

Your life, your well-being

A vision and strategy for adult social care 2016 - 2021



Draft for consultation

Kent County Council Social Care,
Health and Well-being September 2016



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1. Foreword

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

It is well known that as a society we are living longer and, as a result, an increasing number of people have several related needs which need the attention of the health and social-care system. This is in the face of a dramatic reduction of resources since 2010 and all the available information shows that this is likely to continue for more years to come.

Our response to the changing environment is to set out a new vision for adult social care which this strategy is based on. It is a strategy that builds on our past successes but firmly points to the future in how we plan to work with the NHS to meet the challenges that we face. Our partners are people who use our services, carers, providers, the voluntary sector, health services, schools and colleges, district councils and other public services. This strategy sets out the overall direction that we aim to follow in the coming years, amidst the financial challenges and the ever-increasing demand for services that we know is the result of a growing population and the changing needs of people living in the area.

This new strategy is also based on the Care Act 2014, as opposed to the post-war legislation that it replaced. Under the 2014 legislation adult social care now has a broader responsibility to promote the well-being of adults when carrying out our legal obligations in relation to people living in the area.

This five-year strategy clearly explains our plans for the future. It provides the basis for health and social care integration which is in progress and aims to deliver more person-centred care and support, keep people safe, help people to have choice and control, make sure that there are enough care and support services available, work in partnership and, above all, make better use of our resources.



Graham Gibbens Andrew Ireland

Our vision for adult social care is built on existing work with social-care professionals, doctors, carers, the public, and other partners in developing new models of care for the future. As a result, our vision is part of the broader process of joining up health and social care under the NHS Five Year Forward View work programme for transforming service provision at scale and pace in the coming years.

By improving integrated commissioning and provision people will receive their health and social care from one community place linked to their GP surgery.

People with more intense and complicated ongoing needs will have one professional who will lead on coordinating their care and build a team of support for the person. This support will include single assessment and enablement (helping people to become more independent by gaining the ability to move around and do everyday tasks).

We will make the best use of digital technology to share information between partners and as a tool for those receiving health and social care support.

We will also break down barriers between sectors and organisations where they get in the way of better care and support. Our vision, to put it simply, is to 'help people to improve or maintain their well-being and to live as independently as possible'. This document will interest members of the county council, our staff, the public and partner organisations who may want to know how the services we arrange or pay for would change during the lifetime of this strategy.

2. Strategy at a glance

<p>Purpose</p>	<p>Adult social care is there to support people (adults, young people and carers) who need help with daily living so they can live as independently as possible in the place of their choice.</p>
<p>Context</p>	<ul style="list-style-type: none"> • Efficiency and finance • Quality of care • Outcomes and well-being.
<p>Strategic outcomes (Strategic Statement)</p>	<p>Strategic outcome 3: Older and vulnerable residents are safe and supported with choices to live independently.</p>
<p>Our vision for adult social care</p>	<p>To help people to improve or maintain their well-being and live as independently as possible.</p>
<p>Achieving our vision through three themes</p>	<ul style="list-style-type: none"> • Promoting well-being • Promoting independence • Supporting independence.
<p>What will make it happen?</p>	<ul style="list-style-type: none"> • Protection (Safeguarding) • Workforce • Commissioning • Integration and partnerships.
<p>Our values and principles</p>	<ul style="list-style-type: none"> • Person-centred care and support • Supporting people to be safe • Promoting independence • Prevention • Quality of care • Integration • Answering for what we do • Best use of resources.

3. Introduction



Over the last 10 years we have been transforming adult social care in Kent, as can be seen from the timeline (on the following page).

This strategy replaces the previous 'Active Lives' strategy. The vision and aims set out in this document strongly link with and support 'Increasing Opportunities, Improving Outcomes: Kent County Council's Strategic Statement 2015-2020' and the principles described in the 'Commissioning Framework for Kent County Council'. It is important to understand that this strategy sits between the council-wide strategies and other specific social-care group strategies such as the Learning Disability Joint Commissioning Strategy, the Strategy for Adults with Autism in Kent and Live Well Kent Principles for Mental Health.

What is the purpose of adult social care?

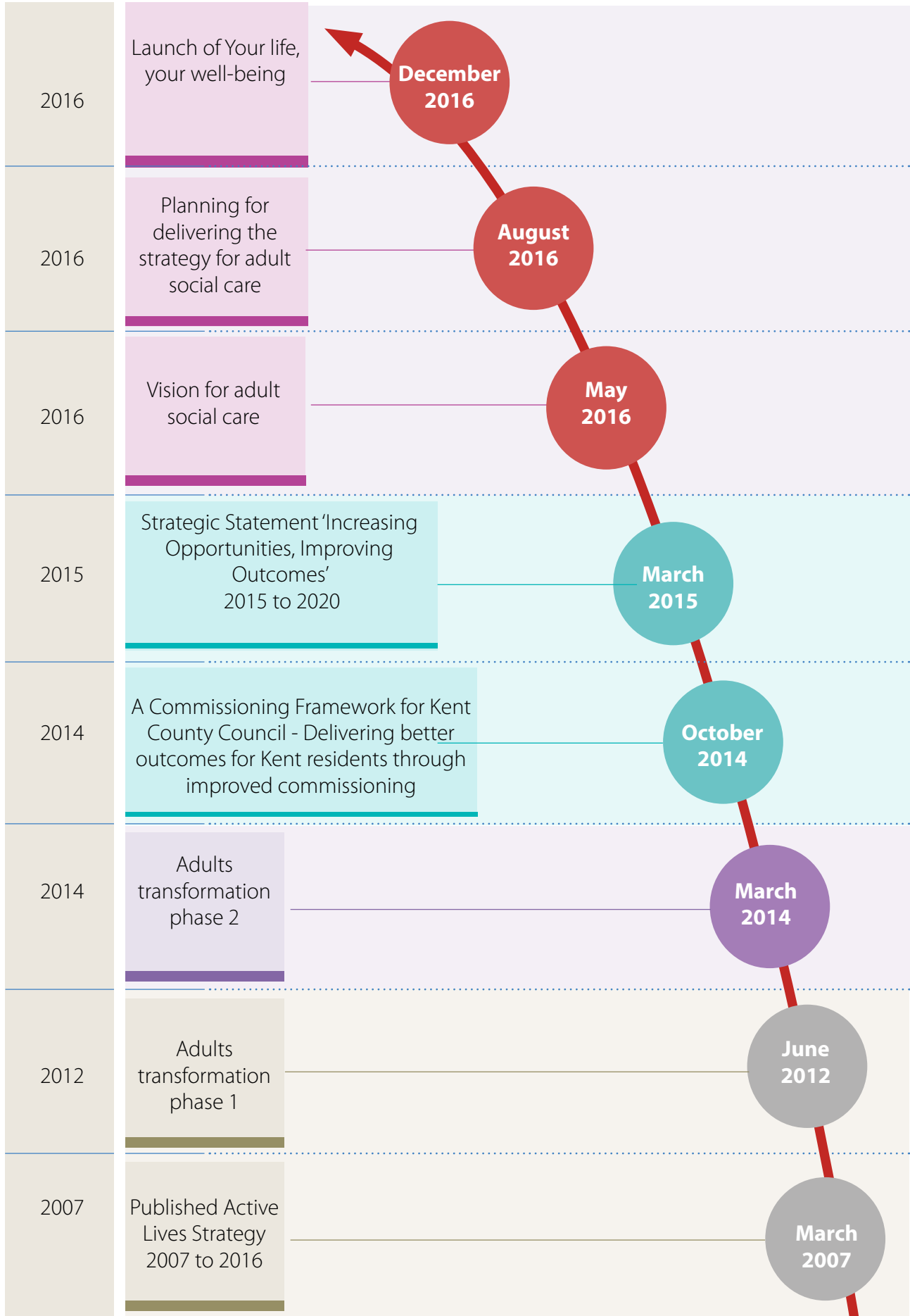
Adult social care is there to support people who need help with daily living so they can live as independently as possible in the place of their choice. The care and support that adult social care commissions (arranges or provides) is based on needs assessments of adults (including carers and young people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

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

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

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

Timeline



4. Our vision and strategic approach to adult social care



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

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

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

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

Supporting outcomes:

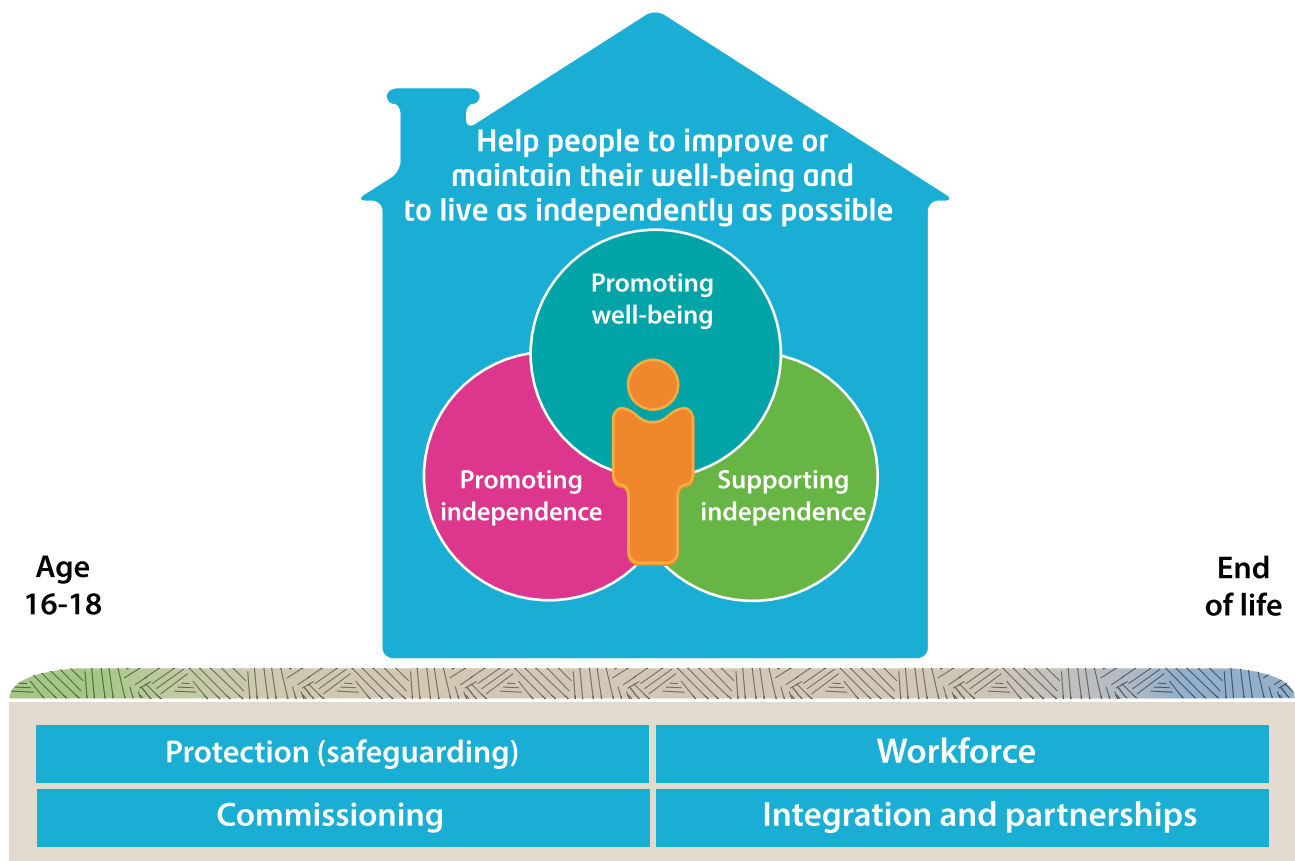
- Those with long-term conditions are supported to manage their conditions through access to good quality care and support
- People with mental health issues and dementia are assessed and treated earlier and are supported to live well
- More people receive quality care at home avoiding unnecessary admissions to hospital and care homes
- The health and social care system works together to deliver high quality community services
- Residents have greater choice and control over the health and social care services they receive

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

Supporting outcome:

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

Our strategy for adult social care over the next five years breaks our approach down into three themes, supported by four building blocks, as shown in the image overleaf. The three themes cover the whole range of services provided for people with all kinds of social-care and support needs, and their carers, throughout their adult lives. Chapters 6, 7 and 8 explain our plans over the next five years for each of the themes, and Chapter 10 explains our plans for the building blocks, but we give a brief overview overleaf.



The vision explained

Promoting well-being

This is delivered through services which aim to prevent, delay or avoid people from entering formal social-care or health systems, by helping people to manage their own health and well-being.

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

Promoting independence

This involves providing short-term support that aims to prevent or delay people’s entry to the formal care system, and provide the best long-term outcome for people. They will have greater choice and control to lead healthier lives.

- We will promote independence by

providing short-term support such as community equipment, enablement and other assisted living technology (products designed to help people live independently in their own homes).

- Our aim will always be to achieve the best long-term outcomes for the person.

Supporting independence

This is delivered through services for people who need ongoing support and aims to maintain well-being and self-sufficiency. The aim is to keep people safe and help them to live in their own homes, stay connected to their communities and avoid unnecessary stays in hospitals or care homes.

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

Four building blocks

Our approach to adult social care is supported by four building blocks that support the way we work and the changes we need to deliver.

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

Care pathways

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



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

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

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

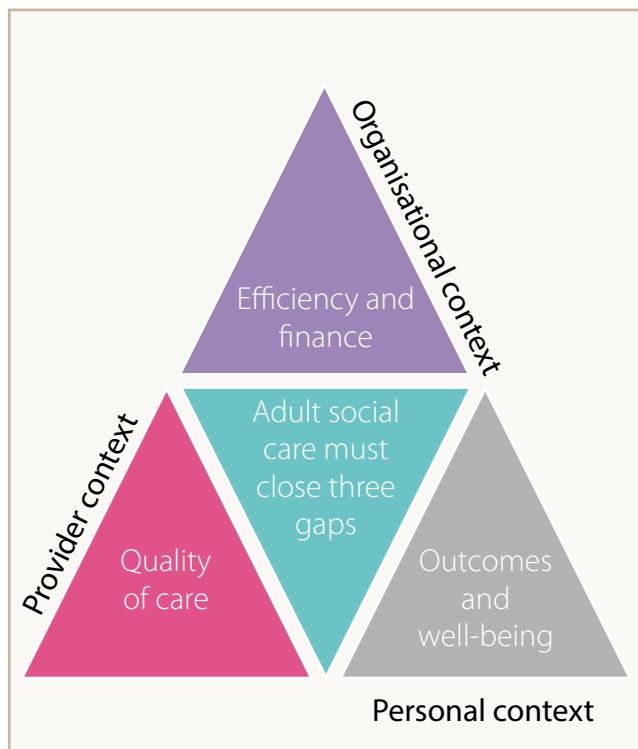
By prevention we mean any act that prevents or delays the need for people to receive care and support by keeping them well.

We recognise the importance of managing the move to adulthood for disabled young people receiving care and support. This can apply up to the age of 25. Our strategic outcome for children and young people is to make sure

that they get the best start in life. So, it is vital that we work with services for young people to make sure that they can have access to the appropriate preventative services as well as having the right links with health, education and housing. Getting this right should mean that we will be able to help young people to be with their families, until they can live independently (which will depend on their development needs). In making the changes described in this strategy, we will link with the 0-25 Portfolio Board’s vision and priorities for transformation which is about supporting every child and young person in Kent to achieve their potential.

Background

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



Organisational background (efficiency and finance gap)

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

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

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

Provider background (quality of care gap)

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

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

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

Personal background (outcomes and well-being gap)

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



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

Well-being is defined very broadly in the Act and includes personal dignity, physical, mental and emotional well-being, protection from abuse and neglect, control over day-to-day life, taking part in work, education, training or recreation, social and economic well-being, domestic, family and personal relationships, suitability of living accommodation and the person's contribution to society.

We will continue to put the well-being of the person at the centre of everything we do. This means that we will listen and respond to the views and issues that are important to the person when working with them and use information more intelligently, such as identifying people at most risk.

Outcomes for people are influenced by a number of factors including housing, education and lifestyle choices, some of which fall within our responsibilities in terms of public health.

This is an area where we believe more needs to be done working with our health partners, district councils and local communities, to reduce health inequalities (the differences in health between different population groups. For example, people from less well-off backgrounds tend to suffer from health problems more).

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



How the strategy will be put into practice

This strategy explains our vision for adult social care over the next five years. We will deliver it through the next phase of the transformation journey that adult social care is already on. The details of how we will deliver it will be set out in an implementation plan which we are developing for this strategy. In summary, this will include activity over the next 18 months around the following:

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

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

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

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

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

5. Our values and principles

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

- **Person-centred care and support**

We provide care and support that is tailored to the person so that they can achieve the things that matter most to them. This means putting the person at the centre of everything we do, supporting them to decide what care and support they want to receive so they can lead their lives in the way they choose.

- **Supporting people to be safe**

Working with people to help them to manage risks of abuse or neglect is central in everything we do.

- **Promoting independence**

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

- **Prevention**

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

- **Quality of care**

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



- **Integration**

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

- **Answering for what we do**

We answer to the people we provide care and support to, their carers and the whole community. We are clear about our roles and responsibilities and honest and open about our performance.

- **Best use of resources**

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

6. Promoting well-being



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

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

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

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

How things are today

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

How we want things to be in the future

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

We will continue to make information and advice an important part of the ‘community hubs’ we hope to have in all local areas. They could be developed around an existing GP practice, for example, or in other prominent locations where people can pop in for advice and support.

Community hubs – these are at the heart of our future vision. They will be based in GP surgeries and provide quick, co-ordinated access to a wide range of services and therapies close to or at home. They will contain the same main services:

- Integrated nursing and social-care services including home care, community nursing, occupational therapy, mental-health services, crisis care and palliative (end-of-life) care
- Services to prevent health problems and promote good health
- Access to voluntary and community services

We will develop these locally to reflect the needs in different areas of the county.

We will make sure information and advice can be accessed through a variety of channels and formats including, for example, advice lines, drop-in services, websites and care navigators or brokers (Care navigators or brokers are people whose job it is to give advice and information about what services are available in a person's area so that they can choose to arrange the care and support that best meet their needs).

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

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

We will expand the use of 'care navigators', or other forms of community worker that we arrange using voluntary organisations. Their role is to help people manage their own health and well-being by accessing local community-based services, aids and equipment, benefits and other sources of support.

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

We will be looking at how medical and social-care professionals can use social-prescribing models more widely. By social prescribing we mean, for example, GPs could prescribe a course of exercise classes rather than, or as well as, antidepressants for someone with mild depression or anxiety.

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



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

George is 75 and, since his wife died two years ago, has been living on his own in the house he had shared with her for the previous 40 years.

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

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

George belongs to his local Neighbourhood Watch as do most people in his area. Recently they have decided to add to what they

do by looking out for their more vulnerable members, including older people, like George, who live alone.

The local council provided some training for them and other local groups in recognising signs of social isolation, dementia and other problems among older people and also where to go for information and advice to help with these things. As a result, one of George's neighbours invited him for tea and suggested that he goes to or phones the new community hub at his local GP surgery (recently expanded to try to provide a one-stop shop for information, advice and support for people who may need this due to loneliness, health problems, disabilities and so on).

A week later George saw someone at the community hub and, as a result, was given the information he needs to:

- join a befriending group organised by Age UK (this includes finding someone to go with him on regular walks);
- join his local University of the Third Age (a self-help organisation for retired and semi-retired people providing leisure, educational and creative activities) which holds all sorts of regular group activities (he is interested in the art appreciation one);
- arrange for a walk-in shower to be installed in his bathroom instead of his bath and to have grab rails put alongside the toilet; and
- signs up to a scheme whereby a volunteer driver will take him to see a friend who lives about five miles away (once a week).

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

7. Promoting independence

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

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

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

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

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

How things are today

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



Enablement

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

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

How we want things to be in the future

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

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

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

much more short-term support for people at the crucial points when this is needed.

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

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

We will not just try to increase independence when we are first in contact with a person. At every opportunity we will see if there is more that we can do. For example, we might provide a person with a learning disability a support worker to help them learn the route to work so they can get to work on their own. We will not assume that this support will be needed forever and will regularly review whether it is still needed.

While continuing to review the support we provide in this way, we will also be sensitive to the fact that people need some certainty about the help they will be given. Because of this, we will make it clear that, while the aim of any support is to encourage independence and that some support might be short-term, it can also be increased when needed.



Ben's story: Promoting independence in the future

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

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

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

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

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

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

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

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

As a result of the support being offered to Ben, his mum's situation as a carer has been helped. Jane has been given a personal budget and can use this for a monthly trip to a local spa which helps ease the stress of caring. She has also joined a local carers' support group.

8. Supporting independence

Providing effective ongoing support

Supporting independence is the final part of our strategic approach to adult social care and is aimed at those who need ongoing care, whether at home or in a residential setting. It allows people to live in their own homes where possible, stay connected to their communities and avoid unnecessary stays in hospitals or care homes. Supporting independence is delivered through services that aim to maintain individual well-being and self-sufficiency, keep people safe and allow people to live and be treated with dignity.

How things are today

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

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



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

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

How we want things to be in the future

By joining together health and social-care services in Kent, people who need ongoing care will receive personalised care and support that is focused on helping them achieve the outcomes that are important to them. More people will receive care in their communities or, wherever possible, in their own homes.

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

People will receive all of their health and social care from one 'community hub' linked to their GP surgery (see page 15). This means people will have quick, co-ordinated access to a wide range of services close to or at home. Working with the person and their carer, all the professionals who are involved in providing care to the person will assess their needs and share their records meaning there will be no duplication or gaps and the person's mental capacity will be taken into account (following the Mental Capacity Act). (Mental capacity deals with a person's ability to make decisions for themselves. The law says that a person may lose their right to make decisions if this is in their best interests.)

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

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

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

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

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

We will routinely use technology to help keep people safe and maintain their health and well-being at home. This includes telehealth, which allows medical professionals to remotely monitor a person's vital health signs including blood pressure and blood sugar, and telecare. We will continue to work with our providers to identify and, where helpful, put into place cutting-edge assistive technology. We will also make better use of technology to help people keep in touch with loved ones and stay connected with their community and the things that matter to them.

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

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

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

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

Extra care housing

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



Anita's story: Supporting independence in the future

Anita is 54 with a degree in French. She was born with cerebral palsy and uses a walking frame to get around. Later in life she has developed diabetes, and over the last year has had to stay in hospital frequently. Anita needs support with daily living, including her personal care, cooking and help around the house. Up until recently she has been able to manage living on her own in her own home with daily visits from a home-care worker. However, she has started to struggle being on her own in the house between homecare visits and is in need of some further adaptations to her house. She also now needs support a couple of times a day to help manage her medication and monitor her blood-sugar levels.

As Anita has complex ongoing conditions, she has been allocated a care co-ordinator (one person leading the planning, working with others) from the community hub that is responsible for Anita's care and support. Anita's care co-ordinator, James, meets with Anita to understand what is important to her, how she would like to live her life and the goals she would like to achieve. James has access to all of the assessments and records that the different health, mental-health and social-care professionals who have been involved in

Anita's care and support have made. Based on this and what Anita has told him about what she wants, James brings together a team of health and social-care professionals with the right skills to support Anita including her GP, her community nurse with diabetes specialism, home-care worker and occupational therapist. Together they create a plan for Anita's care and support.

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

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



9. Supporting carers

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

We will continue to work with carers' organisations in Kent to help identify and assess carers who could benefit from support.

Over the next five years we will work with carers to develop a new set of services and support for them. The new services will provide support for carers in all areas of their life that are affected by their caring responsibilities, helping them to achieve the things that are important to them. This should allow them to continue their caring role and also protect their own health and well-being, something which the Care Act puts at the very centre of care and support. This will also apply to carers who care for someone who is not receiving formal care and support.

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

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

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

10. Building blocks

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

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

Protection (Safeguarding)

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

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

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

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



it clear that they have a zero tolerance of abuse. In other words, they will not put up with it at all.

- We will give priority to preventing abuse by raising the awareness of adult-protection issues and by fostering a culture of good practice by providing support and care, commissioning and contracting.
- Adults who are vulnerable or subjected to abuse or mistreatment will receive the highest priority for assessment and support services.

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

We also recognise that we share these protection responsibilities with other partners – providers, the NHS, the police and the community in general. To this end we will work to make sure that the collective roles and



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

Workforce

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

Delivering tailored care that focuses on supporting people to achieve their outcomes will involve some changes to the skills, working practices and culture of the social-care workforce. We will make sure our staff and staff in partner organisations have the skills and

knowledge needed so that people can have as much choice and control as possible. The emphasis will be on what works best to meet a person's outcomes, rather than what services are available that we can fit a person into. So we will encourage staff to be imaginative in the solutions they develop. People who provide care will take a new and creative approach in supporting people to maintain their independence. This will include the ability to design services alongside those receiving them and others involved in providing services. It also involves a sophisticated understanding of people's right to choose to take risks so they can lead the lives they want.

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

Social care and health will increasingly work together so staff will need to work across organisational boundaries, which will help reduce current duplication in assessments and other activities. We will need to support changes in culture so we can achieve this and support staff to make the best use of digital technology to share information between partners and as a tool for those receiving social care. If the team is to work as one, the planning and management of the workforce needs to take a whole-system approach. We are working with the NHS on developing our workforce to be ready for the future, and some of our agreed priorities include the following:

- Existing and emerging gaps – identifying where we currently have a shortfall in the workforce we need and where we are likely to have a shortfall in the future, including succession planning (finding and developing people with potential to move

into important roles in organisations)

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

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

We are using analysis of long-term hard-to-recruit professions to help us plan future care so that we move away from relying on locums

or overstretching the current workforce. We are currently developing a strategic workforce action plan for health and social care together.

Commissioning

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

As we move towards becoming a commissioning authority, we will be in a good position to adopt this model, and will do so by working with the NHS. Clinical commissioning groups and NHS England are also shifting their approach to commissioning to an outcome-based approach. When this is done jointly, the entire assets of a community or neighbourhood can be considered and made best use of. Where a good community network or organisation exists and can contribute to achieving the outcomes of this vision, it will be able to play its part and benefit from this approach. This could be from the voluntary or community sector, or from a wider range of providers and public-sector organisations than currently delivers services for health and care. We recognise that making the shift from the current way of working to the future outcome-based commissioning approach will be a challenge for commissioners and all providers. It will also involve having appropriate IT systems in place, capturing and analysing information and tracking and monitoring quality.

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

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

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

Increasingly our commissioning will be led by 'care pathways' for defined groups of users with similar characteristics and needs, for example young adults with long-term care needs or older people with dementia. We will be clear on our overall commissioning responsibilities and approaches, which consider the needs of the whole population, and which are different from place-based commissioning to meet local needs.

Integration and partnerships

Kent has a good track record of health and care working together in partnership. It was one of the original 14 Integration Pioneers named in 2013 and this has continued through the Better Care Fund and the current Sustainability and Transformation Plans (STPs) which are to be the plans for delivering the NHS Five Year

Forward View. The Five Year Forward View and the STPs give a name and framework to what Kent had already been moving towards. This involves approaching the health and care of the population as a whole system and breaking down barriers between sectors and organisations where they get in the way of better care and support.

This shift is necessary both to deliver the quality of care we want to see the people of Kent receive, but also making sure that the finances of health and social care are secure. In spite of this strong track record of partnership working, there are some barriers that we must work hard to overcome, such as a lack of common language and shared priorities, multiple IT systems, different performance frameworks and budget cycles. These all combine to make what we want to achieve more difficult at the current time.

Our vision for adult social care is built on existing work with social-care professionals, clinicians, carers, the public, and other partners in developing possible new models of care for the future. As a result, our vision is part of the broader process of joining up health and social care.

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

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

- finding the money to invest in the changes, including creating the 'community hubs';
- sharing information, which is vital for

high-quality, integrated care, but must be carefully managed in ways that keep to the Data Protection Act 1998 and various other laws;

- finding incentives and targets that work across health and social care, given the different audit systems and payment models which can result in conflicting interests, and problems in agreeing how evaluation will be measured; and
- differing workforce practices. These range from different employment terms and conditions through to different organisational cultures and attitudes.

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

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



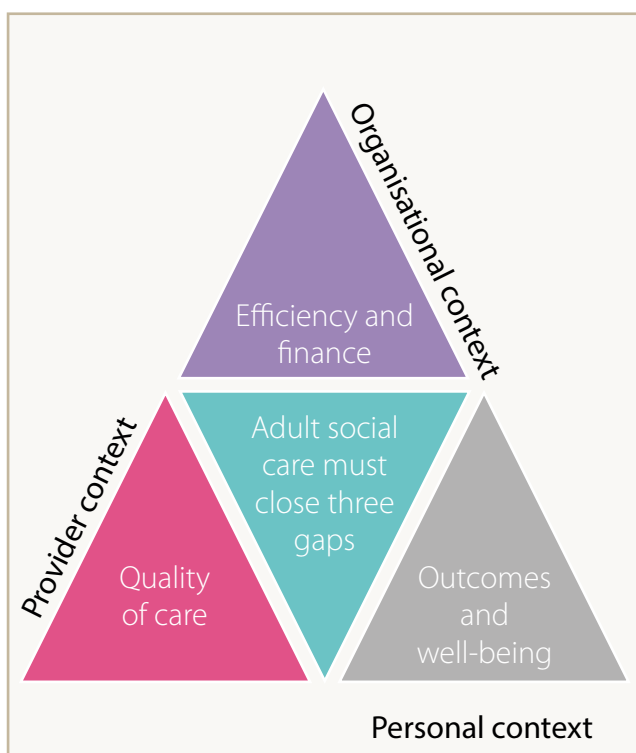
need to be flexible and responsive enough to meet the challenge of working with commissioners, and being commissioned on an outcomes-focused basis.

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

We will continue to work with the voluntary and community sector who will play an even more significant role in supporting people's independence. We will continue to support the sector so it can cope with the changing and increasing demands for care and support in the communities that it works with. We will encourage new enterprises (for example, befriending schemes) and work with existing organisations to help them work in new areas (for example, Neighbourhood Watch schemes, allotment societies and so on).

11. Monitoring our performance

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



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

- Measures of success – a one-page activity, finance and performance information report used by adult social-care managers on a monthly basis to keep track of progress

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

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