was a significant challenge which faced all upper-tier authorities in the country. He said that it was important to ensure that the policy for the Care in Home service was clear, and that the Adult Social Care services that were provided by Kent County Council were within the available budget whilst continuing to support the most vulnerable people in Kent. Penny Southern said that the work that had been carried out over the last 2 years had shown an investment within Kent's domiciliary services across the market. She said that the Care in Home contract was a procurement process which would stable the market. She added that the contracts would run for specified length of time with the new monies investment and the additional money that Kent had provided to sustain the market over the last year was positive news for the market to support prevention and discharge to hospitals.

   d) In response to a question, Jack Moss said the vulnerable adults that were receiving care packages would be contacted by Kent County Council to confirm whether there would be any changes to their package. He said that it was important to ensure that the transition was smooth and did not cause any major concern to service users.

   e) In response to a question, Clare Maynard said that the services had been commissioned externally over recent years. The provider base needed to be rationalised to allow a better understanding about the market, plan for provider failure and to have greater control.

f) In response to a question, Jack Moss said that across service provisions, there were a higher proportion of small and medium enterprises of which a good proportion were Kent-based businesses.

g) In response to a question, Jack Moss said that through a recent re-let, Adult Social Care in Kent had gained a better understanding of how much unpaid care work was carried out in Kent. He said that he would provide the figure to Committee Members outside of the meeting.

h) In response to a question, Penny Southern said that people often did not want to disclose their sexual orientation which led to a lack of responses to the sexual orientation question in the consultation. She said that it was an important question to ask in terms of how services were commissioned to ensure that the right services were in place for the different types of people that needed them.

i) In response to comments and questions, Jack Moss discussed the figures relating to expenditure that were within the report. Clare Maynard said that all of the separately-commissioned services were delivered into the current budget that was attached to them. She said that by bringing services together it enabled Kent to observe efficiencies and invest wisely as an integrated service. Penny Southern added that the Adult Social Care and Health budget was over £418m and a significant percentage of the budget was spent within the market in Kent, and a significant amount was spent on home care, supporting independence services and residential and nursing homes. She said that the home care services needed to be delivered as a statutory responsibility, if assessed as a need.

j) Mr Gibbens said that it was important to ensure that Kent County Council were doing all that was possible to secure a sustainable market.

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

a) procure a new integrated Care in the Home Service for adults and children with assessed needs, to commence from April 2019; and

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

be endorsed.

(Mr Chittenden, Ida Linfield and Mr Lewis asked that it be recorded that they did not vote in favour of the resolution.)

94. 18/00031 - Residential Care for People with a Learning Disability, People with a Physical Disability and People with Mental Health Needs
(Item 8)

Clare Maynard (Head of Commissioning Portfolio – Outcome 2 and 3) and Paula Watson (Senior Commissioner) were in attendance for this item

1. Clare Maynard introduced the report which set out the intention to establish new contracts for care homes for People with a Learning Disability, People with a Physical Disability and People with Mental Health Needs from April 2019.

   a) In response to a question, Paula Watson said that the residential care market was decreasing. There was an oversupply in the lower service provision and more specialist support needed to be developed. She said that the costing model had allowed transparency in relation to costs to the provider.

   b) Penny Southern said that the market was for younger adults and although there had not been an appropriate contract in place, a person-centred approach had been taken to look at ways in which people that wanted to live in a registered care home through the cost model could be supported, which had changed the market going forward.

   c) In response to a question, Mr Gibbens said that Mosaic was the new client information ICT system which had replaced SWIFT.

   d) In response to a question, Paula Watson said that assessments would take place to ensure that people's needs were met.

2. Mr Gibbens invited the Committee to speak to him directly with regards to specific contract issues and he would ensure that Contract Monitoring items were brought to future meetings of the Committee.

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

   a) enter into market engagement with the aim to procure new contracts for care homes for People with a Learning Disability, People with a Physical Disability and People with Mental Health Needs; and

   b) 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,

be endorsed.

95. Annual Equality and Diversity Report
(Item 9)

Akua Agyepong (Corporate Lead, Equality and Diversity) and Michael Thomas-Sam (Strategic Business Advisor – Social Care) were in attendance for this item

1. Michael Thomas-Sam introduced the report which set out a position statement for Adult Social Care and Health regarding equality and diversity work and progress on equality objectives for 2017/18. Akua Agyepong referred to the corporate policy context within the report and provided an update on the progress that had been made.

   a) In response to a question, Anne Tidmarsh said that although it had proved challenging to recruit staff who were under the age of 25, Adult Social Care

had been focusing on the carer workforce specifically and targeting schools and the NHS to promote careers in social care.

b) In response to a question, Akua Agyepong said that a report could be brought to a future meeting of the Committee in relation to Domestic Abuse.

c) In response to a question, Penny Southern said that specific, targeted work had been undertaken to ensure that providers used the extra money that had been invested in home care appropriately.

2. RESOLVED that report be noted.

96. Performance Dashboard
(Item 10)

Steph Smith (Head of Performance & Information Management) was in attendance for this item

1. Steph Smith introduced the report which set out the progress against targets set for key performance and activity indicators for April 2018 for Adult Social Care.

a) In response to a question, Steph Smith talked about the figure within the report relating to Kent and Medway Partnership Trust – Delayed Transfers of Care and said that the reasoning behind the low figure was being investigated further.

b) In response to a question, Steph Smith said that the targets within the report were set by Kent County Council and were based on demand, population demand, the trend in the service over the last year, and the budget.

2. RESOLVED that the report be noted.

97. Work Programme 2018/19
(Item 11)

1. RESOLVED that the Work Programme for 2018/19 be noted.

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From:	Graham Gibbens, Cabinet Member for Adult Social Care and Public Health Penny Southern, Corporate Director of Adult Social Care and Health
To:	Adult Social Care Cabinet Committee - 27 September 2018
Decision Number:	18/00055
Subject:	**DIRECT PAYMENT SUPPORT SERVICE**
Classification:	Unrestricted
Past Pathway of Paper:	Adult Social Care and Health Directorate Management Team – 19 September 2018
Future Pathway of Paper:	Cabinet Member Decision
Electoral Division:	All

Summary: The option for families with a disabled child to choose to receive a direct payment in lieu of a provided service was given by The Carers and Disabled Children Act 2000. To support families, children and young people in the management of direct payments, the County Council commissions a Direct Payment Support Service. The service was competitively tendered in 2016. The contract is due to expire on 31 March 2019 and there is no scope to further extend the contract. There is a need to procure a new service to ensure support continues.

The annual budget for the service is £342,038, although the exact value of the contract will be determined through a competitive procurement process. The new contract will start on 1 April 2019 with an initial term of three years.

Recommendations: The Adult Social Care Cabinet Committee is asked to **CONSIDER** and **ENDORSE** or make a **RECOMMENDATION** to the Cabinet Member for Adult Social Care and Public Health on the proposed decision (attached as Appendix A) to:
a) **PROCURE** a new contract for the Direct Payment Support Service; and
b) **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.

1. Introduction

1.1 Kent County Council (KCC) commissions a Direct Payment Support Service to help service users manage their direct payments, ensuring that their support needs are being met as described within their care plan. The service also helps to ensure that public money is being used appropriately and to recover money which is not being used.

1.2 The contract for the current service is due to expire on 31 March 2019 and there is no option to further extend the contract.

1.3 This paper aims to provide information about the performance and outcomes of the current service and sets out the commissioning plans for the service from 1 April 2019.

2. Background

2.1 Support to manage direct payments is provided by the Direct Payment Support Service. The service is open to:

- Parents and carers of disabled children
- Parents and carers of children with special educational needs
- Young people aged 16-25 with special educational needs
- Young disabled people aged 16-25

2.2 Most of the support received through the service is for the employment of a suitable personal assistant, who has the skills, knowledge and experience required to support their child/young person. Support workers assist with the writing of job descriptions, contracts of employment and support around advertising. They also ensure that they comply with employment legislation and adopt 'good employer' practices to support staff satisfaction and retention.

2.3 The service also ensures that young people in transition to adulthood and their families have a good experience of support for the transition of their direct payment. Young people over the age of 16 years, with the mental capacity to so do, are supported to manage a direct payment in their own right should they choose to.

2.4 Although the service does not include support for the management of personal health budgets, it does require the service provider to work in partnership with the Clinical Commissioning Groups (CCG) to support a joined-up approach to social care and health direct payments. This helps to ensure, as far as possible, that families who receive joint funding also receive unified support.

2.5 The demand for direct payments are increasing year on year as parents of children with Education Health and Care Plan (EHCP) choose the greater flexibility that direct payments bring.

2.6 The current service was competitively tendered in 2016 and is currently delivered by We Are Beams Ltd.

2.7 The contract expires on 31 March 2019 and there is no option to extend past this date. A competitive procurement process is needed to award a new contract and ensure the service continues to be available.

3. Performance

3.1 The current contract is performing well, and service user evaluation undertaken in January 2018 showed that 92% of service users said that the information and

support provided was either good or excellent. 96% of service users said that the service had made a positive impact on their family.

3.2 The target for undertaking financial reviews with service users has been consistently met by the service provider.

3.3 A strong partnership working has developed with the Adult Direct Payment Support Service which is delivered in-house by KCC. This has ensured that young people avoid a 'cliff edge of care' during the transition into adulthood.

4. Procurement Approach

4.1 Analysis of service provision in other authorities has been completed and market research and engagement indicate that there is a competitive market in Kent. When the service was procured in 2016, KCC received 29 expressions and interest and five organisations submitted a successful tender application.

4.2 Support for Direct Payments is generally provided by Local Authorities in-house, but increasingly councils are seeking external expertise from their provider-base. In most cases where this happens, most of these providers are charities or not-for-profit organisations.

4.3 The options for the procurement of a new service have been considered. There are advantages and disadvantages to each approach but the option to retain an externally commissioned service is recommended. The model encourages a positive relationship to be built between the provider and the Adult Direct Payment Support Team putting Children and Young People at the centre of activities to create a seamless transition into Adulthood. There is robust contract management in place and good levels of performance and customer satisfaction.

4.4 The contracts will be for an initial term of three years, with the option to extend for a further two years.

4.5 It is the intention to undertake a competitive procedure with negotiation and invitations to tender for the service will be published in October this year. The table below sets out the timetable for the procurement process:

Procurement Timetable	
Tender opportunity published	11 October 2018
Tender submission deadline	8 November 2018
Tender evaluation (including service users)	9 – 14November 2018
Negotiation window	15– 21 November 2018
Tender clarification meetings	22– 23 November 2018
Contract award preparation and standstill	w/c 26 November 2018
Contract awarded	w/c 3 December 2018
Contract mobilisation	January – 31 March 2019
New contract commencement	1 April 2019

5. Financial Implications

5.1 The Direct Payment Support Service is funded from the Adult Social Care and Health budget for young people aged between 18 to 25.

5.2 The maximum available budget is £1.7m over the five-year term of the contract although the exact contract value will be determined through the competitive tendering process. The on-going commissioning and contract management process will ensure that KCC maximises the return on this investment.

5.3 A three-year contract with an option to extend for a further two years will give the provider certainty, whilst allowing streamlining the service, standardisation of delivery activities and continuity of Support Worker from childhood through transition to Adulthood.

5.4 The overall contract price will be evaluated through the tender process and will take account of the value and quality of each proposal as well as the cost. This will enable the Council to secure best value through the commissioning process. As the contract value is expected to exceed £1m, delegated authority has been requested to allow the Corporate Director for Adult Social Care and Health to approve the award report.

6. Risks

6.1 The key risk for this service is ensuring that a provider is in place for 1 April 2019 to avoid a break in availability for service users, this has been mitigated in part by the proposed time table for completing this procurement.

6.2 Any change in supplier would present a risk in disruption to delivery. This risk has been mitigated by including mobilisation as a key criterion in tender

evaluation, bidders will be required to provide a detailed mobilisation plan as part of their tender response.

7. Legal Implications

7.1 Direct payments for parents of disabled children is a statutory duty under the Children Act 1989 as amended by Sections 17A (inserted by the Health and Social Care Act 2001) and 17B (inserted by the Carers and Disabled Children Act 2000).

8. Equality Implications

8.1 None

9. Conclusion

9.1 Re-procuring the Direct Payment Support Service will support corporate objectives by ensuring that services are commissioned in line with identified need to deliver corporate priorities on Children and young people in Kent get the best start in life and supporting people to be independent and to take control.

9.2 The increased demand for assessments and for a child to have an Education Health & Care Plan (EHCP) means Direct Payments are increasing year on year as parents of children with plans choose the greater flexibility that direct payments bring. There are high levels of customer satisfaction from service users and parents communicated through surveys conducted annually that demonstrate the success of the current model. Also, there are high levels of satisfaction in the internal Adults service and CCGs about how the provider interfaces with them demonstrated the options will deliver better outcomes. The current provider has continuously met the performance targets set them and agreed to raise the targets under the last contract review.

9.3 The recommendation of the successful bidder will be presented to the Corporate Director of Adult Social Care and Health. A proposed Record of Decision has been included as an accompanying paper to this report.

10. Recommendations

10.1 Recommendation: The Adult Social Care Cabinet Committee is asked to **CONSIDER** and **ENDORSE** or make a **RECOMMENDATION** to the Cabinet Member for Adult Social Care and Public Health on the proposed decision (attached as Appendix A) to:
a) PROCURE a new contract for the Direct Payment Support Service; and
b) 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**.**

11. Background Documents

None

12. Report Author

Karen Sharp
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Karen.sharp@kent.gov.uk

Relevant Director

Penny Southern,
Corporate Director of Adult Social Care and Health
03000 415505
Penny.southern@kent.gov.uk

KENT COUNTY COUNCIL – PROPOSED RECORD OF DECISION

DECISION TO BE TAKEN BY:	DECISION NO:
Cabinet Member for Adult Social Care and Public Health	18/00055

For publication

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

Subject: DIRECT PAYMENT SUPPORT SERVICE

Decision: As Cabinet Member for Adult Social Care and Public Health, I propose to:
a) **PROCURE** a new contract for the Direct Payment Support Service; and
b) **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.

Reason(s) for decision: The option for families with a disabled child to choose to receive a direct payment in lieu of a provided service was given by The Carers and Disabled Children Act 2000. To support families and children in the management of direct payments, the County Council commissions a Direct Payment Support Service. The service was competitively tendered in 2016. The contract is due to expire on 31 March 2019 and there is no scope to further extend the contract. There is a need to procure a new service to ensure support continues.

Financial Implications: The maximum available budget is £1.7m over the five-year term of the contract although the exact contract value will be determined through the competitive tendering process. The on-going commissioning and contract management process will ensure that KCC maximises the return on this investment.

Legal Implications: Direct payments for parents of disabled children is a statutory duty under the Children Act 1989 as amended by Sections 17A (inserted by the Health and Social Care Act 2001) and 17B (inserted by the Carers and Disabled Children Act 2000).

Equality Implications: None

Cabinet Committee recommendations and other consultation: The proposed decision will be discussed at the Adult Social Care Cabinet Committee on 27 September 2018 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:

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signed date

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From:	Graham Gibbens, Cabinet Member for Adult Social Care and Public Health Penny Southern, Corporate Director of Adult Social Care and Health
To:	Adult Social Care Cabinet Committee – 27 September 2018
Decision No:	18/00041
Subject:	**COMMUNITY NAVIGATION SERVICE (CARE NAVIGATION AND SOCIAL PRESCRIBING**)
Classification:	Unrestricted
Past Pathway of Paper:	Adult Social Care and Health Directorate Management Team -11 July and 22 August 2018, Strategic Commissioning Board - 23 July 2018
Future Pathway of Paper:	Cabinet Member decision
Electoral Division:	All

Summary: This report details the approach for progressing a Wellbeing and Resilience Strategy with focus on Care Navigation and Social Prescribing services with Health services. The report also provides an outline plan to establish appropriate arrangements for a high number of current grant arrangements. The new arrangements will ensure full compliance with KCC and national policy.

This paper therefore recommends a decision to approve the commencement of a tender process for the provision of Care Navigation and Social Prescribing services. It also recommends a decision to establish interim arrangements throughout 2019 for the remaining grant arrangements to allow for a tender or appropriate process for a Community Based Wellbeing Service during 2019.

Recommendation(s): The Adult Social Care Cabinet Committee is asked to **CONSIDER** and **ENDORSE**, or **MAKE RECOMMENDATIONS** to the Cabinet Member for Adult Social Care and Public Health on the proposed decision (attached as Appendix A) to work with commissioners to:
a) **UNDERTAKE** an open tendering process for a Care Navigation and Social Prescribing Contract;
b) **ESTABLISH** interim arrangements from 1 April 2019 for a minimum period of nine months for the majority of the remaining historic grants to allow for the full tender or appropriate process by 2020 in relation to community-based wellbeing services; and
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.

1. Introduction

1.1 Kent County Council's Adult Social Care and Health (ASCH) Directorate currently provides grant funding to 53 organisations in the voluntary and community sector. (see appendix 1a and 1b). These grants fund a range of community-based support for Older People, People living with Dementia, People with a Physical Disability and People with Sensory Impairments. There are also interim contracts for support services for carers. Some grants are historic arrangements dating back over ten years, and the current practice of awarding them places the ASCH Directorate in non-compliance with the Council's Voluntary, Community and Social Enterprise (VCSE) Policy.

1.2 Work undertaken during 2017-18 to commission a Core Offer of Community-based Wellbeing support for Older People and People living with Dementia, and an offer for People with a Physical Disability was halted to achieve savings against the voluntary sector budget. Recognising the impact that the reduced budget would have on existing proposals, the Adult Social Care Cabinet Committee agreed at its meeting of 23 November 2017, that a new approach was needed to end the remaining grants and to commission wellbeing support.

1.3 This paper outlines the proposed new two stage approach. Specifically, that the Council will commission care navigation services that connect people to the support that they need by 1 April 2019, and then commission the support that people are navigated to for 1 April 2020. (see Appendix 2). This approach will necessitate interim arrangements for historic grants from 1 April 2019 (see section 7).

2. Financial Implications

2.1 The proposed Care Navigation and Social Prescribing Contract will be funded by ending existing historic grants for community care navigators and the contract for carers assessment and reinvesting the money into the new contract.

2.2 Dartford, Gravesham, Swanley and Swale Clinical Commissioning Group (CCG) have gained agreement to invest £200k and will jointly commission care navigation with adult social care for their locality.

2.3 The proposal is to increase funding in this service by £411,242, effectively doubling the number of care navigators commissioned by ASCH. Additional funding will be sourced from ending existing grants and the predicted underspend in the adult social care demand led element of the carers contract, creating a total contract value of £5,931,861 per year (£23,727,444 over four years) - see appendix 3 for details.

3. Strategic Statement and Policy Framework

3.1 This proposal supports the strategic outcomes of the Council by providing a support service which works with people to identify their aims and aspirations,

connects them to community resources and activities that promote wellbeing and reduce social isolation.

3.2 It will support the Your Life, Your Wellbeing Strategy 2016 – 2021 through enabling people to remain well and independent through the delivery of sustainable services and managing demand on social care services.

3.3 The proposal supports the development of Local Care Models as outlined in the Kent and Medway Sustainability and Transformation Plan by commissioning care navigation and social prescribing to reduce demand on health and social care and improve outcomes for people through the use of non-medical interventions.

3.4 The proposal will enable the Council to meet its duties under the Care Act 2014 by promoting wellbeing for individuals and their carers, through the provision of information and advice that enables people to make choices about their care, by preventing or delaying people deteriorating to the point where they require health or social care support and through supporting market sustainability.

4. Current Arrangements

4.1 The Council currently commissions 12 community-based care navigators, one per district. Funding for these roles will end on 31 March 2019. The CCGs in Kent also commission a range of care navigation and social prescribing services that reflect the needs and demands of their populations. District councils have invested in care navigator roles to support people specifically in relation to their housing needs.

4.2 As a result, demand for these services is being met through a range of different care navigation models and roles across the county. These are not all linked up or coordinated creating duplication, lack of clarity regarding remit and a disjointed pathway for professionals and people.

5. Proposed model

5.1 Care Navigation has a key role to play in managing demand on health and social care services. It is defined as a role providing a proactive link between different parts of the system; being both a first point of contact for individuals, carers and health and social care professionals, as well as guiding and co-ordinating the individual's journey through the care system.

5.2 Social prescribing is a way of linking people to sources of support within the community, providing health and social care professionals with non-medical/non-service focused options that can operate alongside existing treatments or care packages to improve health and well-being.

5.3 These roles work with people to identify the type of support that they need to be as well and independent as possible. Care navigators and social prescribers connect people to community-based support and activities, reducing social isolation and minimising dependence of health and social care services, except

where necessary. They work with people to maximise their benefits, enabling people to be financially independent and be able to afford to attend activities and groups. Care navigators can also act as a trusted assessor for small equipment and telecare.

5.4 Following engagement with a range of stakeholders, the Council intends to commission a care navigation role, which embeds an ethos of social prescribing at its heart. The role will support older people, carers and people living with dementia not only to identify community assets that can support them but to initially engage in those activities recognising that some people will need this. Carers needing a carers assessment will be able to receive one through this service.

5.5 While the preferred option would be to have an agreed county wide model of care navigation and social prescribing, it is recognised that commissioned models need to reflect the needs of local populations and that existing arrangements prevent a fully jointly commissioned model being implemented at this time. Therefore, the proposal is to jointly commission where possible and coordinate services and align pathways where not.

5.6 The inclusion of carers assessments within the scope of this contract will mean that care navigators can work with people as a family unit, identifying support for the individual with care needs as well as their carer and providing a statutory carers assessment if required.

6. The Contract

6.1 As part of the new contract, commissioners will expect to see more people being connected to local community assets, arts, culture and heritage groups and sports and physical activities, rather than community based 'services'. The role will seek to work with people taking a holistic approach, identifying issues before they arise as opposed to simply focusing on the reason for referral. Care navigators will be closely aligned to GP clusters and multi-disciplinary teams (MDTs). In addition, there will be stronger links between community care navigators and community teams within District Councils to encourage information sharing especially on local services, assets and gaps in support. Local groups will be able to advertise and promote their services with the care navigators and networks so that local people with specific interests are directed to groups. There are good examples where this has worked successfully where networks are established, particularly with arts, culture and heritage groups not traditionally considered as services.

6.2 Engagement has been undertaken both in relation to current proposals and in relation to the predecessor of this proposal, the Older Person and People Living with Dementia Core Offer.

6.3 The following options were considered to implement this proposal included:

- block contract
- framework contract
- framework with a block element

- moving existing grants onto interim contracts, essentially maintaining the status quo

6.4 Following an appraisal of these options, the preferred option is to commission using a block contract.

6.5 To support movement towards joint commissioning, the block contract will be set up for an initial four-year period with clear break and extension clauses. It will include the facility to vary the contract in relation to value and specification, enabling the CCGs to utilise the contract where appropriate as their existing commissioning arrangements end.

6.6 The contract will be lotted geographically aligning to CCG boundaries i.e. East Kent, West Kent and Dartford, Gravesham, Swanley and Swale and there will be two service lots (Community Care Navigation and Carers Care Navigation).

6.7 It is proposed that, following a competitive tendering process, the Corporate Director of Adult Social Care and Health will agree to award the contract(s) under the Council's Officer Scheme of Delegation.

7. Interim Arrangements for remaining grants from 1 April 2019

7.1 As noted above (section 1.3), the Wellbeing Strategy outlines a two-stage process whereby the Council will commission care navigation services by 1 April 2019, and the support that people are navigated to, by 2020. The proposal will necessitate interim arrangements for the remaining historic grants from 1 April 2019.

7.2 Once grants for care navigation are removed, the remaining historic agreements, and hence the interim measures, will involve 48 organisations and a total of £5.9m funding per year. Interim measures will clearly detail the terms and conditions of the funding provided, include a performance monitoring framework, information requirements and will be General Data Protection Regulation (GDPR) compliant. A financial assessment of organisations will be undertaken to understand the impact of interim measures.

7.3 In line with the Kent Compact, commissioners will write to the organisations affected by the end of September 2018 to detail what interim arrangements will mean for them and will work with providers to have interim arrangements in place for 1 April 2019.

7.4 It is proposed that the current funding arrangements are established via a grant arrangement from 1 April 2019, for a minimum period of nine months, to 31 December 2019. Additional performance measures information exchange and General Data Protection Regulation compliance will be established so that the specification for the Wellbeing and Resilience Contract is well informed. This will be for a minimum of nine months whilst a tender or other appropriate process for the Community Based Wellbeing Contract which is expected to be in place from 2020.

7.5 Once the arrangements are in place, monitoring will be undertaken to establish how and what the demand is for services for people eligible for social care, the types of activities undertaken and the overall design for the tender for future community-based wellbeing services.

8. Legal Implications

8.1 Given the nature of the current grant agreements, it is likely that TUPE will apply for a contract from 2020. The specific arrangements established for the impacted organisations will need legal advice, which is being explored.

8.2 Advice is being sought on requirements for General Data Protection Regulations and proportionate performance monitoring information.

9. Equality Implications

9.1 An Equality Impact Assessment had been completed and is attached as Appendix 4.

9.2 The people most likely to be impacted by changes to this service are older people and carers who are the recipients of the current service. The service to this group will continue and because it is a short-term intervention, people are unlikely to experience a change in provider as part of a handover process, although there may need to be a waiting list implemented while transition between providers occurs. Overall the positive impact is likely to outweigh the negative as the service is more integrated, with reduced duplication of roles and pathways. Increasing investment will enable more people to receive support.

10. Conclusions

10.1 Care navigation and social prescribing can play a key role in promoting wellbeing and improving outcomes for people by connecting them to assets and resources within their local communities. The Adult Social Care and Health Directorate benefits from people being less dependent on their services.

10.2 Kent's CCGs, district and borough councils and adult social care all invest in care navigation and social prescribing services to different degrees resulting in a patchwork of provision across the county and different models that, while meeting demand, is disjoined, unclear and creating duplication.

10.3 The proposal is to commission a Care Navigation and Social Prescribing Service to support older people, carers and people living with dementia which will improve outcomes for people, reduce duplication and create clearer pathways. There will be an emphasis on aligning community care navigators to GP clusters and MDTs as well as closer working with District Council Community Teams. The service will be jointly commissioned where possible and coordinated where existing arrangements prevent joint commissioning.

10.4 Given the increasing evidence regarding impact, the proposal is to increase Adult Social Care investment in this service. The new contract will take effect on 1 April 2019.

10.5 Following the implementation of this contract, work will begin to design a range of community-based services promoting wellbeing and resilience that people can be navigated to. This new service will be in place in 2020.

10.6 This will require interim measures for existing historic grants agreements.

11. Recommendation(s)

11.1 Recommendation(s): The Adult Social Care Cabinet Committee is asked to **CONSIDER** and **ENDORSE**, or **MAKE RECOMMENDATIONS** to the Cabinet Member for Adult Social Care and Public Health on the proposed decision (attached as Appendix A) to work with commissioners to:
a) **UNDERTAKE** an open tendering process for a Care Navigation and Social Prescribing Contract;
b) **ESTABLISH** interim arrangements from 1 April 2019 for a minimum period of nine months for the majority of the remaining historic grants to allow for the full tender or appropriate process by 2020 in relation to community-based wellbeing services; and
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.

12. Background Documents

Older People and People Living with Dementia Wellbeing Core Offer
https://democracy.kent.gov.uk/mgIssueHistoryHome.aspx?IId=45456&Opt=

Physical Disability Wellbeing Core Offer
https://democracy.kent.gov.uk/mgIssueHistoryHome.aspx?IId=46001

13. Report Author

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KENT COUNTY COUNCIL – PROPOSED RECORD OF DECISION

DECISION TO BE TAKEN BY:	DECISION NO:
Cabinet Member for Adult Social Care and Public Health	18/00041

For publication

Key decision

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

Subject:

Decision: As Cabinet Member for Adult Social Care and Public Health, I propose to work with commissioners to:
a) **UNDERTAKE** an open tendering process for a Care Navigation and Social Prescribing Contract;
b) **ESTABLISH** interim arrangements from 1 April 2019 for a minimum period of nine months for the majority of the remaining historic grants to allow for the full tender or appropriate process by 2020 in relation to community-based wellbeing services; and
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.

Reason(s) for decision: Commissioning a Care Navigation and Social Prescribing Service to support older people, carers and people living with dementia which will improve outcomes for people, reduce duplication and create clearer pathways. There will be an emphasis on aligning community care navigators to GP clusters and MDTs as well as closer working with District and Borough Council Community Teams. The service will be jointly commissioned where possible and coordinated where existing arrangements prevent joint commissioning.

Financial Implications: The proposed Care Navigation and Social Prescribing contract will be funded by ending existing historic grants for Community Care Navigators and ending the contract for Carers Assessment and reinvesting the money into the new contract. Dartford, Gravesham, Swanley and Swale Clinical Commissioning Group have gained agreement to invest £200k and will jointly commission care navigation with adult social care for their locality. It is proposed to increase funding in this Care Navigation Service by £411,242, effectively doubling the number of care navigators commissioned by Adult Social Care and Health. Additional funding will be sourced from ending existing grants and the predicted underspend in the Adult Social Care and Health demand led element of the carers contract, creating a total contract value of £5,931,861 per year (£23,727,444 over four years).

Legal Implications: Given the nature of the current grant agreements, it is likely that TUPE will apply. The specific arrangements established for the impacted organisations will need legal advice, which is being explored. Advice is being sought on the right route for an interim arrangement for 2019-20 for the second stage required in implementing the full Community Based Wellbeing Service.

Equality Implications: An Equality Impact Assessment had been completed and is attached as. The people most likely to be impacted by changes to this service are older people and carers who are the recipients of the current service. The service to this group will continue and because it is a short-term intervention, people are unlikely to experience a change in provider as part of a handover process, although there may need to be a waiting list implemented while transition between providers occurs. Overall the positive impact is likely to outweigh the negative as the service is more integrated, with reduced duplication of roles and pathways. Increasing investment will enable more people to receive support.

Cabinet Committee recommendations and other consultation: The proposed decision will be discussed at the Adult Social Care Cabinet Committee on 27 September 2018 and the outcome included in the paperwork which the Cabinet Member will be asked to sign.
Any alternatives considered:
Any interest declared when the decision was taken and any dispensation granted by the Proper Officer:

....

signed date

Appendix 1a: Summary of Adult Social Care Grants within scope of the Wellbeing and Resilience Commissioning Strategy

Client group	18/19 Spend	Number of Organisations	Examples of services provided	Examples of Organisations
Older people	£4,446,985	39	Day services for elderly frail people Befriending services for people who are housebound or socially isolated Care navigation for older people	Age UK Canterbury CROP (EK) Involve Tonbridge Baptist Church
Sensory	£1,081,472	2	Assessment and rehabilitation for people with sensory issues Services, such as hearing aid clinics, for people with sensory impairments	Hi Kent Kent Association for the Blind
Dementia	£655,576	5	Dementia Cafes and peer support groups Day services for people living with dementia Dementia outreach services	Alzheimer's Society (Kent & Medway) Caring Altogether on Romney Marsh (CARM) Trinity Community Resource Centre
Physical Disability	£148,616	3	Information and advice for people with physical disability	Centre for Independent Living in Kent (CILK) Disability Information Services Kent (DISK) Kent Association for Spina Bifida and Hydrocephalus
All	£18,408	4	Voluntary transport	Ashford Citizens Advice Bureau Compaid Trust Edenbridge Voluntary Transport Service Sevenoaks Volunteer Transport Group
Total	**£6,351,057**	**53**		

*contract

Appendix 1b: Details of Adult Social Care Grants within scope of the Wellbeing and Resilience Commissioning Strategy

Organisation	Adult Social Care Grant Value for 2018-19	Location		Client Group	Primary Service	Commissioning Plan
		CCGs	Districts			
Age Concern Deal	£ 170,739.50	South Kent Coast	Dover	OP	Advocacy Bathing Social Opportunities	Interim arrangement 2019-20. End for new contract 1st April 2020
Age Concern Malling	£ 78,680.15	West Kent	Tonbridge & Malling	OP	Social Opportunities	Interim arrangement 2019-20. End for new contract 1st April 2020
Age UK Ashford	£ 118,946.89	Ashford	Ashford	OP	Advocacy Bathing Social Opportunities	Interim arrangement 2019-20. End for new contract 1st April 2020
Age UK Canterbury	£ 198,725.98	Canterbury & Coastal	Canterbury	OP	IAG - Care Navigator Younger Person Dementia Day Support Social Opportunities Dementia Day Support All Ages	Reduce for 2019 for care navigation contact. Interim arrangement 2019-20. End for new contract 1st April 2020
Age UK Dover	£ 78,767.51	South Kent Coast	Dover	OP	Bathing Social Opportunities	Interim arrangement 2019-20. End for new contract 1st April 2020

Age UK Faversham & Sittingbourne	£	475,130.27	Canterbury & Coastal Swale	Swale	OP	Advocacy Bathing - Domiciliary IAG Social Opportunities Dementia Carers Support	Reduce for 2019 for care navigation contact. Interim arrangement 2019-20. End for new contract 1st April 2020
Age UK Folkestone	£	137,862.40	South Kent Coast	Shepway	OP	IAG Social Opportunities	Interim arrangement 2019-20. End for new contract 1st April 2020
Age UK Herne Bay & Whitstable	£	271,831.99	Canterbury & Coastal	Canterbury	OP	Dementia Café Bathing Social Opportunities	Interim arrangement 2019-20. End for new contract 1st April 2020
Age UK Hythe & Lyminge	£	200,046.15	South Kent Coast	Shepway	OP	Bathing Social Opportunities	Interim arrangement 2019-20. End for new contract 1st April 2020
Age UK Maidstone	£	216,731.39	West Kent	Maidstone	OP	Advocacy Bathing - Domiciliary Social Opportunities	Interim arrangement 2019-20. End for new contract 1st April 2020
Age UK NWK	£	575,235.27	Dartford, Gravesham & Swanley	Dartford	OP	Advocacy Bathing - Domiciliary Social Opportunities	Interim arrangement 2019-20. End for new contract 1st April 2020
Age UK Sandwich	£	83,820.64	Canterbury & Coastal	Dover	OP	Social Opportunities Social Opportunities - Dementia	Interim arrangement 2019-20. End for new contract 1st April 2020

Age UK Sevenoaks & Tonbridge	£	287,664.75	West Kent	Sevenoaks Tonbridge & Malling	OP	Advocacy Social Opportunities	Interim arrangement 2019-20. End for new contract 1st April 2020
Age UK Sheppey	£	139,478.49	Swale	Swale	OP	IAG Social Opportunities	Interim arrangement 2019-20. End for new contract 1st April 2020
Age UK Tenterden	£	68,207.04	Ashford	Ashford	OP	Bathing Social Opportunities	Interim arrangement 2019-20. End for new contract 1st April 2020
Age UK Thanet	£	200,134.50	Thanet	Thanet	OP	Bathing Social Opportunities Social Opportunities - Dementia	Interim arrangement 2019-20. End for new contract 1st April 2020
Age UK Tunbridge Wells	£	217,597.16	West Kent	Tunbridge Wells	OP	Bathing - Domiciliary Social Opportunities	Interim arrangement 2019-20. End for new contract 1st April 2020
Alzheimer's & Dementia Support Services	£	263,499.72	Dartford, Gravesham & Swanley	Dartford Gravesham Sevenoaks	OP	Dementia Community Support	Interim arrangement 2019-20. End for new contract 1st April 2020
Alzheimer's Society (Kent & Medway)	£	286,395.54	West Kent	Maidstone Tonbridge & Malling Tunbridge Wells Sevenoaks	OP	Dementia Community Support	Interim arrangement 2019-20. End for new contract 1st April 2020
Ash Cum Ridley Parish Council	£	2,404.92	West Kent	Maidstone Tonbridge & Malling Tunbridge Wells	OP	Day Opportunities	Interim arrangement 2019-20. End for new contract 1st April 2020

			Sevenoaks			
Ashford & District Volunteer Bureau	£ 83,441.89	Ashford	Ashford	OP	Befriending IAG IAG – Care Navigator	Reduce for 2019 for care navigation contact. Interim arrangement 2019-20. End for new contract 1st April 2020
Ashford Citizens Advice Bureau	£ 746.02	Ashford	Ashford	ALL	IAG	Interim arrangement 2019-20. End for new contract 1st April 2020
Bright Shadow	£ 6,871.20	Thanet	Thanet	Dementia	Dementia Peer Support	Interim arrangement 2019-20. End for new contract 1st April 2020
Caring Altogether on Romney Marsh (CARM)	£ 49,080.00	Ashford	Ashford	Dementia	Day Opportunities	Interim arrangement 2019-20. End for new contract 1st April 2020
Centre for Independent Living in Kent (CILK)	£ 74,684.05	Ashford Dartford, Gravesham & Swanley	Ashford Dartford Gravesham Sevenoaks	LD/PD	Advocacy IAG Peer Support	Interim arrangement 2019-20. End for new contract 1st April 2020
Christians Caring	£ 8,597.83	West Kent	Maidstone Tonbridge & Malling Tunbridge Wells Sevenoaks	OP	Day Opportunities	Interim arrangement 2019-20. End for new contract 1st April 2020

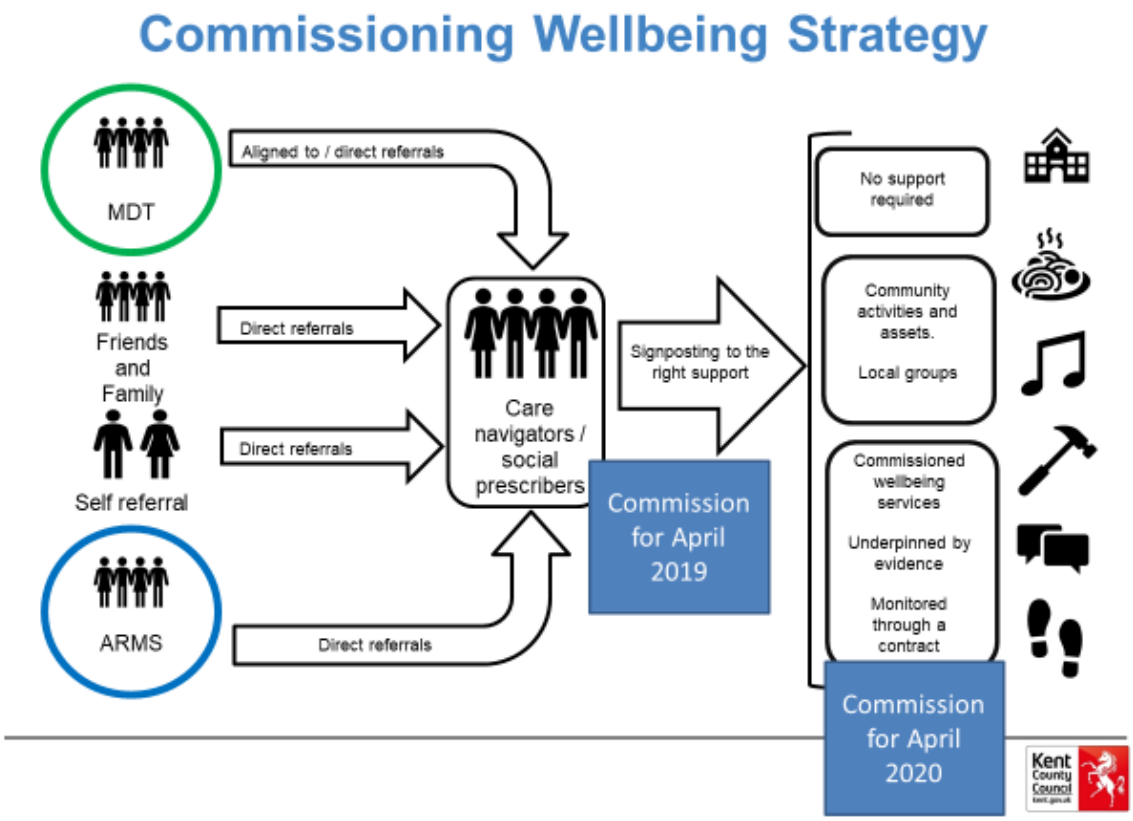
Compaid Trust	£	11,484.72	West Kent	Maidstone Tonbridge & Malling Tunbridge Wells Sevenoaks	ALL	Day Opportunities	Interim arrangement 2019-20. End for new contract 1st April 2020
CROP (EK)	£	69,465.00	Canterbury & Coastal	Canterbury	OP	IAG	Interim arrangement 2019-20. End for new contract 1st April 2020
Disability Information Services Kent (DISK)	£	42,520.95	South Kent Coast	Thanet Shepway Dover	LD/PD	IAG	Interim arrangement 2019-20. End for new contract 1st April 2020
Edenbridge Voluntary Transport Service	£	4,459.41	West Kent	Maidstone Tonbridge & Malling Tunbridge Wells Sevenoaks	ALL	Transport	Interim arrangement 2019-20. End for new contract 1st April 2020
FACE (Faversham Assistance Centre)	£	14,366.70	Canterbury & Coastal	Canterbury	OP	Miscellaneous	Interim arrangement 2019-20. End for new contract 1st April 2020
Good Neighbour Project	£	24,540.00	West Kent	Maidstone Tonbridge & Malling Tunbridge Wells Sevenoaks	OP	Befriending	Interim arrangement 2019-20. End for new contract 1st April 2020
Heart of Kent Hospice	£	13,742.40	West Kent	Maidstone Tonbridge & Malling Tunbridge Wells Sevenoaks	OP	Day Opportunities	Interim arrangement 2019-20. End for new contract 1st April 2020
Hersden	£	4,908.00	Canterbury &	Canterbury	OP	Day Opportunities	Interim arrangement

Neighbourhood Centre Association		Coastal				2019-20. End for new contract 1st April 2020
Hi Kent	£ 277,662.25	Ashford Canterbury & Coastal Dartford, Gravesham & Swanley South Kent Coast Swale Thanet West Kent	Ashford Canterbury Dartford Dover Gravesham Maidstone Sevenoaks Shepway Swale Thanet Tonbridge & Malling Tunbridge Wells	Sensory	Assessment and Equipment	Interim arrangement 2019-20. End for new contract 1st April 2020
Hospice in the Weald	£ 24,540.00	West Kent	Maidstone Tonbridge & Malling Tunbridge Wells Sevenoaks	OP	Befriending	Interim arrangement 2019-20. End for new contract 1st April 2020
Imago Community - Care Navigators	£ 190,192.85	Dartford, Gravesham & Swanley Swale	Dartford Gravesham Sevenoaks Swale	OP	IAG - Care Navigators	End 2019: Care navigation contract
Involve - Befriending	£ 6,225.31	West Kent	Maidstone Tonbridge & Malling Tunbridge Wells Sevenoaks	OP	Befriending/Forums	Interim arrangement 2019-20. End for new contract 1st April 2020

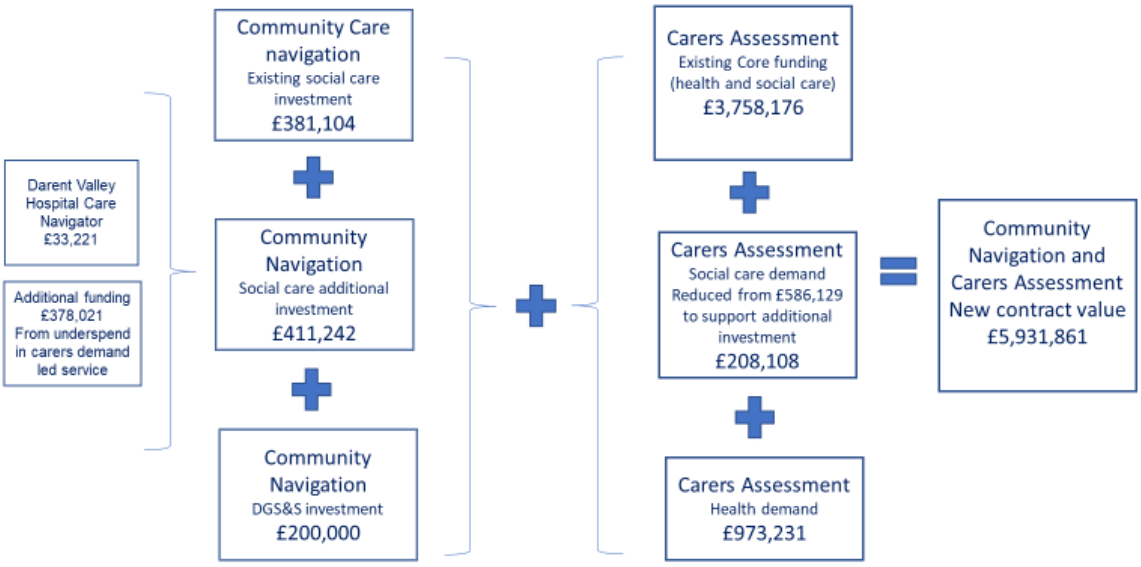
KAB	£	803,809.66	Ashford Canterbury & Coastal Dartford, Gravesham & Swanley South Kent Coast Swale Thanet West Kent	Ashford Canterbury Dartford Dover Gravesham Maidstone Sevenoaks Shepway Swale Thanet Tonbridge & Malling Tunbridge Wells	Sensory	Assessment and Equipment	Interim arrangement 2019-20. End for new contract 1st April 2020
Kent Association for Spina Bifida and Hydrocephalus	£	31,411.20	Dartford, Gravesham & Swanley	Dartford Gravesham Sevenoaks	LD/PD	IAG	Interim arrangement 2019-20. End for new contract 1st April 2020
NWK Volunteer Centre	£	38,251.97	Dartford, Gravesham & Swanley	Dartford Gravesham Sevenoaks	OP	Befriending	Interim arrangement 2019-20. End for new contract 1st April 2020
Peabody South East	£	98,446.63	South Kent Coast	Thanet Shepway Dover	OP	IAG – Care Navigator	End 2019: Care navigation contract
Romney Marsh Day Centre	£	148,261.85	South Kent Coast	Shepway	OP	Social Opportunities	Interim arrangement 2019-20. End for new contract 1st April 2020
Rural Age Concern Darent Valley	£	61,641.00	Dartford, Gravesham & Swanley	Sevenoaks	OP	Social Opportunities	Interim arrangement 2019-20. End for new contract 1st April 2020
Sevenoaks Volunteer	£	1,717.80	West Kent	Sevenoaks	ALL	Transport	Interim arrangement

Transport Group						2019-20. End for new contract 1st April 2020
Shepway Volunteer Centre	£ 21,325.26	South Kent Coast	Thanet Shepway Dover	OP	Befriending/Café	Interim arrangement 2019-20. End for new contract 1st April 2020
Swale CVS	£ 17,668.80	Swale	Swale	OP	Befriending	Interim arrangement 2019-20. End for new contract 1st April 2020
The over 60's Community Service (Northgate Ward & Canterbury District)	£ 63,538.97	Canterbury & Coastal	Canterbury	OP	Older Persons Community Support	Interim arrangement 2019-20. End for new contract 1st April 2020
Tonbridge Baptist Church	£ 11,376.74	West Kent	Maidstone Tonbridge & Malling Tunbridge Wells Sevenoaks	OP	Day Opportunities	Interim arrangement 2019-20. End for new contract 1st April 2020
Trinity Community Resource Centre	£ 49,729.82	Thanet	Thanet	Dementia	Day Opportunities	Interim arrangement 2019-20. End for new contract 1st April 2020
West Kent Housing Association - Lifeways	£ 24,448.71	West Kent	Maidstone Tonbridge & Malling Tunbridge Wells Sevenoaks	OP	IAG – Care Navigator	End 2019: Care navigation contract

Appendix 2: Wellbeing and Resilience Commissioning Strategy



Appendix 3: Financial implications



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Kent County Council
Equality Analysis/ Impact Assessment (EqIA)

Directorate/ Service:
Strategic and Corporate Services

Name of decision, policy, procedure, project or service:
Community Navigation (care navigation and social prescribing) – new contract from April 2019

Responsible Owner/ Senior Officer:
Clare Maynard

Version:

V1.0	29/06/2018	Kate Silver	Initial draft
V1.1	26/07/2018	Sylvia Rolfe	Review
V1.2	01/08/2018	Kate Silver	Updated
V1.3	13/08/2018	Akua Agyepong	Review
V1.4	15/08/2018	Kate Silver	Updated
V1.5	16/08/18	Samantha Sheppard	Review

Author:
Kate Silver – Commissioner, Strategic Commissioning

Pathway of Equality Analysis – to include:

- Public consultation as part of the Older People and People Living with Dementia Core Offer (12 June – 23 July 2017)
- Design Workshops and meetings with representatives from:
  - the Kent & Medway Sustainability and Transformation Partnership (STP)
  - Kent Clinical Commissioning Groups (CCGs)
  - Kent's District Councils
- KCC ASCH DivMT (OPPD)
- KCC ASCH DMT
- KCC Strategic Commissioning Board

Summary and recommendations of equality analysis/impact assessment.

- **Context**

Under the Care Act 2014 the Council's has a statutory duty regarding:

Promotion of peoples' wellbeing

- Provide information and advice enabling people to make good decisions about their care and support
- Promote peoples' wellbeing by providing Services that help prevent people developing needs for care and support or delay people deteriorating such that they would need ongoing care and support.

Carers

- The wellbeing principle applies both to those with care needs and those caring
- Prevention includes the duty to provide preventative services which reduce carers need for support
- Provision of assessment based on the appearance of need meaning that the only requirement for a carers assessment is that the carer may have need for support now or in the future

The Council currently grant funds a range of services in accordance with these duties, including care navigators, information and advice, day services, befriending services, dementia outreach services and voluntary transport services. In addition, the Council commissions support for carers and has delegated its duty to undertake carers assessments to the external provider market. These services all support people to remain well, independent and connected to their communities and enable carers to keep caring for friends and family members.

A number of services currently funded by KCC Adult Social Care include elements of care navigation / social prescribing within their role. This includes 12 grant funded Community Care Navigators (one in each district across the county), which are delivered by the following organisations (or 'providers'):

Provider	Number of Care Navigators	Districts Covered
Imago	5	Maidstone, Tonbridge and Malling, Tunbridge Wells, Dartford, Gravesham
Peabody	3	Thanet, Dover, Shepway
Ashford District Volunteer Bureau	1	Ashford
Age UK Canterbury	1	Canterbury
Age UK Faversham and Sittingbourne	1	Swale
West Kent Housing Association	1	Sevenoaks

The grants for these posts (which total £381,104 for 2018/19) are scheduled to end 31st March 2019.

- **Aims and Objectives**

  In Kent, care navigation and social prescribing have been commissioned in an ad hoc way over the past years – by both Kent County Council (KCC) and the Clinical Commissioning Groups (CCGs). As a result, there are a diverse range of commissioned services in place across the county, which has resulted in a patch work approach with demand being met through a multiplicity of roles. Both adult social care and Kent CCG's are cognisant of the need to remove duplication within the workforce and make pathways clearer to people, and are committed to jointly designing a new contract for care navigation/ social prescribing in order to achieve this.

  The proposal is that care navigation / social prescribing services are recommissioned so that:

  - A new contract for Community Navigation is commissioned for 1st April 2019
  - That this is a 4 year block contract with variation clauses that allow for variation of the specification, as well as addition or reduction of funding to reflect demand and potential for Clinical Commissioning Groups to invest.
  - That additional funding is invested in these services to commission additional navigators, in recognition of the key role that they play in the strategy to reduce demand on health and social care resources

  This EqIA reviews the anticipated impact of recommissioning the service in this way.

Summary and recommendations of equality analysis/impact assessment.

Adverse Equality Impact Rating
Medium

We have rated this EqIA as medium because we are currently unable to secure information about some protected characteristics in relation to those currently accessing the service, and there may be some groups who are under-represented compared to the county population profile which KCC needs to be aware of. A number of actions have been identified in the 'Action Plan' at the end of this document, which will be monitored and updated throughout the life of the contract, accordingly.

Attestation
I have read and paid due regard to the Equality Analysis/Impact Assessment concerning **Community Navigation.** I agree with the risk rating and the actions to mitigate any adverse impact(s) that has /have been identified.

Head of Service
Signed: Name: Clare Maynard

Job Title: Head of Commissioning Portfolio (Outcomes 2 and 3)
Date:

DMT Member
Signed: Name: Anne Tidmarsh

Job Title: Director Older People and Physical Disability
Date:

Part 1 Screening

Could this policy, procedure, project or service, or any proposed changes to it, affect any Protected Group (listed below) less favourably (negatively) than others in Kent?

Could this policy, procedure, project or service promote equal opportunities for this group?

Protected Group	Please provide a brief commentary on your findings. Fuller analysis should be undertaken in Part 2.			
	High negative impact EqIA	**Medium negative impact** Screen	**Low negative impact** Evidence	**High/Medium/Low Positive Impact** Evidence
Age	No	Yes - Decommissioning of grant funded services to re-commission community navigation through a formal tender process may affect older people (55+) and people with dementia currently accessing this support via grant funded services, as they may experience a change in the provider delivering their current service offer.		Yes - 88% of those currently being supported by the Care Navigators funded by KCC are aged 55+. There will be no change to the eligibility criteria with regard to age, as the proposal is to continue with the current model of delivering a service targeted at older people (aged 55+) and those with complex issues / frailty (under 55 years). There will therefore be no change in the services available for people based on age. We anticipate that the contracts will result in improved referral pathways to match people requiring

				support with the organisations delivering the service. Better matching means a stronger likelihood that service users' needs are met and personal goals are achieved. The focus on a personalised approach will continue.
Disability	No	No	No - There will be no change to the eligibility criteria with regard to disability, therefore there will be no change in the services available for people with a disability to access (based on this criteria alone). Older people (55+) with a physical or learning disability are likely to already be known to adult social care and receiving support through that route.	
Gender	No	No	No - The service will continue to be accessible to all regardless of gender, although there are more females over 55 than males (both in terms of demographic trends, and those who have	

			historically accessed the Care Navigation services commissioned by Kent County Council).	
Gender identity/ Transgender	No	No - The service will continue to be accessible to all regardless of gender identity /transgender, and we therefore assume there will be no impact to this group. However, we have no statistical or anecdotal evidence to support this decision.	No	Yes - More person centred, outcome based services should have a positive impact on the basis of gender identity / transgender.
Race	No	No	No - Ethnicity data gathered by Care Navigators shows that current uptake of the service is in line with the race breakdown of the whole local population aged 55+ (as detailed in appendix 2). There will be no change to the eligibility criteria with regard to race, therefore there will be no change in the services available for people based on this. We are	Yes - More person centred, outcome based services should have a positive impact on the basis of race.

			aware, however, that language barriers or cultural attitudes to accepting support may continue to impact on the success of the contract, and we do not know how attitudes have changed through successive generations of immigrants.	
Religion and Belief	No	No - There will be no change to the eligibility criteria with regard to religion and belief, therefore there will be no change in the services available for people based on this. However, older people of different religions may have differing attitudes towards services that impact on social and familial support systems. A variety of daily living activities may be profoundly influenced by a person's religious and spiritual beliefs: modesty and privacy; clothing, jewellery and make-up; washing and hygiene; hair care;	No	Yes - More person centred, outcome based services should have a positive impact on the basis of religion and belief

		prayer; holy days and festivals; physical examination; contraception; attitudes to death, dying and mourning; medication; healing practice etc. We need to understand this better and Key Performance Indicators (KPIs) will be put in place to address this gap in knowledge (see action plan)		
Sexual Orientation	No	No - The service will continue to be accessible to all regardless of sexual orientation, and we therefore assume there will be no impact to this group. However, as we have no statistical or anecdotal evidence to support this decision Key Performance Indicators (KPIs) will be put in place to address this gap in knowledge (see action plan).	No	No
Pregnancy and Maternity	No	No	No - The Care Navigation service is currently, and will continue to be, targeted at those aged 55+, so it	No

			is unlikely (although possible) that any changes to the contract will have a negative impact on pregnant women or those on maternity leave. Whilst it is possible that adult carers who require support, or a carers assessment, may be pregnant, there will be no change to the eligibility criteria with regard to pregnancy and maternity, therefore there will be no change in the services available for people based on this alone. However, as we have no statistical or anecdotal data regarding the uptake of Care Navigation services by pregnant women, Key Performance Indicators (KPIs) will be put in place to address this gap in knowledge (see action plan).	
Marriage and Civil Partnerships	n/a	n/a	n/a	n/a
Carer's	No	Yes - Recommissioning	No	Yes - Approximately 15% of

Responsibilities		carers' assessments may have a negative impact on this group as they may experience a change in the provider delivering their current service offer.		those currently being supported by Care Navigators are carers. With Carer Assessments and support being brought into scope for this contract we anticipate that this percentage will increase. The contracts will result in improved referral pathways to match people requiring support with the organisations delivering the service. Better matching means a stronger likelihood that service users' needs are met and personal goals are achieved. The focus on a personalised approach will continue.

Part 2

Equality Analysis /Impact Assessment

Protected groups
A merged role undertaking both care navigation and social prescribing tasks would focus on older people (over 55 years) as this represents the largest area of demand on both health and social care systems. (CCG commissioning will focus on those higher on a frailty index and with complex levels of need). Carers' Assessments would also be brought into scope.

Information and Data used to carry out your assessment

- CCG local care toolkits put together by Carnall Farrar (using Kent Integrated Dataset (KID) data from 2015/16, and CCG and local authority data returns)
- Kent Public Health Observatory
- Kent.gov.uk – facts and figures about Kent (Equality and Diversity)
- 2011 Census

Who have you involved consulted and engaged?

- Kent & Medway STP
- Representatives from all Kent CCGs (commissioners and local care leads)
- Representatives from all District Councils in Kent
- Patient and Public Advisory Group (PPAG)
- Market Engagement
- Pre-engagement with over 200 older people, people living with dementia and their carers
- DivMT (OPPD)

The Older People and People Living with Dementia Core Offer (which included information and advice, and a new model of care navigation) was subject to a public consultation that ran from 12th June to 23rd July 2017.

Appendix 1 contains a summary of the engagement carried out.

Analysis

Adult social care currently grant fund 12 community-based care navigators. They support adults over age 55, but there are minimal other criteria focusing their work. The original job descriptions stated that the purpose of the role is:

To act as a community service that supports resolution of identified needs/life stage/change through a person centred planning process that identifies local resources that enable people to choose the option that best fits their need.

Care navigation and social prescribing type services can be shown to have a significant impact on reducing demand for health and social care services and as such there is a focus on these roles within the STP and Local Care Models.

Community Navigation

Following a period of extensive engagement in 2017, and subsequent engagement with CCGs, district councils and providers in June 2018, it was agreed that the new contract would focus on a merged role undertaking both care navigation and social prescribing tasks. The role will focus on older people as this represents the largest area of demand on both health and social care systems. The role would not be 'case holding' and so would be time limited, but it must also be flexible enough to meet individual needs. It will not be a model that supports behaviour change but will need to extend beyond simple signposting as there is recognition that vulnerable people may need support in order to engage in new activities or seek additional support.

Carers assessments have recently been moved to a contract (as of 1st April 2018) to facilitate more detailed performance monitoring and data collection. From this it can be seen that a significant portion of time and contract value is spent on the brokerage element of the role. This is akin to the role that care navigators play in supporting people to identify support that is right for them and the proposal is therefore that this service is brought into scope for this contract.

Based on the analysis done, the proposal is for KCC to increase the level of investment made in this service in anticipation of additional demand that will come from linking more closely to GP clusters / hubs. Based on population data (using a ratio of 1 community navigator : 20,000 people over 55) social care would require an additional 13 roles across the county, as shown below:

CCG	Total Population	Total Population Aged 55+	% of Kent	Number of Community Navigators Required	Current Number of KCC Care Navigators	Number of Additional Posts Needed	Additional Annual Investment Required
Ashford	127,250	38,479	30.2%	2	1	1	£ 31,634.00
C&C	215,077	68,319	31.8%	3	1	2	£ 63,268.00
DGS	258,962	73,868	28.5%	4	2	2	£ 63,268.00
SKC	198,365	75,499	38.1%	4	2	2	£ 63,268.00
Swale	108,131	34,481	31.9%	2	1	1	£ 31,634.00
Thanet	142,587	50,285	35.3%	3	1	2	£ 63,268.00
West Kent	478,966	147,289	30.8%	7	4	3	£ 94,902.00
Total for Kent	1,529,338	488,220	31.9%	25	12	13	£ 411,242.00

Scope of the role:

The role will focus on supporting the following groups:

- Older people (over 55 years)
- People with complex issues / frailty (under 55 years)

The role will encompass (but will not be limited to) the following tasks:

- Care Navigation tasks
- Social Prescribing tasks
- Trusted Assessor role
- Benefits maximisation

The contract will be let in 3 geographic lots (East Kent, West Kent, DGS&S), with the option to commission the following lots in each area:

- Community Navigator (the term being used to refer to the combined care navigator and social prescribing role)
- Carers Assessment

This support with apply equally to all eligible adults, regardless of whether or not they are currently receiving other services through adult social care, and those delivering the service will be mindful of specific needs based on protected characteristics.

- **Age**

  The majority of people currently supported by KCC commissioned Care Navigators are over the age of 55, however, flexibility is given based on the judgement of the care navigator, to offer support to others below that age range who have complex needs. This will not change under the new contracts.

  Those aged over 55 years represent the following section of the Kent population:

CCG	Total Population	Total Population Aged 55+	% of Kent
Ashford	**127,250**	38,479	30.2%
C&C	**215,077**	68,319	31.8%
DGS	**258,962**	73,868	28.5%
SKC	**198,365**	75,499	38.1%
Swale	**108,131**	34,481	31.9%
Thanet	**142,587**	50,285	35.3%
West Kent	**478,966**	147,289	30.8%
Total for Kent	**1,529,338**	**488,220**	**31.9%**

  As the intention is to increase the number of posts delivering the service within the community, and to jointly commission the service with CCGs, the expectation is that the new contract will have a positive effect on age groups characteristics.

- **Disability**

  Having a disability or long-term condition is not a prerequisite for eligibility to this type of service. KCC commissioned Community Navigators will compliment and work in conjunction with CCG commissioned navigation roles focusing on those with the highest levels of need. We therefore consider that this characteristic will be positively affected.
  (see appendix 2 for data taken from 2011 Census)

- **Gender**
  The gender split of those currently receiving a care navigation service is roughly in-line with the whole Kent population aged 55+ (54% female, 46% male). We do not consider that this characteristic will be affected adversely.

- **Gender Identity/Transgender**
  There is no data available concerning gender identity, however, we do not consider that this characteristic will be affected adversely. More person centred, outcome based services should have a positive impact on the basis of gender identity/ transgender identity. KCC has Transgender Guidance which can be shared with contracted providers, to complement their own equality and diversity policy.

- **Race**
  Ethnicity data gathered by Care Navigators shows that current uptake of the service is in line with the race breakdown of the whole local population aged 55+ (as detailed in appendix 2). We do not consider that this characteristic will be affected adversely.

  Religion and Belief
  We do not have any data relating to care navigation services that identifies peoples' religion and beliefs, however, we do not consider that this characteristic will be affected adversely. Action has been identified to follow up on this during life of the contract.
  (see appendix 2 for data taken from 2011 Census)

- **Sexual Orientation**
  We do not have any data relating to the uptake of the care navigation services currently commissioned by KCC that identifies peoples' sexual orientation. Whilst we do not consider that this characteristic will be affected adversely, statistics published by Stonewall (https://www.stonewall.org.uk/sites/default/files/older_people_final_lo_res.pdf) tell us that a significant proportion of older gay people are likely to live alone, have limited family support and rely on formal services for help in the future. Action has therefore been identified to follow up on this and gather data on the sexual orientation of those who access the service during life of the contract.

- **Pregnancy and Maternity**
  We do not consider that this characteristic will be affected adversely.

- **Carers Responsibilities**
  Bringing carers assessments into scope of the contract will streamline the support available, meaning the same point of contact can be used for signposting or brokering support for carers once the assessment is completed. We therefore consider that this characteristic will be positively affected. (see appendix 2 for information regarding the numbers of carers in Kent aged 65+, by sex and CCG/CCG Cluster)

Potential Adverse Impact:
Ending grants could potentially have a negative impact on both the people accessing the services and the providers themselves. If organisations are not awarded contracts and become unviable due to the withdrawal of funding, their services may end or may need to be redesigned. Financial analysis will be completed on existing providers to understand the financial viability of organisations whose funding will be impacted. For those people currently accessing care navigation support via grant funded services this means that they may experience a change in the provider delivering their current service offer depending on which organisations are awarded the contract. We need to be aware of the people who use these services and if changing providers would have an adverse effect on any of the older people, people with disabilities, transgender individuals, LGBT, carers and BME groups. This may create anxiety for them. However, the risk of this is considered to be low as the new contract is looking to replicate and enhance the services currently being delivered by the grant funded organisations rather than remove services already in place, and all commissioned services must be open to all older people with wellbeing needs, with providers being required to demonstrate adherence to equality legislation and the ability to meet the needs of people with protected characteristics. In addition, TUPE is likely to apply regarding individual workers, and the service is not case holding i.e. people move through the service. It may however be necessary to halt referrals prior to contract handover in order to prevent people the need to transfer people over to different providers.

Potential Positive Impact:
We anticipate that the proposed model will simplify the process for members of the public who are in need of care navigation and social prescribing support, and result in more equitable service delivery across the county. We anticipate that the contracts will result in improved referral pathways to match people requiring support with the organisations delivering the service. The focus will be on an outcomes based approach to best meet peoples' identified needs. The care navigation and social prescribing roles delivered by the contract will provide the support vulnerable people may need in order to engage in new activities or seek additional support. Aligning the roles to district and CCG commissioned roles, and to GP clusters will provide clear referral pathways for professionals, enabling them to refer people to care navigators easily and quickly.

Moving to longer term contracts will provide sustainability for the providers and services, moving away from annual grant funding that creates uncertainty. This will mean reduced anxiety about the continuity of services for older people and their families and carers and give providers opportunity to invest in the development of their services.

JUDGEMENT
It is acknowledged that there may be potential adverse effects on some groups with protected characteristics as a result of the proposed changes linked to this project. These impacts are assessed as being low to medium and in most cases are rated as such due to the absence of concrete

performance information related to how people with specific protected characteristics are accessing the current services. Actions have been identified to mitigate these effects, including the development of Key Performance Indicators that will measure this information. We anticipate that this model will simplify the process for members of the public who are in need of care navigation and social prescribing support, and result in more equitable service delivery across the county.

- **No major change** - no potential for discrimination and all opportunities to promote equality have been taken

Internal Action Required Yes

There is potential for adverse impact on particular groups and we have found scope to improve the proposal, as detailed in the action plan.

Equality Impact Analysis/Assessment Action Plan

Protected Characteristic	Issues Identified	Action to be Taken	Expected Outcomes	Owner	Timescale	Cost Implication
Age	Decommissioning of grant funded services to re-commission community navigation through a formal tender process may affect older people (55+) currently accessing this support via grant funded services and as a result they may experience a change in the provider delivering their current service offer.	**No major change:** Incorporate feedback from engagement sessions into the service specification. Understand the number of people that are receiving support from current providers and will be impacted. Continue to engage with people and providers. Develop a performance framework to ensure that the outcomes of the contract are monitored and delivered. Ensure that the specification recognises that people using services should continue to be engaged in their re-design and / or transformation. Give maximum notice to current service providers (minimum 6 months) of grants terminating in order for them to prepare. Ensure that all commissioned services will be open to all older people with wellbeing needs and providers will be required to demonstrate adherence to equality legislation and the ability to meet the needs of people with protected characteristics.	The design process will provide standardised outcomes and a standard service specification for all elements of the service across the county. The service will be commissioned for older people 55+ and people with dementia (but there will be some flexibility around this based on complexity of needs). The proposal will reflect the range of needs of older people, from universal support through to specialist support services (including adult safeguarding, the needs of those at risk of self-neglect, mental health issues, frailty, autism, sensory impairments etc.)	Samantha Sheppard	July 2018 – September 2018 Ongoing throughout life of contract	None
Disability	Decommissioning of grant funded services to re-commission community navigation through a formal tender process may affect older people (55+) with disabilities accessing grant funded	**Adjust and continue:** Incorporate feedback from engagement sessions into the service specification. Continue to engage with CCGs and providers. Develop a performance framework to ensure that the outcomes of the contract are	The proposal will improve and standardise the community navigation service commissioned by including support services for older people with a disability.	Samantha Sheppard	July 2018 – September 2018 Ongoing throughout life of contract	None

	services and as a result they may experience a change in the provider delivering their current service offer.	monitored and delivered. Ensure that the specification recognises that people using services should continue to be engaged in their re-design and / or transformation. Give maximum notice to current service providers (minimum 6 months) of grants terminating in order for them to prepare. Ensure that all commissioned services will be open to all older people with wellbeing needs and providers will be required to demonstrate adherence to equality legislation and the ability to meet the needs of people with protected characteristics. Contracts will stipulate that all services will meet the needs of those who use them, regardless of any disability they may have, including people with sensory impairments. Assess the number of older people with learning disabilities accessing community navigation services through performance monitoring of the new contract. .	The redesign process will provide standardised outcomes and a standard service specification for all elements of the service across the county The proposal will reflect the range of needs of older people, from universal support through to specialist support. The service will be inclusive and performance monitoring will enable commissioners to determine the levels at which people with disabilities are accessing the service. This will be used to implement changes within the proposed services, breaking down barriers that prevent people accessing services and informing commissioning proposals, including whether specific groups / services are required for older people with a learning disability and / or mental health issue are required.			

Gender Identify	Historical service commissioning may not have taken the needs of this population into account No historical monitoring data of gender identity therefore KCC has limited understanding of the populations needs.	**No major change** Ensure that all commissioned services will be open to all older people with wellbeing needs and providers will be required to demonstrate adherence to equality legislation and the ability to meet the needs of people with protected characteristics. The number of people on the gender reassignment pathway is unknown, in part as equalities monitoring data cannot be collected from grant funded providers, but also as this is a sensitive topic that people may not wish to disclose. Assess this through contract performance monitoring.	Intelligence from performance monitoring will inform any further decision making concerning inclusion of these groups.	Samantha Sheppard	July 2018 – September 2018 Ongoing throughout life of contract	None
Religion/belief or none	Older people of different religions may have differing attitudes towards wellbeing services that impact on social and familial support systems.	**Adjust and continue** Give maximum notice to current service providers (minimum 6 months) of grants terminating in order for them to prepare. Commissioned services will be open to all older people and providers will be required to demonstrate adherence to equality legislation and the ability to meet the needs of people with protected characteristics. Contracts will stipulate that services will not adversely affect older people's religion and beliefs.	The proposal will improve and standardise the community navigation service commissioned. The service will be inclusive and performance monitoring will enable commissioners to determine the levels at which people with specific religious and beliefs are accessing services. This will be used to inform future commissioning proposals. The performance monitoring of equality information will enable commissioners to determine whether the number of people accessing the services meet expectations based	Samantha Sheppard	July 2018 – September 2018 Ongoing throughout life of contract	None

			on demographic information. This information can be used to further improve services, challenge underperformance and break down barriers that prevent people accessing services.			
Pregnancy and Maternity	No historical monitoring data of the uptake of services in relation to pregnancy and maternity therefore KCC has limited understanding of the impact of the contract for this section of the population.	**No major change** Ensure that all commissioned services will be open to all older people with wellbeing needs and providers will be required to demonstrate adherence to equality legislation and the ability to meet the needs of people with protected characteristics.	The proposal will improve and standardise the community navigation service commissioned. The service will be inclusive and performance monitoring will enable commissioners to determine the levels at which pregnant women and those on maternity leave are accessing services. This will be used to inform future commissioning proposals.	Samantha Sheppard	July 2018 – September 2018 Ongoing throughout life of contract	None
Carers	Recommissioning carers' assessments may have a negative impact on this group as they may experience a change in the provider delivering their current service offer.	**No major change:** Incorporate feedback from engagement sessions into the service specification. Understand the number of people that are receiving support from current providers and will be impacted. Continue to engage with people and providers. Develop a performance framework to ensure that the outcomes of the contract are monitored and delivered. Ensure that the specification recognises that	Carer Assessments and support are being brought into scope for this contract. We anticipate that the contracts will result in improved referral pathways to match people requiring support with the organisations delivering the service. The focus on a personalised approach will continue.	Samantha Sheppard	July 2018 – September 2018 Ongoing throughout life of contract	None

		people using services should continue to be engaged in their re-design and / or transformation. Give maximum notice to current service providers (minimum 6 months) of contracts terminating in order for them to prepare.				

Have the actions been included in your business/ service plan? (If no please state how the actions will be monitored)
Yes

Appendix 1

Engagement as part of the Core Offer

Extensive engagement was undertaken with a range of stakeholders in relation to this project. A new model of care navigation (the wellbeing coordination service) was initially designed in 2017 as part of the Older People and People Living with Dementia Core offer. That proposal was subject to engagement both with those accessing the services and their carers, market engagement and public consultation and findings have been integrated into the design of Community Navigation model.

Pre-engagement with over 200 older people, people living with dementia and their carers identified the accessibility of good quality information and advice as vital in supporting people to live independently.

How people get their information	Key feedback
	• Majority of people did not have access to computers. • Even people with a computer did not necessarily trust the information provided and used the computer to identify someone to talk to. • Most people sought information and advice from family and friends, local GP's, faith groups and local charities.

Quotes included:

"Everything is on the 'internet' some of us don't have a computer or want one."

"I can look things up on google but if it's something important I would want to talk to a person, you can't always trust what you find out on google."

"We have a noticeboard here but there is very little on it and it's not in a good place, by the bus stop would be good!"

"I hear most things by word of mouth and I like it that way."

Based on this engagement a number of personal outcomes related to information and advice were included in the proposal for a new contract. This was subject to a public consultation that ran from 12th June to 23rd July 2017.

The outcomes identified were:

- I know where to find information and advice and I am confident that this is accurate and easily understood
- I have knowledge of which benefits are available and where to source financial advice
- I know what is available in my community

The question relating to outcomes received 204 responses, with a slight majority of people either agreeing or strongly agreeing with the outcomes identified. Less than a third of respondents actively disagreed with the proposed outcomes.

109 of the people asked also identified other outcomes that they thought should be considered including:

- Information and advice for carers
- Information and advice for self-funders
- Information and advice that is easy to understand and not full of jargon
- Information and advice that is accessible
- The need to differentiate between information and advice and signposting
- The importance of a multi-media approach i.e. leaflets, website and someone to speak to
- The importance of impartial advice
- Information needs to be timely, appropriate and proportionate
- Clear information about the financial aspects of paying for care
- Issues with information becoming out of date
- Need for GP surgeries to do more signposting
- People who are housebound are safely supported to discuss confidential issues such as abusive partner, debt worries
- Challenges in accessing information for people who are not on the internet
- Suggestions of ways that people can receive information related to their care when they receive other information e.g. regarding power of attorney, GP's
- People value someone to talk to

"People only seem to look into these things when these services are needed, and it can be quite confusing especially for anyone without IT facilities."

"Without internet access my mother finds it very hard to access services. She has no idea what is available or how to access it. As a result she is reliant on me. It is essential that all services are easily accessible with a 'one stop' contact number that is widely known."

"Whilst empowerment is a worthy aspiration, many elderly persons will value help and assistance – 'a friendly familiar place to turn to'."

Recent engagement

Subsequent engagement has been undertaken with a range of stakeholders as part of this Community Navigation design project. With this, there has been a focus on defining the outcomes of the service, clarifying terms, defining the role, agreeing scope and timelines for support and discussing what a future contract might look like.

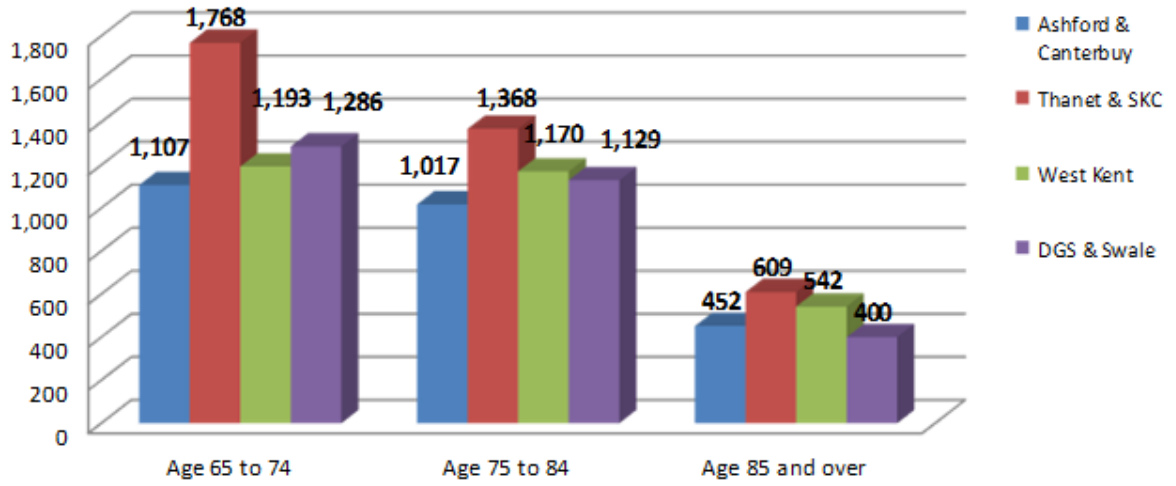
Engagement has included two workshops and ongoing dialogue with representatives from Kent CCG's (commissioners and local care leads), attendance at Patient and Public Advisory Group (PPAG), district councils and market engagement events.

Feedback from PPAG included:

- Social prescribing and care navigation should be one role to avoid duplication / confusion
- The role should be signposting people only
- People who need ongoing support should be referred to ‘buddies’ or services
- Prevention aspect of the role is key
- They need to be available to people where they are, so could be virtual in terms of location and need to be visible around hubs
- There should be a set intervention period, but this needs to be flexible

Appendix 2

People Aged 65+ with a Long-term Health Problem or Disability whose Day to Day Activities are Limited a Lot or whose Health is Bad or Very Bad
N.B. This information is limited to those aged 65+, rather than 55+
(Source: 2011 Census - Table DC3203EW)



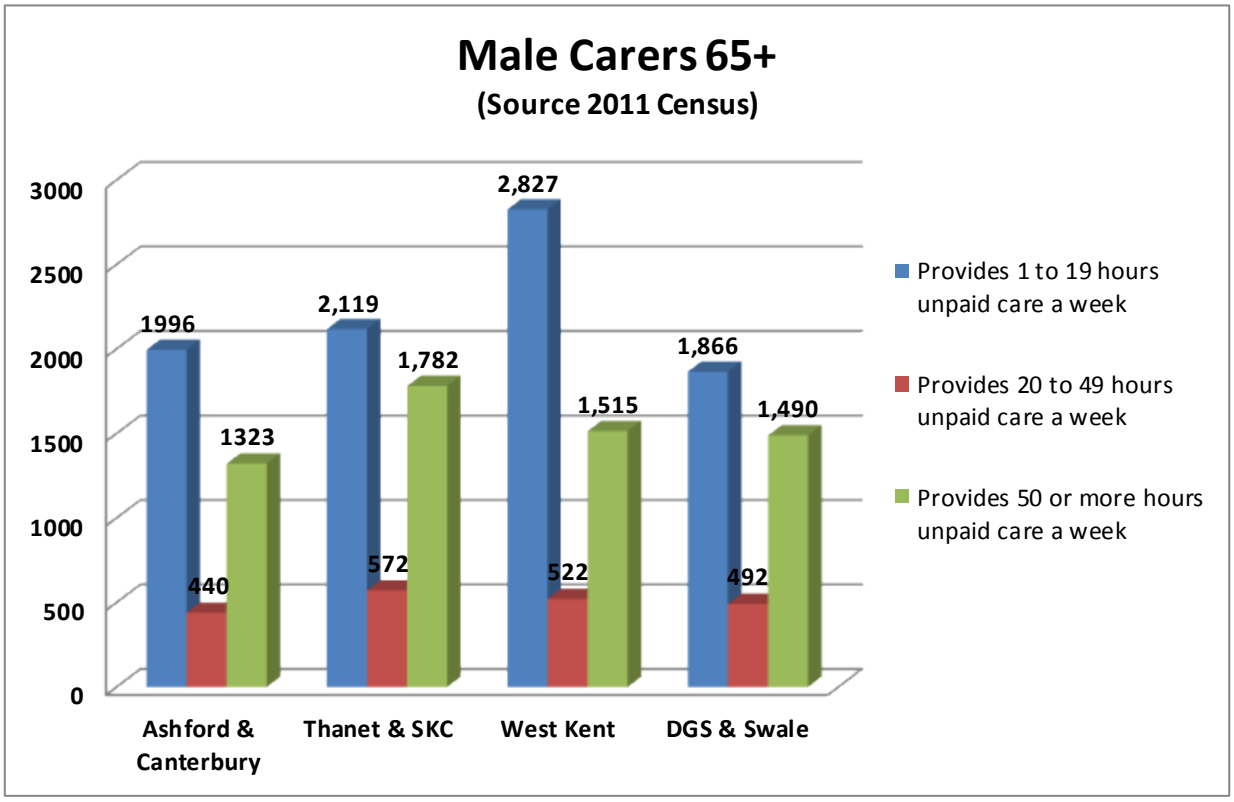
Ethnicity 55+, by CCG/CCG cluster
(Source: 2011 Census - Table DC2101EW)

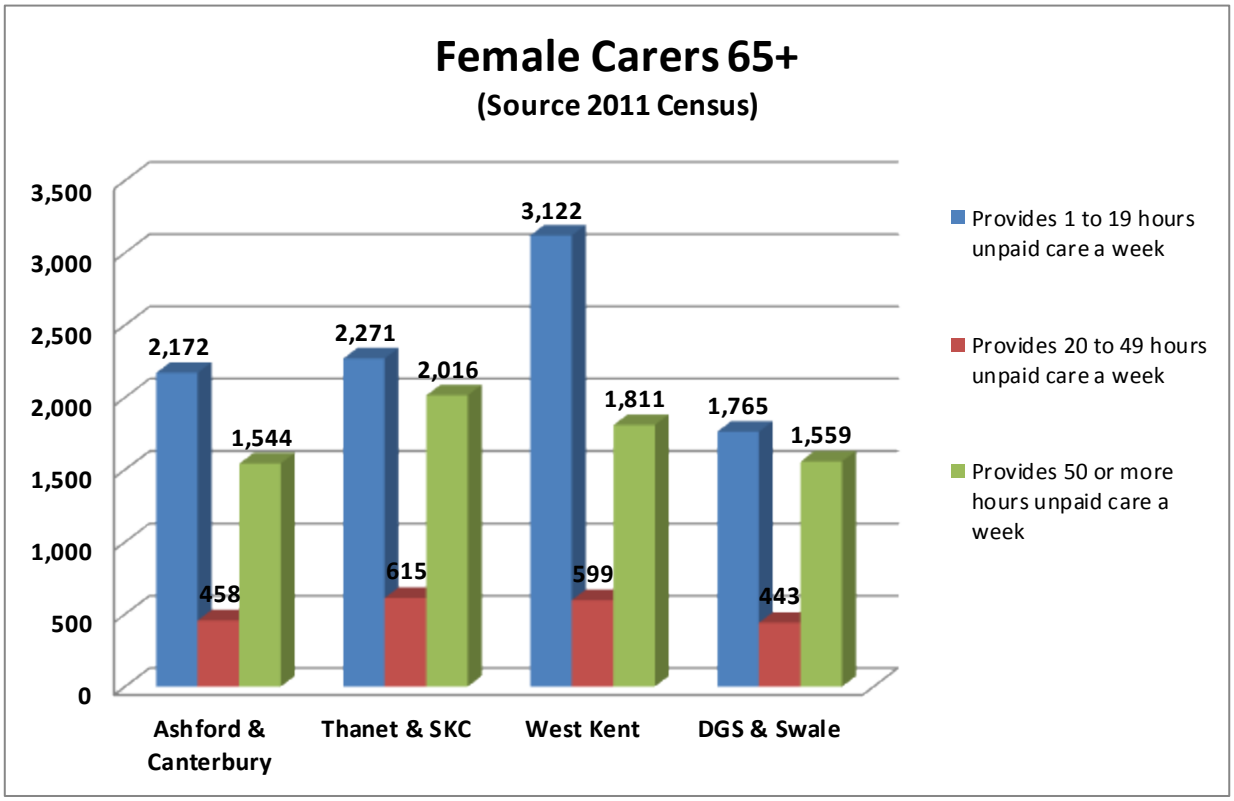
Ethnicity	Ashford & Canterbury	DGS & Swale	South Kent Coast & Thanet	West Kent
White	79,475	87,646	119,553	147,836
Mixed/Multiple Ethnic Group	308	361	476	537
Asian/Asian British	788	2,844	858	1,538
Black/African/ Caribbean/ Black British	203	469	212	298
Other Ethnic Group	110	354	179	234

Religion 55+, by CCG/CCG Cluster
(Source: 2011 Census - Table DC2107EW)

Religion	Ashford & Canterbury	DGS & Swale	South Kent Coast & Thanet	West Kent
Christian	62,634	71,783	94,528	117,666
Buddhist	223	210	326	378
Hindu	214	478	239	417
Jewish	130	101	234	245
Muslim	179	279	219	340
Sikh	46	1,731	27	98
Other religion	296	323	444	409

Numbers of Carers 65+ by sex and CCG/CCG Cluster
N.B. This information is limited to those aged 65+, rather than 55+





Please forward a final signed electronic copy and Word version to the Equality Team by emailing diversityinfo@kent.gov.uk

If the activity will be subject to a Cabinet decision, the EqIA must be submitted to committee services along with the relevant Cabinet report. Your EqIA should also be published.

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

By:	Graham Gibbens, Cabinet Member for Adult Social Care and Public Health Penny Southern, Corporate Director of Adult Social Care and Health
To:	Adult Social Care and Health Cabinet Committee – 27 September 2018
Decision Number:	18/00042
Subject:	**LOCAL ACCOUNT FOR KENT ADULT SOCIAL CARE (APRIL 2017 – MARCH 2018)**
Classification:	Unrestricted
Previous Pathway of Paper:	Adult Social Care and Health Directorate Management Team – 22 August 2018
Future Pathway of Paper:	Cabinet Member decision
Electoral Divisions:	All

Summary: This report provides the Adult Social Care Cabinet Committee with an update on the development of the Local Account for Adult Social Care (April 2017 – March 2018). The report summarises engagement activities undertaken to date across Adult Social Care and outlines how user engagement feedback from these activities has informed the development of the Local Account for 2017-2018.

Recommendation: The Adult Social Care Cabinet Committee is asked to **CONSIDER** the Local Account document– 'Here for you, how did we do?' (April 2017 – March 2018) (attached as Appendix 1) and **ENDORSE** this as the final version.

1. Introduction

1.1 Adult Social Care Services at both a local and national level are currently being delivered against a backdrop of ongoing challenging financial constraint, a population that is living longer with associated increasing complex care needs and people wanting better quality and choice in the services they use.

1.2 There is also greater emphasis on Councils to work collaboratively to improve performance and outcomes for people and to deliver joint services with the NHS and other partners.

1.3 In the past, the Care Quality Commission (CQC) used to assess how well Local Authorities were performing in Adult Social Care. They no longer do this, and as part of national changes, all Local Authorities are now asked to produce a document in partnership with their residents to enable them to hold the

authority to account. As a result, the annual report for Adult Social Care in Kent - **'Here for you, how did we do?'** has been produced.

1.4 The Local Account, '**Here for you, how did we do?' April 2017 - March 2018** describes the achievements, improvements and challenges faced by Kent Adult Social Care during the past year as we have continued to transform our services. It also sets out our vision for the future and provides updates on the key issues that people have told us are important to them.

1.5 It is an important way in which people can challenge and hold us to account and this is the seventh year that it has been developed in partnership with people who use our services, their carers, voluntary organisations and service providers as well as Members, District and Borough Councils and our staff.

2. Development of the Local Account

2.1 A key ongoing challenge for the Council is to ensure that people continue to be at the centre of the care they receive and that we actively engage with our service users, their carers, voluntary organisations, our partners, service providers and our staff as part of the ongoing development of our service provision.

2.2 We need to ensure that we continue to deliver cost effective Adult Social Care Services not only in line with our strategy for Adult Social Care "Your Life, Your Wellbeing" and our strategic statement – "Increasing Opportunities, Improving Outcomes", as well as through effective Strategic Commissioning and in conjunction with the Care Act and sector led service improvement which places important emphasis on engaging with and listening to our customers.

2.3 Whilst user engagement activity is already carried out across the Adult Social Care and Health Directorate, the ongoing development of the Local Account provides further opportunity for us to listen to, work with and take action on what our customers are telling us about our service provision enabling us to work collaboratively with people in Kent to deliver sustainable Adult Social Care Services now and for the future.

2.4 There is also a strong link between effective service user engagement and the 'Think Local, Act Personal (TLAP) and 'Making it Real' agenda which is focused on enabling people to have more choice and control to live full and independent lives.

3. User Engagement Activity to inform the Local Account

3.1 There are several forums, boards and partnerships already in place across the Adult Social Care and Health Directorate and work has been undertaken to link into or utilise these to inform the Local Account.

3.2 The easy read version of the Local Account from last year was posted on the Kent Learning Disability Partnership website together with an easy read cover letter and tailored commentary to encourage feedback. The Local Account has

also been distributed widely and has been sent to all Kent Libraries, Gateways, Clinical Commissioning Groups, Parish Councils and over 170 Patient Participation Groups to increase awareness, particularly across Health.

3.3 The Local Account video that was developed in 2016/17 to enable people to review the Local Account and its content without having to read it has continued to be utilised. This is available for people to watch on the Kent County Council website and can be viewed with subtitles for those people with hearing difficulties.

3.4 The video incorporates an introduction to the Local Account and the ways in which people can provide feedback. The animation has also been designed to encourage people to tell us what they think of the Adult Social Care services we provide, and our ongoing transformation plans for the future.

3.5 There are a number of forums and groups across Kent that support and provide a voice for vulnerable adults and links to these have continued to be developed. Presentations on user involvement and the Local Account have been delivered to carers and to the pilot Peoples' Panel established in conjunction with Healthwatch Kent. The Local Account has also been shared with the Kent Physical Disability Forum and the Older Persons Forums.

3.6 An Adult Social Care User Engagement database containing over 1,600 active contacts has continued to be developed. All contacts within the database have received a copy of the previous version of the Local Account in the most appropriate format – e-version, easy read, standard edition or plain text requesting feedback. The database will be utilised again for the current version. Where possible (and if appropriate), the Local Account has been distributed electronically to minimise printing costs.

3.7 Additionally, the database, which is General Data Protection Regulation (GDPR) compliant has been used to provide suggested user engagement contacts to help gather insights to inform service developments, i.e. with 18 to 24 year olds who have issues with drugs and alcohol and from sensory (Deaf/Visually Impaired/Deafblind) clients to support work being undertaken by the Sensory Services team.

3.8 Ongoing communication to Adult Social Care staff promoting the Local Account and the importance of feedback has been developed, including features in Transformation Newsletters and regular web-based updates.

3.9 An informal briefing for all members of the Adult Social Care Cabinet Committee was held on 11 September 2018.

4. Financial Implications

4.1 A key objective when developing the brochure and our user engagement approach has been the consideration of how to enhance value for money utilising wherever possible existing forums or approaches already in place

across the Adult Social Care and Health Directorate or working in conjunction with existing partners to minimise costs.

4.2 There will be a cost implication in the production and distribution of the Local Account; however, these will be managed within the budget planning forecasts.

5. Legal Implications

5.1 There are no legal implications associated with this report.

6. Equality Implications

6.1 There are no equality implications associated with this report.

7. Future Publication, Distribution and Feedback

7.1 The final document will be ready for publication in late October 2018 and will be distributed as widely as possible to give everyone the chance to read it, challenge our approach, ask questions and feedback their views.

7.2 All contacts within the User Engagement database (1,600+) will receive a copy in the most appropriate format – e-version, easy read, standard edition or plain text requesting their feedback. Where possible (and if appropriate), the Local Account will also be distributed electronically to minimise printing costs. Hard copies will also be distributed to public accessible social care locations, i.e. Libraries, Gateways, Day Centres, Patient Participation Groups, Parish Councils.

7.3 An easy read version of the Local Account will be developed and posted on the Kent Learning Disability Partnership website together with an easy read cover letter and tailored commentary to encourage feedback.

7.4 There are already existing feedback mechanisms in place, including through the Kent County Council website, twitter, email, post and phone. Feedback from these as well as user engagement at forums and other events will continue to be used in the development of the next document.

7.5 Service users, carers, the voluntary sector, providers, Members, Healthwatch Kent and our staff will continue to be encouraged to play a part in the evaluation and ongoing development of the Local Account.

8. Recommendations

8.1 Recommendation: The Adult Social Care Cabinet Committee is asked to **CONSIDER** the Local Account document– 'Here for you, how did we do?' (April 2017 – March 2018) (attached as Appendix 1) and **ENDORSE** this as the final version.

9. Background Documents

Increasing Opportunities, Improving Outcomes, Kent County Council's Strategic Statement 2015-2010
http://www.kent.gov.uk/about-the-council/strategies-and-policies/corporate-policies/increasing-opportunities-improving-outcomes
Your life. Your well-being, a vision and strategy for Adult Social Care 2016-2021
http://www.kent.gov.uk/about-the-council/strategies-and-policies/adult-social-care-policies/your-life-your-wellbeing

Care Act 2014
http://www.kent.gov.uk/about-the-council/strategies-and-policies/adult-social-care-policies/care-act

Think Local, Act Personal 2011
https://www.thinklocalactpersonal.org.uk/Browse/ThinkLocalActPersonal/

Local Account 'Here for you, how did we do?' April 2016 - March 2017
http://www.kent.gov.uk/about-the-council/strategies-and-policies/adult-social-care-policies/local-account-for-adult-social-care

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KENT COUNTY COUNCIL – PROPOSED RECORD OF DECISION

DECISION TO BE TAKEN BY:	DECISION NO:
Cabinet Member for Adult Social Care and Public Health	18/00042

For publication

Non-Key

Subject: Local Account for Kent Adult Social Care (April 2017 to March 2018)

Decision: As Cabinet Member for Adult Social Care, I propose to approve the Local Account for Kent Adult Social Care (April 2017 – March 2018).

Reason(s) for decision: With the withdrawal of external inspection of the Council's performance in Adult Social Care, there is now more emphasis on councils to manage their own performance, work collaboratively with the sector to improve performance and outcomes and explain how they have performed to local residents. The Local Account has emerged as a standard feature of the new local accountability framework.

Financial Implications: The proposed development of the Local Account does not include savings targets, however a key objective when developing the brochure and our user engagement approach has been the consideration of how to enhance value for money from a Council perspective utilising wherever possible existing forums or approaches already in place across the Directorate or working in conjunction with existing partners to minimise costs. There will be a cost implication to the production and distribution of the Local Account; however, these will be managed within the budget planning forecasts for the Unit, i.e. ongoing production of the Local Account.

Legal Implications
None.

Equality Implications
None.

Cabinet Committee recommendations and other consultation: The proposed decision will be discussed at the Adult Social Care Cabinet Committee on 27 September 2018 and the outcome included in the paperwork the Cabinet Member will be asked to sign.

Any alternatives considered:

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

....
signed date

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Here for you, how did we do?

Local account for Kent Adult Social Care

April 2017 - March 2018

Report highlighting the achievements, improvements and challenges of Kent County Council Adult Social Care and Health during the past year and our vision for the future.

Kent County Council
kent.gov.uk

Contents

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

Foreword

By: Graham Gibbens, Cabinet Member for Adult Social Care and Public Health and Penny Southern, Corporate Director of Adult Social Care and Health.

Graham Gibbens

Penny Southern

We are pleased to publish, "Here for you, how did we do?" the Local Account for Kent County Council Adult Social Care for April 2017 - March 2018.

This Local Account describes the achievements, improvements and challenges of Kent County Council Adult Social Care in the past year and sets out our vision for the future.

There continue to be challenges ahead and Adult Social Care is changing the way in which we deliver our services to meet the needs of our population and deliver what the people of Kent need to stay safe and connected to their communities.

Over the last three years, we have transformed our services to ensure that they are meeting the requirements of our statutory responsibilities within the Care Act but are also relevant and flexible for people in Kent. We want to make sure that you are at the centre of any decision made and receive advice, guidance and support that enables you to stay as independent as possible. We want to focus on what you can do, not on what you cannot do.

A major piece of this is to work with our partners in Health, our wider market of the voluntary, private sector provision and our borough and district councils to ensure we join up our approach to avoid duplication and deliver a seamless response and service delivery. We firmly believe in supporting people to live independent and fulfilling lives in their own homes and communities and achieve outcomes that are important to them.

We know that quality care matters to people and we will continue to work to find innovative and efficient ways to deliver these services.

In 2017-18, we strived to:

- keep vulnerable adults safe
- support people to live independently in their own home
- increase investment in enablement services (see glossary) and Telecare (see glossary) provision to enable people to regain their independence and remain at home
- reduce the number of permanent admissions to residential care
- support more people through a person-centred approach, building on an individuals' strengths and capability
- support more people with a disability into employment
- use surveys and other feedback to look at what we are doing well and what needs improving
- work with Health and other partners to plan and provide joint services
- work seamlessly with Health to reduce Delayed Transfers of Care from hospital to ensure that people are able to access the right support when they are medically fit and safe to be discharged.

Many people, including those who use our services, their carers and voluntary organisations were crucial in putting this Local Account together and we would like to thank all those who contributed. We will continue to listen to and work with people in Kent to build a sustainable service for the future.

Introduction

Welcome to this year's annual report for Adult Social Care in Kent - '**Here for you, how did we do?' April 2017 - March 2018** which describes the achievements, improvements and challenges faced by Kent Adult Social Care during the past year as we have continued to transform our services. It also sets out our vision for the future.

In the past, the Care Quality Commission (see glossary) used to assess how well Local Authorities were performing in Adult Social Care. They no longer do this, and as part of national changes, all Local Authorities are now asked to produce a document in partnership with their residents to enable them to hold the authority to account. As a result '**Here for you, how did we do?**' has been produced.

The Local Account is an important way in which people can challenge and hold us to account and this is the seventh year that it has been developed in partnership with people who use our services, their carers, voluntary organisations and service providers as well as members, district councils and staff.

Throughout this document, we will provide updates on the key issues you have told us are important to you and we will also tell you about the new things we have been developing and are working on.

Feedback from you is enormously important and many people played a crucial role in putting this Local Account together either through providing us with feedback or taking part in meetings to let us know the areas that were important to you.

We will continue to listen to and work with people in Kent to build a sustainable Adult Social Care Service for the future and we will continue to distribute the Local Account as widely as possible to give everyone the chance to read it, challenge our approach, ask questions and feedback their views.

If you have not had the opportunity to contribute to the Local Account or have been involved in the past and would like to continue to help us shape how the Local Account looks and what it includes going forward, please email us at: kentlocalaccount@kent.gov.uk letting us know how you would like to be involved.

If you have any questions regarding the content of this report or you would like to submit your comments, please complete our feedback form online. The feedback form only takes five minutes to complete and we would love to hear from you.

We also have a paper feedback form which you will find in the centre of the booklet. Please contact us if it isn't included and we can arrange for a copy to be sent to you.

Further copies of the Local Account can be downloaded directly from our website at: www.kent.gov.uk/localaccount where you can also find plain text and easy read versions as well. Alternatively, please contact us and we can arrange for further copies to be sent to you.

You told us that you would like to know:

- How to access our services (page 10)
- How are we supporting people with mental health needs (page 45)
- How we support carers (page 47).

Symbols used in this report

Refers to what is new this year.

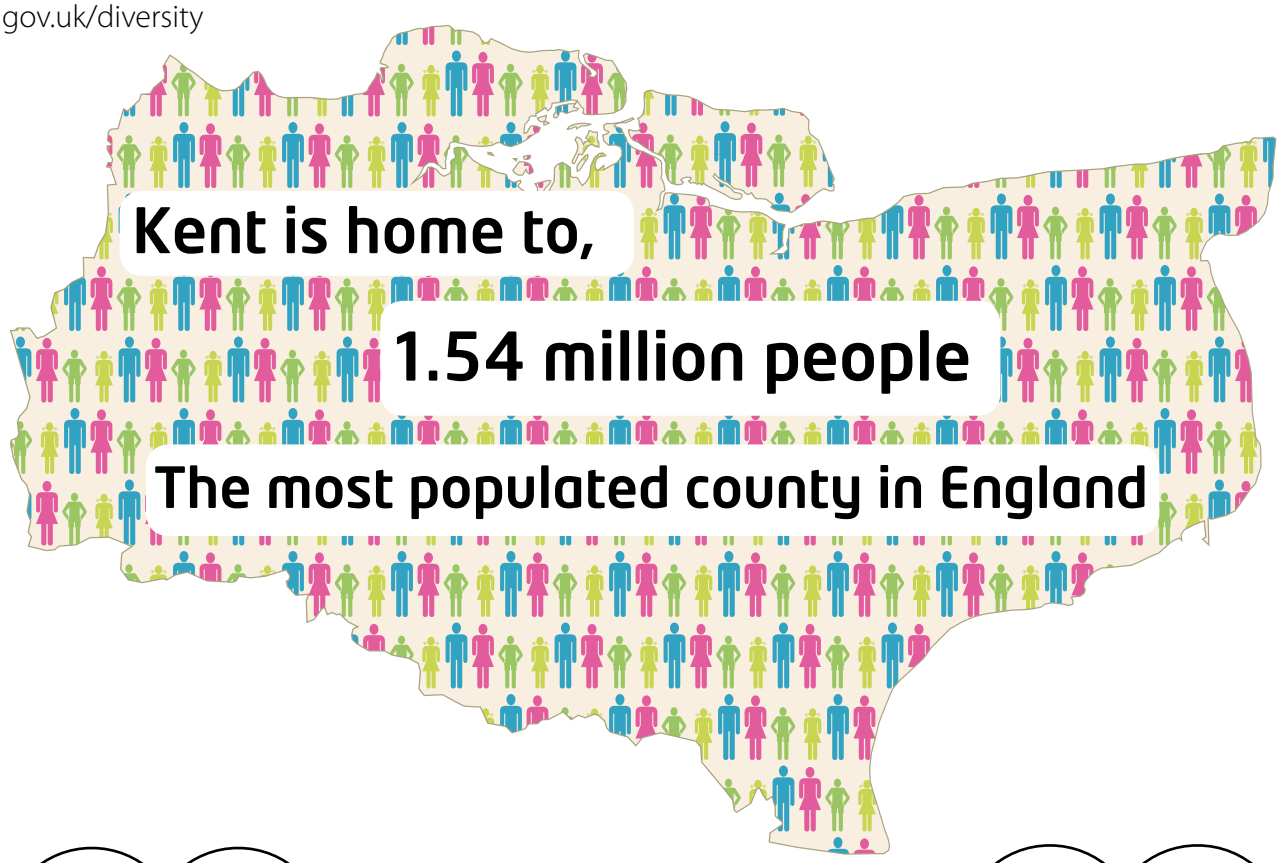
Refers to an update on last year.

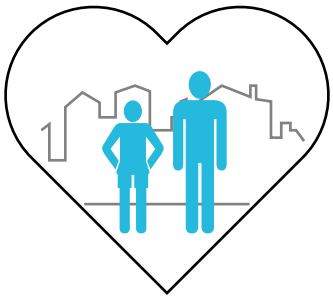
Kent and its people

At Kent County Council, we recognise the diverse needs of our community. We value and celebrate diversity and believe it is essential to provide services which work well for all our customers and staff making Kent a great county in which to live and work.

Equality is one of the values underpinning the work we do in Adult Social Care - adopting a person-centred approach tailored to each individual so they can achieve the things that matter most to them. This means supporting people's own sense of identity and working from a clear diversity perspective so that we acknowledge and celebrate the difference people bring.

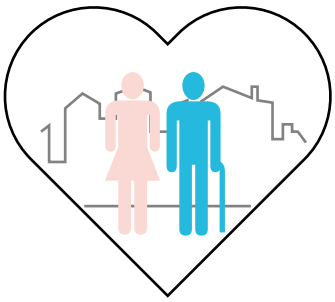
Further information on the council's objectives for equality and diversity can be found at www.kent.gov.uk/diversity





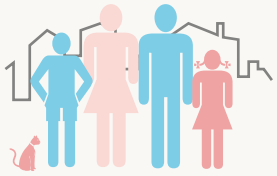
12,902 people aged between 18-64 are supported by Adult Social Care

33,598 people in Kent are supported by Adult Social Care

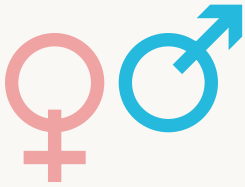


20,696 people supported by Adult Social Care are over the age of 65

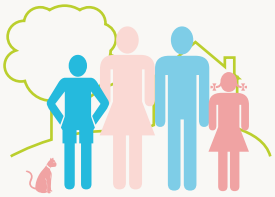
Facts and figures about Kent (excluding Medway)



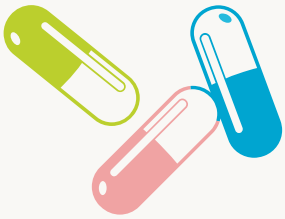
74% of the Kent population live in urban areas



51% of the population is female and 49% male

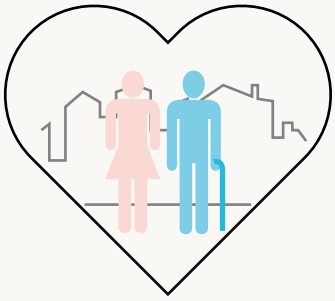


26% of the Kent population live in rural areas



17.6% of the Kent population have an activity limiting illness or condition (257,000 people)

46% of people in Kent supported by Adult Social Care are over the age of 85



57.5% forecast increase in over 65 year olds between 2016 and 2036

5,335 people (18-64) supported by KCC Adult Social Care have a physical disability

4,878 people (18-64) supported by KCC Adult Social Care have a learning disability

3,215 people (18-64) supported by KCC Adult Social Care have mental health issues

Further facts and figures about Kent can be found at www.kent.gov.uk/about-the-council/information-and-data

What does Kent Adult Social Care do?

'Together, we want to make sure people are at the heart of joined up service planning and feel empowered to make choices about how they are supported.'




What is our purpose?	What is our aim?	What are our responsibilities?	Who do we support?
To provide person centred, practical care and support to adults and carers of all ages, disabled children and young people. To work with individuals with care and support needs, arranging person centres outcome based care and support to help them lead independent and fulfilling lives, wherever possible in their own homes and communities.	To promote an individual's well-being; supporting them to live independent and fulfilling lives in their own homes and communities and achieving outcomes that are important to them. To ensure that the right level of support is provided at the right time, right place and the right cost for vulnerable adults, children, young people, their families and carers in Kent.	• provide information, advice and advocacy • carry out needs assessments • commissioning • provide and/or arrange services for adults with eligible care and support needs • keep people safe (safeguarding adults at risk of abuse or neglect).	• people with physical disabilities • people with learning disabilities • disabled children and young people • older people • people with mental health needs • people with sensory disabilities including dual sensory impairment and autism • people who provide voluntary care and support to friends or family • young people approaching 18 years old who are transitioning to Adult Social Care.

We firmly believe in supporting people to live independent and fulfilling lives by focusing on what people can do, not what they can't do ('strengths' based approach).

How Adult Social Care in Kent is structured

The Adult Social Care and Health Directorate is made up of two Divisions which are recognised as a formal part of the organisational structure of Kent County Council.

- Disabled Children, Adult Learning Disability and Mental Health (DCALDMH) Division
- Older People and Physical Disability (OPPD) Division

Both Divisions work together to meet the statutory responsibilities for social care that Kent County Council is obliged to fulfil as well as working in partnership with the NHS, District and Borough Councils, the Police, care providers, community, voluntary and social enterprises and other partners.

Disabled Children, Adults Learning Disability and Mental Health (DCALDMH) Division	Older People and Physical Disability (OPPD) Division
Commission and provide a range of services for people with mental health conditions; and for children, young people and adults with disabilities.	Arrange and provide a range of services to improve outcomes for older people and physically disabled adults, and their carers.
The purpose of the Division is to support vulnerable adults and children by promoting their well-being and supporting them to live independent and fulfilling lives in their own homes and communities.	**The purpose of the Division** is to support older people and working age adults to improve or maintain their well-being, and to live independent and fulfilling lives in their own homes and communities.
Key business areas - Disabled Children and Young People Teams, Community Learning Disability Teams, In-House Provision, Mental Health Services and the Operational Support Unit. The Division's services for adult mental health and learning disability already work in integrated teams with NHS colleagues.	**Key business areas** – Area Referral Unit, Adult Community Teams, Kent Enablement at Home, Sensory and Autistic Spectrum Conditions Service, Integrated/Registered Care Centres, Day Centres, and the Health and Social Care Integration Team.

The Directorate works closely with the Children, Young People and Education Directorate in providing appropriate support services to disabled children and the Strategic Commissioning Division who deliver our commissioning activity.

Additional information about the business areas of the Adult Social Care and Health Directorate can be found in the Annual Business Plan at www.kent.gov.uk and search Business Plans.

Challenges facing Adult Social Care Services

Adult Social Care Services across Kent continue to face four huge challenges:

- people want better quality and choice in the services they use
- the population is living longer with complex needs putting further demand on social care
- the financial climate is imposing massive constraints on local authorities
- we need to deliver joint services with the NHS and other partners.

As the population of Kent and demand on services increases, we need to ensure that we continue to deliver cost effective Adult Social Care Services where people remain at the centre of the care they receive.

Predicted Kent population growth (excluding Medway) 2015 – 2024

Age Band	2016	2017	2018	2019	2020	2021	2022	2023	2024
18-64	899,700	906,000	914,700	924,800	933,200	939,700	945,900	951,900	957,900
65+	307,000	312,800	319,400	326,100	332,600	339,600	347,100	355,100	363,700
Total	1,206,600	1,218,800	1,234,100	1,250,900	1,265,900	1,279,200	1,293,000	1,307,000	1,321,600

Source: KCC Housing Led forecast (Oct 2015), Strategic Business Development & Intelligence, KCC.

Your journey with Adult Social Care

Sometimes we all need a little extra support. It may be to get back on your feet after an operation or illness, things may be getting more difficult to do around the home or you may need support in caring for someone. Social care comes in all shapes and forms and it is provided by many organisations.

Getting the right care and support is important and you need to take time to consider all the options and information available. Many people will manage their support needs themselves, often with help from family and friends. Some people are not able to do this and need help from Kent Adult Social Care.

Care and support is the term used to describe the help some adults need to live as well as possible with any illness or disability they may have. It can include help with things like; getting out of bed, washing, dressing, getting to work, cooking meals, eating, seeing friends, caring for families and being part of the community.

Contact

If you feel you have care and support needs, you need to contact us and we will provide you with information, advice or guidance to help you or start an assessment of your needs based on what you tell us. A relative, GP, neighbour, friend or carer can also contact us on your behalf.
See page 60 for our contact details.

Your Needs Assessment:

- is an opportunity for you to tell us about your situation and discuss your care needs to helps us to understand things from your point of view
- will happen over the telephone or face to face and will help us to see if you are eligible for care and support services
- will look at how your needs impact on your wellbeing and what you would like to achieve in your daily life.

We will assess your care and support needs with you and decide if they are at the level where you need help. If you have eligible needs, we will discuss with you how you would like these met based on the information you gave us during your assessment and we will work with you to develop a care and support plan. If you do not have needs that are eligible, we will give you information and advice about what care and support is available to help you locally. This could include help from a local charity or voluntary organisation.

Planning your Support (your Care and Support Plan)

- This will set out how your eligible needs will be met and we will support you to organise the right balance of care and support services to achieve the goals in your plan.
- You can put the plan together on your own, with the help of your family and friends or with our help.

Supporting you to be Independent

- Where we can, we will aim to support you to stay in your own home and live independently, maybe by providing you with simple equipment to make life easier such as a grab rail for the bath or adapted cutlery and non-spill cups.
- By helping you to do more for yourself, we aim to improve your quality of life and wellbeing.
- If you pay for some or all of your care, doing more for yourself may help reduce the cost of your care and support.
- If you receive a service that is time limited, we will reassess you when it ends to see whether you still need our support or service.

Paying for your care and support

- We will assess how much you need to pay towards your care and support by carrying out a financial assessment.
- This looks at your capital (savings and investments) and your weekly income (which includes most pensions and benefits) to see how much you will need to pay towards the cost of your support.
- We may contribute to the cost of your care but this depends on the financial assessment.

Arranging your Support

- Once we have agreed with you how your needs will be met, you can choose to use the care services we provide and arrange or you can make your own care arrangements with a direct payment.
- This gives you greater choice and control over the care you receive.
- A direct payment is the money we will pay toward the cost of your care. We pay this onto a Kent Card.

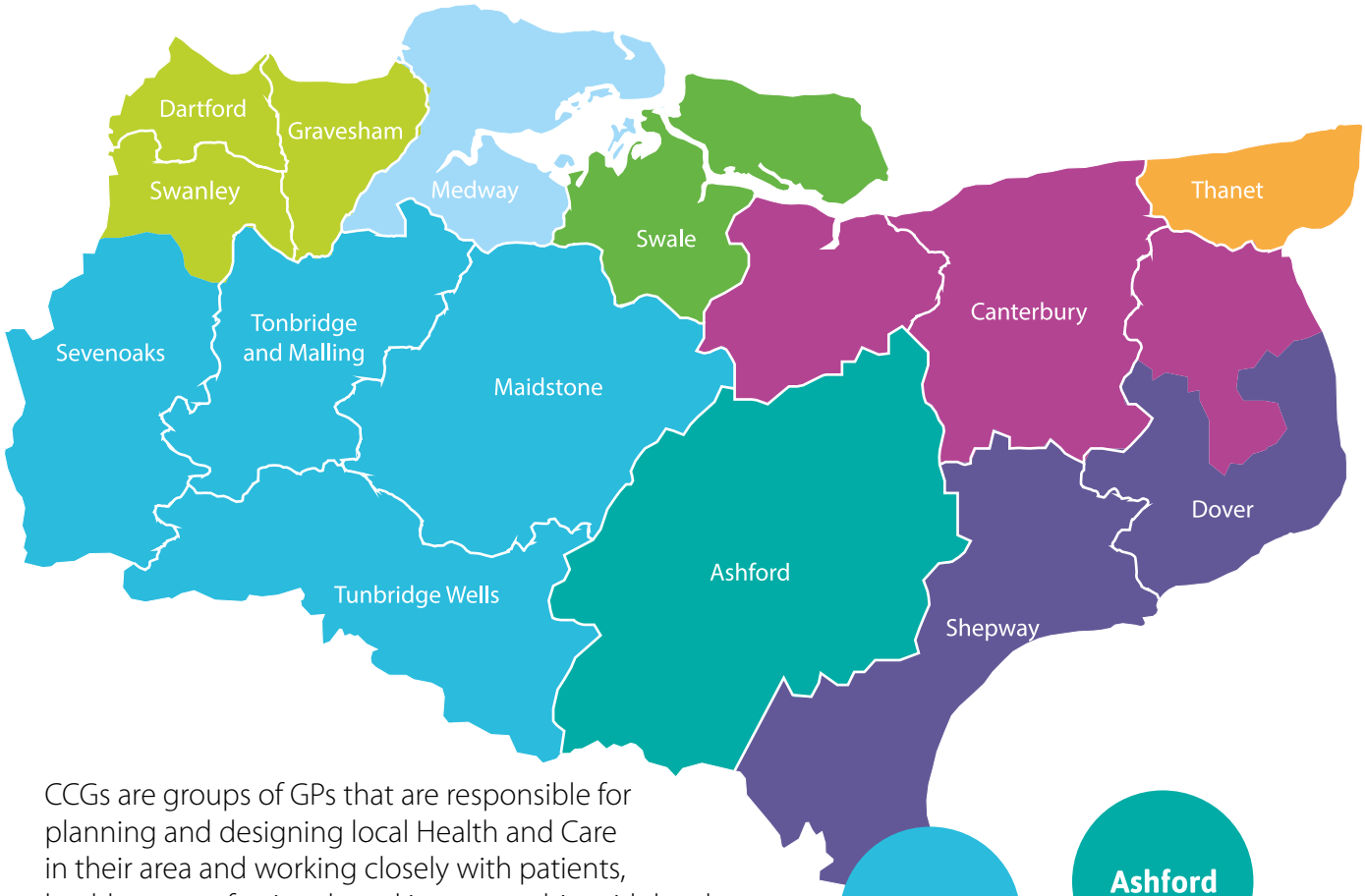
Reviewing your care and support

- We will contact you to check that your care and support is going well and that you are happy with what is being provided.
- This will happen within eight weeks of starting your care and support and then at least every year.
- We will also review your care and support if you or your carer contact us to let us know that your care is not working for you or if your circumstances have changed.

Sometimes things will improve so much that you may no longer need our services or you may need different help from someone else. We will help you with any advice you need about other organisations which might be able to support you.

All our employees wear name badges at all times so you can clearly identify them as KCC employees

Clinical Commissioning Groups - CCGs



CCGs are groups of GPs that are responsible for planning and designing local Health and Care in their area and working closely with patients, healthcare professionals and in partnership with local communities and Kent County Council. There are seven CCGs across Kent as well as Medway CCG.

West Kent is the largest CCG. It has the biggest overall population and highest number of people aged 16-64, over 65+ and aged over 85+. Thanet is the most densely populated followed by Dartford, Gravesham and Swanley CCG.

Of all the local authority districts in Kent, Maidstone has the largest population with 165,700 people, Dartford has the smallest population with 105,100 people.

People living in the East of the County (Thanet, Dover, Shepway, Canterbury and Swale) are more likely to consider themselves to have a limiting health problem or disability than the average for the county.

Further information on how Kent County Council is working with your local CCG can be found at www.kent.gov.uk and search Kent Clinical Commissioning Groups.

*Please note the coloured areas detail the CCG boundaries, the outlined areas are the district boundaries, resulting in some overlap. Map also highlights Medway CCG.

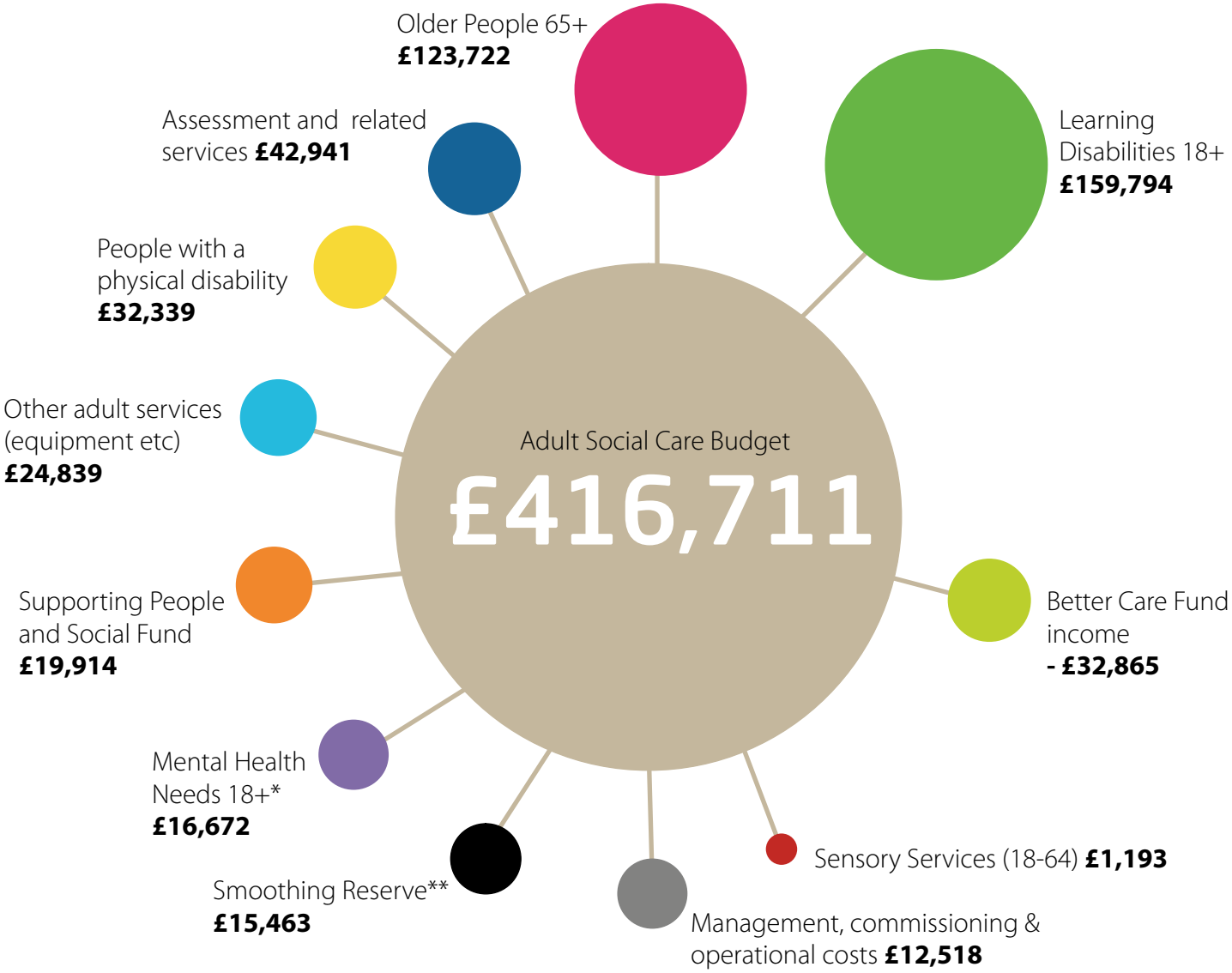
How we spend our money

KCC's net expenditure is £1.854 billion per annum and the budget is split into three areas:

- direct services to the public - £1.67 billion
- financing items - £115 million (authority wide costs that are not service specific)
- management, support services and overheads - £69 million.

The Adult Social Care net budget is £416,711 million per annum, below is an illustration of how this is spent across all our client groups. For more detailed information go to: **www.kent.gov.uk/budget**

How we spent our money £'000



* Mental health services are also funded and provided by Kent and Medway Partnership Trust (KMPT) who work in partnership with KCC.

**Smoothing reserve enables expenditure to be smoothed/spread over financial years.

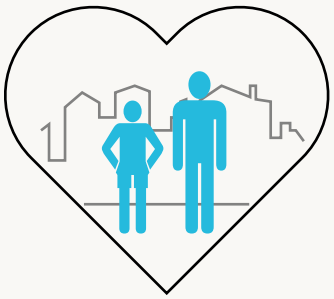
How we spend our money

Service	Net (£'000s) 2017-18	Percentage of Budget	Net (£'000s) 2016-17
Assessment - staff costs for carrying out community care assessments, support plans and reviews	42,941	10.3%	42,459
Residential care and nursing care including non-permanent care such as respite	163,514	39.2%	160,561
Domiciliary Care services provided to individuals in their own homes and those within extra care housing	38,328	9.2%	33,575
Direct payments - money which is passed directly to individuals so they can purchase and manage services to meet their eligible needs	44,420	10.7%	47,662
Supported Living and Supported Accommodation arrangements	73,754	17.7%	58,596
Day Care, Community Support Services and Meals	18,925	4.6%	20,073
Non-residential client charging – client contributions towards community based services	-17,742	-4.3%	-14,901
Enablement - intensive short term support which encourages people to be as independent as possible	11,427	2.7%	8,220
Advanced Assistive Technology	5,793	1.4%	4,627
Voluntary organisations contributions for social support related services	20,320	4.9%	18,175
Support for Vulnerable People - Supporting People and Social Fund	19,914	4.8%	19,900
Better Care Fund income	-32,865	-7.9%	-31,819
Management, commissioning and operational costs	12,519	3.0%	12,661
Smoothing Reserve Movement*	15,463	3.7%	
Total adult spend	**416,711**		**379,789**

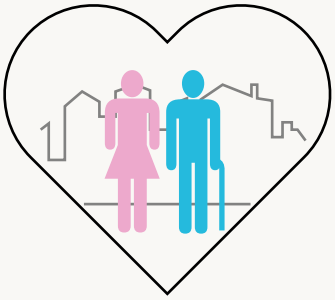
*Smoothing reserve enables expenditure to be smoothed/spread over financial years.

Headline figures

33,598 people in Kent are supported by Adult Social Care



12,902 people aged between 18-64 are supported by Adult Social Care

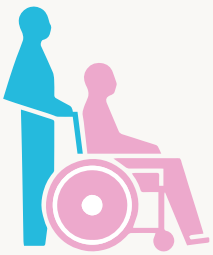


20,696 people supported by Adult Social Care are over the age of 65

Assessments

32,100 people received an assessment of their needs

27,704 people who received an assessment had eligible needs



6,827 assessments were completed that took account of carers' needs.

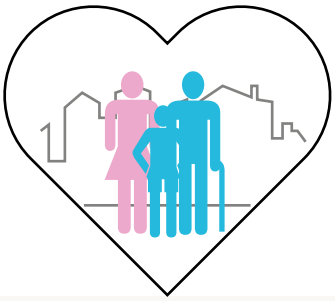
Personal Budgets

12,187 people had a Personal Budget

5,146 people decided to take their Personal Budget as a Direct Payment

3,202 people received their Direct Payment through a Kent Card

Services in the community



6,993 people received a home care support service so they could stay in their home

7,976 people received an enablement service

75% of people could return home due to an enablement service

2,363 people received a day care service

1,397 supported living placements were made

Residential and nursing care

4,140 people in permanent residential placements

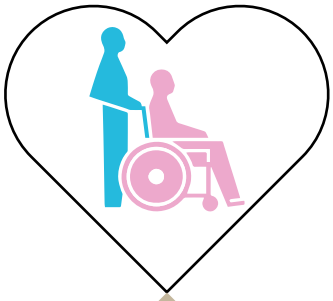
1,171 older people were resident in nursing care homes

1,040 residential placements were made for people with learning disabilities

451 suppliers provided services in relation to permanent residential placements

117 suppliers provide services in relation to nursing care homes

Carers



693 carers received a 'something for me' payment

Reviews

14,105 people received a review of their needs

Additional information on KCC's performance can be found at: www.kent.gov.uk/about-the-council/information-and-data

Transformation programme

Our transformation programme has enabled outcomes for thousands of older and vulnerable people across Kent to be improved

Update

To meet the challenges facing Adult Social Care Services across Kent, we have been transforming our existing services to deliver better outcomes for people building on people's strengths and capabilities, promoting their independence and improving their health and well-being.

We have been driving forward transformation, working closely with people who use our services, their carers, the public, our staff, Health, the voluntary and community sector and other organisations to help us achieve our desired outcomes and deliver savings.

Having completed a number of successful programmes, the current transformation programme is more complex and requires more involvement of other agencies.

The programme is being delivered in line with our strategy for Adult Social Care "**Your Life, Your Well-being**" and aims to:

- create a practical translation of the vision
- enable greater integration with Health
- provide a basis for further improvement in the future.

We are focusing on services and pathways that involve interaction with partners in Health and other services and we are identifying innovative approaches that require the development and implementation of new models of delivery.

Our strategy for Adult Social Care "Your Life, Your Well-being"

Find a copy at www.kent.gov.uk/careandsupport

What have we been working on?

The transformation programme is focused on opportunities to re-design the client pathway of support from preventative support in the community through to ongoing support for people who need long-term care.

We are continuing to modernise our services as well as our approach to the provision and delivery of services. We are implementing new operating models which will focus on being preventative, enabling, maximising independence and choice, and providing targeted personalised support where it is required.

New

OPPD operating model – this defines specific pathways for clients where the primary intention will be to work in a focused manner. It includes an integrated triage point, a robust assessment function to support decision making and a short-term rehabilitation service to support people to be able to carry on with their lives as independently as possible. People with ongoing care and support will have the right package of care to support them to live as independently as possible in the community. Promoting Independence reviews will be in place working with providers to ensure the care remains as effective as possible.

Mental Health Operating Model - a new approach will be developed and delivered to provide an integrated and seamless response to people and their carers across Kent and Medway Partnership Trust (KMPT), Kent County Council and wider partnerships.

Autism & Sensory operating model – this is currently being designed to create a long-term Social Care team; which will incorporate an '**integration ready**' service for a new model of care when the expected new Neurodevelopmental (ND) Health Service is procured and embedded across Kent and Medway in mid-2019. It will also create an all age multi-agency (children, young people and adults) Sensory pathway for D/deaf, sight impaired and deafblind people in Kent.

The Kent and Medway Sustainability and Transformation Plan is "seeking to deliver an integrated Health and Social Care model that focuses on delivering high quality, outcome focused, person centred, coordinated care that is easy to access and enables people to stay well and live independently and for as long as possible in their home setting". Within this, the model for Local Care and its accompanying toolkit are focused on delivering eight core components:

- care planning and navigation
- supporting people to improve their health and well-being
- healthy living environment
- integrated Health and Social Care multi-disciplinary team
- single point of access
- rapid response
- discharge planning and reablement
- access to expert opinion and timely access to diagnostics.

We are working closely with Health colleagues to develop Local Care teams, working across a range of service providers and GP practices within the local care geographical area.

Local Care teams will co-ordinate care and support networks that can be accessed by clients when required and will:

- work closely with the voluntary sector to set up a network of support
- co-ordinate any specialist intervention such as safeguarding concern or a specialist health intervention to manage an exacerbation of long term condition to prevent a hospital admission
- work with GP practices to reduce hospital admissions and support any hospital discharge in a timely manner to reduce delayed transfers of care

Lifespan Pathway operating model - taking a practice-led approach to deliver the best outcomes for people ensuring that all reviews are as effective as possible, that everyone has the package of support that best helps to improve or maintain their well-being and to help them live as independently as possible.

In-house provision (Inspiring Lives) - improving quality whilst providing a flexible workforce able to support Inspiring Lives Community Services and Adult Short Breaks, streamlining processes to make best use of resources, provide support for those with complex needs and upgrading and developing some of our buildings.

We are also reviewing areas of commissioned spend and practice, implementing solutions to streamline expenditure and, where possible refining practice whilst ensuring a correct package of care is put in place to support independence. This requires us to work with care providers to ensure they are delivering outcome focused care and support to meet individual's goals.

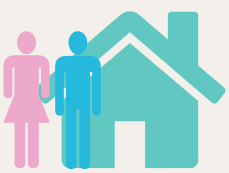
What a difference our Transformation has made so far!

Additional 3,600 people each year receiving Promoting Independence Reviews.

Average package size for people receiving care after enablement has reduced by 55 minutes per week.

3,500 more people every year benefiting from our enablement service.

Additional 350 people per year going home when discharged from hospital.



Ongoing Challenges in our transformation

One of our biggest challenges is to ensure people are at the centre of their care and live as independent a life as is possible given their needs and circumstances.

Although we have achieved significant savings and implemented more efficient ways to deliver our services, we are not complacent and continue to face significant challenges as we move forward.

We need to ensure we continue to deliver quality care that offers value for money for the future, improve social care outcomes within the constraints of a challenging financial climate, pay a fair and affordable price for our services, work closely with the NHS to co-ordinate joint priorities, planning and sharing of data and that our social care practitioners are supported by efficient and effective functions.

Kent Sustainability and Transformation Plan (STP) - transforming Health and Social Care in Kent and Medway

We are working together with the NHS and Public Health in Kent and Medway to plan how we will transform Health and Social Care services to meet the changing needs of local people.

The Kent and Medway Sustainability and Transformation Partnership has been set up by local Health and Care leaders and we are focused on how best to encourage and support better health and well-being, and provide improved and sustainable Health and Care services, for the population of Kent and Medway.

The Partnership is a collaboration of all NHS organisations across Kent and Medway, Kent County Council and Medway Council. The Partnership oversees the development of the Health and Social Care Sustainability and Transformation Plan (STP) for Kent and Medway.

The STP sets out how we think services need to change over the next five years to achieve the right care for people for decades to come. It describes what we think needs to be done differently to bring about better health and well-being, better standards of care, and better use of staff and funds.

However, it is work in progress. We will only be able to decide on and implement any changes following a period of engagement and consultation with local communities in Kent and Medway.

Transforming health and social care in Kent and Medway

Promoting well-being Promoting independence Supporting independence

Health and Social Care Integration

'Many people who need support from Social Care may also need support from Health. By working more closely together, people can get more seamless services, have better outcomes and we can help reduce costs.'

Design and Learning Centre for Clinical and Social Innovation

'Making out-of-hospital care safer for both citizens and the professionals.'

The Design and Learning Centre for Clinical and Social Innovation is based at Discovery Park in Sandwich and was officially launched in 2016. The Design and Learning Centre was created to support how we transform and integrate Health and Social Care services across Kent and Medway.

The focus of work is to reduce frailty, develop safe new services and transform the Health and Social Care workforce by promoting independence and self-care as we work towards making out-of-hospital care safer for both citizens and professionals.

To achieve this, the Design and Learning Centre is enabling new ways of working by co-designing and evaluating sustainable solutions to meet the needs of a changing population.

To support co-designing solutions, the Design and Learning Centre has held a number of Innovation Workshops which bring people together across organisations and disciplines, so we can work together to find the best possible solutions.

Workshops have covered a range of topics including medication, dementia support in the community and research and evaluation.

The Design and Learning Centre is also bringing new models of care to Kent such as **ESTHER** and **Buurtzorg** to transform the delivery of Health and Social Care.

The Centre recognises that we are not alone in our ambition to make care better for people and a number of partnerships and collaborations have been developed both locally and internationally.

The Design and Learning Centre, in collaboration with the Academic Health Science Network (AHSN) Kent, Surrey & Sussex and the Medway and Swale Centre of Organisational Excellence (MaSCoE) has been recognised as the innovation facility for the Kent & Medway Sustainability and Transformation Partnership (STP) Clinical and Professional Board. This partnership is known as the Collaborative.

The Design and Learning Centre is currently leading and supporting a range of projects:

Medication in the Community

With an increasing number of people being diagnosed with multiple long-term conditions, managing medications can become very complex with care providers having huge challenges in relation to supporting people with medications.

The Design and Learning Centre has recruited a Project Manager to take this project forward and has been working with a multi-professional group including staff from Adult Social Care, Health, Hospital Pharmacists and providers. Together this group and the Design and Learning Centre are working towards developing an agreed '**Medication in the Community**' model for Kent and Medway.

The project has received endorsement from the Kent and Medway Sustainability and Transformation Partnership. We are also working with the Association of Directors of Adult Social Services to discuss and agree the responsibilities of social care in relation to the administration of medication.

As part of this project we are working to release guidance for care staff for the administration of medication. We will also be running a Medicines Administration Record (MAR) chart pilot which will be looking at a standardised MAR Chart that will be adopted across Kent and Medway. In the future the project will be looking at creating a digitalised MAR chart.

Transforming Integrated Care in the Community – Bringing Buurtzorg to Kent and Medway

Transforming Integrated Care in the Community (TICC) is a four-year social innovation project seeking to transform the delivery of community care, guided by the principles of Buurtzorg. The project has been approved and funded by the Interreg 2 Seas Programme 2014 – 2020 (co-funded by the European Regional Development Fund).

The Buurtzorg model is a nurse led model of holistic care that revolutionised care in the Netherlands. The model, which was founded by Jos de Blok in 2007, started with one team of four nurses which increased to 850 teams within ten years.

One of the defining features of the model is that the teams of nurses are self-managing. The teams are responsible for the delivery of care

The Kent and Medway Mission:
"To challenge and adapt the health and social care system to enable the phased implementation of the principles of the Buurtzorg homecare model across the majority of Kent and Medway by October 2021"

and support as well as managing themselves as a team including planning, sharing responsibilities, decision making and building their own caseloads.

The Buurtzorg model in the Netherlands has been successful with the highest client satisfaction rates, high staff satisfaction and generating savings of 40% to the Dutch healthcare system.

As part of the Transforming Integrated Care in the Community Project, we are working to bring Buurtzorg to Kent and Medway by implementing a new model of community care that will be guided by the principles of Buurtzorg.

Within this project, our vision is to create systematic change in our Health and Social Care services that will better suit an ageing population and provide high quality local care delivered by fully integrated self-managed teams.

In Kent, Kent County Council is working with Kent Community Health Foundation Trust to implement the new model of community care to ensure the teams will be fully integrated. The new teams will work closely with and be aligned to local GP Practices.

The project officially began in July 2017 with our first pilot site identified to implement an integrated community team being in Edenbridge. We are currently in the initial planning stage with implementation planned for September 2018.

There are fourteen partners across France, Belgium, Netherlands and the UK working on this project. Kent and Medway have been identified as implementation sites in the UK with further implementation sites in France and Belgium.

Interreg
2 Seas Mers Zeeën
TICC

The Learning and Development Hub – A One Stop Shop

The Design and Learning Centre with support from the STP workforce has implemented the Learning and Development hub to support the care sector workforce. The hub is designed to establish an integrated, sustainable and competent care sector workforce through:

- enhancing the quality and focus on outcomes
- skilled and competent care workforce through development and new ways of working as new models of care are developed
- creating a new and sustainable supply of workforce
- developing career pathways and new roles for the future
- supporting the sector to innovate and utilise technology
- developing innovative and confident leaders.

During the year, there has been a lot of activity and support to the Care Sector workforce including a care sector conference attended by over 200 providers and the launch of a care sector recruitment campaign which included a short film to raise the profile of working in the sector. You can view the film at: https://vimeo.com/277111409/f233f5e09d

The Esther model - Learning from Health and Social Care in Sweden

Esther has everyone inspired!

In Kent, we are continuing our ESTHER journey. We have now trained over **300 ESTHER Ambassadors** and this number continues to grow. We have also trained **50 ESTHER Coaches** with even more future coaches currently in training.

ESTHER is a way of working developed in Sweden to look at how a person's experience of Health and Social Care can be more joined up, proactive and engaged with the person themselves. The approach focuses on what is important to the individual.

The programme which has been running for more than 20 years in Sweden, has seen hospital admissions drop by 30 per cent.

Esther was a real person who became unwell with serious heart failure and was admitted to hospital. There were delays in diagnosis, treatment and care planning. Overall the experience that Esther had was not good and the staff involved in her care recognised that there was a different way of doing things that would lead to better outcomes, higher quality care and efficiency.

Esther Cafés

We held five ESTHER cafés during 2017/18. An ESTHER Café is an informal meeting place where ESTHERs and all the organisations involved in their care can informally come together.

As part of the ESTHER Café, ESTHERs share their experience of care with those in the room so that Health and Social Care providers can hear experiences first hand and from this can seek to work together to make improvements that matter to ESTHER and make best use of resources.

An ESTHER café in January 2018 focused on people accessing Mental Health services and outcomes from this have informed where improvements are required.

"It's all about how small things can make someone's life better and happier. This is the way forward."

One of the ESTHER cafés in action

What have we achieved in Kent with ESTHER?

We have continued to share the ESTHER philosophy of care through our training opportunities and we are seeing the numbers of ESTHER Ambassadors and ESTHER Coaches constantly increasing.

We held our first ESTHER Inspiration Day in November 2017 which was attended by 100 people including Health, Social Care and those who use our services. As part of the event, we introduced the ESTHER Model and gave attendees the chance to take part in a number of workshops which included a mini ESTHER café, the impact of implementing ESTHER at Hawkinge House, ESTHER Training Opportunities and ESTHER Coaches and their improvement projects.

At the end of the day and following the event, attendees were invited to join one of our ESTHER Ambassador training sessions.

"Good information regarding ESTHER - workshop useful. Will use to influence my practice"

"ESTHER care was a wonderful eye-opening experience"

"ESTHER Ambassadors resonated with me, very good session and learning"

"The ESTHER concept was amazing"

ESTHER has been introduced to trainee GPs in East Kent as part of a frailty workshop that took place in May 2018. During this event, an ESTHER Ambassador training session was held along with an ESTHER café with three ESTHERs joining us on the day to share their experiences of care.

The Kent **ESTHER philosophy** and way of working has gained recognition by national bodies, such as Health Education England and the Department of Health and Social Care and was highlighted as a model of good practice within the Lyn Romeo Chief Social Worker Annual Report for 2017/18. The ESTHER model was also recently a winner of the ICT Enabled Social Innovation (IESI) award for European Social innovations.

What is next for ESTHER in Kent?

We will be continuing to roll out ESTHER across Kent. Next steps include holding a second ESTHER Inspiration Day to continue to raise awareness of ESTHER and our progress in Kent.

We are also looking forward to launching our ESTHER Network for our ESTHER Coaches which will enable our ESTHER Coaches to connect virtually to share their experiences, improvement work and to support each other.

Further information about the Design and Learning Centre and our work can be found on our website at:
www.designandlearningcentre.com

Case Study

Colin's Story - The Journey from Nil by Mouth to Christmas Lunch

New ESTHER coach and Speech and Language Therapist Belinda Walker and ESTHER Colin Black (Wilfred) talk about Colin's journey back from 'nil by mouth' tube feeding to eating Christmas lunch with his wife.

When Speech and Language Therapist Belinda Walker received a referral for Colin after his stroke, she admits her heart sank. The prognosis, on paper, did not look good. His stroke had left him with severe dysphagia (swallowing disorder) and it seemed unlikely that he would make much of a recovery.

She went to meet him and before she had even taken her jacket off, he said 'I will be able to eat again, won't I? I so want to eat'. It was early October, and he said that, more than anything, he wanted to eat Christmas lunch when the time came. Here was something that mattered to ESTHER, yet this looked like it would be very hard to achieve.

Belinda checked the exercises given to him to by colleagues at the William Harvey and added some new ones. Colin was diligent in carrying these out and soon began trying sips of water. As the weeks passed, more fluids and small amounts of pureed foods were added. Colin's chest remained clear and he began keeping a food and fluid chart himself and wrote down how many times he had performed the exercises.

The ESTHER ethos was picked up by the home and staff involved with Colin. He had his breakfast at 7.30, so Belinda arrived at that time, so he could eat at his preferred time. The chef at the home prepared lovely small breakfasts and lunches – all well-presented and of the right texture. He also provided this food at unusual times outside the normal 'meal run'.

Medical staff monitored Colin's chest and nurses sat with him to ensure his enthusiasm for eating was kept in check by gently reminding him of the safe swallow strategies. Even the other residents cheered from the side-lines. '**Colin is an amiable man who struck up many friendships.**'

Swept away on this tide of goodwill, he kept to his exercise goal and at Christmas was able to enjoy a small, slightly modified texture Christmas meal with his wife. His wife had also been unwell but was given a clean bill of health, so this meal was a double celebration!

Belinda says '**Colin was real joy to work with**. By changing work patterns and involving everyone at Wells House care home, he was able to achieve his dream. At times he needed to be held back! He was keen to try more and more, but hopefully the good relationship between Colin, myself and the other care staff contributed to the fact he was prepared to hold back and follow what must have seemed like over-cautious precautions.

I could see the ESTHER approach in action here. It is difficult when what an ESTHER wants to achieve looks difficult on paper. We always have to be mindful of being hopeful, yet realistic about what can be done.'

Colin said '**I cannot believe I am eating! It is marvellous!**'

Belinda Walker - ESTHER Improvement Coach

Promoting well-being Promoting independence Supporting independence

Kent Enablement at Home

What is Kent Enablement at Home?

Kent Enablement at Home or KEaH is a short term service which supports people to do more for themselves at home, by learning or re-learning skills to make an individual feel safe and happy in their own home. The service offers support that aims to encourage and enable people to lead as independent and fulfilling a life as they can, in the way that they want.

How does it work?

KEaH is not about doing things for people, it is about giving people the skills and confidence to complete daily living tasks for themselves.

Support may include help getting in or out of bed, washing, dressing, getting to work or being part of the community, providing Fast Track Equipment (basic pieces of equipment to make daily tasks around the home easier or the provision of Telecare – personal and environmental sensors in the home that provide 24-hour monitoring.

How long is it for?

The programme does not have a fixed duration. It will depend on a person's progress, may last up to 6 weeks and is part of the needs assessment.

The KEaH Team have three key priorities:

- everyone should get the best chance to be independent through structured delivery of enablement
- everyone who can benefit from the service should have access to it. We should try our best to never turn someone away
- to deliver the support service users need efficiently and we should adjust our operational practices to best meet this need.

These priorities are met by:

- sharing best practices and knowledge between teams, introducing input from Occupational therapy, Case Managers and Purchasing Officer to help achieve best outcomes
- setting enablement goals which aim for the greatest level of independence possible for a service user
- actively managing the visit time with service users, ensuring they are working towards the end goal of enablement in a structured way
- providing visibility of visit lengths to enable the team to make more informed scheduling decisions
- reducing unnecessary service user visits by mapping and tracking a clear end goal to enablement and by managing the transition to increased independence for those whom have met their enablement goals
- providing visibility of service users progress
- highlighting and learning from the reasons why outcomes have not been achieved.

KEaH is monitored by the Care Quality Commission (CQC) and in May 2018, the service was rated overall as **GOOD.**

Sensory and Autism Services

Kent Adult Social Care has its own specialist unit for sensory impaired people (d/Deaf, sight impaired, deafblind) and individuals with an autistic spectrum condition. The unit comprises both in-house teams and commissioned specialist services.

The Teams:

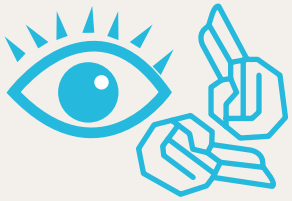
- provide a county wide specialist assessment and provision service for children and adults with sensory impairment

- provide a county wide specialist service for people with autism including self-management and promoting independence, in support of clients with higher functioning autism.

The specialist services in the unit include:

- **Hi-Kent** who provide statutory assessment for equipment for older people, resource centres for the purchase of equipment and a hearing aid maintenance service
- **Kent Association for the Blind** (KAB) who provide statutory assessments, rehabilitation training (mobility, daily living and communication skills training), registration as sight impaired and a Guide Communicator service – a specialist one to one support service for deafblind people
- The **Royal Association for Deaf People** (RAD) provide interpreting services for d/Deaf and deafblind people
- **Advocacy for All** provides peer support groups for people with an autistic spectrum condition across Kent. People with autism come together regularly to help and support each other and the groups organise activities and speakers
- **Specialist Teaching and Learning Service** who have a team of intervenors to support Deafblind children.

Headline figures

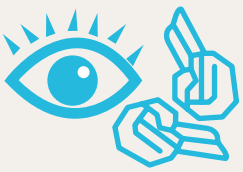


5,066 contacts were made to Sensory Services in 2017-18

2,872 new referrals were made

1,527 in KAB

521 in Hi Kent



307 by Sensory Services

517 Autism referrals

Sensory Facts

National figures indicate that **between 2010 and 2030**, the number of adults with **sight impairment** will **increase by 64%**.

A significant proportion of sight impairment is related to age with over **80% of sight impairment occurring in people aged over 60**. This population is set to increase by 21% nationally by 2020.

There will be a significant **increase in the numbers** of people, particularly older people, **who are deafblind by 2030**. Sense forecast this to be 86% for those who are severely deafblind and 60% for those who have any hearing and sight impairment.

It is expected that sight will deteriorate with age and therefore **people just 'accept'** their sight is failing (UK Vision Strategy).

Between 2010 and 2030, there will be a **56.5% increase in** the number of people aged 18 and over with a moderate or **severe hearing impairment** in Kent.

By 2030, the number of people with a **profound hearing impairment** will have increased by 42% for those aged 65-74 and 59.7 % for those aged 75-84.

One in six people are now deaf.

90% of all deaf children are **born to hearing parents**.

D/deaf children are **30% to 50%** more likely to experience mental health issues than hearing children.

New

Sensory Strategy

The Sensory Strategy, which looks at what services are required to meet the Health and Social Care needs of children and adults who are d/Deaf, deafblind and sight impaired within Kent over the next three years has been developed following extensive consultation with individuals with sensory impairment and their families and carers.

Our vision outlined in the Strategy is to support d/Deaf, deafblind and sight impaired people of all ages to be independent, to have choice and control and to participate fully in society.

It has been shaped by what you have told us, national policy, research and best practice, our own review of how services are delivered, the need to redesign services to create efficiencies, improve outcomes, reduce costs in line with our Transformation agenda and the need to improve Health and Social Care integration

The Strategy has been approved by the Adult Social Care Cabinet Committee and will be driven forward through a Sensory Collaborative comprising of service users and carers, KCC, Health and the voluntary sector.

Sensory Facts in Kent

Older People

- Thanet, Canterbury and Maidstone have the highest populations of over 75s and are more likely to have a larger population of people with a sight impairment.
- The number of older people in Kent is projected to increase by 67% by 2033. The largest increases will be in Dartford (32%) and Ashford (31%).
- East Kent coastal districts of Shepway, Dover and Thanet will continue to have the largest proportion of older people in their population.

Hearing Impairment

- Approximately 5% of over 85s in Kent will have a profound hearing impairment.
- The number of people aged over 85 with a moderate or severe hearing impairment in Kent is set to increase by 110% between 2010 and 2030.

Learning Disabilities

- Kent's population of people with learning disabilities is estimated at 26,000, of which up to 8,000 people may have significant sight difficulties and 9,620 may have some degree of deafness. A significant number of these are likely to have a dual sensory impairment.
- Of the 2,243 people in Kent with Down's syndrome, (Learning Disabilities Needs Assessment 2010), 1,570 have hearing problems.

What have you told us?

A lot of sensory impaired people are isolated especially in more rural areas – it's hard to know of other people with similar conditions especially if you don't use the internet. There needs to be some sort of network where people can get in touch with someone going through the same experience – even if it's to meet up for a drink every couple of months. It's good to get out and meet people similar to you – then you don't feel so alone.

Where are we now?

- We provide a rehabilitation programme for service users and several self-management and peer support pilot programmes have taken place in partnership with voluntary agencies such as Hearing Link, Kent Association for the Blind, Sense, Kent Deaf Children's Society and Guide Dogs for the Blind Association.
- Specialist programmes are delivered to children and young people to help them understand their sensory impairment and improve their independence.
- Family Days and Short Break opportunities have been provided to develop resilience and independence for young people and their families.

Development of an All Age Sensory Pathway

Work has commenced on developing an All Age Sensory Pathway and redesigning the current Social Care teams for children, young people and adults who are d/Deaf, visually impaired and deafblind to enable a smooth transition from Children's to Adult services.

We are working with Health Commissioners and the Local Eye Health Network to explore opportunities for more integrated services and joint commissioning.

We are also working with people with sensory impairments, families and carers, our staff, and our partner organisations (the voluntary sector, Education, Health) to see how we can deliver support in new ways and achieve improved outcomes for the people we work with in Kent.

Deaf Well-being and Access Project

People who are born Deaf or become Deaf during their early childhood are most likely to use British Sign Language (BSL) as their first language.

The Deaf community is recognised as a cultural and linguistic minority group and has a strong and unique culture based around their language and identity as Deaf people.

In 2003 the Government officially recognised BSL as a language in its own right and as an indigenous language used in the UK.

A new pilot project, the Deaf Well-being and Access project was established in April 2017 and this has resulted in the establishment of a Deaf forum and significant engagement with local Deaf people in Thanet, including in partnership with Health.

We have engaged a Deaf Community Worker to work with the Deaf community in Thanet (where there is a high number of Deaf people) to improve their access to services.

The project has recently been evaluated and found to be successful in delivering change so will be extended to cover the whole of Kent.

"The Deaf Community Worker has helped us to be stronger and more confident."

(service user comment)

Key outcomes:

- accessible information workshops tailored for Deaf people who use sign language
- inclusion in steering meetings with Community Health, Healthwatch Kent, Kent Police and a Deaf Charity
- improved health outcomes such as Deaf accessible 'quit smoking' group
- deaf accessible social opportunities
- KCC Sensory Services Facebook page with information/events in BSL and subtitled which has promoted two-way communication.

British Deaf Association Charter for British Sign Language

The British Deaf Association (BDA) is asking local and national services across the UK, in the public, private and voluntary sectors to sign up to their Charter for British Sign Language. The Charter sets out several key pledges which aim to promote better access to public services for Deaf communities as typically, Deaf BSL users have a marked reduction of opportunity to access services.

In December 2016, Kent County Council considered the Charter and agreed to action being taken to improve access and rights for the Deaf BSL users.

Progress made by Kent County Council to implement the pledges.

- During public consultations, organisers can access the Council's BSL interpreting service and we have undertaken several consultation events with local Deaf people including "We Share You Share" event to enable Deaf people to raise issues with local public services.

- We manage a public partnership contract for sign language interpreting for Deaf and deafblind people on behalf of other public bodies in Kent including Kent Police, Kent Fire and Rescue, Kent and Medway NHS and Social Care Partnership Trust, Kent Community Health Foundation Trust and Dover District Council.

- The interpreting service is provided by the Royal Association of Deaf People (RAD) and only qualified and registered interpreters are used. This contract is held up nationally as an example of Best Practice. All council services have access to this contract including Kent schools so that Deaf people can have equal access to services.

- New technologies are being explored to meet the information and access needs of Deaf people including video interpreting and the use of Skype. Our Sensory Services Facebook page provides information for Deaf people in BSL.

- Gateway "drop ins" are run across the county where Deaf people can be assisted to understand information or gain access to services with the help of practitioners skilled in BSL. These are highly valued by the Deaf community. A specialist advocacy service provided by RAD has also been commissioned which provides Deaf people with independent access to services.

- Staff in our specialist Sensory Services teams are skilled in BSL and have a good understanding of the Deaf community and Deaf culture. Practitioners have a minimum of BSL level 2 and several have higher levels. Staff are given regular opportunities to further develop their skills and have a long history of pro-actively recruiting d/Deaf staff and assisting them to qualify as Social Workers.

Case Study

Bill's Journey

Bill* (aged 70) is a very gentle and unassuming man. He has very complex needs and he is unable to communicate freely. He never complains, even though this does mean that it is very easy for him to be overlooked.

He is Profoundly Deaf, without speech and has undiagnosed ASD. He lives alone, has no friends and his extended family (elderly brother) lives 250 miles away. His only communication with his brother is by fax and he sees his family very infrequently (only once in the last two years).

Because Bill finds it hard to communicate easily, he has always experienced great difficulties in accessing appropriate facilities to enable him to have equitable access to various services and he is very suspicious of others. He is also extremely isolated due to his inability to mix with others because of his complex needs. This has resulted in him having a history of mental health issues.

Because Bill also has ASD, anyone visiting his home would think that he is managing well as his house is immaculate. This belies the fact that he is just existing and doesn't ever use any room other than his bedroom, which is practically bare, the toilet and kitchen. Until a little while ago, he would even go to the local swimming baths to take a shower to avoid using his bathroom.

Bill's Assessment

Bill was visited by a sensory worker just after his medication was stopped by his GP because he had developed what was thought to be the start of Parkinson's disease. At that time, he was in a very serious psychotic state.

Although it was initially difficult for Bill to accept people coming into his house and that he required support to keep him safe, the sensory worker identified that unless Bill was monitored, he would be extremely vulnerable.

Although Bill could communicate initially by writing a message, he became unable to write at all, having to point to words. His current health also deteriorated to a point of him needing daily care calls and a signing personal assistant to help establish his actual needs as unless someone was there to observe his daily living, it would be easy to miss the detail, particularly as Bill was unable or unwilling to ask for help.

Where Bill is now

Gaining Bill's trust and working through the difficulties he has had with communication has meant moving at Bill's pace, working with him to help him see what risks he is putting himself in by not having appropriate support in place and encouraging him to accept the support he needs.

Although Bill requires ongoing support, the involvement of the sensory team has enabled multi-agency working to take place with occupational therapy, specialist nurses, Bill's own GP, speech and language therapy and Community Mental Health all working together to ensure that Bill's support needs continue to be addressed.

*Name, details and image have been changed to protect identity.

Strategy for Adults with Autism in Kent

In our last brochure, we updated you about our new Strategy for Adults with Autism in Kent which sets out the direction we are going to follow over the next five years to achieve our vision for people with Autism in Kent.

Our vision is for people with autism to receive the right support at the right time, to be enabled to develop to their full potential and to be active and accepted members of their communities. At the core of this strategy is the desire to create an autism friendly society in its widest sense.

The Strategy which was developed by the Kent Autism Collaborative taking into account the views of people with autism, their families and carers, professionals and voluntary organisations who work with people who have autism was launched in July 2017.

The Strategy and the Autistic Spectrum Conditions Joint Needs Assessment can be found on the kent.gov.uk website.

Developments in Autism

We have been working with key stakeholders and colleagues across Kent Clinical Commissioning Groups to formulate an action plan that will address the needs identified from the Autism Strategy and Joint Needs Assessment (JNA).

The transformation action plan for Adults with Autism and or ADHD targets key priorities and objectives identified from the Adults Autism Strategy and the JNA to improve the gaps experienced in services across Health, Social Care and Education for people with higher functioning Autistic Spectrum Conditions (ASC) and or ADHD.

The action plan targets ten key areas of priority for transformation spanning its five-year commitment to improve and transform services for service users and carers.

Areas of priority for Transformation for Adults with Autism and or ADHD

Diagnosis, Assessment and Support
Leadership, Plannning and Commissioning
Co-Production
Life Facing - Transitions
Training and Further Education
Employment
Housing, Care and Support
Workforce Development
Criminal Justice System
Carers

The Neurodevelopmental (ND) Transformation Programme has been set up to oversee and monitor the progress of the required transformation.

Update on projects initiated so far under this new programme of work:

- **The Integrated Neurodevelopmental (ND) Multidisciplinary Team (MDT) for Health & Social Care Service**

  Working In collaboration with Health Commissioners to develop a Kent and Medway wide Neurodevelopmental (ND) Health Service, with the intention of integration with Kent Social Care Autism service under an Alliance partnership within Kent for the future. The development is still

at an early stage with Health Commissioners considering a business case for this new service.

- **The Complex Autism Service (Transforming Care)**

  NHSE Transforming Care, along with Kent County Council, Medway Council and Kent and Medway Clinical Commissioning Groups have funded a new service across Kent and Medway for those presenting with complex autism and or behaviour that challenges.

  This new service provides community-based clinical interventions as an alternative to out of area placements and or hospitalisation for those with high level needs. It also provides a stepdown facility for those already in out of area placements or hospitals to enable people to return to their own communities.

- **The Social Care Autism Team Redesign**

  The ASC Social Care Team is redesigning its service to ensure it is '**integration ready**'; when it forms a functional multidisciplinary team (MDT) with Health commissioned diagnostic services post 2019. This specialist Social Care Service has expanded rapidly since it was commissioned in 2012. What commenced as a short-term Interventions service will soon become a long-term team, supporting adults with Autism throughout their duration of need for services.

  The service will be considering expanding its specialism in working with autistic spectrum conditions to include other neurodevelopmental conditions, such as ADHD. The redesign project is due to be completed by January 2019, when the newly redesigned service will be active.

Case Study

Andrew's* Journey

Andrew* was a young man (23 years old) who was living with his family when the ASC Team first met him. Andrew wanted to live independently, however he had no daily living skills. He also wasn't accessing any benefits to support him.

Andrew's Assessment

A holistic assessment was completed with Andrew where it was identified that one of his key strengths was his confidence working with strangers and his passion to achieve his goal of living independently. This enabled the ASC Team to start intensive work with him from day one.

A further strength was Andrew's relationship with his Mother who took the lead from the ACS team and the support worker on areas to "step back from" and areas where she needed to continue to provide support. This joint working approach encouraged Andrew to develop the key skills needed for him to become independent, whilst enabling him to continue to feel supported.

An eight-hour care and support package to develop daily living skills was set up for Andrew and support was also given to him to enable him to apply for relevant benefits and to identify housing options.

Where Andrew is now

Andrew made progress in all aspects of daily living skills and now lives in an independent flat that is a two-minute walk from his Mother's house. His support package was reduced to two hours for complex tasks such as budget management. Andrew is now in full receipt of benefits, he has a positive balance in his life of social based activities and he has a job at his local superstore.

*Name, details and image have been changed to protect identity

The Adult Social Care Autistic Spectrums Conditions Service has been working actively to source funding across Health, Social Care and Education for several more projects which will enhance and support the wider transformation of services; these will include training and developing of the wider workforce, effective risk mitigation for those individuals who are at risk of in-patient care, the development of building resource and support within the community to provide an alternative to transforming in-patient care and out of area placements for those individuals with complex and or behaviour that challenge.

New

Innovative approach to enablement for adults with autism

In November 2017, the Autistic Spectrum Conditions team hosted an inspirational event on its new enablement approach which has been developed to promote the independence of adults with autism.

The session explored the learning from the team's research looking at:

- the intervention's impact upon costs and personal outcomes
- the use of assessment tools and assistive aids
- research findings, including personal stories from clients who participated
- the potential for further development of the approach for this client group.

The event also saw the official launch of a book on the new approach based upon the work done in Kent.

Case Study

David's* Journey

David* was a young man in his mid-twenties who was living with his family in over-crowded accommodation when the ASC Team first met him. David had limited experience with independent living skills, was socially isolated outside of his family, struggling to manage part time employment and he had been refused benefits at assessment.

David's Assessment

Primary desire from David was for independence and to be able to manage his life without support from parents, whilst his parents felt he would require some form of supported accommodation. A needs assessment was completed focused on goal setting.

A six-hour support package was put in place, initially to begin developing daily living skills around cooking, meal preparation and food shopping whilst David remained in the family home. Intervention through Kent Supported Employment was used to seek reasonable adjustments at the workplace to allow David to remain in employment. David was also supported to engage with local 'talking therapies' who counselled him to manage social anxiety and to use peer support groups to provide social opportunity. Support was provided through case management to complete an application for housing through his local council and to appeal the benefit decision.

Where David is now

David is now living independently in his own council tenancy, he has maintained employment long term and he continues to engage with support services to manage the transition to independent living and further develop independent living skills. His benefits appeal was also successful, resulting in a high level Personal Independence Payment (PIP) which has providing financial security to enable David to continue to live independently.

Promoting well-being | Promoting independence | Supporting independence

Integrated Community Equipment Service and Technology Enabled Care Services

Update

Integrated Community Equipment Service play a crucial role in helping us to support the most vulnerable people in Kent to remain in their own home. Through the provision of equipment, people are enabled to carry out everyday activities independently or are provided with equipment which supports them to be cared for at home.

Nottingham Rehab Limited (trading as NRS Healthcare) provide these services under a contract let in partnership with KCC and the seven NHS CCGs in Kent.

We also commission Invicta Telecare Limited (trading as Centra Pulse and Connect) to provide a Digital Care and Telecare service to supply, install, maintain and monitor telecare alarms, provide service user support and staff training. This is a KCC contract.

Both services reduce care home/foster care and hospital admissions and assists with timely discharge from hospital.

Headline figures

From April 2017 – March 2018

- **50,461** service users were seen by the Integrated Community Equipment Service
- **159,791** items of equipment were provided to support the most vulnerable people in Kent to remain in their own home
- **73,954** items of equipment were collected and recycled
- In March 2018, Kent had **8,900** telecare connections in place to support people to live independently.

In December 2017, the Integrated Community Equipment Service received recognition of achievement from the Kent Environmental Champions Group for their commitment towards the environment.

Safe and Well

Safe and Well is a service provided by NRS Healthcare which enables people who aren't eligible for social care to find out about getting personal equipment to support their independent living. The service includes free online self-assessment, local demonstration and telephone advice, links to Centra services (technology and Telecare), occupational therapist visits (fee charged) and a directory of trusted local suppliers

Further information on Safe and Well can be found at www.safeandwell.co.uk

County Technician Service

The team provide minor adaptations to the homes of adults and children across Kent ranging from simple grab rails to more complex ramping and other access solutions. The service is fully mobile and out and about within the county with simple, minor adaptations provided within seven days with more complex work requiring further time to complete.

In the last 12 months, the service provided **9,795** adaptations/ equipment to **5,492** people. In addition, the service also completed **932** bathing assessments.

The Kent Blue Badge Service

Between April 2017 and March 2018, the KCC Blue Badge Team received **26,390** Blue Badge applications and issued **24,969** badges.

Shared Lives

We are always looking at different ways we can provide support and the Shared Lives scheme is just one example of how we are transforming the lives of Kent residents.

Similar to fostering, Shared Lives offers eligible people over the age of 16, a safe and supportive placement within a Shared Lives family home for:

- long term – living with a Shared Lives family on a long term/permanent basis where this is the person's main home
- short breaks – staying for a couple of days, a week at a time or longer if required
- day support –one session is up to five hours and can be any time during the week at the Shared Lives Host's home.

Shared Lives is about opening the door to choice, satisfying experiences and providing a sense of belonging whilst enabling people to keep their own independence.

As well as offering an excellent form of quality care and support, Shared Lives saves, on average around £26,000 per year, per individual, against the cost of residential care.

How does Shared Lives work?

Shared Lives is available to individuals with a wide range of care and support needs, such as older people, people with learning or physical disabilities, people with mental health issues, people on the autistic spectrum or with Asperger's, people living with dementia and people with a sensory impairment.

Our experienced team work with the individual to match them with a suitable household. We match the person with a family who have the right skills and characteristics to give the care and support needed. Shared Lives hosts could be a single person, a couple, friends or a whole family. Our hosts will also be that all important link to wider social experiences and the local community. Our hosts are thoroughly assessed, trained and monitored throughout their time with Shared Lives.

What difference can it make?

The Shared Lives scheme can make a real difference to the people who use the service. It can provide people with:

Improved quality of life

✓ new life experiences, whether it's birthdays and weddings or going on a holiday for the first time

✓ a live-in family environment, developing relationships that could last a lifetime

Social inclusion

✓ a family network, introducing them to an extensive group of people in the wider community

✓ getting involved with their local community, many get jobs or develop a new social activity

Support

✓a better service for users than traditional forms of care

✓consistent and continuous personalised care.

Over **220** people have accessed our Shared Lives service and we have many individuals in placements with hosts and their families.
We have also continued to recruit new hosts in all areas of Kent and the service now has over **180** hosts and their families for people that wish to consider Shared Lives as an alternative to living in a residential service or using other day services or short breaks units.

Shared Lives is monitored by the Care Quality Commission (CQC) and in July 2017, the service was rated overall as **GOOD**.

Further information on Shared Lives can be found on our website at www.kent.gov.uk/sharedlives, phone: 03000 412 400 or email: sharedlives@kent.gov.uk.

Case Study

Nicole's Story

Nicole who has Cerebral Palsy and is a wheelchair user, has been living with Godfrey since 2001. At 18, Nicole came over to Shared Lives to enable her to stay living with Godfrey as she is very happy and settled there. Nicole loves animals and has completed a Diploma in Advanced Animal Management at Mid Kent College. Since then she has done some voluntary work at a local vets and also at the Dogs Trust.

Nicole loves wheelchair football and plays regularly in a team/ league. She has recently been interviewed on local TV regarding her football. Nicole has her own car and is currently learning to drive and regularly goes out with Godfrey for practise lessons as well as continuing her driving lessons.

Godfrey's Story

Godfrey has been a foster carer for over 25 years and in that time has looked after many children. Nicole has lived with Godfrey since she was 7 years old and he wanted her to be able to continue residing with them when she became an adult as this was what Nicole wanted. Being part of Shared Lives has enabled this to happen. Godfrey actively encourages Nicole's independence and he has put in specially adapted worktops in the kitchen area to aid her. When Godfrey has some free time, he likes walking and he and his partner Mary go on lots of short walking breaks when they are able to.

Case Study

Susie's Story

Susie is a lady in her early 50's with a learning disability who was living in a residential setting since 1994 before she moved in with her Shared Lives Host Maria, Kevin, their two dogs and a cat.

In the very short space of time since moving in, Susie and Maria have accomplished a great deal...

Susie went on holiday for the first time in years to Devon, enjoying train rides, going on walks, taking in the scenery, going to the beach and visiting the valley of the rocks.

Susie was previously prone to trips and falls, but now walks with Maria and her two dogs daily and is able to walk much further and no longer trips. Susie goes on the local swings when on her walk with the dogs, something she thoroughly enjoys, going really high and scaring Maria!

Susie enjoys cooking with Maria and regularly makes cakes and is able to help prepare meals by cutting up vegetables, giving Susie a sense of achievement.

Susie and Maria went on the Shared Lives day event at Brogdale Farm and Susie particularly enjoyed the tractor trailer ride.

Susie meets up regularly with some of the people she shared her residential home with and they have done numerous activities including crazy golf, bowling, feeding the ducks and various lunches out! As well as going to a local boot fair and also a local fayre where she played 'hook a duck'.

Susie is very proud of her new bedroom which has been decorated in pink and features a large picture of 'Frozen' adorned with fairly lights and Susie says she is very happy in her new home.

For the future……..a pantomime at the Marlow Theatre and a trip to Butlins next April have already been booked so many opportunities are now open to Susie.

Promoting well-being Promoting independence Supporting independence

Supported Living for Adults with Learning Disabilities

Supported living is a way of helping adults with learning disabilities to have the opportunity to live as independently as possible.

The Government and Department of Health are clear that people with learning disabilities should be allowed to live as independently as possible to enjoy a more fulfilling life. We are supportive of this and are working to make sure all adults who are eligible are given the choice to live more independently by moving from Residential Care to Supported Living.

Examples of supported living that may be more suitable are a flat with shared communal areas with other service users, shared housing or shared living with a family (Shared Lives).

Promoting well-being | Promoting independence | Supporting independence

Kent Pathway Service

Enabling people with a learning disability to live more independently

The Kent Pathways Service (KPS) supports young people aged 16-25 with a learning and or physical disability and adults (26+) with a learning disability to become more independent by supporting them to develop their life skills so they can do more for themselves.

From April 2017 to March 2018, 524 successful referrals have been completed increasing individuals' skills and confidence in many areas of daily living.

The support provided (up to twelve weeks) is intensive and task specific enabling people to learn and develop skills at home and in the community such as daily living skills, community safety, learning to travel independently, preparing for work or college and finding daily and social activities.

How Kent Pathways Supports Individuals:

- to ensure continuity and build a successful working relationship, individuals work exclusively with a single Support Worker during their programme
- programmes are bespoke and the frequency and timing of support is flexible to best meet the individuals needs and outcomes
- the rate of progression is individual to each person. Support workers may spend the first couple of weeks simply building a relationship with the individual
- individuals and their Support Workers work in partnership to come up with **SMART** objectives so that they have realistic goals to work towards
- progress towards outcomes is monitored through regular reviews with the individual at three, six and nine weeks where the next stage of support is planned with them.

Case Study

Kieran was referred to Pathways for finding work as he was intending to finish at college and needed placements to fill his time.

Kieran was supported to find volunteer placements at local heritage sites, local conservation projects and others. Kieran chose to volunteer at Sissinghurst Castle Gardens and help with conservation projects run by Kent Wildlife Trust. Kieran was supported to make his applications and attend taster sessions. He was also supported to build his independence.

Kieran is now attending the Kent Wildlife Trust each week independently and enjoys being outside. He is also completing his induction at Sissinghurst Castle Gardens working as a steward and is developing his independence there.

Promoting well-being Promoting independence Supporting independence

The Kent Learning Disability Partnership Board

Valuing People is all about you!

The Kent Learning Disability Partnership Board (KLDPB) has groups across Kent where people with learning disabilities, their carers and families can talk about the things that are important to them in their lives. Everyone is welcome to take part.

The KLDPB was set up following the Government White Paper Valuing People Now (Jan 2009) which wants all people with learning disabilities to have the right to lead their lives like any others, with the same chances and responsibilities.

The Board meets four times a year and members include people with learning disabilities, carers, the voluntary sector and senior people from the main public services who make decisions.

The Board looks at the main issues affecting the lives of people with learning disabilities. It does this through the following Delivery Groups - Good Health, Keeping Safe, What I Do.

The KLDPB encourages individuals, groups and organisations across Kent to get involved in exciting projects that are important to people with learning disabilities. It could be as simple as making friends or influencing Government Policy - the Board has seen both happen in Kent as well as many other activities.

More information on the Kent Learning Disability Partnership Board and the different ways people could be involved can be found on the KLDPB website at www.kentldpb.org.uk

Kent Learning and Disability Partnership Board

Supporting Mental Health and Wellbeing -Live Well Kent

Mental health problems can affect any of us at any time in our lives. For most people with mental health needs, the first place to get help is your doctor, who can often refer you to other professionals.

Some people need more intensive support. Most of these services are provided by Kent and Medway NHS and Social Care Partnership Trust (KMPT). Other services are provided by independent providers, voluntary organisations and others.

Live well Kent Community wellbeing

We have taken a proactive approach to improving the mental health and wellbeing of people of Kent.

Live Well is a website designed to promote better wellbeing and mental health for all of the residents in Kent and Medway and to help people connect with support in their local communities. The vision for Live Well Kent is to keep people well and provide a holistic offer of support for individuals living with both common mental illness and severe and enduring mental health diagnosis.

The approach puts a greater focus on outcomes and engages people in innovative ways to achieve these outcomes, based on recovery and social inclusion.

Key aims of the Live Well Kent Service are to:

- aid recovery and prevent relapse, improve health and social care outcomes for individuals with poor mental health and wellbeing
- reduce the stigma associated with mental illness
- connect people with their communities, ensuring they have access to the widest possible range of community support and services to meet their particular needs.

Live Well Kent is delivered on behalf of Kent County Council and the NHS by two charities:

- **Porchlight** works across Kent to address people's housing, social, economic and health issues. It makes a positive impact on adults, children, families and communities as a whole.
- **Shaw Trust** is a national charity helping people to achieve their ambitions and gain greater independence.

Kent Enablement and Recovery Service (KERS) works with people experiencing mental health difficulties to address social care needs over a short period of time (up to 12 weeks). We provide support to maximise your wellbeing and quality of life, in a way that suits you. We also work with local community services to help you find a creative and realistic response to your needs.

Time to Change pledge

Kent County Council along with a number of our partner organisations has signed the **Time to Change pledge**, a national mental health campaign (supported by the Department of Health and leading charities such as Rethink and Mind) to demonstrate our commitment to changing the way we all think and act about mental health in the workplace.

Mental Health Facts

Nationally

One in four adults will experience a common mental illness during their lifetime and one in six adults in England has a mental health and wellbeing issue problem at any given time. *('No Health without Mental Health', Mental Health Strategy for England, February 2011)*

Mental illness is the largest single cause of disability in the UK and represents 23% of the national disease burden in the UK. *(Chief Medical Officer (CMO) annual report: public mental health, 2013)*

Mental illness and wellbeing costs the UK economy £70–£100 billion per year. Only 25% of people with mental illness are receiving treatment.

Adults with mental health problems are one of the most socially excluded groups in society. People with serious mental illness die on average 15 to 20 years earlier than those without, often from avoidable causes.

Mental ill-health is the leading cause of sickness absence in the UK, costing an average of £1,035 per employee per year.

1 in 4 British workers are affected by conditions like anxiety, depression and stress every year although 95% of employees calling in sick with stress gave a different reason.

Further information can be found on the Live Well website at www.livewellkent.org.uk to make a referral please call 0800 567 7699 or email: info@livewellkent.org.uk

In Kent

89,595 people (5%) in Kent with longer term and more complex mental issues such as severe depression or post-traumatic stress disorder.

250,866 people (14%) in Kent with common mental health problems, such as anxiety and depression.

125,433 people (7%) will have mental health issues associated with their physical health needs in Kent.

Across Kent, there were **3,193** emergency hospital admissions in 2016/17 for serious mental health conditions (Source QOF, 2016/17).

(Source: Kent and Medway Joint Strategic Needs Assessment for Mental Health, April 2009).

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Carers in Kent

Being a Carer can be a positive experience but it can also be challenging and exhausting. Carers often find they don't have time to look after their own health and social needs.

You are a Carer if you look after a family member, partner, friend or neighbour who due to physical or mental illness, disability, age related difficulties or an addiction cannot cope without your support.

'Caring' for someone covers lots of different things, including; helping with their washing, dressing or eating, taking them to regular appointments or keeping them company when they feel lonely or anxious.

Carers Assessments

If you provide care and support to an adult friend or family member, you may be able to get more help to carry on caring and to look after your own wellbeing.

If you give unpaid care to someone who is over the age of 18, you can ask for a carer's assessment.

You can have a carer's assessment even if the person you care for does not get any help from the council, and they will not need to be assessed. You also don't need the permission of the person you are caring for to request a carer's assessment. You are entitled to ask for one in your own right.

However, you can request a combined assessment - where you will be assessed at the same time as the person you care for has their needs assessment.

The Kent Carer's Emergency Card

The Kent Carer's Emergency Card is a credit sized card to carry with you at all times if you have caring responsibilities. The card has a unique registration number on it and a telephone number for our 24-hour service. If you are suddenly taken ill or have an accident, anyone with you can call the number on the card and our staff will use the registration number to carry out a pre-arranged emergency plan.

You can apply for the card if you live in Kent, are over 18 and care for someone else. The card is free of charge.

A break from caring

Being a carer can be physically and emotionally challenging and it's important you have the opportunity to take a break from your caring role.

There are lots of ways you can take what we call a 'short break' from caring. This could be for a few hours, overnight, a weekend or longer. The person you care for will be looked after in a supportive, safe environment and perhaps enjoy new activities while you take some time for yourself.

There are different kinds of short breaks available, depending on the sort of needs the person you're caring for has.

Crossroads Care can provide you with a break from caring if you are providing care or support to a family member or friend who is ill, elderly or has a physical or learning disability.

Volcare provide a respite service between 1 day and two weeks for carers who provide full time care to relatives in their own home. This service is available in Canterbury, Thanet and Dover districts.

Local carer organisations

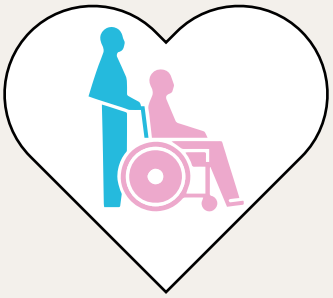
If you give unpaid care to someone who is over the age of 18, you can get in touch with your local carer organisation who can offer you help, advice, training and support in your role as a carer. They can talk to you about your needs as well as the needs of the person you care for, and then let you know how they can help.
Local carer services are run by different organisations for each area of Kent.

- **Carers' Support for carers in Canterbury, Dover and Thanet**
- **Carers' Support for carers in Ashford, Shepway & Swale**
- **Involve Kent for carers in Maidstone and Malling**
- **Carers FIRST for carers in South West Kent, Dartford, Gravesham, Swanley or Medway**
- **Crossroads Care Kent for Carers aged 5-18 years in Maidstone and Malling**
- **Kent Young Carers, a county wide service for Carers aged 5-18 years.**

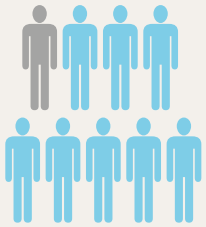
The voice of carers in Kent

Facts about Caring

1 in 9 adults in Kent are carers (Census 2011).



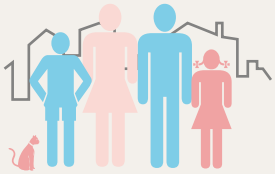
152,000 people (10.4%) of Kent's total population or 1 in 9 adults estimate they provide unpaid care.



The number of Carers in the UK is set to grow from **6 million to 9 million** in the next 30 years and 3 in 5 people will end up caring for someone at some point in their lives.

23,253 is the increase over the past ten years in the number of people providing unpaid care in Kent.

Many Carers don't use the term Carer to describe themselves - "I'm just a wife, husband, parent, friend, neighbour."



3 in 5 Carers have a long-term health condition.

- 46% have been depressed due to their caring role in the last year
- 61% said their physical health had worsened
- 70% said they have suffered mental ill health. as a result of being a carer

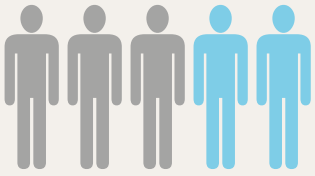
24% of Kent's residents who provide unpaid care estimate that they provide care for 50 hours or more a week.

25% of Carers say they haven't had a day off from caring for more than five years and 40% haven't had a day off from caring for more than a year.

Physical disabilities and dementia comprise the primary health condition of half those being cared for by carers working with Carers Assessment and Support organisations.

15,502 people (11.5%) in Thanet are carers, the highest proportion across Kent, Tunbridge Wells has the smallest proportion with 10,539 people (9.2%). (Census 2011).

3 in 5 people in Kent will become a Carer at some point in their lives (State of Caring 2017, Carers UK).



1 in 9 workers combine working with caring for a family member, partner, friend or neighbour but are invisible in the workforce, often being reluctant to discuss their personal situation or unaware of the support available to them.

State of Caring 2017, Carers UK

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Adult Safeguarding Unit

'It is everyone's right to live in a safe environment, free from harm. Adult safeguarding is about keeping people safe and protecting them from abuse and neglect wherever possible.'

What is safeguarding?

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

Abuse is a breach of a person's rights and may be a single act or happen repeatedly over a period of time.

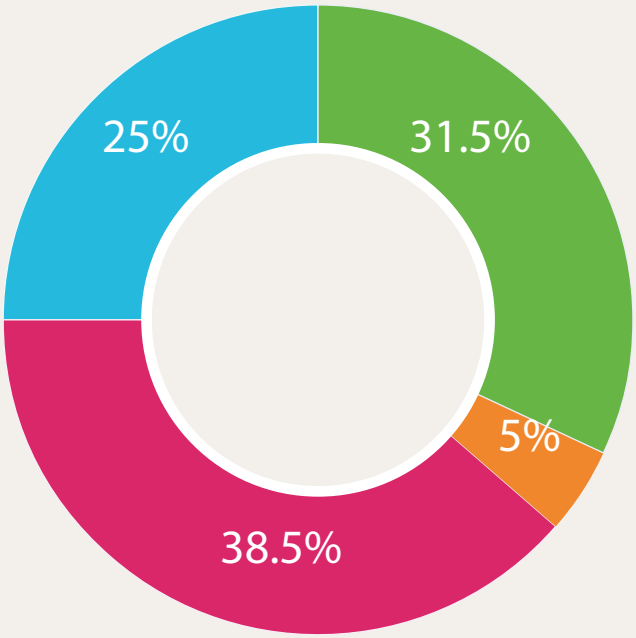
Abuse may be deliberate, or it may happen because of poor care practices or ignorance. People who abuse are not always strangers, they can also be: partners, relatives, a friend, neighbour or carer and it can happen anywhere.

Facts and figures

We have continued to see an increase in the number of Safeguarding Enquiries carried out.

5,884 Safeguarding Enquiries were carried out during 2017/18 compared to 2016/17 when there were 5,715. This is partly due to increased awareness of safeguarding and more robust reporting following the implementation of the Care Act 2014.

6,939 Safeguarding Enquiries were concluded during 2017/18 and of these:



31.5% of the Enquiries carried out had insufficient evidence to confirm or discount them*. This is an increase from 2016-17 where the percentage was 25%.

5% of Enquiry ceased at the individual's request.

38.5% of the Enquiries had abuse confirmed or partially confirmed.

25% of the Enquiries were not evaluated as abuse or discounted.

*This does not mean that no action was taken, but people were supported in other ways.

What should you do if you suspect or have witnessed an adult being abused?

You should contact Adult Social Care on 03000 41 61 61 (social.services@kent.gov.uk) for Kent and 01634 33 44 66 (ss.accessandinfo@medway.gov.uk) for Medway. We advise against approaching the person directly.

If you wish to discuss your concerns outside normal office hours, you can contact the Out of Hours Team on 03000 41 91 91 for Kent and Medway.

If you think that someone may be at immediate risk of harm, you should contact the Police by calling **999**.

Abuse or neglect can take many forms including the *10 abuse categories as described in the Care Act 2014:

- Physical abuse*
- Modern slavery*
- Sexual abuse*
- Psychological abuse*
- Financial or material abuse*
- Self-neglect*
- Neglect and Acts of Omission*
- Organisational abuse*
- Forced honour based violence
- Mate crime
- Hate crime
- Discriminatory abuse*
- Domestic abuse*

The Kent and Medway Safeguarding Adults Board

The Kent and Medway Safeguarding Adults Board (see glossary) is a statutory service following the implementation of the Care Act and exists to ensure that all member agencies are working together to help keep Kent and Medway's adults safe from harm and protect their rights. The Board has an Independent Chair and meets three times a year, supported by additional multi-agency forums.

The implementation of the Care Act places safeguarding adults on a statutory footing. Making Safeguarding Personal is an essential part of all our work. We engage the adult in a conversation about how best to respond to their safeguarding situation in a way that enhances involvement, choice and control as well as improving quality of life, wellbeing and safety.

Extensive work continues to be undertaken by KCC and multi-agency partners, many of them being led by the Kent and Medway Safeguarding Adults Board.

More information and the Kent and Medway Safeguarding Adults Board Annual Report can be found on www.kent.gov.uk and seach 'Kent and Medway Safeguarding Adults Board'.

Advocacy - someone to speak up for you

What is Advocacy?

Advocacy is a process of supporting and enabling people to:

- express their views and concerns
- access information and services
- defend and promote their rights and responsibilities
- explore choices and options.

Sometimes you may feel you are not being listened to by Health and Social Care workers or your own family. You may feel unable to communicate or express yourself in order to get your own view point across.

An advocate is someone who will support you to make sure that your views and rights are respected, that you are treated fairly, your concerns are taken into account and you have real control over the big decisions in your life. They can help you speak up at meetings, deal with difficult issues and help understand important decisions that are being made. They are professionally trained, fair and impartial, and the service is completely confidential and independent of the local authority.

Some advocacy services you can get for yourself, without any help from us, by contacting our local advocacy providers direct. Other advocacy, usually the advocacy we have to provide by law will only be given to you if we agree that you are eligible for it.

If you're unsure about your right to have an advocate, you can speak to one of our local advocacy providers or your case worker, if you have one.

Kent Advocacy

The Kent Advocacy Contract is a countywide independent advocacy service which provides all of the Council's statutory and non-statutory advocacy for vulnerable people aged 16 years and over.

The Council used a co-production approach to commission the Kent Advocacy Contract. A range of people, including those who use advocacy services, carers and service providers were involved to help define what advocacy means to people and how it should be delivered.

The contract was awarded to seAp (Support, Empower, Advocate and Promote) who work collaboratively with seven organisations (independent of the NHS and KCC) that all specialise in providing different services across the county. Together, they offer their advocacy services under the same name.

There is now one website and contact number for all advocacy services for adults within Kent and one referral form which makes referring to advocacy very simple.

The co-production approach used to commission the Kent Advocacy Contract was highlighted on the Think Local Act Personal (TLAP) website as a practical example of how co-production can lead to better commissioning and improved outcomes. The Council was also nominated for a National Advocacy Award for co-production.

More information can be found at:
www.kentadvocacy.org.uk

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Home care services

Home care services are provided by care workers to people in their own home, so they can be supported to live independently and can manage activities of daily living.

Home care services are delivered by private companies on our behalf and are arranged through the Kent County Council Home Care contract.

We reviewed and re-let these contracts in 2017, keen to ensure the services provided were of a good quality, were value for money and supported people to live as independently as possible in their own home.

Strategic Commissioning manage the home care contracts, in close liaison with Adult Social Care and specifically Area Support Managers. We use intelligence gathered from teams, the home care specification and key performance indicators to manage home care agencies to deliver improving home care services.

Care Navigators

Care Navigators help people over 50 stay independent in their own homes. They are based with local voluntary organisations around Kent

Care Navigators can help with:

- managing your money and benefits
- finding the right sort of home
- staying safe in your own home
- maintaining and adapting your home to your needs
- planning the support you need
- filling in forms
- going through an assessment process.

Comments, compliments and complaints

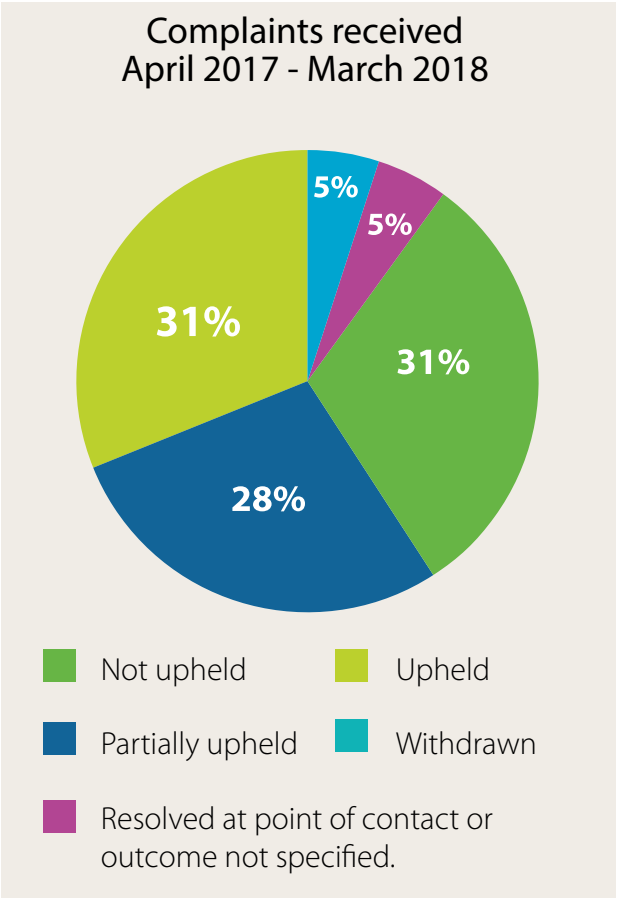
We welcome feedback on the services that we provide and on the services we arrange for people but might be provided by another care provider. Hearing people's views on the services helps us to identify where improvements are required as well as where things are going well.

We aim to provide a complaints service that is accessible and fair and we try to ensure the response to the complaint is proportionate to the issues being raised. A key part of the complaint process is to find a resolution to the issue giving rise to the complaint and provide an explanation if the service has not been to the standard we would expect.

Each year we analyse the complaints and enquires that we have received to identify any lessons we need to learn and need to communicate to staff.

In 2017-18 we received:

- 637 Complaints
- 276 Enquiries
- 507 Compliments.



The key themes and issues arising from complaints are anonymised and discussed at management meetings and at the Quality and Practice meetings for practitioners.

Topics covered in 2017/18

The need to ensure any change of circumstances for the service user is logged in a timely way. Delays in the information being recorded on the system can cause delays in the person being charged the correct amount for the care they receive or a delay in a financial assessment being completed. At the Quality and Good Practice meetings, practitioners were reminded of the need for any changes to the case records to be made promptly.

Some of the complaints received related to a lack of communication relating to safeguarding where families did not feel they were being

kept sufficiently informed. The national "Making Safeguarding Personal" initiative has helped to address this, along with the provision of relevant information leaflets. In addition, a major initiative to reduce the timescales for safeguarding enquires has enabled people to be informed of outcomes more promptly.

Following a reorganisation of a service, it was apparent that some of the practitioners were new to Adult Social Care and did not have a comprehensive understanding of the Adult Social Care financial assessment and charging arrangements. To address this, workshops were provided for the staff group

A complaint about one of the in house residential care units highlighted the need for staff to "escalate" issues to a senior manager if they have encountered difficulties in engaging a practitioner from a partner organisation. A workshop was held with relevant staff to ensure lessons were learned from the complaint.

It was apparent from feedback that some staff were finding it difficult to convey difficult messages to service users or their representatives particularly about contentious issues. This was covered in presentations and workshops with staff.

Feedback from service users and carers helps us to improve our services and people are entitled to complain if they are not happy with the service they have received. A person can complain on their own behalf or with the help of someone else such as a relative, carer, friend or advocate. We may need to seek consent from an individual if someone is making a complaint on their behalf. A member of our complaints team can assist if help is needed in making a complaint or if an advocate is needed.

The Kent Adult Social Care "Have Your Say" leaflet provides more information about the Adult Social Care complaints procedure and further information can be found on the Kent County Council website.

Compliments

We also welcome compliments when people make contact to commend the service or the work of an individual. Set out below are a few examples of the compliments we have received over the past year.

"S is very grateful for all the support she has recevied. Each and every support worker arrived with a smile"

"Thank you for helping to give me more independence."

"Thank you for the equipment, it's brilliant. Great service, very professional."

"The case manager is compassionate, understanding and truly cares."

"The warmth and care shown to me after a spell in hospital has been excellent and supportive in every way."

Glossary

Assistive Technology: These technologies help you to maintain independence. Telehealth provides equipment and devices used to remotely monitor aspects of a person's health in their own home. Telecare can be a combination of remotely monitored passive alarms and sensors to maintain independence at home.

ASC (Kent Autistic Spectrum Conditions Team): This integrated specialist team aims to address the unmet needs of adults with autism, including those with Asperger's Syndrome, who do not meet the eligibility of Learning Disability services. The service is jointly commissioned by Kent County Council (KCC) and Kent and Medway NHS and Social Care Partnership Trust.

Audits: Regular audits will be undertaken by the police, Adult Social Care and Health, to determine where improvements can be made and ensure that policies and procedures are being followed.

Autism Collaborative: The collaborative is a collection of stakeholders including clients and carer representation, the local authority, Health and all the main voluntary and charitable organisations. The aim of the group is to examine services and ensure that they are meeting the needs of adults with autism. If not how the group might plan to meet any gaps in services. The Collaborative will draw together various pieces of work from all sectors in order to fully complete the Kent Autism Strategy.

Better Care Fund (BCF): The BCF, worth £3.8 billion, was announced by the Government in the June 2013 spending review. It is designed to support the transformation and integration of Health and Social Care Services, to ensure local people receive better care.

BME: Black minority ethnic residents in Kent.

Care Quality Commission (CQC): The CQC is responsible for the inspection and registration of services including care homes, independent Health Care establishments and the Shared Lives Scheme.

Clinical Commissioning Groups (CCG): This is the name for the new health commissioning organisation which replaced Primary Care Trusts in April 2013. CCGs make it easier for us to work directly with our partner organisations and make the best use of resources.

Countywide Safeguarding Group: This is a meeting for senior managers within Kent County Council chaired by the Director of Commissioning for Social Care, Health and Wellbeing. The group reviews safeguarding activity across the county to ensure that robust systems are in place to provide appropriate support to individuals who raise allegations or concerns about adult abuse.

Dementia Care Mapping (DCM): A set of observational tools designed to evaluate quality of care from the perspective of the person living with dementia.

Department of Health (DH): They lead, shape and fund health and care in England, making sure people have the support, care and treatment they need, delivered with the compassion, respect and dignity they deserve.

Deprivation of Liberty Safeguards: Aim to prevent the unlawful detention of adults in hospitals and care settings who lack capacity to choose where they live and/or to consent to care and treatment.

Direct Payment: Cash payments to individuals who have been assessed as having eligible social care needs. The amount paid is less any contribution that is required by the individual following a financial assessment.

Domiciliary Care: These services can help people with personal care and with some practical household tasks to help them to stay at home and live independently.

Enablement: This is a short term, intensive service that can help you remain in your own home or regain independence if you have been ill or in hospital.

Good Day Programme: This programme enables people with learning disabilities in Kent to choose what they want to do during the day, evenings and weekends, have support when and where they need it, and be an equal citizen of their local community.

Hi Kent: A registered charity for deaf and hard of hearing people, who work in partnership with Kent County Council. Hi Kent carry out assessments of need for people aged over 65 years old, provide advice and a range of equipment.

KAB: A rehabilitation service for people who are blind or partially sighted in Kent. KAB aim to provide a quality service sensitive to the individual's needs to help them attain the highest levels of independence.

Kent Card: A secure way of receiving Direct Payments without the need to open a separate bank account. The card is a chip and pin visa card and works in the same way as a visa debit card. It can be used to pay a Personal Assistant (PA), makes record keeping easier and reduces paperwork.

Kent Health and Wellbeing Board (HWB): The Board lead and advise on work to improve the health and wellbeing of people in Kent. It does this through joined up engagement across the NHS, Social Care, Public Health and other services that the Board agrees are directly related. The Board aims to reduce health inequalities and ensure better quality of care for all patients and care users.

Kent Integration Pioneers: Aim to drive forward innovative ways of creating change in the Health Service which the Government and national partners want to see spread across the country. Kent is an integration pioneer.

Kent Wide Carers' Publication: An information booklet for carers about the range of support services available in the local area.

Mutli-Disciplinary Teams (MDTs): Joint teams between Social Care and Health that aim to minimise duplicate referrals.

National Transforming Care Programme: A programme of work led jointly by NHS England, the Association of Adult Social Services (ADASS), the Care Quality Commission (CQC), Local Government Association (LGA), Health Education England (HEE) and the Department of Health (DH) to improve services for people with learning disabilities and/or autism, who display behaviour that challenges, including those with a mental health condition.

Occupational Therapy: This service provides assessment, advice, equipment and adaptations for disabled people living in their own homes.

Personal Budget: Money paid by Kent Adult Social Care to you so that you can arrange your own care and support services.

Promoting Independence Reviews: These assess your abilities and difficulties with managing every day activities. We will work with you to identify what you are able to do and what you hope to be able to achieve, in order to continue to live independently. The Promoting Independence Service helps you to maximise how much you can do for yourself, and regain or learn new skills before any decisions are made about your ongoing support needs.

The Royal Association for Deaf (RAD): A British charitable organisation who promote the welfare and interests of Deaf people. RAD

provide employment and legal advice, host activities and support groups for families with parents and/or children who are deaf or hard of hearing and also offer an interpreting service.

Safeguarding: Safeguarding is about protecting children, young people and adults from abuse or neglect. The policy aims to tackle how adult abuse can be prevented through community cohesion, communication, good practice and to ensure that everyone is treated with dignity and respect.

Safeguarding Adults Board: The Board consists of representation by senior management from the Local Authority in Kent and Medway, CCGs, Police, Health, Kent Fire and Rescue, Prison Service, District Councils, Carers and Voluntary and Private sector representatives. A range of these partners may be involved in an investigation/Social Care enquiry regarding suspected abuse or neglect.

Self-Neglect: This is described as "the inability (intentionally or non-intentionally) to maintain a socially and culturally acceptable standard of self-care with the potential for serious consequences to the health and wellbeing of those who Self-Neglect and perhaps to their community".

Shared Lives: This scheme helps vulnerable adults who want to live as part of a family or household find somewhere suitable. It is similar to fostering, but for adults rather than children. Placements can either be on a short or long term basis or act as a stepping stone towards independent living.
www.kent.gov.uk/sharedlives

Telecare: Any service that brings Health and Social Care directly to a user (generally in their homes). It enables people, especially older and more vulnerable individuals, to live independently and securely in their own home by providing them with personal and environmental sensors in the home. These remotely monitor over a 24 hour period and should something happen like you have a fall, a warning is sent to a response centre and the required help is sent to assist you.

Telehealth: is part of Telecare, but relates specifically to remote monitoring of a person's vital signs, including blood pressure, weight and blood glucose.

Transformation: Over the next four years KCC will be looking at how their existing services currently operate, the difference they make, and if there's a better way to do things. We will also bring services together to avoid duplication and improve efficiency, shaping them around people and place. This is known as Transformation.

Data Sources

- ONS mid-year estimates 2012
- PCIS population June 2014
- Health and Social Care Information Centre (HSCIC) website
- Office of National Statistics (ONS) website
- Direct Payment services report
- Residential Monitoring and Non Residential Monitoring services report
- KCC Annual return reports

Getting in Touch

There are several ways for you to contact us.

Telephone our contact centre
For non-urgent telephone calls, please contact us Monday to Friday between 8.30am and 5.00pm.
The contact centre is based in Maidstone and is open for business 24 hours a day, 7 days a week.
Telephone: 03000 41 61 61

Text relay
A text relay service is available for Deaf, hard of hearing and speech impaired customers and is available 24 hours a day, 7 days a week.
Text Relay: 18001 03000 41 61 61

Out of hours service
Not every crisis occurs during office hours. Kent and Medway Social Services provide for these times with our out of hours service that can offer advice, support and help to ensure that vulnerable people are not left at risk.
Telephone 03000 41 91 91

Calls from landlines are typically charged between 2p and 10p per minute; calls from mobile typically cost between 10p and 40p per minute.

Email and website
You can email us with queries or questions about any of our services or information.
Email: social.services@kent.gov.uk or see our website at:
www.kent.gov.uk/careandsupport

For more information on the Local Account
email: kentlocalaccount@kent.gov.uk
www.kent.gov.uk and search 'local account'

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

From:	Graham Gibbens, Cabinet Member for Adult Social Care and Public Health Penny Southern, Corporate Director of Adult Social Care and Health
To:	Adult Social Care Cabinet Committee – 27 September 2018
Decision No:	18/00050
Subject:	**SHARED SUPPORTED LIVING AND 24-HOUR CARE AND SUPPORT ELEMENT OF THE SUPPORTING INDEPENDENCE SERVICE**
Classification:	Unrestricted
Past Pathway of Paper:	Strategic Commissioning Board- 23 July 2018 Adult Social Care and Health Directorate Management Team – 19 September 2018
Future Pathway of Paper:	Cabinet Member decision
Electoral Division:	All

Summary: Shared supported Living (or Supported Accommodation) describes the arrangement whereby someone who already has, or who wants their own tenancy or own home, within a property where there is the possibility of support being shared by the tenants. The tenant will be supported by a "care and support" provider to help them live as independently and safely as possible. They will receive support and help with any aspects that are required to live an ordinary life as possible, such as managing money, cooking, getting a job etc. 24 Hour Care and Support describes those clients who require round the clock care and support. This report sets up the rationale behind requesting an extension of the Shared Supported Living Services and 24-Hour Care and Support under the Supporting Independence Services Contract for 11 months in order to enable the Council to fully analyse the service and develop solutions. This will further enable flexible ways of working and ensure a fair and equitable base for providers to demonstrate deliver of a quality service.

Recommendation(s): The Adult Social Care Cabinet Committee is asked to **CONSIDER** and **ENDORSE** or make a **RECOMMENDATION** to the Cabinet Member for Adult Social Care and Public Health on the on the proposed decision (attached as Appendix A) to:

a) **APPROVE** the extension of the Shared Supported Living Services and 24-Hour Care and Support under the Supporting Independence Services Contract for 11 months, allowing for a phased inclusion in the Care and Support in the Home Contract; and

b) **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.

1. Introduction

1.1 Supported Living (or Supported Accommodation) describes the arrangement whereby someone who already has, or who wants their own tenancy or own home, within a property where there is the possibility of support being shared by the tenants. The tenant will be supported by a "care and support" provider to help them live as independently and safely as possible. They will receive support and help with any aspects that are required to live an ordinary life as possible, such as managing money, cooking, getting a job etc. 24 Hour Care and Support describes those clients who require round the clock care and support.

1.2 This report sets up the rationale behind requesting an extension of these Services under the Supporting Independence Services Contract for 11 months in order to enable the Council to fully analyse the service and develop solutions. This will further enable flexible ways of working and ensure a fair and equitable base for providers to demonstrate delivery of a quality service

2. Strategic Statement and Policy Framework

2.1 The Supported Living Service links with the following strategic outcomes:

Outcome 1 - Children and young people in Kent get the best start in life
Outcome 2 - Kent communities feel the benefits of economic growth by being in work, healthy and enjoying a good quality of life
Outcome 3 - Older and vulnerable residents are safe and supported with choices to live independently

3. Care and Support in the Home

3.1 The Care and Support in the Home Service will commence from April 2019 with additional elements potentially implementing shortly thereafter. The existing services in scope, Homecare and the community-based element of the Supporting Independence Service (SIS), deliver very similar tasks in people's homes and there is an opportunity to achieve improved consistency and cost efficiency across the market by bringing these services together.

3.2 Aligning services under one contractual arrangement will enable the Council to take a consistent and equitable approach in shaping the market to focus on the personalisation and outcomes agendas, supporting the Council's strategic outcome that 'Older and vulnerable residents are safe and supported with choices to live independently'.

3.3 Both the community-based SIS and its Supporting Living element were in scope for the Analyse Phase of Care and Support in the Home Services, finalised in June 2018.

3.4 SIS is a countywide, outcome focused service, based on independence and social inclusion principles for people with health and social care needs in Kent,

including young people and adults. The focus of the service relates to the person as an individual, enabling them to make their own informed choices wherever possible and live as independently as they are able.

3.5 The service is a chargeable, potentially offering 24-hour, seven day a week and provides day, sleep night or wake night support as required to meet the assessed need. The service puts individuals at the centre of their care and support process by identifying their needs, preferences, goals and aspirations. Individuals may then make choices about how and when they are supported to live their lives. This approach can give people with eligible needs more freedom, choice and control over the type of care and support that they receive.

3.6 The service is purchased for a single person on a one to one basis, or for two or more people on a shared service basis in Supported Living Accommodation. In either case the service will be delivered in the home of the individual or within the community, as required with the package of support based on the assessed needs of each person.

4. Supported Living

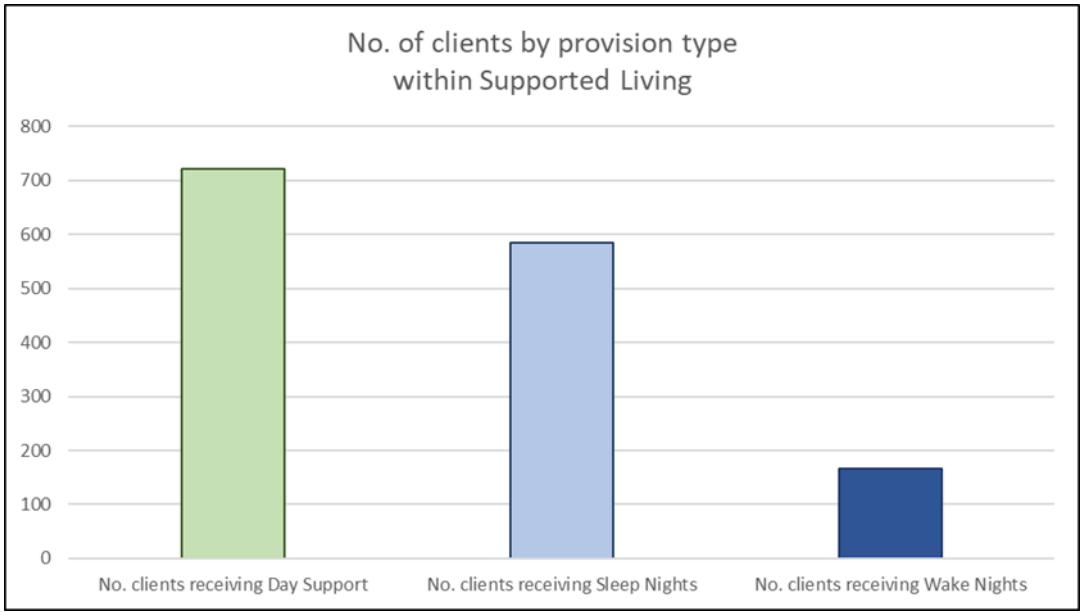
4.1 Supported Living (or Support Accommodation) describes the arrangement whereby someone who already has, or who wants their own tenancy or own home, within a property where there is the possible of support being shared by the tenants. The tenant will be supported by a “care and support” provider to help them live as independently and safely as possible. They will receive support and help with any aspects that are required to live an ordinary life as possible, such as managing money, cooking, getting a job etc.

4.2 Unlike community-based SIS and Homecare, care and support delivered in a Supported Living or Support Accommodation environment is further complicated by the implementation of Shared Support, based on assessed need and the ratio of tenants that are able to share staff support. Shared Support is based on the number of tenants that benefit from either defined shared activities in line with their Care and Support Plan or Shared Support to mitigate risk should tenants be assessed as not being safe to be left alone in a property without staff presence.

4.3 Due to the nature of Supported Living being a property-based service, unlike community-based services, staff often have a place of work to carry out their shift, with a reduced travel requirement over staff delivering community-based rounds of care and support within individual’s homes.

4.4 Supported Living accounts for approximately £38,000,000 of annual spend across 68 providers.

4.5 The table and graph below illustrate the number of clients within Supported Living receiving day support, sleep night or wake night support. Some clients have two to one support 24 hours per day and can be in receipt of both a sleep and wake night, so some clients are double counted within the data below:



4.6 The Council defines 'Day Hours' as care and support delivered between the hours of 07:00 and 22:00, a potential 15 hours per day. For those clients requiring care and support for every waking hour each day, equating to 105 'Day Hours', the resulting staff rota and associated shift patterns are very similar to those in place within Shared Supported Living services.

4.8 If the Council takes the decision to maintain the cohort of community-based SIS packages with 105 hours or more per week to existing SIS rates, directly linked to the approach taken with Shared Supported Living during the extension period to April 2020, a cost avoidance will be realised. This is considered proportionate as these Services do not incur the same level of overheads as the Community Support packaged which fall within the scope of Care and Support in the Home Services.

4.9 Although a further annual cost avoidance of may be realised if packages of 70 hours or more are maintained at the current contracted SIS rates, this is not deemed appropriate due to the way in which hours may be flexibly utilised. As such, the recommendation is to solely incorporate the 24/7 Community Support packages within the scope of this Shared Supported Living extension.

5. Next Steps

5.1 The Adult Social Care Cabinet Committee is asked to endorse the proposed decision to approve the extension of the Shared Supported Living Services under the Supporting Independence Services Contract for 11 months.

5.2 Whilst the contract expires on 31 May 2019, the extension would continue provision until 5 April 2020.

5.3 The proposed extension to these Services will enable the Council to consider Supported Living Services separately to community-based support. This is

appropriate as the Services are sufficiently different that there are contrasting market factors and price drivers which must be taken into account when recommissioning.

5.4 Furthermore, there is scope in the contract to deliver care and support in a more flexible way in the future, possibly involving a move to 'envelopes of care' that enable providers to flexibly deliver hours according to the needs of a person on a daily basis. The implementation of new systems throughout the contract term will be critical.

5.5 A phased approach will enable the Council to fully analyse and develop solutions to achieve key milestones throughout the life of the contract.

5.6 There is also scope to utilise the forthcoming Positive Behavioural Support (PBS) Framework Agreement to consider how best to meet the needs of the most complex clients.

5.7 Following approval, the Council's Strategic Commissioning Division will issue letters to all Supported Living Providers that outline the extension, its purpose and request a signed response of confirmation.

6. Financial Implications

6.1 The current spend in relation to Supported Living Services is circa £38m. This service will be subject to an annual fee awards process, at the commencement of the 19/20 financial year.

7. Legal Implications

7.1 The main legislative framework for the Supported Living Service is the Care Act 2014, and the principles of Mental Capacity Act 2005. These are statutory duties, and the Supported Living Service will be compliant with both pieces of legislation.

8 Equality Implications

8.1 The intention is for the Supported Living Service to be included in the Care and Support in the Home Contract after the extension period. An existing Equality Impact Assessment (EqIA) (Attached as Appendix 1) is in place and this will be updated as the work to include new elements within the contract is undertaken.

9. Conclusions

9.1 Supported Living (or Supported Accommodation) describes the arrangement whereby someone who already has, or who wants their own tenancy or own home, within a property where there is the possibility of support being shared by the tenants. The tenant will be supported by a "care and support" provider to help them live as independently and safely as possible. They will receive support and help with any aspects that are required to live an ordinary life as possible, such as managing money, cooking, getting a job etc.

9.2 This report sets up the rationale behind requesting an extension of the Shared Supported Living Services under the Supporting Independence Services Contract for 11 months in order to enable the Council to fully analyse the service and develop solutions This will further enable flexible ways of working and ensure a fair and equitable base for providers to demonstrate deliver of a quality service.

9.3 The proposed extension to these Services will enable the Council to consider Supported Living Services separately to community-based support. This is appropriate as the Services are sufficiently different that there are contrasting market factors and price drivers which must be taken into account when recommissioning.

10. Recommendation(s)

10.1 Recommendation: The Adult Social Care Cabinet Committee is asked to **CONSIDER** and **ENDORSE** or make a **RECOMMENDATION** to the Cabinet Member for Adult Social Care and Public Health on the on the proposed decision (attached as Appendix A) to:
a) **APPROVE** the extension of the Shared Supported Living Services under the Supporting Independence Services Contract for 11 months, allowing for a phased inclusion in the Care and Support in the Home Contract; and
b) **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.

11. Background Documents

None

12. Contact details

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KENT COUNTY COUNCIL – PROPOSED RECORD OF DECISION

DECISION TO BE TAKEN BY:	DECISION NO:
Cabinet Member for Adult Social Care and Public Health	18/00050

For publication

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

Subject: SHARED SUPPORTED LIVING ELEMENT OF THE SUPPORTING INDEPENDENCE SERVICE

Decision: As Cabinet Member for Adult Social Care and Public Health, I propose to:
a) **APPROVE** the extension of the Shared Supported Living Services under the Supporting Independence Services Contract for 11 months, allowing for a phased inclusion in the Care and Support in the Home Service Contract.
b) **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.

Reason(s) for decision: Supported Living (or Supported Accommodation) describes the arrangement whereby someone who already has, or who wants their own tenancy or own home, within a property where there is the possibility of support being shared by the tenants. The tenant will be supported by a "Care and Support" Provider to help them live as independently and safely as possible. They will receive support and help with any aspects that are required to live an ordinary life as possible, such as managing money, cooking, getting a job etc.

To approve the extension of the Shared Supported Living Services under the Supporting Independence Services Contract for 11 months will allow for a phased inclusion in the Care and Support in the Home Contract. A phased approach will enable the Council to fully analyse and develop solutions to achieve key milestones throughout the life of the new Care and Support in the Home Contract. This will further enable flexible ways of working and ensure a fair and equitable base for Providers to demonstrate deliver of a quality Service.

Financial Implications: The current spend in relation to Supported Living services is circa £38m. This Service will be subject to an annual fee awards process, at the commencement of the 19/20 financial year. This pressure will be met from the Council's Pay and Prices budget allocation, to be agreed through budget setting.

Legal Implications: The main legislative framework for the Supported Living Service is the Care Act 2014, and the principles of Mental Capacity Act 2005. These are statutory duties, and the Supported Living Service will be compliant with both pieces of legislation.

Equality Implications: The intention is for the Supported Living Service to be included in the Care and Support in the Home Contract after the extension period. An existing EqIA is in place and the Care and Support in the Home EqIA will be updated as the work to include new elements within the Contract is undertaken.

Cabinet Committee recommendations and other consultation: The proposed decision will be discussed at the Adult Social Care Cabinet Committee on 27 September 2018 and the outcome included in the paperwork which the Cabinet Member will be asked to sign.

Any alternatives considered:

Do nothing - allow the current commissioned services to terminate when Contracts come to an end in June 2019. The main risks of this approach are;

- The Authority will fail in its duty under the Care Act 2014 in carrying out a care and support function;
- Older and vulnerable residents with assessed needs will be left unsupported, leading to potential safeguarding concerns;
- Judicial review of the lawfulness of the Authority's decision
- Reputational damage to the Local Authority

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/ Service:
Strategic and Corporate Services

Name of decision, policy, procedure, project or service:
Commissioning Care and Support in the Home Service – Commencing April 2019

Responsible Owner/ Senior Officer:
Jack Moss

Version:

V1.0	04/10/17	Glyn Pallister	Initial draft
V1.1	24/10/17	Glyn Pallister	Updates with supporting statistical data
V1.2	25/10/17	Kerry Turner/Glyn Pallister	Second draft
V1.3	13/11/17	James Lampert/Glyn Pallister	Updates and corrections
V1.4	5/12/17	Glyn Pallister	Updates following E&D Team review
V1.5	12.1.18	Glyn Pallister/Luke Edwards	Updates following meeting with Akua Agyepong 22.12.17
V2.0	1.5.18	James Lampert	Reviewed against revised scope
V2.1	10.5.18	James Lampert	Updated following review by Corporate Lead, Equalities and Diversity
V2.1	16.5.18	James Lampert	Updated following workshop with adult and children's commissioners
V2.2	22.05.18	Jo Harding	DC&YP references & data added
V2.4	07.06.18	Jack Moss	Updated with comments from Akua Agyepong
V2.5	18.07.18	Sholeh Soleimanifar	Updates and corrections following changes in scope of contract (Supported Living and Children's services are outside of scope of contract)

Author:
Glyn Pallister, James Lampert, Jo Harding, Sholeh Soleimanifar – Commissioning Unit

Pathway of Equality Analysis:
- Commissioning Care Models (CCM) Steering Group (to November 2017)
- Care in the Home Working Group (from May 2018)
- ASCH DivMT (OPPD and DCLDMH)
- ASCH DMT
- Strategic Commissioning Board (SCB)

Summary and recommendations of equality analysis/impact assessment.

- **Context**

  Kent County Council commissions a range of services that are designed to provide care and support for people in order that they can safely reside in their own homes or in supported living accommodation. They will be assessed as eligible and having unmet need(s) in accordance with the Care Act 2014. These services include (list is not exhaustive):

  - Home Care
  - Extra Care Support
  - Supporting Independence Services (SIS and SIS+) – People with a learning disability and with mental health needs
  - Discharge to Assess

  Each service is currently let to a number of agencies (or 'providers') through a contract arrangement. Contracts are arranged in a number of ways depending on the type of service provided. All care and support contracts have been aligned to expire at around the same time in May 2019 (HRS ends September 2018).

  In total, KCC spends approximately £100m on care and support services every year.

  These services are utilised by around 7000 Kent residents at any given time:

Home Care	4600
SIS	2000
HRS (LD/Vulnerable Adults)	250
Discharge to Assess	3380

  (See supporting data analysis in appendices for a full demographic break-down of service users according to their protected characteristics).

- **Aims and Objectives**

  As part of the Adult's Social Services "Your Life, Your Wellbeing" modernisation programme and working across all social services disciplines we are developing a model that will drive the future commissioning of care and support services for all client groups and all ages.

  KCC's modernisation programme aims to satisfy the Council's Strategic Outcomes, and this project impacts on Outcomes 1, 2 and 3:

  Outcome 2 - Communities to feel the benefits of economic growth by being in work, healthy and enjoying a good quality of life
  Outcome 3 - Older and vulnerable residents to be safe and supported with choices to live independently

- **Summary of equality impact**

Adverse Equality Impact Rating Medium

We have rated this EqIA as medium because we are currently unable to secure information about some protected characteristics and there are some groups who are under-represented compared to the county population profile which KCC needs to be aware of. A number of actions have been identified in the 'Action Plan' at the end of this document, which will be monitored and updated throughout the life of the contract, accordingly.

Attestation
I have read and paid due regard to the Equality Analysis/Impact Assessment concerning **Commissioning Care in the Home Services for April 2019**. I agree with risk rating and the actions to mitigate any adverse impact(s) that has /have been identified.

Head of Service
Signed: Penny  Name: Southern

Job Title: Corporate Director Adult Social Care & Health
Date: 19.09.2018

DMT Member

Signed: Name: Anne Tidmarsh

Job Title: Director Older People and Physical Disability
Date: 19.09.2018

Part 1 Screening

Could this policy, procedure, project or service, or any proposed changes to it, affect any Protected Group (listed below) less favourably (negatively) than others in Kent?

Could this policy, procedure, project or service promote equal opportunities for this group?

Protected Group	Please provide a <u>brief</u> commentary on your findings. Fuller analysis should be undertaken in Part 2.			
	High negative impact EqIA	**Medium negative impact** Screen	**Low negative impact** Evidence	**High/Medium/Low Positive Impact** Evidence
Age	No	No	No	Yes – we anticipate that this model will better match service user need with the 'best-fit' service provider. This will offer a more personalised approach to all service users. Better matching means a stronger likelihood that service users' needs are met, and personal goals are achieved.
Disability	No	No	No	
Gender	No	No	No	Yes - More person centred, outcome-based services should have a positive impact on the basis of gender.
Gender identity/ Transgender	No	No We assume there is no impact to this group.	No	Yes - More person centred, outcome-based services should have a

		However, we have no statistical or anecdotal evidence to support this assumption. We will continue to search for reliable data and seek advice from specialists.		positive impact on the basis of gender identity/ transgender identity.
Race	No	Yes – there is an underrepresentation of BME so further work needs to be done to understand why this is and if changes need to be made, through engagement with local communities. Also improve understanding and monitoring activity amongst frontline staff and service providers.	No	Yes - More person centred, outcome-based services should have a positive impact on the basis of race
Religion and Belief	No	No - We assume there is no impact to this group. However, we have no statistical or anecdotal evidence to support this assumption. We will	No	Yes - More person centred, outcome-based services should have a positive impact on the basis of religion and belief

		ask our current providers to help us collect this information and update this document accordingly.		
Sexual Orientation	No	No We assume there is no impact to this group. However, we have no statistical or anecdotal evidence to support this assumption. We will monitor and react to any issues as they are identified. Also improve understanding and monitoring activity amongst frontline staff and service providers.	No	Yes - More person centred, outcome-based services should have a positive impact for older and disabled LGBT people. Service providers should ensure that services are outcomes based, considering people with physical and learning disabilities in the support delivered re: sexuality
Pregnancy and Maternity	No	No	No	People becoming parents could benefit via more outcomes focussed support services
Marriage and Civil Partnerships	N/A	N/A	N/A	Yes - More person centred, outcome-based services should have a positive impact on the basis of Marriage and Civil Partnerships

Carer's Responsibilities	No	No	No	Yes – by promoting independence of the individual, this should also have a positive impact for carers too

Part 2

Equality Analysis /Impact Assessment

Protected groups
Any Kent resident assessed as eligible under the Care Act.
Age (see below)
Disability (see below)
Race (see below)
Transgender people (unknown impact, see below)
Any unpaid carer.

Information and Data used to carry out your assessment

- Adults Social Services SIS and Home Care data (Adults Social Services Performance Team)
- Kent Public Health Observatory
- Kent.gov.uk – facts and figures about Kent (Equality and Diversity)
- 2011 Census

Who have you involved consulted and engaged?

A public consultation with members of public and/or people who currently use the service is not planned for this tender. If any changes to services, necessitating consultation, are planned to occur during the life of the contract then public engagement and consultation will take place then.

- Personalised Care and Support Steering Group and Care in the Home Working Group
- Practitioners and Managers from DCLDMH
- Practitioners and Managers from OPPD
- Practitioners and Managers from Sensory and Autism Services
- Operational Support Unit (Adult Purchasing Team)
- Commissioners
- Newton Europe
- KCC Adults Transformation Managers and Leads
- Strategic Home Care Providers Forum
- DivMTs (OPPD and DCLDMH)
- Kent Parent Carer Forum

Analysis

We want to move to a position, over time, where care and support services can be better matched to meet service users' need(s) and personal outcomes. Providers will be expected to work with service users to ensure that outcomes are achieved in line with their assessed needs and actively consider their protected characteristics. These are included in the performance indicators in the contract and will be done in accordance with standard procedures for reviewing care plans.

Over the life of the contract, we are proposing to commission home care and Supporting Independence Services that encourage providers to move toward delivering outcomes, rather than the more traditional 'time and task' care delivered now. This approach will better meet the needs of those identified within the 'protected characteristics' groups, as each persons' outcomes will be identified with their involvement. This change will take some time to achieve and KCC will work alongside providers on this journey. Our social care teams and purchasing functions will be able to match the most appropriate service(s) from a pool of contracted providers for this service to support service users to meet their needs and reach their personal goals (outcomes). Expectations will need to be managed to ensure the wishes of individuals (and their careers, if any) are achievable within the scope and capacity of the contracted service model.

An outcome-based approach puts the service user and their families at the heart of all discussions and involves them fully in identifying needs and aspirations. They will be able to make choices about what, who, how and when they are supported to live as independently as possible. It may require significant changes for KCC systems*, processes, staff and services to ensure we are equipped to put services users first in this way.

*we are communicating with the Technology Enable Change Project Team (Servelec Mosaic – the replacement client system due to be implemented January 2019) who will identify any staff implicated by system changes and any impact this has on them.

Ultimately, we aim to:

- Improve care and support for our services users by selecting the most appropriate service provider(s) that could meet their needs. This will be monitored via the standard review process. This will be analysed by protected groups.
- Reduce volumes of care and support services required by supporting service users to achieve their goals so that they realise their full independence and wellbeing potentials. This will be analysed by protected groups.
- Reduce the number of service users who are admitted to acute hospital care and delay the numbers who transfer to residential services. This will be analysed by protected groups.
- Speed up hospital discharges and reduce any waiting lists by making the arrangement of care and support services quicker and better focused.
- Simplify the purchasing of care and support so that KCC teams spend less time purchasing care, but are confident that they have arranged the best support and care that they can for their service user
- Give service providers more responsibility for managing the process of delivering care and support and helping service users achieve their goals. This will be done via the principles of person

centred planning. In circumstances where someone lacks the capability to participate independently, an independent advocacy service could be used.

- Better connect the range of care and support services (contracted services, carers and family, health services, voluntary sector and community support) by employing better systems and building in accountability for all agencies to do this.

All of these outcomes apply equally to all service users and potential services users and are mindful of specific needs based on protected characteristics.

- **Age**
  A majority of current 'home care' recipients (personal care) are over 70 years old (78%). However around 10% are under 50 years old. The reverse is true for SIS services (non-personal care).

A purchasing tool to help purchasing officers select the right service (either Home Care or SIS) based on 'best-fit' will ensure that the most appropriate service provider is selected to meet service users' needs. This will have a positive effect on age groups characteristics.

- **Disability**
  All individuals receiving care and support services within the context of this service have a disability or long-term condition. This is a prerequisite for eligibility to this type of service. We do not consider that this characteristic will be affected adversely.

- **Gender**
  The gender split of care and support services are roughly in-line with the Kent population. We do not consider that this characteristic will be affected adversely.

- **Gender Identity/Transgender**
  There is no data available concerning gender identity. However, we do not consider that this characteristic will be affected adversely. More person centred, outcome-based services should have a positive impact on the basis of gender identity/ transgender identity. KCC has Transgender Guidance which can be shared with contracted providers, to complement their own equality and diversity policy.

- **Race**
  Data collated evidences that some ethnic groups are under-represented as recipients of care and support services compared to Kent, South East and England figures (Indian, Black African, White Irish, Asian Other). This will be reviewed as part of ongoing contract review to ensure any issues highlighted are noted and action plans developed to mitigate/ improve the service offer for this cohort. We do not consider that this characteristic will be affected adversely.

Religion and Belief
'None' or 'not recorded' was recorded for approximately 70% of all recipients of care and support services. All religions appear to be under represented compared to national and local figures. However, we do not consider that this characteristic will be affected adversely. Action has been identified to follow up on this during life of the contract.

- **Sexual Orientation**
'Prefer not to say' or 'not recorded' was recorded for approximately 75% of all recipients of care and support services. There is no national or local data to show comparative numbers of people with this protected characteristic that are in receipt of a care and support service. We do not consider that this characteristic will be affected adversely. Action has been identified to follow up on this during life of the contract.

Pregnancy and Maternity
We do not consider that this characteristic will be affected adversely.

- **Marriage and Civil Partnerships**
We do not have any data relating to care and support services that identifies service users' marital status. We do not consider that this characteristic will be affected adversely.

- **Carers Responsibilities**
We do not have enough reliable data to tell us how many unpaid carers who have been properly assessed are looking after recipients of care and support services. Action has been identified to follow up on this during life of the contract.

Adverse Impact,
The needs assessment used to determine any care and support requirement should thoroughly investigate a person's circumstances where it has relevance. The resulting service should be best matched to take all of these into consideration. There should be no adverse impact on any protected characteristic when arranging a package of care and support.

Positive Impact:
This project aims to secure provision of Home Care and Supporting Independence Services for the Kent population. Over time, work will be done with provider organisations to refocus the delivery of care to achieving outcomes, rather than simply the delivery of hours of care ("time and task") to better match the care and support provider with services users' needs and stated outcomes. Any protected characteristics that are relevant should be considered in the development of outcomes focussed care, with equalities information being monitored and action taken as required.

JUDGEMENT

There are no identified adverse effects to any group with protected characteristics by this project. We anticipate that this model will better match service user needs with the ‘best-fit’ service provider, who in time, will have a greater focus on helping people to achieve their goals (outcomes). This will offer a more personalised approach to all service users.

- **No major change** - no potential for discrimination and all opportunities to promote equality have been taken

Internal Action Required **Yes**

Equality Impact Analysis/Assessment Action Plan

Protected Characteristic	Issues identified	Action to be taken	Expected outcomes	Owner	Timescale	Cost implications
Race	Statistically under represented as recipients of care and support services in relation to the general population.	Monitor against baseline and take action as required. Improve understanding and monitoring activity amongst frontline staff and service providers.	Intelligence will inform any further decision-making concerning inclusion of these groups	Jack Moss	Life of contract	N/A
Religion	All religions appear to be under represented compared to national and local figures.	Monitor against baseline and take action as required.	Intelligence will inform any further decision-making concerning inclusion of these groups	Jack Moss	Life of contract	N/A
Carers	No data available concerning numbers of unpaid carers looking after service users in receipt of a care and support service	Work with Performance Team to determine data. This information has now been picked up and rectified**. Action complete**	Inform work to better integrated carers support services into packages of care	Jack Moss	June 2018	N/A
Sexual Orientation	No data collected	Consider how to engage	Intelligence	Jack Moss	Life of	N/A

		throughout the life of the contract. Improve understanding and monitoring activity amongst frontline staff and service providers.	will inform any further decision-making concerning inclusion of these groups		contract	
Gender Identity/Transgender	No data collected	Consider how to engage throughout the life of the contract. Improve understanding and monitoring activity amongst frontline staff and service providers.	Intelligence will inform any further decision-making concerning inclusion of these groups	Jack Moss	Life of contract	N/A
All protected groups	Monitoring progress towards achieving aims of the service	• Improve care and support for service users by selecting the most appropriate service provider(s) that could meet their needs. • Reduce volumes of care and support services required by supporting service users to achieve their goals so that they realise their full independence and wellbeing potentials.	Outcomes achieved	Jack Moss	Life of contract	N/A

		• Reduce the number of service users who are admitted to acute hospital care and delay the numbers who transfer to residential services.				

Have the actions been included in your business/ service plan?
Yes (included in the project plan)

Appendix

Please see additional documents:

1. Adults SIS and Home Care Equalities Data

Please forward a final signed electronic copy and Word version to the Equality Team by emailing diversityinfo@kent.gov.uk

If the activity will be subject to a Cabinet decision, the EqIA must be submitted to committee services along with the relevant Cabinet report. Your EqIA should also be published.
The original signed hard copy and electronic copy should be kept with your team for audit purposes.

Appendices

Data : Adult Social Care Client Systems (SWIFT) – equalities recording (23/5/18)

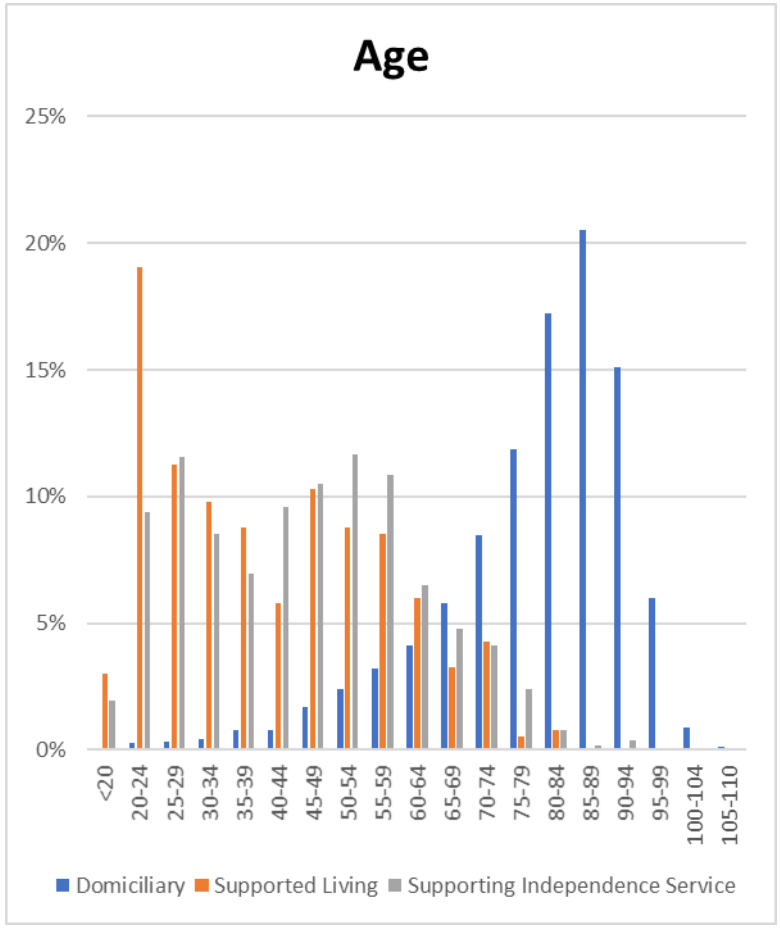
- Figure 1 – Age
- Figure 2 – Primary Support Reason
- Figure 3 – Ethnic Origin
- Figure 4 – Religion
- Figure 5 – Sexual Orientation

- Figure 1: Adults – Age of Care in the Home Recipients

Age

Percentage of records with Age recorded 100%

Age	Domiciliary	Supported Living	Supporting Independence Service	Grand Total	Domiciliary	Supported Living	Supporting Independence Service	Grand Total
<20	4	12	38	54	0.1%	3.0%	2.0%	0.6%
20-24	20	76	182	278	0.3%	19.0%	9.4%	3.0%
25-29	21	45	224	290	0.3%	11.3%	11.5%	3.1%
30-34	29	39	165	233	0.4%	9.8%	8.5%	2.5%
35-39	53	35	135	223	0.8%	8.8%	7.0%	2.4%
40-44	53	23	186	262	0.8%	5.8%	9.6%	2.8%
45-49	118	41	204	363	1.7%	10.3%	10.5%	3.9%
50-54	165	35	226	426	2.4%	8.8%	11.6%	4.6%
55-59	223	34	211	468	3.2%	8.5%	10.9%	5.1%
60-64	285	24	126	435	4.1%	6.0%	6.5%	4.7%
65-69	400	13	93	506	5.8%	3.3%	4.8%	5.5%
70-74	587	17	80	684	8.5%	4.3%	4.1%	7.4%
75-79	819	2	47	868	11.8%	0.5%	2.4%	9.4%
80-84	1193	3	15	1211	17.2%	0.8%	0.8%	13.1%
85-89	1419	0	3	1422	20.5%	0.0%	0.2%	15.4%
90-94	1044	0	7	1051	15.1%	0.0%	0.4%	11.4%
95-99	415	0	0	415	6.0%	0.0%	0.0%	4.5%
100-104	62	0	0	62	0.9%	0.0%	0.0%	0.7%
105-110	8	0	0	8	0.1%	0.0%	0.0%	0.1%
Grand Total	6918	399	1942	9259	100%	100%	100%	100%

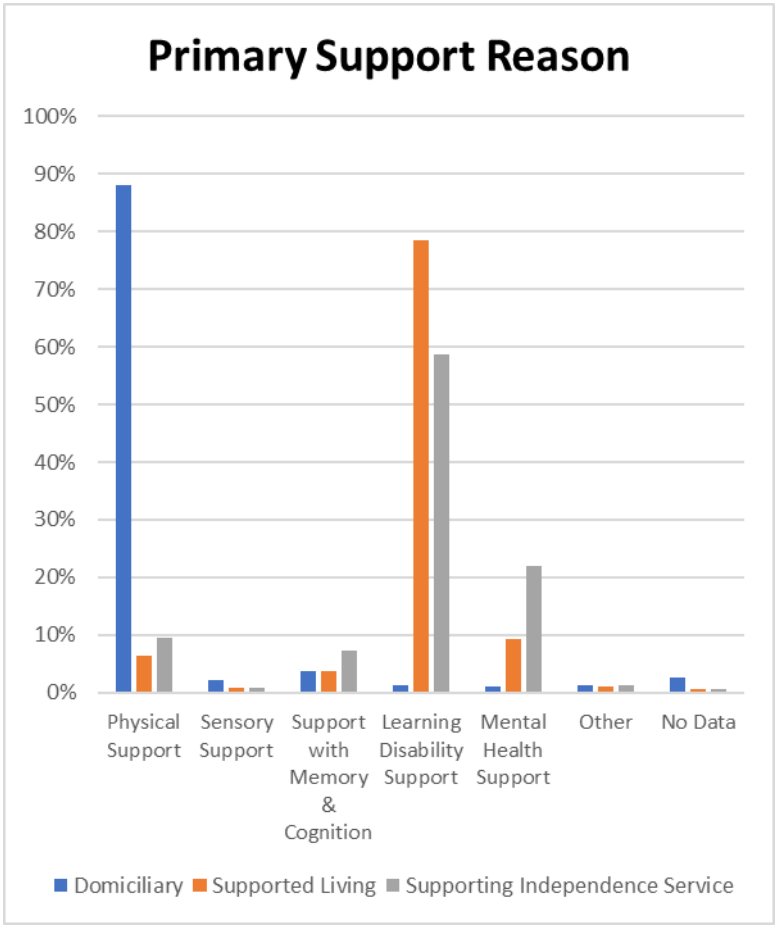

Age
25%
20%
15%
10%
5%
0%
<20
20-24
25-29
30-34
35-39
40-44
45-49
50-54
55-59
60-64
65-69
70-74
75-79
80-84
85-89
90-94
95-99
100-104
105-110
Domiciliary
Supported Living
Supporting Independence Service

- Figure 2: Adults – Primary Support Reason of Care in the Home Recipients

Primary Support Reason

Percentage of records with PSR recorded 97.99%

Primary Support Reason	Domiciliary	Supported Living	Supporting Independence Service	Grand Total	Domiciliary	Supported Living	Supporting Independence Service	Grand Total
Physical Support	6100	25	183	6308	88.2%	6.3%	9.4%	68.1%
Sensory Support	141	3	14	158	2.0%	0.8%	0.7%	1.7%
Support with Memory & Cognition	259	15	142	416	3.7%	3.8%	7.3%	4.5%
Learning Disability Support	90	313	1139	1542	1.3%	78.4%	58.7%	16.7%
Mental Health Support	67	37	428	532	1.0%	9.3%	22.0%	5.7%
Other	88	4	25	117	1.3%	1.0%	1.3%	1.3%
No Data	173	2	11	186	2.5%	0.5%	0.6%	2.0%
Grand Total	6918	399	1942	9259	100%	100%	100%	100%


Primary Support Reason
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Physical Support
Sensory Support
Support with Memory & Cognition
Learning Disability Support
Mental Health Support
Other
No Data
Domiciliary
Supported Living
Supporting Independence Service

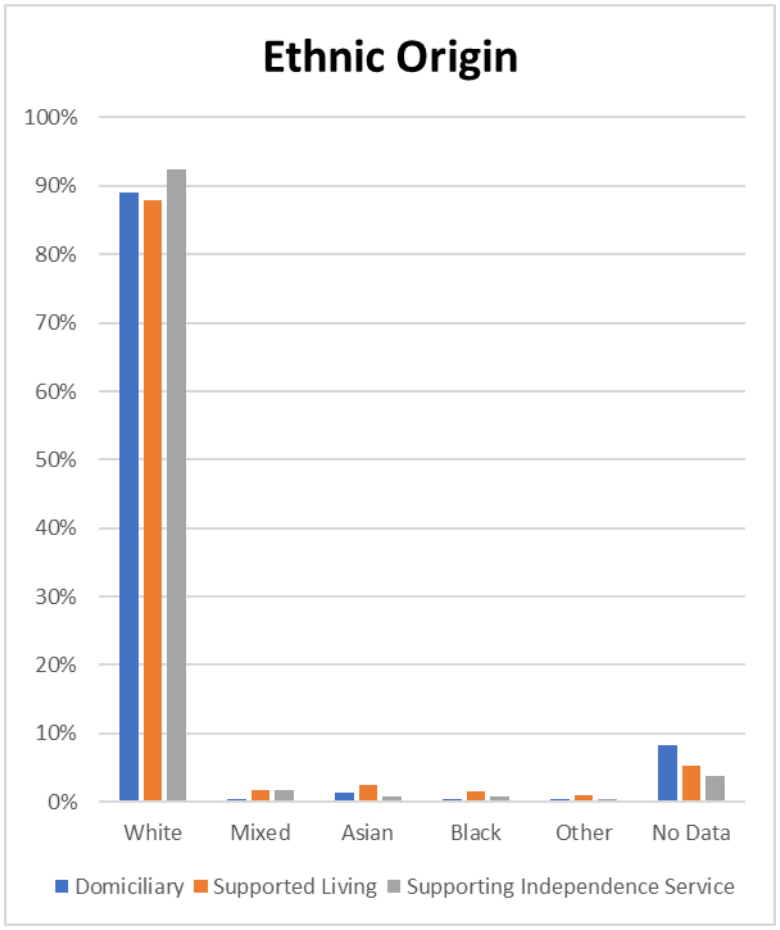
- Figure 3: Adults – Ethnic Origin of Care in the Home Recipients

Ethnic Origin

Percentage of records with Ethnic Origin recorded 99.97%

Ethnic Origin	Domiciliary	Supported Living	Supporting Independence Service	Grand Total	Domiciliary	Supported Living	Supporting Independence Service	Grand Total
White	6162	351	1793	8306	89.1%	88.0%	92.3%	89.7%
Mixed	25	7	35	67	0.4%	1.8%	1.8%	0.7%
Asian	95	10	17	122	1.4%	2.5%	0.9%	1.3%
Black	27	6	17	50	0.4%	1.5%	0.9%	0.5%
Other	33	4	7	44	0.5%	1.0%	0.4%	0.5%
No Data	576	21	73	670	8.3%	5.3%	3.8%	7.2%
Grand Total	6918	399	1942	9259	100%	100%	100%	100%

Note: No Data includes: - 'Error', 'Info Declined', 'Information Not Yet Obtained', 'Not Recorded', 'Not Stated', 'Refused' and 'Unknown'.


Ethnic Origin
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
White
Mixed
Asian
Black
Other
No Data
Domiciliary
Supported Living
Supporting Independence Service

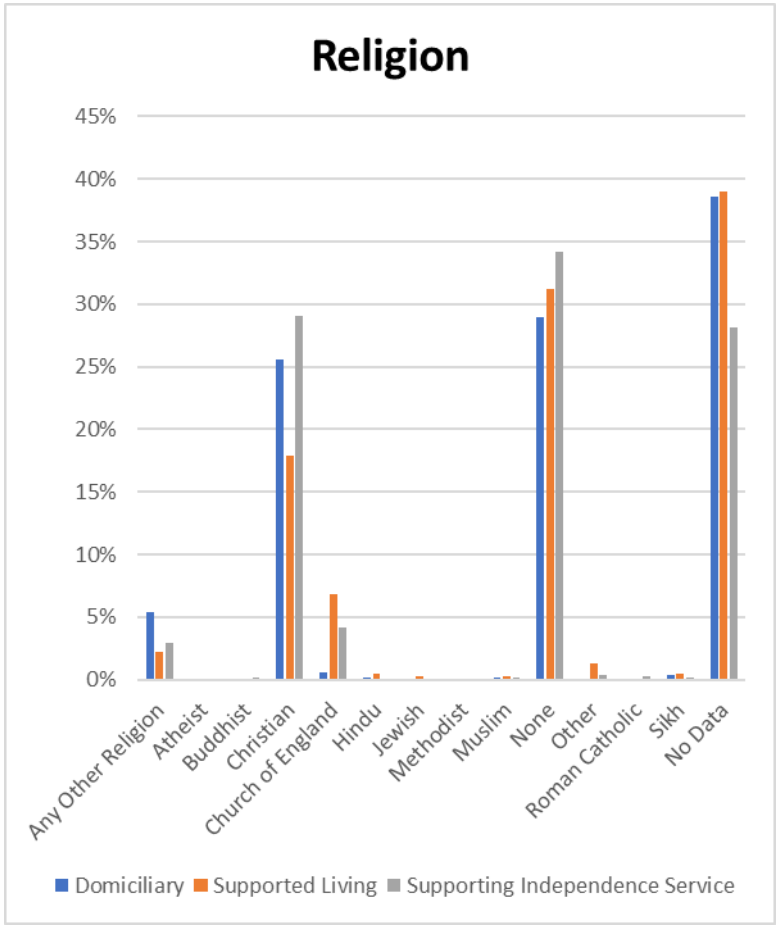
- Figure 4: Adults – Religion of Care in the Home Recipients

Religion

Percentage of records with Religion recorded 64.32%

Religion	Domiciliary	Supported Living	Supporting Independence Service	Grand Total	Domiciliary	Supported Living	Supporting Independence Service	Supporting Independence Service
Any Other Religion	370	9	58	437	5.4%	2.3%	3.0%	4.7%
Atheist	0	0	2	2	0.0%	0.0%	0.1%	0.0%
Buddhist	6	0	3	9	0.1%	0.0%	0.2%	0.1%
Christian	1768	71	565	2405	25.6%	17.9%	29.1%	26.0%
Church of England	41	27	81	150	0.6%	6.8%	4.2%	1.6%
Hindu	10	2	2	14	0.1%	0.5%	0.1%	0.2%
Jewish	3	1	1	5	0.0%	0.3%	0.1%	0.1%
Methodist	1	0	0	1	0.0%	0.0%	0.0%	0.0%
Muslim	10	1	4	15	0.1%	0.3%	0.2%	0.2%
None	2005	125	663	2793	29.0%	31.2%	34.1%	30.2%
Other	4	5	7	16	0.1%	1.3%	0.4%	0.2%
Roman Catholic	6	0	5	11	0.1%	0.0%	0.3%	0.1%
Sikh	23	2	4	29	0.3%	0.5%	0.2%	0.3%
No Data	2670	156	547	3372	38.6%	39.0%	28.2%	36.4%
Grand Total	6918	399	1942	9259	100%	100%	100%	100%

Note: No Data includes:
- 'Declined to Disclose', 'Lacks Capacity - Religion', 'Not Known' and 'Not Recorded'.


Religion
45%
40%
35%
30%
25%
20%
15%
10%
5%
0%
Any Other Religion
Atheist
Buddhist
Christian
Church of England
Hindu
Jewish
Methodist
Muslim
None
Other
Roman Catholic
Sikh
No Data
Domiciliary
Supported Living
Supporting Independence Service

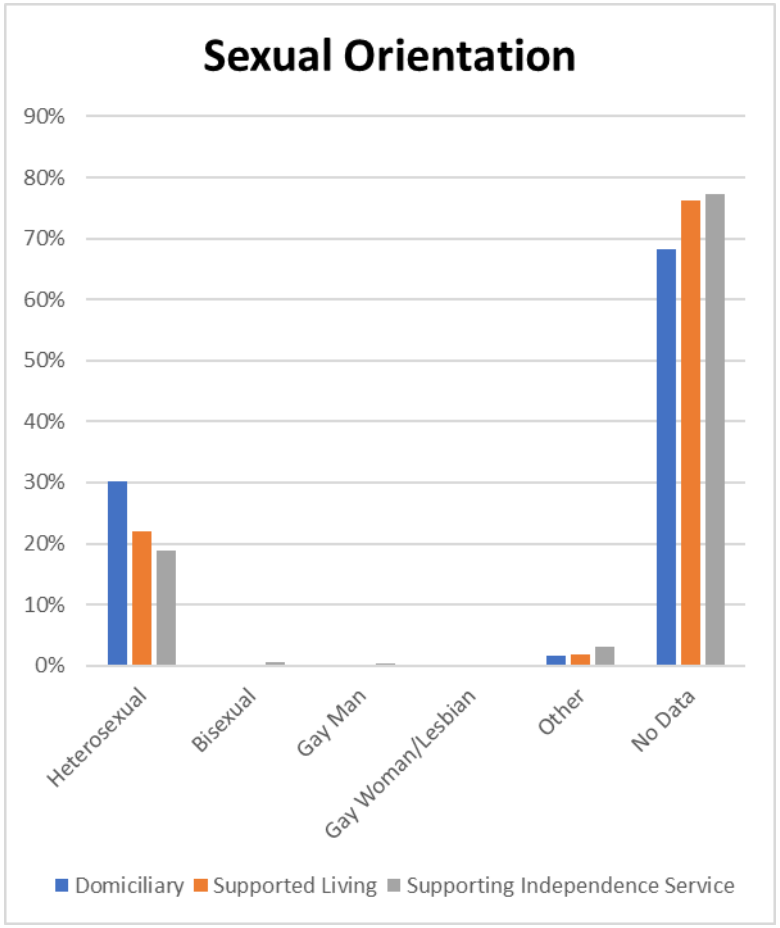
· Figure 5: Adults – Sexual Orientation of Care in the Home Recipients

Sexual Orientation

Percentage of records with Sexual Orientation recorded	61.09%

Sexual Orientation	Domiciliary	Supported Living	Supporting Independence Service	Grand Total	Domiciliary	Supported Living	Supporting Independence Service	Grand Total
Heterosexual	2084	87	368	2539	30%	22%	19%	27%
Bisexual	0	0	9	9	0%	0%	0%	0%
Gay Man	0	0	7	7	0%	0%	0%	0%
Gay Woman/Lesbian	3	0	1	4	0%	0%	0%	0%
Other	109	7	58	174	2%	2%	3%	2%
No Data	4722	305	1499	6526	68%	76%	77%	70%
Grand Total	6918	399	1942	9259	100%	100%	100%	100%

Note: No Data includes: - 'Lacks Capacity', 'Not Recorded' and 'Prefer Not To Say'.


Sexual Orientation
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Heterosexual
Bisexual
Gay Man
Gay Woman/Lesbian
Other
No Data
Domiciliary
Supported Living
Supporting Independence Service

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From:	Graham Gibbens, Cabinet Member for Adult Social Care and Public Health Penny Southern, Corporate Director of Adult Social Care and Health
To:	Adult Social Care and Health Cabinet Committee - 27 September 2018
Subject:	**INTEGRATED ADULT LEARNING DISABILITY COMMISSIONING SECTION 75 AGREEMENT**
Classification:	Unrestricted
Past Pathway of Paper:	Adult Social Care and Health Directorate Management Team – 19 September 2018
Future Pathway of Paper:	None
Electoral Division:	All

Summary: This report provides an update regarding the Learning Disability Section 75 Agreement which was established to host integrated commissioning arrangements between Kent County Council and the seven Kent Clinical Commissioning Groups (CCGs).

Recommendations: The Adult Social Care and Health Cabinet Committee is **CONSIDER** and **COMMENT** on the progress and achievements made within the Section 75 Agreement.

1. Introduction

1.1 This report provides an update regarding integrated commissioning arrangements for Adult Learning Disability Services which became operational in April 2016. Under a formal Section 75 Agreement, Kent County Council (KCC) leads this work on behalf of all of Kent's Clinical Commissioning Groups (CCG). This arrangement was endorsed at the Adult Social Care and Health Cabinet Committee in December 2015.

1.2 The purpose of the arrangement is to provide a central point of expertise on adult learning disability for all the partners to the Section 75 Agreement. This ensures there is a critical mass of expertise and knowledge around the commissioning of support and provides a consistent approach to health and social care commissioning for Adults with a Learning Disability across Kent. It also ensures that the organisational memory of the considerable positive changes which have been achieved in recent years is retained and built upon through continued improvements.

1.3 The Council act's as representative commissioner for the delivery of this agreement which supports KCC's strategic aims:

- To develop and rapidly deliver a shared vision for the integration and redesign of health and social care services across Kent
- Ensure more people receive quality care at home avoiding unnecessary admissions to hospital and care homes
- The health and social care systems work together to deliver high quality community services

2. Policy Framework

2.1 The Section 75 Agreement links with the following strategic outcomes:

- Outcome 1 - Children and Young People in Kent get the best start in life
- Outcome 2 - Kent communities feel the benefits of economic growth by being in work, healthy and enjoying a good quality of life
- Outcome 3 - Older and vulnerable residents are safe and supported with choices to live independently

2.2 The Section 75 Agreement supports the above strategic outcomes by:

- Supporting those with long term conditions to manage their conditions through access to good quality care and support
- Enabling more people to receive quality care in the community avoiding unnecessary admissions to hospital and care homes
- Enabling the health and social care system to work together to deliver high quality services
- Improving physical and mental health by supporting people to take more responsibility for their own health and wellbeing

2.3 By supporting older and vulnerable residents in Kent with assessed needs, to remain living independently in their own homes, KCC aims 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

3. The Section 75 Agreement

3.1 Has established, and set out the governance arrangements for, the Section 75 Learning Disability Partnership Board, which is chaired by the Strategic Commissioner for Kent. The Board ensures collaborative decision making and consistency with governance arrangements of each of the partner organisations.

3.2 Has established the Integrated Commissioning Team for Learning Disability which is hosted by KCC. This brings together and centralises commissioning expertise relating to learning disabilities across health and social care in Kent to commission and improve services in the collective interests of the Section 75 Partners.

3.3 A core principle of the Integrated Learning Disability Commissioning Team Specification is '*to put the individual with a learning disability at the centre of decision making, giving them more choice and control over their lives'*. The pooled resource ensures a joined-up approach to both the commissioning and delivery of strategies to reduce the inequalities and disadvantage faced by people with a learning disability. This work enables the health and social care system to work together to deliver high quality community services. This team performance manages the integrated Community Learning Disability Teams (CLDT) and supports their work by ensuring appropriate high-quality community services are available to support Adults with a Learning Disability

3.4 Has created a functioning health and social care pooled budget which sets out the final contributions for each partner. This is hosted by KCC on behalf of the Section 75 Partners to fund the Integrated Commissioning Team for Learning Disability and brings together the previously separate learning disability services funding. This has enabled the Section 75 Board to integrate Health and Social Care Learning Disability Services into an Alliance Agreement.

3.5 The integrated commissioning arrangement under the Section 75 has enabled the successful negotiation and completion of the Learning Disability Alliance Agreement. Kent Community Health Foundation Trust (KCHFT), Kent and Medway Partnership Trust (KMPT), and Kent County Council (KCC) have come together to create a Learning Disability Alliance Agreement, the Alliance comprises of the individual organisations underpinning service contracts. This means that the KCC's staffing budget for the CLDTs is now part of the pooled budget. Any plans for spending on CLDTs are now developed in consultation with the CCGs through the Section 75 Learning Disability Partnership Board and managed through the pooled budget.

3.6 Has established a sound foundation and expansion is being considered to include other associated areas of commissioning, e.g. services for disabled children and health funded support packages for Adults with A Learning Disability and/or Autism.

4. The Learning Disability Alliance Agreement

4.1 The Alliance underpins and makes real the aspirations of the Section 75 Agreement and has been established for the provision of integrated care. The Alliance has been in place since 1 February 2018 and has an initial three-year term. To our knowledge, this is the first of its kind. This work has been acknowledged by the Kings Fund who are going to make information about the Alliance available via their website to support other areas who are progressing similar work.

4.2 The Alliance ensures a collaborative approach between the three providers, KCC, KCHFT and KMPT and Commissioners. It enables better joined up conversations about how best to meet people's needs, it is supporting providers to think more strategically and beyond the boundaries of their own organisation.

4.3 The Assistant Director for Community Learning Disability Teams, stated in September 2017 "*we've shifted the focus from where does my responsibility end, to how do we depend on each other and how can we strengthen that?"* There have been many benefits of this approach, one example being that now teams can refer to each other without having to go through a GP, this has sped up access and removed a layer of bureaucracy from the primary care system taking work from hard pressed GP surgeries.

4.4 An integrated performance framework is being developed to further joint working across Provision and Commissioning, this framework will utilise the contractual levers available to drive performance and test the value this brings to Kent residents and Commissioners, in preparation for recommissioning the Alliance from 2021.

5. Key Achievements

5.1 The Transforming Care Programme came out of the post Winterbourne View scandal; is a structured programme to ensure people with learning disabilities and/or Autism do not stay in hospital for longer than is necessary. To date the Kent and Medway Transforming Care Partnership has supported 44 people to leave long stay NHS facilities and lead more independent and fulfilled lives in the community. The Transforming Care Programme is due to end March 2019; however, the work will continue as part of the Alliance's work plan. See Appendix 1 for a full report about this work.

5.2 A Service Operational Manual (SOM) is in development, the SOM sets out clearly the role of the Integrated Community Learning Disability Teams. What the professional roles are within the team and what they do. It also explains how the different professions work together to support people with learning disabilities and their families. The creation of the SOM will help when planning for the future workforce and addressing the issues we are currently facing ensuring that Community Learning Disability Teams have the right skill mix to provide high quality person centred support.

5.3 Annual Health Checks are essential in ensuring that people living with learning disabilities can access health care and reduce the inequalities they have historically experienced. Work is required to increase the number of Annual Health Checks delivered across Kent, the Integrated Commissioning team and Alliance Partners have highlighted this, and it is now being explored by the CCGs through quality governance routes with the support of NHS England. All GPs have been offered Annual Health Checks Training and all practices have an allocated link nurse from the Alliance Team who they can call on for advice and support when meeting the needs of people with a learning disability on their practice list.

5.4 The Integrated Commissioning Team has successfully rolled out the national LeDeR Programme across Kent and Medway, with a Steering Group chaired by Public Health. The LeDeR Programme reviews all deaths of people with learning disabilities. The review process:

- ensures that any lessons learnt about how the system could have provided better care are actioned in the continuous improvement of services and support.
- contributes to reducing premature deaths among the learning-disabled population by informing better commissioning and delivery of services by informing practice change across the health and social care system.

5.5 In conjunction with the Alliance the Integrated Commissioning Team has implemented the Care (Education) and Treatment Review process. This process brings providers and commissioners together to discuss individuals with complex needs in order to design packages of support to better meet their needs and prevent inappropriate hospital admissions. Care and Treatment Reviews are for people aged 18 or older, with Education being part of the process for people under 18 years old.

5.6 The Alliance has also successfully implemented a new Complex Care Response (CCR) Service. This new service is delivered by the Alliance partners to support individual's outcomes and to prevent breakdowns in community support. The service works with other community care providers to manage difficult situations in the community and to facilitate timely discharges. Since this service has been in place there has been a dramatic reduction in community admissions to NHS assessment and treatment facilities.

5.7 The Good Health Group, Alliance Partners and the Integrated Commissioning Team are working with hospital trusts across Kent and Medway to ensure people with a learning disability have a positive experience and equal access of hospital care. People with a learning disability are influencing this work directly as key members of the Good Health Group, two people with a learning disability co-chair the group alongside a member of the Integrated Commissioning Team. Each hospital has a Learning Disability Liaison Nurse whose role it is to improve service delivery and quality of care across the Trust. This has already resulted in the sharing of best practice and acute trust tailoring care to be appropriate to people with additional needs by making reasonable adjustments. For example, Medway Maritime has implemented and shared with the three Kent Trusts a system for ensuring people with a learning disability are identified and offered the support they need.

6. Next Steps and Future Developments

6.1 To support the Transforming Care Programme an additional investment of £2.25m has been secured from NHS England, to enhance community services for people with learning disabilities and/or Autism. This investment is intended to further develop the community services to both support people leaving acute hospital setting and better meet needs in the community to prevent further admission.

6.2 The commissioning of individually tailored services is being developed with funding to prevent future admissions widening the remit of learning disability commissioning to include people with a single diagnosis of Autism, and to young people.

6.3 These and any further additions to the pooled budget require an amendment to the Section 75 Agreement and are being taken through the appropriate governance arrangements.

7. Financial Implications

7.1 The Section 75 Agreement sets out how the integrated commissioning arrangement operates, describes the respective responsibilities of the partners and the governance arrangements to ensure all partners to the Agreement are fully engaged.

7.2 The Section 75 Agreement has a functioning pooled budget which has respective funding contributions for the Integrated Commissioning Team, and the Kent wide integrated community teams (including mental health) under the Alliance contract

7.3 Development of processes to ensure that funding contributions from NHS England and Kent's CCGs in relation to known patients with specific complex needs are made through the pooled budget.

8. Equality Implications

8.1 The commissioning specification which is part of the Section 75 Agreement address equality issues, a major purpose of the arrangement is to reduce the inequalities faced by people with learning disabilities.

9. Legal Implications

9.1 A Section 75 Agreement is a legally binding document which provides the legal basis for integrating health and social care commissioning of service for people with learning disabilities in Kent.

9.2 A Deed of Variation is currently being prepared to ensure the integrated commissioning arrangements remain legal. Consideration is being given to widening the scope of integrated commissioning to include autism and young people with learning disability and/or autism.

9.3 Future progression may include Medway CCG becoming a partner to the S75 Agreement so that funding available is spent in the most effective way across the Sustainability and Transformation Partnership footprint.

10. Conclusions

10.1 The Section 75 Agreement has formalised the partnership between KCC and the seven CCGs in Kent, ensuring that adults with learning disabilities in Kent

are served by an experienced and knowledgeable team, maintaining a critical mass of expertise to advise all partners.

10.2 The Agreement has also ensured that the resources of all partners can be effectively and efficiently used to deliver good quality integrated care for people with learning disabilities and continue to reduce the inequalities which they face.

10.3 The Agreement will continue to develop the partnership arrangements so that the resources of all partners deliver good quality integrated care to benefit people with autism, and prevention of escalation of need in young people with learning disability and/or autism, to both reduce inequality and ensure that money is more effectively spent.

11. Recommendation(s)

11.1 Recommendations: The Adult Social Care and Health Cabinet Committee is **CONSIDER** and **COMMENT** on the progress and achievements made within the Section 75 Agreement.

12. Background Documents

Integrated Learning Disability Section 75 Agreement
https://democracy.kent.gov.uk/ieDecisionDetails.aspx?ID=848

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Kent County Council Adult Social Care and Health

Transforming Care Review Project

Our progress on implementing the Transforming Care Review against the national framework, identifying gaps and taking action.

June 2018

Kent County Council
kent.gov.uk

Contents

Foreword

By Penny Southern,
Corporate Director for Adult Social Care and Health

I have been part of the Kent Transforming Care Programme for over six years. I am committed to ensuring we deliver the right outcomes for individuals who require bespoke support services and we continue to develop an understanding of their needs to ensure our programme delivers a safe local service.

I do not know anyone in our services in Kent who were not affected by the reporting of the significant failings which rested in the culture of abuse at Winterbourne View.

It was shocking to see and to read about this scandal and I was determined to make sure that the Kent Transforming Care Programme learnt lessons from this, and that it delivered person centred services to individuals and their families who do not need to remain in a hospital environment.

To date, Kent have discharged 44 individuals into local services. Although the National Programme's focus was on planning and discharge of individuals from acute hospital settings, the Kent and Medway Transforming Care Board supported my request to undertake a comprehensive review of everyone we worked with who had moved from an acute hospital setting over the last four years of the programme.

I felt it was crucial to hear the voice of the individual and their families on the experience of the programme, but also the voice of the staff in Health & Social Care and to find out how they had responded to the programme.

I wanted to know how services have been commissioned, how providers have responded to the challenges and what lessons could be learnt of the Transforming Care Project Team for the people we need to continually work with to ensure a timely discharge and a sustainable service to meet their needs.

I am delighted that the Board supported this piece of work and they have agreed to monitor the implementation of the 14 recommendations made in the report. This will enable us to continually improve our services and how we response to the individuals we still need to support through the Kent and Medway Transformation Programme.

I want to thank Alan Stewart for the commitment to this piece of work and the care he has taken to spend time and listen to the people he visited during the review. I also want to thank all the individuals and their families, the staff and providers of services for all their contributions to this review.

Penny Southern
Corporate Director for Adult Social Care and Health

Transforming Care Review Project



Written by Alan Stewart
Transforming Care Project Officer

1. Introduction

Transforming Care is a national programme which has been established to improve services for people with learning disabilities and/or autism who display behaviour which is challenging and who may also suffer from different mental health conditions.

Locally, Kent and Medway have been grouped together to form the Kent and Medway Transforming Care Partnership. Kent and Medway are both committed to working in Partnership to implement Transforming Care when it is prudent to do so, such as when there is a clear benefit to service users and their families and carers or when there is a clear cost benefit to working together.

An integrated commissioning structure has been in place in Kent since 1st April 2016 to enable Kent County Council and the seven Kent Clinical Commissioning Groups (CCGs), to make sure the NHS in Kent and KCC work together to make a real difference for people with learning disabilities, by pooling their resource and expertise. In Kent, we have been working hard across health and social care to ensure that people in hospital, who are no longer receiving active treatment, can be discharged safely into the community.

2. Project brief

At the Kent and Medway Transforming Care Partnership Board which met on September 29th 2017 it was agreed to plan and implement an independent review of all the Kent patients who had at that point been discharged from hospital under the Transforming Care programme. The review would determine:

If the programme is delivering:

- better outcomes and/or quality of life for service users.

If the programme's requirements are being met by:

- integrated commissioning
- provider delivery
- specialist health and social care assessment and review.

If the provision is providing:
- value for money for the commissioner.

3. Methodology and time-frame.

It was decided that the information that would inform the outcome of the review would be best obtained by visiting providers, and carrying out face to face interviews with placement managers and with as many service users and their families as possible.

The basis for these interviews would be the key questions facing the review;

- **Has the transforming care programme succeeded in improving service users' quality of life?**
- **How has this been achieved?**
- **What more needs to be done to improve community services and reduce the need for people diagnosed with a learning disability or autism being admitted to hospital?**

Care managers and care coordinators would also be contacted and joint visits to placements would take place with attendance at some reviews where possible. It also became clear that the views of carers who have experienced all the highs and lows of their relatives' journey through their care pathway, would be essential if we are to obtain a full and clear picture of how effective the Transforming Care Programme has been, and shape services for the future. Interviews would therefore be arranged with some carers to collect their views and record their experiences.

The effectiveness of the discharge process would also be evaluated by examining the discharges that took place in 2017. The care managers and care coordinators involved would be contacted for information which would determine whether the responsible agencies are managing discharges to an acceptable standard.

Stage 1: Information gathering and initial data collection: four weeks

The project started at the beginning of October 2017 with a clear brief, but before setting out to review all the patients who had been discharged and measure the effectiveness of the Transforming Care Programme I needed to do two things:

1a) Read key documents to acquaint myself with relevant information about national and local Transforming Care Implementation Programmes.

These included:
- Building the Right Support (2015)
- Service model for commissioners of health and social care services (2015)
- Care and Treatment Reviews (CTR's): Policy and Guidance
- Kent and Medway Transforming Care Plan
- Transforming Care Programme 'Medway The Current Picture'.

There is a comprehensive list of documents available on the NHS England website: www.england.nhs.uk/learning-disabilities/care/

1b) Produce an effective set of data.

The size of the task was unclear and there was no collective information or central Transforming Care database detailing who this specific group of service users are, where they are placed and who is involved. I was provided with a list of names held by the commissioners and a spreadsheet provided by finance. These needed to be cross-referenced to achieve a coherent picture of the workload of the review.

It soon became clear that the information that was held was out of date, with three service users having moved placement, and a number having had a change of care manager or care coordinator.

At the outset the number of Kent patients who had been discharged from hospital under the Transforming Care Programme stood at 35, and

as the review has progressed the number has increased to 44. All the service users' details needed to be checked on the electronic information systems of both Kent County Council (KCC) (SWIFT) and the Kent & Medway NHS and Social Care Partnership Trust (KMPT) (RiO) to ensure that there were accurate details of address, provider and care manager/care coordinator.

KCC has Local Authority responsibility for this group of service users, but in some cases the lead professional is one of the KCC staff seconded to KMPT the local secondary mental health provider. In all cases I had to obtain the service users' KCC SWIFT number before I could confirm their details and the identity of their care manager and then establish whether the case was being managed by KMPT. Where KMPT was the lead agency involved I contacted the appropriate CMHT to confirm the identity of the care coordinator. I also liaised with the administrator for the mental health Complex Needs Panel to confirm the details of the service users who had been referred to the panel.

Meetings were also arranged with the following key individuals:

- Chris Beaney, Assistant Director Lifespan Pathway, Community Learning Disability Teams.
- Stuart Day, KCC Senior Accountant, to review the information held by the finance department and included in their spreadsheet.
- James Kerrigan, Commissioning Manager of Kent Integrated Learning Disability Services, to cross reference the information held by the commissioners with that held by finance.
- Sue Young, National Health Service England Case Manager, to confirm that details of the Kent patients discharged from National Health Service England funded secure hospital placements.
- Troy Jones, KCC Commissioning Officer, to obtain up to date details of providers and their service managers.

- Cheryl Fenton, KCC Assistant Director Mental Health, to review those service users who had been placed via the Complex Needs Panel.
- Lorraine Foster, Medway Council and Medway Clinical Commissioning Group Programme Lead for Partnership Commissioning, to discuss the report Transforming Care Programme 'Medway The Current Picture'.
- Keith Wyncoll, Transforming Care lead for Skillnet Group, to discuss the Co-Production Forums.
- Hannah Chandler, KCC Administration Officer for Transforming Care, who would manage the database.

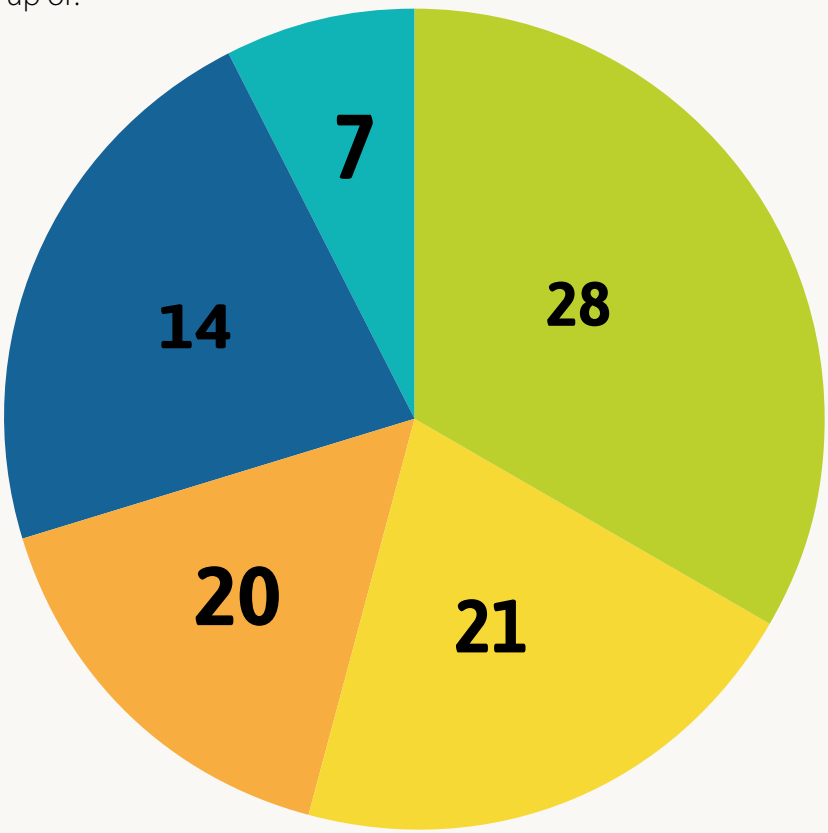
The finance spreadsheet formed the basis for the database, and it was expanded to include SWIFT ID numbers, personal details (date of birth etc), placement, care manager/care coordinator details and costs.

The spreadsheet also includes a list of all the providers who are or have been involved in providing services to this group (both by organisation and by individual facility) and the date and result of the latest Care Quality Commission inspection has been added. There is also a comprehensive list of the 77 current Kent in-patients which includes their personal details, the progress that they have made in their treatment programmes and the stage that they have reached in their Transforming Care Pathway.

Interviews by type

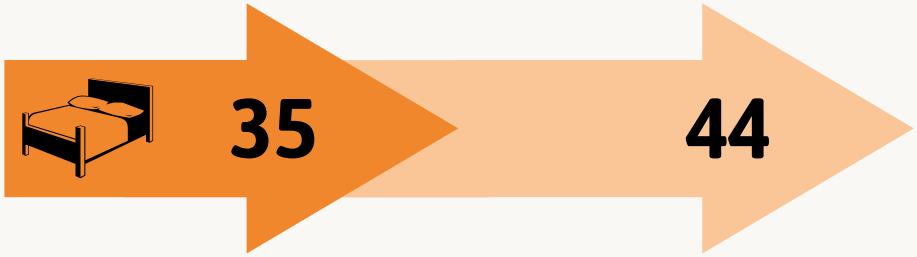
I interviewed a total of 81 made up of:

- Care managers and care coordinators 28
- Providers 21
- Service users 20
- Carers 14
- Reviews 7



Number of discharges

The number of service users discharged under Transforming Care has increased from 35 to 44 during the course of the review.



The creation of a comprehensive database has been essential in the effective review and ongoing monitoring of this important group of service users. A group of staff have been given read only access to the database, but to ensure accuracy the responsibility for modification remains with only two staff - the transforming care administrator and the senior accountant from finance. It is the responsibility of all other staff to inform them of any changes that need to be made.

Recommendation 1: *The creation of a database is essential.*

Stage 2: Communication - contacting care managers, care coordinators providers and service users: two weeks

Once the database was created and the initial contact information collected I was then able to begin planning the next stage of the review process which was to inform care managers, care coordinators providers and service users of the review and begin arranging to visit placements.

Letters were produced for care managers and care coordinators which informed them of the review project, explained why it was being undertaken and outlined its aims. The letter also informed them that more information was available on the KCC website and included a link to the NHS England website and a recommendation that *Building the Right Support* would provide a very helpful summary of the Transforming Care Programme.

A letter in easy read format was also produced for service users and sent out to providers asking them to discuss the review with the care manager or care coordinator and decide who would be the best person to share the letter with the service user.

Stage 3: Face to face interviews with providers, service users, care managers/ care coordinators and carers

Interviews were arranged to start during the second week of November. Information gathering took the form of face to face interviews where the following eight questions were addressed:

A. Does the current care package meet the needs of the individual?

B. Has the individual's quality of life improved?

C. Have the level and range of risks presented and described as in-patients reduced, decreased or not presented in the community.

D. Have the current costs of after-care decreased from the costs at the point of discharge?

E. Does each individual have an identified representative from the relevant community learning disability or mental health team who reviews their care, has the appropriate skills to manage the case and has completed the statutory reviews?

F. What is the frequency and range of MDT of support to the individual from the locality community teams?

G. Is the provider providing capable and sustainable support to the individual despite their needs?

H. Has the placement been appropriately commissioned and is there evidence of:

- Person Centred Planning
- A detailed Placement Specification incorporating the PCP and clinical and risk assessments.
- Training, skills and experience of the provider that is matched to the provider requirements in the Placement Specification
- The support plans and commissioned hours matching the assessed needs of the client.

Currently the number of face to face interviews and email/telephone contacts is as follows:

- Service users: 16 at face to face interviews, four attended their review and two I met briefly at their placement
- Carers: 14 in total
- Reviews: seven - (four service users did not attend)
- Providers: 21 visited and one by phone discussion
- Care manager/ care coordinator: 28 in total by interview, at review or by email/ telephone.

4. Findings and recommendations

A. Does the current care package meet the needs of the individual?

The interviews did not produce any major concerns about the current placement or the package of care. The overwhelming view of the nine sets of carers interviewed was that they were just glad that their relative was no longer in hospital and the predominant emotion was one of relief. Five voiced their concerns about the quality of care provided in hospital, and the distances involved in visiting on a regular basis.

Concern was expressed by two sets of carers that placement reviews should be more frequent, and two carers expressed the view that care managers and care coordinators should be far more rigorous in ensuring that the package that is being commissioned is actually being delivered, and that what is being delivered is satisfactorily meeting the service users' needs. Three carers stated that the placement may not meet all their relatives needs but that was preferable to their relative remaining in hospital.

I have had direct discussions or correspondence with 28 care managers and care coordinators and have not been informed of any concerns about the quality of placements. They have informed me that they are satisfied that the packages of care do meet the needs of the individual, although they recognise that reviews are not as often as they should be to ensure accurate monitoring. In many cases the care manager or care coordinator was relatively new to the case. Changes seem to be frequent.

One case was unallocated at the time of the review and being dealt with via the locality duty system.

Eight carers and three service users raised concerns that there is a lack of continuity because of the regular changes of care manager or care coordinator. One provider mentioned that the care manager attending the review can be a different one each time which makes it difficult for the rigorous monitoring of care packages that some relatives would like to see if the only monitoring of the care package is annually and by a different professional who has no knowledge of the case. It was suggested by one provider and by two carers that occasionally reviews have been carried out by an unqualified member of staff in the absence of a care manager or care coordinator. I also attended two reviews that were carried out by a care management assistant.

Everyone involved appears satisfied with the packages of care being offered, so the conclusion to be drawn is that this amounts to a general acceptance that needs are being met in the absence of more detailed information. It is not evident that the current monitoring process is in any way designed to reassure everyone that care packages do meet the needs of the individual. The reporting process should demonstrate how the commissioned hours are being provided, and whether those hours are commissioned accurately.

Recommendation 2: *There is a need for more regular reviews given the complexity of these cases. The frequency of reviews (1,3 or 6 monthly) should be agreed and evidenced in supervision by the case holder.*

B. Has the individual's quality of life improved?

19 of the service users, and all 14 of the carers interviewed were overwhelmingly in agreement that their quality of life had improved since they were discharged from hospital. It was clear that the very fact that they had been discharged from hospital was seen as an automatic improvement in their eyes. This is in some ways a great positive, but it is essential that everyone recognises that discharge is not simply the end objective and that staying out of hospital and presenting few problems should not lead to an assumption that the care package is providing all that it should.

The positives for the relatives and service users were often not about the current placement but were focused on the improvements in their circumstances since discharge from hospital. There were no longer long distances for relatives to travel, and they therefore felt much more involved in the care process. They were also not having to deal with hospitals who they felt were not very helpful, and in some cases delivered poor care. Changes in Care Coordinator or Care Manager meant that they did not hear from the local authority as often as they would have liked. They complained of poor communication from the hospital, with three carers describing the regime as oppressive, and stating that periods of inpatient treatment were over-long. They also spoke of their relative's excessive weight gain in hospital and concerns for their physical health.

Although carers felt very strongly that their relatives' quality of life had improved since discharge there were some who felt that there could still be more community integration and an increase in activities that are available.

One relative suggested that providers could be more imaginative when identifying and providing activities. Two service users also said that their opportunities were somewhat limited by staff availability and that there should be a wider range of activities. When asked about this, providers did say that opportunities can be limited by the conditions under which some service users have been discharged and not all requests can be facilitated. One residential home has five residents discharged under Transforming Care who have complex histories, three of whom are subject to formal supervision. The manager's view is that despite the risks which still remain their quality of life has improved since discharge.

***Recommendation 3**: In the care plans there must be evidence that robust discussions have taken place concerning the suitability of activities requested by a service user who is subject to supervision.*

Service users were generally of a mind that their circumstances and quality of life had improved, and particularly mentioned the ability of their families to visit them more regularly.

I have attended seven reviews, liaised directly with 28 care managers and care coordinators and undertaken a survey of 11 discharges in 2017/18 and all agree that there has been an improvement in service users' circumstances and feel that there is considerable support on offer with access to the community where at all possible. There must be some restrictions in certain cases but there has still been an overall improvement in their quality of life.

***Recommendation 4:** When considering suitable community activities for service users there must be evidence that robust risk assessments have taken place.*

C. Have the level and range of risks presented and described as in-patients reduced, decreased or not presented in the community.

There have now been 44 people discharged under Transforming Care and there is clear evidence of positive risk taking given that some cases are very complex with offending and forensic mental health histories. Some service users have a range of disabilities and require close management with considerable health and social care input.

Care managers and care coordinators felt that despite the potential for problems following discharge risks have been managed effectively with no readmissions and only one example of re-offending. Risks have even been reduced as has the level of supervision with some service users being discharged from their Community Treatment Order. Regular Care Programme Approach Reviews and Multidisciplinary Team Meetings have been essential in providing a coordinated clinical approach to case management. Only one service user complained of late CPA Reviews. Two providers stated that they are reassured by the availability of the Complex Case Response process if problems arise.

So far there have been some issues raised which demonstrate the problems that can arise if communication isn't effective. Five providers have suggested that sometimes there is a lack of detailed risk information made available, and that on occasion they have had to chase professionals for basic information and clarification of specific details which they need if they are to manage the placement effectively.

***Recommendation 5**: Professionals involved in the discharge of a patient from hospital should ensure that all relevant clinical information, (particularly information relating to risk (including lessons learned from SI investigations) is made available to the service managers of possible placements to ensure that the appropriate provider is identified.*

Providers also feel that the lack of care manager and care coordinator continuity is a risk as it seriously affects their ability to communicate with the local authority and the mental health trust. Quite often they do not know who they should approach if they have issues that they want to discuss. This can be particularly important when the service user is subject to statutory supervision. One provider was awaiting the allocation of a social supervisor for a service user subject to Ministry of Justice supervision under Section 42 of the Mental Health Act. There were decisions to be made about this resident's leave which were being delayed because of the lack of an allocated social supervisor. Two providers and three carers suggested that there should be a specialist service to manage this group of service users.

There was also concern expressed about the lack of forensic community follow up for service users with a learning disability. There are also examples of late CPA reviews. This is not necessarily due to the lack of an allocated care coordinator but a combination of issues including poor administration, large case-loads, and organisational changes.

***Recommendation 6**: This is a group of service users with complex clinical histories. Some will have had contact with the Criminal Justice System and may be subject to statutory supervision. Cases should only be allocated to staff with the appropriate knowledge, skills and experience.*

Six carers and five providers raised their concerns about the lack of suitable local emergency provision for anyone with a learning disability who requires readmission to hospital. Since the closure of the Birling Centre in 2014 it is likely that an emergency readmission would result in an out of area admission. Four carers

were complimentary about the Birling Centre as it provided a safe and secure environment for their relative after a period of unsettled and disturbed behaviour in the community. They are not keen on further experiences of out of area placements.

One service user in a residential care home was concerned about a lack of suitable move on accommodation as he would like to be near his parents, but there isn't anything that would be appropriate in that area of the county. This issue was also mentioned by five providers.

They feel that many service users have complex histories and that the step down from residential care to supported accommodation is currently too great for them. One manager felt that the gap between residential care and supported accommodation was far too great for many of his residents and that gap needs to be filled by appropriately commissioned services.

***Recommendation 7**: Commissioners in Kent should give serious consideration to the creation of enhanced supported accommodation as part of the Transforming Care pathway.*

D. Have the current costs of after-care decreased from the costs at the point of discharge?

The KCC finance department have continued to improve the quality of the information held on the database, and regular meetings have been set up to ensure that current and accurate information is available which informs the Transforming Care Board about the cost of each care package. The number of service users discharged under the Transforming Care Programme now stands at 44.

KCC finance have struggled to obtain information at the point of discharge and often were only aware of a discharge under the Transforming Care Programme when payment costs began appearing on the KCC Oracle system. This could be some months after the service user was discharged from hospital.

They have also not been informed of NHS costs so have not been clear in many cases of the proportion of the total local authority and NHS costs per care package. This has made it difficult to establish the total cost of the programme.

Finance have obtained a SWIFT printout of all the care packages under Transforming Care and have been able to compare current costs to those at the point of discharge. The initial finding is that there has been very little reduction in the cost of the after-care packages.

When contacted care managers and care coordinators stated that cases may show a slight reduction in costs as some have been 'tweaked'. However the general response from them which is borne out by the work of KCC finance is that packages remain mostly unchanged.

The current review process means that packages of care can remain unchanged for considerable periods of time. Some of the packages are high cost and that there needs to be a change in the frequency of the reviews if there is to be accurate monitoring of the delivery of these packages of care, appropriate changes made according to client need and costs adjusted accordingly.

It must be said that this group of service users have complex needs and this is reflected in the cost of their after-care. It is essential that we regularly check to ensure that the packages of care are appropriately commissioned, that they are being delivered and that they meet the needs of the service user. The only way to ensure this is to review them on a more frequent basis and ensure that these reviews are robust. Whether the reviews should be carried out by the care manager or care coordinator is an issue that should be considered. At the moment the lack of continuity of allocated professionals appears to impact on the regularity of reviews, and when the review is carried out by a new worker it is quite possible that a lack of knowledge of the case means that changes to the package are less likely to be suggested.

***Recommendation 8**: KCC should consider whether all service users discharged under Transforming Care should be supervised by a central specialist team rather than by local care managers or care coordinators.*

E. Does each individual have an identified representative from the relevant community learning disability or mental health team who reviews their care, has the appropriate skills to manage the case and has completed the statutory reviews?

It became clear that care managers and care coordinators change on a regular basis, and it was soon apparent that the care manager or care coordinator who had been involved in the discharge process was no longer the allocated professional at the time of this review project. Most cases did have an allocated care manager or care coordinator but quite often they were new to the case and the latest review would be their first meeting with the service user.

One case is currently being held by the duty team and as the review project has proceeded there have been changes, and in some cases more than one. This is not to suggest that care management reviews and care programme approach reviews are not taking place, but it can mean that they are delayed. Also, it can be the case that a review can be the first time that the provider and the service user have met the allocated worker. This can unquestionably lead to a lack of continuity.

Four relatives complained of constant changes of worker and a lack of contact with KCC or KMPT. Eight providers have also said this and suggest that this may mean that reviews are not occurring as frequently as they should. It has also been said by one provider that unqualified staff have been sent to reviews either because the allocated worker is unavailable or because the review has come at a time when the case needs reallocation. I attended two reviews that were led by an unqualified care manager assistant.

There have been concerns expressed by providers that the mental health trust seems to be having staffing problems and that allocated care coordinators are not very 'visible'. One provider stated that their attendance at statutory Mental Health Review Tribunals or Managers Hearings cannot be guaranteed. Communication with providers, service users and relatives could be much improved. I have been informed of a service user who doesn't know the identity of his statutory supervisor under Section 42 of the Mental Health Act (Ministry of Justice Supervision), and another who has struggled to establish the identity of her care coordinator at a time when her CPA Review is three months overdue.

At the beginning of the review project I found that many of the names that were given as the allocated professional were wrong and it took some time to obtain up to date information. When emails were sent to the worker responses were slow and even between updating the list and contacting the worker there were occasions when I found that there had been another change. One would hope that the significance of Transforming Care would ensure that priority would be given to this group of service users, but care managers and care coordinators are managing very large case-loads with conflicting priorities. Knowledge of Transforming Care seemed to be rudimentary and when asked if they had received any training many said that they had not. KCC has had a major reorganisation during the last few years and this was cited by staff as a reason for the lack of continuity of worker and for the inability to attend training on Transforming Care.

***Recommendation 9**: The training programme for Transforming Care should be reviewed.*

F. What is the frequency and range of MDT of support to the individual from the locality community teams?

One service user did complain about continuity and changes of worker. Eight providers and four relatives said much the same thing and feel that

although reviews do take place they are not always to time. There also appears to be some uncertainty about which team is involved and whether it is the CMHT from the mental health trust or the integrated CLDT from the local authority.

Most of the service users had been detained in hospital under the Mental Health Act and are subject to Section 117 after-care. They have complex histories and diagnoses, and in many cases can present risks both to themselves and to others. A number have committed offences and five are subject to statutory supervision by the Ministry of Justice under Section 42 of the Mental Health Act or monitoring and supervision via MAPPA, SHPO and the Sex Offender Register. Five others are subject to supervision under a Community Treatment Order (CTO) and five others were originally supervised under a CTO before it was discharged.

One service user and her relatives have raised concerns about the range of MDT support available.

A recommendation had been made as part of her discharge plan that she should be followed up by the eating disorder service and the psychological services. This had not happened, and the provider in this case has suggested that access to local psychological services is affected by the length of waiting lists. This service user was placed back in Kent after a long period of out of area inpatient treatment and was placed with clear treatment recommendations. It has been difficult to facilitate these recommendations.

Given that many service users have complex mental health histories one care manager voiced some concerns that these cases may be closed to the local CMHT and managed by the local adult services team, or that if still open to mental health the transfer to the local CMHT may be delayed. There are delays transferring CPA responsibility to the CMHT local to the placement if they have been managed and placed by a team from another part of the county. These issues have raised anxieties for providers if there is a clear mental health history, and mental health support is being provided from a distance. One care coordinator is currently trying to arrange a handover CPA review to the CMHT which is local to the placement after managing the case at distance for nine months.

Some service users are placed in residential homes where the provider has a contract which includes the provision of in-house multidisciplinary support, but local services remain involved in a care management or care coordination role. These providers have MDT support and there are fortnightly multidisciplinary meetings held which have regular input from other disciplines. Three such service users have mentioned the importance to them of regular sessions with the psychologist. It has been suggested that liaison between this in-house provision and local services could be better. The management of the service user under the mental health act still requires local input from KMPT and according to providers this could be better.

Generally, care managers, care coordinators and providers who have contributed to the review think that the frequency and range of MDT support is acceptable, but could be improved if there was more clarity about areas of responsibility. One service user also was unclear why his case was closed to KMPT once his CTO was discharged.

***Recommendation 10**: The discharge planning process begins in hospital with the Care and Treatment Reviews. NHS Care & Treatment Reviews: Policy and Guidance (Appendix 2) sets out the 10 discharge standards which should be met by effective use of Person Centred Planning.*

G. Is the provider providing capable and sustainable support to the individual despite their needs?

I have attended seven reviews, and undertaken a survey of 11 discharges in 2017/18. I have also liaised directly with 28 care managers and care

coordinators and they are of a view that most placements are satisfactory and that providable and sustainable support is being delivered. There is a range of provision on offer which is designed to meet the needs of a group of service users with complex needs. They also talk of the experience of some of the providers who have been managing service users with complex histories and challenging behaviour for many years.

Many of the 44 service users are placed in residential care and some of the placements include the provision of a multidisciplinary team. There are providers who specialise in dealing with service users with a learning disability who also have mental health problems. It is essential that these providers have a full understanding of the issues involved and that they have all the necessary information available to enable them to manage some of the complex behaviours that are presented.

Four providers did say that they sometimes do not receive all the information that should be available to them. It is necessary that they communicate effectively with the local authority and with the mental health trust and that they are also able to feel confident that support from those agencies and from primary care is available when required. Four providers have stated that they do feel "left to their own devices" at times and the lack of continuity of care managers and care coordinators and their inability to visit as often as providers would like does leave them feeling isolated.

***Recommendation 11**: Case holders must ensure that information relating specifically to risk and which would affect the providers ongoing ability to provide capable and sustainable support should always be shared.*

All 14 carers interviewed are relieved that their relatives are no longer detained in hospital and see that as the greatest positive of their placement in the community. Most are satisfied with the placement and praise the efforts and the quality of support provided. One carer has felt the need to request copies of reports to satisfy herself that her son has an active programme and that his needs are being met. They have some issues that they would like to see addressed and five carers would like to see an improvement in the communication from the provider, and one suggested a more imaginative use of activities and more support to get involved in occupational activities in the community.

Of the 16 service users who have had a face to face interview only one said that he doesn't like his placement. His view was not shared by the two other service users at this facility who were interviewed, and his opinion may be coloured by the fact that he says that he did not want to return to Kent when he originally left hospital.

H. Has the placement been appropriately commissioned and is there evidence of:

- Person Centred Planning
- A detailed placement specification incorporating the PCP and clinical and risk assessments.
- Training, skills and experience of the provider that is matched to the provider requirements in the placement specification
- The support plans and commissioned hours matching the assessed needs of the client.

When considering appropriate and effective commissioning I looked most closely at 11 discharges from hospital which took place in 2017/8. I hoped that by focussing on recent discharges the care manager/care coordinator involved in the discharge planning would still be in post, and that there would be a completed placement specification form (This had been developed by the commissioning manager/transforming care lead) I also met with Sue Young the National Health Service England case manager who leads some of the Care and Treatment Reviews at the hospitals.

Person Centred Care Planning: There was clear evidence of person centred care planning. In all the 11 2017/18 discharges reviewed the service

user was fully involved in discussions about the proposed placement. Sue Young confirmed that Service users are always invited to their CTR's and that most choose to attend.

There was evidence that service users were fully supported. One was finding the process quite upsetting as identifying a placement was proving difficult. Her VoiceAbility advocate therefore took an active role in supporting her. Two service users were placed out of area, and they were fully involved in the discussions about their future placements. One could not return to Kent because of victim issues, and the other wanted to live closer to his parents in the southwest. Both gave consent for their teams to seek placements and were fully involved throughout the process. They also both consented for their clinical and personal information to be shared with the mental health services who would take over their management.

Service users were given as much choice as possible and all 11 had the opportunity to meet staff and visit their proposed placements before discharge. They were fully involved in the discharge process and consulted about potential placements. Carers were also as involved as possible.

Placement Specification: The placement specification form produced by the Commissioning Manager of Kent Integrated Learning Disability Services was not used in any of the 11 2017/18 discharges.

However, it was clear that all discharges had followed full multidisciplinary and multi-agency discussions which relied upon comprehensive clinical and risk assessments to inform decisions regarding the most suitable type of placement. Sue Young confirmed that discharge plans were always formulated after considering full multidisciplinary reports and needs assessments which would be presented at the Care and Treatment Review. They also have the chance to discuss their discharge plans at multidisciplinary ward rounds and at CPA Reviews. CTR's should work alongside the CPA process.

One case required the use of an independent assessor to recommend an appropriate placement as the family were unhappy with the proposed care pathway. There were also diagnostic issues, and once these were resolved an appropriate placement was found.

The placement produced a very detailed specification which demonstrated that the service users' needs could be appropriately met.

Recommendation 12: *The Kent and Medway Transforming Care Programme Person Centred Placement Specification form must be used in all cases. The form must be recirculated to all teams to ensure its use.*

Training, Skills and experience of the provider: All the Care Coordinators and Care Managers involved in the 2017/8 discharges were satisfied with the outcomes. They were guided by knowledge of the commissioning team and often the discharging hospital had previous experience of the proposed provider. In three cases the commissioners had already identified the most appropriate placement in advance of the care manager or care coordinator.

The review of 2017/18 discharges didn't establish how much information care managers and care coordinators have about the training, skills and experience of the provider. In many cases the original choice of placement was the

only one available. The placement chosen was usually at the recommendation of the hospital team, the commissioners or the care manager/ care coordinator and those choices were based on previous experience of working with the provider and confidence that they were able to meet the needs of the service user. In two of the 2017/18 cases the choice was not based on previous use of the placement as the service user was placed out of area. In those instances, liaison with local health and social care providers plus personal assessment of the placements being offered reassured those involved that the provider had staff with the necessary training, skills and experience to meet the needs of the service user.

***Recommendation 13**: Staff who are seeking to identify placements should always consult the Commissioning Team.*

The support plans and commissioned hours matching the assessed needs of the client.

Care managers and care coordinators did not express any concerns about the choice of placement, and despite the lack of a detailed placement specification form feel that the process worked effectively with the local authority and Clinical Commissioning Group (CCG) leading the discussions. There were full multidisciplinary meetings held at the hospital where clinical issues and risk factors informed the discharge plans and the choice of placement. Service users and relatives were as fully involved as possible, and advocacy services used when required.

I have had meetings and correspondence with 28 Care Managers/Care Coordinators and all were satisfied that the support plans that were put in place were appropriate and agreed after considerable in-depth discussion.

Providers were of the view that the commissioning process is effective and that the different stages of the transition process from initial referral through to discharge from hospital ensures that the service user is ready to move in to their placement. Providers also stated that they were satisfied that the assessment and subsequent familiarisation process ensured that the agreed package of support would match the needs of the client.

Discussions about the 2017/18 discharges and about earlier placements under Transforming Care raised some concerns about the transition process. 13 providers said that they felt that the transition process is too long and therefore costly. They recognise that this group of service users have complex needs, are detained under the Mental Health Act, and that there are various reasons why the client cannot be immediately discharged and that there must be a thorough assessment and familiarisation process if the placement is to proceed.

However, they feel that this comes at a cost to the provider that can be prohibitive, particularly if the provider is one of the smaller ones. There is the initial cost of their visits to the hospital to carry out their assessment. If they then agree that a placement would be appropriate there is the cost of keeping a vacancy in order that the client is able to have day visits followed by overnight leave. The transition process can take months and represents a considerable loss of revenue.

Recommendation 14: *The local authority and the NHS commissioners should develop a whole systems approach to the funding of the transition process.*

One provider also raised the issue of readmission, and the cost of support that might be needed from the provider if the vacancy is being held. Providers also have concerns about the funding process and three specifically mentioned the length of time that can be taken before funding is agreed. They also spoke of unacceptable delays in receiving payment. One stated that there was a problem with the Financial Activation Notice, and four complained of slow payments from both the local authority and the NHS. Three also

mentioned the different invoicing and payment cycles of the local authority and the NHS.

Five carers also raised their concerns about the length of time that transition takes and how keen they were to leave hospital. Four service users said that said that they hated hospital and couldn't wait to move. Four others said that it took far too long for their move to take place and two complained about funding difficulties which slowed the process. It must be said though that there were no major concerns raised by service users or carers about the placements or the support plans that have been put in place.

The effectiveness of the discharges in 2017/18 reflects the way in which the process has been developed and refined since the beginning of the Transforming Care Programme. This is demonstrated by a discharge which took place in 2015 where the provider was told by the hospital on the day of a scheduled visit that the service user was in fact being discharged and would be left at the placement. There have been no recent examples of such practice.

5. Conclusions

The Transforming Care Review project began in October 2017. The task was to review all the Kent patients who had been discharged from hospital under the Transforming Care programme. At that point the number stood at 35, and the effectiveness of the programme can be illustrated by the fact that the number of discharges has increased to 44 as the review has progressed.

I have had the opportunity to meet service users, carers, providers and professionals with first-hand experience of the Transforming Care Programme and have been pleased with the positive responses that I have received, both to my initial request to meet and to the questions put at interview. Everyone who has contributed has been positive and upbeat about the success of the programme in facilitating the discharge of a group of service users with complex needs and challenging histories who in many cases have spent considerable lengths of time in secure institutional care. For many the very fact that the service user has been discharged from hospital is success in itself.

The review set out to obtain the views of everyone involved to establish whether the Transforming Care process was effective and the interviews and the analysis of the 2017/18 discharges were intended to highlight areas where the programme was succeeding and identify where improvements could be made.

As stated above there have now been 44 people discharged under the Transforming Care Programme, and this number is set to increase noticeably as new facilities being developed through the work of the integrated commissioning team together with local providers come on stream during the next year.

During the programme there has only been one example of a failed placement with the person involved committing an offence and being imprisoned. There have been no readmissions to hospital. That represents a major success as this is a very challenging group of individuals with complex needs, and difficult histories.

Many discharges could be described as examples of positive risk taking combined with detailed and comprehensive care planning and effective support and supervision in the community.

The review has confirmed that the programme has been very successful in facilitating the discharges of a large group of people who might still in hospital but for the positive approach and commitment of the Kent and Medway Transforming Care Partnership, the leadership of the Executive Board and the commitment of all involved in delivering services. The review has also detailed areas which could be improved and includes suggestions and 14 recommendations about how changes could be made.

The discharge process begins at the hospital, and carers have commented about the quality of inpatient care provided, and about the difficulty that they have in sustaining their relationship with their family member at distance. They have also commented that this isolation is exacerbated by the quality of the communication from the hospital and not improved by the communication with services in Kent who are also some distance from the hospital.

Service users, carers and providers have all commented on the length of time that transition takes. It can take a considerable time for placements to be identified, particularly when there are disagreements about where someone should be placed, and then for funding to be agreed. Resolving whether there should be single agency or joint local authority and NHS funding can take time as can the internal discussions within KCC when there are diagnostic issues which can require the involvement of the local mental health services. Once the placement is identified and a discharge programme put in place there is then the problem of protracted periods of leave. It is obviously crucial that leave is facilitated to ensure that a placement is an appropriate one, and to put all the elements of the Care and Support Plan in place, but this does come at a cost to the provider who must keep a vacancy throughout the leave process to enable the service user to have day visits and then overnight leave. Providers are also concerned about the amount of information that they receive when referrals are made, stating that they occasionally only discover important details about the service user after they have been discharged from hospital.

The constant changes of care manager and care coordinator have been raised by some service users, carers and providers. There have been many examples of this as the review has progressed, and there are many reasons for this both within KCC and KMPT. The obvious one is the volume of work that both organisations have and the size of caseloads. There have also been internal reorganisations, and in addition there have been problems in filling posts which have placed further pressure on teams. KCC has been taking positive steps to address the recruitment problems.

It has been suggested that this complex group of service users should receive a specialist community service particularly as many have a forensic history. Unlike service users with mental health problems discharged by the forensic service, here is no forensic outreach service provided for people with a learning disability, nor is there a community forensic service. For service users with a dual diagnosis there is confusion for service users, carers and providers about how decisions are reached about who will manage a case in the community. They also suggest that this lack of clarity is demonstrated by poor communication between organisations.

The review process following discharge also has its weaknesses, with care management reviews only being carried out annually by KCC, unlike service users being managed by KMPT who have 6 monthly reviews under the Care Programme Approach, The local authority funds virtually all the 44 people discharge under the Transforming Care programme either fully or in part, so it is essential that the local authority monitors and reviews Care and Support Plans to ensure that they are appropriate and cost effective. This responsibility is delegated to staff seconded by KCC to KMPT when the case is managed by the mental health services.

Although this group of service users receive a six monthly review of their clinical progress under CPA, it is difficult to establish whether their Care and Support Plans are also being reviewed within the CPA framework. KCC is looking to address this issue during the next few months.

The success of the programme has resulted in a large group of service users with differing needs and abilities being discharged from hospital. The placements have all demonstrated a commitment to providing a caring and

supportive environment in which the service user can continue to develop their personal skills and become as independent as possible. Opportunities within the community for social and vocational day activities are harder to come by and carers have spoken of limited opportunities. Providers facilitate social activities as much as they can but there is a need for more vocational support to encourage and enable service users to use their time more creatively. The Transforming Care Forums in East Kent which are facilitated by the Skillnet Group (a learning disability charity which supports self-advocacy) have highlighted this issue. The forums are attended both by people who are still in hospital and people who have been discharged into the community under the Transforming Care Programme.

A key finding of the forum is that people discharged under Transforming Care feel less restricted or constrained but are asking "is this all there is?" They would like the chance to have a more active community life and are asking for more vocational opportunities. In Kent there are locality forums where KCC and providers meet to discuss issues arising from the Transforming Care Programme, and it is recommended that the provision of supported employment is a standing agenda item.

There were three key questions facing the Transforming Care Review Project, which were the basis for the interviews:

- Has the transforming care programme succeeded in improving service users' quality of life?
- How has this been achieved?
- What more needs to be done to improve community services and reduce the need for people diagnosed with a learning disability or autism being admitted to hospital.

Has the transforming care programme succeeded in improving service users' quality of life?

The view of service users and carers is that this is certainly the case. Many were very unhappy with their treatment in hospital so to be discharged was inevitably going to be seen by them as an improvement in their quality of life. This is a great positive, but discharge should not be the end objective, and remaining out of hospital and presenting few problems should not lead to an assumption that all has been achieved.

My meetings with service users, carers and providers confirmed that there is much to be commended about the changes in, and improvements to the circumstances of this group of people. They now have much more contact with their families, and in some cases have re-established regular contact with certain family members who they hadn't seen for some time. Although some are still subject to formal supervision, they have more freedom to become involved in community activities and do not feel as constrained. Some service users have made enough progress for their level of supervision to be reduced (Community Treatment Orders being discharged) and others are being considered for step down from residential to supported accommodation.

How has this been achieved?

There is no doubt that the move to integrated commissioning has had a positive effect and driven the transforming care programme. The implementation of the Care and Treatment Reviews has resulted in a more person-centred discharge focused approach, and has seen commissioners working actively to support care managers and care coordinators to facilitate discharge plans.

The discharge process has been streamlined and improved and providers feel that they are more involved in the process. The introduction of the CCR's has also given them the confidence to manage risk and offer placements to people who they may have turned down before.

Commissioners are also encouraging positive risk taking and supporting care managers and care coordinators to make creative use

of existing resources and developing care packages to enable people to be placed who once would have been considered not to fit the profile of the placement.

Providers have also demonstrated a commitment to this group of people despite the challenges that they face. The complexity around history, diagnosis and behaviour has not deterred them despite the difficulties faced by KCC and KMPT in providing regular and consistent support. Most carers are satisfied with placements and praise the efforts and quality of the support provided. They do have some issues that they would like to see addressed including an improvement in the communication from the provider, more imaginative use of activities and more support to become involved in occupational activities in the community.

What more needs to be done to improve community services and reduce the need for people diagnosed with a learning disability or autism being admitted to hospital?

The success of the Transforming Care programme is evident with 44 people having been discharged into the community and only 1 placement failing. This is a group of service users with complex needs, multiple diagnoses and histories of challenging behaviour. Some have forensic histories and are subject to formal multi-agency supervision in the community. We now need to consider what more can be done not only to sustain this success but to improve on current performance and widen the range of services on offer in the future.

Service users and carers have both said that they are pleased that discharge has been facilitated and that progress has been made in the community. The next question for many has been "what happens next?"

The type of accommodation that is available is an issue, and there appear to be gaps in the care pathway which result in limited choice. There are some service users who have been discharged to residential care who will both

want and need to move on in the future if they continue to display a consistent level of progress and remain well and present no behavioural problems. Their current placements provide considerable support and can include the provision of a Multidisciplinary Team to meet their clinical needs. However, these service users have quite well established daily living skills and in their current residential care environment have limited scope to enable them to develop more independence. They continue to require supervision but would benefit from having more personal space and responsibility.

The forensic mental health service has worked in partnership with a local provider and the commissioners to develop resources which provide an enhanced supported accommodation service. This provides individual flats or bedsits within a block, with the provider providing support and 24-hour supervision seven days per week, and communal areas for residents who want to spend time with staff or other residents. This model enables residents to have more personal space, cater for themselves and manage their day to day activities. I would recommend that commissioners consider developing this type of accommodation for service users who are ready to step down from residential care.

Vocational support is also required. There seem to be limited opportunities for service users and providers would like to be able to offer more choice for their residents. Social activities are essential to enable and support community inclusion, but there are service users who want

to develop their skills and ultimately undertake initially some voluntary work to establish whether they could be considered for paid employment.

There is also the need to consider how this group of service users are supported in the community. There seems to be confusion for service users, carers and providers alike about how decisions are reached about funding, and community follow up.
The forensic service provides outreach to people with mental health diagnoses who are discharged from secure care. Currently this service is not available to those people with a learning disability and/or autism who are discharged under Transforming Care. This gap in provision needs to be addressed as many of this group of service users have complex histories and some are subject to formal statutory supervision. The lack of involvement of the forensic service is something that providers have mentioned. They would feel more confident about managing this challenging group of individuals with specialist support. It would also hopefully provide the continuity that local teams are struggling to deliver, and they would feel more comfortable if they were able to work alongside the forensic service before assuming case responsibility following a seamless handover.

In conclusion I would like to offer the following positive comments about the performance of the Transforming Care programme in Kent during the course of the review project.

1.The programme has proved to be very successful with the number of discharges from hospital increasing from 35 to 44.

2. Only one placement has failed.

3. There is clear evidence of positive risk taking.

4. All service users and carers who contributed to the review felt that their quality of life had improved.

5. There is clear evidence of full multidisciplinary person-centred discharge planning.

6. Integrated commissioning has had a positive effect on the discharge process with Care and Treatment reviews providing a commissioner led and therefore less clinically driven discharge process.

6. Integrated commissioning has had a positive effect on the whole discharge process with CTR's providing a commissioner led and therefore less clinically driven review process.
It is essential that all 14 recommendations are agreed by the Kent and Medway Partnership Board and that an action plan and an implementation plan with named individuals is agreed and monitored by the board in order to continue to meet they needs of the individuals who have already benefited from this programme and for future people having the support to live an ordinary life in the county of Kent.

Appendix 1

Kent and Medway Transforming Care Partnership

Kent Cohort Review – Project outline - 2017

Project Description

To plan and undertake an independent review of all Kent patients discharged under the Transforming Care programme to date to determine if the programme is delivering better outcomes and/or quality of life for individuals, that integrated commissioning activity, provider delivery and specialist health and social care assessment and review are meeting the programmes requirements and the provision is providing value for money for commissioners.

Project Approach

A collaborative approach to the review of each patient with care providers, care managers/community based clinicians and CCG/KCC commissioning.

The approach will include a mix of table top reviews and face to face visits to the individual and provider as appropriate.

This TC cohort Review will dovetail with existing KCC projects aimed at reviewing support packages to avoid duplication of work

- KCC has 3 assessment tools that care managers use for assessing care and support needs; one for residential service and two for individuals that live in their own tenancies, one for support that would be in a shared property and one for individuals that live on their own.
- Targeted Interventions; this project is looking into support that is delivered above core on a one to one basis so all individuals that have commissioned support on an additional basis will be reviewed

Project Scope

The project will cover 35 patients (as at 04/07/17) for which KCC are commissioning aftercare support.

Reviews will be carried out on a provider by provider basis. There are nineteen providers including

- Craegmoor (1)
- United Response (1)
- LDC Dover (2)
- Cartref Homes Ltd (2)
- Sequence Care (5)
- CMG (1)
- Elysium Supported Living (1)
- CLBD (1)
- Nexus Programme Ltd (1)
- Caretech (2)
- Insight Partnership (2)
- Optima Care (8)

- Holly Lodge (1)
- Frontline Assoc Supported Tenancies (1)
- Bayview Care (1)
- Oaklands (1)
- Voyage Care (2)
- Phoenix House (1)
- Langley House Trust (1)

Duration of Project

Reviews will be carried out over a 3-4 month period from August 2017 with a report of findings drafted by December 2017.

Project sponsor

Penny Southern – KCC Director of Mental Health, Learning Disability and Disabled Children

Project Outcomes

1. A summary of each individual's care and support that addresses the following

- Current care package meet the needs of the individual.?
- Quality of life has improved for the individual (Community integration/participation)
- Level and range of risks presented/described as in-patients have decreased/not presented in the community
- Current costs of aftercare have decreased from costs at the point of discharge?
- Each individual has an identified representative from the relevant community LD or MH team reviewing their care, who has the appropriate skills to manage the case and has completed the statutory reviews?
- The frequency and range of MDT of support to the individual from the locality community teams? i.e. labour intensive aftercare?
- The provider can provide capable and sustainable support to the individual despite their needs?
- The placement has been appropriately commissioned i.e.
  - Evidence of Person Centred Planning (patient/family views of type and location)
  - The choice of placement was based on a detailed Placement Specification that incorporates the PCP and clinical and risk assessments.
  - The training, skills and experience of the provider is matched to the provider requirements in the placement specification
  - The support plans and commissioned hours match the assessed needs of the client

2. A summary statement of the impact of the overall programme on individuals lives.

Link to other projects

The quality and outcomes research unit at University of Kent, continues to work on a scoping review for a larger evaluation of the quality of life and quality of care outcomes experienced by people with learning disability, autism or both as they move into the community from inpatient services, as well as those who are at risk of moving into inpatient services. The

Department of Health have now advertised for the main evaluation of Transforming Care with the main emphasis on quality of life and quality of care.

Commissioners will meet with representatives from the UoK to explore opportunities for linking this project with the wider national project commissioned by the DH.
Jimmy Kerrigan

28/7/17

Appendix 2 - Recommendations

1. The creation and management of an accurate and up to date database is essential.

2. There is a need for more regular reviews given the complexity of these cases. The frequency of reviews (1,3 or 6 monthly) should be agreed and evidenced in supervision by the case holder.

3. In the care plans there must be evidence that robust discussions have taken place concerning the suitability of activities requested by a service user who is subject to supervision.

4. When considering suitable community activities for service users there must be evidence that robust risk assessments have taken place.

5. Professionals involved in the discharge of a patient from hospital should ensure that all relevant clinical information, (particularly information relating to risk (including lessons learned from SI investigations) is made available to the service managers of possible placements to ensure that the appropriate provider is identified.

6. This is a group of service users with complex clinical histories. Some will have had contact with the Criminal Justice System and may be subject to statutory supervision. Cases should only be allocated to staff with the appropriate knowledge, skills and experience.

7. Commissioners in Kent should give serious consideration to the creation of enhanced supported accommodation as part of the Transforming Care pathway.

8. KCC should consider whether all service users discharged under Transforming Care should be supervised by a central specialist team rather than by local care managers or care coordinators.

9. The training programme for Transforming Care should be reviewed.

10. The discharge planning process begins in hospital with the Care and Treatment Reviews. NHS Care & Treatment Reviews: Policy and Guidance (Appendix 2) sets out the 10 discharge standards which should be met by effective use of Person Centred Planning.

11. Case holders must ensure that information relating specifically to risk and which would affect the providers ongoing ability to provide capable and sustainable support should always be shared.

12. The Kent and Medway Transforming Care Programme Person Centred Placement Specification form must be used in all cases. The form must be recirculated to all teams to ensure its use.

13. Staff who are seeking to identify placements should always consult the Commissioning Team.

14. The local authority and the NHS commissioners should develop a whole systems approach to the funding of the transition process.

Appendix 3 - Acknowledgements

It has been a pleasure to work with all the people who have contributed to the completion of this report. I would like to extend my thanks to all the service users and their relatives who were willing to describe their experiences, and to the many staff from Kent County Council and the Kent & Medway NHS and Social Care Partnership Trust who have been involved.

I would also like to thank the following individuals and organisations:

James Kerrigan - Commissioning Manager of Kent Integrated Learning Disability Services
Cheryl Fenton - Assistant Director of Mental Health Kent County Council
Stuart Day - Senior Accountant Kent County Council
Troy Jones - Commissioning Officer Kent County Council
Hannah Chandler - Administration Officer for Transforming Care Kent County Council
Sue Young - Case Manager Specialised Commissioning NHS England
Matt Clifton - Chief Executive Skillnet Group
Keith Wyncoll - Project Lead for Transforming Care - Skillnet Group
Chris Beaney Assistant Director of Community Learning Disabilities Team Kent County Council

Voyage Care
Learning Disabilities Care (Dover)Ltd
Scott's Project Trust
Insight Specialist Behaviours Service Ltd
Optima Care
Sequence Care
Cartref Homes UK Ltd
Langley House Trust
CLBD (Changing Lives Building Dreams) Ltd
Frontline Associates Supported Tenancies
Bay View Care
Care Management Group Ltd
CareTech Community Services Ltd
Little Oyster Ltd
United Response
Avenues Trust
Harbour Homes
MCCH (Maidstone Community Care Housing Society) Ltd

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From:	Graham Gibbens, Cabinet Member for Adult Social Care and Public Health Penny Southern, Corporate Director of Adult Social Care and Health
To:	Adult Social Care Cabinet Committee – 27 September 2018
Subject:	**DEVELOPMENT OF THE FUTURE PROVISION OF SOCIAL CARE AND SUPPORT FOR ADULTS WITH MENTAL HEALTH NEEDS**
Classification:	Unrestricted
Past Pathway of Paper	Adult Social Care Cabinet Committee – 9 June 2017
Future Pathway of Paper	None
Electoral Division:	All

Summary: This report provides an update on the progress in achieving the roadmap for the future provision of social care and support for adults with mental health needs. The programme of change is in response to the changing strategic and commissioning landscape at national and local levels as set out in the report previously presented to the Adult Social Care Cabinet Committee.

Recommendations: The Adult Social Care Cabinet Committee is asked to **CONSIDER** and **COMMENT** on the progress to date in developing the new mental health social care operating model, including the transfer of the line management of mental health staff from the Kent and Medway Mental Health Partnership Trust to Kent County Council.

1. Introduction

1.1 The purpose of this report is to provide an update to the Adult Social Care Cabinet Committee, by setting out the changes the Council is making to deliver social care and support to adults with mental health needs, in the context of the system wide integration agenda, exemplified by the Your Life Your Wellbeing (YLYWB) Transformation Programme and the Kent and Medway Sustainability and the Transformation Plan (STP).

1.2 The changing landscape for the commissioning and provision of health and social care support services provides a unique opportunity to introduce a new operational model, to deliver integration at an individual, service and organisational level.

1.3 There is a renewed focus on implementing commissioned support services which are based on the expressed objectives of improving outcomes and well-being of individuals. Current models of care, developed through co production

and delivering these objectives include Live Well Kent, the Primary Care Social Work Service and the Kent Enablement and Recovery Service.

1.4 Kent County Council (KCC) and Kent and Medway NHS Partnership Trust (KMPT) adopted a project approach to deliver the transformation programme required to achieve the agreed operational model. This commenced in January 2018 and the first phase of the changes including the transfer back of the line management of KCC staff in Community Mental Health Teams will take place on 1 October 2018. Implementation plans have been developed across all key considerations including workforce, stakeholder engagement and communication; information sharing; systems solutions and governance. Healthwatch has been engaged throughout. There have been two additional workstreams focusing on the Approved Mental Health Practitioner (AMHP) service and Kent County Council only considerations e.g. Out of Hours (OOH) service arrangements.

2. Policy Context

2.1 The national policy and local context for the developments in partnership working in KCC mental health services are outlined in the previous report to Adult Social Care Cabinet Committee. The current key themes of the Council's vision for Adult Social Care are:

- **Promoting wellbeing** – supporting and encouraging people to look after their health and wellbeing to avoid, or delay, them needing adult social care.
- **Promoting independence** – providing short-term support so that people are then able to carry on with their lives as independently as possible.
- **Supporting independence** – for people who need ongoing social care support, helping them to live the life they want to live, in their own homes where possible, and do as much for themselves as they can.

2.2 Five Year Forward View (5YFV)

2.2.1 In February 2016 the Mental Health Taskforce published "Five Year Forward View for Mental Health: An independent report of the Mental Health Taskforce." The key recommendations in the strategy were:

- Inequalities must be reduced to ensure all needs are met, across all ages
- Care must be integrated – spanning people's physical, mental and social needs achieved through partnership working across the NHS, public health, voluntary, local authority, housing providers, education and youth justice. Integrated population-based commissioning will combine health and social care spending power to improve mental health outcomes
- Access to high-quality services close to home: ensuring that local community services are immediately available so that people experiencing mental health crisis do not need to wait. If people need to use hospital services, they should not have to travel out of their area for the right care

- Co-production: people living with mental illness and carers should be involved in the design and delivery of mental health services
- Improved carer engagement: health professionals should be trained to involve carers. Services should also show evidence that they effectively engage with carers as part of their inspections
- Action on physical health: people with mental illness should get enhanced help with their physical health through better screening and lifestyle support. People with physical health conditions should receive better support for their mental health needs
- Health and Well-being Boards to have plans in place to promote good mental health, prevent problems arising and improve mental health services
- The right data must be collected and used to drive and evaluate progress
- Prevention and early intervention must be prioritised with rapid transformation of services for children and young people.

3. Health and Social Care Future Intentions

3.1 Sustainability and Transformation Plans (STPs)

3.1.1 As part of the planning process to deliver the 5YFV, all NHS bodies and Local Authorities were asked to produce STPs by June 2016 setting out the steps to help local organisations deliver a sustainable, transformed health service and improve the quality of care, wellbeing and NHS finances across a local health and care system. STPs cover the period October 2016 to March 2021. Substantial progress will need to be made in three key areas including:

- Improving access to and availability of mental health services, focusing on children and young people's services, specialist perinatal services and access to psychological (IAPT) therapies to meet 25% of need which is integrated into physical health pathways.
- Developing community services, taking pressure off inpatient settings by providing all age mental health liaison services in acute hospitals and increasing resources in primary care.
- Providing people with holistic care, recognising their mental and physical health needs, ensuring access to physical health checks in order to reduce the health inequality gap.

3.1.2 By 2020/21 the picture should look very different with the person at the center of integrated physical and mental health, social and third sector services, delivering seamless care and measurable outcomes with an increased choice of providers. Kent is committed to improving the care for those with long term conditions, shifting care into the community and closer to home, making care more personalised and supporting people to live independently for longer. Better coordination between different providers and across the boundaries of care is needed.

3.1.3 The Kent Clinical Commissioning Groups (CCG) are at various stages of developing both strategies and concept papers to move more resource out of secondary mental health services and further expand the service offer in primary

care. KCC is involved in these discussions and this direction of travel has been key in influencing the new operational model for mental health and the flexibility this offers to move the focus of the service to promote prevention and enablement in primary care whilst delivering KCC's statutory responsibilities.

3.2 Commissioning Intentions

3.2.1 It is the commissioning intention to further develop our Live Well Kent Model to ensure that we have a robust psycho-social model. This will enable the Council to meet its statutory obligations under the Care Act. As health resources are moved from secondary mental health services and invested into the development of an enhanced primary care model, council staff will be organised into a single mental health social care offer across primary and secondary care aligned with the Kent Enablement and Recovery Service and become fully integrated with the voluntary sector Strategic Partners to provide a seamless service to people with mental health needs as they build independence and recover.

4. Financial Implications

4.1 There are no financial implications.

5. Legal Implications

5.1 Several key pieces of legislation define the statutory responsibilities of adult social care and the most significant of these are the Care Act 2014, the Mental Capacity Act 2005 and the Mental Health Act 1983. In broad terms these set the rights of individuals and obligations of the local authority covering needs assessment, care planning, legal safeguards, provision and reviews.

5.2 In addition, there are emerging, or new laws made by Parliament that have a material impact on mental health provision. The Policing and Crime Act 2017 is the most recent legislation that falls into this category.

6. Equalities Implications

6.1 All service changes are subject to a full Equalities Impact Assessment consistent with both our legal responsibilities and the Council's Equalities Objectives.

7. Implementation of the New Social Care Operating Model

7.1 The approach adopted by KCC and KMPT to deliver the adjustments to the partnership arrangements will ensure they are fit for purpose for the future and in line with health and social care commissioning intentions. The key principle that has governed this work is that partnership working should be maintained, providing an integrated multi-disciplinary response to people who access services while delivering KMPT and KCC's statutory responsibilities. An example of one of the communication bulletins is attached as Appendix 1 and provides further details of the new operating model.

7.2 Key to achieving the joint future vision is the agreement for the Council's social care staff to be line managed and accountable to KCC. This will ensure more robust delivery of the Council's statutory responsibilities and financial management while maintaining the advantages of co-location and multi-disciplinary working with KMPT colleagues. KCC staff based in Community Mental Health Teams will transfer back to the line management of KCC on 1 October 2018. KCC staff based in the Forensic Service will transition back to the line management of KCC during the autumn of 2018. The AMHP service staff will transfer back on 1 April 2019.

7.3 The adoption of a model which provides a single mental health social care service and removes the boundary between primary and secondary care will improve efficiency and provide continuity for a person who may move between the health elements of this pathway.

7.4 There will be greater flexibility for Council services to shape the developing local care arrangements and their role within these. This flexibility will also extend to the development of joint working arrangements with a range of partners including the North East London Foundation Trust (NELFT) which provides local mental health services for Children and Young People and people of all ages who have an eating disorder.

8. Conclusion

8.1 There is external evidence from recent audits that the partnership with KMPT delivers many benefits and it is widely agreed that partnership working to deliver outcomes for the people of Kent is the right approach. However, it is essential that KCC and KMPT are equipped with a robust operating model to deliver the changing commissioning landscape at an operational level.

8.2 This will mean over time a greater investment in local community services. This could be in the voluntary sector, the social care workforce in primary care and new models of care emerging from the STP work.

8.3 The new operating model will deliver the Adult Social Care Vision along with the Council's statutory responsibilities within the financial envelope while maintaining the role of the social worker at the heart of its delivery.

9. Recommendations

9.1 Recommendations: The Adult Social Care Cabinet Committee is asked to **CONSIDER** and **COMMENT** on the progress to date in developing the new mental health social care operating model, including the transfer of the line management of mental health staff from the Kent and Medway Mental Health Partnership Trust to Kent County Council.

10. Background Documents

Adult Social Care Cabinet Committee Report Direction of Future Mental Health Provision of Social Care and Support to Adults with Mental Health Needs. https://democracy.kent.gov.uk/ieDecisionDetails.aspx?ID=2079

Your life, your well-being a vision and strategy for adult social care 2016 – 2021
https://www.kent.gov.uk/about-the-council/strategies-and-policies/adult-social-care-policies/your-life-your-wellbeing
Kent and Medway Sustainability and Transformation Plan
http://kentandmedway.nhs.uk/stp/

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

Lord Darzi's Next Stage Review
http://webarchive.nationalarchives.gov.uk/20130107105354/http:/www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_085826.pdf

East Kent Mental Health Strategy 2016-201
http://www.liveitwell.org.uk/wp-content/uploads/2016/08/EK-MH-Strategy-2016-2021-FINAL.pdf

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

Children and Young People's Emotional Wellbeing Strategy 2015
https://democracy.kent.gov.uk/mgConvert2PDF.aspx?ID=52738

Live Well Kent
http://livewellkent.org.uk/

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KCC AND KMPT PARTNERSHIP TRANSFORMATION
UPDATE AUGUST 2018

The aim of the Partnership Transformation project is to deliver a new approach which ensures an integrated and seamless service and the robust delivery of social care statutory responsibilities.

Social care staff within the Community Mental Health Teams [CMHTs] will transfer to KCC on 1st October 2018, with the Approved Mental Health Practitioner [AMHP] service transferring to KCC on 1st April 2019.

Future mental health social care workforce structure

A new KCC mental health social care structure has been agreed; highlights include:

- There will be five localities (based on existing locality boundaries):
  - Ashford and Canterbury & Coastal
  - Dartford, Gravesham & Swanley and Swale
  - Maidstone & Malling and South West Kent
  - South Kent Coast
  - Thanet

- The Primary Care and Secondary care divide will end by 1st February 2019.
- Most staff will remain in their current positions in their current locations. There will be five new locality Service Managers who will report into the Assistant Director Mental Health KCC; recruitment for these posts in underway.

Joint Delivery Model for Community Mental Health and Social Care (*operating model*)

An operating model has been agreed which establishes parallel processes for assessment to allocation and duty, which ensure a joint response when required. The model also clarifies the responsibilities of lead professionals within the CMHT.

Health and social care staff will remain collocated from 1st October 2018 to support integrated service delivery.

Systems solution

It has been agreed that in future, for inputting and accessing data, KMPT staff will use the RiO system and KCC staff will use the new KCC Mosaic system, including a RiO Information Viewer [RIV] which enables Mosaic users to view RiO data (due to 'go live' February 2019).

Between October 2018 and Mosaic 'go live', social care staff will continue to use RiO.

Further information

Partnership Transformation intranet pages are live on KNet and can be found at:

http://knet/Change/Pages/KCC-KMPT-Partnership-Transformation.aspx

31 August 2018

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From:	Graham Gibbens, Cabinet Member for Adult Social Care and Public Health Penny Southern, Corporate Director of Adult Social Care and Health
To:	Adult Social Care Cabinet Committee – 27 September 2018
Subject:	**CARE AND SUPPORT IN THE HOME SERVICES**
Classification:	Unrestricted
Past Pathway of Paper:	Adult Social Care and Health Directorate Management Team – 19 September 2018 Strategic Commissioning Board **–** 23 July 2018
Future Pathway of Paper:	None
Electoral Division:	All

Summary: To provide an update to the Adult Social Care Cabinet Committee on the progress of the Care and Support in the Home Services tender, including provider engagement and market feedback on the specification. To provide an oversight of the project's key issues and risks, and the mitigating actions being taken to manage them.

Recommendation(s): The Adult Social Care Cabinet Committee is asked to **CONSIDER** and **COMMENT** on progress of tendering for the new Care and Support in the Home Services Contract.

1. Introduction

1.1 This paper provides an update on the progress of tendering a new contract for Care and Support in the Home Services.

2. Strategic Statement and Policy Framework

2.1 The Care and Support in the Home Service links with the following strategic Outcomes:

Outcome 1 - Children and young people in Kent get the best start in life
Outcome 2 - Kent communities feel the benefits of economic growth by being in work, healthy and enjoying a good quality of life
Outcome 3 - Older and vulnerable residents are safe and supported with choices to live independently

2.2 The Care and Support in the Home Service will support the above strategic outcomes by:

a) Those with long term conditions are supported to manage their conditions through access to good quality care and support
b) More people receive quality care at home avoiding unnecessary admissions to hospital and care homes
c) The health and social care system work together to deliver high quality community services
d) Physical and mental health is improved by supporting people to take more responsibility for their own health and wellbeing
e) We keep vulnerable families out of crisis and more children and young people out of KCC care
f) Children and young people have better physical and mental health

2.3 By supporting older and vulnerable residents in Kent with assessed needs, to remain living independently in their own homes, the Council aims to:

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

3. Background

3.1 The Care and Support in the Home Service will commence from April 2019 with additional elements potentially implementing shortly thereafter. The services in scope (Home Care Services; Extra Care Support; Discharge to Assess Services; Supporting Independence Services (SIS) and Supported Living Services) deliver very similar tasks in people's homes and there is an opportunity to achieve improved consistency across the market by bringing these together.

3.2 Aligning services under one contractual arrangement will enable the Council to take a consistent and equitable approach in shaping the market to focus on the personalisation and outcomes agendas and supporting the Council's strategic outcome that 'Older and vulnerable residents are safe and supported with choices to live independently'.

3.3 The vision for Care and Support in the Home Services represents a significant change in the way that services are delivered, with improved consistency of practice and a greater focus on personalisation and outcomes-focused care. It is recognised that these changes cannot be achieved with a big-bang approach, and therefore a phased approach will be adopted to realising the long-term vision.

3.4 The first phase of the contract will bring together the services previously known as Home Care and Supporting Independence Services under the Care and Support in the Home Service Contract. This will require providers to develop their capability to deliver across a broader range of client needs and to support skills development of their workforce to enable this.

3.5 Further services will be incorporated within the life of the contract in a phased approach. Discharge to Assess and Extra Care Support hours will both be subject to further competitions.

3.6 It is proposed that new approaches to service delivery will be tested and integrated during the life of the contract. These will include:

- enabling providers to flex hours up and down according to changes in an individual's eligible needs;
- delegating statutory reviews to providers; the introduction of technology such as Electronic Call Monitoring and
- more collaborative working with health partners.

3.7 For each of these changes commissioning recommends that the change is trialled in a discrete area to test its effectiveness before being rolled out across the county and incorporated into the contract.

3.8 This phased approach to implementing the long-term vision of the Care and Support in the Home Service will enable the Council to mitigate against the risks associated with significant changes such as delegation of duties and systems changes. Clearly defined and closely managed change projects will support both commissioners and operational teams in managing the demand on their resources and assuring quality of delivery throughout periods of change.

3.9 The Adult Social Care Cabinet Committee has been asked to endorse a recommendation to extend the Supported Living element of the Supporting Independence Service (Decision Number 18/00050). The Supported Living element will be phased into the Care and Support in the Home Service in due course.

4. Stakeholder Engagement – Progress Update

4.1 A market engagement exercise has been undertaken with both existing and potential providers to deliver key messages about the new Care and Support in the Home Service Contract. This consisted of two half-day events open to all providers who registered through the portal. The agenda covered the Council's Modernisation agenda, the approach for the Care and Support in the Home Service Contract as well as providing an opportunity for providers to give feedback and ask questions of Senior Commissioners from the Council.

4.3 Providers were asked a series of questions about their existing position in the market and their interest in contracting with the Council in the future:

a) Do you have existing working relationships with other local providers?
b) Would you consider developing working relationships with other local providers?

c) Do you already have partner organisations in mind?
d) Would you like the Council to assist your organisation with developing working relationships with other providers?
e) How can the Council assist you with developing working relationships with other providers?

4.4 Providers were overall positive about the potential to work closely with partners and work towards the formation of consortia

- 97% of the providers in attendance responded that they would consider developing their working relationships with other local providers.
- 34% of providers stated that they already had potential partners in mind.
- 70% of providers were also keen for the Council to provide further support in facilitating the development of working partnerships through networking events and sharing contact information of other local providers, where consent is given for information sharing.

4.5 Engagement with the market has also been undertaken through publishing the draft Care and Support in the Home Service specification to the Portal. The specification was published on the Portal on 10 August and was live for two weeks, during which time providers had the opportunity to raise questions and submit feedback on the proposals for the Care and Support in the Home Service. Feedback from this activity has generally been positive.

4.6 The next phase of market engagement for the Care and Support in the Home Service consisted of collecting, collating and sharing of 'Pen Pictures'. Providers submitted information to the commissioning team which they wanted shared with other providers. The intention is that these provider profiles will enable the market to have a better understanding about other local providers including their expertise and their ambitions, with the expectation that this will facilitate conversations about the formation of consortia.

4.7 Commissioners are also planning a networking event in September, where they will facilitate conversations between providers who have an interest in developing their partnership working capabilities and identify potential partners for joint working. This will enable providers to better consider and evidence their partnership working aspirations in their bids for the Care and Support in the Home Service Contract.

5. Tender Documentation – Progress Update

5.1 Specification

5.1.1 The draft specification (Attached as Appendix 1) was circulated to internal stakeholders on 30 July 2018 for comments and feedback. Feedback received hs been reviewed and where necessary incorporated into the specification.

5.1.2 As outlined in the specification, commissioners will work in partnership with Adult Social Care and Health Directorate Modernisation Team to support a phased approach to achieving the vision for outcomes-focused, flexible Care and Support in the Home Services. The specification enables the Council to

look at new ways of working collaboratively with providers during the life of the contract to trial new ways of working such as flexing care; providers delivering reviews and delivering integrated care and support with health partners.

5.1.3 It is recommended that these new ways of working are incorporated to the contract as part of a phased and agile approach rather than a big-bang implementation. Bringing together Supporting Independence Service (SIS) and Home Care as one service provision already represents a significant undertaking in the implications for assuring consistency of practice for both Kent County Council and provider organisations. For each of the additional aspirations detailed above, there are significant systems and operational resource implications which need to be fully understood to assure successful implementation. Additionally, phasing these approaches in discrete areas will ensure the Council maintains control of the budgetary impacts and is able to take an evidence-based approach to the implementation of new methodologies.

5.1.4 The delivery of Care and Support in the Home Services as one aligned service provision will also require the Council to ensure that its own teams are effective in their alignment and ability to work collaboratively. Key stakeholders in the Adult Social Care and Health Directorate Modernisation and Operational Teams have provided feedback to ensure the specification meets the needs of both the Older People and Physical Disability and Disabled Children, Adult Learning Disability and Mental Health Operational Teams. Over the next few months work will continue to ensure that internal processes and practices are aligned across these teams and that providers have a consistent experience in their work with different teams.

5.2 Pricing Strategy

5.2.1 A comprehensive cost modelling exercise has been undertaken to determine the impact of a number of variables on the financial position of the Care and Support in the Home Service. These variables include considering the current differential rates across the market, approaches supporting equitable access to services across the county, consideration of rates for half hour and 45-minute calls, and social and unsocial rates.

5.2.2 In bringing together the current community-based SIS and Homecare services, the disparity in the rates paid to the respective contracted providers was considered in all cost model calculations. The pricing strategy addresses the disparity in the rates for the historical services and the price compression that has been seen in SIS since 2013.

5.2.3 To meet the strategic objective of the Care and Support in the Home Service Contract in achieving a financially sustainable provider market, with the capacity and capability to meet assessed needs regardless of postcodes, SIS rates needed to rise to those of Homecare as a minimum to enable all providers to remain equally sustainable.

5.2.4 Uplifts will be applied to some areas of the county based on Rurality Indices to support financial sustainability for providers and equitable access to services.

Areas will be defined based on Office for National Statistics Rurality Indices, which break down areas into the following categories:

- urban city and town,
- urban major conurbation,
- rural town and fringe
- rural village and dispersed

Urban areas will be paid at a standard rate, packages delivered in a rural town and fringe area will be subject to a 5% uplift on the standard cost and packages in a rural village and dispersed area will be subject to a 10% uplift on the standard cost.

5.2.5 The Lower of the Standard Support Financial Envelope was calculated based on a weighted average of contracted and non-contracted costs and 30-minute, 45-minute and hour unit costs. The top of the Standard Support Financial Envelope is 1p lower than the bottom of the Complex Support Envelope.

5.2.6 The bottom of the Complex Support Financial Envelope was calculated based on the average variance of between contracted Standard and Complex rates. The top of the Complex Support Financial Envelope was based on the average variance of contracted complex rates.

5.2.7 As referenced throughout this report, the provider market has repeatedly escalated the issue of financial viability in relation to both their unit rates and the volume of hours required to ensure their business is sustainable. As part of the tender process, providers will be asked to submit information about their financial viability thresholds in order to allow the Council to better understand and promote market sustainability.

5.3 Tender evaluation process

5.3.1 As part of the tender, providers will be asked to achieve a minimum quality score; this will be evaluated through questions surrounding Workforce, Quality, Mobilisation etc. Providers will also be asked to submit a rate within a Financial Envelope, per service provision, such as for Standard and Complex Support. Providers with the lowest rate past the Quality Threshold will be awarded a Contract. Where Lots require multiple providers, for example five, the five providers with the lowest rates who have met the Quality Threshold will be awarded a contract.

5.3.2 The proposed Quality Questions have been shared with internal stakeholders for comment and feedback, which has been collated and applied to the questions as necessary. There are eight question areas with responses limited to either 500 or 1000 words.

5.3.3 An evaluation strategy is being developed with scoring guidance for those participating in the evaluation exercise to ensure consistency of approach. It is recognised that evaluating the quality of this quantity of questions across an, as yet, unknown number of submissions is a large piece of work and should be managed with joint input from Commissioning and Operational teams. It is

intended that each question will be evaluated by a diverse panel of a minimum of three Officers.

5.3.4 Invitations to take part in the evaluation process have been extended to the Operational Teams, Workforce Officers and Modernisation Teams. Included in this invitation were target dates and an indication as to time and work commitment necessary to complete the activity.

5.3.5 Operational teams have expressed a wish to be a part of this activity; however, they are unable to commit the resources necessary i.e. having one officer to evaluate all the submissions for one of the Quality Questions.

5.3.6 Alternative methods and options for completing this activity are currently being evaluated, these include approaching former or retired staff to be part of the evaluation process or splitting Kent into sections to enable multiple staff per question. This discussion and option will need to be agreed in early September to enable staff time to be secured.

6. Implementation - Bringing together SIS and Home Care as one provision

6.1 Whilst the overall market position is strong across the county, there are distinct variations in service unit costs between SIS and Home Care. Since 2013, annual price lifts have seen a disparity of funding creep in, where Home Care Providers have seen inflationary rises in their unit costs which have gone unmatched in the SIS market. In bringing together the two services as one contracted provision, the Council must address the financial disparity and standardise the rates to ensure equity across the market.

6.2 Financial pressures in the market will be exacerbated by the additional investment needed to accommodate a shift in working culture to move towards outcome-focused delivery. Delivering differently will require extra time resources, training for skill gaps and robust oversight of care workers and significant culture change within both the Council and providers. Cost may also be impacted by the development of new processes and implementation of new systems to underpin change.

6.3 <u>Mobilisation</u>

6.3.1 Strategic Commissioning Board has supported the recommendation that the Care and Support in the Home Service Contract will not force mobilisation on the basis of reduced costs. The approach recognises the importance of continuity of care for people receiving services and provides assurance that quality of care and support provision will be prioritised above cost.

6.3.2 This approach presents challenges for providers who do not hold an existing contract with the Council. Where current contracted providers do not bid for the new contract or fail to be awarded a Care and Support in the Home Service Contract, they will still retain their existing client base to support continuity of care. This means that providers newly entering the contracted market will have

to slowly build a client base from new referrals into their contracted cluster areas.

6.3.3 Where new providers will be slowly building their client base in cluster areas during the first months of the contract and providers exiting the Contract will see their volumes of hours reducing, commissioners must carefully manage this process. Although there will not be a 'big bang' mobilisation, commissioners will need to carefully consider how they will support sustainability to avoid handbacks due to providers reaching a point of financial unsustainability.

6.4 Sleep Nights Position

6.4.1 The Sleep Nights position is informed by a paper taken to Strategic Commissioning Board in July 2018.

6.4.2 Night support, particularly within current SIS services, is provided in increasingly contentious units of delivery and subject to an ongoing court appeal regarding Care and Support Worker pay for these units. In February 2015, Her Majesty's Revenue and Customs (HMRC) changed its guidance on the treatment of sleep-in shifts and reclassified these from unmeasured time to measured time (time worked). Along with the introduction of the National Living Wage (NLW), the Council regularly receives requests from providers to increase their fees to comply with the new regulations to take account of the impact to them as the employer.

6.4.3 In November 2017, the Government launched a new Social Care Compliance Scheme for social care providers that may have incorrectly paid workers below legal minimum wage hourly rates for sleep-in shifts. Social care employers will be able to opt into the new Social Care Compliance Scheme giving them up to a year to identify what they owe to workers. Employers who identify arrears at the end of the self-review period will have up to three months to pay workers. The scheme has been designed to help ensure workers are paid what they are owed while also maintaining important services for people who access social care. HMRC will write to social care employers who currently have a complaint against them for allegedly underpaying minimum wage rates for sleep-in shifts to encourage them to sign up to the scheme. Employers that choose not to opt into the scheme will be subject to HMRC's normal enforcement approach. Back-pay spans a six-year period from 1 April 2012.

6.4.4 In July 2018 the Court of Appeal overturned the 2017 tribunal ruling and ruled that flat-rate payments for Sleep Nights were fair. The Trade Union, Unison has since applied to appeal to the Supreme Court seeking to overturn the Court of Appeal's 2018 ruling.

6.4.5 The Council has an obligation under the Care Act 2014 to ensure there is a sustainable marketplace and that the eligible needs of vulnerable people are met. In light of the potential pay liabilities, while the Council may not be contractually required to increase prior to a request, nor meet the costs of back pay, should a provider suffer financial difficulty resulting from the obligations

under pay legislation, the Council is likely to need to consider the requirements of the Care Act 2014 to ensure a sustainable marketplace.

6.5 TUPE

6.5.1 Lessons have been learned from the implementation of the 2014 Home Care Contract, when people receiving Home Care Services were mobilised to newly contracted providers where ever new providers delivered more cheaply, sometimes only by a few pence. This extensive mobilisation required significant investment of resources from both the provider market and the Council, disrupted continuity of care for hundreds of people and resulted in many people deciding to take a Direct Payment to enable them to retain their Care and Support Workers.

6.5.2 Strategic Commissioning Board has supported the recommendation that the new Care and Support in the Home Service Contract will not force mobilisation on the basis of reduced costs. Instead, where appropriate, and in agreement with the person receiving the service, contracted providers will arrange equitable swaps to support sustainable care rounds within their contracted clusters. This approach will be phased during the first few months of the contract and seeks to avoid a resource-intensive and disruptive mobilisation process.

6.5.3 As the default position will be to not mobilise, TUPE information is not being received from providers. Where mobilisation is determined to be appropriate, as detailed above, this will be managed on an individual basis.

6.6 Public consultation

6.6.1 Advice has been sought from the Engagement and Consultation Team regarding the Council's requirement to undertake a Public Consultation exercise in tendering Care and Support in the Home Services. The requirement for Public Consultation is primarily where a person is likely to lose a service or be worse off as a result of a change to a service. Given that the approach to the Care and Support in the Home Service Contract will not result in people perceiving a change to the service, commissioners have been advised that at this stage it is not necessary to engage in a full Public Consultation process.

6.6.2 However, where changes are proposed that may impact service delivery over the life of the contract, the need to undertake Public Consultation will be kept under consideration and incorporated where necessary.

7. Interdependencies - Transforming Integrated Care in the Community (TICC)

7.1 To progress the health integration agenda, EU funding has been secured to pilot the delivery of a new model of integrated health and social care, the Buurtzorg Care Model. Buurtzorg is a nurse-led model for community care which was established ten years ago in the Netherlands and has supported improvements in patient outcomes and workforce development.

7.2 Despite the model evidencing sustainable benefits it has not yet been successfully transitioned into any other country. This is thought to be because the model is being adapted to fit current systems rather than the system being adapted to fit the model. The aim is to challenge and adapt the current Health and Social care systems to enable the implementation of the Buurtzorg Care Model across the majority of Kent and Medway by October 2021.

7.3 The Council will be working in partnership with Kent Community Health Foundation Trust (KCHFT) and GP practices to initially implement two project teams, one in West Kent and one in East Kent. Medway Community Healthcare (MCH) is also implementing one team in Medway. The projects are planned to start in September 2018. The growth and spread of the teams will be determined as the effectiveness of various implementation methodologies is understood and will be dependent on how effectively the barriers to implementation have been mitigated.

7.4 The project teams will combine various skillsets including qualified nurses, health care assistants, care and support in the home workers and enablement staff and will work closely with the GP practices around which they are based. They will be small self-managing teams of between eight and 12 people serving a population of approximately 10,000 to 15,000 people. The teams will be underpinned by effective IT systems and a small supportive back office and facilitating coach.

7.5 The challenge faced in managing the interdependency between the Buurtzorg project and the new Care and Support in the Home Service Contract is in trialling the project in Edenbridge, an area in which it has historically been challenging to secure packages of care and support. The low volume of hours, rurality of the area and proximity to London make the area financially unviable for many Providers.

7.6 There is a significant risk in trialling Buurtzorg in the Edenbridge area, as it will reduce the volume of hours available to contracted providers and further reduce the financial viability of the area. It is not feasible for the Buurtzorg project to take on all of the clients within this cluster group, and so the volume of hours within the cluster will be split between the project and contracted provider(s). The risk is that as the Buurtzorg project builds and delivers more of the available hours in the Edenbridge area, there will come a point of failure for the provider at which they will no longer be financially sustainable and will likely hand back the remaining hours in the area.

7.7 The Council must consider how it will balance the delivery of the Buurtzorg project with its duty under the Care Act to support market sustainability, and how it will give confidence to providers to contract with the Council and invest in Services.

8. Resource, Personnel and Training Implications

8.1 Implications for Providers

8.1.1 There are implications for the skills development of care and support workers over the life of the contract to support the move to outcomes-focused, flexible provisions. Over the life of the contract providers will need to consider the skills base of their workforce and where they may need to address skills gaps to deliver new activities such as statutory reviews. Providers are also required to support social value in their community through responsible recruitment, retention and employment practices.

8.1.2 This contract seeks to support the aspirations of the workforce development programme within the Council to enable our providers to train and develop their staff in a range of career pathways. The full Personnel and Training requirements for providers are detailed in the specification.

8.2 Implications for Kent County Council

8.2.1 There are Resource, Personnel and Training implications for the Council's own staff in bringing together SIS and Home Care Services as one provision. Until the new contract takes effect, and throughout the phased implementation in 2019, council teams will be required to work collaboratively to ensure consistency of practice to support the provider market.

8.2.2 At present there are multiple practices across the operational teams, which will need to be considered and rationalised to enable this new service to be successfully adopted. This will involve work around reviews, documentation, terminology, purchasing and payments amongst others.

8.3 Contract Management

8.3.1 A more involved and robust service which will be subject to transformation throughout the lifecycle of the contract will result in the need for careful and dedicated contract management from both commissioning and operational teams. This approach will have resource implications which have yet to be fully understood and may be tested through delivery of pilot projects.

8.3.2 A scorecard approach to contract management has been agreed which will feed into a quality and risk matrix, allowing the reactive elements of contract management to focus on the areas of biggest risk to service continuity.

8.3.3 Proactive contract management will take place through individual and joint meetings, pilots and shared communications.

8.3.4 Conversations are ongoing with operational teams to identify delegation of contract management activities to ensure the appropriate teams manage the various aspects of the contract. As an example, commissioners would lead on areas relating to contract compliance and situations affecting more than one

individual, where operational teams would focus on the situations relating to individuals and their personal care and support plans.

9. Implementation of MOSAIC and Finestra

9.1 The Council is phasing out its current social care systems provisions SWIFT and its payment mechanism system, Transactional Data Matching (TDM). This represents an opportunity to source systems which will enable a better interface between council and provider systems where appropriate, reduce duplication and support operational teams in prioritising and managing their caseloads more efficiently.

9.2 The existing systems will be replaced by MOSAIC and Finestra, which will be implemented from January 2019 onwards.

9.3 There is an aspiration that in the future Care and Support in the Home Service providers will utilise systems, including Electronic Call Monitoring, that enable an improved interface with the Council's systems and reduce duplication in the information held by each organisation. Commissioners are engaging with colleagues in the Technology Enabled Change (TEC) Team on an ongoing basis to identify interdependencies in the implementation of these systems and the Care and Support in the Home Service Contract.

9.4 Any future requirements for providers to align their systems to the Council's technology will need to clearly define how these will interface with the MOSAIC and Finestra systems once in place.

10. Financial Implications

10.1 The planned contract arrangements for the Care and Support in the Home Service is anticipated to run for four years, with an option to extend, with a total value between £100m and £140m per annum, to be determined through the contract solution design which is currently in progress.

11. Legal Implications

11.1 The main legislative framework for the Care in The Home Service is the Care Act 2014 (for adults), the Children Act 1989 (for under 18s), and the principles of Mental Capacity Act 2005. These are statutory duties, and the new service will be compliant with these key pieces of legislation.

11.2 Transfer of Undertakings (Protection of Employment) Regulations 2006 as amended by the Collective Redundancies and Transfer of Undertakings (Protection of Employment) (Amendment) Regulations 2014 (TUPE) is likely to apply, and the Council will ensure in the event of a change of employer, that it will undertake necessary arrangements, within its remit, to provide for the protection of employees' rights.

12. Equality Implications

12.1 An Equality Impact Assessment has been completed and will be updated as the work to deliver the new contracts is progressed.

13. Conclusions

13.1 The Adult Social Care Cabinet Committee is asked to note the updates included in this report, particularly in relation to the next steps for letting the Care and Support in the Home Service Contract and the associated financial implications.

13.2 The first phase of the contract will bring together the services previously known as Home Care and Supporting Independence Services under the Care and Support in the Home Service Contract. This will require providers to develop their capability to deliver across a broader range of client needs and to support skills development of their workforce to enable this.

13.3 Further services will be incorporated within the contract in a phased approach. Discharge to Assess and Extra Care Support hours will both be subject to further competitions which will only be open to contracted Care and Support in the Home Service providers.

13.4 It is proposed that new approaches to service delivery will be tested and integrated during the life of the contract. These will include enabling providers to flex hours up and down according to changes in needs, delegating statutory reviews to providers, the introduction of technology such as Electronic Call Monitoring and more integrated working with health partners. For each of these changes, it is proposed that the change is trialled in a discrete area to test its effectiveness before being rolled out across the county and incorporated into the contract.

13.5 This phased approach to implementing the long-term vision of the Care and Support in the Home Service will enable the Council to mitigate against the risks associated with significant changes such as delegation of duties and systems changes. Clearly defined and closely managed change projects will support both commissioners and operational teams in managing the demand on their resources and assuring quality of delivery throughout periods of change.

13.6 Commissioners will continue to provide regular updates on the progress of the Care and Support in the Home Service.

14. Recommendation(s)

14.1 Recommendation(s): The Adult Social Care Cabinet Committee is asked to **CONSIDER** and **COMMENT** on progress of tendering for the new Care and Support in the Home Services Contract.

15. Background Documents

None

16 Contact details

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SCHEDULE 2

CARE AND SUPPORT IN THE HOME SERVICES SPECIFICATION

Service	This Schedule defines the Services and activities in scope to be delivered within the Care and Support in the Home Service.
Strategic Commissioning Lead	Jack Moss - Senior Commissioning Manager

Table of Contents

1 INTRODUCTION

1.1 This Service Specification in conjunction with the Contract Terms and Conditions and other documents which form this Contract, define the Council's minimum requirements for Service Providers who provide Care and Support in the Home Services purchased by the Council. It details the standards and outcomes that must be achieved and describes how these will be evidenced and monitored.

1.2 The Care and Support in the Home Services purchased in Kent will provide care and support to adults aged 18 and over, who have been assessed to meet the Councils eligibility criteria for unmet needs. This includes (but is not limited to) adults who have assessed care and support needs associated with older age, sensory impairment, learning disability, physical disability, physical ill health, chaotic lifestyles, substance misuse and mental illness.

1.3 This Specification brings together several Services within one Service Specification which were previously known as Home Care, Supporting Independence Services, Discharge to Assess and Extra Care Support. The objective of Care and Support in the Home Services is to support the Council's strategic objective 'to help people to improve or maintain their well-being and to live as independently as possible' and to meet the councils Care act responsibilities. The Council has an ambition to deliver the Service through a sustainable market that collectively has the capability and capacity to deliver a quality and accessible Service countywide, in both urban and rural locations.

1.4 Aligning Services under one Contractual arrangement will enable the Council to promote a consistent approach to the delivery of Services and ensure equitable access to Services for eligible people across client groups and localities.

1.5 Bringing Services together will also develop a clearer pathway, with less transfers/hand offs between Services for people, supporting improved continuity of care. Providers will also have greater flexibility and control to manage fluctuations in demand to meet assessed needs as defined by the Care Act.

1.6 Care and Support in the Home Services are designed to promote individual well-being and keep people safe, help people do as much as they can for themselves and allow people to live as independently as possible in their own home. Care and Support in the Home can provide suitable alternatives to Residential, Hospital, Parental or other care provisions.

1.7 In Kent, Care and Support in the Home Services will form part of a continuum of care and support delivered by the voluntary and community sector, private sector and the Councils In-House providers. This continuum of care and support ranges from support to access communities and care for people in their own homes, through to specific supported accommodation with appropriate levels of care for assessed need, to high-level residential and nursing care home accommodation.

2 SCOPE

2.1 The scope of this Contract (which constitutes Phase One) includes the Home Care (formerly known as Domiciliary Care Services), Supporting Independence Services and the Service offer for more complex needs, Supporting Independence Services Plus.

2.2 Shared Supporting Living and Supported Living 'packages of care' with 105 hours of care (effectively 24 / 7 packages) are not within scope for the current contract. Shared supported living can be defined as the arrangement whereby someone who already has, or who wants their own tenancy or own home, within a property where there is the possibility of support being shared by the tenants. The tenant will be supported by a "Care and Support" Provider to help them live as independently and safely as possible.

2.3 The Council may choose to amend any aspect of this Specification during the life of the Contract. If the Council chooses to do this, they will discuss with the Provider any proposed changes and how they may be implemented. Changing national or local policies and priorities may also necessitate changes to the Specification. The views of Providers, people receiving support and their Care/Support Workers will be considered in any review of the Specification and their views will be welcomed at any time during the life of the Contract

2.4 This Specification supports the aim of developing a new outcome-focused care and support model throughout the Contract term to meet the Council's strategic objective that 'Older and vulnerable residents are safe and supported with choices to live independently'.

2.5 The Council's aspiration is to encourage and incorporate feedback by embracing the opportunity to work with people receiving Services and Providers over the life of the Contract and where necessary further define and refine the Service requirements and mechanisms for delivery. This will include but is not limited to further integration with Health partners, use of technology and delivery through consortia of Providers.

2.6 Providers will input into the design and piloting of any new activities to ensure the benefits of a co-produced model which will inform both this Service and future provision. The Council recognises the opportunity to improve the understanding of supply and demand and reserves the right to ask Providers for information, such as their workforce to help inform such areas.

2.7 The Services included for Phase Two, for which the Council will specify and determine commencement dates throughout the Contract Term, are:

a) Extra Care Support; Extra Care Housing is a form of accommodation where older people live independently with their own front door in a scheme that has a range of communal facilities and access to care staff 24 hours a day. There is care on-site, but it is not a care home. The care is flexible and can fit around a person's personal needs and can support people over 55. It needs to support people as a direct alternative to residential care and must be able to address night time needs of people. Extra Care Support refers to the provision of flexible care and support hours within the Extra Care settings, not the built environment of the facilities.

b) Discharge to Assess; with the progress toward 'Home First'. The aim of the Discharge to Assess Service is to provide the wrap around support to people in their own homes for up to three days post discharge from hospital (with potential to extend for a further two days if the individual's outcomes will either negate the requirement for ongoing Service or reduce the need). It will be an integral part of Home First, which is where people go home with an enabling/assessment/short-term Service to essentially free up hospital beds and contribute to the Council's Delayed Transfer of Care (DTOC) requirements/targets. The focus of the Service is to ensure the person is safe at home and to focus on maximising the independence of the person with agreed outcomes set against an assessment of their needs. The Discharge to Assess service will not be limited to those providers allocated a contract in phase 1.

3 REGULATORY REQUIREMENTS

3.1 Providers must conform to the requirements of relevant Health and Social Care legislation

3.2 It is a requirement that all Providers will be registered with the Care Quality Commission (or any successor) for the delivery of Regulated Activities, including Personal Care. Providers must maintain registration throughout the duration of the contract and any subsequent packages of care as required by legislation. It is the Provider's responsibility to maintain up-to-date knowledge of the current Regulator's codes and to keep to the correct registration.

3.3 The Council reserves the right not to award a contract to any organisation who has applied to be a Care and Support in the Home Provider and who has an overall CQC rating of "requires improvement" or "inadequate" at the contract award stage applied at any care office the service provider intends to operate the Contract from.

3.4 Should a provider, during the life of their Contract, not maintain or cease to hold their Registration, for any reason, the Council reserves the right to Terminate the Contract without prejudice to any contractual notice period set out within the Contract, and at no cost to the Council. In any such case the Provider will work with the Council to ensure continuity of care for all people using the Service, and provide all information as requested by the Council

3.5 The regulations required for Registration, their associated standards and the monitoring of the achievement of those regulations and standards are not, therefore, duplicated in this specification. It is expected that the regulations will be met through Registration activity.

3.6 Providers will be required to inform the Council of any relevant CQC activity as detailed in Appendix 1 of this Schedule

4 SERVICE AIMS

4.1 The aim of the Service is to enable Service Users receiving Care and Support in the Home to lead a full qualitative life, maximising their independence, promoting their health and wellbeing and supporting them to remain safe and comfortable in their own homes for as long as possible whilst maintaining their individual dignity, privacy, freedom of choice and treating them with respect.

4.2 To provide a service which has the capability and capacity to deliver quality services across Kent regardless of the location or postcode.

4.3 The Service will have a strong emphasis on maintaining and developing abilities and skills with a 'supporting to' rather than 'doing for' approach. There will be a focus on the principles of enablement, maintenance, recovery and self-care and on improving resilience to deal with potential health and social care needs in the future.

4.4 The Service will be flexible, and person centred. It will implement effective, positive risk management and design Services which address the needs of individual Service Users and ensure outcomes of Support Plans are met.

4.5 The Service will address the needs of Service Users holistically, value difference and ensure the social, cultural and religious needs of Service Users are acknowledged and addressed. It will work to sustain the support offered to them by their Carers and Representatives and their local communities.

4.6 The Service will seek and be responsive to Service Users' and Carers views and priorities and work collaboratively with other Service Providers and internal and external partners to ensure quality.

4.7 The Service will be commissioned to meet the person's eligible needs under the Care Act based on the Council's social care eligibility assessment. The Service will be available 365 days a year (366 in a leap year), including Bank Holidays

5 PERSONALISATION

5.1 The Council is presently going through steep changes in the way it commissions, delivers and manages Services, as well as the relationships it holds with Contracted Providers. This includes the realignment of the Older People and Physical Disability Division to enable change in the way the Council works with its Providers to develop and deliver Services. This realignment process will enable staff to work in new ways with providers to develop practice and support the delivery of outcomes-focused, personalised care. Providers will benefit from improved access to Council practitioners which will support continuous improvement for quality in care and workforce development.

5.2 Work is progressing within the Council's Lifespan Pathway project to develop outcomes-focused practice within the workforce. The project is also working closely with Providers to ensure that the packages of care and support that are put in place are appropriate for the level of need, remain appropriate throughout their delivery and support people to increase their independence and well-being. This process will be from the outset of the Contract for clients with Learning disability or Mental Health needs and may subsequently be rolled out to all clients.

5.3 It is expected that Providers will support the development of more outcomes-focused, personalised Services by working closely with the Council through the life of the Contract to identify development requirements and produce action plans to meet objectives which support continuous improvement.

5.4 The Council and CQC support Person Centred approaches such as ESTHER and will through the Design and Learning Centre support providers to implement the ESTHER person centred approach. Detailed further in Appendix 2 of this Schedule

6 GENERAL DESCRIPTION OF THE CARE AND SUPPORT IN THE HOME DELIVERY MODEL

6.1 The Council has worked with Providers to design geographical areas called 'Clusters' which form the Lots for Providers to bid against. Clusters are designed to create geographical areas around which Providers can structure their business and rounds of care to ensure capacity in the Service.

6.2 It is expected that Providers work within their cluster to ensure sufficiency of supply and where appropriate continue their vertical growth within their cluster. There are 19 clusters. Schedule 3 outlines the clusters within Kent.

6.3 Providers are also expected to have the flexibility and willingness to take packages of care from neighbouring clusters if the need arises.

6.4 The Council cannot guarantee that all indicative hours will be available to a Service Provider, for example, a Service User may choose to utilize a personal budget to purchase a service in ways other than a Council commissioned, Service. In addition, the move to new ways of working as described throughout this specification may reduce the number of contracted hours required.

6.5 Currently the Home Care Services are based more upon a time and task model of Service, whereas the Supporting independence Service is designed around a more flexible version of care and support. During the contract period it is anticipated that there will be movement from the status quo towards the delivery of more outcomes-focused, personalised care.

6.6 This will be achieved through negotiation, pilots and collaboration with contracted providers and following any necessary periods of consultation governance and other processes.

6.7 The Council recognises that the bringing together of multiple historically separate Services under one Contract represents a significant challenge, both for the Council and the Providers delivering Services. The Council will adopt a phased approach to Contracting for Care and Support in the Home Services to ensure a stable transition to the new Contract and support market shaping activities

6.8 The first phase, which will commence from 8 April 2019, the Services previously known as Home Care and Supporting Independence Services will be brought together under one provision. Providers delivering Care and Support in the Home will be expected to demonstrate their capability to meet all needs supported by these Services from 8 April 2019. Providers will also be assessed against their capability and willingness to develop over the life of the Contract to support ongoing Service improvement and move towards the delivery of more personalised, outcomes-focused care.

6.9 Discharge to Assess Services and Extra Care Support will be Let within the life of the Care and Support in the Home Contract in a further competition. The council reserves the right to extend this process to Providers who do not hold a Care and Support in the Home Contract.

6.10 Shared Supported Living Services will be further explored, and a decision made to either include within subsequent phases of this contract or for the service to be delivered under a separate Contract. Shared Supported Living is defined in section 2.2 in this Schedule

7 MOBILISATION OF THE NEW CARE AND SUPPORT IN THE HOME SERVICES

7.1 Providers should be aware that the Council is not proposing mass mobilisation of people from existing Providers to any new Service Providers who may be awarded a Contract. Instead, people will be mobilised on an individual basis where appropriate and agreed with the person and relevant Providers. New Providers to the Contract will grow their presence over a transition period as they receive new referrals into the Service

8 ALLOCATION OF CARE PACKAGES

8.1 The referral will be allocated to the Provider based on the person's address, purchasing protocol and instructions agreed between the person and their case manager. These instructions include:

a) The planned care and support allocated hours;

b) A start date for the Service and any end date (if applicable)

c) Any special requirements that the person has and should be supported with;

d) A copy of the statement of need/ relevant sections of the Care and Support Plan;

e) A clear statement of the person's agreement with the Service, or any specific parts of the Service for which the person lacks capacity and relevant decisions are therefore made in their best interests by the Council in consultation with their families and advocates (with the person's permission where applicable.

8.2 Refusal information will be collated and used to inform the Providers Scorecard as detailed in Schedule 14 (Contract Management)

8.3 During the first three months of the contract the Council will work with Providers to agree a set of roles, responsibilities and expectations around the Purchasing Protocol and process

8.4 Further information can be found in Schedule 1 section 3 (Purchasing Protocol)

9 SERVICE CAPACITY

9.1 The Service Provider must ensure that they have the capacity and capability to deliver Services 365 days per year (366 in a leap year). The Service Provider must be able to demonstrate flexibility in deploying Staff across geographical areas and hours of Service at all times. The Service Provider must conduct regular reviews of Staffing levels and resources especially at times of increased demand to include winter pressures, Bank Holidays, Christmas and school holiday periods.

10 WORKFORCE REQUIREMENTS

10.1 The Provider is expected to use recruitment and selection procedures that meet the CQC minimum standards; ensuring records are maintained to demonstrate best practice in this area. Providers must comply with Disclosure and Barring Service (DBS) requirements for staff and ensure renewal is completed every 3 years.

10.2 All roles within the Provider's organisation must also have written job descriptions and person specifications and an Equality Policy for the recruitment, selection, development and care of the workforce (including volunteers, trustees/management committee members and apprentices)

10.3 Providers must deliver a workplace induction to new Care and Support Workers and ensure that they complete the Care Certificate within 12 weeks. Providers should also use the Care Certificate as a refresher for their Care and Support Workers where appropriate.

10.4 All staff should meet formally on a one to one basis with their line manager for supervision, to discuss their work on a quarterly basis (every three months) and written records of these supervision sessions must be kept demonstrating the range, content and outcome of the discussion at each meeting.

10.5 Providers should be able to demonstrate how staff are supported and advised between supervisions and that additional meetings are facilitated where required.

10.6 With the consent of the person, at least one supervision a year should incorporate direct observation of the Care/Support Worker providing care and support to the person with whom they regularly work to observe competencies. Where consent has not been granted, this must be recorded with reasons where available.

10.7 Regular meetings must be held at least quarterly with peers and/or other team members to discuss and share issues and best practice. This must be recorded.

10.8 All staff must have an annual appraisal, and this must include identification of training and development needs with their line manager. A copy of the appraisal will be placed on the personnel file for each Care and Care/Support Worker.

10.9 The Provider must ensure that there is a clear link between staff appraisals, identified training and development needs and the training plan. Managers and supervisors must receive training in supervision skills, undertaking performance appraisals and planning for workforce development.

10.10 A record must be kept of any disciplinary incidents and details entered in the personal file of the Care/Support Worker concerned, referrals to the Independent Safeguarding Authority must be made, if appropriate, and recorded on the Care and Care/Support Worker's file, or person staff member's personal file. The Council must be kept informed. Please refer to Clause 12 of the Contract Terms and Conditions.

10.11 Providers must take appropriate measures to understand whether the Care/Support Workers within their employment are also engaged in other employment. The Provider must regularly review with each Care/Support Worker whether any care Sanctions or incidents involving the police and criminal justice system will affect their capacity to carry out their role and responsibilities as a Care/Support Worker.

10.12 The Provider must have a written policy for the management of violence and aggression towards staff and ensure that suitable training and relevant risk assessment is provided to reduce the risk of violence and aggression towards staff. Adherence to the Health and Safety at Work Act 1974 will ensure that staff are safe whilst at work.

10.13 Providers must support the implementation of the ESTHER model Countywide. The ESTHER Model was created in region Jönköping in Sweden in 1997. The model has two main purposes: to create smoother and safer pathways for ESTHER and to support more efficient use of Provider resources with a communal goal to always do what matters to ESTHER. Adult Social Care and Health are committed to the roll out of this model in Kent and therefore expect providers to deliver and work to this model. More information on ESTHER in Appendix 2 of this schedule. https://designandlearningcentre.com/overview-of-our-work/esther/ Link correct as of 11th September 2018.

10.14 Workforce development requirements are detailed in Appendix 3 of this Schedule.

11 OFFICE LOCATION

11.1 The Service Provider is expected to operate from an office base which allows a physical presence in the area in order to demonstrate:

a) The ability to visit Service Users and Carers at home to carry out introductory visits, investigate complaints, etc.

b) Local management – readily accessible to Staff and Service Users

c) Local recruitment

d) Local Staff

e) An understanding of the locality

f) Links with integrated teams and other associated professionals in the locality

g) Reduced travel for Staff attending the office for meetings. Supervisions, to collect Personal Protective Equipment (PPE), etc.

h) The ability to supervise and support Staff in the workplace

12 MONITORING REQUIREMENT

12.1 The Service Provider and the Council will performance manage this Service to ensure current delivery meets the required standard. The Council will continue to use electronic methods for collecting and collating all Key Performance Indicator data, all Providers will be expected to work with the Council to deliver this effectively and to ensure compatibility with the Council's systems and requirements.

12.2 This Contract will be managed through a Scorecard approach which looks at the areas of:

a) Quality and Contract assurance;

b) Cost/ flexibility and innovation;

c) Service deliverables;

d) Relationship development;

e) Business/ workforce assurance and risk.

12.3 Each Score card area will be measured through the collection of monthly KPI submissions and quarterly provider self-assessment submissions

12.4 The Scorecard and supporting methodology links to a quality and risk matrix approach which will enable triangulation of data sources including:

a) Data & intelligence received from feedback from Care and Support Workers and Practitioners, people receiving the Service and their carers;

b) Provider self-assessment and reporting;

c) Balanced Scorecard;

d) KPIs;

e) CQC inspection results;

f) Contract Sanctions and Safeguarding;

g) Market Share.

12.5 Identification, collection and analysis of this data combined will facilitate:

a) Identification of themes and trends;

b) Identification of system-wide and local risks;

c) The construction of dashboards to show compliance levels and improvements over time, allowing for reports on local, regional and county wide trends.

12.6 The level and intensity of quarterly Contract management actions per provider will be

directly proportionate to the maturity of the Contract and the level of risk identified by the quality and risk matrix.

12.7 Providers will be expected to actively participate in local Cluster meetings where appropriate. These may be conducted either in person of via teleconference.

12.8 Full Contract management methodology, Scorecard elements, Key Performance Indicator requirements and Monitoring meetings are laid out in Schedule 14 Contract Management.

12.9 Schedule 14 Contract Management details the requirements of both the Providers and of the Council. The Council reserves the right to undertake a review of the supply arrangements with Providers within the Clusters at any time and to work with Providers to ensure optimum delivery arrangements.

13 CARE AND SUPPORT IN THE HOME SERVICE

13.1 This Specification has been developed to be outcome-focused and therefore articulate Service requirements specific to improving the outcomes delivered to the people receiving the Service.

13.2 The Care Needs Assessment identifies the needs and outcomes of each individual, the Care and Support Plan describes the eligible needs and the outcomes the council has agreed to meet, The Provider must deliver a flexible approach towards achieving these goals and priorities. This principle reflects the added value delivered by a flexible care approach rather than only focussing on the task undertaken

13.3 The Provider must define their approach through their Care Plan, which will detail how the Provider will achieve the outcomes agreed in the Care and Support Plan and the goals they will work towards to meet these outcomes. Provider Care Plans will be underpinned by SMART principles to ensure that goals are Specific, Measurable, Agreed, Realistic and Time-based. The Provider Care Plan must also include a comprehensive Risk Assessment which is personalised according to the person's specific needs

13.4 Providers must submit reports, supply requested information and attend meetings as part of a review, reassessment, Business Continuity, Safeguarding and complaints process. All meetings, including Service Provider Forums must be attended by a senior Staff member who has the knowledge, skills and authority to act on behalf of the Service Provider.

13.5 Providers must work in partnership with other people involved in the care and support of the Service User to ensure the Service User's needs are met, e.g. Social Workers, Brokerage Officers, Health Workers, other Service Providers, etc.

13.6 The Provider must have a robust Business Continuity and Disaster Recovery Plan in place to ensure prevention, planning and management of potential harm to the business are identified and minimised effectively. Plans must be in place to ensure that disruption to Service Users Service is kept to an absolute minimum in the event of a major incident, severe weather or disaster affecting the Service including the Service Providers premises. Disaster Recovery plans are detailed in Schedule 12.

13.7 The Provider will ensure all Care/Support Worker annual leave and sickness is covered within the Service.

13.8 Providers must ensure that during all hours of operation, Care/Support Workers have access to the Provider's Duty manager/Co-ordinator. An out of hours contact is available to provide advice, information and support to Care/Support Workers and persons outside of office hours but within the hours of Service provision. This will be staffed by a suitably qualified and experienced supervisor/manager with access to all the information for people and Care/Support Workers necessary to ensure the provision of Care/Support Workers and Service at short notice

13.9 The lists of activities detailed in this Specification are neither exhaustive, prescriptive or needed in all cases and will depend on the tasks identified to best support the person's outcomes and meet their needs, as identified in their Care and Support Plan and the presenting needs of the person on the day. The activities may require varying degrees of support and an enabling approach. Where the person requires support in decision making or lacks the mental capacity to make specific decisions for themselves the Principles of the Mental Capacity Act 2005 must be applied

14 ACCESS, ASSESSMENT, ELIGIBILITY AND CARE AND SUPPORT PLANNING

14.1 The people who can access this Service will be:

a) Adults for whom care in the home has been agreed to help meet the outcomes identified in their Care and Support Plan;

b) All groups including Adults living with Learning Disabilities and/or Physical Disabilities, those with Mental Health needs, Older People, and People living with Dementia.

c) Ordinarily resident and living in Kent.

14.2 It should be noted that this is not an exhaustive list.

14.3 The referral and purchasing protocol for accessing the Service can be found at Schedule 1 (Special Conditions) However, within the contract term covered by this Service Specification the Modernisation Agenda will bring optimisation and pathway changes intended to streamline the process. Changes will occur to document types and names, and to access and referral pathways. The Provider will use the new documents, pathways and systems as instructed by the Council. The document templates issued to Providers will include but not be limited to Review templates, goal monitoring sheets and Care Plan templates or equivalent.

14.4 Adult Social Care and Health Staff complete a needs assessment. Following this they will work with the person to develop a Care and Support Plan which confirms eligible met needs and eligible unmet needs. The plan thereafter describes the personal outcomes related to eligible unmet need, and the outcomes the local authority has agreed to meet.

14.5 The Provider will develop their own Care Plan for each person in conjunction with them and if they wish, their family/carers and/or other professionals, based on the Care and Support Plan.

14.6 The Provider Care Plan will be completed at the first visit, and at the latest the second visit with the person. The Care plan will show how care will be delivered to meet the identified eligible needs and provide the detail of how Services will help the person achieve their outcomes. The Provider will receive their instructions from the Service Delivery Order (SDO) or Financial Activation Notice (FAN) and the Care and Support Plan which initiates and tailors the Service for the person.

14.7 The Service required for a person will not always be prescribed in terms of task requirements, or timescales. A Care and Support Plan will identify a range of desired outcomes for the person, which will be agreed with them, the Provider and the Council. Some Outcomes will have specific Goals that the person wishes to achieve to support their progress towards the Outcome. A Goal is usually something with a shorter timeframe for achievement rather than an Outcome which could be longer term. It is expected that the Provider will make the initial arrangement to confirm the times of call with the person and then confirm this with the Council. Goals and outcomes will be defined as:

14.8 Personal outcomes – the individual's aspirations;

a) Agreed outcomes – what the local authority has agreed to support;

b) Goals – the steps the Provider will take to meet agreed outcomes.

14.9 The Regulator requires, under regulation 9 (2)(b) - designing care or treatment with a view to achieving the person's preferences and ensuring their needs are met that: "The Service makes sure there is staff cover across the geographical area, so people receive a consistent and reliable Service. The Service considers travelling time to make sure people receive the amount of care that has been agreed in their care plan".

14.10 Where there are specific decisions in the Care and Support Plan for which the person lacks capacity, these are highlighted in the Care and Support Plan as best interest decisions which are reached following involvement of the person and consultation with families and friends, advocates where appropriate and professionals.

14.11 The Provider will start to provide the Service on the start date specified by the Council and shall continue to provide the Service until the end date, unless the package is cancelled, suspended or varied in accordance with the Contract. Providers will:

a) Review records at least once a month, to ensure receipt of feedback from the person, carers and staff and to inform whether a more formal Provider or Council review is necessary;

b) Provide information to the Council prior to the annual Statutory Review to maximise the effectiveness of the Statutory Review and enable participation from the person receiving the Service where appropriate;

c) Maintain oversight of any special requirements and changes to special requirements, and ensure these are integral to all of the person's records the Provider holds;

d) Consider the person's requests for adjustments in the Service and make changes in arrangements, provided there has not been a substantial change in the person's circumstances or needs;

e) Ensure staff know how to notify the Provider and the Council of any increase or deterioration in physical or mental health and/or any other relevant events and record these in the person's notes kept by the Provider;

f) Ensure processes are in place to notify the Council of these changes and ensure that the support provided remains at an appropriate level;

g) Ensure the full time indicated on the Service Delivery Order (SDO) or Financial Activation Notice (FAN) and within the Care and Support Plan is delivered to the person needing the Service and appropriate time is allocated for travel, and that records can demonstrate this delivery.

15 UNITS OF PURCHASE

15.1 The Care and Support in the Home Service will not have a differentiated Social and Unsocial Rate. Therefore, the below units of purchase will apply.

15.2 Day Support (07:00 – 22:00); The Care and Support in the Home Service will be purchased and calculated for payment in the following day units:

a) Half Hour – Paid at 60% of Provider's contracted Full Hourly Rate.

b) Three Quarter Hour – Paid at 80% of Provider's contracted Full Hourly Rate.

c) Full Hour – Paid at the Provider's contracted Full Hourly Rate.

15.3 Sessions (continuous support of more than one Full hour) will be paid on a pro rata basis from the Provider's contracted Full Hourly Rate.

15.4 Rurality Indices Rate Uplift

15.5 The Office of National Statistics 'Rurality Indices' categorise the postcodes across Kent into the following four distinct classifications:

Urban Major Conurbation	Urban City and Town	Rural Town and Fringe	Rural Village and Dispersed

15.6 In recognition of the additional associated travel costs when delivering Care and Support in harder to reach rural communities, the Council will apply an increase to contracted hourly rates based on each client's postcode against the Rurality Indices as set out in the table below:

Urban Major Conurbation	Urban City and Town	Rural Town and Fringe	Rural Village and Dispersed
N/A	N/A	+5%	+10%

15.7 These uplifts will be confirmed on a per client basis and will be reflected in the associated FAN / SDO / PO as applicable.

15.8 The Council's Position on Banking / Flexible use of hours for Care and Support in the Home Services:

a) The Council commissions services based on the identified needs of an individual following assessment by the Council's in-house qualified practitioners.

b) The Provider then agrees to deliver these hours at their contracted rates, within the agreed units set out in 15.2 and invoice in line with their payment cycle or agreed payment period (a full week is calculated Monday through Sunday).

c) The provider may flexibly provide the commissioned hours within the agreed payment cycle or period but must not exceed the total unless by agreed exception.

15.9 The following table provides examples of both correct and incorrect use of flexible use of support hours:

15.10 Client requires 10 hours of one to one support each week, totalling 40 hours over a 4-week period:

15.11 Flexible use of hours table.

		Week 1	Week 2	Week 3	Week 4	Invoiced Hours	Total	
	Commissioned Hours	10	10	10	10	40	40	
Example A	Actual Hours Delivered	10	12	10	8	40	40 (commissioned hours flexibly used within period)	
Example B	Actual Hours Delivered	10	16	10	8	44	44 (no KCC approval sought by exception for additional hours)	
Example C	Actual Hours Delivered	10	6	8	10	34	34 (commissioned hours are under delivered provider wishes to roll remainer over)	
Example D	Actual Hours Delivered	10	6	8	10	34	34 (commissioned hours are under delivered but the provider only invoices for actual hours delivered and communicated with Care Manager)	
Example E	Actual Hours Delivered	8	8	8	8	32	32 (commissioned hours are under delivered but the provider has invoiced for the full 40 commissioned hours)	

15.12 The number of units and frequency of delivery will be outlined in the Service Delivery Order (SDO) or Financial Activation Notice (FAN). No change to the status of the Contract will be made without formal consultation and agreement with the Council.

15.13 The specific Service for each person must be delivered in accordance with the requirements of the SDO or FAN and must not be varied without the appropriate authorisation as outlined in the table examples under point 15.8

15.14 The Council will monitor compliance to the SDO or FAN through the person's Care and Support Plan Reviews and annual Statutory Reviews, feedback via the Council's complaint process and through Contract Management detailed in Schedule 14.

15.15 In the event the Provider does not deliver in accordance with the commissioned units of delivery, the Council is entitled to remedies in accordance with but not limited to Clause 41.4 of the Terms and Conditions.

16 NIGHT WORKING (SLEEPING AND AWAKE)

16.1 In certain circumstances, there may be a requirement for the provision of a night service to ensure the needs of Service Users are met and/or to support Carers. The requirements for these services will be identified during Assessment and will be outlined in the individuals Support Plan. Depending on the needs of the Service User and/or their Carer, the night service may require the Staff member to remain awake throughout the night or to sleep and only be disturbed as and when assistance is required.

16.2 The Care and Support in the Home Night support Service will be purchased and calculated for payment in 9-hour sessional units. Please see Schedule 3 Pricing for further information.

17 OUTCOMES AND ACTIVITIES

17.1 An outcome can be described as the impact a Service has on the person. Outcome-focused Services are fundamentally person-centred in approach, recognising that each person is unique and will have different needs and requirements. The Council has identified a range of outcomes to be achieved in the delivery of these Services;

a) To support people to take greater control of their lives;

b) To increase people's choices to live as independently as possible and to live as well as possible;

c) To manage any long-term conditions well.

17.2 Care and Support Plans and the delivery of care and support packages must be aligned to the Care Act Eligibility Criteria Outcomes. These will form the basis for the individualised outcomes detailed in each person's Care and Support Plan, and the goals that the Provider will work towards to achieve these.

17.3 The Service will focus on the person's wellbeing. The Care Act Eligibility Outcomes relating to the person's Care and Support Plan will be the basis on which the effectiveness of the Service will be determined. A person's Care Act Eligibility Outcomes will be documented in their Care and Support Plan.

17.4 In order to achieve required outcomes, the Service Provider shall undertake a range of tasks and activities, the following is a description of the activities and tasks that Staff may be required to perform to meet a Service User's individual care and support needs. These may include but not be limited to:

a) Personal care and support;

b) Promotion of well-being and self-care support for the person;

c) Accessing the community, education or employment;

d) Promotion of safeguarding support;

e) Cleaning and support around the home;

17.5 More detailed examples of Outcomes and Activities can be found in Appendix 4 of this schedule

18 DOUBLE HANDED CARE

18.1 During some care activities two Care/Support Workers will be required and this will be specified in the Care and Support Plan. It is essential that where two Care/Support Workers are required to carry out care that both Care/Support Workers arrive at the person's home in time to work together. The first Care/Support Worker to arrive should not begin to care for the person until the second arrives, unless some of the Care and Support Plan activities relate to a need that a single Care/Support Worker can meet.

18.2 Utilisation of moving and handling equipment to better manage transfers and care delivery should be considered and actively promoted to and by Care/Support Workers, wherever this has been identified by an Occupational Therapist who has assessed and provided advice. Providers must contact Occupational Therapists where equipment is or can be used for assisted transfers.

18.3 Occupational Therapists will conduct an assessment for an increase from single to double handed care or decrease from double handed to single handed care as a result of equipment use. Any change to a care and support package as the result of utilisation of moving and handling equipment will necessitate a Care and Support Plan Review and update to the Care and Support Plan. Providers will be required to update Risk Assessments and Moving and Handling Assessments accordingly.

19 SHARED HOURS:

19.1 In some cases, it may be the case that a couple is living together who are both in receipt of a Care and Support in the Home package. In this case, Practitioners completing the Care and Support Plans will provide guidance where any activities should be delivered as a package of shared hours. For example, this may be appropriate where the care and support needs are related to meal preparation and nutrition or night support. Where the provider identifies that a package of support could be shared they will inform KCC.

20 IMPROVED HEALTH AND WELL-BEING

20.1 The Provider will contribute to the person maintaining good physical and mental health for as long as possible and ensure they feel satisfied that arrangements are in place to access treatment. People will be supported in managing any long-term conditions and disabilities through promotion of self-care, self-management, self-determination etc. Where possible, the Provider will support the person to improve their management of long-term conditions and/or disabilities.

20.2 People will maintain well-being, independence and feel in control of their lives. They will:

a) Feel the Service has assisted them to regain confidence and access choices;

b) Receive Services that reflect and support their changing circumstances and where possible are encouraged to undertake physical activities appropriate to their health, circumstances and abilities;

c) Maintain good health, and feel confident that Care/Support Workers are aware of their personal, cultural or otherwise special dietary and nutritional needs;

d) Have physical, mental and emotional needs identified (including sadness and depression) and supportive measures put in place e.g. Befriending and mental health support Services as appropriate;

e) Be supported to monitor and maintain both nutritional and fluid intake to promote well-being.

21 ENHANCING QUALITY OF LIFE

21.1 The person is central to decision making concerning the support they receive and is encouraged to carry out errands and access leisure and social activities to maximise independence and mental and physical well-being. They feel part of the community, are informed about and participate in local activities and initiatives. The person will:

a) Maintain maximum independence both in their own home and local community and be involved in day to day decisions about the care or level of support offered and taking greater control of their life;

b) Where possible develop personal resilience and resilience within their wider support networks e.g. Family, local community etc.;

c) Be supported to undertake useful and meaningful activities and lead a fulfilling life, with whatever assistance is required and is supported to access local social, cultural, vocational, working and/or leisure activities;

d) Have the opportunity and feel supported to follow their cultural and/or spiritual beliefs within legal boundaries, to include recent and changing legislation e.g. The Prevent Duty Guidance;

e) Be satisfied with the support they receive to access training and employment (where this is an appropriate outcome for the person);

f) Be supported to maintain social/community and family networks;

g) Receive ongoing information relating to the local community and be satisfied with the arrangements made to assist them in making or retaining contacts with the wider community and encouragement to participate in activities;

h) Be supported to maintain health and hygiene within their personal environment;

i) Experience support in accessing dentists, opticians, chiropodists and other healthcare Services;

j) Develop life skills; including where appropriate support to find employment, reduce debts and manage money better;

k) Be encouraged to be involved in local decision making;

l) Supporting the person in all aspects of community and social relationships;

m) Be supported to continue to develop their decision-making capacity in relation to their own care and support needs.

22 PROMOTING INDEPENDENCE - DELAYING AND REDUCING THE NEED FOR CARE AND SUPPORT

22.1 The person will be supported to maintain their independence and manage this as much as they can themselves, through the delivery of self-care advice and techniques and expert by experience schemes. The person will be supported to develop personal resilience and resilience in their wider support network.

22.2 People will be supported to manage their independence utilising a strengths-based approach, which will focus on their abilities rather than their disabilities or long-term conditions. Where care and support arrangements must be put in place, the least restrictive option must always be considered first and actively promoted, in line with Deprivation of Liberty Safeguards 2005.

22.3 Avoidable admissions to hospital will be managed as much as possible with people being supported to access the right care at the right time through the Provider's liaison with health and social care partners. The person will:

a) Be supported to better manage their long-term conditions and disabilities and experience improvements through this, wherever possible;

b) Be supported by the Provider working across the health and social care economy

c) with colleagues in Health teams, social care and within private and voluntary sector Providers and community groups, working in a consortia approach as appropriate;

d) Stay in their own home, as independently as possible, for as long as possible;

e) Have a delayed and / or reduced need to access residential care;

f) Be supported to consider broader housing options;

g) Experience increased independence through the utilisation of equipment and Telecare / Telehealth solutions to meet needs previously met in a hands-on way;

h) Be supported to consider positive risk taking and be able to identify and manage risks within their environment, making informed choices based on sufficient information;

i) Maintain health and hygiene within their personal environment;

j) Take prescribed medication safely in accordance with the Provider organisation's medication policy/protocol;

k) Understand the benefits of eating healthily and exercise.

23 ENSURING A POSITIVE EXPERIENCE OF CARE AND SUPPORT

23.1 Families, carers and advocates will be, with the person's permission, aware of the support delivered and any improvement in outcomes for the person. Families and carers will feel involved and informed about the support delivered with the person's permission. Where possible and appropriate, the person, their families, carers and advocates will be involved in any Care and Support Plan Review and Statutory Review.

23.2 The flexible package of support hours will be pivotal to ensuring a flexible delivery model, as the Provider will support the person to:

a) Be supported to develop communication skills and have a strong voice in the support received;

b) Be enabled to control the Service they receive, with minor changes enabled to meet day to day changing needs;

c) Experience consistency in the scheduling of Services and times the person expects or requires;

d) Experience continuity of care, supported by a 'trusted team' of Care/Support Workers, who they trust and respect, with early introductions made to reduce the fear of new people.

e) Be better informed regarding their care choices and better able to access information on Providers of care in their local area;

f) Experience consistency in the good quality of provision;

g) Be assisted in writing/designing their Care Plan;

h) Have their individuality promoted.

24 CONTINUITY OF CARE/SUPPORT WORKERS

24.1 To ensure that the person is comfortable with their Care/Support Worker(s), the Provider will:

a) Ensure people are supported by a team they trust; the Provider should try and match Care/Support Workers to meet specific needs of the person wherever possible;

b) The amount of Care/Support Workers in this trusted team should ideally be kept to no more than four and in any case as low as possible, or in the case of a high number of support hours delivered, (including double handed, triple handed and live in Care/Support Workers) eight Care/Support Workers;

c) The person is consulted and kept informed about their 'trusted team' always and any changes that may become necessary.

25 PERSON-CENTRED SUPPORT

25.1 People must be at the centre of any Care and Support Planning and Services should be easy to access and use, of good quality and designed to maximise people's ability to live independently and safely in their own homes and communities. This will include;

a) Providing Services that are personalised, that meet their needs rather than the needs of the Service – developing systems to better match Care/Support Workers to people in terms of their interests, to support the establishment of good working relationships, including the development of one-page profiles;

b) Negotiating meaningful Provider Care Plans with people. Clarifying the responsibilities of all people who are supporting the person to achieve these goals;

c) Ensuring action plans are written with the direct involvement of people and consultation of their families where appropriate and with consent, listening to their needs and requirements and being flexible regarding when support is provided rather than fitting persons into pre-arranged rounds of calls;

d) Working in partnership with the person requiring support, carers, families and colleagues to provide care and support interventions that not only make a positive difference but also do so in ways that respect and value diversity including age, disability, gender reassignment; marriage and civil partnership; pregnancy and maternity; religion or belief; sex; and sexual orientation;

e) Addressing the causes and consequences of stigma, discrimination, social inequality and exclusion of people requiring support and carers in all Services. Creating, developing or maintaining valued social roles for people in communities they come from.

f) Supporting the person to access existing opportunities in their local community rather than creating or attending segregated activities and increase the capacity of communities to accommodate those with health and social care needs.

g) Enabling people requiring support to have greater access to personal budgets and ensuring that the people requiring support are central in this process. This will enable people requiring support to have greater choice about the things that they wish to achieve, the type of support that is required to achieve this and will help to facilitate dependence.

26 STRENGTHS BASED APPROACH

26.1 Providers will support people to use their own abilities and strengths to be as resilient and independent as they can. Providers will support people to identify and build on ways they can care for themselves, and will support people to access support from family, friends and carers to resolve problems themselves and deliver their own solutions. This will include:

a) Valuing the capacity, skills, knowledge, connections and potential in the person, their families and their communities;

b) Working in collaboration, helping people to do things for themselves becoming co-producers of support and developing shared care partnerships;

c) Promoting persons becoming active consumers of support, preventing passive consumption;

d) Using a strengths-based approach to maintain and improve social networks and enhance well-being;

e) Encouraging and supporting self-care and exercise.

26.2 The Provider will be expected to work in partnership to provide care and support that enables people to be resilient in regard to their health and social care needs so that they maintain a good level of well-being and can live healthy lives.

27 PROMOTING SAFETY AND POSITIVE RISK TAKING

27.1 People will be empowered take control of their lives with the support of Providers and the Council's Practitioners. People will be supported to manage the tension between promoting safety and positive risk taking. This will be supported by:

a) Ensuring people are supported by a team they trust and not receiving care from numerous Care/Support Workers, the Council recognise that continuity of support is important in building trusting relationships;

b) People and their support team identifying, assessing and then managing risks whilst understanding that risk is an everyday experience;

c) Care/Support Workers accepting the need to work within a wide range of home conditions, subject to a risk assessment;

d) Ensuring people and Care/Support Workers assess risk dynamically, understanding that decision making can be enhanced through positive collaborations;

e) Understanding that risks can be minimised, but not eliminated;

f) Empowering the person requiring support, within reason, to decide the level of risk they are prepared to take with their own health and safety. This includes working with the tension between promoting safety and positive risk taking, including assessing and dealing with possible risks for people requiring support, carers, family members, and the wider public.

g) Providers taking responsibility in encouraging a no-blame culture whilst not condoning poor practice;

h) Providers working with the Council to understand and meet the changing needs and expectations of people and their families and supporting them to have more control over their lives, health and care;

i) Conducting risk assessments where there is potential for significant harm, self- neglect, injury or death. Examples could be but are not limited to the following: choking/falling/scalding/transfers (hoisting)/not following specialist instruction/skin integrity/infection control/Control of Substances Hazardous to Health /labelling and signage (for persons living with Dementia).

28 KEEPING CUSTOMERS INFORMED - INFORMATION PACKS

28.1 Providers will provide an information pack that will include basic information as set out below and will ensure that this is available to the person as the Service starts. The information pack will be in an accessible format e.g. Large print, good standard of English, photographs, audio tape, Braille (where necessary), easy read, video etc. And will be made available to person and their Care/Support Workers. It will include:

a) Statement of purpose: aims of the Service, model of care and support, who the Service is for, including the range and level of care and support Services provided, cultural and social needs catered for and support for Care/Support Workers;

b) Contact details for the Service including telephone numbers for the Service and its Duty Managers/co-ordinator (including out of hours and emergency contact numbers);

c) Service provision: the type of Service, facilities, and range of activities;

d) A statement of person's rights to self-determination;

e) A statement regarding the consequences of unacceptable behaviour;

f) The procedures/contingency arrangements in place in the event of emergency

g) temporary closure, Service reduction or permanent closure;

h) Safeguarding information, including procedures followed;

i) The process of quality assurance;

j) Information regarding where a copy of the most recent CQC and/or other relevant inspection reports or information can be obtained;

k) Details of payment options should they pay all or part of their care direct to the Provider;

l) Information management assurance;

m) Contact details of the relevant Council departments;

n) Complaints/compliments procedure.

28.2 Providers will act as first point of contact and triage all queries and/or issues relating to clients' care and support e.g. Issues or concerns with individual Care/Support Workers, changes in visit timings without prior arrangement, etc. Providers will resolve all issues and queries except those where Social Services have a statutory responsibility (for example safeguarding or social work).

29 PROVIDING SERVICE INFORMATION

29.1 Providers will register with the Council's On-Line Service Directory (or any site that succeeds it). Providers will keep their contact details up to date on the site and any failure to do so may result in a Contract Sanction. These details will be used to communicate with the Provider including any Service changes, enhancements, developments, price increases etc.

29.2 The Council requires Providers to register and actively monitor a suitable generic email address (i.e. Admin@provider.com or office@provider.com) that will be used as the main means of communication between the Council and the Provider. This email address cannot change with any staff turnover within the Provider's organisation and avoids the need for many amendments and possible miscommunications. This must be in compliance with Data Security recommendations from the NHS Data Security & Protection toolkit: https://www.dsptoolkit.nhs.uk/

29.3 The Council requires Providers to follow the Council's Contract Change Control process.

30 PERSONAL DIGNITY

30.1 The person and their family do not experience anxieties about the Services received and is satisfied that the person's environment is maintained to their own standards. The person:

a) Feels confident that Care/Support Workers will assist in their personal care with discretion and in such a way that dignity is maintained with the Care/Support Worker taking direction from the person, wherever possible;

b) Is satisfied that the changes they had hoped to achieve have been realised and the balance between support and assistance is appropriate to their circumstances;

c) Knows that information relating to them is kept confidential and only shared on a need to know basis.

30.2 Information should be detailed in the Care and Support Plan.

31 EXERCISING CHOICE AND CONTROL

31.1 The person is informed and enabled to influence the way in which care is provided in a flexible and appropriate way, with Services responsive to needs and preferences of the person. They will:

a) Feel confident that Care/Support Workers support their choices regarding all aspects of daily living;

b) Feel confident that the Care/Support Worker will arrive and leave within timescales that enable the completion of the required support and will inform the person if there is any change in timing of the support required;

31.2 Feel listened to and able to give feedback regarding the Service (e.g. Complaint or compliment) or when suggesting improvement.

32 TRAVEL

32.1 Support may be required outside the home environment which may be for socialisation or to provide support with practical tasks such as collecting shopping, paying bills, attending appointments with Health workers, etc. Details will be documented on the Support Plans and must be followed. The Service Provider must ensure:

32.2 Vehicle Usage: To ensure that the person is transported safely and appropriately and in accordance with the current legal requirements. The Provider must ensure all Care/Support Workers driving vehicles for people accessing the Service shall:

a) Hold the appropriate vehicle insurance;

b) Hold the appropriate vehicle licensing;

c) Have a valid licence with no more than a maximum of six endorsements, and no disqualifications. Where a care/support worker has more than 6 points the provider must conduct a thorough risk assessment.

d) Have regular driving licence validity, endorsements and disqualifications checks directly with the DVLA using a Driver Check Code, every six months – paper/card licence checks are not valid;

e) Ensure the vehicle is taxed and has a valid MOT;

f) Have awareness of their responsible for safety of the vehicle whilst driving, etc. And will therefore need to ensure the appropriate pre-driving vehicle checks for road worthiness are completed with the vehicle at the start of each period of driving; the provider will ensure this training forms part of the core training needed for the Care/Support Worker;

g) Have time to familiarise themselves with the vehicle, to include understanding of any bespoke features, seat belt usage for wheelchair users, and any other additional non-standard features of vehicles by the person who is the owner of the vehicle;

h) Have awareness of the protocols for correct use of Blue Badges where necessary.

32.3 The provider will work with the person accessing to the Service to ensure the following:

a) The vehicle owner has the appropriate valid documentation for the vehicle each time a Care/Support Worker commences a driving period with the vehicle; to include MOT (Ministry of Transport) test certificate, V5C (vehicle registration document), a print out of vehicle tax validation from the DVLA, and insurance certificate;

b) The vehicle owner or appropriate person demonstrates all bespoke controls and safety features, seat belt usage for wheelchair users, and any other additional non-standard features of the vehicle.

32.4 Concessionary Travel: The Provider will ensure all Care/Support Workers are aware of the protocols for correct use of the following:

a) English National Bus Pass/Kent County Council;

b) Concessionary Bus Pass Scheme;

c) Disabled Persons Railcard;

d) Kent Karrier;

e) Any form of assistive travel.

33 SERVICE USER ACTIVITIES AND TRANSPORT SUPPORT.

33.1 The Care Plan will state focussed specific activities.

33.2 Service users must pay for their own activities and support workers must try to get concessionary arrangements where possible. If concessionary arrangements are not available any costs must be agreed with the Care manager.

33.3 We will only reimburse the cost of the activity on the submission of evidence of the activity having taken place (e.g. tickets, receipts)

33.4 Service users must be supported to use public transport wherever possible however if this is not possible:

33.4.1 Service users in receipt of a Mobility element of Personal Independence payment or other benefit, must use this to fund their transport needs

33.4.2 If the service user is not in receipt of a Mobility element of Personal Independence payment or other benefit the Support Worker will transport the service user to agreed activities.

33.5 Journeys must be linked to an agreed activity in the care plan and journeys and mileage rates must be agreed with the Care Manager.

33.6 Non-routine or unplanned journeys where a Support Worker transports a service user must be agreed by the Care Manager prior to the journey taking place.

34 MULTI-DISCIPLINARY TEAMS (MDTS)

34.1 Providers may be represented at Local Care Multi-Disciplinary Teams as they develop and will engage with Local Care development in their area where appropriate.

34.2 Providers will ensure that any social care needs are recognised, and the correct specialisms are fully engaged. Providers can co-ordinate, arrange and maintain local Services that compliment or are more suitable than the health care Service, to ensure progress towards clients' outcomes (e.g. Arrange for meals to be delivered or refer to day care etc.)

35 END OF LIFE CARE

35.1 Staff must work cohesively with the Service User and where appropriate their Carer and/or Representative and Health Workers to ensure that the wishes of the Service User are adhered to in relation to their end of life care and included in their care plan.

35.2 End of Life Care has been defined by the National Council for Palliative Care as:

35.3 ‘care that helps all those with advanced, progressive, incurable illness to live as well as possible until they die. It enables the supportive and palliative care needs of both patient and family to be identified and met throughout the last phase of life and into bereavement. It includes management of pain and other symptoms and provision of psychological, social, spiritual and practical support’.

35.4 The Service Provider must:

a) Ensure staff at all levels have been appropriately trained and possess the skills and experience required for working with the Service Users and their Carer and/or Representative who have supportive and palliative care needs.

b) Work collaboratively with the multi-disciplinary team, working with, for example, gps, District Nurses, Macmillan Clinical Nurse Specialists, Community Matrons and Carers Support Services.

c) Have the flexibility and responsiveness to meet the changing needs of Service Users and their Carer and/or Representative to enable Service Users with End of Life Care needs to remain living in their own home

36 COMPLEX CARE AND SUPPORT

36.1 The standard Care and Support in the Home Service will be provided to most people requiring Support but there will be some exceptions where the Complex Service will be required.

36.2 The Care and Support in the Home Complex Service is for people requiring Support who are assessed by the Council as having complex and/or challenging needs, where higher risks are present that cannot be reduced by additional Staffing. Complex level Support may also require additional training above that included in the Provider's mandatory expectations the Council's Practitioners are responsible for assessing the need for Care and Support in the Home Complex Services and defining the Service required in the Care Plan.

36.3 Where people are assessed by a Practitioner as requiring Complex Services, this will be approved by the Council's Practice Assurance Panel and may be underpinned by risk assessment alongside the Care and Support Plan.

36.4 In recognition of the additional requirements set out above, the Care and Support in the Home Complex Service contracted rates are higher than those of Standard Support.

36.5 The Care and Support in the Home Complex Service requires the Provider's Staff to be trained to a higher level to meet the greater complexity of needs of the people requiring Support. In addition to the general standard Providers will:

a) Prepare in depth risk assessments around the areas of higher risk and/or specific behaviour(s) together with what has been put in place to minimise and manage those risks;

b) Provide clear Behavioural Support Plan for people requiring Support that details: the identified behaviour(s); how the behaviour(s) manifest; clear guidelines as to how the person requiring Support should be Supported to reduce the behaviour(s) and what alternative solutions have been considered and/or implemented;

c) Have clear boundary settings;

d) Evidence that Care and Support Workers have had training appropriate to the complex needs of the individual, in particular where there are clinical presentations of mental health issues; Dementia and Neurological function;

e) Evidence that Care and Support Workers have had training in the delivery of intervention strategies;

f) Engage with professionals from other agencies who provide specific Support and guidelines and that you follow their guidelines as required; and

g) Engage with relevant professional Support networks.

36.6 Illustration examples of Complex Support:

Example A: Simon (Standard Support)

A person requiring:

- Prompting with morning and evening medication
- Support with Personal Care
- Prompting with Meal Preparation

10 Hours per week @ Standard Rate

Example B: Ethel (Complex Support)

A person presenting challenging behaviour and hearing loss, requiring:

- Communication via level 3 BSL
- Support with morning and evening medication
- Support with Meal Preparation
- Sleep Night Support

25 Hours Day Support per week @ Complex Rate
7 Sleep Nights @ Contracted Rate

37 SERVICE USER DISCHARGE FROM HOSPITAL

37.1 People in hospital when medically fit, who require support on discharge, will be offered an enablement package in the first instance, where this is the appropriate type of care and support. This is a short-term intensive support package focusing on the enablement of the person.

37.2 Providers will be expected to support discharge from hospital for known people (who already have a Council funded care package with the Provider), where there is no change in need and no Council re-assessment necessary

37.3 Providers will:

a) Follow the person's progress through the acute pathway by communicating directly (with permission) with the hospital ward and person, promoting self-care for some needs from the outset (where appropriate);

b) Be expected to work with hospital staff to determine when the person is fit for a safe discharge.

37.4 The Provider must ensure they are kept aware of all that has happened that will be relevant to their continued care and should visit the person in the acute setting or speak to them via the telephone to ensure they keep in contact.

37.5 There may be occasions when the Provider feels that they are unable to support a care package reinstatement from hospital. In these circumstances the Provider should notify the Council and the ward so that appropriate measures can be put in place to reassess the person's needs. Providers must report any safeguarding concerns in the usual way and should trust in their judgement regarding safe discharges from acute settings.

37.6 Providers must keep the Council informed whilst the person is in hospital and upon their discharge as the Care and Support Plans may need to be altered to reflect any changes in needs. This notification is important as it will prompt changes to the Council's social care records system to ensure Providers are paid appropriately.

37.7 Further details can be located in Schedule 1 section 2.3

38 CARE AND SUPPORT PLAN REVIEW

38.1 Formal Reviews of the person's Care and Support Plan will be conducted by the Council. The first Review will be held within 8 weeks following the commencement of the person's care and support package, in line with requirements under the Care Act. Thereafter, a Review will be held as often as the Council, the Provider and the person feels is necessary; at least annually, or as determined by the milestones detailed in the action plan. This will include updates to the Care and Support Plan where required. Where necessary Service Users can access Advocacy through the Councils advocacy contract.

38.2 Reviews will be delivered, in line with Care Act requirements, at least annually. These will incorporate a review of the Care and Support Plan to ensure it remains fit for purpose and review of the Care Plan held by the Provider. Initially these Reviews will be conducted by the Council, but in the long-term there is an aspiration that Providers will complete these reviews. More detail is provided in Section 4.

38.3 Providers will complete Provider Pre-Review Information Form (PPRIF) to inform the Council's preparation for the Care and Support Plan Review. PPRIFS allow Providers to clarify hours of support, identify where development is possible and suggest any new goals and to state if there are any current goals being worked towards. This process will be from the outset of the contract for clients with Learning disability or Mental Health needs and may subsequently be rolled out to clients with Older person or Physical disability needs.

38.4 The Review will involve the person and the designated Council representative. The Provider will only be present if the person wishes them to be, but they must contribute to, and provide information, for the Review and confirm that they are able to support the goals and outcomes identified at the Review. Any other people who can actively contribute and whose input the person has requested may also be present with consent from the person.

38.5 The Review will also address the extent to which the initial outcomes are being met, determine whether eligibility criteria continues to be met and whether the person still requires the Service or if the level of Service needs to change.

38.6 The Provider should note that this process may change as part of the Council's Modernisation programme and review of Care Pathways and Optimisation. Providers will be informed of any changes. Potential changes to the Review process, roles and responsibilities are set out in section 56 of this Schedule.

39 PROVIDER REVIEW RESPONSIBILITIES

39.1 It is expected that the Provider will highlight the need for Review whether the needs have increased or decreased. The Provider also has a responsibility to report any child or adult safeguarding concerns in accordance with Kent and Medway Multi-Agency Safeguarding Vulnerable Adults Protocols. The Provider's delivery plan may consequently be amended as necessary to reflect new outcomes as required. In addition, upon significant change to the person's condition or in the way that the person would prefer their Service provided, Providers should signal the need for an early review or re-assessment of the arrangements commissioned by the Council.

39.2 The Provider will undertake informal continuous reviews during visits and, as determined by the person's action plan, and within reason will initiate additional Reviews at the Council's request, or as requested by the person. The Service review will address the extent to which the outcomes required of the Service are being met. Where the Provider

has identified that Telecare/Telehealth (Assistive technology) may be beneficial, this should be notified to the Council. If outcomes are not being met the Provider will adjust the action plan accordingly in conjunction with the person and notify the Council.

39.3 The Provider should signal to the Council the need for a Review upon either a significant change to the person's condition, or a change in the way the person would prefer their Service provided in order that the Service review or re-assessment processes can be commenced.

39.4 The Provider should contact the Council and any Attorney or Deputy (as appointed by the Court of Protection) should there be a need for GP intervention.

40 VISIT PROTOCOLS

40.1 A communications book must be provided in each person's home, or if a Provider is using an alternative electronic document access must be provided for the person, family members and other professionals, to keep an ongoing record of the care provided and any refusals of agreed support, any financial transactions and regular feedback from the person receiving the Service.

40.2 The communications book and electronic document remain the property of the Council.

40.3 Providers must ensure that all financial transactions are carried out in accordance with the specific requirements identified in the person's Care and Support Plan and Care/Support Workers should be supported to fully understand policies and procedures in this regard.

40.4 Late/Early calls are defined as a call starting 45 minutes or more later or earlier from the time stated on the Service Delivery Order.

40.5 A missed call is defined as a call not made, or one that is started more than two hours after the time stated on the Service Delivery Order.

41 INFECTION CONTROL

41.1 When carrying out all personal care support, the following applies:

41.2 The Provider shall provide all personal protective equipment necessary for the supply of Services and any small pieces of equipment that help Care/Support Workers to support people back to independence. The Provider will ensure all Care/Support Workers have the appropriate clothing, footwear, and appearance whilst on duty to comply with Infection Control procedures, and the guidance detailed in the Health and Safety at Work Act 1974 and PUWER.

41.3 Anti-bacterial hand gel must have 60% alcohol content and must be provided along with paper towels, for households identified on the risk assessment as having inadequate hand washing facilities.

41.4 Staff must have received training in infection control during induction

41.5 The Provider will ensure Care/Support Workers, when carrying out caring of domestic tasks with people, will not wear nail varnish, artificial nails, hair accessories of any kind and jewellery that is likely to cause a health and safety risk including cross infection

42 EMERGENCY PROTOCOLS

42.1 Occasionally Care/Support Workers are faced with emergency situations throughout the course of their work/activities. This can be stressful and upsetting. The procedures below give clear instructions about action which should be taken. Care/Support Worker will have received immediate support from the appropriate provider organisation manager/care co-ordinator. Guidance will be immediate, clear, calm and supportive of the person receiving care and the Care/Support Worker.

42.2 If a Care/Support Worker cannot obtain an answer from the person at home or the usual family/parent carer they should:

a) Check through the letterbox, windows and back of the house to see if it is accessible;

b) If you cannot see the person check with neighbours;

c) If the neighbour cannot help, telephone the Provider's office and the Duty Manager/Co-ordinator will inform you as to further action.

42.3 If the Care/Support Worker can see the person in receipt of the Service and they are on the floor or not responding Providers should advise Care/Support workers to:

a) Ring for an ambulance dialling 999 immediately;

b) Ring your provider organisation's allocated Duty Manager/Co-ordinator;

c) If you are aware of a key holder nearby, go to them – contact your Provider organisation when you reach the additional key holder to gain further advice.

42.4 If a Care/Support worker finds a person in receipt of the Service who appears dead when the Care/Support Worker arrives – providers should advise Care/Support Workers to:

a) Call the emergency Services by dialling 999 immediately and follow their instructions. They must be informed if there is a DNACPR (Do not attempt cardiopulmonary resuscitation) in place if known and follow the specific person-centred advanced care statement procedure for DNACPR.

b) If the person lives in Extra Care/sheltered accommodation pull the emergency cord.

c) The service user must not be moved unless at the instruction of the 999-emergency call handler.

d) Once the emergency services are in attendance they will take the lead and continue with emergency procedures before confirming the death.

e) Avoid touching anything unless directed to do so by the emergency services and once it is established that death has occurred leave the room and close the door to restrict access by people or pets.

f) Call the Provider office, your provider Duty Manager/Co-ordinator and request that the Kent County Council Keyworker/Care Manager is notified

g) Wait for the provider to send a senior member of personnel to assist you at once;

42.5 Should an emergency occur during the course of care being given, Care/Support Workers must ensure the following protocol is followed:

a) If a person falls and may be injured they must not be moved unless they are in serious and imminent danger, e.g. Form fire, drowning, road traffic accident etc.;

b) They must be made comfortable and dial 999 immediately;

c) If it is known that the person may be prone to occasional falls or collapse this should be considered in the risk assessment and a contingency action plan devised for this eventuality;

d) If a person collapses or is taken seriously ill dial 999 immediately and make the person made as comfortable as possible – the emergency Services personnel may advise you of action to take while awaiting their arrival;

e) In these situations, call your Provider Office and speak to the Duty Manager/Co-ordinator who will arrange for your subsequent visits to be covered while you stay with the person or will send someone to relieve you for you to continue the visits on your schedule if you are able to continue.

42.6 Providers shall:

a) Ensure subsequent visits are covered immediately once a Care/Support Worker contacts to advise about any of the above situations, alternatively you must send someone to relieve the worker for them to continue visits on their schedule;

b) Ensure the person (and where appropriate, carers, advocates) is aware of this Emergency protocol at the commencement of the Service, and is included within the Information Pack;

c) Call ahead to advise people in receipt of the Service with the Care/Support Worker/s about the incident and whether they will receive a different Care/Support worker or whether their visit will be late;

d) Advise the appropriate Council personnel by phone and followed up with an email within 12 hours of the incident;

e) Ensure Care/Support Worker's Induction Training encompasses Emergency Protocols;

f) Ensure a refresh of Emergency Protocols is conducted every quarter

g) Draft an Emergency Protocols pocket guide is carried at all times by Care/Support workers;

h) Decide whether the format of the pocket guide to Emergency Protocols e.g. Laminated A6 format, credit card size format, or included on the reverse of the identification worn by Care/Support Workers;

i) Put in place additional support for Care/Support Workers who have witnessed a distressing situation;

j) Work cooperatively with any additional statutory agency regarding follow-up investigations.

42.7 If an emergency or crisis arises the Provider will deploy additional Care/Support Worker time without the prior consent of the Council for the period of 1 hour. The Provider will notify the Council of such a change and any additional Care/Support Worker hours utilised immediately, clearly stating the reasons for the additional hours and any ongoing need. The person will not be required to make any payment to the Provider.

43 MENTAL CAPACITY ACT

43.1 Providers must comply with the principles of the Mental Capacity Act and empower people to make decisions for themselves wherever possible. Assessments of capacity are time and decision specific, where a person has been assessed as lacking capacity in a decision then any action taken, or any decision made for or on behalf of that person, must be made in his or her best interests and the Provider should ensure such decisions are clearly documented.

43.2 Providers may be required to contribute to and/ or attend Best Interest Decision meetings

44 EQUALITY AND HUMAN RIGHTS

44.1 The Equality Act 2010 introduced a public-sector equality duty which must be exercised by the Council in performing its functions. The Duty underpins this specification and Service Providers must pay due regard to:

a) Eliminating unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act;

b) Advancing equality of opportunity between people who share a protected characteristic and those who do not;

c) Fostering good relations between people who share a protected characteristic and those who do not.

44.2 These are sometimes referred to as the three aims and arms of the general equality duty. Simplified, the act describes the need to have due regard for the advancing of equality which involves:

a) Removing or minimising disadvantages suffered by people due to their protected characteristics; Taking steps to meet the needs of people from protected groups where these are different from the needs of other people;

b) Encouraging people from protected groups to participate in public life or in other activities where their participation is disproportionately low.

44.3 Providers must operate in accordance with the Human Rights Act 1998, the statute which made the European Convention on Human Rights (ECHR) part of English law. It requires public authorities and those Services they commission to act compatibly with the ECHR.

44.4 It is a priority of the Council to meet its Human Rights Act obligations. This Service specification has been designed to help promote and protect the human rights of people receiving Care and Support in the Home Services. Contracted Providers must deliver Care and Support in the Home in ways that protect persons' rights to respect, dignity, privacy and autonomy.

44.5 The Equality and Human Rights Commission's framework for human rights in Care and Support in the Home has been adopted by the Council and underpins our expectations for the delivery of this Service. The Council will take positive steps to protect the human rights of people who receive Care and Support in the Home Services.

45 ACCESSIBLE COMMUNICATION STANDARDS

45.1 Service Providers are under a contractual obligation to promote and protect human rights, with a zero tolerance of neglect and abuse. Providers must find effective ways of communicating with each person to ensure that they are at the centre of their Care and Support Plans

45.2 Ensure staff are aware and use the Accessible Communication Standards published by the Department for Work and Pensions, Office for Disability Issues (August 2014)

46 FINANCIAL PROTECTION

46.1 The Provider will have policies and procedures in place for staff on the safe handling of money and property belonging to the person, which covers:

a) Recording the amount and purpose of all financial transactions undertaken on behalf of the person. Records which must be signed and dated by the Care/Support Worker and the person or nominated advocate, attorney or deputy;

b) Collection of pensions or benefits;

c) Safeguarding the property of the person whilst undertaking care and support tasks;

d) Reporting the loss or damage to the property whilst providing care and support.

46.2 The Provider's Safeguarding policies and procedures must make clear that staff must not:

a) Use credit or debit cards, pre-payment cards, or any on-line accounts, cheques belonging to the person, or have knowledge of the person's PIN number;

b) Accept gifts (beyond a very minimal value of £5);

c) Use loyalty cards except those belonging to the person for the person;

d) Use offers, vouchers, stamps or discounts other than for the person;

e) Undertake personal activities during time allocated to provide care and support to the person;

f) Witness or support with writing legal documentation for the person e.g. Will writing;

g) Make personal use of the person's property (e.g. Broadband);

h) Involve the person in gambling syndicates (e.g. National Lottery, online betting);

i) Borrow from or lend money or vouchers to people within the Service;

j) Sell or dispose of goods belonging to the person and their family; Sell goods or Services to the person and/or buy goods or Services from the person including any free Services e.g. Freecycle;

k) Incur a liability on behalf of the person;

l) Take responsibility for looking after any valuables on behalf of the person;

m) Allow any unauthorised person (including children) or pets to accompany them when visiting the person, with exception of assistance dogs with consent of the person, without their permission and the Council's approval;

n) Make or receive telephone calls that are personal or are regarding other people;

o) Use time allocated to care and support the person for any other purpose;

p) Undertake any activity which is in breach of UK legislation.

46.3 Provider must have policies and procedures in place for Staff concerning the investigation of allegations of financial irregularities and the involvement of Police, Customs Officials, Adult Social Care and Health and other professional bodies.

47 SAFEGUARDING AND FREEDOM FROM ABUSE

47.1 The person will feel and be safeguarded from neglect and abuse and will know that any concerns will be listened to and acted upon promptly. The person will

a) Be free of deliberate abuse and neglect, with the Provider responding promptly to the sharing of any concerns and understanding when this can/should be escalated to the Council;

b) Know who to report concerns to and issues regarding their care and support;

c) Know that concerns are taken seriously and addressed through the appropriate governance;

d) Live safely in their own home/community;

e) Know that home security is not compromised by the Service;

f) Be supported to develop good communication skills and be enabled to have a voice regarding any concerns, alleged discrimination and/or harassment.

47.2 To ensure that the person is free from abuse and appropriate action is taken where it is suspected, the Provider will:

a) Respond to alerts immediately after ensuring the person is safe;

b) Attend Safeguarding Adults Review meetings;

c) Comply with the requirement that Safeguarding Adults Review Panel requests for Independent Management Reports are completed within six weeks;

d) Comply with any relevant guidance to safeguard children, including but not limited to Working Together to Safeguard Children (2018) and Keeping Children Safe in Education: Statutory Guidance for Schools and Colleges (September 2016);

e) Where children are present in the home (whether by residence, visit or because they are receiving care as part of the service), immediate consideration will be given to their independent safeguarding needs and the Kent and Medway Safeguarding Children Procedures followed to ensure their welfare and safety is protected. http://www.proceduresonline.com/kentandmedway/

f) Ensure that all staff are aware of their duties in keeping young people safe from Child Exploitation and have training in this which is recorded. Staff must be able to identify risks associated with all forms of Child Exploitation and Providers will agree a risk management strategy with the Council;

g) Make representation in court as and when necessary;

h) Ensure there is a Safeguarding Adults policy available that compliments the Multi-Agency Safeguarding Policy, Protocols and Guidance for Kent and Medway.

i) Ensure staff are familiar with the Kent and Medway Adult Protection Procedures and with the Providers' own policy and procedures on Safeguarding and Adult Protection;

j) Ensure the Kent Adult Safeguarding Form (KASAF) is completed to notify the Council if adult abuse is witnessed or reported;

k) Work in partnership with officers of the Council (or any others that the Council chooses), to make enquires in fulfilling its duties under section 42 of The Care Act 2014;

l) Participate in adult protection assessments and enquiries and comply with any recommendations where practicable in post abuse action plans;

m) Ensure staff training is provided in safeguarding and is refreshed at regular intervals (minimum of every 2 years) and ensure staff attend relevant safeguarding adults training appropriate to their position;

n) Comply with the Disclosure and Barring Service (DBS) requirements for staff. These checks should be done every three years as a minimum;

o) Take positive action to combat discrimination in line with UK legislation;

p) Respond to the Prevent Duty Guidance.

47.3 Safeguarding for Children and Vulnerable adults is defined in Clause 13 of the contract terms and conditions.

48 RECORDS

48.1 To ensure that records of visits to the person's home and details of support given are comprehensive and shared as appropriate, the Provider must ensure that;

a) Any refusal of support agreed within the Care and Support Plans must be recorded in the person's communications book;

b) The Council's authorised staff can see records required by this specification at any time;

c) They accommodate visits by the Council's authorised staff, which may take place at any time and could be unannounced at the Provider's premises. The Council will be reasonable in exercising this right;

d) Care/Support Workers visiting the person for the first time sign the person's file to show they have read the relevant sections and are familiar with the person's needs;

e) Appropriate sections of the person's personal file are accessible to relevant care staff;

f) The current communications book is left in the person's home always; completed pages should be removed and placed on the person's file at the Provider's premises after one month;

g) Care/Support Workers are aware of the Provider's policy regarding confidentiality of records;

h) Care/Support Workers will record the date and time of every visit, the support provided and any significant occurrence. Records will be factual, legible, signed and dated and kept in a safe place as agreed with the person, as per the record keeping policy.

48.2 Records will include:

a) Assistance with medication;

b) Care provided;

c) Any specific person-centred requirements.

d) Details of changes in the person's circumstances, support needs, health condition and any mental capacity concerns which raise questions about the person's ability to consent with specific decisions of the care and support arrangements;

e) Any accidents, untoward incident, or emergency to the person and/or Care/Support Worker;

f) Activities undertaken, and any achievements and/or goals achieved;

g) Any information that will assist the next Care/Support Worker to ensure consistency in the Service provision.

48.3 The person will be informed about what is written and will have access to the communications book and any contents past or present. The person will be encouraged to have the current communications book kept in their home. Records will be available to the Council and/or person on request.

48.4 Any significant occurrence or changes in circumstances/support needs should be reported to the Providers and the Council's teams. Where the person does not agree, the Provider will record this refusal on the personal file held by the Provider, with the exception of Safeguarding concerns.

48.5 All information must be stored in accordance with current data protection legislation.

49 SECURITY

49.1 Providers must have clear protocols in place in relation to entering the home of the person. In some cases, it may be necessary for Care/Support Worker to have keys, entry fobs, and/or entry codes. The protocols will cover:

a) Knocking/ringing bell and speaking out before entry;

b) Written and signed agreements on key/fob/entry code holding;

c) Safe handling and storage of keys/fob/entry codes outside the home;

d) Confidentiality of entry codes;

e) Alternative arrangements for entering the home;

f) Action to take in case of loss or theft of keys/fobs/entry codes;

g) Action to take when unable to gain entry;

h) Securing doors and windows;

i) Discovery of an accident involving the person;

j) Other emergency situations.

49.2 Providers will ensure that all Care/Support Worker and/or staff are identifiable employees of the Provider by supplying identity cards to Care/Support Workers entering the home of the person. Identity cards must display:

a) A photograph of the member of Care/Support Worker or staff member;

b) The name of the Care/Support Worker and/or staff member and Provider organisation in large print and braille if required for the person in receipt of the Service;

c) The contact number and/or textphone number of the Provider;

d) Date of issue and expiry date, which must not exceed 36 months from the date of issue.

e) Identity cards must be:

I. Available in large print for people with visual impairments and/or braille if needed by the person in receipt of the Service;
II. Laminated or otherwise tamper proof;
III. Renewed and replaced within 36 months from the date of issue;
IV. Returned to the Provider and destroyed appropriately within 24 hours when employment ceases or when the card is renewed.

49.3 The Provider will keep up-to-date with the developments in new security technology and where necessary provide enhancements to a person's security after gaining the person's permission and informing the Council.

50 HEALTH AND SAFETY

50.1 Accidents and Injuries: To ensure the Provider's Staff are informed and deal confidently with accidents, injuries and emergencies the Provider must ensure that:

a) All staff are aware of the Providers' policies and procedures for dealing with medical emergencies;

b) Any accidents or injuries to the person that require hospital or GP attendance that the Care/Support Worker has knowledge of, are reported to the Council and noted in the person's Contact Book.

50.2 Risk Assessments: To ensure the appropriate risk assessments are conducted for the acquisition, use, and ongoing support of equipment used in the person's home, and activities supporting the person. This will include regular safety checks, appropriate training and preventative measures put in place whilst conducting duties to minimise the risk of harm to the person and Care/Support Workers, associated with the acquisition, use, and ongoing support of equipment used carry out duties for the person, by ensuring:

a) There are clearly defined and designated roles and responsibilities for the management of the device/equipment;

b) Equipment Audits are carried out annually to include current test certification organised by the equipment owner;

c) Care and Support Plans received the Council contain consent forms for the use of bed rails, and these were signed the person or a family member where the person was unable to do this themselves;

d) Equipment has an annual assessment for safety and recorded to include LOLER, should this be conducted by another Provider or the Council, this must be shared with the provider;

e) Care/Support Workers understand how to use bedrails, shower commode chairs, and how safety straps are fitting to make sure people are safe.

50.3 Transmittable Diseases: To ensure that the person, his/her family, staff and visitors are protected from transmittable diseases, the Provider must ensure that:

a) A policy in relation to transmittable diseases (e.g. HIV/AIDS and Hepatitis A, B and C) is available and known to all staff;

b) Appropriate risk assessments are in place;

c) All staff are trained to work safely with people always.

50.4 Data Protection and personal security to ensure that the protection of the person's home is maintained, and is not compromised by any action undertaken by a Care/Support Worker from the Provider's organisation, the Provider must:

a) Comply with GDPR requirements set out in Schedule 20 Annex 1a/ 1b;

b) Make staff aware of the risk of unintended breaches of confidentiality and make sure staff can identify situations in which it may occur through the provision of appropriate training;

c) Ensure that staff know of the policies and procedures which are in place in respect of the person's safety;

d) Make sure that staff do not carry with them more confidential information than they need for a week's work programme (e.g. Lists of names and addresses);

e) Ensure, when it is necessary for staff to keep written information detailing passwords or keypad numbers with them, that they understand the need to preserve security; The Provider must also make sure passwords or keypad numbers are not kept alongside names and addresses and key fobs should not carry the name or address of the person on them;

f) Liaise and negotiate with the person if a change of Care/Support Worker or a suspected breach of security occurs, to see whether a change of access code number will be acceptable to them;

g) Have policies and procedures in place to make sure that when Care/Support Workers leave or change, an appropriate transition plan is in place for the person.

h) Ensure, where appropriate, that they have achieved or are working towards the NHS Data Security and Protection toolkit.

51 NOTIFICATIONS TO THE COUNCIL

51.1 Providers must notify the Council immediately in writing via email of any:

a) Safeguarding concerns in respect of the person;

b) Emergency incidents as detailed in section 6.3, including serious accidents or incidents involving the person or the Care/Support Worker, hospital admissions and/or deaths of the person, including any other change in the Service related to circumstances or emergency;

c) Regular and/or persistent (three or more times in consecutive visits) refusal by the person to accept support to meet outcomes mutually agreed in the Care and Support Plan;

d) Failure to provide the Service to the person, missed, late, void or 'No response' calls (within the contract tolerance);

e) Delivery of 'flex hours' above or below the hours defined in the SDO and the reason for this change;

f) Deterioration in the person's health or well-being

g) Improvement in the person's circumstances, including mental capacity issues – improvement or deterioration of the person's mental capacity in relation to specific decisions of the Care and Support Plan. This may also include the achievement of a goal

and/or outcome which may be associated with a reduction in the hours of care and support required.

52 NOTICE PERIOD

52.1 Regarding handing back packages of care and support packages, Providers must immediately discuss with the Council, and give the Council notice as laid out in Schedule 1 section 2 of any proposed hand back, except as otherwise mutually agreed. The Provider and the Council will work together to minimise any disruption and maintain continuity of Service to the person whilst supporting a transition plan for the person.

52.2 The communications book and action plan for the person must be handed back to the Council or the alternative provider on the last day of Service delivery

53 FUTURE SERVICE REQUIREMENT PROPOSALS

53.1 Moving forward into the Contract we expect the focus of the Service to be on outcomes within a flexible package of support hours defined within the Care and Support Plan. The Care and Support Plan will detail the outcomes to be achieved for the person within these hours; the hours can then be used flexibly within the billing period set out to support the person as agreed.

53.2 This delivery style will support the flexible delivery of outcomes-based care, give greater choice and control for the person, using a strength-based approach.

53.3 As part of the aspiration to enable Providers to deliver care and support more flexibly there is the aspiration for the Council is to delegate responsibility for annual statutory reviews to the Provider. This will support a reduction in duplication of activity, as it is known that at present both Providers and the Council conduct their own annual reviews of a person's care and support package

53.4 At present the process for Older people care and support often starts with a short period of care and support delivered by the Kent Enablement at Home service this allows the Council to gain a good understanding of the care and support needs of a service user. Throughout the life of this contract we will look at piloting a pathway for Learning Disability Clients which may utilise the Kent Pathway Service in a similar fashion. There will also be consideration given to assistive technology such as 'Just Checking'.

53.5 The Council expects to start discussions with providers in relation to these proposed changes in Summer 2019.

53.6 Providers must be mindful of the Councils continuous improvement in relation to systems, technology and processes and work towards compatibility with the Council. This may include activities such as The Kent and Medway Care Records.

54 ELECTRONIC CALL MONITORING AND TECHNOLOGY

54.1 At present there is inconsistency in the use of Electronic call monitoring systems and other technological systems supporting tasks such as automated invoicing, creation of rotas and record keeping across the Provider market.

54.2 As part of the Council's aspirations in relation to market-shaping and ensuring market capability to deliver in a more flexible and personalised way, the Council wishes to see

increased use of available technology underpinning the delivery of Care and Support in the Home Services. Some of the types of systems that the Council wishes to see Providers scoping and implementing and their associated benefits are listed below:

a) Paper-based documentation will be replaced by electronic care plans that support person-centred care and assist providers to more effectively demonstrate and ensure compliance.

b) Electronic Call Monitoring systems can give care workers a live rota on their mobile handsets and real-time task lists and service user data. It can also allow managers to see, instantly, if a care worker is running late for an appointment.

c) Electronic Medication Administration Records (emar) enable care and nursing staff to more effectively coordinate, monitor and administer medications and provide more accurate and timely medication information for staff, and further improve safety.

d) Smart scheduling and rostering systems can enhance accessibility to personalised care services in the most efficient ways. This allows an organisation to deliver more flexible and personalised care, therefore driving improved outcomes for the Service user.

54.3 It is expected that Providers who are successful in their bid for a Care and Support in the Home Services Contract will work with the Council to test and implement new technological systems which will support more efficient ways of working. Providers will be engaged to design any pilot projects and given appropriate notification of their commencement. The Council will work with providers to agree reasonable timescales for the implementation of new systems. However, it is envisaged that all Providers will be in a position to operationalise from April 2020.

55 HEALTH INTEGRATION

55.1 Health Integration is about placing service users at the centre of the design and delivery of care with the aim of improving patient outcomes, satisfaction and value for money. Working more closely with Health partners will seek to improve the customer journey through the service pathway, resulting in a more seamless transition from hospital to care in the community Services. The Council has an aspiration to support the progression of the Health and Social Care integration agenda during the life of the Care and Support in the Home Contract to help meet its strategic outcomes.

55.2 Integration could support efficiencies such as joint assessments of a patient's care needs across more than one Service provision, improved use of back-office functions and reducing delayed transfers of care, all of which could support financial savings for both partners.

55.3 Improved integrated working could also deliver benefits by sharing best practice across care workers and health professionals. In the longer term, this could support the development of a better-defined career pathway for care professionals.

55.4 The Council has already given consideration to how best to enable joint working, particularly in the Lotting Strategy for Care and Support in the Home Services. Where appropriate, clusters will align to Local Care boundaries to enable closer joint working between Health and local Providers of Care and Support in the Home.

55.5 It is expected that from 8 April 2019, Providers will engage with Local Care organisations in their localities, and where appropriate will attend and support Multi-Disciplinary Teams to enable a joined up working approach.

55.6 Over the life of the Contract, Providers will be expected to work collaboratively with Health partners and the Council to design and run pilots across which will trial methods to progress the Health and Social Care integration agenda. This may include the delivery of a Health Alliance Contract, subject to further scoping during the life of the Contract.

56 PILOTING FLEXING OF HOURS

56.1 As part of the aspiration to deliver in a more personalised, outcome-focused way and support people's independence in the most appropriate way, the Council recognises that it is sometimes necessary for Providers to deliver additional care above the hours specified by the care and support assessment, for a limited period of time.

56.2 The Council recognises that the Providers who deliver Care and Support in the Home Services will be the body best placed to identify where people require additional short-term support and implement this efficiently.

56.3 Flexing of hours may be required, for instance, in a situation where a person has developed a urine infection which is being treated with antibiotics but needs additional support for 72 hours to prevent admission to hospital. In a model enabling flexing of hours, a Provider could deliver additional hours within a defined tolerance for a defined, short-term period.

56.4 During the life of the Care and Support in the Home Contract, the Council intends to select a discrete geographical area where it will test enabling Providers to flex care up or down for a limited period within a defined tolerance. Testing the concept will enable the Council to build an evidence base and demonstrate whether this approach results in improved outcomes for the individual, and outcomes such as hospital admission avoidance.

56.5 Testing the concept of flexing of hours will be subject to additional work to scope the impact on the charging process, implement appropriate systems to support efficient payment mechanisms and consult with the public as required.

56.6 It is expected that Providers who are successful in their bid for a Care and Support in the Home Services Contract will work with the Council to test the concept of flexing hours, if they deliver in a Cluster area where the Council wishes to pilot. Providers will be engaged to design any pilot projects and given appropriate notification of their commencement.

57 PILOTING PROVIDERS DELIVERING STATUTORY ANNUAL REVIEWS

57.1 As part of the aspiration to enable Providers to deliver care and support more flexibly, and the recognition that the Provider is best placed to understand and meet a person's changing needs, a long-term aspiration for the Council is to delegate responsibility for annual statutory reviews to the Provider.

57.2 This will support a reduction in duplication of activity, as it is known that at present both Providers and the Council conduct their own annual reviews of a person's care and support package.

57.3 In order to delegate authority for carrying out statutory reviews to Providers, the Council will need to enact robust risk mitigation measures and be assured of the market's capability and capacity to deliver these activities, and the maintenance or improvement of outcomes for people using Services.

57.4 During the life of the Care and Support in the Home Contract, the Council intends to select a number of Providers who will test the delivery of annual reviews. Testing the concept will enable the Council to build an evidence base and demonstrate the value of delegating this activity to Providers. It will also allow a time period where the Council can provide a higher level of oversight of these activities to quality assure the delivery before implementing across the market.

57.5 It is expected that Providers who are successful in their bid for a Care and Support in the Home Services Contract will work with the Council to test the delivery of annual statutory reviews.

57.6 Subject to successful testing of Providers delivering reviews, there will be a further competition for a Contract which delegates responsibility for annual statutory reviews to the Provider. It is expected that Providers will develop their capability and capacity over an agreed timeframe to support this objective.

58 PARTNERSHIP WORKING

58.1 Where Providers are working alongside other agencies to deliver care and support packages, they will work in partnership with the other agencies to ensure the Services are provided in accordance with the person's Care and Support Plan and to maximise gains. Providers will sign up to an interface agreement provided by the Council and will actively support a consortia approach.

58.2 The principle of improved cross-sector working will be supported through the contract management approach using a balanced scorecard methodology with specified KPI's to encourage integrated, participative working with statutory bodies, other Care and Support in the Home Providers, private and voluntary Providers of social care Services and other organisations outside of the social care system.

58.3 Providers will be required to sign up to an interface agreement to support long-term consortia plans.

58.4 The Council wishes to work in partnership with Providers in delivering a high quality comprehensive Care and Support in the Home Service to its people. By signing up to a partnership approach the Council and Service Providers are making a commitment to:

a) Seek to develop and maintaining constructive working relationships with the person requiring support, carers, families, colleagues, professionals and wider networks

b) Have a contract that is flexible enough to reflect changing needs, priorities, strategy, seek continuous improvement through fostering a learning environment and working together, and which has person and Care/Support Worker participation at the centre;

c) Work towards achieving key outcomes and objectives;

d) Communicate openly and honestly with each other clearly and regularly;

e) Share relevant information, expertise and plans;

f) Avoid duplication wherever possible;

g) Monitor the performance of all parties;

h) Seek to avoid conflicts but, where they arise, to resolve them quickly at a local level wherever possible.

58.5 Improve cross-sector working to ensure integrated, participative working, not only across statutory and voluntary providers of Services and social care but also with and between providers outside the social care system. These could include:

a) Faith groups;

b) Minority ethnic community organisations;

c) Employers and employment organisations;

d) Colleges:

e) A full range of providers of sports and leisure activities;

f) an Informal support groups.

59 QUALITY ASSURANCE REQUIREMENTS

59.1 Providers must ensure that a quality management system is in place to ensure internal quality control and consistency of practice. Providers must also be committed to a process of continuous Service improvement driven by feedback from people receiving Services, the Regulator and the Council. Outcomes and key performance indicators will be reviewed throughout the life of the contract and the Council reserve the right to utilise a third-party representative to manage this on our behalf.

59.2 Providers will inform the Council within 7 days regarding any defaults, incentivisation protocols linked to poor practice and non-contractual compliance.

59.3 Contract review visits may be either pre-planned or unannounced and the Council (or our representative) reserves the right to view all records that relate to both our people and those of self-funders that reside in Kent to fulfil safeguarding and Care Act requirements.

59.4 The Council will utilise contract Sanctions to denote non-compliance with the Contract and Specification. Sanctions will also be used as a temporary measure whilst investigating concerns, which may not result in an offence being found. Non-compliance with the Contract and Specification will be identified through KPI's, Contract Management and Monitoring processes and notifications from the Council's Practitioners.

59.5 There are three types of Contract Sanctions:

a) Poor Practice Sanctions to express levels of non-compliance with the Service Specification;

b) Contract Compliance Sanctions to express levels of non-compliance with the Terms and Conditions;

c) Safeguarding Sanctions where a person(s) is/are reported to be at risk of harm, abuse or neglect.

59.6 Each of these Contract Sanctions have three risk levels starting at Level 1 and escalating up to Levels 2 and 3. A copy of these can be found at Annex B. A Level 3 flag will prevent the Provider from being offered or accepting referrals from the Council. The Council will immediately apply a Level 3 Contract Sanction if:

I. The Regulator has issued a Warning Notice;

II. Significant risks to people have been identified;

III. The assessed needs of people are not being met.

IV. Scorecard elements of 1, Quality or 3, Delivery being scored as inadequate

59.7 Where contractual non-compliance is evidenced, the Council will require the Provider to draw up an action plan that addresses areas of concern and articulates the milestones to be achieved. This must be returned to us within 7 calendar days of the non- compliance being evidenced. The plan will be agreed by the Council and must be delivered by the Provider.

59.8 The Council will escalate Sanctions where Providers fail to meet the plan. It is the Provider's responsibility to evidence that improvements have been made and the Council will not commit to monitoring visits with Providers who have not shared some evidence of improvement following a desk top review.

59.9 Continuous non-compliance or more than three episodes of non-compliance within a 12-month period could lead to the termination of an order or the Contract itself and the removal of all persons funded by the Council. The Council will be entitled to terminate the Contract or any order without issuing a sanction if the Council finds the Provider to be in serious breach of the Contract.

59.10 Providers (owners, corporate managers and local managers) must participate in local health and social care Provider meetings organised by the Council and its partners. The Provider will take part in any events in relation to The Care Act, other legislative work and the Transformation agenda. Failure to do so may result in a Contract compliance sanction being placed on the Provider. The Council reserve the right to:

a) Publish any information in relation to compliance Sanctions or any contractual or quality audits undertaken by the Council or our representatives;

b) Publish lists of Providers who attend events managed by the Council and those who do not;

c) Recoup any costs incurred in supporting the recovery or managed exits of Services, where Providers have demonstrated an unwillingness or inability to improve or manage the Service themselves;

d) Alter this policy at any time and will provide notice to Providers of any changes.

60 COMPLAINTS AND COMPLIMENTS

60.1 Providers must ensure an easily understood, well-publicised and accessible procedure is in place to enable people to make a complaint or compliment and for complaints to be investigated. The Provider's complaints and compliments policy should also refer to the Regulator, Ombudsman and the Council Complaint Team, if the complaint requires an alternate signposting route.

60.2 The Provider will be expected to investigate any complaints, compliments or quality issues that arise in a clear and concise way with all evidence clearly documented. The Provider will have an established Complaints and Compliments Policy. The Provider must evidence how they ensure learning from complaints and compliments improves the quality of the Service, and an enhancement to the training provided to staff.

60.3 Where there is a local advocacy group or Peer Forums, it is expected that the Provider will make constructive use of these organisations always and specifically to help resolve complaints and problems as early as possible. All complaints whether they have been formally or informally resolved should be recorded.

60.4 The Provider will report serious complaints and issues to the appropriate organisations e.g. RIDDOR, Police, etc. In addition to the Council.

60.5 A record of compliments should be maintained together with evidence if available and be used to reinforce good practice. Providers must be able to evidence how they share feedback on the Service via their quality assurance process.

60.6 The record of the complaint / compliment must include:

a) The date of the complaint / compliment;

b) Details of who made the complaint/compliment;

c) Details of the organisational staff member who managed the complaint/compliant;

d) Full details of the actual complaint / compliment;

e) The date the complaint / compliment was received (if different);

f) The date when the complaint / compliment was responded to;

g) The outcome of the complaint;

h) Details of whether the complainant was satisfied with the response/outcome;

i) Any further actions arising from the complaint / compliment to ensure improvement in the Service quality.

61 COMPLIANCE AND GOVERNANCE

61.1 Roles and Responsibilities of the Council

61.2 Strategic Commissioning is responsible for the commissioning and procurement of this contract. This is the team that Providers should inform of any Regulatory Warning Notices or other actions required by this contract that relate to Service delivery and Service quality. Providers should email [TBC]@kent.gov.uk with this information. Providers will be informed should this email address change; the commissioner will use the generic email address that the Provider has given. The commissioning team also lead on Contract management, arrangement of price uplifts, any Contract variations, and the review of kpis, although the Council reserve the right to utilise a 3rd party representative to manage this (wholly or in part) on our behalf.

61.3 Purchasing Staff support the management and control the offering of care packages to Providers in line with the Purchasing Protocol (attached at Annex C). They will issue the Service Delivery Order or the equivalent when MOSAIC is adopted and confirm the persons' details and Care and Support Plan.

61.4 Assistant Directors and their Service Managers have the responsibility of overseeing Adult Social Care and Health's new geographical areas which have been aligned to the Clinical Commissioning Groups geographical areas where appropriate. Providers should escalate practice concerns to Service Managers if they have not been resolved by the Council in their geographical area, and only then to Assistant Directors if the issue is not resolved.

61.5 Team Managers are deployed to arrange and review Services of sufficient quality for people who have been found on assessment to be owed a duty under various enactments. This should also be taken to include Care Manager (within Learning Disability), Care Co-ordinator (within Mental Health), Registered Practitioner, Occupational Therapist, Nurse, Social Worker, Physiotherapist qualified/state registered, Purchasing Officer and any other authorised representative.

61.6 The Payments Team is responsible for the payment cycle, person billing and any issues relating to payment.

61.7 The Safeguarding Team has the role of safeguarding vulnerable adults and statutory duties regarding adult protection. Providers are expected to work with all the Safeguarding Adults Team to address any relevant issues.

61.8 The Complaints Team has the responsibility of co-ordinating activity and investigation to support complaint resolution.

62 LEGAL / LEGISLATION STATUTES

62.1 The Care Act 2014 was the biggest reform in health and social care for 60 years; the act has made care and support more consistent across the country and puts the well-being of people at the heart of health and social care Services.

62.2 Section 29 National Assistance Act 1948 (NAA 1948) and Section 2 Chronically Sick and Disabled Persons Act 1970 are the key provisions for Care and Support in the Home and community-based Services. There is significant overlap between the various statutes, but it is these two provisions that the majority of a person's legal entitlement to support within the home stems from.

62.3 Section 30 NAA 1948 allows a local authority to provide the Services itself or to make arrangements for the Services to be provided by a third party. Section 1 Local Government Act 1997 in general terms permits a local authority to contract with that third party to provide the necessary support to people for whom they have a responsibility for.

62.4 However, such a contract does not discharge the Council of its duty to the person to ensure that they receive the necessary care. The Council must ensure that the support provided is both adequate and effective. If the care provided to the person is inadequate and inconsistent this could amount to breach of statutory duty. This will of course depend on the seriousness of the complaint and the reasons for the failings e.g. Staff sickness, the behaviour of the person etc. Notwithstanding this there is the potential risk of there being a case for maladministration against the Council for failing to have systems in place which keep under review the quality of care delivered and compliance of the Contract with the Care and Support in the Home Service.

62.5 The Health and Social Care Act 2008 sets out the framework for the regulation of care Services. Section 8 is an introduction to Chapter 2 of Part 1 of the Act which deals with registration of provision of health and social care. Its starting point is to define a "regulated activity" as an activity that involves or is connected to the provision of health or social care. Section 9 (3) defines "social care" as including all forms of personal

62.6 Any person who carries out a regulated activity without being registered as a Service Provider will be guilty of an offence under section 10 and is liable on summary conviction to a fine not exceeding £50,000 or to imprisonment for a term not exceeding 12 months, or both. If convicted on indictment, then the penalty will of course be greater and there is no upper limit on the fine that the court could impose. The requirement to register pursuant to section 10 applies to a natural person, a partnership or a company

62.7 The Mental Capacity Act 2005 is the primary legislation for all adult social care and the 5 statutory principles should be an integral part of all the work of care Providers. Section 44 of the MCA 2005 introduces two new criminal offences, namely ill treatment and wilful neglect of a person who lacks capacity to make relevant decisions.

62.8 Additional legislation, regulations and checking Services is listed below however the list

should not be regarded as complete or exhaustive but constitutes guidance for Providers. Providers must ensure they remain aware of and comply with all relevant and applicable legislation, this specification and UK law to include the following:

a) Care Standards Act 2000;
b) Care Act 2014;
c) Control of Substances Hazardous to Health Regulations 1989;
d) Data Protection Act 2018;
e) General Data Protection Regulation 2016
f) Disclosure and Baring Service;
g) Employment Rights Act 1996;
h) Essential Standards of Quality and Safety March 2010;
i) Equality Act 2010;
j) Health and Safety at Work etc. Act 1974;
k) Health and Social Care Act 2012;
l) Health and Social Care Act 2008;
m) Health and Social Care Act 2008 (Regulated Activities) Regulations 2010;
n) Human Rights Act 1998;
o) Lifting Operations and Lifting Equipment Regulations 1998;
p) Management of Health and Safety at Work Regulations 1992;
q) Management at Work Regulations 1992;
r) Manual Handling Operations Regulations 1992;
s) Mental Capacity Act 2005;
t) National Association for the Care and Resettlement of Offenders (NACRO) leaflet;
u) National Minimum Wage Act 1998 and Regulations 1999;
v) Part V Police Act 1997;
w) Personal Protective Equipment Regulations 1992;
x) Provision and Use of Workplace Equipment Regulations 1999;
y) Public Interest Disclosure Act 1998;
z) Public Interest Disclosure Act 1998 (Whistle Blowing);
aa) Rehabilitation of Offenders Act 1974;
bb) Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995;
cc) Working Time Regulations 1998 and 1999;
dd) Workplace (Health Safety and Welfare) Regulations 1992.

62.9 This list will be kept under review and updated as appropriate throughout the life of the Contract. Any updates to the list will be issued via the Portal. It is the Provider's responsibility to ensure they maintain an awareness of and comply with any updates to this list.

63 STRATEGIC DIRECTION AND LEGISLATIVE CONTEXT

63.1 Understanding the Council's Strategic Commissioning Direction

63.2 The Council is continuing its journey to transform adult social care in Kent, as detailed in Section 4. This Service is supporting us towards making this vision a reality.

63.3 Providers are expected to attend the Strategic Provider meetings and those detailed in Schedule 14 Contract Management. Provider meetings will support an ongoing understanding of the Council's Strategic Direction and progress towards achieving its long-term objectives.

64 GLOSSARY

Adult Protection – safeguarding vulnerable adults from abuse, harm and exploitation.

ASCH – the Adult Social Care and Health Directorate within the Kent County Council.

Area Referral Management Service (ARMS) – the main access points for people wanting to contact Social Care, Health and Well-being about needs relating to themselves or others. They deal with contacts regarding adults with a physical and/or learning disability, people with sensory needs and older people.

Assistive technology – any item, piece of equipment, or product system, whether acquired commercially, modified, or customized, that is used to increase, maintain, or improve functional capabilities of people with support needs.

Behavioural Support Plan – a document created to help understand and manage behaviour in children and adults who have learning disabilities and display behaviour that others find challenging. It provides carers with a step by step guide to support a good quality of life and to identify when they need to intervene to prevent an episode of challenging behaviour.

Breach (of contract) – an action in the direct opposition to defined agreed requirements.

Branch – the physical office registered with the CQC from which packages of care are Serviced.

Business Continuity Plan – an effective plan of helping business to build resilience against any disaster.

The Care Act – the paper that takes forward the Government's commitments to reform social care legislation and improve the quality of care following the findings of the Francis Inquiry.

Care in the Home (previously referred to as Domiciliary/ Home Care) – Care provided in a person's home following an assessment of need.

Care Package – a combination of Services put together to meet a person's needs arising from an assessment or a review.

Care and Support Plan – a document produced by the Council giving particulars of how to support, enable and achieve independence and well-being. It is a written statement regularly updated and agreed by all parties, setting out the health and social care support that a person requires in order to achieve specific outcomes and meet assessed needs.

Care Quality Commission (CQC) – the Regulatory body that ensures that standards of quality and safety are being met where regulated activity is provided. The body has a wide range of enforcement powers if Services do not meet the standards required.

Care/Support Worker – a member of staff employed by a Provider organisation to deliver the Care and Support in the Home Service.

Cluster – the geographic boundary(s) that the County has been divided into for the provision of the Services.

Consortium – an association of two or more organisations who participate in a common activity and pool resources to achieve a common objective.

Controcc – the Council's database that contains key information on the needs and treatment of children and young adults up to and including 25 years old, receiving a Service as well as the organisations providing care.

Commission – the process by which local authorities decide how to spend money to get the best possible outcomes for persons and communities, based on identified needs.

Commissioner – Members of the Council's staff who have responsibility for determining what Services will be purchased to meet assessed eligible needs.

Common Induction Standards – standards that are set by the CQC that state that all adult social care practitioners should reach within 12 weeks of starting their job.

Communication / Contact book – book used by staff to record interaction with the person.

Co-produce – active input into Service design by the people who refer into and use the Service.

Core Team – means the Care/Support Workers who are rostered to provide the relevant care to the Service User under the Contract. The Provider will seek to match Care/support Workers to meet specific needs of the person wherever possible. This team does not include workers on scheduled annual leave / holiday, however would be impacted by other absences including sickness, failure to report to work and any other reasonable explanation.

The Council – Kent County Council – the Council has a duty to arrange and review Care and Support in the Home Services for people who have an assessed need. In this agreement the Council could include Care Manager (within Learning Disability), Care Co-ordinator (within Mental Health), Case / Care Manager Assistants, Occupational Therapist, Nurse, Social Worker, Physiotherapist qualified/state registered, Purchasing Officer and any other authorised representative.

DVLA - Driver and Vehicle Licensing Agency.

Declined Package of Care – will be defined and confirmed via the Strategic Provider Forum by the end of the first quarter of the Contract. For the first quarter of the Contract kpis relating to this definition will be monitored but not enforced.

Deprivation of Liberty Safeguards (dols) – extension of the Mental Capacity Act (2005) which aims to ensure that the person in receipt of social and health care are looked after in a way that does not inappropriately restrict their freedom.

Disclosure and Barring Service (DBS) – the tool that helps employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups, including children. It replaces the Criminal Records Bureau (CRB) and Independent Safeguarding Authority (ISA).

Driver Check Code – This is a code the owner of a driving licence can generate with the DVLA directly, to give to an organisation to enable them access to the driver's licence history and check whether there are any endorsements/penalties or disqualifications on a driving licence.

European Convention on Human Rights (ECHR) – is an international treaty to protect human rights and political freedoms in Europe.

Expert patient schemes – a self-management programme for people with support needs or are living with long-term conditions.

Financial Activation Notice (FAN) – a document which outlines the costs associated with the assessed needs of an individual for the package of care and support.

Flexible Package of Support – a package of hours for a person in receipt of the Service to be used in an outcomes-based way to support the person's care and support needs as specified on the Care and Support Plan.

Improvement Plan – a response to raise standards in key areas in Service development and delivery within agreed specified timescales.

Kent Enablement at Home (keah) – the Council's in-house provider of enablement Services.

Key Performance Indicator (KPI) – criterion that helps to measure Service quality and providers' contractual obligations.

Key Performance Indicator dashboard – a tool that communicates Service achievement in a succinct way that facilitates the process of action being taken to raise the quality of the Service.

Late/Early Call – Calls made more than 45 minutes after/before the time stated on the Service Delivery Order.

Locality Team – integrated community health and social care professionals managing the care of people with LD and MH issues (some areas).

Manager Induction Standards – benchmark for managers new in post in adult social care.

Market Position Statement – a declaration that summarises Commissioners' purchasing intentions which also provides intelligence to Providers (the market) to enable them to plan how to respond to the Commissioner's needs.

Missed Call – Non-attendance by staff or attendance more than two hours after time of call identified on the Service Delivery Order.

(Contract) Mobilisation – The development and execution of proposed Service provision.

Mosaic – the Council's new database/ system that will be phased in to replace SWIFT from January 2019.

Must (must) / Will (will) – to be obliged or required by law.

Needs assessment – appraisal of a person's care and support needs for community care Services.

Newly Offered – refers to packages of care that have not been previously offered to the Provider.

NMDS-SC – Skills for Care National Minimum Dataset for Social Care.

Ombudsman / Local Government Ombudsman Officer – whose role is to investigate complaints where persons have been treated unfairly or have received poor Service from government departments and other public organisations and NHS in England.

Outcome – Consequence, impact or result of an activity, plan, process or agreed Intervention and the comparison with the intended projected result.

People / Person – refers to the users of this Service.

Personal Care – care and support provided to people that includes assistance with bodily functions such as washing, bathing or shaving, toileting/continence, getting in or out of bed, eating, drinking and taking medication.

Policy – a set of statements which help person to make sound judgments based on legislation, legal terms and conditions and any Regulatory requirements.

Provider Pre Review Information Form (PPRIF) – A form for the Provider to complete two weeks before the Review which highlights the support being delivered, the level of ability of the individual and the goals that are currently being worked towards. This form is a method of identifying issues to be addressed at the Review so that Council workers and Providers can be prepared for the review meeting. Where appropriate, it should be completed with the person receiving the Service.

Practice Assurance Panel – a panel of Practitioners who quality assure assessed needs and Care and Support Plans and agree spend for care and support packages.

Procedure – the method by which a policy is put into practice.

Protocol – a code of correct conduct.

Provider Care Plan – a statement of intent written by the Provider (usually in conjunction with the person using the Service) describing the goals and aspirations of the person and how these will be achieved. These plans must be Specific, Measurable, Achievable, Relevant and Time-bound.

Purchasing Protocol – the process that the Purchasing Officers and Area teams need to follow to allocate the packages of care to ensure continuity of the clusters that have been designed in collaboration with the Provider market.

Purchasing Officer – an employee of the Council who is authorised to buy goods and Services.

PUWER – The Provision and Use of Work Equipment Regulations 1998

Registered Manager – the person appointed by the Provider to carry out duties as stated in the Health and Social Care Act (2008). Providers must meet the Regulator's requirements in this regard. All Providers must have a Registered Manager and each regulated activity is required to be supervised by the Regulated Manager.

Registered Practitioners/ Case Officers – a targeted, community-based and pro-active Council workforce that assesses people who may have care needs, reviews packages of care and produces co- ordinated Care and Support Plans.

Regulator – the body which is established by statute and whose powers the Provider is subject to. Currently, this is the Care Quality Commission.

Regulatory inspection – an organised examination of an organisation's systems and processes by an authorised body with enforcement powers.

Response time – is the time taken between the package of care being offered to the Provider and the Provider informing the Purchasing Officer if they can take the package of care.

Reviews:
Care and Support Plan review – a statutory Review of a person's Care and Support Plan which must take place at least annually, in line with the Care Act. A Review may also be triggered at any time by a change in circumstances, such as a deterioration or improvement in condition, or the introduction of a piece of equipment. Providers are expected to treat the delivery of care as a continuous informal review which may trigger a formal Review of the Care and Support Plan. Reviews of the Care and Support Plan will provide assurance that the care and support package, goals and outcomes remain appropriate.

RIDDOR – Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013.

Safeguarding – describes the multi-agency process of protecting vulnerable adults and children from abuse or neglect and putting systems in place to prevent harm.

Scorecard – a dashboard-style tool which collects and presents Key Performance Indicator data from Providers and the Council to inform Contract Management processes.

Self-care advice – an umbrella term that includes a range of different situations whereby people are given information on how to better manage conditions or impairments with minimal or no involvement of Services.

Service Delivery Order – initiates and tailors the Service for the person

Strengths based approach – Person led activities that focus on positive outcomes with emphasis on the resources and traits that the person has.

Supervision – a formal recorded meeting on a one to one basis with the Staff member's line manager to enable administrative review, discussion of and reflection on the Staff member's work; learning from practice; personal support; professional development and mediation. Supervision will take place at least quarterly (every three months). Written records of these Supervisions must be kept demonstrating the range, content and outcome of the discussion at each meeting.

Supporting People – the act of assisting a person to complete a task or access the community to remain as independent as possible.

SWIFT – the Council's database that contains key information on the needs and treatment of adults from 26 years receiving a Service as well as the organisations providing care.

Modernisation Agenda – the Council's strategy and teams to improve its Services. This includes innovative ways of working with the Council's partners with renewed focus on rapid response, prevention, targeted interventions, supporting careers and empowering people.

V5C – Vehicle Registration Document.

Warning Notices – to formally make aware in advance of actual or potential harm to the Service or persons receiving care and support.

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APPENDIX 1 - CARE QUALITY COMMISSION (CQC) THE REGULATOR

64.1 The Council must be informed when Providers are due to be inspected.

64.2 The Provider must also inform the Commissioner/Contract Manager within 24 hours of having the inspection that the inspection has taken place and provide the Council with a copy of the written feedback given at the time of the inspection.

64.3 The Council must be informed of the outcome of the most recent inspection within 5 working days of the Provider receiving their inspection report and rating.

64.4 The provider must inform the council when the CQC draft report is received and what their ratings are in each of the five KLOE's – Safe, Caring, Responsive, Effective, and Well Led, and if they intend to challenge and if so why.

64.5 The Provider must inform the council when they receive their final report and state whether the ratings are different from the last inspection and draft report. Should any ratings be lower than previously then the provider must provide us with a copy of their Service Improvement Plan

64.6 The Provider should expect to discuss their latest CQC report at their next contract review meeting.

64.7 The provider must inform the council if they receive any breeches to the Regulation and their plans to address these and timelines.

64.8 The provider must inform the Council if they do not have a Registered Manager in place and state who is therefore over-seeing the service

64.9 CQC are now taking a more rolling approach with a new system, currently being referred to as the "Provider Information Collection" (PIC). The PIC will no longer be an annual "snapshot" or pre-inspection questionnaire, but an on-going monitoring tool. Providers will have to complete the PIC in full once a year. However, they may be asked to update parts of it more frequently by the inspector. The Provider will be expected to submit a copy of this once a year and/or when updated, this will feed into our own contract monitoring.

APPENDIX 2 - THE ESTHER SCHEME:

64.10 Ambassador: An ESTHER Ambassador is someone who promotes ESTHER and raises awareness of the model with those they come into contact with through their work. The training is delivered through a one-hour e-learning package. There is no preparation needed or expected in advance of this training. Upon completion of the training ESTHER Ambassadors are given a badge to wear, it is expected that they wear this.

64.11 Coach: An ESTHER Coach is a person who is trained in quality improvement and coaches their team in this way to make improvements that are of benefit to the experience of esthers receiving care and to their organisations. Prior to ESTHER Coach training all those identified for the training have to complete the ESTHER Ambassador training. The ESTHER Coach Training is run over a period of 5 months with 4 full day training sessions and one half-day which is the final session for the presentation of their improvement projects. The training focusses on quality improvement, coaching skills and working in partnership with ESTHER.

64.12 An Ambassador e-learning package can be accessed by organisations from April 2019. The ambition is:

a) Year 1 – 30% of all staff ambassador trained
b) Year 2 – 60% of all staff ambassador trained
c) Year 3 – 80% of all staff ambassador trained
d) Year 4 – 90% of all staff ambassador trained

64.13 All new staff joining the organisation will need to complete the ESTHER ambassador e-learning as part of their induction. Each organisation will be required to have at least one ESTHER coach within the first year of the contract. E-learning will be provided free of charge. However, for providers to access the coach training there will be a charge to put the one employee through the coach training, which is £1,000. The benefits of accessing the coach training will help to demonstrate to CQC the person-centered approaches that the provider is implementing, and that ESTHER is a recognised model of care.

64.14 There is a virtual ESTHER network to provide ongoing support and Providers will have access to the Design and Learning Centre Learning and Development hub for ongoing support and access to ESTHER training and expertise. Providers will also be invited to an annual ESTHER Inspiration Event (free of charge) to understand how the model is progressing and plans for its further development.

APPENDIX 3- WORKFORCE DEVELOPMENT

64.15 Providers will be registered with the Skills for Care National Minimum Dataset for Social Care (NMDS-SC) and the following criteria must be met:

a) All establishments will complete a NMDS-SC organisational record and must update all its organisational data at least once in the financial year;

b) The establishment must fully complete person NMDS-SC worker records for a minimum of 90% of its total workforce (this includes any staff who are not care-providing);

c) Person records for workers which are included in the 90% calculation must be both fully completed and updated at least once in the financial year;

d) The establishment must agree to share information via the facility within NMDS-SC with the Council, CQC and NHS Choices.

64.16 Providers must show that they are complying with the relevant Regulations covering staff competence and training. Providers must ensure the completion of the Care Certificate (or other standards as set out by the CQC) for all new Care/Support Workers and other employees within 12 weeks of starting their employment. This induction must specifically include Mental Capacity Act (MCA), Safeguarding, Deprivation of Liberty Safeguards (DoLs), Manual Handling and Dementia training. Providers will consider, where appropriate, incorporating the Skills for Care values-based recruitment guidance into their recruitment processes.

64.17 Providers must assess workforce training levels, the training already achieved and skills gap for the workforce as a group. Providers must have financially resourced plans in place to address workforce development requirements. The Provider must have a training plan, a training matrix and keep records of successfully completed training on a person's file and central file to continuously monitor and develop the plan.

64.18 Registered Managers must complete the Manager Induction Standards and have or undertake a recognised qualification for registered managers within the first year of employment. This must be completed within 2 years of employment. Managers should undertake periodic management training to update their knowledge, skills and competence to manage the Service. Where appropriate, Registered Managers should access peer support networks such as local Registered Manager networks to support their development and share best practice.

64.19 Staff must be supported to ensure appropriate skills are maintained to ensure that the highest level of care and support is provided by qualified and competent staff. Providers will ensure:

a) All staff are competent and trained to undertake the activities for which they are employed and responsible;

b) All Care/Support Workers hold a relevant qualification recognised under the Skills for Care Regulated Qualifications Framework E.g. Level 2 Diploma in Health and Social Care or equivalent.

c) Those who do not already hold a qualification at the relevant standard should be supported to achieve the above qualification as a minimum within one year from commencing employment;

d) Care/Support Workers receive specific advice and training about human rights in relation to Home Care Services within three months of starting employment and updated every two years;

e) All staff have training on the prevention of abuse within three months of employment and this must be updated every two years;

f) Any staff aged under 18 are supported in their work and must undertake an approved apprenticeship training programme – it is advised that the Health and Social Care Apprenticeship framework is used;

g) Providers will support the development of staff and ensure that at least 2.3% of their workforce is accessing development through approved apprenticeship standards;

h) Specialist advice, training and information is provided to Care/Support Workers working with specific groups and / or medical conditions and long-term conditions to ensure they are professionally qualified to do so;

i) Staff have training in the requirements of MCA (Mental Capacity Act 2005) and DOLS (Deprivation of Liberty Safeguards);

j) All staff are aware of their Safeguarding responsibilities both for Children and Adults;

k) All staff are aware of and familiar with the Provider's policies and procedures;

l) All staff are aware of and support equality and diversity principles, in line with the Equality Act 2010;

m) All staff are aware of their responsibility regarding the Prevent Duty Guidance.

64.20 Equality, diversity and workforce development

64.21 The Provider will ensure that staff receive the appropriate levels of training to ensure each person receives care that reflects their specific needs in all areas. Providers will also consider longer term workforce development and demonstrate action planning to meet longer term development goals.

64.22 Providers will maintain awareness of and adhere to the Council's equalities policies, all relevant UK employment laws and workers' rights. They will ensure their employees work in an environment where they are shown respect and are not subject to any form of discrimination.

APPENDIX 4- EXAMPLES OF ACTIVITIES AND OUTCOMES

64.23 Personal Care and support. This is defined by the Regulator as meaning physical assistance given to a person and could be in connection to the following types of tasks:

a) Keeping clean and presentable in appearance according to the person's personal choice, this may require daily changes and flexibility based on personal choice etc;

b) Direct assistance with or regular encouragement to perform daily living tasks;

c) Training and providing advice and support on self-care skills including signposting to sites such as Support for Carers, Kent 24hr Dementia Helpline etc.;

d) Assistance with all aspects of daily living e.g. To get up or go to bed, transfers from or to bed / chair / toilet, dressing, all aspects of toileting and continence management, washing/bathing (excluding any activity that requires a health care professional e.g. Podiatrist, tissue viability nurse etc.).

e) Assistance with skin care such as moisturising very dry skin;

f) Medication management in relation to home from hospital support.

64.24 Staff must have received training in infection control and utilise the appropriate PPE to perform these tasks. Staff must also be aware of factors which pre dispose individuals to incontinence such as infections and constipation so that help and advice at an early stage can be sought from the appropriate Health Worker.

64.25 Promotion of well-being and self-care support for the person:

a) Prompts to take medication or safe administration of medication which has been prescribed in accordance with agreed protocols;

b) Assistance with putting on appliances with appropriate training for example leg calliper, artificial limbs and surgical stockings and assistance with visual and hearing aids e.g. Glasses care, hearing aid battery checks;

c) Food or drink preparation including delivery of meals from on-site restaurants/café, planning meals, shopping, healthy eating and budgeting;

d) Eating and drinking (including the administration of parenteral nutrition (that is nutrition not administered through the mouth and alimentary canal)), including any associated kitchen cleaning and hygiene;

e) Dealing with correspondence;

f) Night settling, preparing the person for the night, making the home safe and secure before leaving;

g) Support access to activities including employment initiatives, education and voluntary work, social and community;

h) Health action plan support;

i) Assistance in budgeting and debt avoidance management;

j) Support in claiming benefits (including support at tribunals if additional funding for the support was approved by the respective operational team);

k) Support topping up pre-paid keys for gas or electricity meters;

l) Well-being checks (Extra Care Support).

64.26 Promotion of safeguarding support:

a) Identification and reporting of possible safeguarding adults' concerns including self-neglect;

b) Identification and reporting of possible safeguarding children concerns;

c) Identification and reporting of possible domestic abuse;

d) Reporting back to the Council's Safeguarding Team where risks or hazards have been identified which may require a risk assessment;

e) An awareness of the Prevent Duty Guidance and how to report concerns (guidance can be found):

Https://assets.publishing.Service.gov.uk/government/uploads/system/uploads/attachment_data/file/445977/3799_Revised_Prevent_Duty_Guidance__England_Wales_V2-Interactive.pdf Link correct as of 11th September 2018.

64.27 Social and Vocational Access and Participation:

a) Supporting to attend all aspects community day Services and schemes, training, work experience, appointments, laundry Services, all aspects of home improvement including transport arrangements and any other additional schemes;

b) Assisting with shopping and supporting to handle their own money in multiple formats e.g. Contactless, including accompanying to the shops;

c) Shopping, collecting pensions, benefits, prescriptions, dealing with correspondence, paying bills or other simple errands on behalf of the person where they are not able to do so themselves;

d) Travel training.

64.28 Cleaning and support around the home:

e) Support the person to keep their home clean, which may include vacuuming, sweeping, washing up, polishing, cleaning floors and windows, bathrooms, kitchens, toilets etc. And general tidying as appropriate, using appropriate domestic equipment and appliances where appropriate. Providers will:

f) Make beds and change bedlinen;

g) Dispose of household and personal rubbish (including shredding of confidential material);

h) Assist with the consequences of household emergencies including liaison with local contractors;

i) Assist with household tasks such as cleaning;

j) Wash clothes or household linens, including soiled linen, drying, necessary ironing, storage and simple mending;

k) Light fires, boilers etc., subject to health and safety guidance;

l) Identify and mitigate as far as possible any hazards or risks around the house exit and egress and suggest solutions e.g. Rugs or obstacles, areas with soiling subject to a risk assessment;

m) Supporting the development of a personal evacuation plan;

n) Cleaning any additional aid or adaptation e.g. Walking aid, shower chair, etc.

From:	Graham Gibbens, Cabinet Member for Adult Social Care and Public Health Penny Southern, Corporate Director of Adult Social Care and Health
To:	Adult Social Care Cabinet Committee – 27 September 2018
Subject:	**ADULT SOCIAL CARE ANNUAL COMPLAINTS REPORT (2017-2018)**
Classification:	Unrestricted
Previous Pathway of Paper:	Adult Social Care and Health Directorate Management Team – 22 August 2018
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 2017 and 31 March 2018.

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

1. Introduction

1.1 This report is the Annual Report for Adult Social Care Complaints and provides an overview of the operation of the procedure in 2017/18. 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 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 a 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 issued 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.

2.5 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 KCC and Medway Council.

2.6 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.

2.7 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.

2.8 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.

2.9 In addition to complying with the Regulations, the Complaints Team also seeks to deliver best practice in line with Local Government Ombudsman guidance.

3. Total Representations received by Adult Social Care

3.1 Information about the number and type of complaints received in 2017/18 is shown in Appendix 1.

3.2 The figures show a slight decrease in the number of complaints for the second year in a row with 637 complaints received in 2017/18 compared with 649 the previous year. The number of complaints however remains quite high compared to the numbers that were being received several years ago (538 in 2014/15 and 417 in 2013/14). This reflects the complexity of demand and pressures on services.

3.3 The 637 statutory complaints received also needs to be seen in the context of the large number of people accessing the service. There were 34,716 open adult social care cases at the start of 2017-18 and a further 29,457 new referrals were received during the year. The percentage of people who made a complaint was therefore less than one per cent.

3.4 There was also a decrease in the number of Enquiries. Where correspondence is received from a Member of Parliament or Local Member, on behalf of a constituent or about an aspect of the service, then it is logged as an Enquiry. Enquiries can also include instances where someone wishes to raise an issue without making a formal complaint. In 2017/18, there were 276 Enquiries compared with 362 the previous year.

3.5 In 2017/18, 507 compliments (or merits) were logged. This was an increase on the previous when 430 were recorded. The compliments provide useful feedback where people have written to Adult Social Care with positive comments about their experience of using the service. Several examples are provided later in the report.

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 72% of complaints were responded to within the 20-day timescale agreed with the complainant which is a slight improvement on the previous year when 68% were responded to in 20 working days. Meeting the timescales can be challenging as

managers and practitioners balance the competing demands of complaints investigation with the other demands on their time. Nevertheless, the Directorate is monitoring response times closely and provides updates to complainants where the response is likely to be significantly overdue. A weekly report is also issued to remind staff of any complaints that are pending or overdue. Holding letters are sent to complainants if a response is delayed.

5. Themes identified arising from complaints

5.1 In October 2017, the Complaints Team started using a new council wide Customer Feedback database. A number of the fields on the database were different to the previous database which make it difficult to make direct comparisons over time regarding the detailed subject matter of the complaints. Some complaints might also raise more than one issue – for example if someone complains about a delay and the outcome of a decision. It is however possible to draw out some of the key themes from complaints.

5.2 24% of complaints related to communication with a service user or their family. Examples included the need to communicate the outcomes of meetings more promptly to service users or their family. Another example was the need to ensure any communication sent to members of staff who have taken leave unexpectedly is addressed in their absence. The change to the Lifespan Pathway Service in 2017/18 meant that some service users had a change of key worker and for some service users there was a delay in being notified who their new keyworker would be.

5.3 18% of complaints relate to disputed decisions. Examples included where people considered they required more support than had been agreed or where the support has been decreased following a review of care needs. In some cases, family members or representatives of service users disagreed with the outcome of an assessment or disagreed with the contents of a Care and Support Plan.

5.4 16% of complaints relate to financial processes and charging. This included complaints where people complained about being charged or the amount being charged. Examples included where individuals considered the charging arrangements had not been clearly explained to them or they had received a higher than expected invoice due to a delay in the administration process.

5.5 Other themes included complaints about service provision for example a lack of a local provider or where the contracted care provider was not able to deliver a service at a time the service user would want.

5.6 11% of complaints related to the perceived behaviour or attitude of the member of staff the service user was in contact with. Where a complaint investigation has found 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.

6. The Outcome of Complaints

6.1 The Local Authority is required to report on the number of complaints received that are "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 31% of complaints were upheld; 28% were partially upheld and 31% were not upheld. Approximately 5% were withdrawn and a further 5% were dealt with in another way – for example 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 so it is important to maintain an open and learning culture that is receptive to feedback from customers.

7.2 Complaints reports are presented to 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 are an opportunity to identify lessons to be learnt. Sometimes the feedback will be reminders to staff of practice issues and sometimes the lessons will lead to more tangible changes. 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 2017/18 and discussed at the Quality and Good Practice Group included:

- The need to ensure any change of circumstances for the service user is logged in a timely way. Delays in the information being recorded on the system can cause delays in the person being charged the correct amount for the care they receive or a delay in a financial assessment being completed. At the Quality and Good Group Practice meetings practitioners were reminded of the need for any changes to the case records to be made promptly.

- Some of the complaints received related to a lack of communication relating to safeguarding where families did not feel they were being kept sufficiently informed. The national "Making Safeguarding Personal" initiative has helped to address this, along with the provision of relevant information leaflets. In addition, a major initiative in the

Directorate to reduce the timescales for safeguarding enquiries has enabled people to be informed of outcomes more promptly. Feedback from complaints informed the production of the additional factsheets that are available to the public who wish to receive more information on the safeguarding process. These are also available in Easy Read versions and complement the "Safeguarding What Happens" leaflet.

- Following a reorganisation of a service, it was apparent that some of the practitioners were new to Adult Social Care and did not have a comprehensive understanding of the Adult Social Care financial assessment and charging arrangements. To address this, workshops were provided for the staff group.

- A complaint about one of the in-house residential care units highlighted the need for staff to "escalate" issues to a senior manager if they have encountered difficulties in engaging a practitioner from a partner organisation, (in the case giving rise to the complaint there was a problem engaging a District Nurse). A workshop was held with relevant staff to ensure lessons were learned from the complaint.

- It was apparent from feedback that some staff were finding it difficult to convey difficult messages to service users or their representatives particularly about contentious issues. This was covered in "Key Concepts" presentations and workshops with practitioners.

- In the Quality and Good Practice 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. Linked to this is the need to ensure there is clarity regarding who is managing the individual's finance if they are unable to manage their own finances.

- Following the sad death of a service user with learning disability, there was a delay in other organisations, such as the Housing Authority and Department of Work and Pensions, being notified. A checklist was therefore produced for staff for future reference should a similar situation arise.

- A complaint was received after a person's case file was stolen from a practitioner's car. A communication was sent out to remind staff of the need to safeguard personal information.

- A complaint was received about a delay in arrangements being put in place where an individual's assets had depleted, and they were requesting support to meet the care home fees. Further work is planned to determine if the processes can be streamlined to enable the assessments and decisions to be made more promptly.

- Feedback was received about the Adult Social Care information on the website and this led to a change to some of the information about the Enablement Service and a change to the Blue Badge Misuse Reporting Form.

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. As part of the complaint conclusion meetings with Senior Managers are often arranged with complainants following independent investigations to discuss the findings and recommendations.

7.5 The outcomes from complaints can also lead to training or specific actions for individuals or teams. One example was a complaint where an individual considered that their care assessment had not fully reflected the fact that they are Transgender. The assessor had not referred to this in the assessment document and therefore was not considering all the specific needs of that person. Following the complaint, a workshop was provided for the team to reflect on assessment and support for people who are Transgender and to gain a better understanding of all the current issues affecting the clients who are transitioning,

7.6 Three training sessions were delivered to teams during the period to remind staff of the complaints procedure and how to investigate and respond to complaints.

8. External investigations

8.1 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.

8.2 During the period, four independent investigations were completed. The total cost of these investigations was £8,456.40

9. Financial

9.1 In 2017/18, £7,825 was paid in financial settlements. This included cases where the Local Government Ombudsman 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 nine settlements were for under £1,000 but one settlement was for £4,106.

9.2 During the same time frame 38 financial adjustments were made to accounts totalling £38,501. An example of a financial adjustment is when an error has occurred with the charging process and has been rectified or where part of a debt has been written off as part of a complaint resolution.

10. Complaints via the Local Government and Social Care Ombudsman (LGO)

10.1 The LGO contacted KCC Adult Social Care regarding 42 cases in 2017/18. This includes cases that were carried forward from the previous year and settled during the reporting year. In most of the cases the LGO did not find fault with the Local Authority and deemed no further action was required.

10.2 There were eleven cases where the Ombudsman found the Council was at fault. Nine of these cases related to complaints that had arisen in previous years. The LGO's "Final Decisions" however were made in 2017/18 and so they were recorded as 2017/18 complaints for LGO reporting purposes.

10.3 The reasons giving rise to the complaints where fault was found varied however they included complaints about insufficient levels of support, delays in providing information, and communication about charging.

11. Compliments (or merits)

11.1 The Directorate continues to log compliments or merits, with 507 received in 2017/18. These also provide useful feedback and serve as a reminder of the many people who are very satisfied with the service they have received.

11.2 A few examples are provided below:

- **"**On behalf of my family. I should like to thank you all most sincerely for all your help, kindness and patience in looking after my husband"

- "S is very grateful for all the support she has received. Each and every support worker arrived with a smile on their faces and has given time and confidence to S".

- "I would like to take this opportunity to mention how we have appreciated the amazing care and help given to us by your team of carers".

- "A said she would miss the girls as it was company for her, but they are needed elsewhere to work their magic".

- "Thank you for helping to give me more independence".

- "Just a note to say thanks so much for all the care you gave D. when he was with you for two weeks. We were very grateful for the kindness you showed him and to me. It was much appreciated at a worrying time".

- "Thank you for the equipment -its brilliant. The service was great, very professional".

- "The Care Manager has been so supportive… I appreciate all her hard work. The last two months have been stressful and frustrating, but the Care Manager has very high standards. She always responds as soon as possible and explains the situation as much as she can".

- "Mrs W spoke very highly of the team stating that the ASC Team is a God Send".

- "I would very much like your BOSS to see this e-mail. This is a personal thank you to Tracey regards looking after my Auntie. Tracey has given a FIRST-CLASS service. She has worked above and beyond, showing interest and care to someone that needed extra help. A real credit in my view to your company",

- "Please pass on my thanks to your fitter (technician) for the exceptional service of fitting three rails. The client is as happy as Larry and I am very impressed how quickly this job was completed! Well done!"

12. Complaints Operations

12.1 The Adult Social Care Complaints Team receives, records and administers the complaints, enquiries and compliments for the Directorate. It also assists with complaints responses including responses to the Ombudsman and some of the more complex complaints. The were some changes in personnel during the year which reduced the team capacity for periods of time nevertheless the team endeavoured to sustain the high quantity and quality of work.

12.2 In April 2017, the Children's Complaints Team transferred back to Children's Services to enable close liaison with Specialist Children's Services and other Children and Young People Services.

12.3 A further change in 2017 was the introduction of KCC customer feedback database. This required some adjustment to configure the new database as the previous system was long established and tailored to meet the Directorate requirements.

12.4 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.

12.5 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 year the meetings have proved productive in promoting joint working. 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 NHS Partnership Trust (KMPT) Patient Advice and Liaison Service to ensure effective joint working on complaints about secondary mental health services.

12.6 A focus group was held with some service users to obtain feedback on complaints and the information provided to explain the complaints procedure. This led to some changes to the Easy Read version of the complaints leaflet.

13. Actions Planned in 2018/19

13.1 The Complaints Team will need to adjust its processes to reflect wider organisational changes such as the realignment of Older People and Physical Disability Services

13.2 Changes to Mental Health services will also impact on complaints arrangements. In the past complaints about secondary mental health services were delegated to the Kent and Medway Partnership Trust (KMPT) to respond to both health and social care aspects of the complaint. From 1 October 2018, it is intended that the Adult Social Care Complaints Team will lead on the complaints that relate to the social care element of secondary mental health services and will liaise with the KMPT complaints team on any joint complaints.

13.3 We will continue to use complaints, along with other feedback, to identify opportunities to learn any lessons for the wider service. This will include liaising with the newly appointed Adult Principal Social Worker.

13.4 The service will continue to seek improvements to the complaints and enquiry response times. Managers dealing with complaints are often balancing several priorities however it is important that complaints are responded to within timescales as any delays to complaints can lead to further dissatisfaction. It is important that any follow-up actions, after a complaint is closed, including making payments or undertaking assessments are made in a timely manner.

13.5 The Local Government Ombudsman, along with Healthwatch, recently produced a “Single Complaints Statement”. It is intended for adult social care practitioners and for organisations that commission, arrange and provide social care. The purpose of the statement is to:

- “inform their approach for acting on compliments, feedback and complaints

- set out what people who use services, their unpaid carers, family and their representatives can reasonably expect from organisations that provide and arrange adult social care when they leave compliments and feedback or complain about a service or member of staff; and
- provide prompts or good practice in complaint handling for those organisations".

13.6 The Statement will be used to reflect on complaints practice both within the Adult Social Care and within the wider care sector.

14. Report Conclusion

14.1 In 2017/18 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 Local Government Ombudsman 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. It 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 The number of complaints and enquiries received in 2017/18 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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Customer Care and Operations Manager
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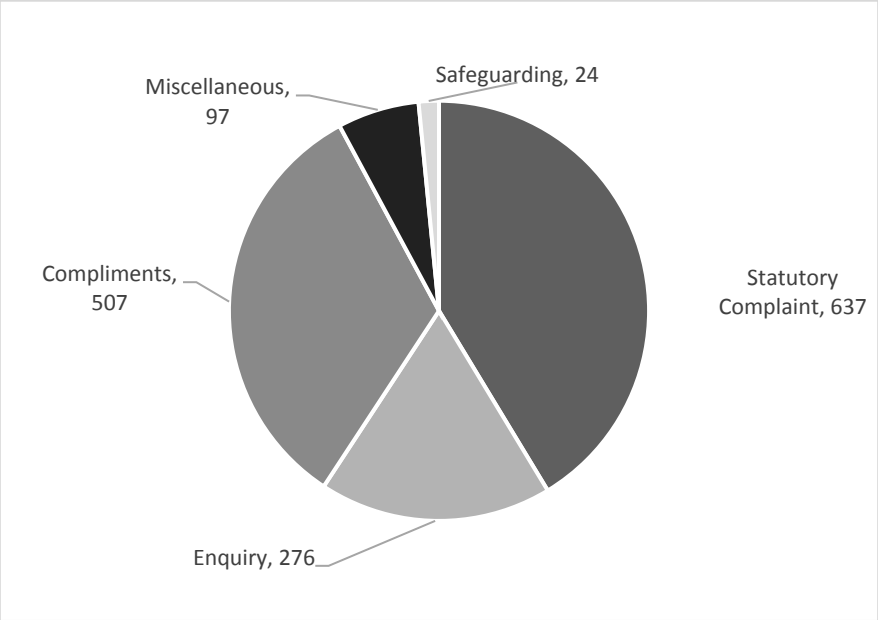
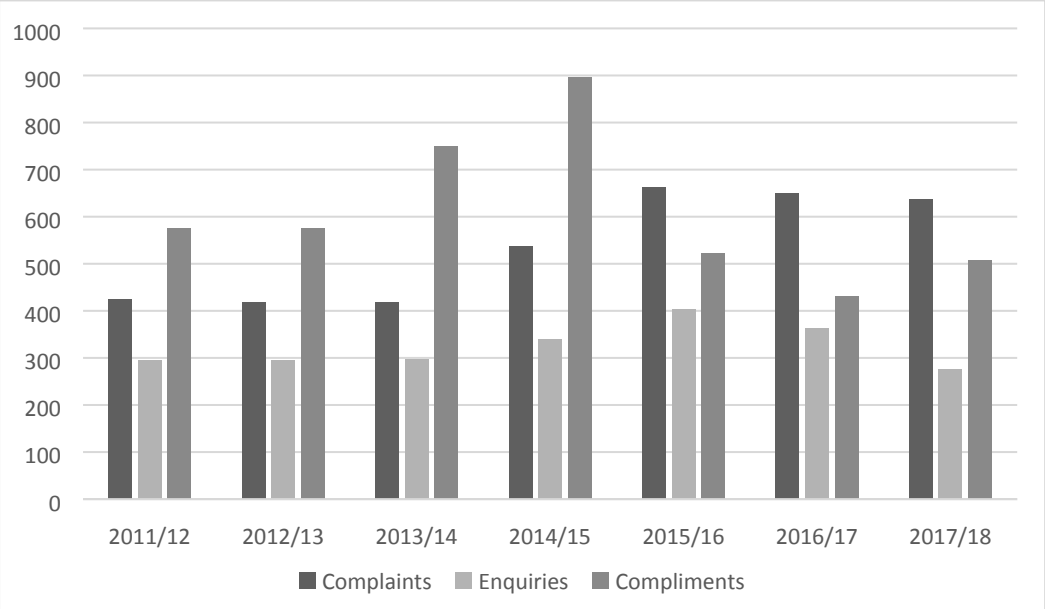
Appendix 1

Complaints and Enquiries Received 1 April 2017 – to 31 March 2018



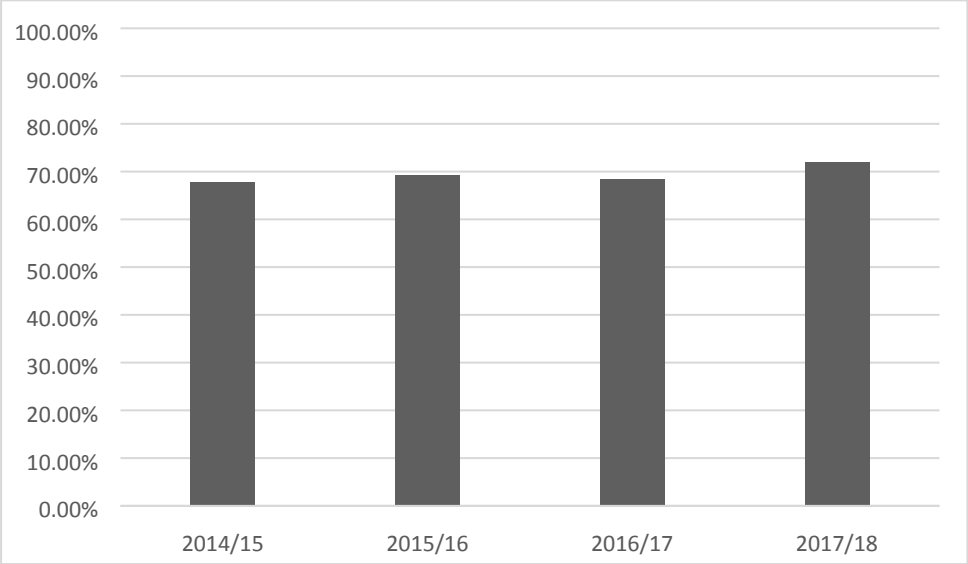
Statutory Complaint	637
Enquiry	276
Compliments	507
Miscellaneous	97
Safeguarding	24

Comparison with previous years



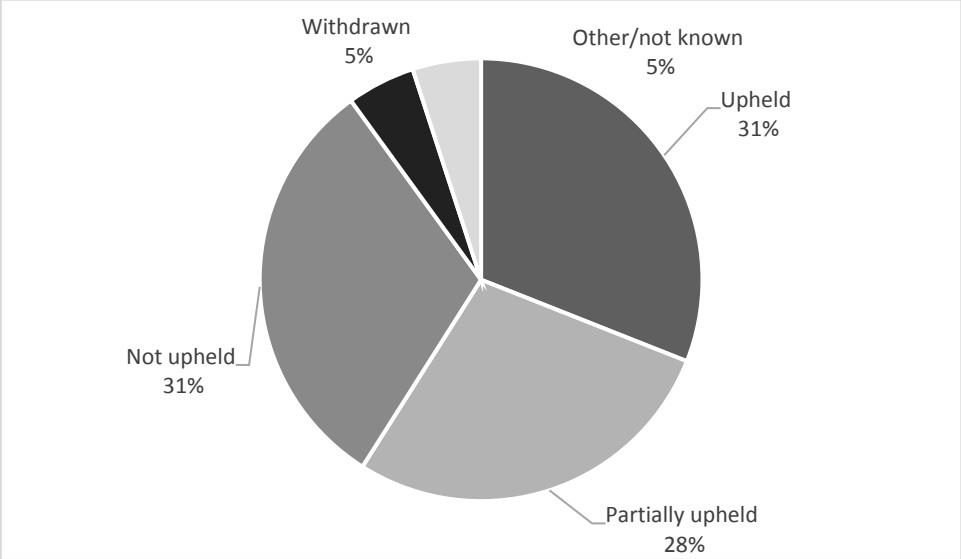
Year	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
Complaints	425	417	417	538	662	649	637
Enquiries	295	295	296	340	403	362	276
Compliments	575	575	750	896	523	430	507

Complaints Response Times with a 20-day target.



2014/15	67.8%
2015/16	69.2%
2016/17	68.4%
2017/18	72%

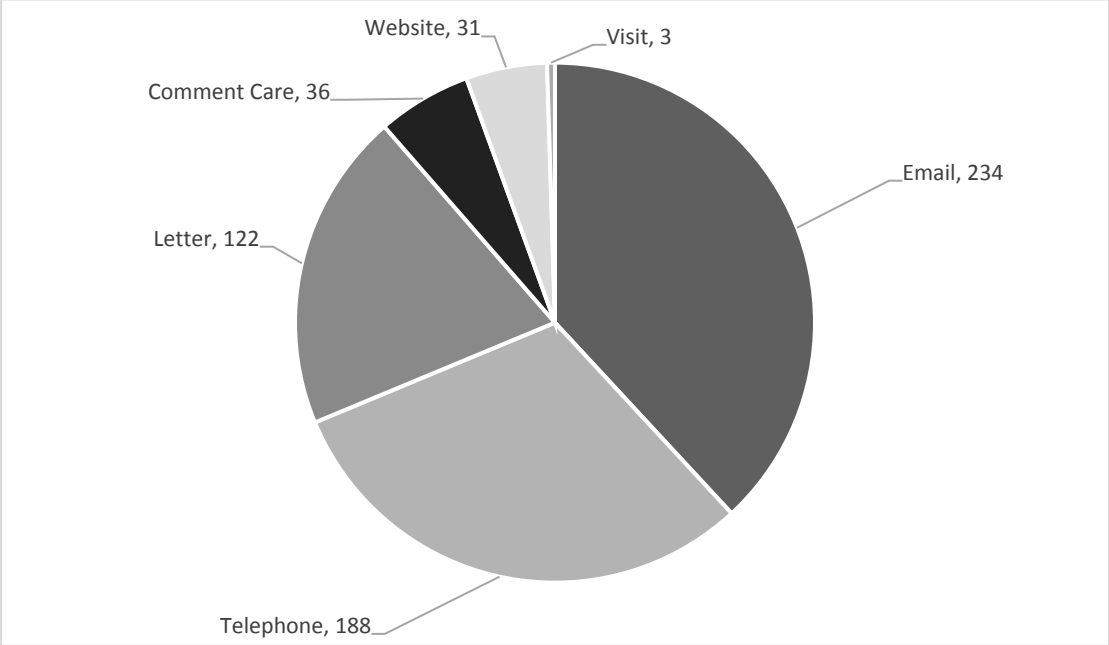
Complaints Outcomes



Upheld	31%
Partially Upheld	28%
Not Upheld	31%
Withdrawn	5%
Other/Not known	5%

Appendix 1

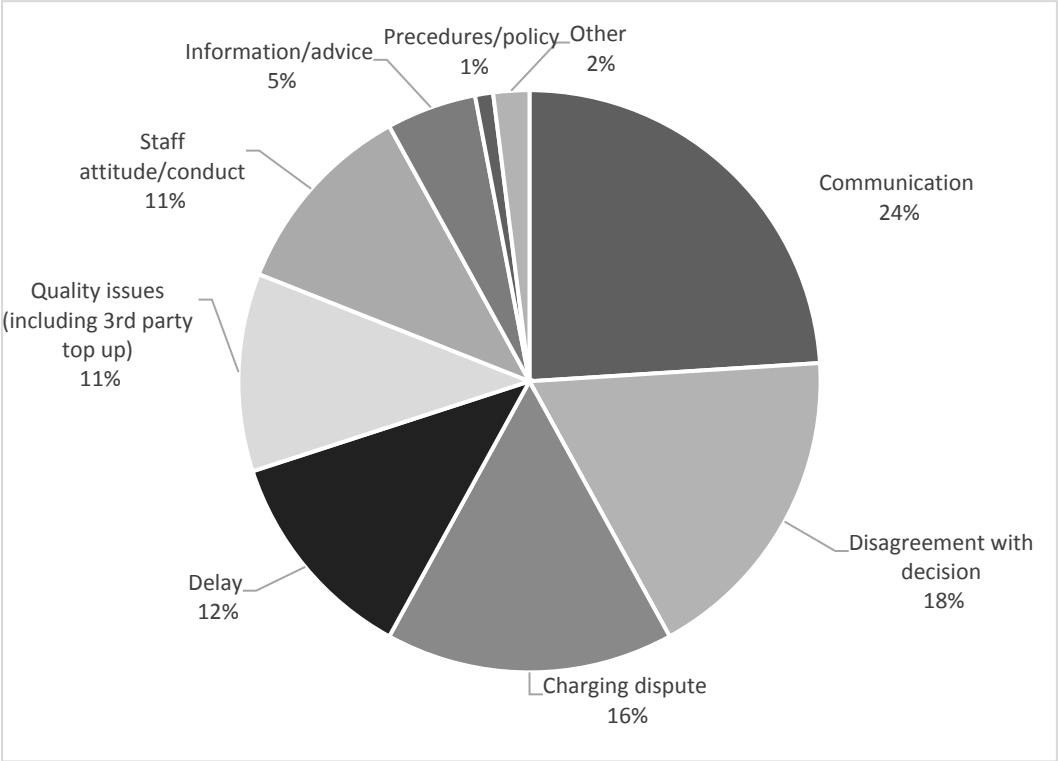
Complaints Method of Contact



e-mail	234
Telephone	188
Letter	122
Comment Card	36
Website	31
Visit	3

Appendix 1

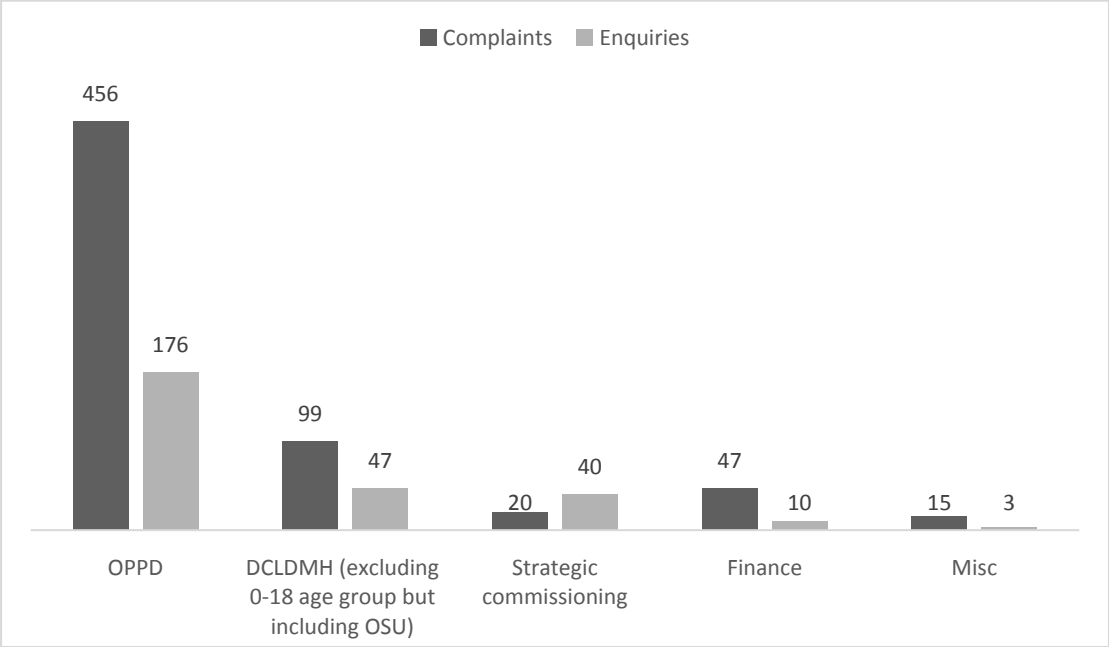
Main themes arising from complaints (provided as percentages for the broad themes as changes were made to the detailed to individual categories part way through the year when there was a change of database).



Communication	24%
Disagreement with decision	18%
Charging	16%
Delay	12%
Quality Issues (including 3rd party provision)	11%
Staff attitude/conduct	11%
Information/Advice	5%
Procedures/policy	1%
Other	2%

Appendix 1

Main Division the Complaints and Enquiries Related To:



	Complaints	Enquiries
OPPD	456	176
DCLDMH (excluding 0-18 age group but including OSU)	99	47
Strategic Commissioning	20	40
Finance	47	10
Miscellaneous	15	3

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From: Ben Watts, General Counsel

To: Adult Social Care Cabinet Committee – 27 September 2018

Subject: **Work Programme 2018/19**

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 2018/19.

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 2018/19

3.1 An agenda setting meeting was held 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 2018/19.

6. Background Documents

None.

7. Contact details

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Adult Social Care Cabinet Committee - Work Programme 2018/19

ASC Cabinet Committee meeting dates	Key Decisions	Commissioning Items/Contract Monitoring	Developing Issues	Members' interests/suggestions	Standing Items
30-Nov-18	18/00052 - Sensory Service Assessment and Rehabilitation Service	Commissioning of Integrated Domestic Abuse Services (16/00014) Performance Dashboard	Adult Social Care Green Paper Adult Social Care Future *(Penny Southern requested at agenda setting on 04/07/18 – name to be altered)*		Verbal Updates by Cabinet Member and Corporate Director Work Programme 2018/19
22-Jan-19	New Mental Health Operating Model 18/00054 - Digital Strategy 18/00053 - Sensory Service British Sign Language Interpreting Contract	Community Day Services for People with a Learning Disability and/or Physical Disability (16/00089) End of Life Care – Update Sensory Strategy Update Safeguarding Adults Update		Update on Social Isolation and Loneliness in Kent and the Social Isolation Select Committee	Verbal Updates by Cabinet Member and Corporate Director Work Programme 2018/19

12-Mar-19	Adults Rates and Charges 2019/20	Performance Dashboard			Verbal Updates by Cabinet Member and Corporate Director Work Programme 2018/19
Future items	• Update on progress against British Deaf Association of British Sign Language Pledges – to come back to Committee in July 2019				

Updated on: 19 September 2018