Your life, your well-being
A vision and strategy for adult social care 2018 - 2021
It is well known that as a society we are living longer and, as a result, an increasing number of people have complex needs and require the support of the health and social care system. This includes increasing numbers of young people with learning and physical disabilities who are moving from Children’s to Adult Services and often need high levels of support. These developments are happening at the same time as a continued reduction in funding. All the available information shows that this reduction in funding is likely to continue.

This document sets out how we are going to respond to the changing environment with a new vision and strategy for adult social care. It is a vision and strategy that builds on our past successes but firmly points to the future in how we plan to work with our partners to meet the challenges ahead. Our vision, to put it simply, is to ‘help people to improve or maintain their well-being and to live as independently as possible’. Our strategy sets out the overall direction that we aim to follow in the coming years to achieve this vision. The aims and principles of the strategy are the basis on how we develop and introduce new ways of doing things in the services we provide or arrange to be provided. The measure of our success will be if we are able to deliver more person-centred care and support, keep people safe and help people to have reasonable choice and control. We will make sure that there are enough care and support services available working in partnership and make better use of our resources.

The new vision and strategy is informed by the Care Act 2014. Under this Act we not only have responsibilities towards adults with care and support needs and their carers, but also a broader responsibility to support the prevention agenda and promote well-being. This should help prevent some needs arising in the first place or delay their development.

The next three years are going to be very challenging, but we are committed to doing all we can to provide the right level of care and support to those who need it.
2. Strategy at a glance

Purpose

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.

Context

Adult Social Care must address three gaps:

- Efficiency and finance
- Quality of care
- Outcomes and well-being.

Strategic outcomes from our Strategic Statement

Strategic outcome 3: Older and vulnerable residents are safe and supported with choices to live independently.

Our vision for adult social care

To help people to improve or maintain their well-being and live as independently as possible.

Achieving our vision through three themes

- Promoting well-being
- Promoting independence
- Supporting independence.

What will make it happen?

- Protection (Safeguarding)
- Workforce
- Commissioning
- Integration and partnerships.

Our values and principles

- Person-centred care and support
- Supporting people to be safe
- Shared responsibility
- 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 page 6.

This strategy replaces the previous ‘Active Lives’ strategy. Its development took into account the views of service users, providers and partners that had been gathered through on-going discussions with these groups.

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 Success’ document. 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,’ ‘Sensory Strategy,’ ‘Being Digital Strategy’ and ‘Live Well Kent Principles for Mental Health’.

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.

By transition we mean the process where young people with health or social care needs move from children’s services to adult services.
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:

4. Our vision and strategic approach to adult social care

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 work 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.

As well as supporting our wider outcomes, the delivery of the vision and strategy will link with the aims of our public-sector partners, including district and borough councils. We will continue to work closely with these partners to deliver our common aims to achieve the best outcomes for the people of Kent. Our strategy for adult social care over the next three years breaks our approach down into three themes, supported by four building blocks, as shown in the image on the page. 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 three years for each of the themes, and Chapter 10 describes the building blocks.
Help people to improve or maintain their well-being and to live as independently as possible.

Promoting well-being

This is delivered through services which aim to prevent, delay or reduce people’s need for social care or health support, 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 community support.

Supporting independence

This is delivered through services for people who need ongoing support and aims to maintain well-being and help people do as much as they can for themselves. The aim is to meet people’s needs, keep them 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 hospitals or care homes.
- We will change the way our services are commissioned and delivered to be more focused on achieving better outcomes for people.

Supporting independence

These show how people’s needs could be met through better use of existing support arrangements and new ways of doing things.

Four building blocks

To deliver the vision and strategy there are important building blocks that must be in place. They are:

- Making sure we provide effective management (with partners) to protect adults at risk of neglect or abuse and making 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 suitable and smooth care pathways 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. This includes a new approach to evaluating performance and contract management.
- 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.

Model of care

A way of providing care based on a set of beliefs and principles about what is right and works best.
Prevention, support and managing the move for young people into adulthood

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 they can have access to the appropriate preventative and early intervention 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).

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%. Improved medical care and higher survival rates following illnesses and accidents also mean that we are seeing significant increases in the numbers of people with complex needs, including 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 £433 million of savings, around £80 to £90 million each year, so 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. If we do not change the way we deliver services, we cannot meet the current and future needs of local people within our existing budget.

Provider background (quality of care gap)

Over 80% of our budget for adult social care is spent through the external market, with many providers being Kent registered. The care market is made up of around 500 providers of services in the public, private and voluntary sectors, employing over 40,000 people. Given our position we have significant buying power, which needs to be exercised rightly to ensure we support and enable a sustainable care economy.

The continuing pressures on finances and increasing demand, in terms of an ageing population and an increasing complexity of need, are causing significant challenges for the whole system. Some providers have not been able to adapt their business in order to survive, others are reporting that they are struggling to recruit, retain and develop staff to ensure they have the right skills to deliver and maintain high-quality outcome-based services.

Outcomes based

Services focused around the individual’s needs and their desired outcomes.

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.

Work has already started with the NHS to jointly commission and deliver a more integrated service provision in the community including discharge services. We will also be examining how the commissioning of NHS Continuing Healthcare and residential services could be aligned. There is a new contract for care and support in the home which will enable providers to increasingly become part of a multi-disciplinary team.

Like all local authorities, we have a duty under the Care Act to shape the local care market and to ensure that market is sustainable. 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
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.

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 we are putting the strategy into practice
This strategy explains our vision for adult social care over the next three years. We will deliver it by bringing together all our change and improvement work into a single new operating model, which works across adult social care.

This new operating model looks at what people can do, and not just what they cannot do. This might be referred to as an asset based approach. The ambitions in this strategy will be accomplished by working together with our partner organisations using a shared approach to deliver care and support. This approach (the new operating model) is described here:

Older people and people with physical disabilities teams
- The teams cover social work, safeguarding, promoting well-being, supporting independence and quality improvement.
- The promoting well-being function delivers information, advice, advocacy and signposting to local services in the community with the aim of preventing, delaying or avoiding people from entering social care or health systems, by helping people to manage their own health and well-being.
- The Supporting Independence teams work closely with health colleagues using integrated screening processes to give people a consistent journey through health and social care services. There will be joint working in the discussion of cases and this will avoid duplication and ensure people are given the right support by the right people at the right time. In the longer term it is hoped providers can take on case holding responsibilities with appropriate support from the Supporting Independence teams.
- Support will be targeted to help people to achieve the goals set in their care and support plan. This will be done with service providers who will become part of the Local Care (see page 17) team (made up of various agencies and professionals).
- There will be a dedicated safeguarding function. Teams will take appropriate steps in providing safeguarding, working with partners to protect people at risk of abuse or neglect. This dedicated function will work to agreed time-scales for when the different parts of their work should be completed.

Advice will also be available to support and assist other staff on safeguarding matters.
- The Quality Improvement Function will ensure providers take steps to improve their care where quality issues have been identified. They work with providers to develop and monitor change and to make sure that these changes are sustained and contribute to improving outcomes for people.
- Social workers will work with clients for 12 to 16 weeks to provide short term support where it is shown this will benefit them. This will be governed by the KCC Social Work Framework.

People with mental health needs
- Our team, which support people with mental health needs work to a new operating model that continues to deliver services in partnership with Kent and Medway Partnership Trust, whilst also continuing to work with a range of other partners.
- The aims of the new delivery model are to make sure that:
  - the person referred to a community mental health team is seen by the right professional at the right time;
  - there is no duplication of process;
  - there are equal services for all people referred; and
  - all professional groups are not expected to work outside their professional accountabilities or eligibility criteria.
- Under the new delivery model, referral screening is undertaken jointly by health and social care staff, and assessments (whether health only, social care only or joint are carried out with the right professionals involved). Any joint assessments are undertaken with a minimum of two professionals to be present, one of whom will be qualified.
- There are two duty systems (one health, one social care) which are co-located and run alongside each other. Case responsibility under the model is determined by the main
needs of the individual; the lead professional could be a health worker, a social worker or joint management.

Adults with a learning disability

- Our teams which support adults with a learning disability over the age of 26 years are integrated with colleagues from Kent Community Health Foundation Trust and Kent and Medway Partnership Trust, also working with Clinical Commissioning Groups.
- The service is part of our Lifespan Pathway that supports disabled children, young people and adults over the age of 26 years who have lifelong complex disabilities. Its aim is to provide support that is seamless with continuity through transition periods in people’s lives.
- The aim is that people with a learning disability in Kent get high quality, integrated health and social care to support them to live healthy, fulfilled and safe lives in their community. The service is provided through five area teams which follow the same allocation processes so that the person is seen by the right professional at the right time with minimal duplication or delay.
- Should there be a breakdown in a person’s placement the service offers a complex care response within four hours to minimize the need for admission to specialist hospitals. Teams also respond to safeguarding concerns and will undertake all necessary safeguarding enquiries.

In-house provision (KCC owned/ run services)

- The services that KCC directly manages are now known as Inspiring Lives. We have renamed our day services as ‘Community Services’ with the expectation that the provision will change to offer outcome focused activities that may not be restricted to 9 to 4, Monday to Friday.
- We will develop plans to have the same processes across our service to speed up referrals and avoid duplication. We look at meeting the right outcomes for people using personalised support planning materials. We will ensure that we are working towards better outcomes for all people we support irrespective of their care needs.
- We have made our job descriptions consistent across the service so we have the same and greater resources. Staff can now be better matched to people who use services. Inspiring Lives have created ‘champion roles’ in various areas, where team members will become trained in things like “positive risk” and “active support” to further enable independence and allow everyone to have choice and control in their lives. We are moving towards very highly trained staff who will be able to deliver bespoke support to enable people (especially those who may have complex behavioural needs), to have a greater level of stability in their everyday lives and have more control.

Principal Social Worker

- Our Principal Social Worker will support us to have a greater focus on the quality of our practice. This will be delivered via the establishment of a Social Care Academy, incorporating the work of our Teaching Partnership with Medway Council, The University of Kent and Canterbury Christ Church University. We will be enhancing our focus on quality by developing a quality assurance framework to support us to measure and understand performance at different levels.

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 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 choose and control what care and support they receive. We will treat every person with respect and dignity.

- Supporting people to be safe
  Working with people to help them stay safe, including managing the risks of harm, abuse or neglect. This is central in everything we do.

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

- Prevention
  We work with our partners to provide advice and support 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, so that people receive the right support at the right time in the right place. 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 communicate clearly about our responsibilities and policies and we are 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

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 talk more about this in the integration and partnerships section of the Building blocks chapter in this strategy.

We will continue to make information and advice an important part of the development of Local Care and local multi-disciplinary teams. People will be able to get information about all the health and social care services and activities in their local area and advice about living healthily and planning for future care needs.

**Local Care**

Local Care is about bringing together primary, community, mental health and social care to offer more joined-up care in people’s homes and local communities. Local Care services are at the heart of our future strategy. Local Care hubs are a cluster of GP surgeries working together with additional services as one to provide quick, co-ordinated access to a wide range of services including therapies close to or at home.

Local Care services are being developed locally to reflect the needs in different areas of the county. The aim is to prevent ill health by helping people stay well, improve the access and quality of care, reduce avoidable demand on hospitals (for example A&E departments) and provide better support in care homes. As a result they will help to reduce avoidable hospital admissions and care home placements in the longer term. They will be made up of the following typical services:

- GPs and paramedic practitioner services, which will support home visiting for those not able to go out
- Integrated nursing and social care services including home care, community, district and specialist nursing, physiotherapy, occupational therapy, mental-health services, urgent and crisis care and palliative (end-of-life) care and support
- Out-of-hospital services such as diagnostics tests and same-day treatment for minor illnesses and injuries
- Prescribing medicines
- Information and advice services to help with preventing health problems getting worse and promote good health
- Support for carers in tackling their different needs
- Access to voluntary and other community services including through social prescribing.

**Social Prescribing**

Information to help people access advice and services to help them improve and manage their own health and reduce the risk of serious illness.

To reduce avoidable hospital admissions and care home placements (for example, A&E departments) and provide better support in care homes.

People will be able to get information about all the health and social care services and activities in their local area and advice about living healthily and planning for future care needs.

We will continue to make sure information and advice is an important part of the development of Local Care and local multi-disciplinary teams. People will be able to get information about all the health and social care services and activities in their local area and advice about living healthily and planning for future care needs.

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 health professionals. 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. Our Being Digital Strategy describes how we would like to make it possible for people to communicate with us in ways that work best for them, this could be through, email, apps, online conferencing, instant messaging or virtual visits. The strategy is built around the five themes of People, Place, Practice, Product and Partnerships.

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), and some equipment. 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. Care navigators give advice and information about what services are available in a person’s area so
that the person can choose to arrange the care and support that best meet their needs. 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 across health and social care. 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. An example of social prescribing could be GPs prescribing a course of exercise classes rather than, or as well as, medication for someone with mild depression or anxiety.

Promoting well-being is also about encouraging and supporting people to live healthy lives, which has benefits for the person in the short term and can prevent a range of health problems in the longer term. Working with our partners, we will continue to promote public-health campaigns and programmes that encourage people to change their behaviour, such as taking more exercise, stopping smoking and attending health screenings that are offered. Well-being is also influenced by wider issues including housing, employment and education, and we will continue to work with partners to make improvements in these areas that will promote well-being.

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.

Case Study

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

George is 87 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 invites him for tea and suggests that he goes to or phones his GP practice which can access services across health, social care and the voluntary sector as part of Local Care.

As a result, George is given information on joining a befriending group organised by Age UK as well as information on joining his local University of the Third Age. This is a self-help organisation for retired and semi-retired people providing leisure, educational and creative activities which holds all sorts of regular group activities, including teaching people about using information technology to keep in touch with relatives. George also gains information on arranging for the appropriate equipment to be installed in his bathroom, which helps him to keep clean and manage his other personal needs. He also gets information on a scheme where a volunteer driver will take him, once a week, to see a friend who lives about five miles away.

George is 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 should 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 deciding what to do next.
7. Promoting independence

Providing the right targeted 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

- 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 then continue to do this throughout the care journey. At every opportunity we will see if there is more that we can do to help people be independent. This will be done through assessing needs and responding to change. 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.

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 try to increase independence when we first make contact with a person and continue to do this throughout the care journey. At every opportunity we will see if there is more that we can do to help people be independent. This will be done through assessing needs and responding to change. 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.

Care and support, whether it is only short term or ongoing, will be co-ordinated by the Promoting Independence teams as part of Local Care and therefore integrated with support from health and the voluntary sector (see box on page 17). 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.

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We need greater choice and availability of services for disabled children and adults, but there is more to do.

Currently we spend about £7 million a year on services for disabled children and adults, but there is more to do.

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 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 supported 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.

How we want things to be in the future

We will always make sure that people who need ongoing care and support receive it, while at the same time working with people to help them to live in their own homes where possible, stay connected to their communities and avoid unnecessary stays in hospitals or care homes.

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 aims to meet people’s needs while allowing them 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 with services that aim to maintain individual wellbeing and keep people safe, help people do as much as they can for themselves 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 more dependent on services than they need to be, 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 lack of connection 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.

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 has 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.

Ben has attention deficit disorder and this and his hyperactivity has affected his ability to learn and hold on to information. While Ben can make himself understood, 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, or if the route changes.

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 in his care. 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, Ben’s mother and carer, 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 in a way which best meets her needs to ease the stress of caring. She has also joined a local carers’ support group.

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 supported 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 £7 million 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

We will always make sure that people who need ongoing care and support receive it, while at the same time working with people to help
them do as much as they can for themselves. 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.

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. 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.

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
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 co-ordinating 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 through Local Care 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 that best meet their needs and control over all of their care. 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 three 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. 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. 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.

We will promote an ambitious and innovative provision of extra care housing which is flexible and responsive to the changing needs of individuals. This may include efficient re-modelling of existing stock, making it an attractive option of alternative accommodation. The ultimate goal is to continue to offer personalised support, and enable people to have increased choice and control through extra care housing. We believe this supports the prevention agenda and helps reduce the number of people going into long term care.

More people with ongoing care and support needs will stay in or enter education, training and employment. This is important to people’s well-being and can help people keep or regain their confidence and 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 enabling and rehabilitative care services and nurse-led home care services coming into care homes and using assistive technology. The Local Care hubs will also aim to promote activity that involves care home residents in their local communities.

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 59 with a degree in French. She was born with cerebral palsy and uses a walking frame to get around but this is becoming more difficult. Later in life she has developed diabetes, and due to problems with her eyesight brought on by this condition, 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 visits from a home-care worker every other day. However, she has started to struggle to cope being on her own in the house between home-care 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 navigator through Local Care. This is the person leading the planning of 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 she has contributed to all of the assessments and records that the care co-ordinator, James, meets with Anita, including her GP, her community nurse with diabetes specialist, 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 weight and blood sugar and sends this information to her nurse and GP so they can help her manage her blood sugar levels and act quickly if there are any signs that problems may be developing.

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 sense of 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 one of the most effective ways 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. The age profiles of carers show that they are getting older and the overall number of carers is increasing. Many carers may be reaching the point where their needs may change so they are not able to carry on. We recognise that this may lead to an increase in demand for services that support carers.

Over the next three 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 Local Care 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.

We will work with our colleagues in Integrated Children’s Services to ensure that young carers receive assessments and are supported in the best way possible, making sure that any risks are properly managed across a range of ages.

Many young carers are ‘hidden’, in that services are not aware of them. In order to identify, engage with, assess and support these young people we will work with our partners, especially schools, health colleagues and our commissioned services to offer the right advice and support, including signposting, one to one support, in school support and workshops.

**Young Carer**

Someone under 18 who is taking on caring responsibilities for a family or a friend with a long-term illness, disability, mental health or substance misuse issue. They may be a main carer or provide partial care for an adult or sibling but are caring for a person on a regular basis.
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) - ‘keeping you safe’

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 will improve our response to safeguarding concerns through a dedicated safeguarding function that manages enquiries effectively. 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. We recognise that adults may need protecting from many forms of danger that can affect their safety. 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 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-protective 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 and 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 - ‘getting the people right’

When we refer to ‘workforce’ in this document, we mean all staff who work in and deliver social care and support services in the public, private, community and voluntary sectors.

The workforce is our most valuable asset in social care and without the right health and social care workforce, we cannot deliver anything in this strategy. The Kent social care market employs over 40,300 staff, most of which work for private, voluntary and independent sector providers.

However, the social care sector is experiencing many challenges to workforce resilience. 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. Levels of training, skills and status are falling compared with other professions. Given these pressures we are working to support and shape the care workforce to address challenges and to provide for and meet the changing needs of the service, and the people it helps.

Recruitment and retention

Making sure that Kent can recruit the people it needs and, once it has done so, keep hold of them is vital for our services. We will continue to work in partnership with the sector and training partners to increase interest and the access routes into social care. Through such approaches, we aim to attract people from wide and diverse backgrounds into a career in caring.

We will carry on supporting our workforce to gain access to training and development opportunities. This will make sure both our staff and those in partner organisations have the skills and knowledge needed to best support people using social care services.

We are developing career pathways to support those who join us as non-registered workers. We will help them to develop their skills and access training opportunities which can lead to registered status. Across social care we are developing new roles for the future and working to nurture the development and recruitment of innovative and confident leaders. One of the ways we are doing this is through the development of talent management programmes.

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 over-stretching the current workforce.
Social care and health will increasingly work together, and staff will work across organisational boundaries to reduce duplication in assessments and other activities. Training will be increasingly integrated, working across both the health and social care sectors, developing a culture of practice which has joint working at its core. 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 appropriately between partners and as a tool for those receiving social care. There is further information described in our ‘Being Digital’ Strategy about the kind of changes we wish to see take place. If the system is to work more efficiently, the planning and management of the workforce needs to take a whole-system approach.

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 (Encompass).

### Developing new models of working

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 and review services alongside those receiving them and others involved in providing these services. This will also involve taking a sophisticated understanding of people’s right to choose to take risks, so they can lead the lives they want.

Moving forward 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 to support this aim. We will expect that tried and tested models will be rolled out.

### Buurtzorg

This is a model of care based on the philosophy of ‘humanity above bureaucracy.’ The core principle of the Buurtzorg model is that teams are local, small autonomous and self-managing. This small scale allows teams to develop localised relationships including strong relationships with GP surgeries. Through Buurtzorg we aim to empower and increase staff satisfaction with improved recruitment and retention through reducing bureaucracy and increasing autonomy.

We will progress a pilot project to implement the Buurtzorg Model over a number of sites in Kent.

### ESTHER

This model was inspired by one person’s (we shall call ESTHER) negative experience of a lack of co-ordination of care across different providers. During her admission Esther retold her story to 36 clinicians before being admitted and receiving treatment. The model aims to place the service user at the centre of their support and focuses on quality of care and information sharing between service providers. The key to ESTHER is strong multidisciplinary working across services supporting and developing greater integration. Training is being offered throughout the county with information being shared at road shows and ESTHER cafés.

The model works across four levels.

1. The person (ESTHER) is involved in their care and listened to.
2. Training and support for social care workforce to promote ESTHER.
3. Multi-disciplinary team meetings to ask, ‘What matters to ESTHER?’
4. Having space to listen to stories of people like ESTHER to make improvements.

The pilot aims to:

- improve the delivery and quality of home health care through leadership and collaboration with the community nurses and social care
- reduce employee turnover
- increase the number of people we are able to help using the same budget
- share learning from the pilot project to help us understand how the model works in practice, and develop future work.
Commissioning - ‘arranging services’

Commissioning is about deciding how best to use the resources available in order to improve outcomes for our service users in the most efficient, effective and sustainable way. These resources could be within KCC, or across the public, voluntary and private sectors.

KCC’s vision to improve lives by ensuring every pound spent in Kent is delivering better outcomes for Kent’s residents, communities and businesses depends on successful commissioning.

Successful commissioning is based on a number of factors which include sharing and integrating with partners, keeping strong working relationships with key critical providers, and managing providers that are less effective.

When commissioning services we make our decisions by looking at all the evidence available. This is done in a planned, common sense way using data, records and insight.

By using an evidence based’ approach commissioners of services can have more confidence in their choices because they can make reference to data that supports the likelihood of that choice leading to the desired outcomes for service users.

The NHS Five Year Forward View recognises and supports this approach, setting out the need to ‘get serious about prevention’. Combining NHS and local authorities’ resources, wherever it is right to do so. This will help close the health, quality and financial gaps. KCC’s vision is to use its public health responsibilities and resources to put health and well-being at the heart of everything it does, thereby helping people to lead healthier lives, both mentally and physically.

Integration and partnerships - ‘working together’

Kent has a good track record of health and social 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 Partnership (STPs) which support the delivery of 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 to make 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, different culture of practice 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 visions 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 integrated care systems. These systems 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 is Local Care, 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
- sharing information, which is vital for high-quality, integrated care, but must be carefully managed in ways that keep to the Data Protection Act 2018 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
- working across 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...
We will continue to work with the voluntary and community sector (VCS) who will play an even more significant role in supporting people's independence and well-being. 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. The way in which we want to work with the VCS in the future is set out in our Voluntary and Community Sector Policy. This highlights our commitments to support the VCS both to respond to communities' needs and as a key partner in delivering services on our behalf. To achieve this, we want to continue to build an on-going, two-way dialogue with the sector, provide infrastructure support that is flexible and responds to the sector’s needs, and be clearer about funding. Some of the more specific things we want to do to support the proposals in this strategy include encouraging new enterprises (for example, befriending schemes) and working with existing organisations to help them expand to new areas (for example, Neighbourhood Watch schemes, allotment societies and so on).

11. How we will know we are delivering the strategy

As explained in the Introduction, this strategy explains our vision for adult social care over the next three years. The full details of how it will be delivered will be set out in the annual business plans of the services in the Adult Social Care and Health directorate.

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 would have developed staff including, those working in the social care market to benefit from career pathways from apprenticeship to higher education and able to use the right tools in their day to day working;
- We would have a continued experience of good quality care by all providers. This being supported by measurable positive experiences of people with care and support needs in helping them achieve their desired outcomes;
- The rate of take up of digital innovation by people who use services, practitioners and providers would be in line with the aspirations set out in the Being Digital strategy in all care settings;
- The services we commission will be more outcome-based with increased ability to offer care and support tailored to needs of the person. We will have greater provider collaboration and alliances operating as part of joined-up provision;
- Integrated health and social care services will be the norm. Staff from public services, private and voluntary care providers in ‘Local Care’ teams will work together at all levels;
- Resources will be managed as efficiently as possible, relying on disciplined use of data and analysis to make informed decisions;
- We regularly report on what we do through internal and external reviews and reports. These include the 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; 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 and independent regulators of care.

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. We will know if we are delivering the strategic policy objectives including the following:

- Efficiency and finance
- Adult social care must close three gaps
- Outcomes and well-being
- Personal context
- Quality of care
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<tr>
<th>Themes</th>
<th>Key strategies relation to the themes of your life, your well-being</th>
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<td>Kent and Medway Joint Health and Wellbeing Strategy</td>
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<td>KCC People Strategy</td>
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