



AGENDA

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Friday, 12th October, 2007, 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 (17)

Conservative (12): Lord Bruce-Lockhart (Chairman), Mr A R Chell, Mr B R Cope, Mr A D Crowther, Mr J Curwood, Mr J A Davies, Mr D A Hirst, Mrs S V Hohler, Mr G A Horne MBE, Dr T R Robinson, Mr R Tolputt and Mrs E M Tweed

Labour (4): Mr M J Fittock (Vice-Chairman), Mrs C Angell, Ms A Harrison and Mrs E D Rowbotham

Liberal Democrat (1): Mr D S Daley

UNRESTRICTED ITEMS

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

Item	Timings
1. Substitutes	
2. Declarations of Interests by Members in items on the Agenda for this meeting.	
3. Minutes - 7 September 2007	
4. Reprovisioning of residential-support Learning Disability Services (Eastern & Coastal Kent PCT)	10:10-11:15 am
<i>Sue Gratton, Joint Planning and Development Manager, Learning Disability Service, Eastern & Coastal Kent PCT will be in attendance for this item.</i>	
Break 11:15-11:30 am	
5. Local Delivery Plans for Eastern and Coastal Kent and West Kent Primary Care Trusts	11:30 am-12:45 pm
<i>Julia Ross, Director of Civic Engagement, West Kent PCT and Lynne Selman, Director of Citizen Engagement and Communication, Eastern & Coastal Kent PCT will be in attendance for this item.</i>	
6. LINKs update	12:45-1:00 pm
<i>Martyn Ayre, KCC Senior Policy Manager, will be in attendance for this item.</i>	

7. Date of next programmed meeting – **Friday 9 November 2008**
commencing at 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)

Stuart Ballard
Head of Democratic Services
(01622) 694002

4 October 2007

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

NHS OVERVIEW & SCRUTINY COMMITTEE

MINUTES of a meeting of the NHS Overview and Scrutiny Committee held at Sessions House, County Hall, Maidstone on 7 September 2007

PRESENT: Lord Bruce-Lockhart (Chairman), Mrs C Angell, Mr L Christie (substituting for Mr M J Fittock), Mr B R Cope, Mr A D Crowther, Mr J Curwood, Mr D S Daley, Ms A Harrison, Mrs S V Hohler, Mr G A Horne MBE, Mr I T N Jones (substituting for Mrs E D Rowbotham), Dr T R Robinson, Mrs P A V Stockell (substituting for Mr J A Davies), Mr R Tolputt and Mrs E M Tweed.

OTHER MEMBERS PRESENT: Mr G K Gibbens (Cabinet Member for Public Health), Mr C J Law, Mr S J G Koowaree.

ALSO PRESENT: Mrs C Swann (Maidstone & Weald Locality Group, West Kent PCT PPIF; Kent & Medway Mental Health & Social Care PPIF), Mr J Larcombe (Maidstone & Weald Locality Group, West Kent PCT PPIF), Mr B D Russell (SECAMB PPIF Lead, Kent Locality Group), Mr J A Ogden (Chairman, KCC Standards Committee; non-executive director, West Kent PCT), Julia Ross (Director of Civic Engagement, West Kent PCT) and Lynne Selman (Director of Citizen Engagement and Communication, Eastern & Coastal Kent PCT).

IN ATTENDANCE: Ms D Fitch (Assistant Democratic Services Manager – Policy Overview) and Dr D Turner (Research Officer to the NHS Overview & Scrutiny Committee).

UNRESTRICTED ITEMS

48. Minutes

RESOLVED:- that the Minutes of the meeting held on 20 July were correctly recorded and that they be signed by the Chairman.

49. Potential to Restructure and Refocus the NHS Overview and Scrutiny Committee

(Item 4 – Report by Overview and Scrutiny Manager)

(1) The Chairman introduced the paper on restructuring and refocusing the Committee. He highlighted the need to update the protocol for the operation of the Committee, which dated from 2001. Discussions were to be held with District Council colleagues in relation to the potential to formally delegate to them some of the statutory powers of the NHS Overview and Scrutiny Committee. The Chairman emphasised that the Health scrutiny function must operate independently of the County Council's Executive; the Committee's independence was a vital element in discharging its role. In relation to the Work Programme, there had been discussions across the political parties and with health colleagues from East and West Kent to obtain their views. Tabled at the meeting was a list of potential items which had come out of these discussions. The Chairman stated that he had been impressed with the way that Parliamentary Select



Committees worked and he would like the Committee to work in a similar style. This would involve setting an agenda at least two to three months in advance and there being a greater understanding of the issues by Members prior to the meeting. This would give Members more opportunity to ask questions, rather than listening to presentations. He referred to the comments of Ms Ross, the Director of Civic Engagement for West Kent PCT, in relation to the way that the Committee worked, which had been circulated to Members. He emphasised that, while NHS colleagues would have an input into the Work Programme, it would also reflect the fact that part of the role of Members of the Committee was to represent patients' and residents' views, and to consider broader issues, including that of value for money.

(2) Members were then given the opportunity to discuss and comment on the issues raised in the document. In relation to the issue of access to health services, particularly as regards transport links, Members, as well as health service colleagues, had a role to play in helping to educate the public about the changing role of the Ambulance Service. This was particularly so in respect of the skill-set that ambulance staff now had and the impact of this on A&E services. It was noted that the South East Coast Ambulance Trust covered three counties and that, given this, the Kent Locality Group of the South East Coast Ambulance PPIF had a particularly important role to play.

Division of work between County Council and District Council Scrutiny Committees

(3) The Chairman reported that a meeting was being arranged with District Council colleagues to discuss the way in which a joint work programme, with delegation of certain items to District Scrutiny Committees, could operate. He stated that there was no fixed timescale for this but it would need to be dealt with as soon as possible.

(4) During discussion of this item the following points were made:-

- Over the last few years there had been much duplication of enquiries at District and County levels, and officers of various health service organisations had been called to a variety of meetings to give the same presentation. This was not productive or useful for either health service or local government colleagues.
- Health scrutiny discussions at District Council level were valuable in trying to gauge the opinions of local people for whom the NHS was trying to provide services. It was essential that elected representatives looking after the local community led on these issues; but they first needed to understand what the issues were and know what the potential service-delivery solutions were.
- The role of County Councillors was more strategic and they should be talking to PCTs as well as acute Trusts. There should be a separation of what the NHS Overview and Scrutiny Committee did at county level and what was done to scrutinise the health service at District Council level.
- The OSC should be able to request District Councils to look at issues in their locality and to come back with suggestions on the way forward.
- When engaging with District Council colleagues it was necessary to be aware that they operated in different ways – for example, their Members often worked during the day and, therefore, preferred to attend evening meetings. It would be necessary to think of innovative ways of engaging with District Council colleagues.



- It was important to meet with the District Councils and see what they would be willing and able to take on; and to have proper devolvement and engagement.
- If issues were devolved to District Councils it was important to have a feedback mechanism to NHS OSC, so that Members could be made aware of the outcomes of discussions.
- District Councils tended to want to be involved in local issues and were generally happy to leave the strategic issues to the County Council.
- Parishes also needed to be involved in this process, to avoid duplication of effort on the part of health service colleagues.
- Mr Phoenix made the point that on certain issues which were focused across a number of districts it might not be appropriate for this to be dealt with by just one of the districts. For example, regarding the proposed reconfiguration of emergency services at Maidstone Hospital, he did not believe that this was an issue that could appropriately be dealt with by Maidstone Borough Council, as it impacted on other districts.
- Working out which issues could be dealt with effectively by District Councils and which needed to be retained by NHS OSC involved achieving a delicate balance.
- It was important that the County Council had a co-ordinating role in relation to NHS Overview and Scrutiny. NHS OSC should be kept aware of what was going on at District level by reports back to the Committee.
- Consideration should also be given to having representatives from the County Council on some District Council Scrutiny Committees, as appropriate.
- It was important to have a draft protocol to form the basis of the discussion at the first meeting with District Councils. This should give a definition of which issues would be strategic and, therefore, retained by NHS OSC; and which could be classed as local and, therefore, possibly devolved to the Districts.

Meetings of the NHS Overview and Scrutiny Committee

(5) In discussion the following points were made about the work of the Committee:

- It would be helpful to look more than two or three months ahead when planning agendas.
- Half-day meetings of the NHS Overview and Scrutiny Committee were good, as long as it was possible to have a focused agenda.
- It was also useful from the point of view of public engagement and accessibility to hold meetings in appropriate locations depending on items on the agenda. This helped with engaging stakeholders.
- It would also be helpful for the Committee to consider holding site visits to complement its meeting agendas.

Other Issues

(6) In response to a question from a Member, Mr Phoenix stated that it was open to the NHS Overview and Scrutiny Committee to look at any NHS issue. However, it was only where there was a “substantial variation” to services that NHS bodies had



formally to consult the Committee. He confirmed that this was something that they welcomed doing as part as of their wider duty to consult with stakeholders. In relation to contentious issues, which could, for example, just mean that one or two people did not like the renaming of a service, it was necessary for the Committee to take a view on whether this was the type of issue that it would wish to consider.

(7) Mrs Angell asked for information on where LINKs fitted in with the work of the Committee and how Kent would be managing the LINKs programme. In response to this, it was agreed that a brief update on LINKs would be given at the next meeting.

(8) Mr Gibbens informed Members that a steering group on LINKs was being set up, which he would be chairing. The Chairman of the Committee, the Vice Chairman and the Liberal Democrat spokesman would also be Members of this group; and there would be representatives from the voluntary sector and PCTs. As part of this process, they would be holding focus groups across Kent in late October/early November working towards the establishment of LINKs by 1 April 2008. He anticipated that a formal decision would be taken on the establishment of LINKs in January or February next year. The Chairman emphasised the importance of the Committee having involvement in the development of LINKs on a cross-party basis.

(9) Ms Ross informed the Committee that she welcomed the general direction of travel outlined in the paper and was pleased to hear that the Committee would like to have a role in raising public awareness in relation to NHS changes. Ms Selman stated that discussions were underway with officers about having a robust induction for Members before the Committee's work was refocused. Ms Ross stated that a key challenge was to balance the list of items which the NHS had a duty to consult the NHS Overview and Scrutiny Committee about and other issues which the Committee might wish to raise with them.

(10) The Chairman stated that an important factor in enabling the Committee to carry out its statutory role on behalf of Kent residents was to have an understanding of the financial situations of local NHS bodies and to have confidence that money was being used in the best interests of Kent residents. Discussions could be held with health service colleagues to work out how best to do this.

(11) Mr Daley referred to what it could be argued were inconsistencies within West Kent PCT's "Fit for the Future" Summer 2007 Update document. It said that financial issues were not driving changes; but it also said that if the changes were not made, money issues would force them to be made. He referred to the removal of the Pain Clinic from Maidstone, which he believed had occurred for financial reasons. Mr Phoenix said that the document might sound contradictory but it was not. He explained the situation in relation to the efficiency savings which NHS bodies were required to make year-on-year. In some areas, the NHS faced financial pressures in addition to the requirement to make efficiency savings; this was not the case in Kent. He stated that the nature and pace of change in the health service was faster than he could ever remember it; and the key driver was the need to improve standards. He gave the example of the stroke standards. He stated that it was a challenge to find a way within the existing financial context to make progress in relation to quality standards. It was important to make sure that scrutiny was not a barrier for change. Some changes were difficult for institutions, practitioners and patient groups to feel comfortable with. There was a need for all those involved to collectively keep their eye on the aim which was to ensure the best health service for patients.



(12) The Chairman pointed out that the Committee was made up of elected Members who would wish to speak up robustly on behalf of patients and residents where they felt it was necessary – but the aim was to be constructive.

(13) RESOLVED:-

- a) That the suggestions set out in paragraph 9 of the report be endorsed and that it be acknowledged a large amount of work needed to be done to achieve these.
- b) That the Committee welcome the work being carried out to revise the protocols, including discussions with NHS and District Council colleagues, regarding the delegation of some issues to District Councils and the establishment as part of this of a clear reporting-back process to the Committee.
- c) That a brief update on LINKs be given to the next meeting of the Committee in October.
- d) That the proposal for an induction/briefing day for Members be welcomed.

50. Tackling Obesity Select Committee – Monitoring Report on how the recommendations of the Select Committee are being taken forward

(Item 5 – Mr Graham Gibbens, Cabinet Member for Public Health, and Mr Mark Lemon, Policy Manager, Kent Department of Public Health, were in attendance for this item)

(1) Mr Gibbens referred to the Tackling Obesity Select Committee report which had been published in December 2006 and commended the excellent job done by the Select Committee. He stated that the recommendations made by the Select Committee had been a useful tool to highlight the roles of the various agencies involved. He referred to £900,000 that had been secured from the Big Lottery Fund to finance a wide range of programmes and projects designed to improve levels of physical activity, nutrition and mental wellbeing across the county. This was a result of successful partnership working between the Primary Care Trusts, KCC Directorates and the Kent Department of Public Health. He informed the Committee that for the first time in three years the full allocation of *Choosing Health* money to PCTs had been designated for use on public health interventions. Attached to the report before the Committee was an action plan which detailed the main activities currently being undertaken to support the recommendations in the Tackling Obesity report. A Kent-wide Obesity Strategy was currently being drafted and should be issued for comment very shortly.

(2) Members asked a number of questions on the action plan. Mr Gibbens acknowledged that some of the recommendations were challenging and that it was important that this was brought out in the action plan and response to the recommendation. Mr Lemon stated that some recommendations were being taken forward in other ways – for example, in relation to Recommendation 7, the NICE guidelines on GPs prescribing exercise to patients should move this forward at a national level. The Obesity Strategy would set out these issues and also would have an action plan that had measurable outcomes.



(3) In relation to a question on the *Choosing Health* money for Kent PCTs Mr Gibbens confirmed that details of how this money was spent would be submitted to Cabinet and to the Committee.

(4) RESOLVED:- that the progress made on the recommendations of the Tackling Obesity Select Committee report be noted.

51. Dartford and Gravesham NHS Trust's Application for Foundation Trust Status
(Mr Mark Devlin, Chief Executive, Ms Susan Acott, Director of Performance and Service Development, and Ms Jenny Kay, Director of Nursing and Workforce, Dartford & Gravesham NHS Trust, were in attendance for this item)

(1) The Chairman welcomed Mr Devlin, Ms Acott and Ms Kay to the meeting.

(2) Mr Devlin referred to the paper produced by the Trust, which had been circulated with the agenda for the meeting, and gave some background to the Foundation Trust application. He stated that he was primarily looking for views on the Trust's proposed service strategy in terms of the areas of service that the NHS Overview and Scrutiny Committee might like to see developed. He pointed out that it was proposed to give the County Council the opportunity to be represented on the Foundation Trust's Council of Governors.

(3) Members then asked Mr Devlin and his colleagues a number of questions in relation to the financial status of the Trust, the rationale for Foundation Trust status and the future relationship of a Foundation Trust with the NHS Overview and Scrutiny Committee as regards accountability.

(4) Mr Devlin gave assurances about the financial status of the Trust and stated that the Trust Board would not be proceeding with the Foundation Trust status application if they were not confident of their financial situation. He confirmed that the Trust had moved from a £4 million in-year deficit (equivalent to 4% of turnover) in 2005–6 to an in-year surplus of £250,000 in 2006–7. The Trust still had a £1.8 million underlying deficit (resulting from the Resource Accounting and Budgeting regime, which had now been removed from the NHS), but anticipated clearing this in the next two years by means of achieving further in-year surpluses. An in-year surplus of £500,000 was anticipated in the 2007–8 financial year. Responding to a question on what management action had been taken to move from deficit to surplus, Mr Devlin explained that this had had a series of strands. Expenditure on pay had been curtailed by means of reducing temporary (bank and agency) appointments, carrying out a workforce review and making a number of posts redundant. Mr Devlin said that a very aggressive programme of redeployment had meant that few individual members of staff had been put at risk of redundancy. In response to a question on what arrangements there were if a Foundation Trust went into deficit, Mr Devlin replied that the NHS would still act as a guarantor regarding repayment of any debts and that the Foundation Trust would have to demonstrate to "Monitor", the regulatory body, that they could service any loans that they sought. He emphasised that as a PFI hospital they had only a small number of assets that they actually owned and therefore the issue of the Foundation Trust being able to sell off assets would not arise.

(5) Mr Devlin was asked whether the Trust would be aiming for services currently provided at London hospitals to be provided by Darent Valley Hospital. He confirmed that the Trust had good links with the London teaching hospitals of Guy's and



St. Thomas's, which were also run by a Foundation Trust, and that his Trust shared consultants with those hospitals. He stated that his Trust wanted to maintain links with them while aiming to offer more services at Darent Valley Hospital.

(6) In response to a question on the impact of the Trust's PFI contract on its finances, Mr Devlin said the PFI had given the Trust a 21st-Century building in which to provide 21st-Century healthcare. He confirmed that he had modelled the costs of the PFI contract on the future budget and he was confident that they could manage the costs. The PFI contract represented a fixed cost and the Trust's income was growing. A few years ago, the cost of the PFI contract had amounted to 19.5% of the Trust's turnover; that figure was now 17.5%.

(7) Mr Devlin said that the Trust was sincere about its relationship with local government. This was shown by the fact that it had offered two places for local authority representatives on the Council of Governors – which they did not have to do. Ms Kay confirmed that the Foundation Trust would still have a duty to consult on service reconfigurations and such consultation would involve the NHS Overview and Scrutiny Committee. She reminded the Committee that their history had been one of openness and engagement and they were intent on carrying this on.

(8) The Chairman stated that the issue of appointing Governors to represent KCC was not a matter for the Committee but that the appointments would be made by the Council's Executive. Mr Devlin confirmed that he was not expecting a decision on this from the meeting but had mentioned it to keep the NHS Overview and Scrutiny Committee abreast of progress. The aim of bringing this paper to the meeting was to give the Committee the opportunity to influence matters.

(9) In response to a question on the statutory "cap" on the amount of money that could be made from private patients by Foundation Trusts, Mr Devlin said that this was to stop Foundation Trusts "privatising by stealth". There was no scope for his Trust to grow this part of their service and they had no intention of doing this anyway, as they wanted to provide an NHS service for their patients.

(10) Regarding the impact of market forces arising from Patient Choice, Mr Devlin stated that, while patients did have a choice, his Trust and the Medway NHS Trust (which was also on the way to becoming a Foundation Trust) actually co-operated closely and did not seek to destabilise each other.

(11) In relation to the Trust's membership strategy, he confirmed that in order to engage with potential members, forums had been held in a number of pubs in the area; and when people came to the hospital they were given the opportunity to become members.

(12) He stated that the staff in Darent Valley Hospital were proud of their hospital and would like to have the opportunity to be the first Foundation Trust in Kent – which would be motivating for staff, and help retain and attract staff.

(13) Mr Devlin reaffirmed that his Trust worked in partnership with other hospital Trusts and was not looking to take over, for example the specialist cancer services that were provided in Maidstone. The aim was that elements of care that could be provided locally should be and that specialist care would still be provided in specialist centres. He stated that the watchword was "partnership".



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(14) Dr Robinson stated that the Trust had not had much time to develop since its 2006 Foundation Trust status application, but it was providing excellent services. It had repatriated cancer services, developed a Heart Centre and expanded maternity services, with a new midwife-led unit opening. He believed that this was the sort of thing that the Committee should be looking at in relation to the Foundation Trust application and that the Trust should be congratulated on these developments. Mr Devlin confirmed that the areas of service that the Trust had developed and grown were for local people and were flexible. The Foundation Trust would invest in services and the question that the NHS Overview and Scrutiny Committee was being asked was whether these were the right services to provide.

(15) The Chairman stated that he would like to have further discussion in relation to the outstanding issues regarding accountability of Foundation Trusts; and that the matter of appointment of Governors would be referred to the Executive. On the issue of the accountability of the Trust and the role of the Committee, he expressed his thanks to Mr Devlin for saying that he wanted to work closely with the Committee. If the Trust was successful in its application, the Chairman looked forward to seeing him back at a Committee meeting. In relation to the appointment of Governors, a feedback mechanism to the Committee should be established.

(16) It was noted that further comments from parish councils, submitted after the papers for the meeting had been despatched, had been tabled.

(17) The Chairman moved that the Committee reassert its unanimous decision made in 2006 to support the Foundation Trust application by Dartford and Gravesham NHS Trust. The matter was put to the vote with 10 votes for the motion, three abstentions and one vote against.

(18) RESOLVED that the Committee reassert its support for the Foundation Trust application by Dartford and Gravesham NHS Trust.

52. Date of next programmed meeting

(1) It was noted that the next programmed meeting of the Committee would be held on Friday 12 October 2007 at 10:00 am.

Chairman _____

Date _____

To: NHS Overview & Scrutiny Committee – 12 October 2007

Subject: Re-provision of NHS supported accommodation in Kent

Introduction

1. The White Papers “Valuing People” and “Our Health, Our Care, Our Say” made it clear that people with learning disabilities should enjoy the same rights as other citizens and should no longer have to live within the NHS. The latter White Paper set a deadline of 2010 by which NHS should stop providing long term residential support.
2. The recent reports of the Healthcare Commission (Cornwall and Merton & Sutton) highlighted the deficiencies of the NHS residential support and have led to a national audit of all such services.
3. A commissioning plan has been developed, setting out a programme to transfer the support currently provided by the NHS in Kent to independent providers with a development path to create a wider range of housing and support options to meet people’s person centred plans. This plan aims to be consistent with the wider strategy in Kent of reducing reliance on residential care.
4. This paper aims to inform the Kent Health Overview and Scrutiny Committee on the content of the commissioning plan and progress to date.

Aims

5. The commissioning plan aims to:
 - a. Meet aims of Valuing People:
 - Person focused
 - Choice and Control
 - Support independence
 - Inclusion
 - Fulfilling lives
 - b. Transfer support out of NHS provision/ NHS managed services.
 - c. Base resources on needs.
 - d. Reduce reliance on residential care and increase supported living.
 - e. Develop and diversify market.
 - f. Be consistent with and enable KCC’s strategy of reducing reliance on residential care in Kent.
 - g. Carry out the programme of work in partnership with all interested parties.
 - h. Transfer commissioning to KCC via Section 28A – future potential S31.
 - i. Be cost neutral to the PCTs and KCC for the resultant provision.

Scope of the Plan

6. In East Kent, Eastern & Costal Kent PCT provides unregistered residential care to 45 people and registered domiciliary care to an additional 33. We are

including both groups as part of this re-provision programme although the second group does not meet strictly the definition of campus as set out in the White Papers referenced in paragraph 1.

7. In West Kent, Kent & Medway Partnership Trust provide unregistered residential care to 97 (was 102) people with Learning Disability, which are included in this re-provision programme as Eastern & Coastal Kent PCT acts as host commissioner for learning disability.
8. Excluded from the scope are 8 West Kent people currently cared for by KMPT in settings, which would meet the campus definition set by the Department of Health. However one client is currently on a discharge path at the Assessment and Intervention Service, and 7 other clients are at Woodend, a long term step down facility, where future service design is under review.

Maintaining a person centred focus

9. Individual person centred plans (PCP) and service designs will be the building block to the programme of change. Individuals will be supported by their circle of support to develop their plan. Their circle of support should include people chosen by the individual and it is envisaged that the circle will include a relative and / or an advocate, a member of staff who knows the person well, someone who will facilitate the group and anyone else who is important to the individual.
10. A care manager will collate the key recommendations from the PCPs to build up a commissioning picture of requirements so that support and housing can be identified and procured to meet individual service designs.

Procurement of support

11. Whilst the market is very large in Kent for residential care it still provides limited choice, thus the aim of this plan is to increase the range of living options available to people and to reduce reliance on residential care.
12. Wherever feasible and providing it is consistent with person centred plans, supported living will be the aim for type of provision to be commissioned. This will be consistent with national and local policies to reduce reliance on residential care and increase opportunities for equality of access to normal housing and greater inclusion in the community. Supported living provides the appropriate level of support to meet individual needs in the person's own home.
13. Existing providers of residential care will be encouraged to re-focus their business on supported living, some already are moving in this direction. Existing providers of supported living will be encouraged to consider limited expansion in areas where there is a lack of supported living.
14. The programme will be split according to procurement methodology which reflects current work in progress or the need for change in people's living arrangements, i.e.
 - a. Group 1 – Continue with current work in progress to find individual move-on plans. (28 people)

- b. Group 2 – Current living arrangements meet individuals plans, no property or staffing issues to address – identify providers to transfer existing services for continuity of existing service. (47 people)
 - c. Group 3 – Services which do not meet individuals plans, properties not fit for purpose or staffing issues and require complex change to deliver new living arrangements for individuals – identify providers to whom service can transfer and can develop new arrangements. (101 people)
15. Within each of the above project groups there will be distinct phases of work. The project Board's approval will be required to agree these phases and will need to give authority for each phase to commence. This will ensure appropriate control of the programme.
16. It is intended that the procurement process will be consistent with KCC purchasing guidelines. The process will be developed with KCC as it is envisaged that the new contracting arrangements will sit within either a Section 28a Agreement* or preferably a Section 31 Agreement**.

Procurement of housing

17. Most of the housing stock used in the existing NHS provision is owned by the NHS provider organisations. The delivery of the project's objective is reliant on these assets being ring-fenced for future use or sale and re-investment into this programme.
18. The Estates strategy must help to deliver the objectives of the overall project by:
- Facilitating choice and independence by providing the means to deliver affordable housing for individuals to lead as independent lives as possible;
 - Ensuring the assets and capital invested in the projects are used for schemes which ensure value for money and provide flexibility of use in the long term;
 - Making sure all possible housing options are explored including council housing, shared ownership schemes and use of clients' own assets where appropriate.
19. Steps to Procurement of housing involve:
- a. Assess Needs: Through Person Centred Planning, produce a requirement of where, how and with whom people wish to live.
 - b. Assess Capital available: This will involve valuation and condition survey of any available capital, including any additional capital that can be made available through Department of Health or Housing Corporation, and client use of their own asset or mortgage contribution through shared ownership schemes where appropriate.
 - c. Agree Systems and processes to transfer this capital so it can be used to provide social housing for clients under the supported living model, where appropriate.
 - d. Tender for any building / refurbishment work as appropriate.

** Section 28a Directions come into force on 1 April 2000 and govern powers of money transfer between NHS and local councils introduced by the Health Act 1999.*

*** The Section 31 partnership arrangements in the Health Act 1999 have been developed to give NHS bodies and local authorities the flexibility to be able to respond effectively to improve services, either by joining up existing services, or developing new, co-ordinated services, and to work with other organisations to fulfil this.*

Community Teams and Clinical Support

20. People living in the NHS have had a varied amount of access to the Community Teams. Some individuals are well known to the community teams while others have had no or limited access to the teams. Very few have had access to a Care Manager.
21. As people move out of the NHS it is important that they have the same access to community support as other people. The components are:
 - Care Management: People will need a community care assessment. In Dartford a Care Manager has been funded through the Learning Disability Development Fund to do the assessments and help people move on. This post was specifically funded to work with the people who lived at Greenacres (Archery House), an NHS campus in Dartford. It is anticipated that similar support will be required elsewhere. In addition, future ongoing needs of the individuals will need to be assessed. Existing section 28a agreements between the PCTs and KCC have allowed for the provision of care management and it is envisaged that this mechanism can be used again.
 - Clinical Support: A distinct work-stream of the project plan will be dedicated to identify if there are any clinical support resource requirements, based on mapping of existing support needs of the target population. The finance appendix assumes future needs in community nurses and this will need to be reviewed in light of overall clinical support. The joint working protocols for Learning Disability and Mental Health, which are in the process of being approved, should provide a sound platform to build on.

Consultation and Communication

22. Formal consultation of interested parties will be undertaken, according to section 7 of the Health & Social Care Act 2001. It is anticipated this will start in October 2007. Due to the complexity and number of audiences involved, a communication plan (attached) has been produced to capture all audiences and required communication timetable. An essential element of the communication plan is to present information in easy to understand formats. The plan and progress against it will be reported to the Project Board that oversees the re-provision programme.

Project Management

23. A Project Board has been set up to oversee the re-provision programme and reports to the Kent Strategic Learning Disability Board (chaired by Oliver Mills).

The Project Board is chaired by David Meikle, Director of Finance and Commissioning for ECK PCT. The project Board includes decision makers in each of the organisations involved (Kent County Council, East & West Kent PCTs and both NHS provider organisations). It also includes representation from the third sector, the Kent Learning Disability Partnership Board and the Joint Planning and Policy Board for housing.

24. A Scheme of Delegation has been agreed, which grants the above Project Board delegated authority to commit project resources and agree tendering and contractual arrangements for the programme to be completed successfully.
25. The Project Board has been meeting monthly since June 2007.

Progress Report

a) Individual move on plans

26. In East Kent, 8 people have moved on to support in the independent sector in recent years, resulting in the closure of 2 services previously provided by the PCT.
27. A further 33 people are living in supported living accommodation. The people remain supported by PCT staff who are part of PCT's domiciliary care agency, the next step will be to outsource this support.
28. There were previously 62 people living at Greenacres in Dartford. There remain 10 people living at Greenacres at August 2007. All but 4 people moved to other provision managed by KMPT, including 2 x 5 people bungalows (Shore Lodge) purposefully designed for older people on the original site. Thus whilst people have moved from the original campus, they have not moved out of the NHS. There is a need to find alternative providers of care. There are currently 7 move-on plans in progress a service still needs to be identified for the remaining 3 clients.
29. Two people have moved on in July 2007 from other services managed by KMPT in west Kent, and there are a further 7 move-on plans in progress in these services.

b) Wider strategic work

30. The Project Board has been established and commissioning plan approved and further developed.
31. The project team has received support from consultants, commissioned by the national Valuing People Support Team. This has provided useful mentoring on the plan and specific help with some of the workstreams, e.g. developing providers, housing and person centred planning. A recent review of the plan with the consultants indicated that substantial progress had been made in the last six months.
32. A register of risks for the project has been established and is monitored regularly by the Project Board. A range of risks have been identified with management action to reduce impact of the risks. However two areas of risk are

worth noting. Agreement of the regulatory body – Commission for Social Care Inspection (CSCI) – to the plan is required as the majority of services are currently unregistered and would not meet CSCI standards. A meeting has been arranged with CSCI to share the plan and seek their support. The second area is around the agreement to fund necessary project costs, this is a matter for ongoing scrutiny of the Project Board.

33. In July two workshops were held, one for providers of support and one for housing agencies. These proved useful in introducing the aims of the commissioning plan, sharing knowledge and ideas and establishing a network of contacts. Through KCC a networking forum of support providers is to be established as a direct result of the first workshop.
34. Recently the Department of Health advised that £175 million of capital is being made available over the next three years to assist the NHS campus closure programme across England. The project team is currently working on a bid for this capital.
35. A communication plan has been produced and a consultation leaflet is currently being prepared.
36. The Project Board has considered and approved some of the processes and related resources necessary to carry out the project. Once the first phase of approval, including formal consultation, has been completed, the project can move on to the next phase of tendering for services.

Conclusion

The HOSC is asked to note the substantial progress which has been made in the set-up phase of the project and individual move-on plans, and the further work required to complete the programme successfully. The HOSC is asked to endorse the future direction of this plan, the outcome of which will provide substantial benefits for people with learning disabilities in Kent.

To: Kent County Council's NHS Overview and Scrutiny Committee – 12
October 2007

From: Eastern and Coastal Kent PCT

Subject: Local Delivery Plans

1.1 Introduction

Local Delivery Plans (LDPs) are the vehicle for the NHS and local authorities to set out how they will take forward and meet key targets within locally-available resources and priorities for investment or service change.

They are designed to deliver against health and social care standards which act as planning guidelines. They are the main performance framework for local implementation of plans against available resources, and for reporting against specific milestones.

They cover a three year period with annual deliverables and trajectories for change within them. They incorporate Public Service Agreement targets, and are closely aligned to LA planning timescales. The framework for NHS and social services authorities to use in planning for the next three years and the standards which all organisations should achieve in delivering NHS care are set out in "National Standards, Local Action: Health and Social Care Standards and Planning Framework (currently available from 2005-07/8).

1.2 The LDP business planning process is similar each year, in that organisations, clinical services and practice-based commissioning clusters of GPs, are required to develop business and service plans, detailing priority work-streams. In addition, where new funding is required through the LDP process, they will also be required to draft individual business cases for consideration by the relevant commissioning groups in the PCT.

1.3 Timescale: The process usually commences in early November with a view to sign off of SLAs with provider organisations by 31st March.

1.4 National guidance is not yet available for 2008/9, but as mentioned above, the LDP covers three years and therefore progress over the last two years' requirements will need to be demonstrated. PCTs are currently producing *Strategic Commissioning Plans* setting out the framework within which our Local Delivery Plans will be drafted.

2.1 Arrangements in Eastern and Coastal Kent PCT

ECK PCT was formed in October 06 from five former EK and Swale PCTs. The PCT covers c710, 000 people and its income is in the region of £1 bn.

For the purposes of the LDP, key working relationships are required across:

- Practice based commissioning clusters (12)
- Our own PCT provided services

- SE Coast Ambulance NHS trust
- K and M NHS and Social Care Partnership Trust
- East Kent Hospitals Trust
- Medway Maritime Hospital Trust
- KCC Adult SS; Kent Children's Trust
- Local authorities (especially local strategic partnerships)
- Specialised services and other providers.

The PCT is committed to a robust, open and transparent service, linked to key national objectives, such as the 18 week referral-to-treatment target; increased choice/choose and book; "choosing health" (egg stop smoking and reducing obesity), reducing delayed discharges etc.. These work-streams are brought together under the umbrella long-term "Fit for the Future" programme – see recent update document (issued Summer 07).

The PCT's *Strategic Commissioning plan* (setting out plans for the next **five** years) is currently being drafted. We have produced a short document in September 07, which has been sent to our 800-strong "Virtual Panel" to enable them to comment on the issues & priorities that are important to them before the document is produced. (Copies will be made available to the HOSC).

The various plans fit together as follows:

- **"Fit for the Future"** is the strategic framework for next 10 years (it takes account of changes in demographics, expected long term income/growth; new technological and medical advances etc.);
- **The strategic commissioning plan** sets out the next five year's aspirations/plans;
- The **local delivery plan** (LDP) is reviewed and refreshed annually but provides a rolling 3 year plan; The PCT is also required to produce a public document entitled the **"PCT Prospectus"** – the first of which is due in March 08, setting out its commissioning plans and how citizen engagement/patient engagement has influenced those plans.
- Each local health organisation produces **annual business plans**

2.2 Patient and Public involvement in commissioning processes within ECK PCT

This includes the following:

- As mentioned above, an update on FFF work was sent out to 7500 individuals and organisations in Summer 07, setting out key work-streams and describing how to engage with our work.
- A document has been sent out (end September 07) outlining some of the key areas to be included in the Strategic commissioning plan, asking members of the PCT's "Virtual Panel" for comments on priorities and areas of focus locally.

- This dialogue will continue throughout the strategic planning and LDP processes
- Individuals (expert patients, PPI Forum members etc.) have been linked to commissioning work-streams and will be supported in this role via our *Patient and Public reference group*, who will also advise on methods of engagement, depending on the issues under consideration.
- Support is being set up in the form of “toolkits” and training for commissioners to assist them in identifying when and how to engage with our public, including in the production of LDP business proposals.
- A *consultation scrutiny group* has been set up comprising a mixture of PCT and other Trust communications and engagement staff, and PPI forum members, Social Services. The purpose of the group is to scrutinise draft consultation documents for readability; accessible key messages; target audiences etc.
- The PCT in 07/8 has made funding available (£100k per local district council area) to pump-prime health and wellbeing partnerships. A key part of the work of these partnerships will be to engage with local people, including voluntary groups, to identify what will work in each area to improve health. Ongoing funding for these projects will be the subject of LDP bids.
- LDP proposals will need to demonstrate the patient and public engagement in developing the plans and how they will be engaged in the ongoing implementation and monitoring of service developments. Similarly Equality Impact Assessments will be required.

3. Process in 08/9 for LDP funding in 09/10 in ECK PCT

The LDP process for the coming year is currently under discussion. More-detailed information will be available for a verbal update at the HOSC meeting on 12th October.

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West Kent



Primary Care Trust

LOCAL DELIVERY PLAN

FRAMEWORK FOR

2008-09

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1. SUMMARY

- 1.1 This paper summarises the process for building and agreeing the Local Delivery Plan (LDP).
- 1.2 The process is a year round cycle and is integral to the delivery of the PCT's Strategic Commissioning Plan. Whereas the SCP covers a period of up to five years, the LDP is a 3 year rolling plan, which identifies the PCT's sources of funding and describes how they will be applied.
- 1.3 The LDP will address delivery of targets and standards across the following three dimensions
 - (i) Key National priorities, published through the NHS Operating Framework
 - (ii) Local priorities as a result of production of the PCT's Strategic Plans
 - (iii) Priorities drawn from the fast emerging Practice Based Commissioning Groups (PBCGs)
- 1.4 The PCT will assess risks to delivery in relation to each of these areas and shape its investments proportionately; which will be described through the LDP.
- 1.5 Due to the dynamic nature of NHS funding and progress on achieving key targets and standards, the LDP is much more detailed for year 1, with indicative spending frameworks for years 2 and 3.
- 1.6 Importantly, the LDP creates the financial, activity and quality framework for contract negotiation year on year.
- 1.7 The following paragraphs describe the indicative timeline for moving from need analysis and risk assessment, through to Service Level Agreement and Contract negotiation, and final PCT Board sign-off.
 - (i) Although **identification of need and planning requirements** is iterative and ongoing, quarters 1 & 2 of the financial year serve as the focus for this stage of the process in planning the subsequent year's delivery
 - (ii) Quarter 3 serves to bring together **risks, priorities and commissioning requirements** (including productivity metrics) with the financial framework for delivery.
 - (iii) Quarter 4 refines these requirements and provides **time for detailed Service Level Agreement** work as well as final PCT Board agreement of the LDP.
 - (iv) It is only through successful Service Level Agreement and Contractual negotiation with a range of providers across the spectrum of care that the LDP can be delivered. It is therefore important that all agreements are reached by February each year, allowing time for provider budget setting and final sign-off of the LDP by the PCT Board in March of that year

2. CONTEXT

2.1 West Kent PCT was established on 1 October 2006, bringing together the three former PCTs covering Maidstone and Maidstone Weald, South West Kent and Dartford Gravesham and Swanley. The total population is 655,700, expected to grow to over 705,000 (7.5%) in the next 15 years.

2.2 The PCT has 3 main functions:

- (i) Engaging with its local population to improve health and well-being;
- (ii) Commissioning a comprehensive and equitable range of high quality, responsive and efficient services, within allocated resources, across all service sectors; and
- (iii) Directly providing high quality responsive and efficient services where this gives best-value

2.3 Government allocates the PCT's budget, which is £793m 2007/08 and is a 9% increase over the previous year. In planning how this money will be spent towards meeting the health care priorities for the residents of West Kent for the current year, the PCT aims to create considerable scope for improvements.

2.4 The Local Delivery Plan (LDP) describes how the PCT's budget is allocated to secure the delivery of the priorities for the local NHS. At the heart of this LDP is our continuing determination to improve health, reduce inequalities and secure best value services for patients within allocated resources. The LDP is consistent with the White Paper 'Our Health Our Care Our Say', taking a significant step towards:

- (i) Addressing the public health needs of the population
- (ii) Achieving the right balance of health care through maximising opportunities for out of hospital care, whilst optimising hospital services
- (iii) Securing economic stability through effective investment strategies, continued 'Turnaround' processes established in 2006 and Risk Management.

2.5 **Connecting with Fit for the Future (FFF) and the Strategic Commissioning Plan** - the aim of FFF is to meet the future needs of local patients, families and carers through the development of an overarching strategic plan for health and social care such that services are delivered in the most appropriate setting by the staff with the most appropriate skills over the next 3 year period. This LDP is the first step towards delivering the key strategic objectives of the Local Health and Social Care Community (LHSCC).

2.6 The key priority areas for transformation are as follows:

- (i) Planned Care requirements to reduce unnecessary demand for hospital based appointments
- (ii) Unplanned Care, e.g. the establishment of Primary Care run Emergency

- Care Centres to reduce unnecessary demand for hospital based unplanned care
 - (iii) Long Term Conditions to improve the management of patient care
 - (iv) Mental Health and Learning Disabilities to improve care closer to home and reduce reliance on hospital care
 - (v) Focus on strategic service configurations (e.g. Community Hospitals, Pembury PFI, Orthopaedic and Surgical services)
- 2.7 Each of the above steps will confirm facilities requirements for Primary Care, Community Hospitals (currently undergoing a review), Acute Hospitals (plans to improve the Orthopaedic and Surgery at Maidstone and Tunbridge Wells NHS Trust is part and is expected to lead to the right service configuration in preparation of the new Pembury PFI Hospital), Mental Health and Learning Disability services.
- 2.8 Consistency with Fit for Purpose (FfP) – this LDP is consistent with the actions required to address the FfP assessment, which has identified strengths and weaknesses in both PCT infrastructure and resources allocated to implement key National and Local Health Care priorities.

3. DEPENDENCIES

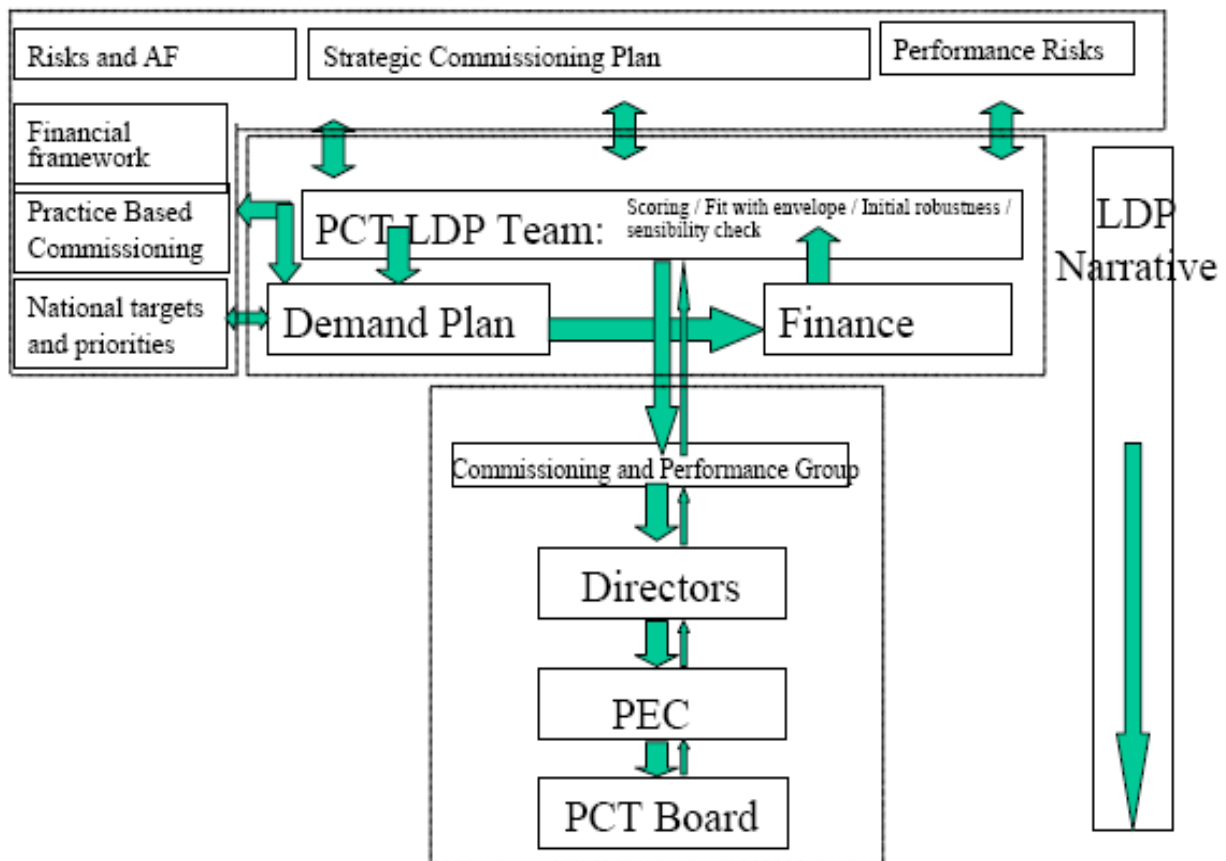
3.1 Key dependencies and feeders for the LDP are:

- Assurance Framework & Risk Register
 - Risk rating have sensibility check across all directorates
 - Risk mitigation feeds into LDP as required
- Practice Based Commissioning
 - PBC business plans agreed by PCT feed into capacity and SLA negotiations
 - Impact PBC business plans are modelled into LDP
- Financial Framework
 - High level financial modelling feeds LDP during quarters 1 & 2
 - Detailed financial projections feed LDP during quarters 3 & 4
- Strategic Commissioning Plan
 - LDP supports and underpins delivery of the SCP
 - LDP link and references back to SCP
- Performance risks
 - Performance reporting identifies other areas requiring further delivery plans
 - Performance management action plans feed LDP where required
- National targets and priorities
 - New targets and priorities feed into LDP
 - LDP demonstrates support and future delivery of targets

4. PROCESS

Dependencies and feeders for the LDP are collected and collated throughout the financial year. In year pressures and urgent requirements for funding are handled outside of the LDP process but will fall into the financial framework for the forthcoming year.

The diagram below shows the cyclic iterative nature for production of the LDP.



In essence, there is an ongoing collation and collection of risks assessed and reported through the corporate and clinical governance process as well as through the commissioning and performance group. Risks that need immediate action are dealt with, and those that can be managed in year are logged for consideration of longer term resolution through the LDP.

Other investment (and disinvestment) requirements are collated. These fall out of the strategic commissioning plan, nation priorities and targets and practice based commissioning pathway redesign. These are assessed and prioritised and matched against the financial framework during Q3, these are discussed at ascending levels within the PCT and ultimately agreement sought at Board.

From this work the SLAs with all commissioned services are developed.

Timetable

	C & P Evaluation	Dependencies/inputs	Planning process	Outputs
Q1		Assurance Framework & Risk Register	Collection and collation of drivers	
Q2		PBC business plans Assurance Framework & Risk Register	Collection and collation of drivers	
Q3		Strategic Commissioning Plan National targets and priorities Financial Framework Assurance Framework & Risk Register	Identification of all pressures and drivers. Evaluation process and dialogue with directorates/ commissioners. Assessment of affordability/ sensibility/ risk/strategic fit. Iterations of plan. Initial draft of scoring/ prioritisation.	
Q4		Assurance Framework & Risk Register	Outline agreement with main providers. Feedback from directors/PEC/Board	Development of LDP narrative Demand plans SLA production

Month	Activity
Aug	Practice based commissioning plans signed off by PCT and fed into following year's LDP
Sep	Evaluation process commences Assessment of affordability commences
Oct	
Nov	Evaluation process completed Assessment of affordability completed
Dec	Prioritisation commences with C&P group Agreement sought from directors / PEC / Board
Jan	SLA negotiation
Feb	Assurance Framework & Risk Register updated to reflect SLA sign-off
Mar	LDP narrative completed
Apr	Refinements made to LDP if financial framework has changed at year end

Prioritisation

The process of prioritisation should be based on the following:

1. Risk – The risk of not delivering the service/investment should be assessed using a 5 x 5 matrix analysing impact and likelihood.

Risks should be analysed as pressures become known. Risks need to be logged with the corporate risk register and reviewed in line with the risk management process.

High risks may need to be dealt with outside of the timescale for LDP and the Commissioning and Performance Group will need to make an assessment as to the level of risk that can be carried in year.

Risk scores are used as one element of the prioritisation and evaluation of need.

2. Strategic fit – Meeting the requirements of the Strategic Commissioning Plan (SCP).

The PCT should consider requirements that come out of the SCP. Funding should be made available to meet the developments and investments that are required within the plan.

The PCT should use strategic fit as an element in the evaluation of prioritisation of funding from the LDP

To: NHS Overview & Scrutiny Committee – 12 October 2007

By: Martyn Ayre, Corporate Policy

Subject: Local Involvement Network – an update

Summary: To update Members on recent developments regarding the establishment of a Local Involvement Network for Kent (LINK).

1. Members of the Committee received a comprehensive report at their meeting on 20 July 2007. That report set out:

- the historical and legislative context
- the proposed role and powers of a LINK
- information about the 9 Early Adopter pilots in England and the initial findings from them and
- brief details of future milestones and funding matters.

Members are encouraged to re-read that report to remind themselves of the background.

2. Since then there have been some significant developments nationally and locally and this report will focus on those.

3. In mid-August, the Department of Health (DoH) issued three documents:

- a. **“Getting ready for LINKs – planning your Local Involvement Network”**. This has been published as Best Practice Guidance and summarises the DoH’s policy expectations. It also suggests:
 - development approaches
 - a range of governance options
 - ideas about possible relationships between LINKs and other strategic partnerships
 - observations on the relationships between the LINK, its Host Organisation and the commissioning Local Authority
 - issues of accountability and performance management and
 - concludes with an Action List.
- b. **“Getting Ready for LINKs – contracting a host organisation”** This too has been published as Best Practice Guidance. It outlines what the DoH anticipates being covered in a local authority’s service specification for the provision of a Host Organisation and its proposed tender requirements. This document indicates that funding arrangements will be in the form of a Specific Grant paid to local authorities. This is detailed further below.
- c. **“Getting Ready for LINKs – an easy-read guide”** As its name suggests, this is a much less technical guide, mainly geared for a wider public audience who may not have any specialist background knowledge.

These documents can be made available on request.

4. The Local Government & Public Involvement in Health Bill is still going through Parliament with Royal Assent expected to be given in November. Further changes to the LINK provisions in the Bill cannot be ruled out but it is expected that the proposals outlined in the Best Practice guidance are likely to be those required to be in place by April 2008. The message from DoH continues to be that there will be considerable local discretion though this will only become absolutely clear when Regulations and more formal guidance are issued – it is thought likely that this will happen in January 2008. Members will appreciate that with a tendering process to be commenced between now and then and an implementation date of 1 April 2008, there are considerable areas of uncertainty and risk for all – the wide range of stakeholders, KCC and PCTs alike.

5. There are two key risks:

- (i) the need to publicly set out a service specification, in the near future, indicating a Host Organisation's likely activity levels without any certainty of the level of funding that will be available overall and without knowing how that funding will need to be apportioned between the costs of the Host Organisation, the LINK once established or the Local Authority (see paragraph 7 below).
- (ii) The tight timescales and the consequent possibility of a gap between PPIFs being abolished and LINKs established.

6. In the previous report to this Committee in July, there was a suggestion that the funding available to councils charged with the responsibility for establishing LINKs was likely to be of the order of £100-150k per annum. The most recent information indicates that the funding will be in the form of a non-ring-fenced Specific Grant. When that Grant Report is published, it will set out individual local authorities' allocations, based on the relative needs funding formula. This formula takes account of geographical and population size, as well as other factors such as population sparsity and deprivation. The best current advice is that KCC's allocation will be in the order of £450k per annum. Confirmation is not anticipated before the Chancellor's announcement of 2008/09 local government expenditure plans in late November/early December. This, of course, is well after the invitation to tender for Host Organisations will need to be issued.

7. There will be three elements to the funding:

- a) the Host Organisation's support function costs
- b) the LINK's expenditure costs
- c) the local authority's contract management costs.

It is prudent to assume that in view of these elements, there are no additional funds for what might be deemed service costs or costs falling to the local authority for servicing the information requests or referrals to NHS Overview & Scrutiny Committees coming from the LINK.

8. Members are reminded that there are two key elements to the County Council's role in establishing a LINK for Kent and this is being mirrored in the way implementation is being undertaken:

- (i) the County Council's role is to stimulate wide public interest in the creation of a LINK and there is a major programme of work to be conducted over the next 3-4 months which is primarily concerned with public and stakeholder engagement.
- (ii) There is a procurement process to be conducted. This is being progressed with colleagues from Commercial Services' Strategic Procurement Group. This tendering process will need to be open and transparent and comply with all relevant competition legislation. DoH guidance indicates that "the Health Overview and Scrutiny Committee within the local authority has a role in scrutinising how the contracting process was undertaken and ensuring that best value is achieved". This needs to be seen in the context that the letting of this contract will constitute a Key Decision (which is logged in the Council's Forward Plan).

9. The key to stimulating wide interest in participation to this new approach to public engagement in the commissioning, delivery and holding to account of health and social care will be a comprehensive engagement and communications strategy. This will entail:

- the creation of a dedicated website
- an extensive programme of engagement and consultation events (both those we organise ourselves plus encouragement to stakeholders, including seldom heard/hard-to-reach groups, inviting us to attend their own events)
- involvement with Kent Volunteers
- contacts with key Third Sector organisations via the Kent Compact protocols
- a regular online newsletter
- features in "Around Kent"
- opportunities to publicise what is happening through local media and Kent TV
- Focus groups and surveys will be conducted to help round out understanding of what Kent's residents want from a Local Involvement Network
- a series of briefings and discussions will take place with all Members of the County Council and to repeat this with Members and officers of district councils (in both cases by encouraging invitations from existing County and local arrangements).

10. Patient & Public Involvement Forums have so far struggled to establish a really tangible public presence. There is an opportunity, through community leadership by KCC and PCT colleagues, to rectify this over the coming months to help ensure that the LINK in Kent begins life with a notable public profile. The programme of work outlined in the preceding paragraph will be exacting but is the key to avoiding past difficulties that the PPIFs have encountered.

11. This work will be undertaken under the oversight of a Project Steering Group, chaired by Graham Gibbens, Cabinet Member for Public Health, and includes Kevin Lynes, Cabinet Member for Adult Social Care, a Non-Executive Director from each Primary Care Trust, Lord Bruce Lockhart, Chairman of the Health Overview & Scrutiny Committee, and Mark Fittock, Vice Chairman, and Dan Daley, the Liberal Democrat Spokesman on this Committee.

12. This membership is intended to emphasise the role of KCC and the PCTs as *commissioners* of this new service. The initial meeting is scheduled for 5 October.

13. On a day-to-day basis, implementation will be managed through a Project Team comprising senior officers from Children, Families and Education, Adult Social Services and Chief Executive's, as well as the PCTs' Directors of Civic Engagement. Full-time support will be provided a member of staff seconded from the Kent Graduate Programme.

14. There are three distinct roles that have been suggested by DoH for the Health Overview & Scrutiny Committee to fulfil with regard to LINKs:

- (i) To have a quality assurance role during the start-up period, with regard to the letting of a contract to a Host Organisation to ensure that the process of selecting and appointing a Host Organisation represents Value for Money for KCC. The setting-up of a LINK and contracting with a Host Organisation to support it represents a Key Decision. This, of course, would be liable to Cabinet Scrutiny.
- (ii) In the longer term (and subject to what the final Regulations will say), there will be a more formal relationship between the Health Overview & Scrutiny Committee and the Local Involvement Network. On the one hand, the LINK will have the power to refer relevant matters, including its own findings and recommendations on them, to the Health Overview & Scrutiny Committee and the power to require a detailed response within a set timescale.
- (iii) A HOSC may also wish to commission a LINK to undertake survey or research work on its behalf in respect of a health or social care matter under its consideration or invite members of a LINK to participate, perhaps via co-option, in specific scrutiny activities. This aspect does not appear to have been fully thought through as yet by DoH. So whilst the DoH has clearly indicated it does not foresee a LINK as an alternative form of scrutiny, it will be prudent for the HOSC to seek to establish protocols for working with the LINK in Kent, to ensure their separate and distinct roles do not end up becoming blurred and confusing. By the same token, the new inclusion of social care in the LINK's remit could inadvertently see social care matters being referred to a HOSC. This raises questions about the inter-relationship within KCC between the Health Overview & Scrutiny Committee and the Adult Social Services Policy & Overview Committee. Draft regulations and some further associated guidance were published on 28 September for a 12-week consultation period, closing on 21 December 2007, and it is intended that appropriate advice will be taken during this period to help clarify this further.

Recommendations

Members are invited to NOTE this report.

Martyn Ayre

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*Background Documents – report to Health Overview & Scrutiny Committee,
20 July 2007*

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