HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Friday, 25th March, 2011

10.00 am

Council Chamber, Sessions House, County Hall, Maidstone

AGENDA

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Friday, 25th March, 2011, at 10.00 am
Council Chamber, Sessions House, County Hall, Maidstone

Ask for: **Paul Wickenden**
Telephone: **01622 694486**

Tea/Coffee will be available from 9:45 am

Membership

Conservative (10):	Mr N J D Chard (Chairman), Mr B R Cope (Vice-Chairman), Mr N J Collor, Mr G Cooke, Mr A D Crowther, Mr K A Ferrin, MBE, Mrs J A Rook, Mr C P Smith, Mr R Tolputt and Mr A T Willicombe
Labour (1):	Mrs E Green
Liberal Democrat (1):	Mr D S Daley
District/Borough Representatives (4):	Councillor J Cunningham, Councillor C Kirby, Councillor M Lyons and Councillor Mrs M Peters
LINk Representatives (2)	Mr M J Fittock and Mr R Kendall

Webcasting Notice

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UNRESTRICTED ITEMS

(During these items the meeting is likely to be open to the public)

Item		Timings
1.	Introduction/Webcasting	
2.	Substitutes	
3.	Declarations of Interests by Members in items on the Agenda for this meeting.	

4. Minutes (Pages 1 - 10)

5. Women's and Children's Services at Maidstone and Tunbridge Wells NHS Trust: Update. (Pages 11 - 14)

6. Proposal to Establish Informal HOSC Liaison Groups (Pages 15 - 16)

7. Safe and Sustainable - A New Vision for Congenital Heart Services in England (Pages 17 - 22)

8. NHS Financial Sustainability. Part 1: Commissioning. (Pages 23 - 68)

9. Date of next programmed meeting – Tuesday 19 April 2011 @ 10:00 am

EXEMPT ITEMS

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

Peter Sass
Head of Democratic Services and Local Leadership
(01622) 694002

17 March 2011

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

KENT COUNTY COUNCIL

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

MINUTES of a meeting of the Health Overview and Scrutiny Committee held in the Council Chamber, Sessions House, County Hall, Maidstone on Friday, 4 February 2011.

PRESENT: Mr N J D Chard (Chairman), Mr B R Cope (Vice-Chairman), Mr G Cooke, Mr A D Crowther, Mr D S Daley, Mr K A Ferrin, MBE, Mrs E Green, Mr J F London (Substitute for Mr N J Collor), Mrs J A Rook, Mr C P Smith, Mr R Tolputt, Mr A T Willicombe, Cllr R Davison (Substitute for Cllr J Cunningham), Cllr M Lyons, Dr M R Eddy (Substitute for Mr M J Fittock) and Mr R Kendall

ALSO PRESENT: Cllr John Avey, Cllr Mrs A Blackmore, Su Brown, Gordon Court, Mr J Larcombe, Jo Naismith and Victoria Ong

IN ATTENDANCE: Mr T Godfrey (Research Officer to Health Overview Scrutiny Committee) and Mr P D Wickenden (Overview, Scrutiny and Localism Manager)

UNRESTRICTED ITEMS

1. Membership

(Item)

The Committee noted its new Membership as set out below:

Conservative (10): Mr N J D Chard, Mr N J Collor, Mr G Cooke, Mr B R Cope, Mr A D Crowther, Mr K A Ferrin MBE, Mrs J A Rook, Mr C P Smith, Mr R Tolputt and Mr A T Willicombe.

Liberal Democrat (1): Mr D S Daley

Labour (1): Mrs E Green

District/Borough Representatives (4): Councillor J Cunningham, Councillor C Kirby, Councillor M Lyons and Councillor Mrs M Peters.

LINk Representatives (2): Mr M J Fittock and Mr R Kendall.

2. Election of Chairman

(Item)

Mr B R Cope proposed and Mrs J A Rook seconded that Mr N J D Chard be elected Chairman of the Health Overview and Scrutiny Committee.

Agreed without a vote.

Mr N J D Chard thereupon took the Chair.

3. Minutes

(Item 4)

RESOLVED that the Minutes of the Meeting of 7 January 2010 are recorded and that they be signed by the Chairman.

4. Update on Women's and Children's Services at Maidstone and Tunbridge Wells NHS Trust

(Item 6)

(1) Members had before them the information in the Agenda along with the additional information provided for them by NHS Eastern and Coastal Kent and East Kent Hospitals NHS University Foundation Trust concerning the review of maternity services in East Kent (see Appendix).

(2) The Chairman undertook to provide further information when a reply was received from the Secretary of State for Health.

(3) RESOLVED that the Committee note the attached correspondence.

5. The Future Shape of Community Service Provision

(Item 5)

Meradin Peachey (Kent Director of Public Health), Dr Robert Blundell (Vice Chair, Kent Local Medical Committee), Dr Mike Parks (Medical Secretary, Kent Local Medical Committee), Di Tyas (Deputy Clerk, Kent Local Medical Committee), Philip Greenhill, (Interim Chief Executive, Eastern and Coastal Kent Community Health NHS Trust), Mark Shepperd (Managing Director, West Kent Community Health), Phil Edbrooke (Interim Director of Corporate Services, Eastern and Coastal Kent Community Health NHS Trust), Oena Windibank (Interim Director of Operations, Eastern and Coastal Kent Community Health NHS Trust), and Bill Millar (Head of Primary, Community and Elective Care, NHS Eastern and Coastal Kent) were in attendance for this item.

(1) The Committee had previously discussed the subject of the future of community service provision at the meeting of 5 September 2010. Representatives from the NHS provided an overview of events subsequent to that meeting along with an outline of future progression. Following approval in 2010 the community provider organisation within NHS Eastern and Coastal Kent to become a separate NHS Trust, Eastern and Coastal Kent Community Health NHS Trust was formally established on 1 November 2010. West Kent Community Health currently remains part of NHS West Kent, but following approval of the business case for a Pan-Kent Community Health Trust, this will join with Eastern and Coastal Kent Community Health NHS Trust as a single organisation from April 2011. This organisation will seek Foundation Trust status, which may be granted in 2013.

(2) A formal consultation on these plans had been carried out, but it was reported that there had been more informal than formal responses received. The major concerns raised in these responses centred on the ability and willingness of commissioners, now and in the future, to commission services locally. To

address these concerns, the organisation was being structured so that it could operate on a locality basis and local boards were being established involving stakeholders that would inform service delivery. Members felt there was an opportunity there to tie in these proposed boards with work going on within local authorities in Kent. The NHS said they would look into the idea. In addition, it was pointed out that there would be a public consultation as part of the application for Foundation Trust status and there would be Governors drawn from the public membership of the Foundation Trust.

(3) Areas of the country such as Liverpool, Birmingham and Wigan were reported as seeing a similar size merger take place. Medway was pursuing a social enterprise model. In other areas of the country the community services were joined to a mental health or an acute Trust. One weakness of the latter was that during periods of budgetary constraint, the community services were often the first to experience reductions. However, there were some services for which this may be appropriate and the right option for community paediatrics and stroke services were still being examined.

(4) The original policy proposal was for the community health estate, including community hospitals, to remain with the Primary Care Trusts. With the exception of Private Finance Initiative sites, the estate was largely going to be transferred into the new community services Trust. How these are to be used will be part of the ongoing discussion with commissioners.

(5) Members raised the issue of the establishment of a new Trust adding to the levels of bureaucracy and costs within the health economy. An alternative perspective presented by representatives of the NHS is that the new Trust could be seen as a reduction of bureaucracy and management costs as to community service organisations were forming into one and would need, for example, one Chief Executive. The savings in this area from the merger were estimated at around £1 million per year. They also had a five-year efficiency savings target of £25-30 million and that this needed to be seen against an annual income of around £200 million.

(6) In contrast to acute services, community services were largely funded through block contracts. Any tariff for community services has to be agreed locally as there is no national one. There was an increasing move away from this as a cost per service system was seen as more useful. For example, in Kent a cost per case system for musculoskeletal services was being introduced.

(7) There was also a move by the Department of Health away from process targets, or inputs such as the number of nurse contacts, towards information on outcomes. However, there were issues around data collections and measurements in the community services sector.

(8) The important role that community hospitals can play in the health economy, as for example in reducing and preventing stays in acute hospitals, was acknowledged by all those present and Members of the Committee. Beyond this there was detailed discussion around the different uses they could be put to and the involvement of GPs in their local hospital.

(9) It was reported that there was a sense that a number of GPs felt that in some areas of Kent, the connection between the community and its community hospital was weak. Dr Blundell felt that an admitting radius of ten miles was best as it would make it easier for patients, who tended to be elderly, to receive visits from family.

(10) There was consensus that arrangements between GPs and community hospitals needed to be different to suit different areas and needs. For example, a salaried GP provided cover at Livingstone Hospital in Dartford, and in Sevenoaks Hospital there were GPs on wards as well as an adult physician who managed patients jointly with GPs.

(11) Changes and improvements to the use of community hospitals were reported as already having taken place and would be continuing. For example, in West Kent, the use of community hospitals for end of life care had been a cause of friction in the past, but from July 2010, two beds had been ring-fenced in each hospital for this purpose.

(12) The Chairman expressed his thanks to the numerous community Hospital League of Friend's organisations who had been able to submit information for inclusion in the Committee's Agenda, and several Members echoed these sentiments. Jo Naismith, the Chairman of the League of Friends of Edenbridge and District War Memorial, was present and invited to speak on the topic of community hospitals. She began by thanking the Committee for its interest in the subject and the opportunity to present their views. She went to explain that the situation had improved markedly over the situation a few years ago when the hospital in Edenbridge was threatened with closure and that West Kent Community Health worked very well with them. Her concern with the move towards GP commissioning was that, although the GPs in Edenbridge were very good, if they were not at the forefront of commissioning decisions, there may not be anyone to speak for Edenbridge when it came to service developments.

(13) Members had before them a paper from the Kent Director of Public Health, which she explained was part of an ongoing process of identifying public health funding in commissioning services and that more detail would become available over time and would be made available to the Committee. As this work had not been completed, this explained why there were some apparent discrepancies between East and West Kent. For example, Eastern and Coastal Kent Community Services NHS Trust provided sexual health services in East Kent, whereas Dartford and Gravesham NHS Trust provided the same services in West Kent.

(14) It was explained that the benefits of investments in public health and preventive services often took a long time to be seen. Sometimes it was the case that not enough had been invested in the case, so that no benefit was shown, even if the strategy was potentially effective.

(15) There were some questions raised about specific programmes. The Health Trainer programme was a Department of Health requirement which had a positive aspect in that it involved people who were not registered with a GP and so in more need of additional support. An evaluation of the Home Start

programme was underway and the results would be shared, as would further information around the numbers involved in the programme as well as the funding.

(16) During the final section of this item, Members expressed the view that they would appreciate further information on the following:

1. TUPE regulations;

2. Savings and what might be the management costs now and in the future within community services;

3. The mechanisms of NHS finances; and

4. The broad pattern of demographic changes in Kent and the impact on NHS finances

(17) More broadly, a request was made for more information on the details of Government proposals for the health sector.

6. Date of next programmed meeting – Friday 25 March 2010 @ 10:00 am
(Item 7)

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NHS
Eastern and Coastal Kent

Maternity Review - NHS Eastern and Coastal Kent and East Kent Hospitals University Foundation Trust

Briefing note for HOSC – February 2011

1. *Context*
   - A joint review of Maternity services across east Kent by East Kent Hospitals University NHS Foundation Trust and NHS Eastern and Coastal Kent is being undertaken to ensure the rising number of mothers-to-be continue to receive safe, high quality care and patient choice.
   - In recognition of the changes to commissioning processes the review will be chaired by Dr. Chee Mah, GP clinical commissioner for women's health and Shadow Accountable Officer for emerging GP consortium Deal and Sandwich.
   - The review team recognise there will be a lot of interest in this review and will undertake to keep stakeholders such as HOSC, GPs, local authorities and MPs very much a part of the planning process with regular updates and briefings

   - At present there are two stand alone midwifery-led birth centres for low risk births in Dover and Canterbury. In addition there is one midwifery led unit at the William Harvey Hospital in Ashford, and another due to be opened at the Queen Elizabeth the Queen Mother Hospital in Margate. In addition there are consultant-led obstetric units at Ashford and Margate and some home births.
   - There have been two temporary closures of the Midwifery led units at Dover and subsequently Kent and Canterbury as a precautionary measure during an internal clinical investigation into an increase in neo natal demand, to allow senior midwifery staff to be reassigned to the William Harvey unit.

2. *Joint approach to review of maternity services*

   - Reassurance, information and communication has been given to women and families affected by the temporary closure.
   - This will be followed up with surveys / interviews to quantify if this has had an impact on their experiences of the service and care they received.
   - EKHUFT and NHS Eastern and Coastal Kent are working on a joint approach to this review and have put forward an initial team each who will shortly meet to establish a joint project plan crucial to that will be a communications and engagement plan
   - The Maternity Services Liaison Committee has agreed to advise and work with the review team on the engagement and any subsequent consultation around the Maternity review to ensure it is transparent and inclusive, listening to parents and citizens from across east Kent
   - The review team will analyse all available evidence including engagement during maternity strategy recent maternity services

survey and information available through the EKHUFT hand-held patient experience tracker, compliments and complaints

- Both organisations are aware of the strategic implications of this review given the planned changes to maternity services in NHS West Kent and any emerging plans will give due care and consideration to the needs of our population and the delivery of services across Kent and Medway

3. *Next steps*

- As a critical part of our joint review we will share our draft communications and engagement plan with HOSC for comments
- We will also be happy to share our project plan in more detail at a future HOSC meeting and will ensure that there is representation from both trusts and clinical leads

Restriction of services provided at Midwifery Led Units within East Kent

East Kent Hospitals University NHS Foundation Trust (EKHUFT) closely monitors the safety of all its services, and maternity services are no exception.

In September 2010, it identified an increase in neonatal admissions to the William Harvey Hospital (WHH) neonatal intensive care unit (NICU) which had occurred between July and August 2010.

This increase was immediately reported to the Trust's Executive Team as part of the Trust's routine safety processes. A decision was made to investigate this increase and, as a precautionary measure, to enhance staffing levels at the high risk obstetric unit at WHH while the investigation was being carried out.

To achieve the enhanced staffing levels, births within the Dover birthing centre at Buckland Hospital were temporarily stopped and some midwives were posted to WHH. All other services provided at the centre continued as normal.

EKHUFT reported the situation to our commissioners, the Eastern and Coastal Kent PCT (ECKPCT) and to the South East Coast Strategic Health Authority in September 2010.

An internal investigation with external support from both ECKPCT and a neighboring Trust was carried out and reported to the Board of Directors on 22nd December 2010.

The investigation was unable to pinpoint a specific cause for the increase in admissions to NICU which had been identified in the two month period. However, it considered a significant increase in the birth rate combined with skill mix at the high risk obstetric unit at WHH at the time may have been contributing factors.

The number of neonatal admissions to NICU had normalized since the staffing levels at the high risk obstetric unit at WHH were increased and so the Board of Directors took the decision that a comprehensive review into present and future provision of maternity services in East Kent be initiated and pending the results of this review these staffing levels would need to be maintained.

In the interests of equity, and taking account of social factors the following decisions were made on 22nd December 2010.

1. To reopen the Dover Birthing Centre at the Buckland Hospital.
2. To temporarily close the Canterbury Birth Centre to enable the enhanced midwifery staff levels at WHH while retaining day time services on the MLU.

3. To engage with the PCT and local health economy in longer term strategic decisions on maternity services.
4. Not to open the MLU at QEQM until the review had established exactly what staffing mix would be needed to maintain patient safety.
5. This decision was immediately transmitted to ECKPCT and a meeting planned for 25th January 2011 to take forward public involvement in this difficult area.

Item 5 – Women's and Children's Services at Maidstone and Tunbridge Wells NHS Trust: Update.

By: Paul Wickenden, Overview, Scrutiny and Localism Manager

To: Health Overview and Scrutiny Committee – 25 March 2011

Subject: Women's and Children's Services at Maidstone and Tunbridge Wells NHS Trust: Update.

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1. Background

(a) At the meeting of this Committee of 7 January 2011, the following resolution was passed:

1. That the Vice-Chairman of the Health Overview and Scrutiny Committee (HOSC) writes to the Secretary of State for Health, expressing profound disappointment with his decision to downgrade maternity and paediatric services at Maidstone that overrides the near-unanimous views of HOSC on 19 February 2010 and the local GPs opposing the reconfiguration plans.

2. That the Vice-Chairman of HOSC also requests that the Secretary of State for Health defers his decision until Maidstone GPs as future commissioners of local clinical services, are able to determine the future scope of maternity provision in the County Town.

3. That KCC monitors the impact of the reconfiguration on the number of admissions to the consultant-led maternity units at Medway and Ashford Hospitals.

4. In view of reported shortages of midwives and the temporary closure of the birthing units in East Kent over the Christmas and New Year period, that HOSC requests an urgent review of all birthing units and consultant-led maternity services in Kent.

(b) The subsequent reply from the Secretary of State is attached.

2. Recommendations

The Committee is asked to note the attached correspondence.

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From the Rt Hon Andrew Lansley CBE MP
Secretary of State for Health

Department of Health

POC1_583423

Richmond House
79 Whitehall
London
SW1A 2NS

Tel: 020 7210 3000
Mb-sofs@dh.gsi.gov.uk

Bryan Cope
Chairman, Health Overview and Scrutiny Committee
Kent County Council
Members' Suite, Sessions House
County Hall
Maidstone ME14 1XQ

- 4 FEB 2011

Dear Bryan,

Thank you for your letter of 13 January 2011 about changes to women's and children's services at Maidstone and Tunbridge Wells NHS Trust.

I appreciate your Committee was disappointed by my decision made public on 22 December 2010 that centralisation of specialist inpatient women's and children's services at Pembury Hospital should proceed.

However, in making my decision, I think it is important to stress that I took full account of the advice provided to me by the Independent Reconfiguration Panel, as well as considering the points raised by your Committee over the last year.

In addition, I closely studied the findings of NHS South East Coast's report following their further engagement with local stakeholders in the context of the four tests for service reconfiguration.

As service changes are implemented at Pembury, it is important local engagement continues in order to address outstanding concerns, and NHS South East Coast has committed to doing this.

What is most important is that patient services are safe and offer high quality care for mothers and babies in West Kent.

Maidstone and Tunbridge Wells NHS Trust believes the creation of a purpose-built centre of excellence at the new £225million Pembury hospital, through centralisation of specialist inpatient women's and

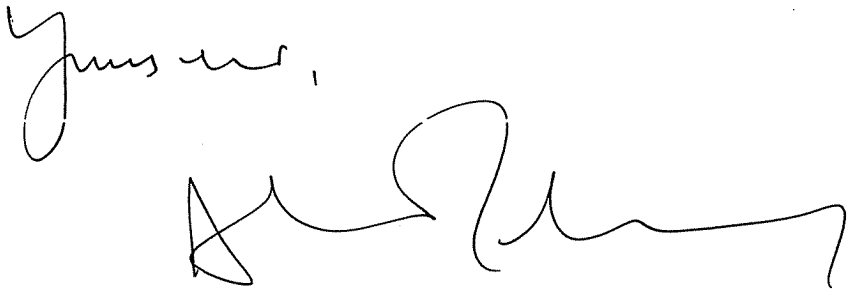
children's services in a unique, single room environment, is essential to ensure safe, sustainable, high quality services for the region.

The vast majority of women's and children's services will remain at Maidstone hospital (for instance, consultant-led antenatal clinics, postnatal clinics, a short stay paediatric unit, a foetal assessment unit and a day case children's unit), and the trust's plans introduce a new option for pregnant women in West Kent with the development of the midwife-led unit at Maidstone.

I listened very carefully to the views of local GPs during my visit to Maidstone hospital on 24 November 2010, and I was impressed by their obvious commitment to maintaining a wide range of services at the Maidstone site in order to promote it as a viable hospital in its own right.

I have made it absolutely clear that in the future, it will be a matter for GPs as service commissioners to assess whether there is an unmet need at Maidstone, and to seek to redesign and commission services where they feel this to be necessary.

In the light of the above, I will not defer my decision about changes to women's and children's services at Maidstone hospital.



ANDREW LANSLEY CBE

Item 6: Proposal to establish informal HOSC liaison groups.

By: Paul Wickenden, Overview, Scrutiny and Localism Manager

To: Health Overview and Scrutiny Committee – 25 March 2011

Subject: Proposal to establish informal HOSC liaison groups

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1. Introduction.

(a) Members of the Health Overview and Scrutiny Committee have expressed the view that there is a need to receive more information on a regular basis concerning matters relating to the planning, provision and operation of health services in Kent. Meetings of the Committee have tended to focus on looking at one or more subjects in depth in order, and there needs to be a process of prioritisation to determine which topics are selected for consideration in a formal meeting.

(b) One way of realising this twin challenge of deepening Members' understanding of health services in Kent and improving the process of prioritisation is potentially through the establishment of informal HOSC liaison groups.

(c) There are a number of ways in which these groups could work, but one suggested way is that a particular Member of the Committee volunteer to lead one of the groups and, with one or two others, meet up with representatives from the major providers of healthcare in Kent and Medway 2-4 times each year for an informal update about issues relating to that specific Trust. The lead Member would then take responsibility for providing occasional updates to the rest of the Committee. It may be possible that the other Members of the groups will be drawn from outside of HOSC.

(d) Once Members have expressed an interest, the relevant Trusts will then be contacted to see if they would be willing to participate. It is suggested that the following trusts be contacted:

- Dartford and Gravesham NHS Trust
- East Kent Hospitals NHS University Foundation Trust
- Kent and Medway NHS and Social care Partnership Trust
- Kent Community Health NHS Trust (as of 1 April 2011)
- Maidstone and Tunbridge Wells NHS Trust
- Medway NHS Foundation Trust
- South East Coast Ambulance Service NHS Foundation Trust

(e) It would be more appropriate if the Members involved in a group relating to a specific Trust had no current formal relationship with that Trust.

(f) One possible role for these groups will be to contribute to the development of the annual Quality Accounts that provider Trusts are

required to produce. Further information of the Quality Accounts is set out in the next section.

2. Quality Accounts

(a) The requirement to produce Quality Accounts formed part of the Health Act 2009 and the first statutory ones were produced in June 2010. The requirement currently only applies to larger providers of NHS services, excluding primary care and continuing care services. This may change in the future and community health services will be included for the first time in 2011/12.

(b) The main purpose of Quality Accounts is "is to encourage boards and leaders of healthcare organisations to assess quality across all of the healthcare services they offer."[1]

(c) There are some mandatory parts to a Quality Account and others that may be determined locally. The following must be included:

- A statement from the Board on the quality of NHS services provided.
- Priorities for quality improvement within the organisation in the coming year.
- A series of statements as set out in regulations.
- A review of the quality of services within the organisation.

(d) Organisations producing Quality Accounts are required to send copies to the appropriate HOSC, LINk and Primary Care Trust for comment prior to publication and these comments are for inclusion in the published version (up to 1000 words are allowed for the HOSC comment). HOSCs are not required to make comments.

(e) The number of Trusts in Kent and the limited time allowed by the process to produce comments has meant this has not been possible in the past.

3. Recommendations

(a) Members of the Committee are asked to approve the establishment of informal HOSC liaison groups and express their views if they wish to lead or be part of a particular group.

(b) Members are asked to delegate authority to the Head of Democratic Services in consultation with the Chairman to invite local district/borough Councillors to be part of these liaison groups where there are vacancies.

[1] Department of Health, *Quality Accounts Toolkit 2010/11*, December 2010, p.8, http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_122540.pdf

Item 7: Safe and Sustainable – A New Vision for Congenital Heart Services in England

By: Paul Wickenden, Overview, Scrutiny and Localism Manager

To: Health Overview and Scrutiny Committee – 25 March 2011

Subject: *Safe and Sustainable – A New Vision for Congenital Heart Services in England*

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1. Background.

(a) Most services in the NHS are commissioned by Primary Care Trusts. There is a different process for commissioning specialised services. These services are defined by law as those services which cover a planning population (catchment) of a million, or more.

(b) There are ten regional Specialised Commissioning Groups, like the South East Coast Specialised Commissioning Group[1], which secure specialised services for their regional populations, such as rare cancers. Around 60 specialised services are commissioned by the National Specialised Commissioning Team (NHS Specialised Services). These are services which affect fewer than 500 people across England or where fewer than 500 specialised procedures are undertaken each year, such as secure forensic mental health services for young people (around 80 patients each year).

2. Review of children's heart surgery in England.

(a) Another example is congenital heart disease which refers to defects in a child's heart which are present from birth. It is a relatively rare, lifelong condition often requiring very complex treatment from a team of heart specialists. 85% of children with the condition survive into adulthood.

(b) Over the past few years NHS Specialised Services has been undertaking a review of children's heart surgery in England. The full title of the review is *'The Safe and Sustainable Review of Paediatric Congenital Cardiac Services in England'*. The review has been undertaken on behalf of all Primary Care Trusts in the country[2].

(c) The review has now reached the stage where a set of options has been agreed for public consultation between 28th February and 1st July 2011. The consultation covers four main areas:

i. Standards of care
ii. Congenital heart networks.
iii. Larger surgical centres.

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[1] See: http://www.secscg.nhs.uk/home/

[2] The consultation document can be accessed here: http://www.specialisedservices.nhs.uk/safe_sustainable/public-consultation-2011

iv. Measuring quality.

(d) There are currently 11 hospital trusts in England with children's heart surgery centres, including three in London. These centres are:

i. Newcastle-upon-Tyne Hospitals NHS Foundation Trust
ii. Leeds Teaching Hospitals NHS Foundation Trust
iii. Alder Hey Children's NHS Foundation Trust (Liverpool)
iv. University Hospitals of Leicester NHS Trust
v. Birmingham Children's Hospital NHS Foundation Trust
vi. Great Ormond Street Hospital for Children NHS Trust (London)
vii. Royal Brompton and Harefield NHS Trust (London)
viii. Guy's and St Thomas' NHS Foundation Trust (London)
ix. Oxford Radcliffe Hospital NHS Trust
x. University Hospitals Bristol NHS Foundation Trust
xi. Southampton University Hospitals NHS Trust

(e) A number of other hospitals provide related services for children with heart conditions but do not provide surgery.

(f) None of the surgical centres are in the South East Coast region, but there are outreach sites at all the acute hospital sites in Kent and Medway.

(g) Data supplied by the South East Coast Specialised Commissioning Group shows that in 2009/10 in Eastern and Coastal Kent there were 45 in-patient hospital stays for paediatric cardiac surgery (43 at the Brompton, 2 in Leeds) and in West Kent there were 37 (all at the Brompton).

(h) A summary excerpt from the consultation paper including the options being consulted on can be found as an appendix to the paper[3].

3. Responding to the consultation.

(a) All HOSCs in England are being asked to consider whether the proposals represent a 'substantial development or variation' to health services for their residents, requiring formal consultation with the committee as set out in health scrutiny legislation. If a number of HOSCs consider this to be the case, one or more large joint HOSCs will need to be established to respond to the consultation.

(b) If a HOSC does not consider the proposals to be substantial there is still the option for the committee to respond informally to the consultation process with any comments it wishes to be taken into consideration.

[3] Ibid. pp.5-8.

(c) For children's heart surgery Kent residents are primarily served by London hospitals, and will continue to be under the proposals. The wider aspects of the proposals such as the standards of care and the proposed role of local non-surgical centres within the networks are common across the South East Coast region. It may be appropriate to develop an informal response to the consultation in conjunction with other HOSCs in the region through the network of South East Coast HOSC Chairmen which meets on a regular basis.

4. Recommendations.

The Committee is asked to agree that a regional response to the consultation be agreed through the South East Coast HOSC Chairmen network.

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2. SUMMARY

We believe change is needed in the way in which children's congenital heart services are planned and delivered. Change will improve outcomes for children and ensure services are *SAFE AND SUSTAINABLE*.

Expert clinicians and parents have highlighted the need for change. This is what we are trying to achieve:

- Better and more accessible diagnostic services and follow up treatment delivered through congenital heart networks
- Better results in surgical centres with fewer deaths and complications following surgery
- Improved communication between parents and all of the services in the network that see their child
- Reduced waiting times and fewer cancelled operations
- A highly trained workforce expert in the care and treatment of children and young people with congenital heart disease
- Better training for surgeons and their teams to ensure the sustainability of the service in the future
- An excellent service that delivers modern working practices using innovative techniques and continuing research and development to advance the quality of care children receive

WHAT ARE WE CONSULTING ON?

In order to make changes to the way services are organised the NHS wants to ask the public for its views. We would like to hear from anyone with a view on the future of congenital heart services including the people most affected: parents, young people and NHS staff. We would like your views on four main areas:

STANDARDS OF CARE

The proposed national quality standards that have been developed to ensure higher standards of care can be provided consistently across the country. Are they the right standards?

CONGENITAL HEART NETWORKS

We are proposing that surgical centres are not just responsible for the care they provide but that they would lead a congenital heart network. These networks would co-ordinate services and strengthen existing local assessment services where they exist and develop more outreach support in areas that have been neglected in the past. Are congenital heart networks the right model of care to improve services for children and young people?

LARGER SURGICAL CENTRES

We believe that the number of hospitals that provide heart surgery for children should be reduced from the 11 current centres to six or seven in response to evidence that suggests that only larger surgical centres can achieve true quality and excellence. Will fewer larger centres improve outcomes for children and young people?

MEASURING QUALITY

We are recommending that new systems are implemented for the analysis and reporting of mortality and morbidity data relating to treatments for children with congenital heart disease. Do you agree that new systems should be implemented to monitor outcomes?

The options for the number and location of hospitals that provide children's heart surgical services in the future are:

OPTION A

SEVEN SURGICAL CENTRES AT:

- Freeman Hospital, Newcastle
- Alder Hey Children's Hospital, Liverpool
- Glenfield Hospital, Leicester
- Birmingham Children's Hospital
- Bristol Royal Hospital for Children
- 2 centres in London

OPTION B

SEVEN SURGICAL CENTRES AT:

- Freeman Hospital, Newcastle
- Alder Hey Children's Hospital, Liverpool
- Birmingham Children's Hospital
- Bristol Royal Hospital for Children
- Southampton General Hospital
- 2 centres in London

OPTION C

SIX SURGICAL CENTRES AT:

- Freeman Hospital, Newcastle
- Alder Hey Children's Hospital, Liverpool
- Birmingham Children's Hospital
- Bristol Royal Hospital for Children
- 2 centres in London

OPTION D

SIX SURGICAL CENTRES AT:

- Leeds General Infirmary
- Alder Hey Children's Hospital, Liverpool
- Birmingham Children's Hospital
- Bristol Royal Hospital for Children
- 2 centres in London

LONDON

LONDON:

The preferred two London surgical centres in the four options are:

- Evelina Children's Hospital
- Great Ormond Street Hospital for Children

Additionally, there are other recommendations for you to consider.

This document sets out the way in which the proposals for change have been developed and what they would mean for you.

On page 132 you will find details about how to give your view. The closing date for responses is 1 July 2011.

By: Paul Wickenden, Overview, Scrutiny and Localism Manager

To: Health Overview and Scrutiny Committee – 25 March 2011

Subject: NHS Financial Sustainability: Part 1 - Commissioning

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1. Background

(a) Following the approval of the Forward Work Programme of the Health Overview and Scrutiny Committee on 7 January 2011, this will be the first of three meetings dedicated to the topic of NHS Financial Sustainability. In overarching terms, the intention is to determine answers to the following strategic questions:

1. What are the challenges to ensuring the NHS in Kent is financially sustainable?

2. Are there any implications for the range and quality of health services available to the people of Kent as a result of any measures being taken to achieve or maintain financial sustainability?

(b) The focus of this meeting will be on hearing from the Primary Care Trusts. The four main Acute Trusts have been invited to the meeting on 19 April and the intention is to consider mental health services, community health services and ambulance services at the meeting of 10 June.

(c) The Kent Local Medical Committee have been invited to attend and asked for any information they wished to provide on this topic. The Kent LINk were invited to submit information if they wished. For background information, the questions asked of the Primary Care Trusts in advance of the meeting are contained in the Appendix to this report.

(d) The Committee has often discussed different ways in which its work can become more outcomes focussed. Due to the depth in which this topic is to be considered by the Committee, one way might be to prepare a number of recommendations over the course of these meetings for submission to the relevant organisations, with their response to be considered at a future meeting.

2. Recommendations

The Committee is asked to agree the following:

1. Members are asked to delegate authority to the Head of Democratic Services in consultation with the Chairman, Vice-Chairman and Group Spokesmen to prepare a list of recommendations to present to a future meeting of the Committee for discussion and agreement prior to their submission to the NHS for a response.

2. To assist this process, Members are asked to suggest recommendations to the Committee Officers following each meeting.

Appendix

(a) Questions to NHS Eastern and Coastal Kent and NHS West Kent:

1. Why is achieving financial balance across the local health economy important and what are the potential consequences of not doing so?
2. What kinds of measures have been taken in 2010/11 in terms of prioritising treatments and changing service provision across Kent in order to try and achieve financial balance?
3. What kinds of measures are being considered for 2011/12?
4. What are the main challenges to achieving financial balance across the health economy?
5. What has been the impact of the NHS Operating Framework for 2011/12 and the PCT allocations for the next financial year?
6. How is the QIPP challenge being met in Kent?
7. What are the particular demographic trends in Kent that will affect NHS commissioning now and in the future, and how does Kent compare on these compared to the rest of the country?

By: Tristan Godfrey, Research Officer to the Health Overview and Scrutiny Committee

To: Health Overview and Scrutiny Committee, 25 March 2011.

Subject: NHS Financial Sustainability: Part 1 – Commissioning.

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1. NHS Finances – Overview

(a) Under the current system, Primary Care Trusts (PCTs) are responsible for around 80% of NHS funding and use this money to commission services to meet the health needs of their populations. These revenue allocations are made directly to PCTs by the Department of Health.

(b) On 15 December 2010, the allocations for 2011-12 were announced by the Department of Health. The overall total was £89 billion – most of this is 'recurrent revenue allocations', but £3.4 billion was non-recurrent allocations for primary dental services, general ophthalmic services and pharmaceutical services, and an additional £648 million was made available to support joint working between health and social care[1].

(c) A weighted capitation formula is used as the basis for allocating budgets to PCTs with the intention of reflecting the different needs of each area. The formula is complex but is based on the PCT populations adjusted for their age distribution, additional needs over and above that of age and the Market Forces Factor (MFF) which takes account of the unavoidable differences in the cost of providing services in different parts of the country. Appendix 1 lays out the various components of the weighted capitation formula[2].

(d) The development of the formula is overseen by the Advisory Committee of Resource Allocation which makes recommendations to the Secretary of State on possible changes.

(e) This produces a weighted capitation target which may not be the same as the actual current allocation and the gap is referred to as the difference from target (DFT). PCTs are moved towards their target at a pace set by Ministers.

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[1] Department of Health, http://www.dh.gov.uk/en/Managingyourorganisation/Financeandplanning/Allocations/DH_076547

[2] Taken from *Resource Allocation: Weighted Capitation Formula Seventh Edition*, Department of Health, 8 March 2011. Fuller details of the different parts can be found in this document. Available at: http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_124947.pdf

(f) The money PCTs receive is not ring fenced, though there are a number of constraints. NHS Trusts and other providers receive funds from PCTs for providing services through contracts or through tariffs, such as the Payment by Results (PbR) system used in the acute sector. Different systems of currencies and tariffs are being developed for different sectors of the health economy.

(g) The distinction between a currency and a tariff is as follows:

1. "Currencies are the unit of healthcare for which a payment is made. They can take a number of forms, covering different time periods – for instance, in acute physical PbR, outpatient attendances are paid on a contact basis, whilst for long term conditions we are looking to develop annual payments adjusted for complexity, which would be more like the care cluster approach. Our initial commitment in mental health is to develop currencies that are being used nationally.

2. "Tariffs are set prices for a given currency unit. The collected nationally determined prices for HRGs are sometimes referred to as the tariff. We have committed to examining the case for a national mental health tariff following the establishment of national currencies. Without a national tariff, prices for a given currency can be set locally or regionally (i.e. at SHA level)."[3]

3. HRGs, Healthcare Resource Groups, are the chosen currency for acute healthcare in England. They are "standard groupings of similar treatments which use similar levels of healthcare resources."[4]

(h) A number of specialised services, such as paediatric cardiology services, are commissioned regionally or nationally.

(i) The remaining 20% (approx.) of the NHS budget includes capital spending along with funds allocated for the delivery of both regional and national programmes and services[5].

(j) In the future the Government proposes that one of the roles of the new NHS Commissioning Board will be to allocate resources for 2013-14 when GP Consortia will take over most of the commissioning currently carried out by the PCTs (see section 3).

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[3] The Department of Health, February 2010, *Payment by Results Guidance for 2010/11,* p.95, http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_112970.pdf

[4] The Department of Health, September 2010, *A Simple Guide to PbR*, p.20, http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_120254.pdf

[5] *NHS funding and expenditure*, House of Commons Library Standard Note, 12 January 2011, http://www.parliament.uk/briefingpapers/commons/lib/research/briefings/snsg-00724.pdf

(k) The PCT revenue allocations for England for 2011/12 can be found in Appendix 2[6].

2. NHS Operating Framework

(a) The NHS Operating Framework for 2011/12 was published by the Department of Health the same day as the PCT allocations were announced (15 December 2010). This document sets out what the NHS needs to achieve during what it refers to as a 'transition year'[7].

(b) The key points of the NHS Operating Framework for 2011/12 are as follows:

- Average growth in PCT recurrent allocations of 2.2%.
- PCTs will receive allocations totalling £648 million to support social care in addition to the £150 million funding for reablement services incorporated into recurrent PCT allocations.
- The delivery of the QIPP (Quality, innovation, productivity and prevention) challenge of £20 billion efficiency savings for re-investment has been extended by one year to the end of 2014/15.
- No automatic capital allocation for PCTs – any capital funding to be granted on a case-by-case basis.
- An overall tariff reduction between 2010/11 and 2011/12 of 1.5%.
- New outpatient attendance tariffs to be introduced. New currencies and tariffs to be developed (and led locally).
- Hospitals will not be reimbursed for emergency readmissions within 30 days of a discharge from an elective admission. Other readmission rates to be agreed locally.
- Where providers and commissioners agree, services can be offered below the tariff price.
- Strategic Health Authorities are to oversee the development of PCT 'clusters' with a single executive team to oversee the transition and support emerging GP consortia (including the assignment of PCT staff to consortia). Locally, Ann Sutton has been appointed to lead the cluster consisting of NHS Eastern and Coastal Kent, NHS Medway and NHS West Kent[8].

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[6] Sourced from *Resource Allocation: Weighted Capitation Formula Seventh Edition*, Department of Health, 8 March 2011, p.76, http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_124947.pdf

[7] Department of Health, NHS Operating Framework, http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_122738

[8] NHS Eastern and Coastal Kent, 1 February 2011, http://www.easternandcoastalkent.nhs.uk/whats-new/latest-news/local-nhs-leaders-step-up-to-challenge-of-reform/

- GP consortia will not be responsible for PCT legacy debt prior to 2011/12. PCTs and consortia to work closely together to prevent PCT deficits prior to 2013/14, when GP consortia will have their own budgets.
- Developing consortia will receive £2 per head to support this process. Running costs of £25 to £35 per head are expected by 2014/15.
- A number of new commitments were made on health visitors, family nurse partnerships, the cancer drugs fund, military and veterans' health, autism, dementia and carers support.
- The areas listed as areas for improvement include healthcare for people with learning disabilities, child health, diabetes, violence, respiratory disease and regional trauma networks.

(c) Details around the extension of the "any willing provider" (AWP) model are being considered by the Department of Health at present, with the expectation "it would apply to many NHS-funded services in future. The 2011/12 Operating Framework made clear that AWP will be introduced for community services during 2011/12."[9]

(d) QIPP (Quality, Innovation, Productivity and Prevention) is a series of 12 workstreams[10] aimed at making efficiency savings to be reinvested in services. These twelve are divided into three areas, as set out below:

Table 1: QIPP Workstreams[11]

Commissioning and Pathways	Provider Efficiency	System Enablers
• Safe care • Right care • Long term conditions • Urgent and emergency care • End of life care	• Back office efficiency and optimal management • Procurement • Clinical support • Productive care • Medicine use and procurement	• Primary care commissioning • Technology and digital vision

(e) The Operating Framework also states that the four tests for service reconfiguration set out in May 2010 stand. These are:

- support from GP commissioners;

[9] Dear Colleague Letter from Sir David Nicholson, NHS Chief Executive, *Equity and Excellence: Liberating the NHS – Managing the Transition*, 17 February 2011, p.14, http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_124479.pdf

[10] Department of Health website, http://www.dh.gov.uk/en/Healthcare/Qualityandproductivity/QIPP/index.htm

[11] Adapted from Department of Health, *QIPP workstreams*, http://www.dh.gov.uk/en/Healthcare/Qualityandproductivity/QIPPworkstreams/index.htm

- strengthened public and patient engagement;
- clarity on the clinical evidence base; and
- consistency with current and prospective patient choice.

(f) The duty of PCTs to consult overview and scrutiny committees on substantial service change is to remain during the transition.

3. *Equity and Excellence: Liberating the NHS*

(a) The Operating Framework for 2011/12 can be seen as setting out how the transition to the new system set out in the NHS White Paper, *Equity and Excellence: Liberating the NHS*, and the Health and Social Care Bill currently progressing through Parliament.

(b) Simplified diagrams comparing the current to the proposed structure can be found in Section 4.

(c) The main elements of the proposals are set out below:

1. NHS Commissioning Board –

i. This will be a non-departmental public body accountable to the Secretary of State with an overarching duty to promote a comprehensive health service. As set out above, the Board will take on the responsibility for allocating resources to GP consortia. It will publish commissioning guidance and model care pathways (based on quality standards produced by NICE). The price-setting structure will be the responsibility of the Board, along with developing model and standard contractual terms for providers.

ii. It will be responsible for the financial performance of consortia and hold them to account for the quality outcomes they achieve. It will also have some specific powers in connection to consortia – ensuring there is comprehensive coverage of England by consortia; ensuring all GP practices are part of a consortium; overseeing a failure regime for consortia.

iii. The Board will also undertake some commissioning. It will commission primary care services (such as community pharmacy, ophthalmology and dental services along with primary medical services provided by GPs). It will also commission a number of services currently commissioned regionally or nationally.

2. GP/commissioning consortia –

i. The majority of health services will be commissioned by GPs and their practice teams through consortia. These will be

statutory bodies and all holders of a primary medical services contract must belong to a consortium. There is considerable local flexibility around the size and structure of these consortia as well as their geographical coverage, and these elements are open to change over time. They will be required to put robust governance arrangements in place and will have an Accountable Officer (not necessarily a clinician).

3. Monitor –

i. Monitor currently regulates NHS Foundation Trusts but under the proposals would become the economic regulator for the health sector. Its three core functions will be to promote competition where appropriate; regulate prices for NHS funded services; and support the continuity of services. The Bill allows for Monitor's role to be extended to regulating adult social care at a later date by Government.

ii. NHS commissioners will consult locally on services which are to be designated as subject to additional licensing conditions with Monitor and which Monitor will ensure continue to be provided, even if the provider fails.

4. Foundation Trusts (FTs) –

i. All NHS Trusts are to become Foundation Trusts (or part of an FT) by 1 April 2014 and NHS Trust legislation would be repealed (meaning non-FT NHS Trusts will not exist). A Provider Development Authority will be set up to performance manage NHS Trusts until they become Foundation Trusts; this Authority will then be wound down. A number of changes are also being made to the governance and financial freedoms of FTs.

5. Health and Wellbeing Boards (HWBs) –

i. Upper tier authorities will be required to set up a HWB, which will be a statutory committee. The membership will consist, at a minimum, of one elected representative, the director of adult social services, director of children's services, director of public health and representative from the local HealthWatch, and one representative from each relevant commissioning consortia (unless the HWB agrees to a single representative of more than one consortia). There will also be involvement from the NHS Commissioning Board. Local authorities and GP consortia will have a responsibility to produce a Joint Strategic Needs Assessment (JSNA) and will develop them through the HWB. They must also develop a joint health and well-being strategy (JHWBS) which will set out how the needs identified in the JSNA will be met.

ii. Other powers and responsibilities, except that of scrutiny, can be conferred on the HWB.

6. Scrutiny –

i. From April 2013, the functions of the current Health Overview and Scrutiny Committee will be conferred on the local authority directly. The exercise of this function could be through a specific health scrutiny committee or through a different arrangement (with the exception that it cannot be exercised by the HWB).

ii. The powers of health scrutiny will expand to include any NHS funded provider and any NHS commissioner. The Bill will allow the regulations around referrals of substantial service change to be changed. The decision to refer is likely to require a meeting of the full council. There is likely to be consultation specifically on health scrutiny regulations at a later date.

7. HealthWatch –

i. Local Involvement Networks (LINks) will transform into Local HealthWatch. They will be commissioned and funded by upper tier local authorities and be based in local authority areas. The functions of promoting and supporting public involvement in the commissioning, provision and scrutiny of local health services will continue. The local authority will be able to commission HealthWatch to provide advice and information to people about health and social care.

ii. The local authority will also commission NHS complaints advocacy services, which may or may not be commissioned from HealthWatch. Commissioning of independent mental health advocacy will also move to local authorities, but will be separate from the NHS advocacy services.

iii Local HealthWatch will have the power to refer issues to HealthWatch England. HealthWatch England will be a statutory committee within the Care Quality Commission (CQC) and will support the Local HealthWatches as well as escalating concerns received from them within the CQC.

8. Public Health –

i. A separate Public Health White Paper, *Health Lives, Healthy People*, was published by the Department of Health on 30 November 2010[12].

[12] The Public Health White Paper and related documents can be accessed at the Department of Health website, http://www.dh.gov.uk/en/Publichealth/Healthyliveshealthypeople/index.htm

ii A new service, Public Health England, will be set up as part of the Department of Health. This will involve the transfer of functions and powers from the Health Protection Agency and National Treatment Agency for Substance Misuse.

iii. Local health improvement functions will transfer to local government, along with ring-fenced funding. There will be a health premium linked to progress made against a proposed public health outcomes framework. Directors of Public Health will be employed by local government and jointly appointed by the local authority and Public Health England.

4. Current and proposed structure of the NHS

(a) These notes apply to the Notes in Chart 1 (next page), providing further background detail of the current structure of the NHS as it applies to Kent and Medway:

1. Strategic Health Authority (SHA) – NHS South East Coast covers Kent, Medway, Surrey, Brighton and Hove, East Sussex and West Sussex.

2. Primary Care Trusts (PCTs) – Three PCTS in Kent and Medway: NHS Eastern and Coastal Kent, NHS Medway and NHS West Kent. They are being brought into a single 'cluster'.

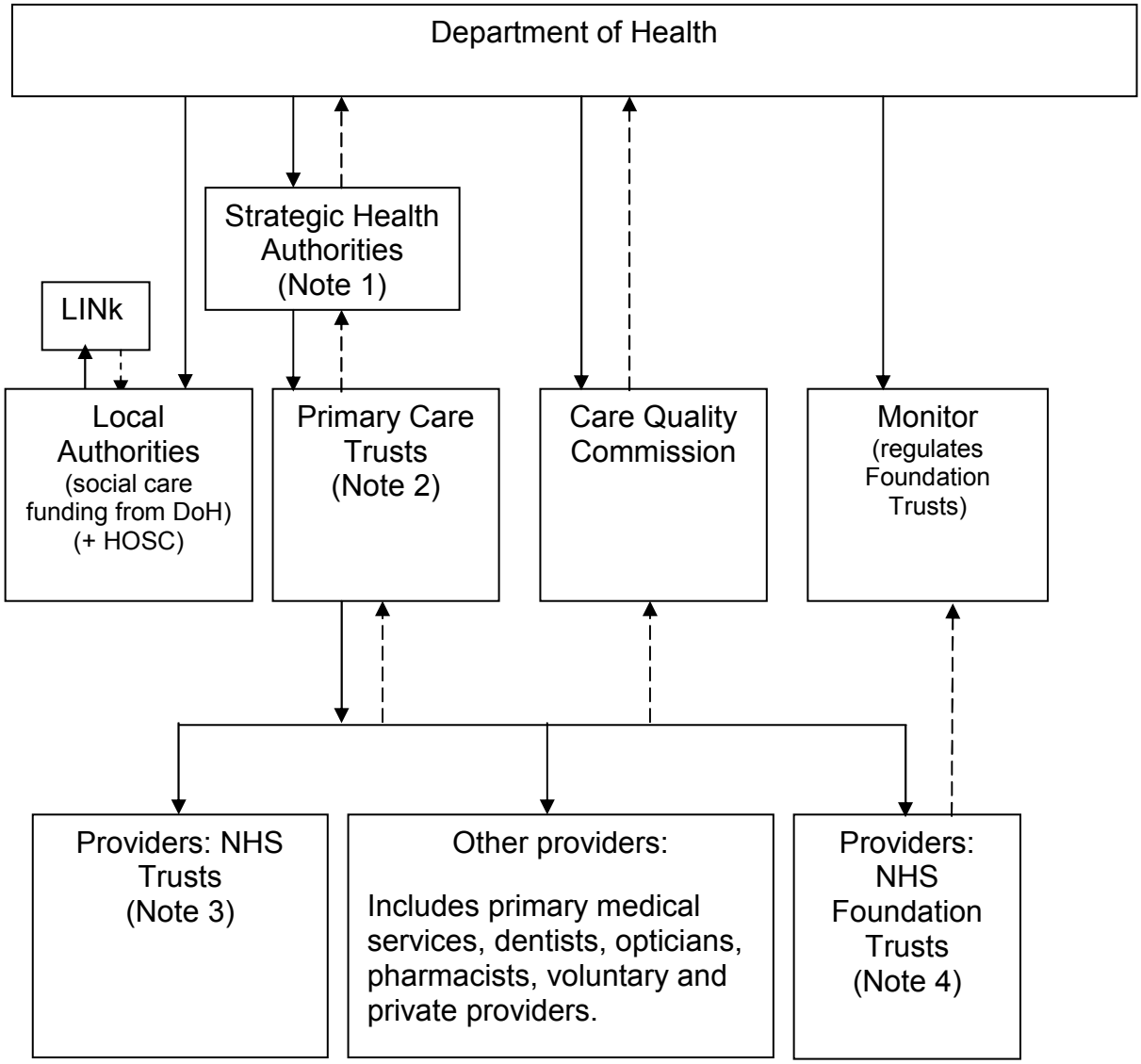
3. NHS Trusts – The main provider NHS Trusts in Kent and Medway are: Dartford and Gravesham NHS Trust, Maidstone and Tunbridge Wells NHS Trust, Kent and Medway NHS and Social Care Partnership Trust, and Eastern and Coastal Kent Community Health NHS Trust (Kent Community Health NHS Trust as of 1 April 2011).

4. NHS Foundation Trusts – The main NHS Foundation Trusts in Kent and Medway are: East Kent Hospitals NHS University Foundation Trust, Medway NHS Foundation Trust, and South East Coast Ambulance Service NHS Foundation Trust.

(b) The above list does not exhaust the list of NHS Trust/Foundation Trust providers – some services are provided within Kent and Medway by other Trusts/Foundation Trusts (for example, South London and Maudsley NHS Foundation Trust) and residents of Kent and Medway access services provided outside the area (for example, tertiary services in London).

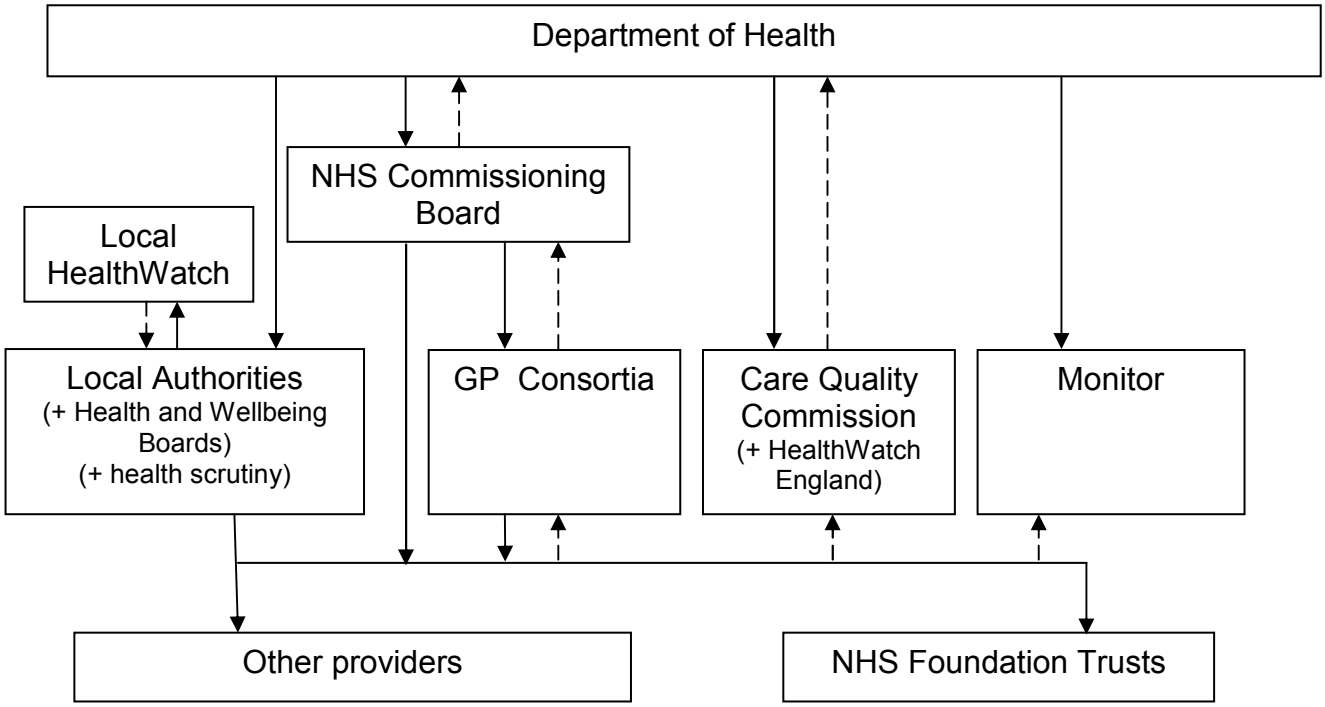
(c) Key to charts:

(d) Chart 1: Current Structure[13].



[13] Both charts adapted from: House of Commons Library, Research Paper 11/11, *Health and Social Care Bill*, p.7, http://www.parliament.uk/briefingpapers/commons/lib/research/rp2011/RP11-011.pdf

(e) Chart 2: Proposed future structure:



5. Summary Transition Timeline[14]

(a) 2011/12: Learning and planning for roll-out

- First year of QIPP delivery as part of broader delivery on Operating Framework priorities.
- SHAs to establish PCT cluster arrangements by June 2011.
- High level structure for NHS Commissioning Board and Department of Health set out in Spring 2011.
- NHS Commissioning Board executive appointments completed by October 2011.
- Shadow national arrangements progressively implemented for the NHS Commissioning Board, new Monitor, Public Health England, Health Education England and the Provider Development Authority.
- Sharing lessons from first wave adopters of consortia pathfinder and early implementer systems of health and wellbeing boards.
- More pathfinders and early implementers, including local HealthWatch.
- Plans drawn up for consortia, involving all GP practices.
- Emerging consortia to lead the process of securing staff, including PCT staff being made available.

[14] Taken from Dear Colleague Letter from Sir David Nicholson, NHS Chief Executive, *Equity and Excellence: Liberating the NHS – Managing the Transition*, 17 February 2011, p.12-13, http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_124479.pdf

- Plans to be drawn up for health and wellbeing boards.
- NHS trusts to apply for foundation trust status, or be planning application in 2012/13.

(b) 2012/13: Full preparatory year

- Second year of QIPP delivery.
- From April 2012, NHS Commissioning Board and new Monitor come into effect, SHAs are abolished, PCT clusters become accountable to the Board, and the Department will have made substantial progress on its change programme and established Public Health England. The Provider Development Authority oversees NHS Trusts.
- More learning from GP pathfinders and health and wellbeing board early implementers.
- Authorisation process of comprehensive system of consortia begins, with all practices as members, acting under delegated arrangements with PCTs.
- Health and wellbeing boards are in place.
- Comprehensive local HealthWatch arrangements in place.
- From April 2012, local authorities to fund local HealthWatch to deliver most of their new functions.
- Consortia notified of 2013/14 allocations.
- By the end of the year, a significant number of NHS trusts have achieved foundation trust status.

(c) 2013/14: First full year of the new system

- Third year of QIPP delivery.
- April 2013, PCTs abolished and all consortia assume new statutory responsibilities.
- April 2013, health and well being boards assume their statutory responsibilities.
- April 2013, Monitor’s licensing regime is fully operational.
- April 2013, local authorities to have responsibility for commissioning NHS complaints advocacy.
- By March 2014, the firm aim is that all NHS trusts have become foundation trusts. NHS trust legislation is repealed, and the Provider Development Authority ceases to exist.

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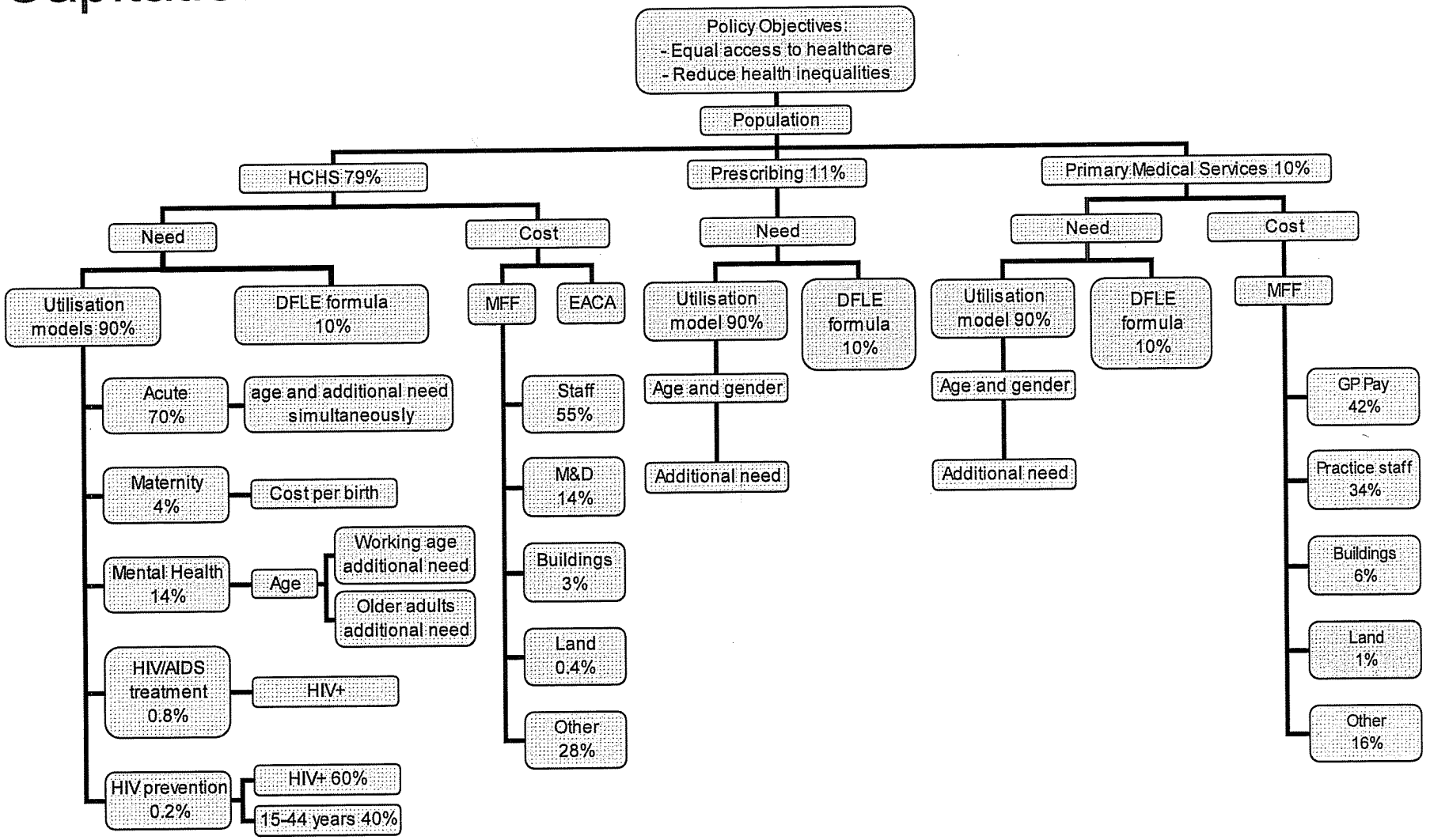
Appendix 1: Schematic Diagram of Weighted Capitation Formula



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PCT Revenue Allocations 2011-12

	A	B	C	D	E	F	G	H	I
	Total 2011-12 revenue allocations			Composition of total allocations			Growth in recurrent allocations plus growth in non-recurrent allocations (for primary dental services, pharmaceutical services and General Ophthalmic Services)	Recurrent allocations	
PCT	Total revenue allocations £000s (Cols D+E+F)	Growth in total revenue allocations £000s (Cols F+G)	Growth in total revenue allocations %	Recurrent allocations £000s	Non-recurrent allocations for General Ophthalmic Services, primary dental services and pharmaceutical services £000s	Support for joint working between health and social care £000s (Included in col B)	£000s (Included in col B)	Growth in recurrent allocations % (Included in Col A)	Distance from target %
Ashton, Leigh and Wigan PCT	573,073	16,712	3.0%	545,249	23,480	4,344	12,368	2.2%	-2.7%
Barking and Dagenham PCT	334,350	9,109	2.8%	318,975	12,943	2,432	6,677	2.1%	0.6%
Barnet PCT	582,442	14,976	2.6%	556,234	22,319	3,888	11,087	2.0%	5.2%
Barnsley PCT	463,325	13,408	3.0%	443,017	16,906	3,403	10,005	2.2%	-3.5%
Bassetlaw PCT	193,806	5,558	3.0%	185,636	6,799	1,371	4,187	2.2%	-3.8%
Bath and North East Somerset PCT	284,515	7,398	2.7%	270,286	12,247	1,982	5,416	2.0%	3.7%
Bedfordshire PCT	609,486	19,931	3.4%	581,481	24,066	3,939	15,992	2.7%	-4.7%
Berkshire East PCT	584,685	16,317	2.9%	559,237	21,769	3,679	12,638	2.2%	-0.9%
Berkshire West PCT	659,139	18,135	2.8%	626,563	28,687	3,888	14,246	2.2%	-1.2%

	A	B	C	D	E	F	G	H	I
	Total 2011-12 revenue allocations			Composition of total allocations			Growth in recurrent allocations plus growth in non-recurrent allocations (for primary dental services, pharmaceutical services and General Ophthalmic Services)	Recurrent allocations	
PCT	Total revenue allocations £000s (Cols D+E+F)	Growth in total revenue allocations £000s (Cols F+G)	Growth in total revenue allocations %	Recurrent allocations £000s	Non-recurrent allocations for General Ophthalmic Services, primary dental services and pharmaceutical services £000s	Support for joint working between health and social care £000s (Included in col B)	£000s (Included in col B)	Growth in recurrent allocations % (Included in Col A)	Distance from target %
Bexley Care Trust	355,831	10,099	2.9%	340,680	12,741	2,411	7,689	2.2%	-0.9%
Birmingham East and North PCT	747,286	22,155	3.1%	713,364	27,891	6,031	16,124	2.2%	-0.3%
Blackburn with Darwen Teaching Care Trust Plus	290,109	8,290	2.9%	274,480	13,600	2,028	6,262	2.2%	-0.7%
Blackpool PCT	293,588	8,774	3.1%	279,807	11,340	2,442	6,332	2.2%	-1.1%
Bolton PCT	488,691	14,250	3.0%	466,837	18,154	3,700	10,550	2.2%	-2.9%
Bournemouth and Poole Teaching PCT	573,647	16,132	2.9%	547,225	22,385	4,037	12,095	2.2%	0.2%
Bradford and Airedale Teaching PCT	906,446	25,475	2.9%	863,552	36,658	6,235	19,239	2.2%	0.1%
Brent Teaching PCT	554,228	13,969	2.6%	530,205	20,609	3,414	10,555	2.0%	15.0%
Brighton and Hove City PCT	481,688	12,454	2.7%	460,044	18,358	3,285	9,168	2.0%	6.1%
Bristol PCT	728,907	21,296	3.0%	694,088	29,254	5,565	15,731	2.2%	-4.6%
Bromley PCT	511,494	12,915	2.6%	491,261	17,057	3,176	9,739	2.0%	3.6%
Buckinghamshire PCT	718,195	20,188	2.9%	685,365	28,161	4,669	15,519	2.2%	-1.9%
Bury PCT	316,152	9,043	2.9%	300,127	13,807	2,218	6,825	2.2%	-3.5%
Calderdale PCT	347,473	9,195	2.7%	330,830	14,121	2,523	6,672	2.0%	1.2%
Cambridgeshire PCT	876,576	25,174	3.0%	837,992	32,343	6,242	18,933	2.2%	-0.8%
Camden PCT	500,788	12,947	2.7%	483,180	14,188	3,420	9,527	2.0%	16.8%

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	Total 2011-12 revenue allocations			Composition of total allocations			Growth in recurrent allocations plus growth in non-recurrent allocations (for primary dental services, pharmaceutical services and General Ophthalmic Services)	Recurrent allocations	
PCT	Total revenue allocations £000s (Cols D+E+F)	Growth in total revenue allocations £000s (Cols F+G)	Growth in total revenue allocations %	Recurrent allocations £000s	Non-recurrent allocations for General Ophthalmic Services, primary dental services and pharmaceutical services £000s	Support for joint working between health and social care £000s (Included in col B)	£000s (Included in col B)	Growth in recurrent allocations % (Included in Col A)	Distance from target %
Central and Eastern Cheshire PCT	725,624	19,889	2.8%	688,859	31,708	5,056	14,832	2.1%	0.4%
Central Lancashire PCT	769,677	22,501	3.0%	730,657	33,125	5,894	16,607	2.2%	-1.4%
City and Hackney Teaching PCT	524,447	13,817	2.7%	505,085	15,518	3,844	9,972	2.0%	9.4%
Cornwall and Isles of Scilly PCT	916,136	27,523	3.1%	873,236	35,135	7,766	19,758	2.2%	-2.2%
County Durham PCT	990,842	29,088	3.0%	948,498	34,646	7,698	21,390	2.2%	-3.5%
Coventry Teaching PCT	595,086	15,565	2.7%	568,297	22,547	4,242	11,323	2.0%	3.3%
Croydon PCT	577,326	16,190	2.9%	551,321	22,291	3,714	12,476	2.2%	-0.5%
Cumbria Teaching PCT	868,674	25,701	3.0%	829,292	32,425	6,956	18,744	2.2%	-2.4%
Darlington PCT	184,181	5,335	3.0%	174,075	8,745	1,362	3,974	2.2%	-0.9%
Derby City PCT	457,183	19,130	4.4%	437,613	16,375	3,194	15,935	3.7%	-4.7%
Derbyshire County PCT	1,173,296	34,847	3.1%	1,118,446	45,315	9,535	25,312	2.2%	-4.7%
Devon PCT	1,226,933	34,947	2.9%	1,167,589	49,673	9,672	25,275	2.1%	0.3%
Doncaster PCT	561,196	16,171	3.0%	531,493	25,643	4,060	12,111	2.2%	-2.7%
Dorset PCT	653,253	19,257	3.0%	625,358	22,739	5,156	14,101	2.2%	-0.4%
Dudley PCT	513,165	15,361	3.1%	489,089	19,783	4,293	11,068	2.2%	-3.0%
Ealing PCT	606,583	15,283	2.6%	578,535	24,320	3,728	11,554	2.0%	7.4%
East Lancashire Teaching PCT	698,066	18,582	2.7%	664,980	28,215	4,871	13,711	2.0%	0.8%

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PCT	Total revenue allocations £000s (Cols D+E+F)	Growth in total revenue allocations £000s (Cols F+G)	Growth in total revenue allocations %	Recurrent allocations £000s	Non-recurrent allocations for General Ophthalmic Services, primary dental services and pharmaceutical services £000s	Support for joint working between health and social care £000s (Included in col B)	£000s (Included in col B)	Growth in recurrent allocations % (Included in Col A)	Distance from target %
East Riding of Yorkshire PCT	489,437	14,519	3.1%	465,386	20,090	3,962	10,557	2.2%	-4.0%
East Sussex Downs and Weald PCT	567,802	15,332	2.8%	542,664	20,650	4,489	10,843	2.0%	1.4%
Eastern and Coastal Kent PCT	1,277,363	35,343	2.8%	1,225,441	43,510	8,412	26,931	2.2%	0.2%
Enfield PCT	487,286	14,005	3.0%	464,549	19,254	3,483	10,522	2.2%	-0.6%
Gateshead PCT	393,002	10,582	2.8%	375,778	14,162	3,061	7,521	2.0%	1.3%
Gloucestershire PCT	917,905	26,479	3.0%	876,466	34,669	6,770	19,710	2.2%	0.0%
Great Yarmouth and Waveney PCT	401,839	11,443	2.9%	382,116	16,958	2,766	8,677	2.2%	-3.8%
Greenwich Teaching PCT	470,162	12,435	2.7%	449,618	17,052	3,492	8,942	2.0%	4.8%
Halton and St Helens PCT	598,676	17,279	3.0%	571,686	22,639	4,351	12,928	2.2%	-1.7%
Hammersmith and Fulham PCT	361,516	9,364	2.7%	345,980	13,052	2,484	6,880	2.0%	22.5%
Hampshire PCT	1,881,544	53,304	2.9%	1,797,207	71,684	12,653	40,651	2.2%	-3.5%
Haringey Teaching PCT	474,901	12,054	2.6%	451,484	20,447	2,970	9,084	2.0%	1.4%
Harrow PCT	348,737	9,235	2.7%	331,640	14,496	2,601	6,634	2.0%	2.4%
Hartlepool PCT	183,126	5,273	3.0%	174,287	7,520	1,319	3,954	2.2%	-1.2%
Hastings and Rother PCT	333,765	8,821	2.7%	320,081	11,291	2,393	6,428	2.0%	1.1%
Havering PCT	416,819	11,674	2.9%	397,724	16,428	2,667	9,007	2.2%	-1.6%
Heart of Birmingham Teaching PCT	578,399	15,375	2.7%	548,881	25,146	4,372	11,004	2.0%	10.9%

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PCT	Total revenue allocations £000s (Cols D+E+F)	Growth in total revenue allocations £000s (Cols F+G)	Growth in total revenue allocations %	Recurrent allocations £000s	Non-recurrent allocations for General Ophthalmic Services, primary dental services and pharmaceutical services £000s	Support for joint working between health and social care £000s (Included in col B)	£000s (Included in col B)	Growth in recurrent allocations % (Included in Col A)	Distance from target %
Herefordshire PCT	289,677	8,614	3.1%	274,490	12,820	2,368	6,246	2.2%	-2.8%
Hertfordshire PCT	1,699,918	47,745	2.9%	1,615,310	73,583	11,025	36,720	2.2%	-0.3%
Heywood, Middleton and Rochdale PCT	396,763	11,548	3.0%	379,236	14,545	2,982	8,566	2.2%	-0.9%
Hillingdon PCT	418,501	10,694	2.6%	401,038	14,736	2,728	7,967	2.0%	2.5%
Hounslow PCT	404,857	10,261	2.6%	383,527	18,782	2,548	7,713	2.0%	1.8%
Hull Teaching PCT	510,332	15,070	3.0%	484,783	21,488	4,062	11,008	2.2%	-2.7%
Isle of Wight NHS PCT	261,259	7,768	3.1%	249,893	9,236	2,130	5,638	2.2%	-0.8%
Islington PCT	450,758	11,820	2.7%	435,038	12,472	3,248	8,572	2.0%	14.1%
Kensington and Chelsea PCT	368,281	9,727	2.7%	358,068	7,485	2,727	6,999	2.0%	20.6%
Kingston PCT	274,176	6,735	2.5%	263,969	8,696	1,512	5,224	2.0%	7.7%
Kirklees PCT	678,239	19,620	3.0%	644,186	29,072	4,982	14,639	2.2%	-0.7%
Knowsley PCT	334,840	9,144	2.8%	320,525	11,589	2,726	6,418	2.0%	1.2%
Lambeth PCT	636,428	16,086	2.6%	613,536	18,921	3,971	12,115	2.0%	8.0%
Leeds PCT	1,312,994	37,670	3.0%	1,252,778	50,902	9,315	28,355	2.2%	-0.4%
Leicester City PCT	548,060	18,240	3.4%	519,975	23,835	4,250	13,990	2.7%	-4.7%
Leicestershire County and Rutland PCT	932,081	26,918	3.0%	889,041	36,247	6,793	20,125	2.2%	-4.1%
Lewisham PCT	535,878	13,853	2.7%	512,150	20,074	3,654	10,199	2.0%	6.6%

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PCT	Total revenue allocations £000s (Cols D+E+F)	Growth in total revenue allocations £000s (Cols F+G)	Growth in total revenue allocations %	Recurrent allocations £000s	Non-recurrent allocations for General Ophthalmic Services, primary dental services and pharmaceutical services £000s	Support for joint working between health and social care £000s (Included in col B)	£000s (Included in col B)	Growth in recurrent allocations % (Included in Col A)	Distance from target %
Lincolnshire Teaching PCT	1,195,077	34,900	3.0%	1,147,176	38,810	9,092	25,808	2.2%	-2.2%
Liverpool PCT	1,006,346	27,242	2.8%	959,680	38,554	8,112	19,130	2.0%	3.1%
Luton PCT	318,264	8,922	2.9%	302,185	14,032	2,047	6,875	2.2%	-2.8%
Manchester PCT	1,032,510	29,673	3.0%	987,197	37,940	7,372	22,300	2.2%	-0.3%
Medway PCT	435,279	11,970	2.8%	413,465	19,252	2,562	9,408	2.2%	-1.5%
Mid Essex PCT	519,638	15,942	3.2%	492,876	22,483	4,280	11,662	2.3%	-4.7%
Middlesbrough PCT	291,680	8,191	2.9%	276,512	13,088	2,081	6,111	2.2%	0.2%
Milton Keynes PCT	360,417	10,221	2.9%	342,698	15,282	2,437	7,784	2.2%	-3.6%
Newcastle PCT	512,007	13,868	2.8%	487,871	20,002	4,134	9,733	2.0%	2.1%
Newham PCT	567,513	14,381	2.6%	540,944	22,997	3,572	10,809	2.0%	13.5%
Norfolk PCT	1,197,636	54,224	4.7%	1,143,821	43,754	10,061	44,163	3.9%	-4.7%
North East Essex PCT	546,723	25,123	4.8%	521,684	21,276	3,762	21,361	4.2%	-5.0%
North East Lincolnshire Care Trust Plus	288,775	7,660	2.7%	275,309	11,345	2,122	5,538	2.0%	1.2%
North Lancashire Teaching PCT	577,453	16,683	3.0%	552,395	20,846	4,212	12,471	2.2%	-1.1%
North Lincolnshire PCT	267,820	7,770	3.0%	256,070	9,763	1,987	5,783	2.2%	-3.2%
North Somerset PCT	328,465	15,361	4.9%	313,145	12,781	2,539	12,822	4.2%	-7.2%
North Staffordshire PCT	347,894	9,965	2.9%	333,191	12,253	2,449	7,516	2.2%	-4.1%

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PCT	Total revenue allocations £000s (Cols D+E+F)	Growth in total revenue allocations £000s (Cols F+G)	Growth in total revenue allocations %	Recurrent allocations £000s	Non-recurrent allocations for General Ophthalmic Services, primary dental services and pharmaceutical services £000s	Support for joint working between health and social care £000s (Included in col B)	£000s (Included in col B)	Growth in recurrent allocations % (Included in Col A)	Distance from target %
North Tyneside PCT	381,092	10,485	2.8%	365,615	12,676	2,802	7,683	2.1%	0.5%
North Yorkshire and York PCT	1,207,348	34,662	3.0%	1,151,558	47,200	8,590	26,072	2.2%	-1.4%
Northamptonshire Teaching PCT	1,042,346	29,768	2.9%	993,560	41,529	7,257	22,511	2.2%	-0.9%
Northumberland Care Trust	555,487	16,130	3.0%	529,708	21,641	4,138	11,992	2.2%	-2.6%
Nottingham City PCT	550,294	21,584	4.1%	522,374	23,669	4,251	17,333	3.3%	-4.7%
Nottinghamshire County Teaching PCT	1,060,677	31,148	3.0%	1,014,027	38,397	8,253	22,895	2.2%	-4.1%
Oldham PCT	422,178	11,524	2.8%	403,029	16,113	3,036	8,488	2.1%	0.5%
Oxfordshire PCT	912,839	23,277	2.6%	871,653	35,290	5,896	17,381	2.0%	1.8%
Peterborough PCT	275,990	7,321	2.7%	259,770	14,152	2,068	5,253	2.0%	1.8%
Plymouth Teaching PCT	445,927	13,148	3.0%	423,443	18,955	3,529	9,619	2.2%	-3.7%
Portsmouth City Teaching PCT	344,340	9,851	2.9%	328,755	13,172	2,414	7,437	2.2%	-1.2%
Redbridge PCT	413,340	11,850	3.0%	391,027	19,383	2,930	8,921	2.2%	-2.9%
Redcar and Cleveland PCT	261,805	6,943	2.7%	249,290	10,552	1,963	4,980	2.0%	2.2%
Richmond and Twickenham PCT	287,464	7,226	2.6%	277,720	7,991	1,753	5,472	2.0%	14.0%
Rotherham PCT	455,107	13,486	3.1%	435,234	16,209	3,665	9,821	2.2%	-2.7%
Salford PCT	476,053	13,885	3.0%	452,069	20,371	3,612	10,272	2.2%	-1.5%
Sandwell PCT	581,994	17,535	3.1%	551,021	25,982	4,991	12,544	2.2%	-3.4%

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PCT	Total revenue allocations £000s (Cols D+E+F)	Growth in total revenue allocations £000s (Cols F+G)	Growth in total revenue allocations %	Recurrent allocations £000s	Non-recurrent allocations for General Ophthalmic Services, primary dental services and pharmaceutical services £000s	Support for joint working between health and social care £000s (Included in col B)	£000s (Included in col B)	Growth in recurrent allocations % (Included in Col A)	Distance from target %
Sefton PCT	536,029	14,368	2.8%	509,507	22,348	4,173	10,194	2.0%	4.0%
Sheffield PCT	984,184	26,324	2.7%	935,514	41,065	7,605	18,719	2.0%	1.7%
Shropshire County PCT	463,809	13,749	3.1%	441,980	18,086	3,742	10,006	2.2%	-2.8%
Solihull Care Trust	326,736	9,362	2.9%	312,017	12,413	2,305	7,057	2.2%	-0.7%
Somerset PCT	855,762	25,201	3.0%	814,270	34,754	6,737	18,464	2.2%	-1.0%
South Birmingham PCT	650,232	17,366	2.7%	620,497	24,745	4,990	12,376	2.0%	1.6%
South East Essex PCT	557,006	16,217	3.0%	530,726	22,086	4,194	12,023	2.2%	-3.3%
South Gloucestershire PCT	350,820	10,085	3.0%	332,408	15,898	2,513	7,572	2.2%	-3.5%
South Staffordshire PCT	936,825	40,651	4.5%	894,158	35,636	7,031	33,620	3.8%	-4.7%
South Tyneside PCT	310,407	8,446	2.8%	295,009	12,893	2,506	5,941	2.0%	1.3%
South West Essex PCT	666,962	19,067	2.9%	636,145	26,154	4,662	14,405	2.2%	-2.9%
Southampton City PCT	409,077	11,938	3.0%	392,048	13,925	3,105	8,833	2.2%	-1.7%
Southwark PCT	542,182	15,984	3.0%	517,156	20,742	4,284	11,700	2.2%	-1.3%
Stockport PCT	482,475	13,111	2.8%	457,712	21,261	3,502	9,609	2.0%	0.6%
Stockton-on-Tees Teaching PCT	325,759	9,303	2.9%	309,549	13,941	2,270	7,034	2.2%	-2.9%
Stoke on Trent PCT	506,432	23,610	4.9%	485,738	16,915	3,779	19,831	4.2%	-5.5%
Suffolk PCT	917,570	27,104	3.0%	878,192	32,078	7,300	19,804	2.2%	-4.0%

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Sunderland Teaching PCT	562,642	16,055	2.9%	537,031	21,271	4,339	11,716	2.1%	0.2%
Surrey PCT	1,683,186	42,535	2.6%	1,615,025	57,676	10,486	32,049	2.0%	5.0%
Sutton and Merton PCT	596,118	15,373	2.6%	570,242	21,849	4,028	11,346	2.0%	3.5%
Swindon PCT	310,287	8,767	2.9%	296,655	11,569	2,062	6,705	2.2%	-3.6%
Tameside and Glossop PCT	429,940	12,879	3.1%	407,470	18,860	3,610	9,269	2.2%	-1.5%
Telford and Wrekin PCT	265,229	7,827	3.0%	250,630	12,491	2,108	5,719	2.2%	-3.8%
Torbay Care Trust	268,093	8,062	3.1%	254,948	10,824	2,322	5,741	2.2%	0.0%
Tower Hamlets PCT	499,544	13,227	2.7%	477,238	18,580	3,725	9,501	2.0%	9.3%
Trafford PCT	379,322	9,817	2.7%	359,873	16,854	2,595	7,222	2.0%	7.6%
Wakefield District PCT	629,748	18,171	3.0%	599,817	25,356	4,575	13,596	2.2%	-3.7%
Walsall Teaching PCT	473,155	13,590	3.0%	451,608	17,674	3,874	9,717	2.1%	0.3%
Waltham Forest PCT	435,049	11,052	2.6%	416,735	15,545	2,768	8,283	2.0%	2.5%
Wandsworth PCT	564,632	14,204	2.6%	543,961	17,217	3,454	10,750	2.0%	15.3%
Warrington PCT	325,135	9,262	2.9%	308,695	14,198	2,242	7,020	2.2%	-2.0%
Warwickshire PCT	828,992	23,921	3.0%	787,474	35,491	6,027	17,894	2.2%	-1.5%
West Essex PCT	434,146	11,583	2.7%	414,749	16,187	3,210	8,373	2.0%	1.1%
West Kent PCT	1,027,962	30,005	3.0%	981,758	38,390	7,814	22,191	2.2%	-2.1%

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PCT	Total revenue allocations £000s (Cols D+E+F)	Growth in total revenue allocations £000s (Cols F+G)	Growth in total revenue allocations %	Recurrent allocations £000s	Non-recurrent allocations for General Ophthalmic Services, primary dental services and pharmaceutical services £000s	Support for joint working between health and social care £000s (Included in col B)	£000s (Included in col B)	Growth in recurrent allocations % (Included in Col A)	Distance from target %
West Sussex PCT	1,299,123	35,345	2.8%	1,239,997	50,349	8,776	26,569	2.1%	0.4%
Western Cheshire PCT	415,749	10,721	2.6%	394,918	18,026	2,805	7,916	2.0%	2.6%
Westminster PCT	493,587	13,250	2.8%	472,361	17,360	3,866	9,384	2.0%	16.1%
Wiltshire PCT	676,186	19,430	3.0%	646,042	25,318	4,826	14,604	2.2%	-2.0%
Wirral PCT	630,164	16,911	2.8%	599,705	25,532	4,928	11,983	2.0%	3.8%
Wolverhampton City PCT	452,258	13,528	3.1%	429,887	18,596	3,776	9,753	2.2%	-2.0%
Worcestershire PCT	864,037	25,138	3.0%	823,904	33,647	6,487	18,651	2.2%	-1.5%
England	89,087,234	2,571,571	3.0%	84,996,081	3,443,153	648,000	1,923,571	2.2%	0.0%

Notes:

1. Responsibility and funding for social services for people with learning disabilities has been transferred from the NHS to local authorities. Growth has been calculated over 2010-11 allocations after subtracting this funding from 2010-11 allocations, and also adjusting for transfers of services and associated funding between PCTs.
2. Total revenue allocations include recurrent allocations and non-recurrent allocations for primary dental services, pharmaceutical services, General Ophthalmic Services and support for joint working between health and social care.

NHS
Eastern and Coastal Kent

Response to questions from HOSC for meeting on 25 March

Introduction
The responses set out below relates to NHS Eastern & Coastal Kent only.

The PCT receives an annual allocation of nearly £1.3bn. Of this, 97% is spent on patient care in the acute sector, mental health, ambulance services, continuing care placements, childrens services, community services, GP, dental, ophthalmic and pharmacy services. The remaining 3% is spent on PCT running costs, including just over 1% on management costs.

Responses

1. *Why is achieving financial balance across the local health economy important and what are the potential consequences of not doing so?*

   The NHS budget is cash limited. A statutory duty is therefore placed on all NHS Organisations to deliver financial balance each year. Allocations to NHS commissioners (currently PCTs, but soon to become GP Commissioning Consortia) are based on a formula that takes into account population numbers, and the demographics of that population.

   If an organisation does overspend, it must recover this position in the future (over a maximum of three years). It will be seen by the NHS as a failing organisation and will be subject to special performance monitoring by the NHS. Recovering previous overspends means that there is less money available for patient care.

2. *What kinds of measures have been taken in 2010/11 in terms of prioritising treatments and changing service provision across Kent in order to try and achieve financial balance?*

   In 2010/11 demand in the acute sector in particular, presented NHS Eastern & Coastal Kent with a financial challenge. A Turnaround Group was set up in September to review all budgets. Commissioning budgets were scrutinised for any savings that would not affect patient care. Some investment mobilisation plans were deferred, but not abandoned. Consultants and GPs were encouraged to switch high cost and prescription drugs (where there was sound clinical evidence) to those that represented better value for money.

   Non-commissioning budgets were targeted. The management cost reduction programme was accelerated, and expenditure on the estate was reviewed, although this did not affect the backlog maintenance programme. A review of business rates led to a claw-back in excess of £1m from estate across the PCT.

GPs collaborated and developed referral and treatment criteria. This meant that GPs took a more consistent approach when referring patients for treatment.

3. *What kinds of measures are being considered for 2011/12?*

   The PCT is working closely with all providers to see how patient pathways can be streamlined, but still deliver safe, effective care, often closer to the patient's home.
   The clustering of PCTs from June is expected to help drive down running costs further than at first planned.

4. *What are the main challenges to achieving financial balance across the health economy?*

   Activity, demand and cost pressures are the main challenges, whilst sustaining targets set out in the NHS Constitution such as 18 weeks referral to treatment, and cancer waiting times.

   This must be managed with a rapidly dwindling management base, and during a time of substantial change – to GP Commissioning, and to a single PCT cluster for Kent & Medway.

5. *What has been the impact of the NHS Operating Framework for 2011/12 and the PCT allocations for next financial year?*

   The PCT will receive an increase to its baseline allocation of 2.2% (£26m) in 2011/12, plus an explicit non-recurrent provision of 0.7% (£8m) for commissioners to spend on measures which support social care and benefit health in agreement with social care commissioners.

   The Operating Framework does stipulate that 2% of recurrent funds (£24m) can only be committed on a non-recurrent basis.

   There is a net tariff reduction of 1.5% which will generate a reduction to overall costs of £9m.

6. *How is the QIPP challenge being met in Kent?*

   Over the past five years, the PCT has received substantial growth to its allocation of funds, but this tapered off in 2010/11 and is below current inflation levels for next financial year. There is a step change required in generating funds within the health economy – through delivery of an imposing QIPP programme.

   The QIPP challenge is being addressed at both a local PCT level, and through emerging GP Commissioning Consortia, and at the Kent & Medway level. The scale of the challenge in NHS East Kent is £67m in 2011/12, with the PCT required to generate £48m of these efficiencies. Delivery plans for 2011/12 are now at an advanced stage, but the scale of the challenge cannot be under-estimated.

7. *What are the particular demographic trends in Kent that will affect NHS commissioning now and in the future, and how does Kent compare on these compared to the rest of the country?*

Population demographics such as age, sex and ethnicity and the changes in population demographics are likely to have an influence on the commissioning of NHS services. Table 1 shows the projected population change in 2028 from a baseline of 2008, by selected age bands. The total resident population of Kent is projected to increase by 24.3% compared to just 19.8% for England. The largest population growth is projected to be in the over 65 population, with those living to 85 or older increase by almost 100%. This is likely to result in greater demand of healthcare services as life expectancy is increasing resulting in more people living longer with long term conditions, such as diabetes, chronic obstructive pulmonary disease and dementia.

The under 5s population is project to increase just over 10% over the next 20 years. This will impact on the need for health visiting services and other services relating to children.

Changes in the ethnic mix of populations also impact on commissioning of services as communities have different health risks for example the smoking prevalence in East European countries is greater than that on England, which may lead to an increase in cancer related and circulatory related illness in these populations in the future.

Population growth for 35-54 is lower than that for other age bands, this is likely to have an impact on the workforce as stated in **KCC 'Bold Steps for Kent', pg20**

"By 2026 the older population of Kent is expected to have increased by 30.7% on 2006 levels, whilst the ratio of traditional working age population compared to those of current state pension age will have fallen from 3.1: to 2:1"

Table 1: Percentage population change from 2008 to 2028

	Kent			England		
	2008	**2028**	**Percentage change**	**2008**	**2028**	**Percentage Change**
Under 5s	83.0	91.4	10.1%	3,129.4	3,409.8	9.0%
05-19	264.3	291.0	10.1%	9,231.2	10,128.3	9.7%
20-34	232.8	254.6	9.4%	10,246.7	11,020.8	7.6%
35-44	205.6	213.6	3.9%	7,715.0	8,190.1	6.2%
45-54	188.9	194.2	2.8%	6793.1	6723.1	-1.0%
55-64	180.1	219.8	22.0%	6,060.9	7,190.4	18.6%
65+	247.0	390.5	58.1%	8,288.3	12,388.6	49.5%
75+	119.8	209.4	74.8%	4,012.6	6,579.9	64.0%
85+	34.7	69.1	99.1%	1,134.6	2,195.7	93.5%
Kent	1,556.2	1,933.6	24.3%	56,611.8	67,826.7	19.8%

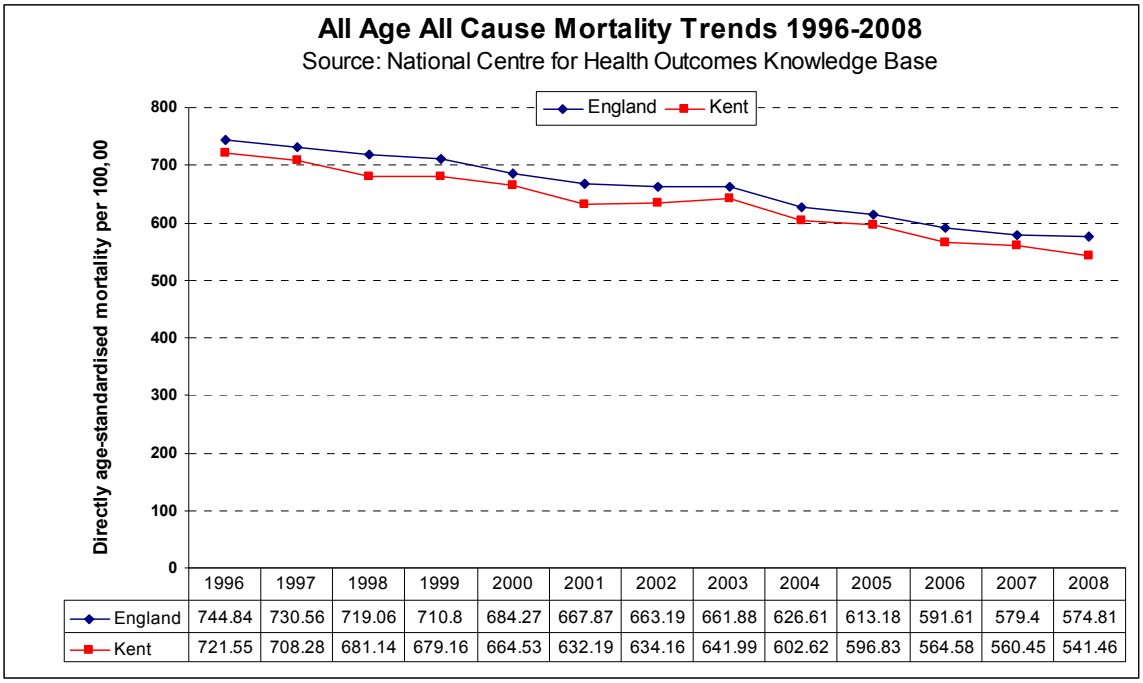
Source: ONS 2008 based population projections

Life expectancy is influenced by changes in mortality table 2 shows the trends in life expectancy for Kent and Medway as a county and England. Figure 1 shows the trend in All Age All Cause mortality, which has been steadily declining since 1996. Kent experiences less mortality than England as a whole.

Table 2: Life expectancy at birth 2004-2008 to 2006-2010

	2004-08			2005-09			2006-10		
NHS area	**Male**	**Female**	**Persons**	**Male**	**Female**	**Persons**	**Male**	**Female**	**Persons**
Kent and Medway NHS	**78.1**	**82.0**	**80.1**	**78.4**	**82.2**	**80.3**	**78.4**	**82.2**	**80.3**
England (2006-2008)	**77.9**	**82.0**							

Source: Public Health Mortality File, 2004-10; ONS CAS ward data; SEPHO, NCHOD



	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
England	744.84	730.56	719.06	710.8	684.27	667.87	663.19	661.88	626.61	613.18	591.61	579.4	574.81
Kent	721.55	708.28	681.14	679.16	664.53	632.19	634.16	641.99	602.62	596.83	564.58	560.45	541.46

NHS West Kent

Rod Smith
Director of Finance & Estates

Briefing Paper
Kent Health Overview and Scrutiny Committee, March 25th 2010

A range of specific questions were notified to the PCT in advance of the meeting which address two broad areas of interest to the HOSC. The intention of the briefing is to answer the questions and provide information that will help members of HOSC to explore the areas further before and on the day.

For convenience the briefing refers to and answers each specific question under the two main headings. Other relevant documents containing greater detail are referred to and attached where appropriate.

1. **What are the challenges to ensuring the NHS in Kent is financially sustainable?**

- ***Why is achieving financial balance across the local health economy important and what are the potential consequences of not doing so?***
  - Achieving financial balance is a statutory duty of NHS organisations. Primary Care Trusts have specific annual requirements, and NHS Trusts have greater flexibility to break even over a rolling three year period, which in some circumstances may be extended to 5 years.
  - Financial balance is consistent with financial sustainability. However, financial sustainability alone is not the challenge. The provision of and access to services that meet required standards on a sustainable basis is the real challenge. Sustainable service provision helps to ensure that valuable services continue to be provided reliably. Financial imbalance is usually an indicator and measure of wider problems and challenges facing a system.
  - Over and above the direct implications for users of services, the resources and activities required to restore financial balance can compete with or even displace the functions of planning, prioritising and making changes to achieve strategic objectives. In extremis intervention by third parties is the consequence, which often diminishes the ability of local stakeholders to work together and drive their locally owned agenda, until a form of balance is restored.
  - Achieving and sustaining financial balance is itself a continuous activity. The public as taxpayers rightly expect services to be continually improved in terms of effectiveness, availability, quality standards and cost. Providing this challenge is tackled collectively and is properly understood in terms of using all of our resources as effectively as possible with due regard to fairness; money becomes the currency, and excellent health and healthcare for local residents is the business.

- ***What are the main challenges to achieving financial balance across the health economy?***
  - The PCT five year Strategic Commissioning Plan "Best Possible Health" was published in January 2010.[1] The PCT is now developing the second Annual Operating Plan based on the strategy. The Strategic Commissioning Plan describes the needs assessment, prioritisation process and engagement that resulted in the final Board approved plan. The document also describes the challenges facing the NHS in general and West Kent in particular. The challenges and risks described in the plan remain relevant today. Ten key points drawn from the Strategic Commissioning Plan are:

    1. Increased investment will be relatively flat from 2011 onwards. *The actual settlement includes over 2% new funding, which is better than the plan anticipated.*
    2. The funding available to West Kent is about right according to current funding formula. *The recently revised and updated national formula indicates that West Kent is 2% below its fair share allocation. The fair share allocation itself is around 10% below the overall average NHS per capita allocation.*
    3. The health of West Kent residents is better than the England average, but there pockets of deprivation.
    4. Benchmarking indicates that there is variation at health programme level. For example, more of our spending is attributed to cancer services than other areas, but the outcomes do not appear to be better than other areas.
    5. High cost providers and PFI facilities mean that more money is spent on buildings and facilities, and less on front-line staff, patient services and medicines. The facilities are high quality, but like all resources they need to be used wisely.
    6. The combined effect of demographic growth, and other drivers including technology, innovation, externally defined standards and regulation mean that over £300m of additional value/ costs need to be absorbed over five years. This will be achieved by managing inflationary pressure including pay increases and by improving productivity. Where real additional costs are incurred, for example more staff, more drugs or more wheelchairs, real costs may need to be reduced elsewhere.
    7. Twelve clinically defined programmes were identified, which mapped into strategic initiatives categorised into operational, tactical and transformational initiatives. *Since the plan was published, the initiatives have been mapped into "QIPP" categories and further developed.*
    8. Public engagement in the transformation of services is critical to success.
    9. An integrated health and well-being model to increase independence and employment and empower and support personalised self-care for people with long term conditions and their carers is an essential part of the five year plan.
    10. The development of GP commissioning and Health and Well Being Boards appear well aligned with the strategy. The strategic direction remains valid in 2011 and will continue to inform the annual operating plan.

- In 2011/12 the PCT needs to take additional steps to reverse increases in hospital activity and costs in order to achieve the improvements identified in the Strategic Commissioning Plan. A range of initiatives intended to enable a full range of services to be delivered within the available funding for 2011/12 has been developed. The initiatives are consistent with the original strategy and reflect the contributions of local clinical leaders.
- The three main risks identified in 2010 are relevant in 2011. (see page 49 of the plan for the detailed wording)
    1. Scale and pace
    2. Engagement and ownership
    3. Achieving transformation, while maintaining grip in an environment of change.

- The mitigation has been strengthened in 2011
    1. Development of Practice Based Commissioning towards GP consortia.
    2. PCT clusters developed to support transition phase of White Paper.
    3. Real terms growth in funding compared with no growth assumed in plan.

- ***What has been the impact of the NHS Operating Framework for 2011/12 and the PCT allocations for the next financial year?***
    - The impact for most parts of the NHS is that the increased allocation, including funds directed towards social care, is almost sufficient to fund some transformational change, expected price/ wage inflation and some demographic pressure.
    - The allocation is not sufficient to fully fund demographic pressure or any new investment in local health systems.
    - Measures to achieve financial plans in 2010/11 need to be made good in 2011/12 in West Kent. This requires a greater effort to deliver the range of services in the Annual Operating Plan within the available funding.
    - Appendix 1 describes the financial headlines from the NHS Operating Framework.

- ***What are the particular demographic trends in Kent that will affect NHS commissioning now and in the future, and how does Kent compare on these compared to the rest of the country?***
    - According to ONS estimates, there will be an increase of more than 56% in the over 65yrs population in West Kent by 2028 compared to 50% for the rest of England.
    - In 2017 this group will constitute approximately 18% of the total West Kent population, rising to 20% by 2028.
    - In terms of five years age bands, the biggest increase will be seen in the 85+ males, approximately 170% increase by 2028 (from 5000 to 13,000)
    - These increases have serious implications for health and care delivery. For example, over 65s are 18 times more likely to suffer long term heart/ circulatory problems.
    - By 2028, the proportion of under 5s and 5-19 yrs population group in West Kent is expected to increase by 12% compared to 9% for the rest of England.
    - The lowest increases are expected for working age population with only 6% increase in the 35-44yrs age group, similar to the England average.
    - Please see the response from East Kent for a Kent wide analysis of demographics.

2. **Are there any implications for the range and quality of health services available to the people of Kent as a result of any measures being taken to achieve or maintain financial sustainability?**
    - Achieving and maintaining financial sustainability is an integral part of the strategy, which will result in the best possible health for local residents.
    - Where service changes are required, current services may be replaced with more effective services or removed altogether if they are no longer relevant to the current needs of the population.
    - Some services may no longer be available if they are considered to be of limited benefit to patients.
    - An underlying principle of QIPP is that improving the quality and safety of healthcare services will derive significant savings across all healthcare provision. This theme of "quality as the organising principle' is central to achieving financial sustainability for the future. A number of contractual measures such as never events, CQUIN and penalty clauses will secure improved quality through financial controls.

- ***What kinds of measures have been taken in 2010/11 in terms of prioritising treatments and changing service provision across Kent in order to try and achieve financial balance?***
    - The Annual Operating Plan[2] for 2010/11 describes the first year implementation of the five year plan.
    - A range of additional measures were considered during the year to help achieve the longer term financial balance. These were considered by the PCT after consultation with clinical groups and representatives of the public. Appendix 2 is a letter to West Kent clinicians together with a summary feedback.
    - Although most if not all of the proposals had been considered or implemented in other parts of the NHS, only some of the proposals were considered to be acceptable. A few of the proposals were considered to have longer term benefits and have been included in the operating plan proposals for 2011/12.
    - GP Commissioners are more involved in agreeing our plans and priorities for 2011/12. This engagement will certainly increase the chances of success.

- ***What kinds of measures are being considered for 2011/12?***
    - The measures being considered in 2011/12 are still under development and will be considered by the PCT Board at the end of March.
    - The financial implications of the proposed initiatives to deliver the objectives of the Annual Operating Plan are summarised using the 18 QIPP categories. For 2011/12 over £30m of resources are freed up to allow greater value to be achieved from the same programme area or actual cash released to enable investment in other programmes.[5]
    - An Operating Plan Assurance statement is being developed to help ensure that the objectives being pursued reflect national operating plan priorities.

- ***How is the QIPP challenge being met in Kent?***
    - PCTs remain responsible for the delivery of the Annual Operating Plan including QIPP.
    - QIPP plans have been developed and pursued at PCT and emerging GP commissioning consortia level, and at Kent and Medway level. This

recognises both the different scale and complexity of some transformational schemes, and the need for all plans to have local ownership.

- PCT clusters are being created as part of the transition phase of the winding up of the PCTs and the development of new arrangements.

References:

1. NHS West Kent five year strategic commissioning plan "Best Possible Health" January 2010. Please refer to the document pages 1 – 52.

   http://www.westkentpct.nhs.uk/Have_Your_Say/Best_Possible_Health_Strategic_Plan/index.html

2. NHS West Kent Annual Operating Plan for 2010/11. Please refer to the document pages 1-16.

   http://www.westkentpct.nhs.uk/The_PCT/Our_plans/index.html

Appendix 1 - Impact of NHS Operating Framework 2011/12

Impact Of NHS Operating Framework 2011/12

Kent Health Overview and Scrutiny Committee

25th March 2011

National Surplus

- Aggregate national PCT surplus delivered in 2010-11
- Draw down to be determined by SHA in conjunction with DH
- No PCT to plan for a deficit
- Still 1% surplus national expectation, but some flexibility
- 2% of budget deployed Non-Recurrently
  - To be held by SHAs
  - Business Cases required to access

PCT Allocations

- Headline growth 2.2%
- Further 0.8% relating to joint working with Social care
- Dental/Ophthalmic and Pharmaceutical now to remain as annually set allocations, pending creation of NHS Commissioning Board
- Not all allocations published as yet
  - SHA Bundle allocations will be critical
    - Prisons
    - IAPT
- A number of announcements in Operating Plan require new funding to be identified from the increased allocation.
- PCT revised Distance from Target – 2.1% (£21m)

Anticipated Resource Limit

Recurrent Allocation		981,758
Primary Care (Dental/Ophthalmic/Pharmaceutical)		38,390
Joint working with Social care		7,814
Regional Transformation Fund	-	19,635
Cancer Drugs	-	1,617
Free School Fruit	-	485
NSCAG	-	6,028
Impairments		2,000
Brought forward surplus		-
Central Budgets		5,132
Other		1,222
Total anticipated Resource Limit		**1,008,551**

Social care

- PCTs have an allocation to invest in social care services to benefit health and to improve overall health gain (£7.814m)
- PCTs will transfer this funding to Local Authorities, e.g.
  - Telecare, falls prevention, community equipment and adaptations, crisis response
- Re-ablement services (£2m)

Tariffs (1)

- Efficiency drives
  - Changing tariff to ensure relatively short stays do not attract long stay tariff
  - All tariffs set 1% below the national average
  - Expansion of Best Practice tariffs
  - Combined, embeds 2% efficiency in tariff structure
- Pay &Price assumption 2.5%
- Efficiency requirement (4.0%)
- Net tariff change reduction (1.5%)
- Applies to non tariff settings as well

Tariffs (2)

- Hospitals not reimbursed for readmissions within 30 days
- PCTs should use Re-ablement funds to coordinate activity on post-discharge support
- New outpatient tariffs
- Review of Specialist Top-Ups
- 30% marginal rate for emergency admissions (same base year of 2008-09)
- New flexibility – providers can offer services below tariff
- CQUIN (quality incentive) remains at 1.5%

- The combined impact of all this should increase PCT purchasing power, but need to await results of Road-testing tariffs before confirming

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West Kent Clinicians via Medical & Nursing Directors and PBC Leads

cc: All West Kent NHS Chief Executives
Acute Trust Operations Directors
PBC Managers

10 January 2011

Dear Colleague

Prioritising Treatments in West Kent

Firstly, thank you to all those who actively engaged with the PCT in discussing the potential options for prioritisation, which I shared in my previous letter. We had a great response with more than 90 replies in total and over 70 clinicians getting involved in the debate.

It was clear from the dialogue that there are many practical and clinical difficulties to adopting a number of the options we laid out. Of course this is no surprise, prioritising treatments is always going to be a difficult thing to do, but I was gratified by the pragmatic nature of the discussion, with clinicians and others accepting that in the current financial climate we will have to find ways to contain burgeoning costs and demand in the NHS. We are very keen to continue this level of open and engaging dialogue with you all in an ongoing manner as we go forward.

In the course of the debate there emerged four categories of idea:

- Those that will have a short-term effect but which we would not wish to continue in the medium term – these focused on capping activity
- Those that were unlikely to create a short term effect but would add benefit in the medium term – these focused on improving quality and prevention initiatives
- Those that we shouldn't do, either because they would have no benefit or created inequity in the system – any kind of blanket ban, for example, fell in this category
- A range of new ideas that clinicians believe will improve efficiency across the system – these focused on changing/improving clinical pathways and in some cases treatment thresholds

The proposals in this letter will be the subject of further contact between NHS West Kent and our partners in the local health economy with regard to implementation. The Chief Executive will be writing shortly to take this forward.

Actions
I have attached a report summarising the feedback we received from stakeholders for your information, and as a result of your feedback and our reflection we propose moving forward in the following way:

1. Stop non-GP primary care referrals with immediate effect. This means that nurses and allied health professionals must get a GP to refer on their behalf and secondary care colleagues will return any other referrals. The only exclusion to this policy is for the Community Ophthalmology Team, which will continue to have direct referral rights.

2. We will work together with all providers to agree reduction in all elective activity for a period to be determined. We are committed to find a way of implementing this that will take real costs out of the system rather than simply shifting costs to the acute sector, which does not deliver what we collectively require. Feedback from clinicians was consistent in suggesting that a small slowdown in all non-urgent elective activity was to be preferred to a more arbitrary approach restricting access to individual conditions.

3. Emerging GP commissioning consortia will continue and re-double focus on reducing variation in referrals from primary care. There will be more emphasis upon reducing the overall average of referrals across primary care and shifting the mean down, by identifying common areas of imperfection within clinical practice, as well as working with outlying individual practices.

4. Clinical colleagues in the acute sector acknowledged that significant variation continues to exist in secondary care practice as well as primary care referral. We will redouble our efforts to work across pathways of care to reduce variation wherever it is seen in the system.

5. We will start work now to agree with clinicians how we can insert smoking and weight advice into treatment pathways with smoking ready for implementation by April 2011 at the latest.

On the other hand, it is important to note that we have decided not to take forward several initiatives in their current form. There will be no further restrictions upon consultant-to-consultant referrals, though the process did map out areas in which GP commissioners might wish to exert a greater influence in future, and these will be dealt with individually.

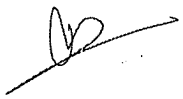
To remind you, these are in addition to the initiatives that have already been implemented and which were laid out in my previous letter. **They will still not be sufficient to close the potential financial gap;** I would appeal to every clinician to consider carefully their activity in the context of the economic position nationally and locally.

Finally, in terms of actions, I am very keen to ensure that we continue the clinical dialogue we have started in adversity. I firmly believe that it is only we as clinicians who can properly solve the economic crisis that faces the NHS, and the brief dialogue we have had has once again highlighted the fundamental willingness and enthusiasm of clinicians to embrace improvement and change, as well to acknowledge austerity. Completing this exercise has proven again that there are no magic solutions; in the end it will be down to the behaviour of clinicians to ensure that the NHS runs as efficiently and effectively as possible, balancing the legitimate healthcare needs of the population within the financial envelope available, and offering a high quality health service alongside value to the tax payer.

In the first instance I attach a detailed collation of and response to the concerns and suggestions provided to me. I will be making arrangements to meet with the wider clinical community in a further series of drop (back) in sessions during January to take this forward. In the meantime we will be setting up a number of topic related discussion forums on the Clinical Network, accessible through the PCT's website. Registration is straightforward - your contributions are both read and valued.

Thank you once again for your contribution to the debate; I do hope you will choose to be actively involved in the future, either through the face-to-face opportunities I've described or via the Clinical Network. I trust that we can rely on your co-operation to implement those things we've agreed and look forward to continuing to work together on solving the economic conundrum that faces us all.

Yours sincerely,



Dr James Thallon
Medical Director

Prioritising Treatments in West Kent – Summary Feedback
December 2010

Proposed Initiative	Feedback	Response	Action
Consultant-to-Consultant Referrals	Most clinicians conditionally supported this initiative but with multiple and various exclusions proposed There was a lack of consensus amongst clinicians about the threshold at which a GP would wish to have control over C2C referrals Lay respondents expressed concern about the potential to extend waiting times and thereby negatively impact outcomes	The multiplicity of exclusions makes this initiative both extremely challenging and potentially costly to implement. The imposition of a blanket ban was felt likely to cause delay, error and thus clinical harm	No direct PCT action but consultants asked to take personal action wherever possible A large number of opportunities for an improved dialogue between primary and secondary care were identified. These will be taken forward individually. Most will have benefits in both clinical quality and operational efficiency
Routine Elective Surgery	There was a preference to extend average waiting times for non-urgent treatment for all rather than penalise individual specialities. The perceived excess of activity in the independent sector was singled out for criticism	The need to spread the inconvenience of increased waiting times equitably within the system is acknowledged.	PCT to work with acute trusts to agree suspension of all elective activity for a period to be determined
Routine elective surgery and patients who smoke	Difficult to enforce. Concerns over equity and ethics. Acknowledgement of the clinical benefits and a wish to do more to deliver these.	Difficulty in implementation of blanket imposition acknowledged.	Public Health to work up plan with clinicians for implementation by April 2011 latest
Selected elective surgery and patients with a BMI >30	The evidence base behind this intervention was felt to be relatively weak compared to smoking and the means to deliver a pre surgical intervention to such a large potential population were felt to be sparse.	The PCT acknowledges this, and will progress the smoking initiative first.	Public Health to work up plan with clinicians for implementation during 2011
Short Stay Admissions	No specific comments received		PCT will work with acute trusts to agree a common tariff for short stay admissions wherever they are in the hospital

Proposed Initiative	Feedback	Response	Action
A&E	A&E was identified as 'the crucible' in terms of the impact of service restriction upon acute trust and health economy functioning. A wide variety of ideas were identified which might seek to improve demand management both in the short and medium terms.	A number of promising ideas and potential interventions were suggested that will feature in the feedback document.	The Urgent Care Boards are seeking to implement a number of immediate operational improvements.
Primary care non-GP referrals	A number of secondary care clinicians provided verbal feedback that this category of referral was generally more variable in quality than GP referrals. There is little empirical evidence to support this, but the assertion received support from more than one source in secondary care.	The scope of this referral source is not well understood in primary care. Action to increase knowledge and control in this field may assist GP commissioners in the long run. A number of exceptions may present themselves as reasonable once exposed.	Implement with immediate effect
Prescribing	There were some reservations expressed over 28 day prescribing, both in terms of possible savings as well as widespread concern over the inconvenience that would be caused to patients.	The potential for a one-off saving in this field will be the subject of a proposal by the Medicines Management department of the PCT.	The PCT will generate a proposal which will be subject to further consultation before implementation.
Low Priority Procedures (LPP)	There were a couple of specific queries about this policy, but there was widespread acceptance of the need for such guidance for clinicians.	The LPP document is always open to reasoned amendment, and we welcome comments upon individual pathways. We plan to develop this further as a Kent & Medway wide policy statement.	The LPP policy and its development will continue as already agreed.
Bariatric Surgery, IVF and Gender Reassignment	There was concern as to the equity of singling out these groups for individual attention	Treatment is to be delayed and not stopped, and the potential for this relatively brief delay to cause clinical harm is felt to be minimal. Urgent cases will be treated without delay at the clinician's discretion.	Implement with immediate effect

Reducing Variation	Obvious in everyday clinical practice in both primary and secondary care. There was recognition that outlying clinical behaviour must be firmly tackled.	There is substantial activity in primary care in this respect, with evident effect at the level of the individual or practice. The principle is well-established in secondary care, for example in MDT or Clinical Governance work, but needs further extension into other fields, for example non-elective care.	Clinical variation will be challenged in both primary and secondary care whenever it occurs. In addition, particular areas will be specified to target primary and secondary care improvement in practice.

Appendix 3 - Summary of QIPP proposals at March 2011

Commissioner based QIPP Expectations 2011/12

as at 14 March

Workstream	Expected Benefit £m	Current plan £m
Acute care	-38.00	-5.48
Children & YP	0	-0.75
EOLC	0	-0.20
LTC	-7.26	-1.71
Mat/newborn	0	0
MH	-2.94	-2.72
Planned Care	-4.83	-10.44
Staying Healthy	1.66	0.25
Back office	-1.89	-1.89
CSU	-3.00	0
CSU-prim care	-5.50	-2.55
Digital vision	0	0
Estates	-2.00	0
Meds Man.	-4.37	-6.90
Safe Care	0	0
Pathology rat.	0	0
Workforce	0	0
TOTAL	-30.51	-30.89

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