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.

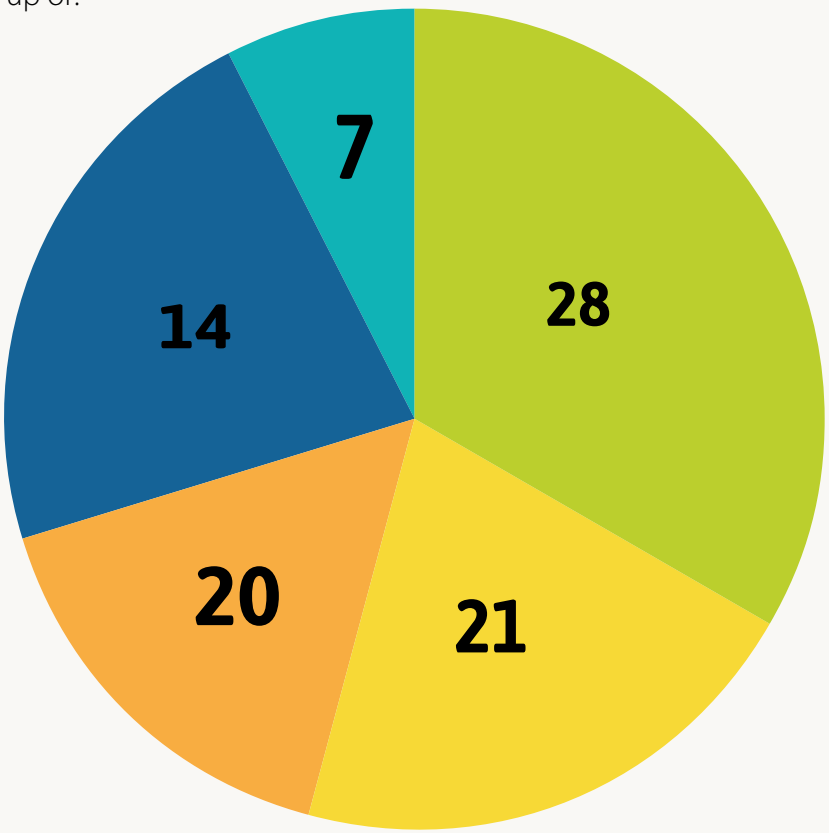
The finance spreadsheet formed the basis for the database, and it was expanded to include SWIFT ID numbers, personal details (date of birth etc), placement, care manager/care coordinator details and costs.

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

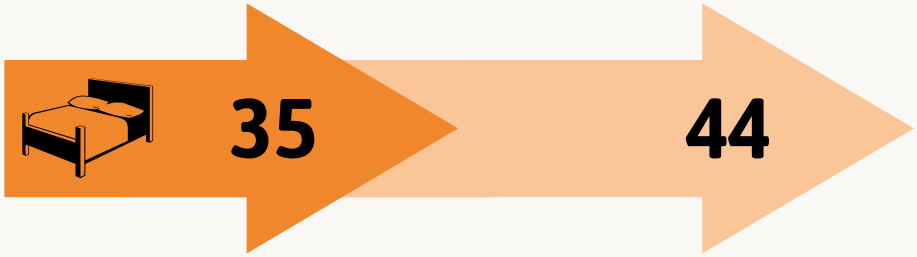
I interviewed a total of 81 made up of:

- 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

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

(PJ 25/7/18) FINAL