CORPORATE POLICY OVERVIEW AND SCRUTINY COMMITTEE

Thursday, 31st March, 2011

10.00 am

Darent Room, Sessions House, County Hall, Maidstone

AGENDA

CORPORATE POLICY OVERVIEW AND SCRUTINY COMMITTEE

Thursday, 31 March 2011 at 10.00 am
Darent Room, Sessions House, County Hall, Maidstone

Ask for: **Denise Fitch**
Telephone: **01622 694269**

Tea/Coffee will be available 15 minutes before the meeting

Membership (12)

Conservative (11): Mr E E C Hotson (Chairman), Mr R W Bayford, Mr D L Brazier, Mr J R Bullock, MBE, Mr R B Burgess, Mr B R Cope, Mrs J P Law, Mr S Manion, Mr R J Parry, Mr J E Scholes Mr M V Snelling

Liberal Democrat (1): Mrs T Dean (Vice-Chairman)

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UNRESTRICTED ITEMS

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

Item No

A. COMMITTEE BUSINESS

A1 Introduction/Webcasting

A2 Membership

A3 Substitutes

A4 Declaration of Interests by Members in items on the Agenda for this meeting.

A5 Minutes - 13 January 2011 (1 - 8)

B. ITEMS FOR CONSIDERATION

B1 Financial Monitoring Report : Corporate Services 2010/11(to follow)

B2 Treasury Adviser Appointment (9 - 16)

B3 Access & Assessment and Workplace Transformation Progress (17 - 24)

B4 Potential Impact and Response to the Localism and Devolution Bill (25 - 32)

B5 KCC progress on changes to health service organisation (33 - 44)

B6 Update on response to consultation on "Healthy Lives, Healthy People" white paper (45 - 96)

B7 Core Monitoring (97 - 116)

B8 KCC's Performance Management Framework (117 - 120)

B9 Human Resources Restructuring (to follow)

C. SELECT COMMITTEE WORK

C1 Select Committees - update (121 - 122)

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

Wednesday, 23 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

CORPORATE POLICY OVERVIEW AND SCRUTINY COMMITTEE

MINUTES of a meeting of the Corporate Policy Overview and Scrutiny Committee held in the Darent Room, Sessions House, County Hall, Maidstone on Thursday, 13 January 2011.

PRESENT: Mr E E C Hotson (Chairman), Mrs T Dean (Vice-Chairman), Mr R W Bayford, Mr D L Brazier, Mr R B Burgess, Mr B R Cope, Mr J A Davies (Substitute for Mr M V Snelling), Mr S Manion, Mr R J Parry, Mr J E Scholes and Mrs J A Rook (Substitute for Mrs J P Law)

ALSO PRESENT: Mr A H T Bowles, Miss S J Carey, Mr R W Gough, Mr A J King, MBE, Mr R A Marsh and Mr J D Simmonds

IN ATTENDANCE: Miss J Clarke (Head of Communications), Mr D Cockburn (Executive Director, Strategy, Economic Development & ICT), Mr R Fitzgerald (Performance Manager), Ms T Gailey (Public Health Policy Manager), Mrs S Garton (Head of County Performance and Evaluation Manager), Mrs T Gleeson (Corporate Web Manager), Mrs C Patrick, Ms M Peachey (Kent Director Of Public Health), Mr D Shipton (Finance Strategy Manager), Ms D Smith (Policy Manager), Mr G Wild (Director of Law and Governance), Mr A Wood (Acting Director of Finance) and Ms D Fitch (Assistant Democratic Services Manager (Policy Overview))

UNRESTRICTED ITEMS

92. Minutes - 12 November 2010
(Item A4)

RESOLVED that the minutes of the meeting held on 12 November 2010 are correctly recorded and that they be signed as a correct record.

93. Update on the NHS White Paper "Equality and excellence: liberating the NHS
(Item)

(1) Miss Gailey informed the Committee that the White Paper had not yet been published. According to the latest information it would be published by the end of January 2011. She stated that before Christmas the legislative framework and the next steps had been published. The Scrutiny element of Health and Wellbeing Boards had been dropped and Scrutiny had been enhanced to include the ability to require Health Service providers who were NHS funded to attend Health Scrutiny Committees.

(2) Regarding GP commissioning, Mr Gough stated that there was rapid movement in some areas and whilst from the County Councils perspective co-terminosity was desirable it was not likely to happen in West Kent. The Dartford, Gravesham and Swanley consortium cut across three local authority boundaries and

had strong links in that area and looked for its acute provision to Darent Valley Hospital.

(3) Mr Gough stated that he was glad that the Government had listened to the County Council and had separated the Health and Wellbeing board from Scrutiny. Also the Health and Wellbeing Boards strategies had a duty to co-operate. Commissioners had to have regard to these strategies which would insure that the commissioning was more joined up. There was an ambiguity as to where Healthwatch would sit, his personal view was that Healthwatch and Scrutiny should work together. He reported on the successful meeting with GP's on 25 November 2010, it had been a good opportunity to hear ideas from GP's. He referred to the Dartford, Swanley and Gravesham GP Consortium which had been named as a pathfinder. He stated that there were some GP's who were enthusiastic about the new proposals but there were also GPs who were very concerned, especially those not involved in practise based commissioning. He referred to the briefing for Members which had been held in early November 2010.

(4) Mr Gough mentioned meetings that he had with East Kent District Council Leaders and the need to keep District Council colleagues informed of progress. The importance of District Council representatives attending meetings of Health Overview and Scrutiny Committee and feeding back to the authorities they represent was mentioned. It was acknowledged that District Councils had strong role in responding to local concerns. The localism agenda should be taken into account as the role of HOSC develops.

(5) RESOLVED that the update be noted and a further update be submitted to the next meeting of the POSC.

94. "Public Health - the emerging picture"
(Item B2)

(1) Ms Peachey introduced a report on the Public Health White Paper – Healthy Lives, Healthy People which had been presented at Corporate Management Team and would be submitted to the next Cabinet Members meeting. The report outlined the major proposals and issues within the White Paper, which was currently out to consultation.

(2) Ms Peachey explained that there were policy officers in every directorate who were gathering views which would inform the response. She was also part of the NHS Public Health team which was also discussing the White Paper.

(3) Members expressed the following views, some of which were responded to by Ms Peachey:-

- The example of the difficulty of establishing cycle paths and to find funding partners was raised. The legislation did not seem to make provision for the funding of facilities.
- There was no one way to encourage people for example to give up smoking, nudging was just one method, peer pressure was also very powerful.
- The importance of avoiding duplication in areas like tobacco control proposals was raised.

- If public health matters were dealt with by lower tier councils there was the possibility of duplication of resources.
- Local flexibility on national vaccination programmes like swine flu vaccination for under 5's might lead to a postcode lottery.
- The establishment of new agencies for high quality intelligence, information and analysis should not lead to the creation of more Quango's.
- It was suggested that this could be considered at HOSC on 4 February 2011 and that other Members could be invited to attend for this item.

(4) Ms Peachey undertook to circulate an aid memoire to POSC Members setting out the generic headings for the response and inviting them to contribute any comments/observations to help inform the consultation response.

(5) RESOLVED that the contents of the report and comments made to inform the consultation response be noted and that that the response be reported to a future meeting of the Committee.

95. Update on KCC Health Inequalities Strategy
(Item B3)

(1) Ms Smith referred to the KCC Health Inequalities Strategy which had been approved by Cabinet on 13th September 2010, along with a summary of the influential report on Health Inequalities, Fair Society, Healthy Lives'. The Committee report included the summary of the Marmot Review an update on the KCC Health Inequalities Strategy.

(2) Ms Smith explained that work was already being carried out using the strategy document with colleagues in District Councils, Primary Care Trusts and the voluntary and private sector. It was difficult to measure the impact on a short term basis. In relation to the way to measure for health inequalities they were looking to the Kent and Medway Observatory to find the right meaningful measure and were identifying good models of working.

(3) Members made a number of comments which include the following:-

- Members were pleased to see that the strategy was starting from first principles and hoped that success would flow from this.
- The recognition in the Strategy of the need to invest in early years support was welcomed.
- There was a need to have a balance between targeted work, which can be very successful, and avoiding stigma by targeting the community as a whole. Ms Smith explained that one way to address this was to have universal policies to get support from the community and then target those in most need.
- It is interesting to see when this document is considered by Children, Families and Education how the budget lines up to support this.
- The importance of engagement with the community, at an early stage was emphasised.
- The effective preventative work being carried out by the Margate Task Force was highlighted.

- The strategy was very high level, Members were interested in having information on delivery and outcomes.

(4) Mr Simmonds stated that he was aware of the need to look at cuts in the intervention budget and the implications of that, he acknowledged the effectiveness of doing more at an early stage.

(5) RESOLVED that the update and the comments made by Members be noted and that a further update be submitted to a future meeting of the POSC in approximately a years time.

96. Financial Monitoring Report : Corporate Services 2010/11
(Item B4)

(1) Mr Shipton introduced the second quarter's budget monitoring report for 2010/11 as reported to Cabinet on 29th November 2010 and the latest exception report on 10th January 2011.

(2) RESOLVED that the projected outturn for the Chief Executive's Department and Financing Items for 2010/11 based on the second quarter's monitoring report to Cabinet and subsequent exception report be noted.

97. Budget 2011/12 and Medium Term Financial Plan 2011/13
(Item B5)

(1) The Committee considered the Chief Executives Departments (CED) Draft Budget proposals set out in the Draft Budget 2011-12 and the Draft Medium Term Financial Plan (MTFP) 2011-2013 and also the report which was circulated specifically relating to the key areas of these documents for this Department.

(2) Mr Wood, Mr Shipton and Mr Simmonds introduced the Draft Budget 2011-12 and the Draft MTFP 2011-2013 for the Chief Executives Department and Financing Items and then answered questions from Members about the following issues:-

(3) Clarification was sought on the "Reduction in Member Allowances & Overheads" of £200,000 (page 99 of the Draft Budget). Mr Simmonds explained that there would be full details by 1 April 2011. This reduction reflected the new Directorate and Cabinet Member responsibilities and would depend on the way that the Cabinet was restructured and the number of Deputy Cabinet Members.

(4) Mr Shipton explained that currently they did not know where the staffing efficiencies would occur, it was expected that that they would be delivered as much as possible through natural turnover and not filling vacancies, which would emerge during the year, but it was inevitable that there would be some redundancies. It was not possible at this stage to say what proportion will be met from natural turnover. Business units had been given a target figure., The top tier re-structuring had already delivered savings and it was expected that further savings would be delivered as this process went though the next tier.

(5) Mr Simmonds explained that £750, 000 had been allocated for savings from the top tier review. He stated that in the Finance Unit it was difficult to say were the

staff saving would come from, as finance staff from the directorates were being re-absorbed into the Finance Unit. Mr Shipton stated that unit staffing figures would be available for the final version of the Budget Book following the County Council agreement of budget (as has been the case in previous years).

(6) In relation to savings from "changes to human resources policies" (page 102 of the Draft Budget), Mr Shipton stated that Ms Beer was working on a proposal and this would be the subject of a consultation.

(7) Mr Shipton confirmed that the largest part of the "other" savings of £1.7million was the reduction in the cost of employer's pension contributions from 23.1% to 21% which would save a significant amount (£526,000) with little direct impact on staff.

(8) In response to a question on what budget consultation would be carried out following the cessation of consultation work by Ipsos MORI, Mr Shipton explained that although the work of Ipsos MORI had been helpful in obtaining in depth feedback from a small group, he confirmed that they were looking at other ways of achieving this including using on line consultation.

(9) Mr Shipton stated that the un-ring fenced grants for LINks could now be used to contribute to the funding of Healthwatch.

(10) RESOLVED that the revenue and capital budget proposals included within the Medium Term Financial Plan 2011/13 be noted and the comments made by Members on the revenue and capital budget proposals be fed into the Cabinet Budget meetings and County Council in February.

98. Open Kent
(Item B7)

(1) Mr Gough and Mrs Patrick introduced a report which provided Members with an overview of the Open Kent project and an update on progress.

(2) In response to a question on who would check the information supplied by partners, Mrs Patrick stated that the information used was already available on the partners websites so the onus was on them to ensure that it was current and accurate. She had found that once there was data that people found useful, and the partners could see the benefit of supplying this information they were likely to keep the information up to day and to supply additional information.

(3) Mrs Patrick confirmed that the £31,960 funding for the Open Kent Trial had come from the Kent Connects Partnership. The £31,960 included the cost of IBM licences. In relation to the cost of the system itself Mrs Patrick explained that because it involved accessing existing data a significant amount of the cost would be for future maintenance of the system and ongoing marketing.

(4) Members emphasised the importance of the information supplied being in plan English and the information being able to be easily be accessed by people with little knowledge of local government or how it works was emphasised. Mrs Patrick confirmed that use of plain English and access was part of user testing for the system.

(5) Mrs Patrick confirmed that it was anticipated that one of the benefits of allowing people to have direct access to the information that they required would be a reduction in Freedom of Information requests, however this would rely on partner organisations being open with their data.

(6) Mrs Patrick explained that Members would be involved with testing the system via the existing Member Information Group, she issued an open invitation to any Members of the Committee who wished to be involved in testing the system to contact her.

(7) RESOLVED that the report and the comments made by Members be noted.

99. KCC Website Update
(Item B6)

(1) Mr Gough, Mrs Oliver, Mrs Gleeson and Mr Mcghie presented a report which updated Members on progress to date and future plans for the KCC website – www.kent.gov.uk.

(2) Mrs Oliver explained that there would still be an option for the public to pay for services etc with cash or a cheque, and that by introducing more online means of payment they were not closing down other channels of access, there would still be a provision for a face to faced Gateway experience.

(3) In response to a request for information on the officer policy for use of social network sites, Miss Clarke explained that the position that had been taken was that officers in corporate communications had social network access in order to carry out their work, but other officers wishing to use social media had to go on a course and be licensed. She confirmed that the use of social media was not open to all staff. Corporate Communications had been very active in promoting Twitter (there were approximately 2100 KCC twitter followers) and Yammer, KCC internal social networking facility, had 1,730 users.

(4) Mrs Gleeson confirmed that the search facility on Kent.gov was evolving as new pages were added. She stated that the aspiration was that everything that the public had an interest in or needed to contact the County Council for would be available on the website, and that these services could be supported by the Gateway and contact centre.

(5) RESOLVED that the report and the comments made by Members be noted.

100. Proposed Company Structures - Rules Applying to the Provision of Legal Service
(Item B8)

(1) Mr Wild introduced a comprehensive report on the rules applying to the provision of Legal Services.

(2) As this was a complex issue it was proposed that an Informal Members Group be set up to hold a single meeting to consider this report in detail.

(3) RESOLVED that an IMG be established to consider this paper, and that Mr Christie and Mr Lees be invited to attend.

101. Core Monitoring
(Item B9)

(1) Mrs Garton and Mr Fitzgerald presented a report is to inform Members on key areas of performance and activity across the authority, she invited comments from Members on the information provided.

(2) The format of the report was welcomed as being more readable and usable. It was suggested that there should be a larger number of data sets including average figures from the Local Authority family. Mrs Garton pointed out that they were already looking at increasing the amount of comparative data for future periods.

(3) In relation to sickness absence figures, Mr Fitzgerald explained that comparisons made with the private sector were not on a like for like basis, as the organisations who completed returns tended to be smaller companies who had a higher percentage of males and a younger workforce. Mr Gough pointed out the there had been a significant reduction in sickness absence.

(4) RESOLVED that the report be noted.

102. Reducing the National Performance and Inspection Burden and Increasing Sector Self Regulation
(Item B10)

(1) Mr Gough and Mrs Garton introduced a report which set out the main changes to the national performance management and inspection landscape since the Coalition Government came to power.

(2) RESOLVED that the report be noted and that the POSC be kept informed of developments in relation to self regulation.

103. Decentralisation and the Localism Bill
(Item B11)

(1) Mr Bowles presented a report on the Decentralisation and Localism Bill. He referred to the Kent Forum which was looking at proposed pilots for three tier working.

(2) The need to discuss the issue of devolving resources to Parish Councils was mentioned.

(3) RESOLVED that an updated report be considered at the next meeting of the POSC.

104. Select Committees - update
(Item C1)

(1) The Committee received a report on the current topic review programme and were invited to put forward suggestions for future Select Committee topic reviews.

(2) RESOLVED that the update be noted and the Democratic Services officer be advised of any potential items for Select Committee topic reviews.

By:	Cabinet Member for Finance Director of Finance
To:	Corporate Policy Overview and Scrutiny Committee – 31 March 2011
Subject:	**TREASURY ADVISER APPOINTMENT**
Classification:	Unrestricted.

Summary: To report the outcome of the treasury adviser tender process.

FOR INFORMATION

INTRODUCTION

1. The Council has been out to competition in a European Union compliant tender process for the appointment of a treasury adviser. The Council currently uses both Arlingclose and Sector – the Butlers team transferred to Sector in October 2010.

2. This report provides a summary of the process and outcome.

TENDER PROCESS

3. The specification for the treasury service was agreed through the Treasury Advisory Group (TAG) taking into account advice from the Corporate Procurement Team and Legal Services. The requirement is attached in the Appendix, there is also a contractual document prepared by Legal Services which was sent to tenderers.

4. There were two responses to the tender document from Arlingclose and Sector. The firms were interviewed by TAG on 2 March – members present were Mr Simmonds, Miss Carey, Mr Hotson, Mr Bowles, Mr Scholes and Mr Prater. Members agreed that Arlingclose should be appointed and an award report has been prepared and has been agreed by the Director of Finance and this has been circulated to all members of Cabinet Scrutiny Committee on 21 March. The award report is restricted because it details commercial terms. The estimated value of the contract over the 5 year period is £294k.

RECOMMENDATION

5. Members are asked to note this report.

Nick Vickers
Head of Financial Services

Ext 4603

KENT COUNTY COUNCIL

Invitation to Tender for Treasury Advisor Services

Section 1 Instructions to Tenderers

Introduction

This tender is for the provision of treasury advisory services to Kent County Council (the Customer).

The services provided must include investment advice and not just the provision of information. The Customer will rely on the advice and information provided in making its own independent decisions on its treasury management and investment activities.

These services supplement the Customer's in-house capacity to take treasury management decisions with specialist treasury management advice enriched by high frequency contact with relevant financial institutions and their regulators and frequent consideration of a wide range of relevant sources of information and analysis relevant to the formation of such advice.

Return Date

Tenders must be submitted by no later than noon on:

Wednesday 5th January 2011

Required Response

Tenderers should complete the form of tender (Section Four), the attached Equality and Diversity questionnaire and provide the following information:

- three references of current work with councils in the UK (not district or boroughs). Details to include:
  - customer name
  - contact name, telephone number and e-mail address
  - nature of contract, i.e. what you are/were contracted to provide
  - contract length
  - start date

  Details must be sufficient for us to take up the reference directly without further contact with the Tenderer.
- total number of UK local authority clients broken down by county, unitary, districts and others as at 31st December 2010
- number of losses and gains of UK local authority clients broken down by county, unitary, districts and others in the 12 months up to 31st December 2010
- evidence of the required Professional Indemnity insurance
- examples of template reports as required in clause 13 of the Specification

- examples of counterparty reports
- examples of your regular economic updates
- details of your proposed fees
- details of the resources available to support this contract, including the names and qualifications of the individuals to be allocated and their back-up
- details of your approach to debt restructuring - maximum of 2 pages
- proposals on how to select and monitor suitable counterparties - maximum of 2 pages
- demonstration of your ideas / options on an investment strategy - maximum of 2 pages.

Assessment of Tenders

All tenders received will be considered on the information contained in the tender or obtained by the Customer as a direct result of the tender process. Tenderers may be asked to present their proposals to a Member panel as part of this process. Submissions will be assessed on the basis of most economically advantageous offer which will take into account the following:

Price	25%
Comprehensiveness of service provided ie. provision of investment advice on different options, timing of debt restructuring 50%	
Quality of staff and robustness of back-up support	25%

Tenders Not Meeting Specified Requirements

Tenderers submitting offers not complying with the specified requirement may not be considered.

Post Tender Negotiations

Post tender negotiation on price is not the usual practice of the Customer. Tenderers must make their best offer on this tender by the closing date.

Acceptance of Tenders and Pre-Contract Negotiation

The Council does not bind itself to accept the lowest or any tender and reserves the right to accept any items in any tender to the exclusion of other items.

Any condition contained in any offer made against this invitation which may vary or replace any term or condition of contract shall not be binding unless such conditions of business or of contract are specifically accepted in writing by the Customer.

a) A contract shall not be concluded between the Customer and the Tenderer until the Tenderer has received a written acceptance from the Customer

signed by or on behalf of the Customer's Director of Finance. Acceptance of the tender shall be deemed to incorporate any modification or amendments agreed in writing in consequence of any discussions or correspondence referred to in (b) below.

b) Until the conditions set out in (a) are satisfied, any discussions/correspondence between the Customer and the Tenderer shall be entirely subject to contract and conducted without any obligation whatsoever by the Customer to enter into or become bound by any contract with the Tenderer.

c) Unless notified to the Tenderer in writing by the Customer's Director of Finance, no Officer of the Customer is authorised to change, amend or modify any of the terms or conditions herein relating to pre-contractual negotiations and/or acceptance of tender.

Section 2 Requirement

Period of Contract

Sixty (60) months from 1st April 2011 to 31st March 2016.

Specification

1. Advise the Customer on its investment strategy including monitoring of and reporting on the suitability of investment counterparties and strategies when set against the overriding objective of the capital preservation of public funds and meeting DCLG and CIPFA requirements. This will include alerting the Customer to movements in credit ratings on a real time basis (email within 24 hours of change). The Consultant must consider all relevant sources of information in performing this monitoring role.

2. Advise the Customer on its existing credit worthiness policy, the interpretation of ratings and wider indicators of credit risk (e.g. credit default swaps).

3. Recommend, in writing, on a monthly basis specific institutions, funds and bonds that, in its opinion, are suitable for the Customer's investment strategy including notifications as set out under clause 1 above.

4. Undertake an annual analysis of the Customer's balance sheet and cashflow to identify borrowing requirements and available resources.

5. Advise on timing of borrowing (short and long term) from either the Public Works Loan Board (PWLB) or market sources and on debt restructuring in light of interest rates, the Customer's long-term borrowing requirement and maturity profile to minimise borrowing costs.

6. Provide weekly updates on relevant economic, political and treasury management changes which may impact on the Customer's borrowing and investment strategy.

7. Provide economic and interest rate forecasts in writing on a monthly basis.

8. Provide a credit ratings service including:

   (1) A comprehensive initial report on the Customer's existing counterparty list including advice on the methodology of assessment, the treatment of lending limits to individual organisations and financial groups.

   (2) A weekly update of individual counterparty list highlighting any changes which have taken place since the preceding review.

   (3) Provide immediate notification of changes to ratings (email within 24 hours or telephone call for urgent issues).

   (4) Advice on any credit rated or non credit rated institution.

9. Provide advice on associated Treasury Management accounting issues likely to change in accounting policy for the accounting bodies, primarily CIPFA. The frequency will depend on the changes made to the accounting rules.

10. Conduct a review of the Customer's own list of investment counterparties reconciled to the latest credit ratings on a monthly basis and advise the Customer.

11. Attend the Customer's quarterly Treasury Advisory Group meetings and monthly meetings with Officers to review investments, discuss borrowing and address other relevant treasury management issues.

12. Provide access to training events and seminars on treasury management for relevant Officers and Members (up to 4 places at each event).

13. Provide template reports for the preparation of:

    (1) Annual treasury strategy

    (2) Annual treasury review

    (3) Treasury Management Practices based on the CIPFA Guide.

14. Undertake an annual "health check" of the Customer's Treasury Management Practices reporting to the Customer's Head of Financial Services.

15. Assist the Customer in developing their internal performance monitoring arrangements.

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By:	Roger Gough, Cabinet Member for Corporate Support Services & Performance Management Tanya Oliver, Director of Strategic Development & Public Access
To:	Corporate Policy Overview & Scrutiny Committee – 31 March 2011
Subject:	Access & Assessment and Workplace Transformation Progress Report
Classification:	Unrestricted

Recommendations

1 Members are asked to **NOTE** the actions being taken to improve access to services and to achieve the savings targets for access and assessment set over the next four years

Introduction

2 (1) The purpose of this report is to keep Members informed of the progress being made on identifying savings from streamlining and improving access and assessment processes.

(2) The report on Access & Assessment to this Committee on 12 November 2010 set out the principles from Bold Steps for Kent which specifically relate to access and assessment:

- "Moving to an integrated initial assessment framework across all services for individuals and families sat behind a single front line (the multi channel Gateway programme - physical, web, telephone access) which solves the majority of customer issues at the first point of contact. Our services will be re-engineered to deliver these savings as quickly as possible." This includes:
    - Expanding the Gateway principles to other access points and linking them more strongly to the physical Gateway network
    - Ensuring residents can increasingly choose how they access services
    - Removing the need for individuals or families to undergo similar assessments from different agencies
    - Developing a single Gateway website and telephone number to complement the face-to-face Gateways
    - Introducing single initial assessment model to speed up access to specialist assessments, if required

(3) A savings target of £14 million has been set for access and assessment over the next four years, to be split across services, and a significant proportion of this will be through improved partnership working. The report also said that in order to ensure that residents can increasingly choose how they access services, a channel shift strategy was being developed to inform the move to providing online access to more services and to encourage people to use more cost-effective channels wherever

possible, so that the more costly types of interaction are reserved for more complex enquiries.

Progress with Access & Assessment Savings to Date

3 (1) Since the previous report to this Committee, the savings identified have increased to £8.77m, to be split over the years 2011/12 to 20214/15 as follows*:

	2011/12	2012/13	2013/14	2014/15	**Total**
	£'000	£'000	£'000	£'000	**£'000**
Savings to be achieved in KASS through review of a range of services including hospital-based services, mental health management and closer working with the Health Service	645	175	2,000	2,487	**5,307**
EH&W - Highways Environment, Waste & Planning	817	11	11	147	**986**
CFE - Free School Meals		85			**85**
Transfer of services into Contact Kent and income into Contact Kent from providing services for other organisations	548	838	200	200	**1,786**
Channel shift	80	203	24		**307**
Gateway saving once physical phase complete			100		**100**
Savings to be reinvested in Gateway – reception closures	100	100			**200**
TOTAL ACCESS & ASSESSMENT SAVINGS IDENTIFIED	**2,190**	**1,412**	**2,335**	**2,834**	**8,771**

* NB This is based on existing structures and may therefore be subject to change in 2011/12.

(2) KASS have identified where they will be looking to achieve their savings allocation of £5.307m. Much of this will be achieved through closer working with partners, particularly the Health Service, to simplify and streamline assessment processes. Other areas include a Hospital Team review, Mental Health Management, Co-ordination Managers, Finance Area Benefit Officers and Assessment & Related savings.

(3) The draft improvement plan "Putting Children First" prepared in response to the Ofsted report on the Inspection of Safeguarding and Looked After Children Services in Kent has set out a number of proposals related to access and assessment:

- To ensure, in the next six months, that all Duty and Initial Assessment Teams are providing effective initial assessment and applying consistent and safe thresholds.

- To improve, in the next twelve months, partners' understanding and engagement in relation to thresholds, eligibility, assessment processes (including CAF) and pathways between universal, targeted and specialist services

- To reduce the number of inappropriate referrals by re-engineering the Kent Contact and Access Service to include the involvement of qualified social workers and managers at the point of first decision making and

- To strengthen CAF arrangements to ensure that children with additional needs are responded to before their needs become acute and require specialist children services.

(4) Initial investigations have highlighted the value of process mapping to further identify blockages and improvements from the customer perspective. Based on the investigations carried out to date, there are concerns in CFE about whether they will be able to achieve the Access and Assessment savings targets originally expected. This is largely due to the fact that units in the Directorate have already identified areas where some of these savings could be made, but have included them in their MTP efficiency or policy savings. These savings cannot be double-counted. There will be changes made to the processes within Children's Social Care as a result of the Improvement Plan. These changes will result in improved outcomes for Children and Young people, but it is not yet possible to identify whether any savings can be achieved from the process. Further work will be required in other areas to identify specific savings.

(5) The unified communications project currently underway across the County Council will provide us with a telephone directory for all KCC staff. This in turn will provide the opportunity to ensure that the improved directory is used rather than using Contact Kent to access internal telephone numbers, with a potential saving of over £130,000 a year. It will also provide "follow me" numbers, which means that each member of staff will have a single KCC number, which can be routed to their mobile phone, home number or a telephone in any office or Gateway building, assisting mobile and flexible working.

(6) Communities have so far identified an additional £1m related to access and assessment (through the introduction of self service in libraries) but this has already been counted against policy savings proposals, in addition to the £350k savings in the current MTP which is predicated on streamlining public access by merging some front line roles. This is not therefore being counted against Access and Assessment.

(7) There is also potential to see if lessons from the Margate Task Force can be used to streamline processes elsewhere. Currently there is a multi-agency assessment form in a pilot stage as a paper form and we would hope to develop it into an online form and also identify whether the type of assessments can be extended.

(8) EH&W intend to achieve the majority of their savings target in 2011/12 through reorganisation in Kent Highway Services. The remainder of the savings will be achieved from a variety of services spread over the four year period.

(9) A bid for £100k has been accepted by the Transformation Fund. The bid was made with a view to investing in technology to make savings in future. The funding will be used to procure two single applications: a workflow web form and an authentication system. These systems will be of benefit to the whole organisation.

(10) While additional funding will be needed in the future much of this will be found from existing budgets where a need has already been identified, therefore we do not propose to bid for additional money but rather utilise the identified money more effectively.

Channel Shift Strategy

4 (1) A draft Channel Strategy has been prepared and has been presented to the Access and Assessment Board and the Member sub-group for website and Digital Kent. The paper is intended to provide Kent County Council with a platform for tackling both the channel shift agenda as well as enabling us to look at current assessment practices and back office processes. It is anticipated that following discussion at the Corporate Management Team, the paper will go out for wider consultation with a final strategy document completed by July 2011.

(2) The Channel Shift Strategy examines how Kent County Council (KCC), in partnership with public sector organisations, will enable their service users to access services in a clear and coherent way, whether it be by face to face, phone or via the web. We must be consistent across the organisation - one negative experience with one aspect of a channel can make people reluctant to use that channel again, regardless of whether it is for a different service. To the customer we are one organisation.

(3) The long-term goal is to achieve a true channel shift, encouraging more users to self-serve via the web, whilst reserving face-to-face and phone channels for the most complex enquiries or for those citizens who cannot interact with us via the web. If achieved, the channel shift will reduce costs whilst improving customer experience, ensuring that customers where possible are using the most appropriate channel for them and for their chosen transaction. The strategy is a key part of developing the Gateway concept beyond the physical locations and encompasses all access channels used by the public including phone and web.

(4) In 2010, Socitm released figures that looked at costs of a transaction across the three main access channels. They estimated that a contact costs 39p online, £3.21 by telephone and £8.23 face to face. These headline figures from Socitm suggest that transferring transactions online would deliver the organisation significant savings but it is important to note that creating meaningful online transactions could also require investment and therefore needs to be carefully thought-out and examined at all stages.

(5) Initial research into the cost of contact via Contact Kent shows that in 2009/10, the cost per contact was £2.50 during the day and £12.50 for out of hours calls, which include the screening function which can involve the full handling of a Social Services issue. These costs are based on the running costs of the service divided by the number of calls received.

(6) Further estimates suggest that 75% of public sector contact with customers may be failure demand or rework. This where a customer calls to chase up an application or a call they have already made. To reduce costs incurred in this way and to enable people to transact with us via the channel of their choice, we as an organisation need to deliver quality and consistent services regardless of the channel chosen (Web, Phone and Face-to-Face), whilst seeking to reduce the cost of transactions across each.

(7) The strategy is not proposing a ‘one size fits all’ approach but will place more emphasis on the citizen to self-serve wherever possible. We know there are groups who use the web for a wide range of activity such as banking, information-searching and shopping who do not transact with us (or other public services) online because the

facility is not available or is not convenient to use. Understanding who accesses our services is very important when proposing a channel shift. We need to ensure that we are collating postcode data on the people using our services to gain a better understanding of how our customers would like to access our services.

(8) There has already been extensive work carried out on profiling Kent's residents creating detailed Mosaic data (customer segmentation) based on postcodes. By inputting the postcodes of customers we can ascertain whether they are likely to transact face-to-face, by phone or via the web, as well as their propensity to migrate to alternative channels if they were available or if the person was shown how to use them. This research will help us to target our approach more effectively.

Further Areas Being Explored To Deliver The Remaining £5.2m Savings

5 (1) Concessionary Fares – It is intended that this process will use an online form and work needs to be done to ensure that an end-to-end process is procured. Currently the process is largely paper-driven. An online solution would speed up processes and in some cases enable the process to be completed without any interaction with KCC staff. This will also require a solution for determining a person's eligibility for the service through an automated system.

(2) Benefits Hub and Community Safety Hub (Abandoned Vehicles) – Benefits Hub work carried out as part of the Gateway development, has found that significant improvements and savings could be achieved by adopting a single, multi-agency hub approach for the delivery of benefits. As an example, the potential saving in staff time on a single instance of the customer journey for redundancy was £62. With a monthly average of 4,750 cases across Kent, this represents a saving of over £3.5m a year across the public sector services involved. Using a similar method of calculation, the potential saving in a case study based on retirement was estimated at £1.5m a year. This does not include the reduced cost of premises or the social return on investment, nor does it try to assess the impact these changes to the customer journey could have on the back office processes of participating organisations. Experience elsewhere however suggests that the potential for efficiency savings in the latter is even greater than in the customer-facing processes. Similarly work on a community safety hub has identified efficiencies that can be achieved, for example in the reporting and removal of abandoned vehicles.

(3) Resolving financial transaction issues – this will open up opportunities to collect payments online both for service provision and income generation. Currently there are several payment systems in existence all paying a separate fee for the provision. In addition there is considerable work being done within directorates to reconcile payments received. It is expected that a single financial transaction system will reduce current costs and increase income generation.

(4) Free school meals – currently there are two options being examined: income generation from Schools for the service and the potential for the service to be delivered by Districts as part of their current benefits assessments. Eligibility for Free School Meals is determined by entitlement to/receipt of certain benefits, of which the Districts would already have knowledge.

(5) Further transactions have been identified which have the potential to be developed into fully online processes, thereby achieving savings (the financial analysis to confirm savings is underway). These range from the Property Service Desk, School

Governor Applications, Freedom Pass applications and reporting a problem on a public right of way

(6) The Tell Us Once project has been successfully piloted in Kent. People reporting a death need only give the information to a registrar. The Tell Us Once Process will ensure that a range of other public sector bodies are informed. The approach is currently being extended to the registration of births. Tell us Once is now being rolled out nationally.

(7) Gravesham Gateway is now operational, bringing to eight the number of open Gateways (plus the two mobiles). Sheerness Gateway is expected to open in the summer of this year as is the Ashford Plus gateway which will replace the existing facility. Subject to resolution of some estate-related issues, Swanley Gateway should be open by the end of the financial year. Remaining Gateway locations, options and opportunities are kept under constant review.

Workplace Transformation

6 (1) Since its creation in 2008, WorkPlace Transformation has been a cross-directorate programme involving representation from all directorates, and with appropriate geographical involvement in relation to individual projects. In conjunction with Personnel & Development, the Programme Manager has met with representatives of the recognised Trades Unions at least twice yearly. Each project has involved the established consultation with affected staff. To date, the programme has reported to the Chief Officer Group/Corporate Management Team, and more recently to the Access & Assessment Board, as well as to this Committee.

(2) In addition to the planned closure of St Lawrence House, Dartford in this current financial year WorkPlace Transformation was tasked at short notice with closing two major office sites: 17 Kings Hill Avenue, and Kroner House Annexes. As part of the longer-term strategy for Maidstone, a former storage area in Sessions House has also been converted, and is now in office use. The one-off costs were £1,717,432, delivering annual revenue savings of £1,499,674.

(3) It should be noted that recent projects had the potential to cause significant disruption and distress. However, to take the example of the closure of 17 Kings Hill Avenue, over 900 staff were moved directly and indirectly by the project, some by a considerable distance, without a single redundancy occurring – indeed, the project was praised at a recent County Council meeting for its communication and engagement with staff.

(4) Once additional programme costs (including officer time, preparatory work for future projects, but excluding borrowing costs, which are calculated across the eight year life of the programme) have been taken into account, the costs and savings to end March 2010 are:

Total costs - £3,120,866 (approximately 50:50 capital:revenue)
Total full-year annual revenue savings - £1,849,874

(5) WorkPlace Transformation has established savings targets in the short to medium term, and a means to achieve them. The programme's prime catalysts are the lease expiry/break dates on our existing leasehold estate, which in some cases are as late as 2015. Operational and other non-office buildings have not been directly

involved in the programme; however, they increasingly form part of the overall solution. WorkPlace Transformation has been considered the "back office" complement to Gateway, and the programmes remain in close contact.

(6) If the remainder of the programme is delivered on schedule, the additional net annual revenue savings are anticipated to be in excess of £1.2m (net of all costs, including reprovision of a proportion of the space). Work in 2010/11 has suggested that this could be increased, were the organisation to choose to take a more radical approach to the release of leasehold offices. However, a number of challenges will be addressed in the coming financial year, prior to a re-visioning of WorkPlace Transformation:

(i) Children's Social Services (CSS) Improvement Plan – the requirement to deliver improvements to the working environment (including access, parking and ICT) for CSS staff will impact directly on the potential for closing additional buildings.

(ii) Total Place – WorkPlace Transformation is now linked explicitly to the Total Place assets agenda, and now leads the discussions with district, county-wide and Whitehall partners, to identify and deliver on opportunities for property savings across Kent.

(iii) Financial Pressures and Restructuring – Current financial pressures and the corporate restructure will inevitably have an impact on the office requirements across the county.

(7) Given the nature and scale of these challenges, it would be inappropriate to speculate on the impact on future savings in the context of this report. The aim of the programme however remains to ensure that we have the right buildings in the right places for the 21st Century - for contact with Kent residents and for our staff, in conjunction with partner agencies, and to deliver real efficiencies, including reduced office costs.

(8) As part of the current restructuring, responsibility for the above services will transfer to the Customer and Communities Directorate on 4 April 2011.

Recommendations

Members are asked to **NOTE** the actions being taken to improve access to services and to achieve the savings targets set over the next four years for access and assessment.

Contact Officer:
Mike Ballard
Project Manager, Strategic Development Unit
mike.ballard@kent.gov.uk
Tel: 01622 694845

Background Documents:
Bold Steps for Kent: The Medium Term Plan to 2014/15
Medium Term Financial Plan 2011 – 13
Budget 2011/12

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By: Alex King – Deputy Leader
Mike Hill – Cabinet Member for Communities

To: Corporate Policy Overview Scrutiny Committee
31 March 2011

Subject: Potential Impact and Response to the Localism and Devolution Bill

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Summary: This report provides Members with an update on the Localism and Devolution Bill, the provisions of the Bill which if enacted will have a direct impact on the County Council and how the County Council working with partners is already responding to the emerging legislative framework.

Introduction

1. (1) At the last meeting of the Committee on 13 January it was agreed that a further report should be submitted to this meeting setting out the potential impact of the legislation on the County Council and how the Council with its partners is planning to respond to this proposed legislation.

(2) For the purposes of this paper we have concentrated on those aspects of the Bill which address the Government's commitment to localism by devolving greater freedoms to local authorities and communities. This includes introducing a general power of competence for local authorities, a community right to challenge and the right for communities to bid for community assets. The Bill also introduces new rules imposing tax referendums when a council sets an excessive council tax and strengthens rules relating to local referendums for other matters.

(3) Attached as **Appendix 1** is a summary of the Bill.

(4) On publishing the Bill, Eric Pickles Secretary of State for Communities and Local Government noted in a written ministerial statement that:

> "The legislation will set the foundations for the Big Society by radically transforming the relationships between central government, local government, communities and individuals. The provisions will devolve greater power and freedoms to councils and neighbourhoods, establish powerful new rights for communities, revolutionise the planning system, and give communities much more control over housing decisions.

> The Bill will expand councils' freedom to act in the interest of their local communities through a new general power of competence. This long awaited new power will mean that rather than needing to rely on specific powers, councils will have the legal reassurance and confidence to innovate and drive down costs to deliver more efficient services.
>
> Powers for councils will be accompanied by greater powers for local people to hold their local authorities to account and to shape their local area. There will be a new right to challenge to take over services; a new right to bid to buy assets of community value such as libraries, public houses and shops; and a new right to veto excessive council tax rises through a referendum."

General Power of Competence

2 The general power of competence for local authorities is a new power intended to give authorities the ability to act in the best interests of their communities, even if specific legislation does not give them the power to take the action they intend. Therefore, no action (except for raising taxes) will be beyond the power of local government, unless that action is prevented by law.

Community Empowerment

3. (1) The Bill introduces a number of measures designed to empower the local community. These include referendums to approve or reject excessive council tax increases, powers for organisations to challenge local authority service provision, and powers to enable organisations to bid for community assets when they are put up for sale. The Bill repeals some of the existing legislation, including the requirement to promote democracy, to take into account petitions from local people and groups and the wellbeing provisions of the Local Government Act 2000.

Local Referendums

(2) The Bill ensures that a principle local authority must hold a local referendum on a local issue if they are in receipt of a valid petition (the threshold for a valid petition is 5% of local electors for the area although it is anticipated that there will be the ability to increase or decrease this threshold by the Secretary of State) from local people, or a request from one of more members of the Council, or if the Council passes a resolution. In general authorities must allow a referendum but there is a clause which sets out the grounds when it will not be appropriate for a referendum to be held for example when the matter is not a local matter over which the authority (or partner authority) have an influence.

(3) Provision for various types of local referendum already exists in local government legislation. This includes the following:-

- Parish Polls which may be demanded at a parish meeting by a specified number of electors. These may be held on any question arising at the meeting but the result is not binding;

- Advisory referendums which may be held by a local authority on any matter relating to its services or powers of well-being
- Mayoral referendums whose results are binding

Council Tax referendums

(4) There are provisions in the Bill to ensure that excessive council tax increases are presented to the local electorate. Any such increases will have to be defended by the authority, and, if the local electorate disagrees with the Councils arguments, they will have the ability to vote against the increase. If this is the case, the Secretary of State must be informed of any Council setting an excessive council tax. The Council must prepare substitute calculations which are not excessive. This would then be used if the excessive increase is turned down by the local community.

(5) The main intention of these provisions is to increase the local accountability of a council, which will have to defend its decision on council tax to the electorate. It also removes the control previously exercised by the Secretary of State over local authority budgets, by removing the ability to cap those budgets.

Community Right to Challenge

(6) The Bill introduces a number of new elements intended to empower local communities. It introduces a community right to challenge the services run by relevant authorities. The right will apply to voluntary or community bodies, parish councils and employees of relevant authorities. If the expression of interest is accepted the authority must consider how the procurement exercise, would promote or improve the social, economic or environmental well-being of the area. The authority must notify the relevant body of its decision, and if the expression of interest is rejected set out its reasons for doing so; but it can only be rejected on grounds to be specified in regulations by the Secretary of State.

Assets of Community Value

(7) Contained within the Bill are some clauses requiring local authorities to maintain a list of community assets within their area.

(8) The provision is seen as an important step in ensuring that community assets such as libraries and pubs are not closed down just because an authority or other organisation can no longer afford to keep them open.

Response to the Emerging Localism Agenda

Kent Forum/Ambition Boards/Locality Boards

4. (1) Attached as **Appendix 2** is a Kent Forum Architecture Diagram which is part of a report which will be considered by the Kent Forum (which has replaced the Kent Partnership), on 25 March 2011. A verbal update on the Kent Forum discussion will be made at the meeting.

Locality Boards

(2) Members have expressed an interest in the emerging Partnership arrangements in particular the emerging role of the Locality Boards which are an exciting opportunity for all Members of this Council through their role both as an elected Member and collectively as a Member of a Locality Board to:-

- Advise the County Council and the District Council on the public service priorities for the locality, for example the Locality Board could become a key contributor to the local Sustainable Community Strategy and the owner of the Locality section of the Vision for Kent;
- To deliver the countywide Ambitions in "Bold Steps for Kent", **to grow the economy, to tackle disadvantage, to put citizens in control** in the locality, as relevant to the locality;
- Advise County and District Councils on service provision, moving towards combined place based commissioning where appropriate;
- Improve the local accountability to residents for public services in their locality; and
- Oversee public services in each locality through direct oversight in the case of local government services and through the exercise of community leadership for non local government services, for example by testing how the service delivery plans of other partners support the public service priorities of the locality.

(3) Locality Boards are a new way for the County Council and District Councils to work together. It is recognised that they will evolve differently and at different speeds.

(4) The core membership of the Locality Boards is the Leader of the District Council (who will be the Chairman of the Board) all Members who represent an electoral Division for that District and the requisite number of District Councillors to achieve parity. Members who are both Members of the County Council and District Council will serve on the Board in their County Council capacity unless they are also the Leader of the District Council.

(5) Working with our District Council partners we are preparing:-

(a) the provisions for a core governance framework;
(b) a core script for briefing our respective Members on the role Locality Board and the Members who serve on the Board; and
(c) the development of some shared training for the changing role of the elected Member to the emerging agenda of localism and devolution

(6) It is envisaged that some Locality Boards will over a period of time develop Commissioning role.

Delivering the Locality Pilots including Community Based Budgets

(7) The Kent Forum has also agreed to five Locality Pilots:-

- Dover - (a project around social cohesion/health). The Dover Locality Pilot has an overarching aim to deliver an integrated health and social care model for the future. A working group has been established and agreed a set of principles and objectives;
- Sevenoaks – a project around youth services;
- Swale – (a community based budget pilot around families with complex needs);
- Thanet – (a community based budget pilot around families with complex needs; and
- Tunbridge Wells (a pilot around community safety and enforcement)

(8) Preliminary statements of interest have been received regarding the Sevenoaks and Tunbridge Wells pilots. No detailed discussion or planning has yet taken place, pending the formal arrangements of the governance of the Locality Boards in these districts.

Scrutiny in the Locality

5. The Scrutiny Board are aware of the evolving Locality Board infrastructure and are keen to ensure that the scrutiny need at both a strategic level as well as in the locality are adequately reflected in the emerging mixed economy for the commissioning of services.

Recommendation:

6. The Corporate POSC are asked to note the comment on the report and the emerging infrastructure for responding to the proposed legislative framework for localism and devolution.

Paul Wickenden, Overview, Scrutiny and Localism Manager
Tel No: (01622) 694486
e-mail: paul.wickenden@kent.gov.uk

Background Information: *Nil*

Summary

The *Localism Bill* will implement the Coalition Government's policy of decentralisation of power to local authorities and local communities. It has been introduced at a time of cuts to local authority budgets as announced in the local government finance settlement in December 2010. A separate Library Research Paper, *Localism Bill: planning and housing*, Research Paper 11/03, has also been published covering the housing, planning and London elements of the Bill.

The Bill is part of the Government's 'Big Society' agenda. It seeks to empower local authorities by making a number of changes to the way in which local authorities operate. The Bill introduces a general power of competence for councils. This would allow them to take any action provided it is legal. This new power would replace the well-being powers available to local authorities under the Local Government Act 2000, which have been widely seen as under used. The Government intends that the new power will actively encourage innovation which the Government sees as particularly important at a time of cuts to budgets.

The Bill will also make changes to the governance arrangements of local authorities, by allowing them to return to the committee system of governance abolished by the Local Government Act 2000, and also allowing for mayoral referendums in the twelve largest cities in England. This has proved a controversial aspect of the Bill as previous experience has not indicated a strong desire on the part of the public for mayors to run major cities (other than in London).

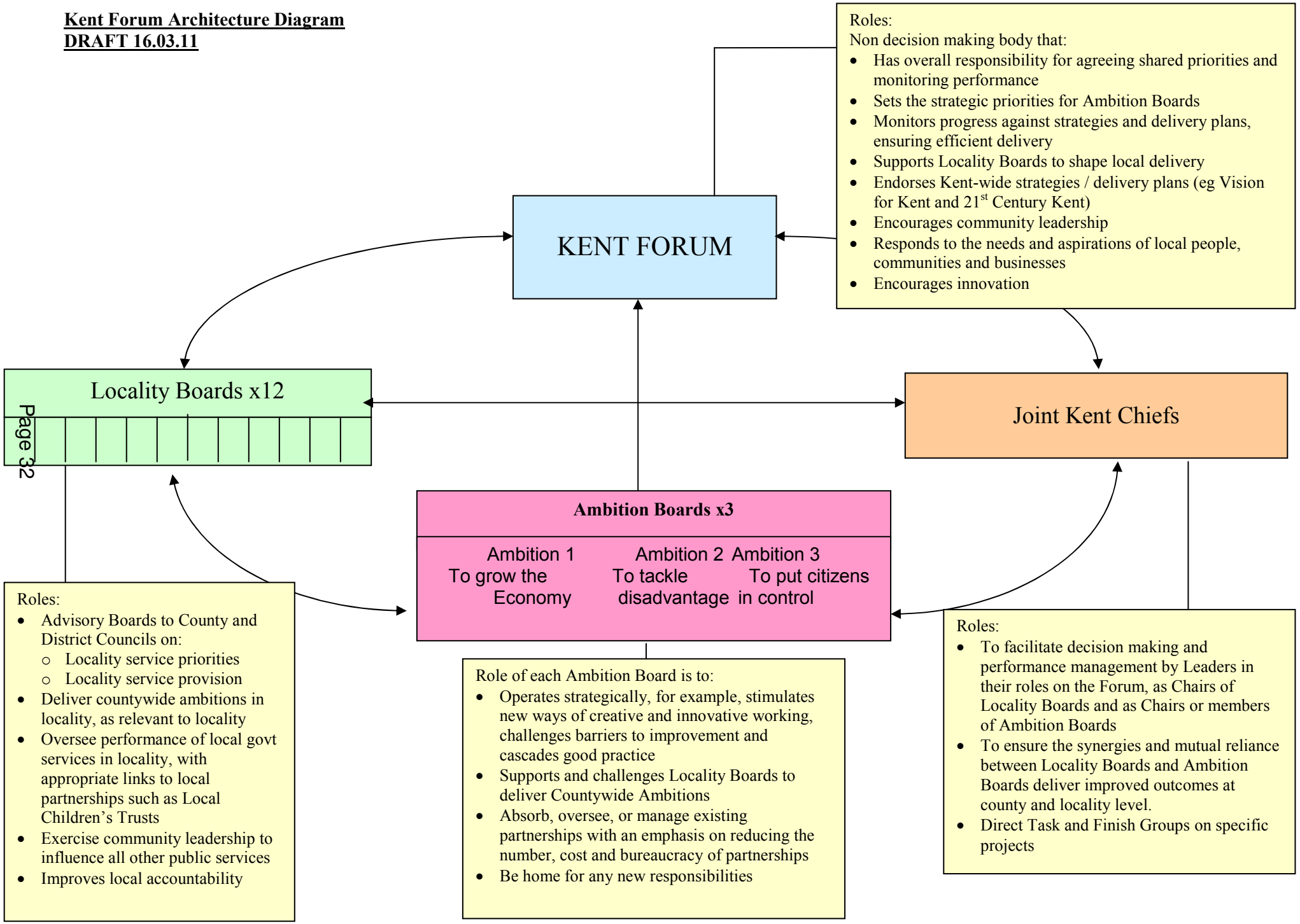
The Bill would abolish the requirement for local authorities to adopt a model code of conduct, instead introducing a voluntary code; and also abolishes Standards for England (previously the Standards Board for England) which oversees the current code. Instead, the Bill will introduce a requirement for local authorities to introduce a register of interests for members, as well as a new criminal offence of failing to declare a relevant interest. This element of the Bill has been criticised by the Committee on Standards in Public Life.

The Bill will introduce a requirement for local authorities to prepare and publish a pay policy for senior officers. The Bill will also introduce a new power to pass on the cost of EU sanctions to public authorities (including the Greater London Authority) in cases where the authority's actions have led to such sanctions. The Bill would make changes to the business rates regime in the areas of business rate supplements, discretionary reliefs and small business rates relief, as well as confirming the Government's commitment to waive substantial and unexpected backdated business rate liabilities suffered by certain port businesses.

The Bill will introduce a number of measures designed to empower communities. The current power to hold local referendums on issues of local interest will be enhanced, although the result of such a referendum will not be binding on the council. A new requirement to hold council tax referendums when the local authority introduces an excessive council tax will also be

introduced. The Bill will provide for a community right to challenge, which will allow community groups to challenge the way in which their local authority runs and delivers its services. Councils will also be required to prepare a list of community assets, which will not be able to be sold until community groups are given the opportunity to prepare a bid for such assets. However, the duty imposed by the previous Government to promote democracy and accept petitions will be repealed.

Kent Forum Architecture Diagram
DRAFT 16.03.11



To: Corporate Policy Overview and Scrutiny Committee

On: 31st March 2011

By: Graham Gibbens (Cabinet Member for Adult Social Care and Public Health)
Roger Gough (Cabinet Member for Business Strategy and Support and Health Transition)
Meradin Peachey (Director of Public Health)

Subject: KCC progress on changes to health service organisation

For: Information

1. Summary:

1.1. Recent white papers and proposed legislation are radically reforming the governance of the NHS, public health and social care. New arrangements to oversee the commissioning of health and other services have to be in place over the next two years. Kent is an "Early Implementer" for some of these changes and significant progress has now been made.

1.2. This report updates Corporate PO&SC on that progress especially regarding the county Health and Wellbeing Board and GP Commissioning Consortia.

2. Introduction

2.1. The Health and Social Care Bill currently before parliament puts into legislation the reforms that were announced in the white papers for the NHS and social care last year.

2.2. Corporate PO&SC has received regular updates on the provisions of the Bill and the changes it contains including the establishing of the NHS Commissioning Board to oversee the NHS, the abolition of Primary Care Trusts and Strategic Health Authorities and the creation of GP Commissioning Consortia (GPCC) who will become responsible for the local commissioning of the majority of NHS services in 2013.

2.3. The local Health and Wellbeing Board will have major responsibilities and the Joint Strategic Needs assessment (JSNA) and local Health and Wellbeing Strategy will assume much greater importance.

2.4. Local Healthwatch will evolve from the current LINK (Local Involvement Network) and assume greater responsibilities. (See attached APPENIDIX).

2.5. Separate reports are also being presented on related changes to the public health system proposed in the public health white paper "Healthy Lives, Healthy People" and the transitional arrangements associated with these.

3. Health and Wellbeing Boards

3.1. The Health and Social Care Bill requires local Health and Wellbeing Boards (H&WB boards) to be established at a unitary or upper tier local authority level and this is now a main focus of activity for local authorities. The board will be a statutory committee of the County Council.

3.2. These Boards must be operating in shadow form by April 2012 and will assume their full responsibilities from April 2013. Indicative budgets will be issued from April 2012.

3.3. Kent has successfully applied to the Department of Health be one of the "Early Implementer" authorities for H&WB boards and progress is now well under way.

3.4. The main functions of the H&WBB are defined in the Bill as:

- Ensuring the production of the Joint Strategic Needs Assessment (JSNA) which will identify the health priorities of the population

- Ensuring the production of the Pharmaceutical Needs Assessment (PNA) to identify what pharmaceutical services are needed

- Ensuring the production of the local Health and Wellbeing Strategy which is the agreed strategy to address the priorities identified by JSNA and PNA

- Ensuring the commissioning plans of the GPCC, Public Health, and Adult and Children's Social Care reflect the priorities of the JSNA and the Health and Wellbeing Strategy

- Promoting integration and partnership and joined up commissioning plans across the NHS, social care and public health

- Supporting joint commissioning and pooled budget arrangements where agreed (s75 arrangements)

3.5. The core membership of the board is also defined by the Bill:

- Elected Member
- Representatives of the GPCC
- Director of Public Health
- Director of Children's Services
- Director of Adult Social Services
- Local Healthwatch
- Others as locally agreed

3.6. Whilst this is the core membership there are obvious roles for others such as district council representatives to be included and it is intended that local arrangements are put in place to achieve this.

4. Kent position

4.1. As an "Early Implementer" Kent is well placed to begin working towards the shadow arrangements necessary from April next year. The first meeting of those organisations that will be involved in the H&WB board was held on 16th March with the inaugural meeting of the Board itself scheduled for June 15th. The meeting of 16th March was very much an exploratory workshop designed to develop relationships and identify what needed to be done to establish the Board proper.

4.2. A number of issues were identified alongside significant opportunities.

Issues:

- The financial challenge inc. £686 million Quality Innovation Productivity and Prevention programme (QIPP) target savings

- Board membership – how can this be wide enough to be representative but small enough to be effective?

- The agenda is potentially huge - how to avoid the board sitting in "permanent session"?

- What tools and support will the Health and Wellbeing Board need to discharge its functions?

- How do we link the county level board to localities?

Opportunities:

- Real involvement in the decision making about how health services will be delivered in Kent

- A process including the JSNA and H&WB Strategy where in depth knowledge of local health needs can influence what is delivered

- A way to integrate commissioning across a wide range of partners to achieve better health outcomes

- Possibility of joint commissioning and pooling budgets and resources to improve health and wellbeing across the county

4.3. GP's at the meeting agreed that a critical issue for the new arrangements will be to redesign care pathways to treat more people in the community and primary care to avoid expensive hospital admissions. Dementia care provides an excellent example of how this is necessary to improve care for patients as well as being more cost effective.

4.4. Some districts are also creating local H&WB boards to consider local health issues and priorities and discussions are ongoing about how these will relate to the overarching county level H&WB board.

5. GP Commissioning Consortia

5.1. GPCC's are being established to replace the commissioning function of the PCT's. (The current PCT's in Kent and Medway are now part of a single "consortium" as part of the transitional arrangements). There are no official guidelines for the size and shape of consortia and GP practices are free to organise themselves as they think best. The only stipulation is that all GP practices must belong to a consortia and the whole geographical area must be covered.

5.2. GPCC are still forming around Kent. It is a very fluid situation and is likely to remain so for some time. There is little co-terminosity between consortia and district council boundaries.

5.3. The current position is that there are 3 consortia in the old WK PCT area covering:

Dartford Gravesham and Swanley
Maidstone and Malling
South West Kent

And 9 in East Kent:

Ashford
C4 in Canterbury
Dover
DASH (Deal, Ash and Sandwich)
Shepway
Swale
Thanet
East Cliff (Thanet)
Whitstable

However we are expecting further significant changes before the final configuration is achieved.

5.4. The new arrangements will require new relationships to be established between the organisations concerned. In particular the County Council and the emerging GPCC need to work effectively together. Effective relations among and between the County Council, Districts and Consortia will also need to be forged. The Health and Wellbeing Board will provide the forum for these discussions to be held over the coming months.

6. Conclusion

6.1. With recent progress Kent is now well placed to develop the role of local authorities in the provision of health and public health in the county. The Health and Wellbeing Board will be an essential element in the necessary working relationships and the JSNA and Health and Wellbeing Strategy will assume major importance in shaping the commissioning decisions of the local authority and GPCC's.

6.2. Taken together the new arrangements should, overtime, provide a real opportunity to ensure the health and social care services in Kent properly reflect the priorities of local people.

6.3. Corporate PO&SC committee are asked to note the progress on implementing the provisions of the Health and Social Care Bill especially those relating to the Health and Wellbeing Board.

Meradin Peachey
Director of Public Health

LINKS AND THE DEVELOPMENT OF LOCAL HEALTHWATCH

Summary of key points

1. Local Involvement Networks (LINks)
    - were set up to strengthen and widen influence of users of health and social care services in the planning, provision and improvement of services
    - are statutory organisations with powers of entry
    - can refer matters of concern directly to the Secretary of State for Health
    - have 2 non-voting seats on the Kent HOSC
    - are funded through Local Authorities
    - are an independent network of local people and community groups

1. The Kent LINk is considered one of the more successful LINks nationally.

2. Contract renegotiations in place between the KCC and Kent and Medway Networks (the organisation that supports the Kent LINk with back office and community engagement expertise).

3. The Health & Social Care Bill currently before Parliament will create a new organisation called Local HealthWatch from April 2011. LINks will become part of Local HealthWatch and retain and strengthen their current community engagement functions. Local HealthWatch will also have other functions that will be commissioned through the Local Authorities:
    - signposting and provision of information
    - supporting the choice agenda for health and social care users
    - complaints advocacy from 2013
    - have a statutory place on the Health and Wellbeing Boards

4. Local Authorities will be held accountable for Local HealthWatch ensuring it
    - operates effectively
    - provides value for money

5. KCC will no longer be able to provide the functions of Kent HealthWatch in-house, so decisions will be needed as to whether to shut-down the current service or transfer to the new Local HealthWatch.

6. The Department of Health has set up a LHW Programme Board with an advisory group and task groups to ensure that the overview set out in the Health and Social Care Bill of how Local HealthWatch will operate is made a reality. KCC would be able to help shape the development of Local HealthWatch if they were to be formally represented at these groups.

7. Local HealthWatch will have strong ties into HealthWatch England, which will be a statutory committee of the Care Quality Commission

Background

The Local Government and Public Involvement in Health Act 2007 replaced Public and Patient Involvement Forums with Local Involvement Networks (LINks). LINks are local community based networks of organisations and individuals committed to strengthening and widening the influence of patients, users of care services, carers and the public in the planning, provision and improvement of health and social care services. The act proscribes PCTs, NHS Trusts etc from being LINks or from directly providing services that are listed as being the responsibility of the LINk. The Health and Social Care Act currently before parliament retains this clause.

The Local Government and Public Involvement in Health Act also sets out the requirement for each LINk to be supported by a Host organisation The role of the host organisation is to support the unpaid volunteers with all back office functions plus expertise in community development, partnership working, priority setting etc. Local Authorities are proscribed from providing Host responsibilities in-house. The Health and Social Care Act currently before parliament retains this clause.

Until 2011, Local Authorities were given a ring fenced grant to run the LINks. From 2011, the grant is no longer ring-fenced but is included in the PSS formula grant. However, in light of many Local Authorities stating an intention to seriously reduce the money passed to their LINk, Lord Howe is proposing to write to Local Authorities re-emphasising their statutory duty to support the LINk.

Current role of LINks

1. promote and support the involvement of people in the commissioning, provision and scrutiny of health and social care services;

2. obtain the views of people about their needs for, and experiences of, health and social care services, and make those views known to those responsible for commissioning, providing, managing or scrutinising those services;

3. enable people to monitor and review the commissioning and provision of health and care services; and

4. make reports and recommendations about how health and care services could, or should, be improved to those responsible for commissioning, providing, managing or scrutinising those services.

LINks currently have specific powers to:

- enter certain types of premises and view the services provided;
- request information and receive a response in a specified timescale;

- make reports and recommendations and receive a response in a specified timescale; and refer matters to a health or social care Overview and Scrutiny Committee and receive a response
- can refer matters of concern directly to the Secretary of State for Health

As per government guidance, LINks has two non-voting seats at the Health Overview and Scrutiny Committee, usually filled by LINk Governors Mark Fittock, and Roger Kendall

The Kent LINk and Kent and Medway Networks

In 2007 KCC tendered for a host organisation to set up and support the Kent LINk and selected Kent and Medway Networks (KMN) who also support the Medway LINk. The contract between KCC and KMN is currently managed within Environment Highways and Waste, chosen as EHW have almost no ties to health or social care and this would therefore ensure that the LINk stayed as independent as possible from KCC.

In Kent, the ring-fenced grant to support the Kent LINk has amounted to approximately £492k per annum of which KCC retains approximately 10%, used to pay for a contract monitoring officer and towards a HealthWatch Development Manager. The remaining £440k is paid in monthly instalments to KMN who retain £258k and pass £182k to the Kent LINk. The Kent LINk has been running with a significant underspend since their creation, mainly because of their slow start. The current underspend is £114k, down from the previous end of year underspend of £214.8k.

The LINk work programme is determined by a combination of horizon scanning and referrals from the LINks Priorities Panel, which considers and weights each issue raised with it. Although the Kent LINk got off to a slow start and still has problems engaging enough active participants to undertake the volume of work it is requested to take on, they have done some excellent work including projects on Hygiene in Hospitals, Transport to Hospitals, Stroke Services. They also run public consultation events, for example a debate on 23rd March entitled "Changes in the NHS - What will it mean for your and your doctor?' Speakers include Ann Sutton, Chief Executive, NHS Eastern and Coastal Kent and Dr Bob Bowes, a Tunbridge Wells GP.

KASS and Eastern and Coastal Kent NHS have commissioned the Kent LINk to undertake additional public engagement events.

The contract between KCC and KMN is due to expire on 31/3/2011. A memo of understanding has been drawn up to role over the existing contract until end of June 2011. Contract negotiations are underway with the intention to vary the contract to improve

- Financial reporting
- Website design
- Complaints
- Review of payments to set up a LHW Development Fund

Local Authority LINk reps are considering how they can benchmark the performance of their LINk and the Host organisation. KCC and KMN are working together to determine what measures we could put in place which would then form part of the contract variations.

KCC are also going to tidy the contract to be more specific about the intellectual and property copyrights of the volunteer database.

Assuming successful negotiation, the contract will be extended to end of March 2012. If KCC wants extra help from KMN in the development of LINks into Local HealthWatch, this will be negotiated separately. The Health and Social Care Bill will allow for Local Authorities to have separate contracts with the LINk and the Host; KCC is reviewing the advantages and disadvantages of this approach.

Local HealthWatch and the future of LINks

Government sees the big difference between LINks and Local HealthWatch as:

"LINks has influence; Local HealthWatch will be part of decision-making"

Within the vision for the NHS described in "Equity and excellence: liberating the NHS" is that the NHS puts patients and the public first; operates around the principle of shared decision-making as the norm; learns from people's experiences of using services; and listens to patients and the public in the commissioning and provision of services for local communities. Local HealthWatch is to be the vehicle that will deliver this part of the vision. Government's strategy is to build on existing arrangements rather than decommission. LINks will be the key building block of the new Local HealthWatch and will provide the same function of strengthening and widening the influence of patients, service users, carers and the public in the planning, provision and improvement of health and social care services. From this perspective, LINks can be seen as evolving into Local HealthWatch.

In addition to this community-based remit, Local HealthWatch will also provide help to individuals through advice and assistance in making choices (from April 2012) and advocacy for those wanting to make a complaint about an NHS service (from April 2013). Local Authorities will have a statutory responsibility to commission and fund these services. The Health and Social Care Bill anticipates that HealthWatch will have available funding of £53.9 million for 2012/13 plus £3.2 million for start-up costs. In 2013/14, when local authorities take on responsibility for commissioning NHS complaints advocacy, the combined funding available for local HealthWatch and NHS complaints advocacy services will rise to £66.1m.

Local HealthWatch is seen by government as a brand rather than a single organisation. Whilst LINks will take on the community voice role, Local Authorities could commission advice & support and advocacy from separate organisations.

Local HealthWatch organisations will be accountable to local authorities for operating effectively and providing value for money. However, Local HealthWatch has a strong link into a new organisation, HealthWatch England, which will be a statutory committee of the Care Quality Commission. Healthwatch England will be a national body representing the views of users of health and social care services, other members of the public and Local Healthwatch organisations. Healthwatch England will advise and provide information to Local Healthwatch organisations on their functions.

At least one representative of Local HealthWatch will sit on the new local authority Health and Wellbeing Board helping to ensure that the consumer voice is part of the wider, strategic decision-making across local NHS services, adult social care and health improvement. It is not yet clear whether and how this may affect the current LINks role on Scrutiny.

Building the future

Central Government has set up a LHW Programme Board supported by the HealthWatch Advisory Group which in turn will be supported by a number of specific task groups.

Local Authorities will have a crucial role in shaping and creating the new Local HealthWatch. This is a great opportunity to set up a system that will play a key role in ensuring that health and social care services meet the needs of the people of Kent in a way that has, arguably, eluded us before. Not only can KCC make a huge difference for the people of Kent, we also have the opportunity, through the Local HealthWatch Pathfinder programme, to influence the national agenda for patient and public participation in the design and quality of health and care services. There are also risks. Central Government currently seem less inclined to listen to Local Authorities than perhaps we would like and restructuring of KCC and the NHS may affect resources available for this work.

Amongst the tasks that we will need to take on to make Local HealthWatch a reality are:

1. Create a Development fund for Local HealthWatch. Most LAs are carving this out of the LINks money. KCC could also provide people to help with this. Currently the resources allocated to LINks are a Performance Management Officer whose contract is due to expire in October 2011. Her current role is to monitor the contract between KCC and the host, KMN; there is also some Health Policy Manager time allocated to the project. Eastern and Coastal Kent PCT has offered some help in running the development project through their Director of Communications and Citizen Engagement.

2. Develop the KCC, Kent LINk and KMN joint bid to become a Local HealthWatch Pathfinder.

3. Reviewing and putting into practice the guidance from the DH Learning Action sets

4. KCC may want to apply for membership of one or more the HealthWatch Task Groups

5. Consider tie in between LINks community engagement and our own community engagement – streamlining, avoiding duplication, reducing costs and taking advantage of the independence of the LINk/Local HealthWatch

6. Review of how Adult Social Care complaints are handled and by whom. How will joint health and social care complaints be dealt with and by whom? Currently, where a complaint involves both KASS and the NHS, the NHS take lead responsibility; the PCT PALS service currently takes a lead role in complaint management and supporting people with their complaints. Complaint information will need to be collated, reviewed and shared with LINks, the Complaints Advocacy Service, possibly the Health and Wellbeing Board.

7. Future of Kent HealthWatch. KCC will not be able to provide this in-house from April 2012. Need to consider shutdown or transfer to other organisation(s).

8. Commissioning new services – complaint advocacy, information and support for choice, signposting.

9. Retendering for the host for Local HealthWatch after 2012

The above are not a full set of tasks – further discussions to scope the project are needed with the Kent LINk, Kent and Medway Networks, the ECK PCT Director of Communications and Citizen Engagement, Customer Care in KASS and Children Social Services, local NHS PALs services, the KCC Director of Communication, Consultation & Community Engagement, once appointed. Further paper(s) giving updates and options for developing the Local HealthWatch will be taken to Cabinet and shared with relevant Overview and Scrutiny Committees

Tish Gailey
Health Policy Manager
KCC Public Health Department

By: Graham Gibbens Cabinet Member for Adult Social Care and Public Health

To: Corporate Policy Overview and Scrutiny Committee 31st March 2011

Subject: KCC response to the consultations on the public health white paper, Healthy Lives, Healthy People and the associated documents on funding and outcomes.

Classification: Unrestricted

For: Information

Summary

1. (1) The Public Health White Paper - Healthy Lives, Healthy People – Our strategy for public health in England and associated documents - Consultation on the funding and commissioning routes for public health, and Proposals for a Public Health Outcomes Framework - have been issued for consultation by the Department of Health for responses by 31st March 2011.

(2) This report brings together the draft of a KCC response to all three consultations that has been considered and amended by CMT and Cabinet and is now before Corporate PO&SC.

Introduction

2. (1) The changes proposed in Healthy Lives, Healthy People are the most far reaching reforms of public health since 1974. They happen at the same time, and are linked to, the reforms to the NHS and adult social care now contained in the Health and Social Care Bill currently before parliament. The new structures are due to come into effect in April 2013, although shadow arrangements are expected to be in place much earlier. Commissioning responsibilities for public health activity will now be split between the new national organisation separate from the NHS, Public Health England (PHE), the local authority, and the NHS Commissioning Board:

Activities to be commissioned through PHE:

- Current functions of the Health Protection Agency
- National nutrition programmes (with some local LA activity)
- Emergency preparedness (supported by LAs)

- Health intelligence and information (jointly with LAs)

Activities to be commissioned through Local Authorities (including some that KCC already has full or partial responsibility for which are italicised):

- *Sexual health services (apart from contraceptive services)*
- School immunisation programmes
- Local initiatives to reduce seasonal mortality excess deaths
- *Local initiatives such as falls prevention services*
- *Mental health promotion, mental illness and suicide prevention*
- *Local activity to promote physical activity*
- *Local programmes to prevent/address obesity*
- *Drug & alcohol misuse services, prevention and treatment*
- Tobacco control
- NHS Health Check Programme (assessment & lifestyle intervention only)
- *Local initiatives to promote health in the workplace*
- Reducing and preventing birth defects (jointly with PHE)
- Campaigns and services to promote prevention & early presentation of cancer and long-term conditions
- Dental public health (supported by PHE for coordination of surveys)
- *Specialist domestic violence services*
- *Support for families with multiple problems*
- *Health intelligence and information (jointly with PHE)*

It is proposed that LAs are mandated to provide or commission a limited number of these services but it has not yet been determined which these should be.

Activities to be commissioned through the NHS Commissioning Board:

- Contraceptive services (via GP contract)
- Vaccine programmes for children
- Flu & pneumococcal vaccines for older people (including via GP contract)
- Targeted neonatal immunisations
- Screening (quality assurance and monitoring by PHE; cervical screening in GP contract)
- Health visiting services
- Healthy Child Programme for school age children (commissioned as part of health visiting services for under 5's)
- Public health care for those in prison or custody

(2) The proposals are extremely significant for local authorities both in terms of new functions and the funding streams that apply to them. The location of public health functions within local authorities is a very welcome development but we must be careful to ensure that the allocation of funding and the ways in which progress will be measured are fair to upper tier authorities in general and Kent in particular.

(3) Work is in hand to ascertain all the resources and funding streams for public health activity currently located within the PCTs. So far over £17m has been identified as being spent on health promotion activities across Kent. These include stop smoking services, healthy

weight services, health trainers, sexual health services, healthy schools, alcohol services etc.

(4) A report concerning the staffing and other transitional issues associated with the transfer of public health functions to KCC by the Director of Public Health is attached as an appendix to this report.

Consultation process

3. (1) This report concerns the KCC response to the consultation. Other organisations involved in public health have made their views and observations known and these have been considered and incorporated where relevant. However this does not replace the responses of any other organisations involved in public health in Kent.

(2) In order to compile the KCC response a cross-directorate working group was established and chaired by the Head of Public Health Policy. This has included active representation from all current KCC directorates and the Kent Forum team.

(3) A well attended consultation event was held with colleagues from district councils the NHS and KCC to discuss the main themes and issues contained in the papers.

(3) The deadline for submission to the Department of Health is 31st March. Usual procedure could include consideration by full cabinet but as there is no cabinet meeting in March KCC sign off is proposed to be by cabinet member following cabinet briefing on 21st March.

(4) Further consultations on specific public health topics will continue to be issued by the DH during the coming year.

Headline issues for Kent in the consultation papers

4. (1) This report does not summarise the main provisions of the consultation papers as for the White Paper this can be found in the initial report to CMT on 7th December 2010. Summaries of the other two documents are contained within this report. However there are some overarching headline issues related to each document that have informed the draft responses.

Healthy Lives, Healthy People

(2) For the white paper itself we welcome changes to PH system and location of PH function within the local authority which we have been advocating for some years. The transfer of a ring-fenced budget is also welcome. PHE being established as a separate entity outside the NHS is a positive move. Introduction of local accountability through involvement of elected members is important. However most details

and key issues are contained in associated consultations on funding and outcomes.

Consultation on the Funding and Commissioning Routes for Public Health

(3) The critical issue is how will the national formula for the main allocation of budget be decided? Kent's experience of nationally applied formulae is that they are often disadvantageous to Kent because of geography and population issues. Similarly how the proposed "Health Premium" is constructed will be critical if Kent is to benefit from it. In particular the population level at which both the basic formula and the health premium are calculated and applied will determine the financial consequences for Kent.

Proposals for a Public Health Outcomes Framework

(4) The population issues that inform the commissioning and funding responses are also critical in deciding which outcomes should be measured. This is also an important consideration in the application of the Health Premium. For an upper tier authority the ability to measure progress at a local level with a variety of indicators that properly reflect local issues and priorities is important. The ability to collect relevant indicators in year, in order to show progress to influence the application of the Health Premium is also an issue in many public health activities.

(5) In considering which outcomes we would support we have applied some basic principles: Does the measure have a direct relationship to the general health and wellbeing of the population? Can its measurement be both accurate and timely? Is it a measure that can be applied to a range of population groups?

SUMMARY OF PUBLIC HEALTH COMMISSIONING AND FUNDING PAPER

1. Healthy Lives, Healthy People: Consultation on the funding and commissioning routes for public health

1) This consultation document complements the Public Health White Paper, seeking views on the functions and commissioning mechanisms for public health, the public health ring-fenced budget and proposed new health premium.

2. The Public Health System

1) Whilst central government will be directly accountable for protecting and improving public health through the new Public Health England. Wherever possible, functions will be devolved to local level. The key elements of the new system are:

- Public Health England (PHE) will be established, combining health protection and improvement functions.
- Responsibility for local health improvement will transfer from the NHS to Local Authorities
- Local Authorities (LAs) will employ Directors of Public Health and will be responsible for preventative services and some health protection functions.
- Health & Wellbeing Boards will be established in upper tier/unitary authorities, bringing together GP Commissioning Consortia, public health and social care, and Healthwatch to promote partnership and coordinate decisions about commissioning.

3. Funding and Commissioning Flows

1) Using a new ring-fenced public health budget, PHE will fund public health through:
   - Allocating funding to LAs (under s31 of the Local Government Act), which will be separate from the funding of existing health protection and public health functions they provide (e.g. housing, leisure and social care primary prevention).
   - Commissioning services via the NHS Commissioning Board (e.g. screening programmes), either directly or by GP Consortia, where 'activity is best commissioned as part of pathway of health care' or already part of primary care contracts.
   - Directly commissioning or providing services (e.g. campaigns & Health Protection Agency functions).

2) Some services will be commissioned at sub-national level, which could be through PHE or LAs e.g. services for victims of sexual violence. The broad funding flows are set out diagrammatically in s2.3 of the consultation.

4. Activities Funded & Proposed Commissioning Route

1) In defining which activities will be funded by the public health budget, the definition given by the Faculty of Public Health is used, account has also been taken of potential impact on health inequalities and decisions have been made on the premise that where ever possible, 'activity should be commissioned by local authorities according to locally identified needs and priorities'. The 'unique advantage' LAs have 'in terms of tackling the wider determinants of health' is acknowledged, in light of their wider functions and their knowledge of the needs of 'vulnerable groups' which will enable them to inform commissioning decisions.

2) Proposed activities and primary commissioning routes are set out against associated NHS-funded activities, so illustrating the boundary of the public health role and NHS activity, whilst acknowledging the interdependency and the fact that public health 'advice will need to be part of designing whole pathways of care'. All but 5 activities have associated activity funded by the NHS. Views are sought on all but a small number of activities and funding route proposals which will be determined through the Health & Social Care Bill. The paper gives further detail of the summary of activities and commissioning routes set out below:

Activities to be commissioned through PHE:

- Current functions of the Health Protection Agency
- National nutrition programmes (with some local LA activity)
- Emergency preparedness (supported by LAs)
- Health intelligence and information (jointly with LAs)
-

Activities to be commissioned through Local Authorities:

- Sexual health services (apart from contraceptive services)
- School immunisation programmes
- Local initiatives to reduce seasonal mortality excess deaths
- Local initiatives such as falls prevention services
- Mental health promotion, mental illness and suicide prevention
- Local activity to promote physical activity
- Local programmes to prevent/address obesity
- Drug & alcohol misuse services, prevention and treatment
- Tobacco control
- NHS Health Check Programme (assessment & lifestyle intervention only)
- Local initiatives to promote health in the workplace
- Reducing and preventing birth defects (jointly with PHE)
- Campaigns and services to promote prevention & early presentation of cancer and long-term conditions
- Dental public health (supported by PHE for coordination of surveys)
- Specialist domestic violence services

- Support for families with multiple problems
- Health intelligence and information (jointly with PHE)

It is proposed that LAs are mandated to provide or commission a limited number of these services but it has not yet been determined which these should be.

Activities to be commissioned through the NHS Commissioning Board:

- Contraceptive services (via GP contract)
- Vaccine programmes for children
- Flu & pneumococcal vaccines for older people (including via GP contract)
- Targeted neonatal immunisations
- Screening (quality assurance and monitoring by PHE; cervical screening in GP contract)
- Health visiting services
- Healthy Child Programme for school age children (commissioned as part of health visiting services for under 5's)
- Public health care for those in prison or custody

3) In addition, it is noted that to 'increase the incentives for GP practices to improve the health of their patients' it is proposed that 15% of the current value of the Quality & Outcomes Framework should be devoted to public health and primary care indicators. This will be 'cash-neutral' with new indicators replacing existing less effective ones.

5. Public Health Budget & Accountability

1) The Secretary of State (SoS) for Health remains accountable for health and social care resources, policy, legislation and progress against national outcomes, with PHE accountable to the SoS. Where services are commissioned by the NHS Commissioning Board on PHE behalf, clear lines of accountability will be established.

2) The overall budget for public health has not yet been determined. In determining ring-fenced budgets for LAs, health inequalities will be taken into account through weighting. The approach to determining the allocations formulae will be based on consideration of 'utilisation', 'cost-effectiveness', 'population health measures'.

3) Data on performance against the Public Health Outcomes Framework will be published by PHE, whilst Health & Wellbeing Boards will provide forums to enable co-ordination of commissioning, underpinned by 'a new health improvement duty' on LAs.

6. Public Health Premium

1) To 'incentivise action to reduce health inequalities' a new 'health premium' will be introduced. Payments will be determined by 'progress made in improving the health of the local population and reducing health inequalities', with greater premiums for progress in disadvantaged areas, 'recognising that they face the greatest challenges'. It will be a sliding scale, dependent on the 'size and extent of a local authority's progress and relative to the authorities position in terms of relative health outcomes'.

2) Early consideration of the commissioning and funding paper raises a number of issues for KCC. The calculation of the Health Premium needs to be at an appropriate geographical level (see briefing on the outcomes framework paper).

3) The amount of funding in the "ring-fenced" allocation has yet to be determined. The general assumption is that it will be c.4% of current PCT budgets (set at 09/10 levels to avoid issues of recent disinvestment in relevant activities). However this figure will include the PHE "top slice" for the activities for which they will retain responsibility, commissioning from the NHS and the Health Premium. The exact figure could be substantially less than previously anticipated.

   The consultations, including all questions and how to respond can be found at:
   http://www.dh.gov.uk/en/Consultations/Liveconsultations/DH_122916

   The deadline for responses to the consultation is: 31st March 2011.

SUMMARY OF PUBLIC HEALTH OUTCOMES PAPER

1. Healthy Lives, Healthy People: Transparency in Outcomes, Proposals for a Public Health Outcomes Framework

1) The Outcomes Framework aims to reflect the collective responsibility of communities, local authorities, their partners and Government in improving and protecting health and wellbeing.

2) The aim is to focus on transparent health outcomes with 'top-down targets' being 'replaced by a new public health outcomes framework'. This is intended to increase accountability with an 'end to central control' and giving 'local government the freedom, responsibility and financing to innovate and develop their own ways of improving public health'. It should also promote the basic principle of the white paper

   "To improve and protect the nation's health and to improve the health of the poorest, fastest."

3) The outcomes framework should reflect the contributions made at national and local level, and across public services. It should promote joint working. It is not a top down framework to drive targets and performance management –it will set out the outcomes for public health across public services and at all levels of responsibility.

4) The framework should:

   - use indicators which are meaningful to people and communities;
   - focus on major causes and impacts of health inequality, disease, and premature mortality;
   - take account of statutory duties including equalities legislation
   - adopt a life course approach, and
   - as far as possible be based on evidence and data.

2. Purpose of the Outcome Framework

1) The Outcome framework has 3 purposes:
   - To set out government's goals for improving and protecting the nation's health and wellbeing, and for narrowing health inequalities through improving the health of the poorest, fastest;
   - To provide a mechanism for transparency and accountability across the public health system at the national and local level for health improvement and protection and inequality reduction; and
   - To provide the mechanism to incentivise local health improvement and inequality reduction against specific public health outcomes through the 'health premium'.

3. Indicators

1) A subset of indicators, agreed by the Department of Health, Public Health England and local government partners, will measure progress especially regarding health inequalities. Improving health inequalities in the area will attract a Health Premium payment in addition to the basic ring-fenced grant given to local authorities, designed incentivise councils.

2) The framework is organised as a set of indicators aligned to each of 5 domains.

   Domain 1 contains overarching indicators for all domains:

   - Healthy life expectancy.
   - Differences in life expectancy and healthy life expectancy between communities.

   These are key indicators for measuring the overall health of the population but suffer from the problem that they take a long time to show accurate results and trends. In order to track progress in shorter timescales other indicators will be necessary.

   The other 4 domains reflect important aspects of health and wellbeing and numerous examples of indicators are given which the consultation process is intended to whittle down to a manageable number.

   Domain 2: Health protection and resilience: protect the population's health from major emergencies and remain resilient to harm.

   Example indicator: Population vaccination coverage (for each of the national vaccination programmes across the life course).

   Domain 3: Tackling the wider determinants of ill health: tackling factors which affect health and wellbeing.

   Example indicator: People killed and seriously injured on England's roads.

   Domain 4: Health Improvement: Helping people to live healthy lifestyles and make healthy choices.

   Example indicator: Prevalence of healthy weight in 4-5 and 10-11 year olds.

   Domain 5: Prevention of ill health: reducing the number of people living with preventable ill health.

   Example indicator: Breastfeeding initiation and prevalence at 6-8 weeks after birth.

Domain 5: Healthy life expectancy and preventable mortality: preventing people from dying prematurely.

Example indicator: Suicide rate.

It is intended that all indicators performance should be publically available.

All the examples are available in the document on the DH consultation website:
http://www.dh.gov.uk/en/Consultations/Liveconsultations/DH_122962

3) The outcomes are also intended to align with those for the NHS and adult social care, also recently issued for consultation.

Early examination of the consultation paper suggests there are several important issues for KCC and other upper tier authorities:

The geographical level at which the outcomes are measured will be critical. For Kent, which has some large areas of deprivation but also many more isolated, smaller pockets within districts, improvements in heath inequality need to be measured at a very local level.

It is also important that the indicators do not generate a new data collection industry and can be aligned with those we will adopt for other purposes such as those for the Kent Forum. Indicators also need to be measurable and relevant.

The proposed indicators contain a mixed bag of those that seem to make a lot of sense, some that reflect serious issues but are not in themselves necessarily good measures of general health and wellbeing, some that could be very useful if listed in a different domain, and some that do not appear to be indicators at all.

Conclusion

5. (1) This consultation exercise enables KCC to help influence the biggest change to public health provision in nearly 40 years. The decisions made on how these changes are implemented and the funding and performance issues associated with them will have profound effects on local authorities for many years to come.

(2) Corporate Policy Overview and Scrutiny Committee is asked to note the draft consultation response.

Appendices

- Response to Healthy Lives, Healthy People
- Response to Proposals for a Public Health Outcomes Framework (Introduction and questions 1 – 12)
- Response to Consultation on the Funding and Commissioning Routes for Public Health (Introduction and questions 1 – 16)
- Proposal for the Public Health Transition to Kent County Council – Report by DPH

Background papers – CMT report on Healthy Lives, Healthy People 7th December 2010

Meradin Peachey

Director of Public Health

21st March 2011

KCC CONSULTATION RESPONSE

Introduction to response to Public Health White Paper – Healthy Lives, Healthy People.

Kent County Council welcomes the White Paper's emphasis on the extensive contribution local government can make to the health of the population through its functions and it is right that the chief responsibility for public health should return to local authorities. We also welcome the opportunity to respond to the consultation on *Healthy Lives, Healthy People* and its associated documents as they herald very significant change and opportunities for local government.

In addition to responding to the specific questions posed in the White Paper there are a number of more general points we would wish to make.

Structure

The thrust of the White Paper and a number of its proposals were widely rehearsed and were also announced in the NHS White Paper "Liberating the NHS". However how the new public health system can be made to work will depend largely on the arrangements for funding and commissioning and the relevance of the outcomes selected. These will be addressed more fully in the relevant responses to the funding and commissioning and outcomes papers that have been issued since the White Paper itself.

The creation of Public Health England is a positive development and it's formal separation from the NHS is welcome. There remains a need for greater clarity of the relationship between public health, the NHS and GP consortia.

The extension of the role of the DPH is also positive as long as the post is properly located within the top tier management of the organisation.

We support the "non-silo" approach at both a national and local level – Public Health is everybody's business

Finance

Ring-fencing of the public health budget has many advantages but it must not be allowed to detract from local ability to determine priorities and funding. It is also important that the budget is not assumed to be committed to the continuance of existing services.

Dependent upon the measures adopted we broadly welcome the Health Premium but the relationship between premium payments and the base budget needs to ensure that does not lead to distortions whereby areas that need resources the most are disadvantaged by premium payments to more "successful" authorities.

Generally the expressed need for simplicity in the funding formula, premium payments and outcomes must be maintained.

It is important for local government to have the full resources to implement its responsibilities for public health. It needs to be recognised the significant responsibilities that DsPH currently have in health protection for the quality assurance of screening programmes, ensuring high uptake rates in all communities of screening programmes all immunisation programmes, commissioning, quality and ensuring high uptake rates in all communities. These functions are carried out by staff in our local public health teams and it is important that all these responsibilities are transferred to local government with the teams.

We support the transfer of health improvement resources to local government and the responsibility for commissioning these. We would like to see commissioning resources to be included within the ring fenced budgets.

Philosophy and approach

Health Inequalities are the most serious public health issue (even in what is often considered to be a relatively wealthy area such as Kent) and we welcome the emphasis placed upon addressing them. We are therefore pleased that the White Paper builds on the Marmot report and we have considered its proposals in the context of Marmot. However we note that the White Paper is silent on the Marmot recommendation "Ensuring a healthy standard of living for all".

We agree with the approach proposed in the White Paper as described by the 4 R's – responsive, resourced, rigorous and resilient. The emphasis on "nudge" rather than "nag" or "nanny" is a positive one and the ladder of interventions provides a useful framework.

We must also be sensitive to the need to balance use of current evidence with the need to build up evidence on the success (or otherwise) of the new approaches – nudge, social cohesion etc. in order to promote innovation.

The wisdom of Responsibility Deals remains controversial and KCC would wish to remain neutral on this point until there are indications as to their effectiveness or not. We would prefer them to be considered as experimental and be properly evaluated before any long-term commitment to them is made.

In response to the wider proposals set out in the Public Health White Paper we would propose that all training and education providers should ensure that the new approaches and emphasis in the Public Health White Paper and in the Marmot review - behaviour change, "nudge", building social cohesion and capital, supporting resilience – are reflected in the provision of all relevant programmes. This will include a range of training and education that is not specifically identified as a public health programme e.g. social work qualifications. The emphasis in the Health and Social Care Bill on localism and putting citizens in control should also feature strongly in training programmes.

KCC RESPONSE TO THE SPECIFIC QUESTIONS POSED IN HEALTHY LIVES, HEALTHY PEOPLE

Question a.
Are there additional ways in which we can ensure that GPs and GP practices will continue to play a role in areas for which PH England will take responsibility?

The involvement of GP's in developing and supporting Public Health is critical. Not only will they control budgets that can make a big difference to PH but it is essential that all elements of the health system become more integrated to be most effective at an individual and population level.

The availability of robust evidence based cost benefit analysis of prevention and public health interventions, with a particular emphasis on how it can support and reduce the necessity for primary and acute care, will be vital. PHE should lead on developing this analysis so that local health and wellbeing boards can use it to inform their JSNA and health and wellbeing strategies.
Involving GP's in the evidence base and data collection – using their local knowledge of the population they serve whilst recognising they mostly see part of it in particular circumstances may help engage them in a positive way.

How GPs can be incentivised to take on a greater role in public health interventions needs more thought. We welcome the idea of quality premium for GPs and would like to see public health outcomes feature prominently in them. Clear leadership from PHE, the NHS Commissioning Board and NICE about the contribution GP's are expected to make to PH would be very useful. In terms of GP outcomes both QUIPP and QOF should be configured to give incentives for positive public health outcomes.

There may some incentivisation for GPs on reducing the time they spend with the "worried well" by better public health information and messaging.

Another important aspect will be the integration of the outcomes frameworks for PH, the NHS and Adult Social Care which should operate as shared accountability measures. We strongly support the creation of the Joint Health and Wellbeing Strategy which will underpin the integration of Public Health and GP commissioning plans.

The role of the GP has predominantly been a medical one although GPs are well positioned and are often the first line of contact with patients whose social circumstances are likely to affect their health. There are many excellent examples of GPs taking a very active role in public health but some GPs may still see their role as treating the ill who present themselves at surgery. The target group for public health services needs to be expanded to include those who defer from attending the GP surgery, as they may be the very people who require early intervention or prevention. Whilst integration of commissioning plans and agreement to work towards the ambitions set out in the Health and Wellbeing Strategy will help GPs to take a more active interest in Public Health, PHE should consider how they can support and incentivise GPs to

take on a more preventative and population based approach. A considered and manageable approach to raising PH awareness, providing advice and identifying commissioning priorities for GPs to help them take on a greater PH role is needed. Ideally, support would be provided for GPs that is delivered in a structured and whole-systems approach. PCTs are currently working very closely with GPs; Local Authorities and other agencies need to be able to tie in with these development plans to ensure that the more integrated approach to health, public health and social care is developed. GPs need to be aware of other commissioning functions performed by the Local Authority within the community to maximise opportunities for referral and avoid duplication.

GP's may need some help in moving more to the social model of intervention to address health inequalities as Michael Marmot's report requires. GP engagement in the wider determinants discussion will be promoted by their inclusion on Health and Wellbeing Boards, their contribution to JSNAs and the Joint Health and Wellbeing Strategies and the integration of commissioning plans. In Kent we are working towards tying in Health and Wellbeing Boards to our local strategic partnership now rebadged as the Kent Forum. The Kent Forum is focussed on delivering outcomes on reduced resources and re-emphasising the leadership role of democratically elected Members. Central to the partnership arrangements is a core focus on the three Ambitions identified as central to the aims of the County, they are:

i) To Grow the Economy
ii) To Tackle Disadvantage and
iii) To Put Citizens In Control.

Tackling disadvantage and putting citizens in control are key to delivering the NHS and Public Health reforms. Public Health England should encourage, support and incentivise Local Authorities, GP Consortia and other key stakeholders to ensure that the public health agenda is central to the ambitions of the organisations

Screening programmes, immunisation and vaccination programmes and other services delivered by GP's will continue to be crucial and need to be maintained. The role of GPs and Local Authorities in delivering and supporting these programmes needs greater consideration

Shadowing arrangements across England could give us the opportunity to test how best to provide professional PH support to GPs – through PH staff working for GP Consortia or GP practices, through co-location, through development and use of PH referral pathways etc. PHE could usefully set up pathfinder arrangements that would evaluate these models and share good practice.

Question b
Public health evidence: What are the best opportunities to develop and enhance the availability, accessibility and utility of public health information and intelligence?

With emerging technologies and an appetite from the public for good quality information, there is an opportunity to be more transparent and open with the data and information that we hold. There is a need to balance the amount of information, to prevent information overload, with the quality of information to ensure consistency.

The availability, accessibility and utility of public health information and intelligence needs to be delivered at a National Level [Public Health England] and at a more local level. The National approach should enable comparisons and benchmarking and offer some level of quality assurance, whilst at a local level the information and intelligence can be more directive with greater interpretation and insight at a local level.

The Kent and Medway Public Health Observatory provides a very good example of how local information can be brought together and made available to all relevant organisations and the public. In response to the PH Outcomes Framework consultation response, we have made a case for the use of local indicators to support locally identified needs; support and funding for local observatories to support the localism agenda would be very welcome.

Also in the PH Outcomes we have asked for national guidance to be produced to clarify the expectations around information sharing across organisations. In Kent we have been developing our own model to promote information sharing that includes an Information Sharing Agreement which recognises the need for agencies to share personal information when appropriate to ensure services are effectively delivered. The Agreement provides a generic standard (including 'Golden Rules'), that must be applied when sharing information between parties. It is accompanied by Standard Operating Procedures that provide more detail on when and how information can be shared to support specific areas of service, for example crime and disorder. The Information Sharing Agreement will promote best practice in sharing information, provide clarity for staff on their responsibilities and allow organisations to share data more quickly and simply.

Organisations which have been invited to become signatories to the agreement include Kent County Council, District Councils, Police, Fire, Probation, South East Coast Strategic Health Authority, Eastern & Coastal Kent PCT, West Kent PCT, Medway PCT, NHS Trusts in Kent and Kent & Medway NHS & Social Care Partnership Trust. GP consortia will be invited to become signatories providing an important opportunity to enhance the availability and accessibility of public health information and intelligence.

This links to the "Open Kent" project which aims to facilitate the sharing and transparency of data across partner organisations. Data can be uploaded, downloaded and visualised in a number of presentation formats, such as

maps, charts and tables. For use by professionals and the public to disseminate and share data**.**

Tools that would organisations develop a more cohesive approach to websites would be very useful. In Kent we have developed Active Kent, which provides health advice to the public as well as practitioners. This is a web portal as well as being a promotional campaign which has helped to galvanise advocates of health in all sectors. If this approach was widely adopted it could create a consistent approach to information dissemination. .

There are a number of different solutions required at a national and local level to deliver efficient and effective public health information and intelligence which incorporates both clinical, service, demographic and wider determinates of ill health and social care. We would recommend establishing a set of core principles for the transparency and openness of public health information and technology, making use of best practices and exemplar organisations where accessibility to information has been successful. We would encourage investment in new technology, software and methodologies to ensure that the information and intelligence is relevant and up to date.

Question c
Public Health evidence: How can Public Health England address current gaps such as using the insights of behavioural science, tackling wider determinants of health, achieving cost effectiveness, and tackling inequalities?

The key issue in using behavioural science is understanding how we should use the right type of intervention with the right group of people at the right time. Many approaches can be effective and the "Ladder of Interventions" is a useful model. PHE can assist and inform local action by developing case studies and disseminating best practice nationally. It could support a stronger focus on segmentation and social marketing, making more use of the media and utilising the skills of private industry in advertising and public engagement to provide a consistent and strong voice as an authority in health advice.

PHE should also work with NICE to develop recommendations for evidence based interventions on the key public health issues.

Public Health England should support research that all the approaches in the ladder of intervention are evidence based across a range of health behaviours and age groups. Public Health England needs to lead the policy discussion drawing on evidence based work that challenges practice and policy which leads to increased inequality and the poor health outcomes that result from it. Models that link increases in social inequity to increased costs to services and society need to be developed in to establish key principles on which policy decisions and central government and local government level can be made.

PHE should support and help evaluate demonstration projects that use behavioural approaches such as "nudge", that build on social capital and social cohesion or are designed to gain a better understanding of building on personal resilience. In Kent we have had great successes with projects such as Curves and Activmobs that used these approaches to promote greater physical activity, especially for those living in the more deprived communities. We would like a forum in which we can share our successes and also learn from other successful projects.

Public Health England needs to recognise and support the continuation of core harm reduction services which are key to reducing drug related harm. Access to sexual health services and smoking cessation services need to be examined to see how these can be best targeted and cost effectiveness assured.

Public Health England needs to promote inclusive housing support and employment practices and work to open up community settings to those who have until now been stigmatised as a result of their behaviours and poor health, especially mental health. Ultimately this requires that Public Health England provides a scrutiny role across Government Departments which will address the impacts on equality of the policies of other parts of Government

We would also welcome Public Health England engaging with the food industry in order to put pressure on the industry to improve nutritional content in all food, especially value brands.

There are many conflicting and constantly emerging sets of research about healthy eating, alcohol use and physical activity constantly appearing in the media that lead to confusion and disengagement amongst the target population. In particular we would highlight the judgement by the Chief Medical Officer regarding an alcohol free childhood. This has failed to be communicated across the population with confusion still remaining about a significant and clearly evidence based judgement. PHE has a role to clarify and explain the conflicting messages that people are being given so that they can better understand how lifestyle changes can be incorporated into their lives.

Young people who are involved in risk taking behaviours tell us that they have lots of information about drugs, alcohol and sexual health but want to have the opportunity to build their skills to ensure that they can make informed choices. We believe engagement in schools settings is vital. We are concerned that the White Paper will not be able to influence schools delivery of Healthy Schools and PHSE. Public Health England must be able to ensure that young people attain developmental appropriately life and communications skills which helps them put into practice the choices that they make and builds their self efficacy.

We fully support the use of Joint Strategic Needs Assessments to inform the development of all our strategies that have a health emphasis. Guidance should be given to ensure JSNA's include assessment of the assets and strengths of local communities and partners to ensure that programmes can be designed and delivered utilising the most appropriate and cost effective resources available.

We would welcome the support of Public Health England in engaging local partners to take more responsibility for education related to health issues, particularly that related to physical activity, substance misuse and sex and relationships. Without a determined and united approach from all government departments, schools are unlikely to prioritise this. In addition, we would particularly welcome promoting the evidence of health benefits of physical activity to GPs as part of patient care.

There are significant opportunities to harness Kent's partnership working. Kent would welcome the opportunity to develop evidence based case studies or act as a pilot under our focus on 'Tackling Disadvantage'. Such analysis would support Kent's work, identify key evidence for Public Health England and be valuable as a dissemination resource for other Local Authorities.

Analysis of the costs and benefits in altering the spending be helpful, especially those with a focus on switching expenditure from acute care to early intervention and a focus on prevention.

Question d
Public Health Evidence: What can wider partners nationally and locally contribute to improving the use of evidence in public health?

As mentioned in our response to Question b, Kent would like to see PHE develop a tool that would help all partners develop and evaluate public health projects. In particular we would like more support for smaller and demonstration projects that test out the new or more strongly emphasised approaches to public health interventions. Compared to medical models, the use and evaluation of projects that use behavioural sciences and approaches that aim to build on social capital and cohesion are still in their infancy. PHE should support a more programme based approach to small projects; lending expertise around evaluation techniques, use of social segmentation tools to scope projects etc would be very useful. A web portal that provides details of the projects that partners have completed and an honest (perhaps external?) appraisal of what worked and what didn't would help build up the evidence base.

With cuts in the public sector and budget squeezes on voluntary organisations and other stakeholders, we are in danger of losing the evidence base for small very localised projects. Not only might this lead to constant wasting of scarce resources, duplication of effort etc, we will miss the opportunities to share good practice and create a new system that is expected to promote localism.

Question e

If we were to pursue voluntary registration, which organisation would be the best suited to provide a system of voluntary regulation for public heath specialists?

We welcome the publication of the Public Health White Paper and the review of the regulation of public health professionals. We consider that it is essential to operate a professionally independent and independently assured regulatory framework for public health.

However it is disappointing that the review does not explicitly refer to the numerous responses submitted by a range of stakeholders during the review period.

The review's focus on the registration of specialist practitioners could jeopardise the growth and development of the wider public health workforce. A range of practitioners and specialists from a variety of organisations will be required to deliver the public health agenda. That agenda described by the Marmot Review ('Fair Society - Healthy Lives', Strategic review of Health Inequalities in England post 2010) demands shared development pathways that conform to clear shared standards for the wide range of workers involved in the delivery of public health. It is essential that a regulatory process is an essential element of professional development pathways.

It is unlikely that a single register model for medics and non medics will happen. How could the GMC manage the regulation of the wide public health workforce in addition? The UKPHR is well placed to provide this and has provided a robust regulatory process for a multidisciplinary non medical specialist public health workforce since 2003 for those not eligible to register with the GMC. This could continue and could include the voluntary registration of practitioners. Regulating practitioners below consultant level would only strengthen public health. There is a substantial unregulated public health workforce which in fact outnumbers the specialist/consultant workforce. This would ensure that all non medic registration would be in one place. Defined specialist registration should continue. It is likely there will be a greater need for Defined Specialists in the new structures

Currently the UKPHR process leaves much of the responsibility to employers for ensuring competent staff but that is also true of other disciplines e.g. pharmacy. This is a desired approach

Practitioners could be registered under Health Professions Council but that would separate the regulation of the profession into 3 regulatory bodies.

There is a case for the statutory registration of Directors of Public Health, consultants and Defined Specialists. However in practice registration with the UKPHR is currently, whilst not statutory, is mandatory in order to be considered for consultant posts.

Having only one route to registration is not viable. There will always the need for retrospective registration and alternative routes. Training and registration are linked but separate issues.

Both Option 1 and Option 6 are viable but this paper favours Option 1 the status quo with the UKPHR being the regulatory body.

Introduction to KCC consultation response on the funding and commissioning routes for public health

It is imperative that there is detail and clarity in the JSNA and Health and Wellbeing strategy so that roles are clearly identified, especially where there may be a variety of commissioning systems throughout the care pathway.

However, members of the public will not be concerned so much about **who** is commissioning, delivering or funding the interventions, but that they are accessible, flexible and commensurate to their needs, including having a joined up approach all along the care pathway. This will make demands on all stakeholders to ensure that there is continuity across services and that consideration is given to prevention at all intervention levels. Commissioners will also need to communicate service changes and improvements to the local population, to demonstrate community co-production in service redesign and incorporate views of the local people in evaluation mechanisms.

The Health Premium could serve well as an incentive to reduce health inequalities, as long as it is applied without prejudice to some of the local authorities where the greatest inequalities exists. Tackling disadvantage and reducing health inequalities are very important priorities but they are not the same thing.

Large local authorities such as Kent (serving 1.4 million population) can face different challenges than smaller authorities as the larger the population, the more likely the variance in range of health outcomes. For example, although the average life expectancy at birth in Kent is higher than the national average, there is a 16.6 year difference between the best and worst wards in Kent. Even in the district with the least difference (Tunbridge Wells) there is a 6.8 years gap between the best and worst wards which is a challenging gap to close.

KCC consultation response to the specific questions on the funding and commissioning routes for public health

Q1 Consultation question: Is the health and wellbeing board the right place to bring together ring-fenced public health and other budgets

Yes, if this is not done at the Health and Wellbeing Board any alternative would merely replicate the Board in another form.

The ring fenced public health budget needs to be accessible to all partners in the commissioning of effective public health initiatives at a local level. In upper tier authorities such as Kent County Council effective arrangements must be put in place to ensure that public health and wellbeing interventions are commissioned at an appropriate population level and in accordance with local priorities. The role of the Joint Strategic Needs Assessment in identifying local priorities and the Health and Wellbeing Strategy that should articulate how these priorities will be addressed will be crucial.

Q2 Consultation question: What mechanisms would best enable local authorities to utilise voluntary and independent sector capacity to support health improvement plans? What can be done to ensure the widest possible range of providers are supported to play a full part in providing health and wellbeing services and minimise barriers to such involvement?

Kent recognizes the value and imperative of the third sector's reach and engagement at community level. The inclusion and representation of the third sector will vary according to the range of local provision provided in their local areas, but their involvement should be included in the JSNA and Health and Wellbeing Strategy, with support to the third sector to provide equal opportunities to bid for contracts. The concept of "any willing provider" should enable voluntary organisations to be included in commissioning plans but it will also be important that smaller providers are able to participate, retaining their independence and without having to resort to forming large trust organisations.

Q3 Consultation question: **How can we best ensure that NHS commissioning is underpinned by the necessary public health advice?**

The public health advice needs to be robust and based on good evidence and experience. This should include relevant NICE guidance for all partners including the NHS and GP Consortia which should be developed to include more public health and preventative issues.

The JSNA should be created in conjunction with Public Health information, data and analysis to ensure the identified priorities reflect the overall health needs of the population. These priorities should be addressed in the Health and Wellbeing Strategy which should identify the interventions required.

These interventions should relate to a holistic view of people's lives including their needs to be supported in healthy living in the community and not be afraid of being innovative.

Q4 Consultation question: Is there a case for Public Health England to have greater flexibility in future on commissioning services currently provided through the GP contract, and if so how might this be achieved?

Public Health England should have the opportunities for greater commissioning flexibility where services can be delivered better through other sources, particularly where local communities identify alternative preferences. The any willing provider principle should apply.

Q5 Consultation question: Are there any additional positive or negative impacts of our proposals that are not described in the equality impact assessment that we should take account of when developing the policy?

The biggest danger in trying to address health inequalities is that of improving health for all but not "improving the health of the poorest, fastest" and thereby increasing the inequalities gap within the overall improvement in the population.

It is important to ensure that there are adequate budgets to effectively support the public health agenda including tackling inequality outcomes. The ring-fenced budget will require support from other mainstream funding to address the wider determinants of health and this will depend on the effectiveness of the joint working arrangements, especially the Health and Wellbeing Board supported by the JSNA and the Health and Wellbeing Strategy.

Q6 Consultation question: Do you agree that the public health budget should be responsible for funding the remaining functions and services in the areas listed in the second column of Table A

Yes, but as above (5), it is important to ensure that there are adequate budgets to effectively support the public health agenda including tackling inequality outcomes. Local Authorities rise to the challenge that public health needs to do more and work differently.

Q7 Consultation question: Do you consider the proposed primary routes for commissioning of public health funded activity (the third column) to be the best way to:
a) ensure the best possible outcomes for the population as a whole, including the most vulnerable; and
b) reduce avoidable inequalities in health between population groups and communities?
If not, what would work better?

Successful Local Authorities are able to engage with their local populations and identify local needs and local issues. They should also be the voice of the local population and the opportunity to work more holistically in public health means that major issues in people's lives can be addressed which will

help define their lifestyle behaviours. These will vary between localities Local Authorities should also be aware of their most vulnerable groups and supra-level pockets of deprivation and inequalities which are sometimes masked at a district population level. By joining up local authority services, resources can be redesigned to provide holistic interventions when and where people need them, particularly throughout their life-course rather than stand alone service interventions.

The proposed routes would appear to provide a basis to deliver in the way intended to reduce avoidable inequalities but this will depend on the effectiveness of the Health and Wellbeing Board to ensure that the JSNA and Health and Wellbeing Strategy enables the public, private and voluntary sectors and the community itself to participate appropriately and effectively.

Q8 Consultation question: Which services should be mandatory for local authorities to provide or commission?

Mandatory service provision has the potential to undermine some of the core principles of the white paper. It has a tendency to create silos of activity around the “must do’s”. It can stifle creativity to deal with the wider determinants of health at a local level by imposing direct service provision rather than promoting commissioning.

Kent is a diverse county made up of many different types of communities with different issues, challenges and strengths. There is no “one size fits all”. Emphasis should be on outcomes rather than giving everyone the same services with local determination of priorities and solutions. A better approach would be to have a suite of mandatory outcome indicators around issues such as tobacco control, alcohol and drug usage, obesity and vaccination rates for children and young people.

The responsibility for screening and vaccination services should be transferred to local authorities to reflect the current involvement of local DPH’s (see also response to Q9).

It is not clear why responsibility for children’s health up to the age of 5 should lie with the NHS Commissioning Board and we would argue that this should also be located within local authorities.

Q9 Consultation question: Which essential conditions should be placed on the grant to ensure the successful transition of responsibility for public health or local authority?

That grant needs to be paid fully at the beginning of the financial year to assist in medium and long term planning.

The grant should be calculated on spend in 09/10 rather than 10/11 to ensure that acute savings imposed this year do not adversely affect the amounts granted.

All public health assets currently located in Primary Care Trusts should be included in the calculation. As well as budgets that support public health activity the commissioning resources should also transfer to local authorities. The resources that deliver the screening and immunisation programmes including staffing should transfer to local authorities along with responsibility for the function.

Indicative shadow budgets need to be issued as soon as possible so that clear commissioning plans can be prepared in the transitional years 2011-2013.

Q10 Consultation question : Which approaches to developing an allocation formula should we ask ACRA to consider?

"Utilisation" in Kent is skewed by problems in parts of the county with the weighted capitation formula and public health spending being cut in order to fund other parts of the health economy. Kent is also a large county, serving 1.3 million residents, with deprivation and inequality existing in patches across the county. Access is also an issue in terms of the wide geographical area covered (much of which is rural) and in terms of behaviour barriers to access. Utilisation would not therefore reflect the actual needs of some of our populations. Any current imbalances in utilisation between areas would become even more ingrained using this measure.

"Cost-effectiveness" is superficially attractive but as mentioned in the paper (4.5), evidence on cost effectiveness of public health interventions is not comprehensive. We need to be mindful that designing some interventions (particularly new ones) sometimes require significant investment at first with longer period pay back benefits. There is a danger that "most cost effective" comes to mean "cheapest" and this is a particular concern especially where there are challenges to reach the most difficult to reach and vulnerable in society rather than the low-hanging fruit and quick wins.

"Population Health Measures" – if they are applied at the right level of population we would agree that this provides the best available measure at the moment.

11 Consultation question : Which approach should we take to pace-of-change?

The issue of destabilising existing services through withdrawal of funding is the major issue. Additional "transitional" funding should be made available to cushion the rate of reductions for those that will suffer them, particularly those that have the most need.

It is anticipated that early improvements in reducing health inequalities will attract increased funding through the Health Premium.

KCC is a large organisation and would be able to manage the risk of being able to use "a rapid increase in the available funding" effectively.

Q12 Consultation question : Who should be represented in the group developing the formula?

Department of Health, Public Health England, Local Authorities (all tiers), GP representatives, health economists, public health observatories, economists who have understanding of demographic and social trends and implications, demographers, and members of the team that produced the Marmot Report into health inequalities.

Q13 Consultation question : Which factors do we need to consider when considering how to apply elements of the Public Health Outcomes Framework to the health premium?

Confidence that progress in the measures selected will ultimately show improvements in the overarching indicators eg. years of good health. (The question of what will happen if the "Health Premium" indicators show improvement year on year but this fails to be reflected in the overall measures of life expectancy and years of good health, or vice versa, is an interesting one).

Measures must be meaningful to people and communities.

Focus on major causes and impacts of health inequality, disease, and premature mortality

Measures must take a life course approach from minus 9 months onwards.

Q14 Consultation question: How should we design the health premium to ensure that it incentivises reductions in inequalities?

Consideration needs to be given to the particular characteristics of each area being evaluated. The premium needs to be able to relate to the issues and priorities of local areas at different population levels. If application of the premium fails to reflect the differences experienced by the various levels of disadvantaged populations in local authority areas it will skew funding and the ability to improve health inequalities.

Measuring actual changes in outcomes rather than levels of service provided is essential.

Health Inequality outcomes are very often measured across a long period of time which also masks social and economic changes. The issue of connectivity between the shorter term measures required for the health premium and the longer term outcomes such as all age, all cause mortality (see Q13) is a real one. One suggestion is that there should be a "health premium" that becomes payable over a longer period dependent upon progress in the overarching indicators.

Q15 Consultation question: Would linking access to growth in health improvement budgets to progress on elements of the Public Health Outcomes Framework provide an effective incentive mechanism?

Linking growth in health improvement budgets to progress on elements of the outcomes framework, could penalise areas that may find making progress most difficult. This could seriously disadvantage some areas and lead to increasing the health inequalities between areas that benefit form increased funding and those that do not – the opposite of improving the health of the poorest, fastest. This would merely compound any effect that failing to achieve the improvement required for the health premium may have.

The Health Premium alone could provide the necessary incentive, (but also see proposal for a longer term premium in Q 14) but national networking systems (such as Communities for Health) provide a good mechanism for sharing good practice and innovative ideas.

Q16 Consultation question: What are the key issues the group developing the formula will need to consider?

In addition to responses to questions 13-15, the formula requires sophisticated modelling of deprivation and disadvantage at a local level in order not to disadvantage large areas/counties such as Kent where significant local pockets of deprivation may be masked by apparent affluence around them. The size of the Kent population also needs to be considered to understand the relative level of inequalities that exists. For example, in some of the most affluent localities in Kent, Tunbridge Wells for example, there could be a disparity of 17 years life expectancy within that locality. Because this is not acknowledged, most national formulae applied to Kent have an inbuilt unfair bias.

Introduction to KCC's response to the consultation on public health outcomes

An Outcomes Framework that effectively describes progress on helping people live longer, healthier and more fulfilling lives whilst reducing health inequalities is crucial to ensuring we deliver the new approach set out in Healthy Lives, Health People.

We welcome the view that the Public Health Outcomes Framework must not replicate the approach of the previous National Indicator Set but think it is perhaps naive to think that publicly available data won't be used in organisation assessments. If plans go ahead for the health premium to be based on improving outcomes for some indicators, it would be impossible for these indicators not to be used as a tool for performance management. The flaws in the National Indicator Set shouldn't stop us from having an outcomes framework that can be used intelligently by us to assess our own performance and benchmark it against other similar authorities. An outcomes framework that could also be used by audit, CQC etc is not a complete anathema as long as the indicators are fair to all organisations and accurately describe progress in improving the health of the nation.

We would have like to have seen a greater emphasis on work being done with communities to improve social cohesion and build on social capital. The indicator proposed on Social Connectedness based on the "Citizenship Survey" is a welcome step in the right direction but is just one indicator in a list of 65. Similarly we would have liked to have seen indicators that identify and report on use and effectiveness of the "nudge" approach.

The essential truth that health inequalities are primarily a socio economic relationship is not well demonstrated in the proposed framework. For example, one of the most significant indicators of economic stability and better health prospects is good exam results which lead to greater employability. The absence of 5 GCSEs A*-C in the Outcomes Framework misses this important link.

Clarification of the legalities around data sharing between LAs and the NHS, especially with Public Health moving into Local Authorities is urgently needed. We would like to see urgent work on Information Sharing guidelines produced by the DH with help from Public Health England, NHS Commissioning Board and local stakeholders

KCC consultation response to the specific questions on the public health outcomes framework

Q1 How can we ensure that the Outcomes Framework enables local partnerships to work together on health and wellbeing priorities, and does not act as a barrier?

The framework must concentrate on outcomes for the population and not process or method. Accountability for achieving outcomes must be clearly defined between the NHS, National Public Health Service, Local Authorities

especially in two tier systems and GP consortia (perhaps through their quality outcome payments). This joint accountability must be reflected in shared outcomes between Public Health, Local NHS, Adult Social Care, Child Health. There should be an expectation that all partners are expected to contribute to achieving the desired outcomes.

Q2 Consultation question: Do you think these are the right criteria to use in determining indicators for public health?

We welcome the criteria given in Principles for Development; we would suggest further criteria need to be developed such as :

1. The level of impact that Local Authorities can have on some causes of poor public health is quite limited and the Outcomes Framework needs to reflect this. For example, global or national recession and resulting high rates of employment will increase stress related illnesses. Whilst Local Authorities clearly have a role in growing their own economy, they rely heavily on national policies and support to do this.
2. There is no mention or measure of access to health services nor quality of health services.
3. The set of indicators must be balanced to reflect a wide range of public health issues and stakeholders ability to impact them. It is important to remember the distinction between correlation and cause.
4. Data must be meaningful and valuable to the organisation that collects it
5. The set of outcomes must be balanced between those which are easily reportable in-year and those that are not. In terms of time lag, it may be useful to review where data seems to take a long time to be published to see if, nationally, this could be speeded up. This may involve new technologies or better prioritising around key data.
6. The cost of collecting data must be proportionate to its value; some data items may be very time-consuming and therefore costly to collect but the importance of the data outweighs this disadvantage.
7. Accountability for production of outcomes must be made clear; Local Authorities must not be asked to be data collection agencies for other organisations.
8. There must be regular review of the outcomes framework and criteria with input from stakeholders. We recommend that an advisory body of Local Authority representatives from both policy and statistical backgrounds and other stakeholders is set up to help ensure that Outcomes Frameworks are developed and reviewed to meet the needs of all organisations and the public.
9. The use of estimated data such as the Health Surveys for England should be discouraged in favour of local surveys following research governance framework standards
10. Data must be measurable at the right population level. This is particularly important to support the localism agenda where we will need to understand data at a very low level.
11. Indicators should not create perverse incentives. For example the need to achieve high numbers for the smoking 4 week quit has encouraged PCTs to concentrate on “low hanging fruit” and leave

tougher and sometimes more urgent cases, such as helping those who smoke during pregnancy.

Q3 Consultation question: How can we ensure that the Outcomes Framework, along with the Local Authority Public Health allocation, and the health premium are designed to ensure they contribute fully to health inequality reduction and advancing equality?

We are concerned that the Health Premium and a weighted allocation will work against each other. Kent has long had issues with our allocation and we fear the PH allocation and health premium will exacerbate this. Kent is large with a diverse population - we have areas where deprivation is amongst the highest in England and areas where it is the lowest. We have areas of very high deprivation around our coastal areas that are made worse by high levels of immigration of already disadvantaged people. There are enormous challenges in improving the health of a poor and mobile society – a reduction in available budget to tackle this due to losing the health premium will further disadvantage this fragile population.

Kent's location also presents particular challenges – proximity to London raises our costs but as a peninsular authority we have fewer options for buying out-of-county services. London boroughs continue to place their poorest people within our authority especially in the eastern part of the County, driving up our service costs, increasing our population health needs and adding to health inequalities. Will the Allocation and Premium formulae be sophisticated enough to take these types of factors into account?

As a two tier authority, we are not clear what KCC will be held to account for and what districts will take responsibility for; many of the social determinants of health are under the control of District Councils whilst the health improvement workforce and commissioning resources will be with upper tier authorities. Whilst Kent has built up strong partnership working with the Districts, the significant cuts to budgets that will affect the Districts could lead to a reduction in funding in projects such as home improvements and fuel poverty and access to leisure centres and parks. These will have a significant impact on the health of the Kent population though KCC will have only limited powers (or resources) for mitigation.

A key issue for two tier authorities is at which level reductions in health equalities will be measured. The districts in Kent are of comparable size to many unitary authorities. Working on the needs identified in the JSNA and local priorities (and the agendas for choice, democratic accountability and greater public engagement through the new Local HealthWatch are all designed to usher in a more local approach) means that it will make far more sense to assess progress at a District level, though it should be acknowledged that even this level is sometimes too high and risks losing sight of real progress in tackling health inequalities. Where there is a national drive to improve particular aspects of public health, it might make more sense to measure at the county level.

Q4 Consultation question: Is this the right approach to alignment across the NHS, Adult Social Care and Public Health frameworks?

We welcome this approach though would like to see more information on shared accountability for specific indicators.

Q5 Do you agree with the overall framework and the domains?

The domains seem clumsy in that very similar indicators appear in multiple domains. In particular Domain 5 should be the outcomes of achieving good results in the first 4 domains. Some of the indicators within the domains are a concern – see response to Question 8

Q6 Have we missed out any indicators that you think we should include?

As mentioned in Q2, there are no measures of accessibility or quality of health services. As part of the GP outcomes, they could be set targets to get a high percentage of the population in their area on their lists, although this data would need regular data quality. Referrals to healthy lifestyle services from GPs would also demonstrate that they are actively involved in public health initiatives. A separate count of healthcare acquired infections would be useful for GP Consortia and the public alike.
A measure of responsible alcohol consumption would be useful and would be a good balance to alcohol-related hospital admissions. Similarly, it would be good to have an indicator that measured drug use as a balance to D3.7 numbers leaving drug treatment free of drugs

Q7 We have stated in this document that we need to arrive at a smaller set of indicators than we have had previously. Which would you rank as the most important?

V1 Life expectancy
V2 difference in life expectancy

D2.12 Statutory homeless households
D2.13 Fuel poverty
D2.14 Access and utilisation of green space
D2.20 Social Connectedness

D3.1 Healthy weight in 4-5 and 10-11 yr olds
D3.2 Prevalence of healthy weight in adults (assuming robust data)
D3.5 Physical activity for adults

D3.7 Numbers leaving drug treatment free of drugs (or even better, a new indicator for drug use prevalence)
An indicator on responsible alcohol consumption

D3.8 Under 18 conception rate
D4.8 Chlamydia rates

D4.4 Breastfeeding 6-8 wks after birth
D3.3 Smoking prevalence (but based on full local surveys not estimated from HSE)
D4.11 Maternal smoking prevalence

D3.9 Dental caries in 5yr olds

Q8. Are there indicators here that you think we should not include?

A lot of the proposed outcomes, whilst Public Health issues, are not causes of poor health, nor are they deeply impacted by PH work. It is important that the Outcomes Framework reflects where PH can make a reasonable difference.

D1.1 (interagency plans), D1.2 (health protection systems in place) and D1.6 (sustainable development plan) are sensible requirements but have no place in an Outcomes Framework
D1.3 Life years lost from air pollution. Data not robust enough, and accountability not clear.)
D2.21 Cycling participation – ignores other forms of exercise, data to hard to collect and the evidence for it being a good proxy for physical activity is weak, it shouldn't be included in the Outcomes Framework
D2.5, D2.6 Whilst truancy and offending may well impact on health, there is not a strong enough correlation for this indicator to be part of the PH Outcomes Framework.
D2.7, D2.8 Indicators that cover disability rely on a firm and agreed definition for disability that we just don't have so data is unlikely to be robust or comparable
D2.10 Employment of people with long-term conditions – not a significant enough cause of poor health to warrant inclusion in the PH Framework
D2.11 Domestic abuse – high reporting levels can be about good relations between police and population and/or good services available.
D2.21 Cycling
D4.1 unintentional and deliberate injuries to 1-5 yr olds. Again, this is an important indicator but PH should not be held to account for it. May be better placed in Children's Social Services Framework.
D4.12 An important issue and possibly useful for measuring public health failures but if data is only collected every 7 years, we would question its inclusion in the PH Outcomes Framework

Q9 How can we improve indicators we have proposed here?

By applying the criteria you have listed and that we have added to in response to Question 2 and by engaging with Local Authorities in developing and reviewing indicators. Being clearer about national priorities and balancing them against local priorities.

Q10 Which indicators do you think we should incentivise through the health premium? (Consultation on how the health premium will work will be through an accompanying consultation on public health finance and systems).

Our preference would be to have a basket of indicators from which Local Authorities could choose the ones that most closely reflect the needs identified in the JSNA and the preferences expressed by local residents (see also comment in response to Question 3). These local indicators would be coupled with the big national priorities and/or overarching indicators such as life expectancy.

V1 and V2, life expectancy and difference in life expectancy (assuming timely data)
D3.1 Healthy weight in 4-5 and 10-11 yr olds
D3.3 Smoking prevalence (but based on full local surveys not estimated from HSE)
An indicator on responsible alcohol consumption
D3.5 Physical activity for adults

Q11 What do you think of the proposal to share a specific domain on preventable mortality between the NHS and Public Health Outcomes Frameworks?

What is the purpose of a shared domain? Is the data on mortality robust enough to be clear about where the direction of travel is attributable to health improvements or lifestyle improvements? Where would accountability for late presentation to GPs and subsequent preventable mortality lie?

Q12 How well do the indicators promote a life-course approach to public health?

More work and emphasis on the social connectedness will better promote a life-course approach. Maybe include an outcome on volunteering once Big Society is more of a reality.

By:	Graham Gibbens Cabinet Member for Adult Social Care and Public Health Meradin Peachey Director of Public Health
To:	Corporate Policy, Overview & Scrutiny Committee
On:	31st March 2011
Subject:	**Proposal for the Public Health Transition to Kent County Council**
Classification:	Unrestricted

Summary: The government proposals for moving responsibility for public health to a new organisation – Public Health England – and to local authorities have been published in a series of White Papers and associated documents. These documents are subject to ongoing consultation until the end of March. This paper proposes a 3 stage transition programme for integration of public health responsibilities and the Public Health function with some early transfers from 1st April 2011

Introduction

1.

1.1 On the 12th July 2010, Andrew Lansley, Secretary of State for Health, published the white paper "Equity and Excellence: Liberating the NHS". This document sets out their future vision for the National Health Service. The Health and Social Care Bill has now passed its second reading and confirms the move of the Director of Public Health (DPH) and public health functions to the Local Authority as well as the establishment of statutory Health and Well-Being boards and Health Watch.

1.2 The Public Health White Paper – Healthy Lives; Healthy People- was published on 30th November 2010 and two very important associated documents have followed:

- Funding and Commissioning routes for public health

- Transparency in outcomes, proposals for a public health outcomes framework.

1.3 The deadline for responses for all three live consultations is now 31st March and a separate paper will come to CMM on the 28th March 2011.

2 PCT Cluster arrangements

2.1 The Kent and Medway PCT Cluster will operate from 1st April, and will have 6 main responsibilities:

- Sustain management capacity, and a clear line of accountability, providing greater security for the delivery of current PCT functions in terms of statutory duties, quality, finance, performance, QIPP and NHS Constitution requirements through to March 2013;

- Provide space for developing GP Commissioning Consortia to operate effectively;

- Provide a basis for the development of commissioning support arrangements, allowing current commissioners and new entrants to develop a range of commissioning support solutions from which consortia and the NHS Commissioning Board can secure expert support;

- Similarly, provide space for new arrangements with Local Authorities, and particularly Health and Wellbeing Boards to develop;

- Provide a mechanism to enable high quality NHS staff to move to new roles in consortia, commissioning support arrangements and the NHS Commissioning Board, including minimising unnecessary redundancy costs;

- Support the provider reform element of the transition particularly in terms of ensuring progress with the FT pipeline through commissioning plans.

2.2 1st April is also the date that the new KCC structure comes into effect. This provides an opportunity to incorporate the NHS Public Health function into the County Council.

3 Public Health Transition

3.1 A Project Initiation Documents (PID) has been developed to support the implementation of the Kent and Medway Public Health transition plan.

3.2 **Stage 1**

Transition from February to April 2011 ensuring the cluster PCTs public health statutory and other functions are clear and clarifying early transfer of staff and responsibilities to KCC In liaison with public health staff and human resources.

3.3 **Stage 2**

Transition to April 1st 2012 with shadow budgets, clarifying public health responsibilities between the NHS and KCC, determining appropriate workplaces across the NHS and KCC and budgets.

3.4 **Stage 3**

Transition with full budgets in April 2013.

3.5 Budgets

Most budgets sit within the PCT's. Mapping of the budget is still taking place; however, we are currently looking at a figure of £15.5m excluding staff costs.

3.6 Public Health Responsibilities and staff

The Public Health team provide the full range of public health skills and responsibilities for:

- Health Improvement
- Health Care
- Health Protection
- Surveillance and monitoring the population's health

The majority of budgets sit in the PCTs to support these responsibilities and programmes.

There is a map of public health lead roles across both Kent and Medway and there is a more detailed piece of work looking at work programmes and where they can be rationalised across Public Health and across the council to enable capacity to be released and better used. (Appendix 1 shows how the range of public health responsibilities is proposed to be distributed in the public health white paper).

Currently we are looking at approximately 59 posts in three public health teams with a salary total of approximately £3.2m. 6 of these staff already sit in the Kent public health team

There are a further 5 KCC staff within the Kent Public Health team

Current Public Health Staffing in PCTs

Director/Deputy Director/Director Consultant	3
Consultants	7
Specialists	7
Practitioners	6
Business Managers	3
Health Promotion	1
Screening	2
Training	1
Emergency Planning	4
Tobacco Control	1
Senior Nurse	1
Imms & Vacs co-ordinator	1
Health Inequalities	1
Personal Assistants	10
Managers	1
Total	**49**

Kent and Medway Public Health Observatory

Head of Intelligence	1
PH Team Leader	1
Knowledge Management	2
Senior analysts	3
Analysts	3
Total	**10**

4.0 **Staff Transition**

A facilitated workshop has taken place with Public Health staff, some commissioning staff and the cabinet member for public health on 1st March 2011. This workshop looked at the following:

1. Engage with staff on the shape of the public health function
2. Develop a core purpose for Kent Public Health
3. Best location for delivering work programme
4. Identify functions and workplace for 1st April 2011 and tasks that need to be completed by April 2012
5. Consider where public health programmes could be integrated within KCC

All functions are related to the delivery of:

- NHS QIPP (Quality, Improvement, Productivity and Prevention).
- Bold Steps for Kent and the three ambitions, tackling Disadvantage, Growing the Economy and putting the citizen in control

4.1 The Director of Public Health (DPH)

The DPH is responsible for the establishment of the Public Health function and reporting this to PCT boards until April 2011, cluster of PCTs from April 11 and KCC cabinet. Statutory responsibility to PCT boards will remain until April 2013, but accountabilities can be arranged locally.

The DPH currently reports to two PCT CEOs and the Group Managing Director of KCC, with NHS ECK CEO as the lead CEO for Public Health. As the DPH post moves to KCC formally by April 2013 it is proposed that the GMD becomes the lead CEO from the 1st April 2011.

It is proposed that the DPH will report to KCC as the lead for Public Health for:

1. the delivery of health improvement
2. the health improvement budgets sitting in the PCTs
3. public health support to GP consortia and QIPP

The Health Improvement budgets can be considered by the shadow Health and Well-Being Board.

The DPH will report to the PCT cluster for

1. the delivery of health improvement
2. the health improvement budgets sitting in the PCTs
3. public health support to GP consortia and QIPP
4. Health Protection

Leading on from the staff workshop on the 1st March, the team came up with its core purpose statement which is:

- Our purpose is to influence the choices we make at all levels about how we design and live our lives so that we maximise health and the achievement of aspirations.

4.2 Arrangement of PH staff as of 1st April

One Kent Public Health team will be operational from 1st April under management of the DPH. Kent and Medway will work together as a network as there are shared responsibilities and a shared observatory (see appendix 1). There will be a small Kent team based in the PCT cluster to oversee the public health budgets and health protection responsibilities.

The proposal for the transferral of staff will take the form of a Memorandum of Understanding (MOU) between the NHS and KCC. There will be no consideration of TUPE until DH HR guidance is available in the summer. Financial risk for staff will stay with the NHS, as will Terms and Conditions.

Shadow public health budgets for KCC should be available by the end of the financial year. This will comprise a staffing and management budget, and a commissioning budget

There are no planned cost implications for KCC in this financial year.

From the 1st April 14 senior public health staff, consultants and or specialists will be working with specific KCC directorates.

Attached as appendix two is a list of the current public health functions

4.3 **The Work Place**

- There are currently 5 KCC staff and 5 NHS staff located in Sessions House on the third floor.
- There are 2 NHS Public Health Library staff located in Sessions House with the Social Services library.
- 7 senior Public Health PCT staff are already hotdesking in Sessions House as part of their joint work programmes with KCC staff, this is helping joint work on CAMHS, alcohol and community safety, Dementia, winter planning with social services, emergency planning, JSNA.
- PCT public health staff are located in 5 different NHS sites, there has been discussion about the possibility of the observatory team moving from Preston Hall to a KCC site (all NHS staff have to move from Preston Hall by the end of April, this is known to KCC property services)

Public Health staff support populations covering District councils, communities, GP commissioners, GP practices, Kent, Kent and Medway and sometimes south east coast. As we move to locality commissioning, locality boards and GP Consortia it may be more appropriate for some public health staff to remain in localities.

There has been no budget discussions about the workplace and there are no budgets for this in public health team budgets.

The workplace is a longer term project for stage 2 by April 2012. One of the items for discussion at the workshop will be where staff are best placed to deliver work programmes in a cost effective way while maintaining team work.

4.4 Human Resources

The Director of Public Health is working with HR representatives from KCC and the PCTs to ensure correct consultation and processes are followed and staff supported.

There will be a need to consult with staff on the move and the timetable. Staff will be treated in accordance with their local change policy to ensure they are

engaged in the decision making. A consultation paper for staff will be produced on proposed moves.

It is proposed that senior NHS public health staff have access to hotdesking in Sessions House and where it makes sense for joint working with directorates and work programmes. There will be no proposed workplace moves unless it makes sense for an individuals work programme or until discussions have taken place on budgets and with property services.

It was very clear from the workshop on the 1st March that NHS staff would like an opportunity for a different type of induction programme into KCC to help them assimilate. It is suggested that this is done through the directorates with the support of HR as well as the Kent Public Health team KCC staff.

It is also important to have an induction/briefings for KCC members and staff to understand the Public Health function and to help with a joint transition.

5.0 Recommendations

- Implement the transition of Public Health staff to KCC as proposed with no cost implications to KCC from 1st April 1011 and continuing during 2011/12 as described in 4.1 to 4.9
- Public Health staff to work as one team across Kent under the management of the DPH and to work as a network with Medway Public Health staff to share resources.
- Develop a memorandum of Understanding between KCC and the cluster of PCTs on the provision of public health resources and functions for 2011/12.
- Corporate directors consider 14 senior public health staff being based in senior management teams/teams where there are joint work programmes.
- Consider an induction plan for NHS public health staff from the 1st April within the directorates where senior public health staff are linked.
- Consider an induction/briefing programme for KCC members and staff from April 1st.
- We ask the NHS for responsibility for Health Improvement Budgets

Contact:
Meradin Peachey
Director of Public Health

Appendix 1

Table of responsibilities

Activities to be commissioned through PHE:

- Current functions of the Health Protection Agency
- National nutrition programmes (with some local LA activity)
- Emergency preparedness (supported by LAs)
- Health intelligence and information (jointly with LAs)

Activities to be commissioned through Local Authorities:

- Sexual health services (apart from contraceptive services)
- School immunisation programmes
- Local initiatives to reduce seasonal mortality excess deaths
- Local initiatives such as falls prevention services
- Mental health promotion, mental illness and suicide prevention
- Local activity to promote physical activity
- Local programmes to prevent/address obesity
- Drug & alcohol misuse services, prevention and treatment
- Tobacco control
- NHS Health Check Programme (assessment & lifestyle intervention only)
- Local initiatives to promote health in the workplace
- Reducing and preventing birth defects (jointly with PHE)
- Campaigns and services to promote prevention & early presentation of cancer and long-term conditions
- Dental public health (supported by PHE for coordination of surveys)
- Specialist domestic violence services
- Support for families with multiple problems
- Health intelligence and information (jointly with PHE)

It is proposed that LAs are mandated to provide or commission a limited number of these services but it has not yet been determined which these should be.

Activities to be commissioned through the NHS Commissioning Board:

- Contraceptive services (via GP contract)
- Vaccine programmes for children
- Flu & pneumococcal vaccines for older people (including via GP contract)
- Targeted neonatal immunisations
- Screening (quality assurance and monitoring by PHE; cervical screening in GP contract)
- Health visiting services
- Healthy Child Programme for school age children (commissioned as part of health visiting services for under 5's)
- Public health care for those in prison or custody
-

Functions to be shared between KCC and Medway Council:

- Kent & Medway Public Health Observatory - sits in Kent Public Health and is funded by each PCT including Medway
- Dentistry – sits in Medway PCT but works across Kent and Medway
- Workforce Development – sits in Kent Public Health but works across all PCT's including Medway
- Screening – sits within Kent Public Health but works across Kent and Medway

These functions have been identified and collated along with the staff that currently deliver them. Some of the main local authority contributions are included in italics:

HEALTH IMPROVEMENT	**WORKFORCE**
Joint strategic Needs Assessments (JSNA) Commission Health and Well being interventions	Consultant in Public Health Public Health intelligence officers *Joint work with LA's esp. KASS and CFE* Consultant in Public Health
Building sustainable capacity and resources for health improvement and reducing health inequalities:	Public Health specialists with commissioning skills *Many LA functions contribute directly to reducing health inequalities – HI Strategy applies*
Sexual health (inc Teenage Pregnancy) Manage business planning, service specification and tender process for service Manage Service Level Agreements and contracts with providers Directly manage provision of chlamydia services Performance management and evaluation	 Consultant in PH PH specialists *Teenage Pregnancy Partnership* *Youth Service*
Smoking cessation and tobacco control Manage Service Level Agreements and contracts with service providers Management of smoking cessation service Performance management Analysis Tobacco control Alcohol and substance abuse services Manage service specification and development Performance management, data collection and analysis	Consultant in PH PH specialists *LA Trading Standards* *LA Environmental Health* Tobacco control manager Consultant in PH PH specialists *Kent Drug and Alcohol Action Team*

Healthy weight SLA and contract with providers Target monitoring and data collection Analysis	 Consultant in PH PH specialists
Mental Health Manage service specification and development Manage Service Level Agreements and contracts with providers Performance management	Consultant in PH PH specialists *Joint Mental Health Service*
Falls prevention Manage service specification and development Activity monitoring	Consultant in PH PH specialists *LA KASS involvement*
Health Care Acquired Infections Performance management and Service Level Agreement monitoring Incident reporting Target monitoring	Consultant in PH PH specialists *Kent HealthWatch*
SCREENING	
Antenatal; Neonatal - newborn hearing; Cancer - breast, cervical, bowel; AAA; Diabetic retinopathy; Chlamydia; Develop newborn physical exam Surveillance monitoring Quality assurance SLA and contract monitoring performance, data collection and analysis	PH specialists Consultant in PH
HEALTH INEQUALITIES	
Healthy living centres service specification, contract monitoring and data analysis Service development Learning difficulties expert input	Consultant in PH *Many LA functions contribute directly to reducing health inequalities – HI Strategy applies* PH Specialists *LA LD services and policy*
Vulnerable groups expert input	*LA services and policy*
PARTNERSHIP WORKING	
Build strategic partnerships Statutory duties include participation in: LSP; CSP; JSNA; Safeguarding Children Board; Children's Trust Board; Local Health and Wellbeing Board Community engagement	Consultant in PH PH Specialists Senior Health Improvement Officers Health improvement specialists Campaigns co-ordinator

Advocacy for health *Kent Partnership* *Kent Agreement*	Consultant in Public Health Health improvement specialists Communications officers *Officers from all KCC directorates and policy functions*
HEALTH AND EUROPE CENTRE	
European partnership working Social enterprises Training opportunities for PH staff	Director and business administrator *KCC International affairs*
SCHOOL HEALTH	
Enhanced healthy school status promotion National Indicators *Healthy Schools programme and PHSE education in schools*	Consultant in PH PH specialists *LA Function within CFE*
HEALTH TRAINERS	
Service specification and development SLA monitoring Professional development of HTs Activity data collection and analysis	Consultant in PH PH specialists
COMMUNICATION	
Social marketing Health promotion	*LA policy and comms functions*
HEALTHCARE - PUBLIC HEALTH	
Clinically and cost effective health services commissioning Needs assessment Care pathways, policies and guidelines to improve health outcomes Assess need, demand, utilisation and outcomes Commissioning support through information provision Decommission where evidence supports	DPH, Consultant in PH, PH Specialists, Information Analysts *JSNAs jointly with LAs* *KASS contribution*
Prioritisation of health and social care services Evaluate clinical and cost effectiveness Exceptional treatment requests •Produce evidence summaries •Panel members Clinically appraise business cases	DPH, Consultant in PH, PH Specialists, Information Analysts, PH Pharmacist
Equity of service provision Monitor access and use of services	DPH, Consultant in PH, PH Specialists, Information Analysts *Kent HealthWatch*

Use of Health Equity Audit Use of Equity Impact Assessment Plan services for vulnerable groups	
Clinical governance and quality improvement Agree service specifications and standards to monitor performance and outcomes Generate information to support QA and monitor performance Audit services and practices to improve outcomes Benchmarking against NICE guidelines	DPH, Consultant in PH, PH Specialists, Information Analysts *Kent HealthWatch*
Healthcare audit, evaluation and research Links with Equity of service provision and Academic PH	DPH, Consultant in PH, PH Specialists, Information Analysts
Patient safety Risk analysis	DPH, Consultant in PH, PH Specialists, Information Analysts, statistician *Kent HealthWatch*
Serious untoward incident management	
Healthcare development/planning Horizon scanning Analyse cost, benefits and risks for new services/technologies Facilitate strategic and business planning Develop service frameworks	DPH, Consultant in PH, PH Specialists
Leadership for health Strategic view of future developments in health Provide leadership for improving health and tackling inequalities	DPH, Consultant in PH, PH Specialists *Public Health policy function*
Capacity building Ensure access to training posts Workforce planning	DPH, Consultant in PH, PH Specialists Workforce planner
HEALTH PROTECTION	
Reactive acute functions Proper Office of local authority Contact tracing Outbreak and incident control Infection control including advice on HCAI Advice on immunisation queries	CCDC, DPH, Health Protection Nurses/Specialists
Proactive prevention functions	

Outbreak prevention plans eg. Tuberculosis, STIs, port health Environmental health liaison Microbiology and tropical diseases medicine liaison Emergency preparedness Business Continuity	CCDC Analysts Emergency planning officer *Emergency Planning function*
Both proactive and reactive functions Advice on novel threats to health and manage risk	 Analysts, surveillance and data support staff
INFECTION PREVENTION AND CONTROL	
Monitoring Tuberculosis Business plan, service specification SLA performance and monitoring Tracing and incidents participation	CCDC, DIPC Consultant in public health (PH), CCDC
Influenza planning Seasonal Pandemic	Consultant in PH, CCDC *Emergency planning*
IMMUNISATION AND VACCINATION	
Performance and contract monitoring Target monitoring and data collection for the following programmes: •Childhood vaccination programme •HPV •Staff flu programme	Consultant in PH Immunisation co-ordinator
PUBLIC HEALTH INTELLIGENCE	
DPH annual report Health needs assessments	DPH PH Consultants
Mapping health indicators Health equity audit Health impact assessment Improving quality of health data PBC tailored inequality planning Economic modelling and evaluation Surveillance Evidence analysis and guidance	PH Specialists PH analysts Knowledge manager Librarian *KCC data and information functions* *Public Health policy function*
ACADEMIC PUBLIC HEALTH	
RESEARCH AND ANALYSIS	
Determine priorities for PH research Formulate specific PH research questions Define outcome measures Gap analyses	PH consultant Lecturer in PH SpR/SPT in PH Social scientist

Translate complex research results into information and knowledge to improve population health and wellbeing Evaluation of health services and PH interventions	Epidemiologist Health service researcher
EDUCATION	
Teaching of other staff, medical students and colleagues Mentorship and group tutorials London/KSS Deanery training programme Specialist portfolio development CPD KSF IPA Public Health Champions	DPH, Consultant in PH, PH Specialists

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By: Roger Gough, Cabinet Member for Business Strategy and Support
Katherine Kerswell, Group Managing Director

To: Corporate Policy Overview and Scrutiny Committee – 31 March 2011

Subject: Core Monitoring Report

Classification: Unrestricted

SUMMARY

The purpose of this report is to inform members on key areas of performance and activity across the authority.

FOR INFORMATION

1. Introduction

An extract from the third Core Monitoring report for 2010/11 is attached and this provides information for the third quarter of the year up to the end of December 2010.

The full Core Monitoring report will be presented to Cabinet on 4 April. Each Policy Overview and Scrutiny Committee is receiving the section of the report relevant to their remit.

2. Core Monitoring Report

The Core Monitoring report contains key activity and performance information for the council. Publication of the Core Monitoring report on the external web site is also an important element of our transparency agenda.

For this quarter the following changes have been made to the format of the report:

- The addition of Data Notes, which show technical information relating to each indicator
- A new header for each page, which provides an 'at a glance' view of the RAG status for each indicator.

3. Future Reports

A new Performance Management Framework, based around Bold Steps for Kent, is being developed for 2011/12. A separate paper on the new framework is being provided to each POSC.

4. Recommendation

Members are asked to NOTE this report.

Contact officers: Sue Garton & Richard Fitzgerald, Performance Management, Chief Executive's Department.

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Kent County Council

Core Monitoring Report

Presented to Cabinet
4 April 2011

Including Information up to the end of December 2010

Contents

General notes on interpreting the data included in this report

A selection of key indicators for the core areas of activity and performance of the council is included in this report. Indicator values are shown by graph and data tables, including Direction of Travel and RAG ratings (see tables below for a key to interpreting these).

A range of presentation styles are provided for different indicators depending on the information available. In some cases we provide the most recent results for the last four financial year quarters, while for other indicators we provide annual data for the last few years with the most recent quarter's data also shown.

Where relevant and available, the indicators are provided with comparative data showing national averages or other suitable benchmark information. See the Appendix for more information on the comparative benchmarks used.

It should be noted that past annual data provided in this report is generally validated data which is public domain and available in many cases within the remit of national statistics.

However, quarterly data provided in this report and all information subsequent to March 2010 is classed as provisional local management information which in some cases is provided on an estimated basis. This data is likely to be subject to future revisions.

Key to RAG (Red/Amber/Green) ratings

		RAG Ratings
Green	★	Performance is significantly better than the most recently published national average/benchmark or exceeds local targets where set
Amber	●	Performance not significantly different from most recently published national average or close to but not exceeding local target
Red	▲	Performance significantly worse than the most recently published national average or significantly behind local targets where set
N/a		Data not available in order to assess performance

Key to DoT (Direction of Travel) ratings

		DoT Ratings
	↑	Improvement in performance or change in activity levels with a positive impact on budgets and resources
	↓	Fall in performance or change in activity levels with a negative impact on budget and resources
	↔	No change in performance or activity levels

Overall Summary of Performance

This is our third Core Monitoring report for 2010/11. It provides information on key activity and performance for the third financial quarter, up to the end of December 2010.

The publication of this report is part of our transparency agenda, making the information and data we use as an organisation more open to public scrutiny.

The main concern in quarter three was the poor Ofsted report for our children's social services received in November. An Improvement Plan has been drawn up and various actions to improve the service are now underway. The improvement of services for vulnerable children is the top priority for the council.

Overall performance for the indicators included in the Core Monitoring is as follows:

RAG Status	Indicators in each category		
	Previous	Current	Change
Green	9	10	+1
Amber	27	27	
Red	14	13	-1
Total	50	50	

The following areas have shown improvement:

- Attainment for Kent children is now significantly better than the national average at Foundation Stage and Ofsted inspection results for early years settings are also now much better than the national average
- Attainment for looked after children at Key Stage 2 has improved and is now close to the national average
- Response times for routine highway repairs improved and came closer to target in the last quarter
- The numbers of people with serious injury in road traffic accidents in Kent has significantly reduced this year and the rate of reduction is significantly better than the last published national average
- The number of new entrants to the youth justice system has reduced this year and is close to the last published national average.

The following areas have shown a drop in performance:

- GCSE results for looked after children have fallen significantly behind the national average and actions to address this are in the Improvement Plan
- Referrals to children social services have become significantly higher than the last published national average and work is underway with partners around appropriate thresholds for making referrals, to reduce this pressure on the service
- The number of looked after children has increased rapidly this year and is now closer to the national average
- Average response times for streetlight repair where KCC is responsible fell slightly behind the target of 28 days in the last quarter, due to increased service demands and staff being diverted into winter maintenance works.

Areas where we have maintained a high level of performance (Green RAG status) are:

- Our contact centre and location switchboards continue to answer more than 80% of calls received within 20 seconds, which is the standard industry benchmark level
- The number of young people aged 16 to 18 not in education, employment or training in Kent continues to be significantly lower than the national average
- Ofsted inspection results for secondary schools continue to be significantly ahead of the national average
- The percentage of household waste taken to landfill in Kent is significantly lower than the national average, due to good recycling rates and the use of incineration to dispose of waste
- The number of apprenticeships provided by KCC continues to be ahead of the target set
- Adult education enrolments in Kent continue to exceed target
- Success rates for drug treatment services continue to be significantly better than national average.

Areas of continuing concern where performance is rated with a Red RAG status are:

- Carbon dioxide emissions from schools have increased and our target for a 10% reduction by 2010 has not been met – with the changing nature of our role with schools, we need to re-examine to what extent we will be able to influence this situation in the future
- Pupil attainment at Key Stage 2 remains significantly behind the national average as do the related primary school Ofsted inspection results – a KCC member Select Committee is looking at this issue
- Attainment results for children with free school meals is significantly below the national average and the above mentioned Select Committee will also investigate this issue
- The number of children with child protection plans continues to increase and remains significantly above the national average – this is being addressed in the Improvement Plan
- The number of unaccompanied asylum seeker children, now aged over 18 and continuing to be supported by KCC continues to be above past levels and KCC continues to work with national agencies to influence this situation
- The number of looked after children placed in Kent by other local authorities continues to be significantly higher than the average for other local authorities and KCC continues to press the case for this practice to change
- The number of adults with learning disability supported in residential care continues to be significantly above the national average resulting in budget pressures
- Average response times for repairing potholes in the quarter was much better than the previous quarter but still significantly behind target
- Average response times for repairing streetlights where the network operator is responsible showed good improvement this quarter but remained some way behind the target level
- The number of library book issues continues to be significantly below the national average and has dropped due to a number of refurbishments in major libraries.

It should be noted that more than one of the areas of concern listed above is not directly within the control of KCC, but the issue remains a concern to us and we will continue to monitor the indicator and take actions to influence the issue.

Further details on these areas of concern and the actions to address them can be found in the main body of this report.

Other points to note:

- Residents are making good use of Kent's Gateway facilities to access public services with transaction levels in the last quarter being 27% above the same time last year
- The number of complaints received each quarter this year has held fairly steady and we continue to learn from resident feedback to improve our services
- We are continuing to press the case with national government for the necessary investment in vital strategic infrastructure in Kent and in December we launched our proposals for transport infrastructure in the document "Growth Without Gridlock"
- We continue to deliver more personalised adult social services with the successful roll-out of Self Directed Support, giving more people control and choice over the support we provide, through the allocation of Personal Budgets.

Looking Forward

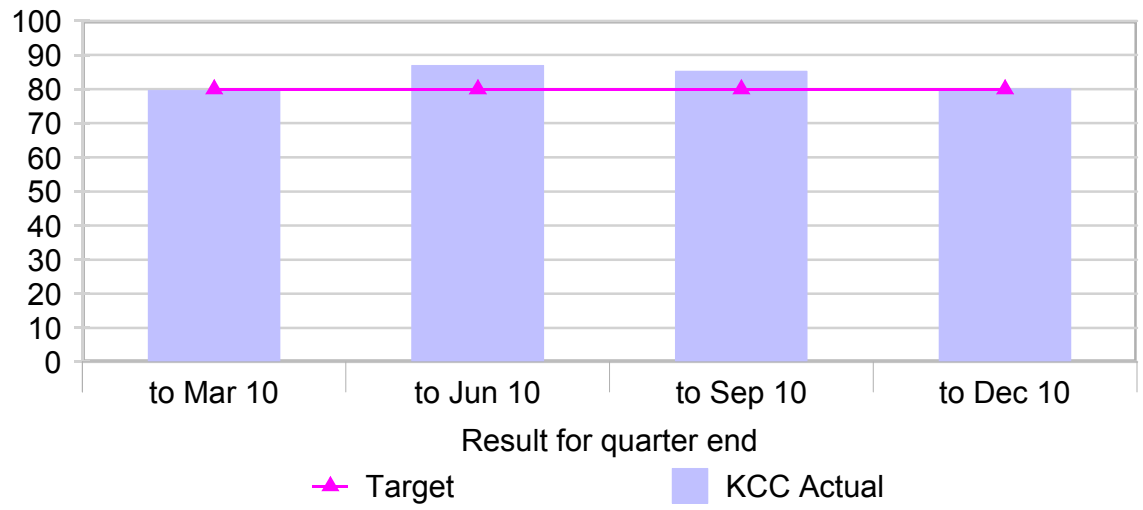
In December we published our new medium term plan, "Bold Steps for Kent", which sets out the council's ambitions and priorities up to 2014/15. These are centred on three aims of 'helping the Kent economy to grow', 'putting the citizen in control' and 'tackling disadvantage'. At the same time the council approved "Change to Keep Succeeding" which will ensure the organisation is lean and flexible, safeguarding frontline services by focussing on efficiencies and innovative approaches to delivery.

Our recent budget settlement from the government, combined with the decision not to increase council tax means we will have to find £95 million of efficiencies and savings in financial year 2011/12. "Change to Keep Succeeding" will help us deliver this and "Bold Steps for Kent" will help us maintain a focus on key priorities, during a time of great change and financial consolidation.

Future reports for 2011/12 will report on progress against the key priorities in "Bold Steps for Kent" which includes many of the items already reported within Core Monitoring and particularly those listed as areas of continuing concern.

Katherine Kerswell
Group Managing Director
Kent County Council

Contact Kent : Percentage of calls answered within 20 seconds	Green



Higher value is better	Quarter end Mar 10	Quarter end Jun 10	Quarter end Sept 10	Quarter end Dec 10
KCC Result	79.6%	87.0% ⬆	85.3% ⬇	80.1% ⬇
Target	80%	80%	80%	80%
RAG Rating				
Calls received	304,000	261,000	270,000	269,000

Contact Kent currently supports 87 different services on a 24 hours a day, 7 days a week, 365 days a year basis. The range of services provided includes library book renewals, reporting pot-holes, arranging temporary housing for Maidstone residents and handling reporting of child protection concerns for both new and existing cases. This requires a high level of customer service skills, dealing with different needs and conversing with a wide range of callers. The services with the highest volumes of calls received are Libraries, Highways and Registrations.

Call answering response rates for Contact Kent are slightly down from earlier in the year but continue to be above the target benchmark. The target level of 80% is a standard industry benchmark and there are significant diminishing returns on resource input in attempting to perform significantly above this level.

December 2010 was the busiest on record for Contact Kent, and saw a very high level of calls due to adverse winter and snow conditions.

Detailed performance information for the complete year is as follows :

	2009 Full year	2010 Full year
Percentage of calls that were answered	94%	95%
Average wait time	15 seconds	13 seconds
Average abandon time	57 seconds	1 min 9 sec

Transactions and footfalls at Gateway facilities	Information only

The Kent public sector Gateways have been hugely popular with residents, creating a single point of access to a wide range of public services in convenient town centre locations.

Transactions

	Oct – Dec 09	Jan – Mar 10	Apr – Jun 10	Jul – Sep 10	Oct – Dec 10
Ashford	8,461	8,829	11,126	12,958	13,519
Dover	8,239	11,514	11,780	11,735	10,267
Maidstone	10,576	13,244	12,652	16,742	10,646
Tenterden	4,534	4,633	6,030	4,987	3,235
Thanet	21,835	29,807	33,586	32,385	33,267
Tonbridge	9,246	15,991	17,640	21,029	13,949
Tunbridge Wells	11,927	17,516	13,409	11,999	10,154
TOTAL	74,818	101,534	106,223	111,835	95,037

Footfall

	Oct – Dec 09	Jan – Mar 10	Apr – Jun 10	Jul – Sep 10	Oct – Dec 10
Ashford	16,607	17,495	22,103	24,735	20,207
Tenterden	59,653	61,209	56,940	63,672	59,608
Thanet	99,386	109,813	104,764	121,012	96,652
Tunbridge Wells	27,840	34,018	30,952	28,407	30,615
TOTAL	203,486	222,535	214,759	237,816	207,082

We now have more than a year's data for public use of Gateway facilities. This has revealed that the quarter to October to December is the quietest period of the year. Gateway transactions in the quarter were 15% lower than the previous quarter but 27% ahead of the same time last year. Similarly footfall was 13% down against last quarter but 2% ahead of the same time last year.

Future plans include embedding the Gateway approach across the full range of KCC services.

Data Notes:

- Variations between quarters reflect seasonal variations and other changes to services offered or advertised at any given time.
- Footfall counters are not currently installed at Maidstone, Dover or Tonbridge.
- Thanet and Tenterden Gateway footfall includes library visitors but library transactions are not counted under Gateway transactions.

The number of complaints made to the council by residents	Information only

Service area	Qtr 1 2010/11	Qtr 2 2010/11	Qtr 3 2010/11	Year to date
Kent Highway Services (KHS)	534	532	646	1,712
Adult Social Services	139	126	123	388
Children, Families & Education	131	104	125	360
Environment & Waste	103	95	44	242
Risk Management & Insurance	96	49	51	196
Community Learning & Skills	32	49	38	119
Libraries & Archives	45	25	23	93
Other services	30	26	27	83
Gateways and contact centre	27	21	10	58
Commercial Services	11	27	18	56
Youth Service	5	12	18	35
Media Centre	1	3	30	34
Supporting People	8	12	5	25
Total	1,162	1,081	1,158	3,401

Lessons learned from complaints received are published within the '**You said, we did'** section of our website which illustrates the changes that are made as a result of complaints received.

The number of complaints this year has been similar each quarter at around 1,100. The majority of complaints received by the council this year have been in relation to Kent Highways Services (49% of complaints).

Complaints about highways increased during the severe weather of December 2010 and were mostly in relation to a perceived lack of action around clearing of ice and snow from pavements and side roads. The approach taken to these complaints was to advise customers at the first point of contact what the published policy was and then direct them to the website rather than logging the requests as enquiries.

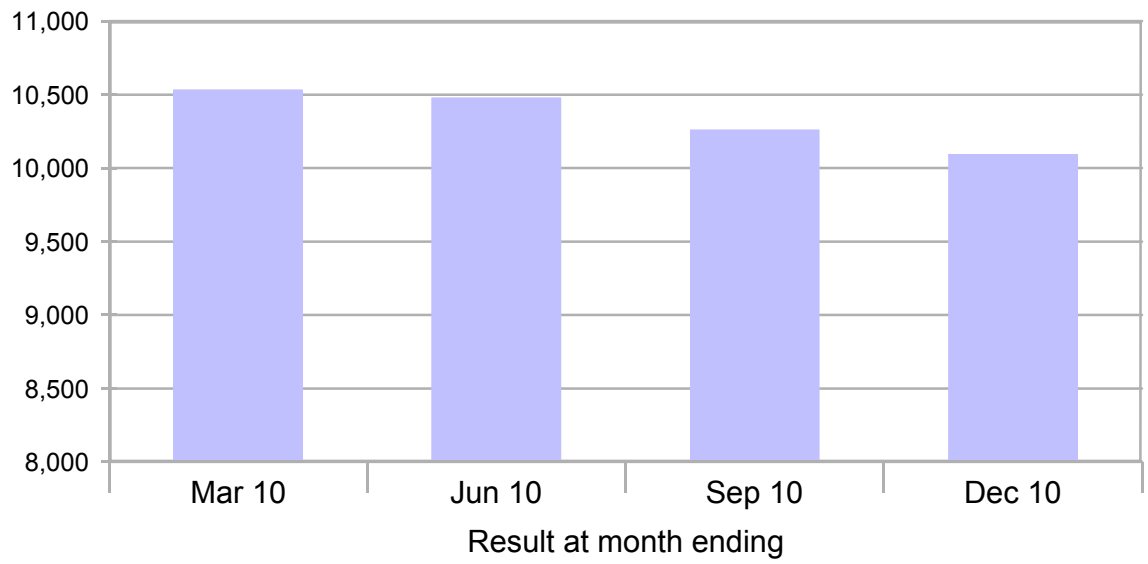
KHS staff also adopted a very transparent approach with customers, letting them know what could and couldn't be implemented under the KHS winter policy. Additional information about the winter actions being taken was also put onto our website.

There was an increase in complaints to the Media Centre in the last quarter due to the Kent Traffic and Travel site not working at all times during the bad weather, the cost of Around Kent and the fact that we ran out of the Battle of Britain CD's advertised in Around Kent.

Data Notes:

- Data presented here shows the number of complaints received, although within this some individuals may have complained about more than one issue. Figures may not therefore agree to other published data on complaints where the analysis is looks at the number of issues complained about.

Number of full time equivalent staff employed by KCC (excluding schools)	Information only



	Mar 10	Jun 10	Sept 10	Dec 10
Staffing numbers – FTE	10,531	10,477	10,259	10,094

The current financial year shows a drop in staffing levels as funding becomes reduced and the council prepares for further funding reductions in the years to follow, as government reduces the national budget deficit.

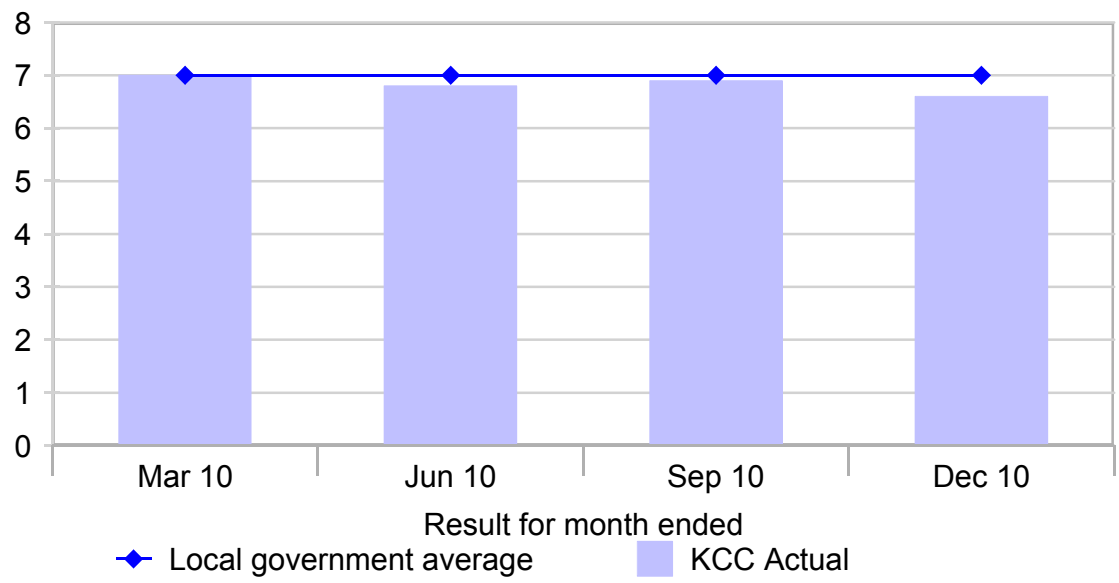
The staff reductions in the year by directorate were:

Children, Families and Education: 127
Communities: 94
Environment, Highways and Waste: 11
Chief Executives: 67
Adult Social Services: 84

Data Notes:

- Data taken from KCC HR Business intelligence system, staff demographics.

Staff aged under 25 years old (as a percentage of headcount)	Amber



Higher value is better	Mar 10	Jun 10	Sept 10	Dec 10
Staff aged under 25	7%	6.8% ⬇	6.9% ⬆	6.6% ⬇
Local government average	7.0%	7.0%	7.0%	7.0%
RAG Rating				
Count of staff aged < 25	1,023	998	977	926

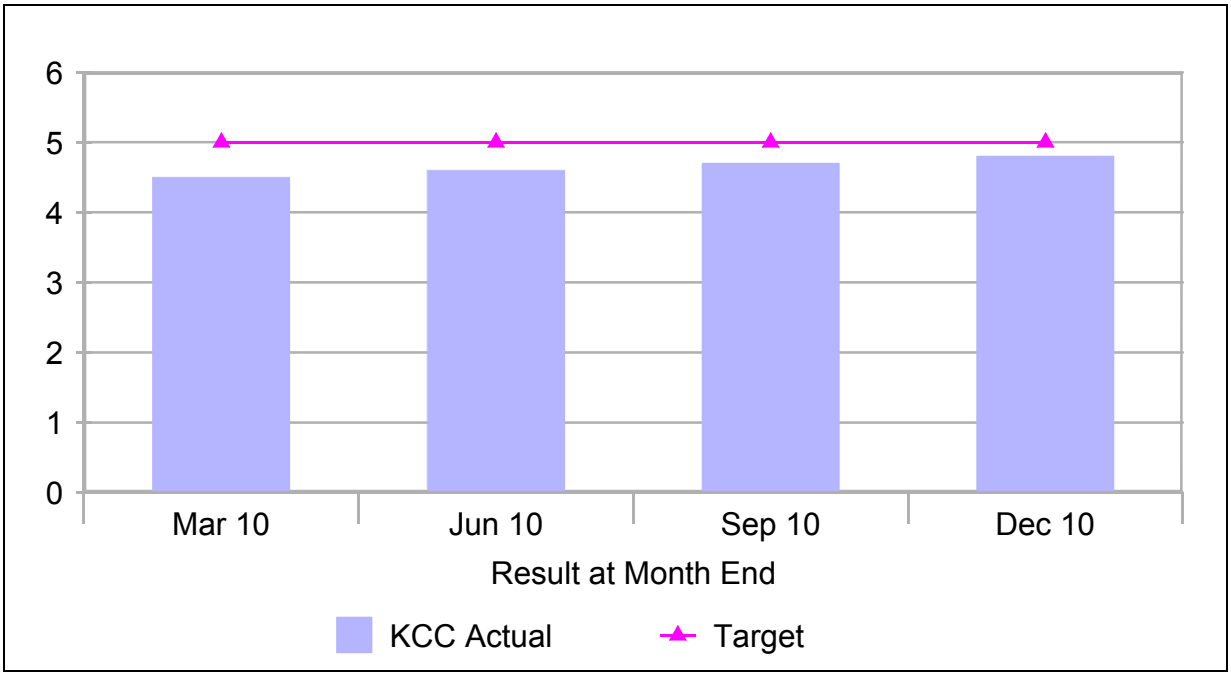
Of staff leavers during the current financial year, a disproportionate number have been from the younger age group which the council has set a priority to support.

Future actions to address this include the commitment for KCC to take on at least 350 additional apprenticeships over the next four years.

Data Notes:

- Data taken from KCC HR Business intelligence system, staff demographics.
- Local government average is taken from the Labour Force Survey.

Percentage of staff headcount from BME groups	Amber



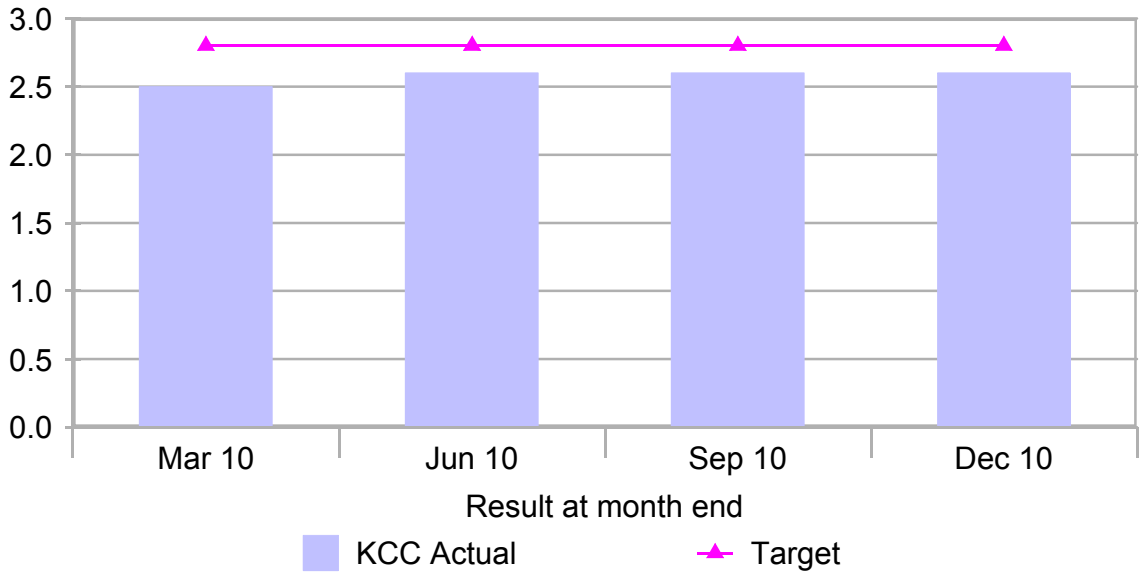
Higher value is better	Mar 10	Jun 10	Sept 10	Dec 10
BME staff	4.5%	4.6% ⬆	4.7% ⬆	4.8% ⬆
Target	5%	5%	5%	5%
RAG Rating				

Progress is being made on attracting and retaining staff from black and minority ethnic groups with numbers continuing to increase.

Data Notes:

- Data taken from KCC HR Business intelligence system, staff demographics.

Percentage of staff declaring a disability (DDA definition)	Amber



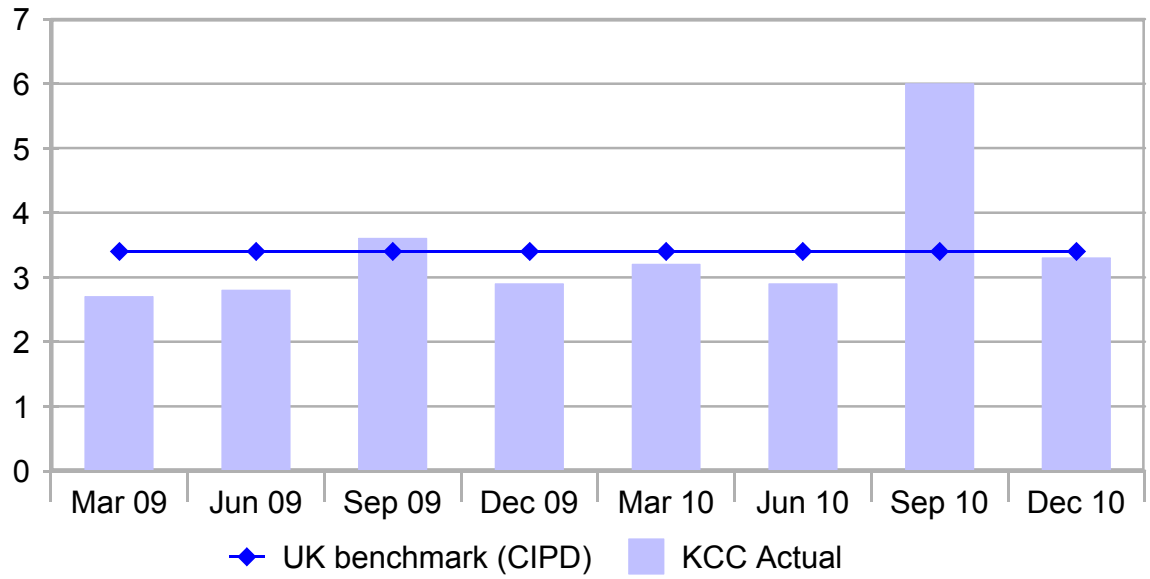
Higher value is better	Mar 10	Jun 10	Sept 10	Dec10
Staff with disability	2.5%	2.6% ↑	2.6% ↔	2.6% ↔
Target	2.8%	2.8%	2.8%	2.8%
RAG Rating	▲	●	●	●
Count of staff with disability	283	286	285	273

The percentage of staff with a disability has been holding at a steady rate all year.

Data Notes:

- Data taken from KCC HR Business intelligence system, staff demographics.

Staffing turnover (leavers as a percentage of headcount)	Not rated



	Quarter to Mar 10	Quarter to Jun 10	Quarter to Sept 10	Quarter to Dec 10
Staff turnover actual	3.2%	2.9%	6.0%	3.3%
UK Benchmark	3.4%	3.4%	3.4%	3.4%
RAG Rating	Not rated – ideal is to be close to the benchmark over the medium term			

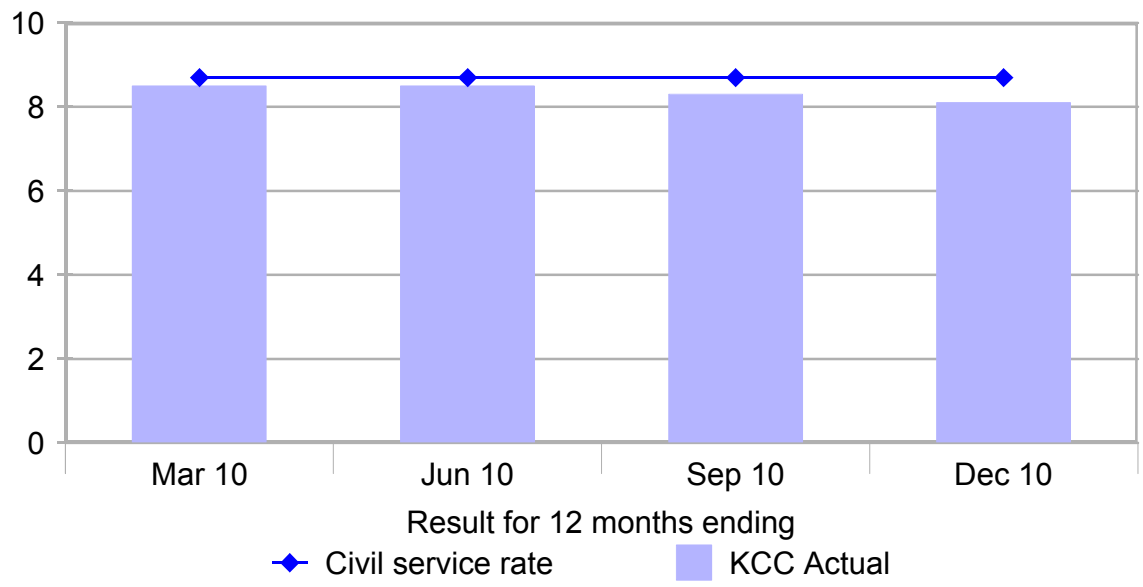
The number of staff leavers has fallen back to the benchmark in the last quarter, following a quarter of high turnover, despite the continuing reductions in staffing numbers.

The high level of turnover in the previous quarter was mostly down to re-structuring within the Children, Families and Education directorate.

Data Notes:

- Data taken from KCC HR Business intelligence system.
- UK Benchmark provided by the Chartered Institute of Personnel and Development.

Staff sickness – average days lost per FTE (rolling 12 months)	Amber



Lower value is better	12 months ending Mar 10	12 months ending Jun 10	12 months ending Sept 10	12 months ending Dec 10
Staff sickness actual	8.5	8.5 ↔	8.3 ↑	8.1 ↑
Civil service rate	8.7	8.7	8.7	8.7
RAG Rating				

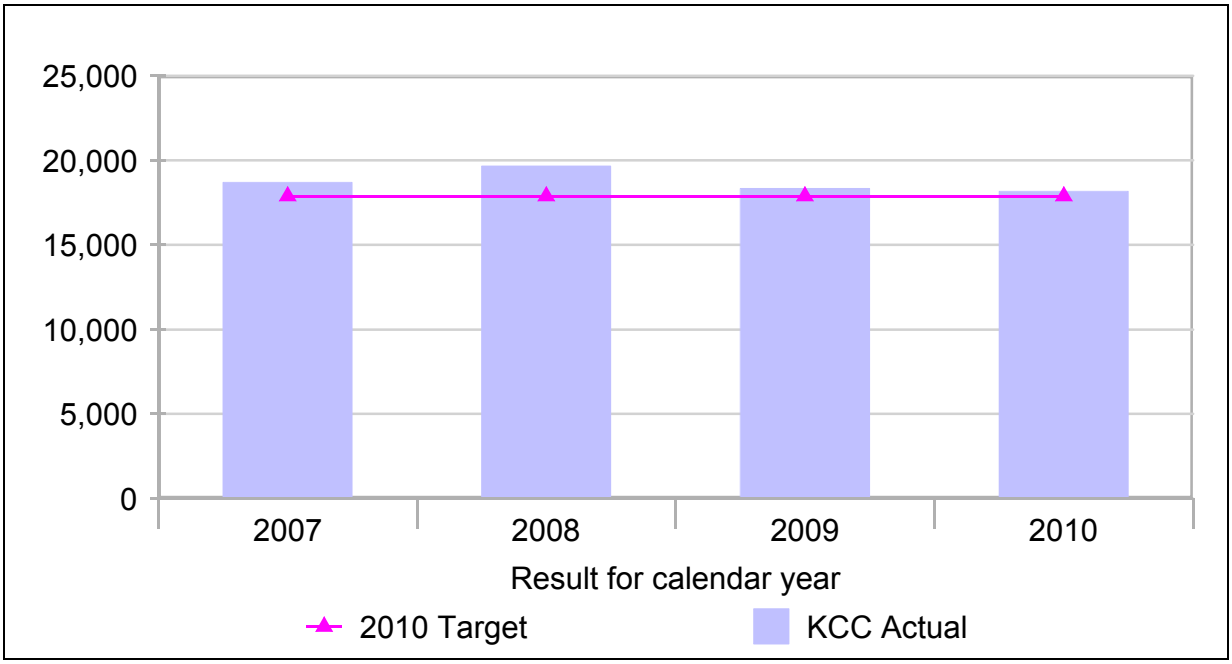
Staff sickness levels continue to reduce with the reduction reported last quarter now exceeded by another quarter of low absence rates.

Sickness days in the last 12 months averaged 8.1 per full time employee which is down from the 8.3 previously reported for the 12 months ending September 2010.

Data Notes:

- Data taken from KCC HR Business intelligence system
- There is no available benchmark for local authorities
- The civil service is used as a benchmark as there are a number of factors in the civil service workforce, which are similar to a large local authority such as KCC. These are the size of organisation, age and gender balance of the workforce, all of which will impact on the sickness rate recorded.
- Note the previous reports shows data by quarter which was not cumulative. The change to showing data as cumulative 12 month totals has reduced the in-year RAG rating of Green, to the Amber now shown.

Tonnage of carbon emissions from KCC non-schools estate, excluding schools	**Amber**
Tonnage of carbon emission from schools	**Red**



Lower result is better	2007	2008	2009	2010 Provisional
KCC non-schools result	18,700	19,700 ⬇	18,300 ⬆	18,200 ⬆
Target		17,900	17,900	17,900
RAG Rating		▲	●	●
Schools result (not graphed)	69,700	76,700 ⬇	75,700 ⬆	77,400 ⬇
Target		59,400	59,400	59,400
RAG Rating		▲	▲	▲

KCC had a target for a 10% reduction in carbon emissions by 2010 compared to 2004. This target has not been met, and instead a growth in emissions has been seen, primarily due to a 50% increase in electricity use in the schools estate.

Non-school buildings emissions have reduced by 8%, just below target. Although good savings are being achieved in our larger estate buildings, the large number of smaller, very old and inefficient properties is holding back performance.
Whilst energy efficiency projects with a payback of less than 5 years continue to be implemented, we expect to see a step change in the next few years as the council reduces the number of county offices through better use of space and delivers several improvements through its ICT infrastructure and flexible working practices.

The increase in schools emissions is due to various reasons including an increase in the size of the physical estate (additional school buildings), a significant increase in use of ICT in schools, longer 'hours of business' e.g. the Extended Schools Programme and new schools with higher energy use than those which they replace. The programme for supporting schools to reverse the upward trend in emissions is being further developed, including exploring different funding mechanisms.

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By: Roger Gough, Cabinet Member for Business Strategy & Support
Katherine Kerswell, Group Managing Director

To: Corporate Policy Overview & Scrutiny Committee – 31 March 2011

Subject: KCC's Performance Management Framework

Classification: Unrestricted

SUMMARY

This paper provides details of work underway to develop a clear Performance Management Framework for the authority.

FOR COMMENT

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1. Introduction

The recent launch of KCC's new strategic statement, Bold Steps for Kent, as well as the restructuring has given the opportunity to review and refresh our current performance management arrangements to ensure they are robust and efficient.

One of the key changes will be the development of a single performance framework, using Bold Steps for Kent at its heart.

This will form part of an overall performance management framework for the authority that is underpinned by a stronger culture of performance management accountability, greater self awareness and transparency across the council. It will also have due regard for the significant reduction in both staff and finances over the coming years.

2. Current position

We currently rely on a number of different processes to help assess the performance of the organisation. These include, for example, quarterly Core Monitoring reports (which also incorporate half-yearly business plan monitoring), quarterly Financial Monitoring reports, and Towards 2010 reports (as was). As well as corporate reporting arrangements directorates have in place their own monitoring and reporting mechanisms.

Each of these various monitoring and reporting processes often uses its own set of performance measures resulting in vast quantities of performance information being produced. This can result in members and the Corporate Management Team not being able to 'see the 'wood for the trees'. This range of current monitoring and reporting processes, some for different audiences, can also lead to a disjointed and sometimes unclear picture of current performance for the authority at any one time. These varying and various processes also have the potential to duplicate activity and therefore add additional costs.

In addition, some of our key strategies that have been published do not yet have an established monitoring and reporting process in place to track progress.

As an authority we need to be much smarter at delivering our performance management processes in a more joined-up and intelligent way in order to give members and the Corporate Management Team what they need to understand the complete performance picture of the organisation, and to assess the outcomes being delivered. This would also drive out duplication in the system.

We also want to ensure that the performance information provided consistently results in proper intervention and targeted actions to improve performance where it is poor or declining and that it has due regard to risk and spotting potential problems before they arise.

3. Principles of KCC's new performance management framework

We will develop a performance management framework which has the following principles:

- We will **establish a single performance framework for the authority that provides an intelligent joined-up assessment of performance against our key priorities.** Bold Steps for Kent will be at its heart. This framework needs to have the confidence of both members and officers, be understandable, transparent and less bureaucratic than current processes. It will include relevant measures and be proportionate. This is described in more detail in section 4, overleaf.

- We will **report the information that members and the Corporate Management Team need** in order to understand current performance. This will be essential information which is readily understood to ensure they are better informed and are able to focus in on the key issues. This reporting will have the principle of subsidiarity at its heart ensuring performance is being correctly managed at its most appropriate managerial and political level

- Reports on progress will be designated by a RAG (red/amber/green) status which will **create a trigger when escalation and intervention is required**. Definitions of the individual RAG statuses will be agreed as will the trigger point for escalation and intervention e.g. when performance is deemed to have turned from 'amber' to 'red'

- We will **performance manage not monitor**. There will be greater transparency about performance and personal accountability and clear decisions will be made about what needs to happen when performance levels are falling or have a 'red' status. There will also be a greater emphasis on anticipating and forecasting performance problems to ensure 'no nasty surprises'

- We will underpin this with a stronger framework to provide **challenge and accountability for poor or reducing performance**

- We will ensure **transparency of performance data** and its availability in the public domain. Data will only be confidential if it *is* confidential

- We will **examine why something is working well** to understand what we can learn from it e.g. is it because we're investing too much money in it or is it good practice we can share?

- The new framework will be **less resource intensive and reduce duplication**; something that is fundamental in an organisation with less money and less support staff

- The new performance framework will also involve staff from all levels in the Council to create wider awareness and additional challenge in the process.

4. Development of a single performance framework

We have published a wide range of key strategies across our services that set out our priorities and commitments to the people of Kent. Bold Steps for Kent is one of these and is our medium term plan to 2014/15. As such, it overarches all of our strategies.

As discussed in section 3, we will develop a single framework that measures how we are performing against all of our strategies using Bold Steps for Kent as its core.

Work is being done to map the high level priorities and commitments made in Bold Steps for Kent to those in our other published key strategies. As expected, there is close alignment between Bold Steps for Kent and the documents mapped so far.

As would also be expected, Bold Steps for Kent does not include specific mention of all of the *detailed* commitments and priorities found in the key strategies mapped but they will be included in the new single performance framework.

The framework will also include the commitments and priorities published in the *underpinning* strategies and plans that cascade from the overarching key strategies.

Finally, the single performance framework will also include any core business not covered in the strategies.

Ensuring all these necessary elements are included in the single performance framework will ensure that *progress can be understood, tracked, managed and reported as a single entity*.

The performance measures used to help track progress will be proportionate, relevant and focused and will include quantitative and qualitative measures and 'lead and lag' metrics. Lead indicators focus on what happens before the event and lag indicators focus on what happened as a result of the event. A lead indicator could be, for example, school attendance and a lag indicator is, for example, exam results.

Indicators used will also include *directly-related measures* as well as those that seek *to take to temperature of the organisation.* This means that we will be able see progress in the round and not just against one single aspect (a key lesson learned from the recent Children's Social Services inspection report).

5. Next steps (April to July)

We want to involve members in evaluating and agreeing the success factors for the key priorities and commitments published in Bold Steps for Kent i.e. what will success look like at the end of its term in 2014/15?

We propose to do this via a structured workshop(s). We will then use this feedback to help shape some of the performance measures to be used in the single performance framework. Baselines will then be established against the quantitative performance measures.

We will seek endorsement to the single performance framework at the June POSCs and approval by County Council in July.

6. Recommendations

Members are asked to NOTE the approach being taken to provide a clear performance management framework for the authority and make any relevant COMMENT.

Accountable officer: Sue Garton, County Performance & Evaluation Manager, Chief Executive's Department, 01622 22(1980).

By: Overview, Scrutiny and Localism Manager

To: Corporate Policy Overview and Scrutiny Committee
31 March 2011

Subject: **SELECT COMMITTEE - UPDATE**

Classification: Unrestricted

Summary: To update the Committee on the current topic review programme and to invite suggestions for future Select Committee topic reviews.

Select Committee Topic Review Work Programme

1. (1) There are currently no Select Committee topic reviews in the work programme which fall under the remit of this Policy Overview and Scrutiny Committee.

(2) Action plans are due to be submitted to the relevant POSC's setting out how the recommendations are to be progressed (or if there are issues with progressing any of the recommendations these will be drawn to the attention of the POSC's).

- Renewable Energy
- Extended Services

(3) The Select Committee work programme consists of the following:-

- Dementia – carrying out visits and hearing sessions.
- Educational Attainment of Pupils and Schools in Areas of High Deprivation – held its inaugural meeting in 3 February 2011 and Mr Wells was elected Chairman.
- The Student Journey – due to start its work in Spring 2011.

Suggestions for Select Committee topic reviews

2. At the Scrutiny Board It was agreed that Members would be asked to consider whether there are any topics that they would like to put forward for consideration for inclusion in the future topic review programme. If Members do have any suggestions could they contact the Democratic Services Officer for this POSC.

3. **Recommendation** Members are asked to note the Select Committee topic review update and to advise the Democratic Services officer of any items that they would like to suggest for inclusion in the Select Committee topic review programme

Denise Fitch
Tel No: 01622 694269
e-mail: denise.fitch@kent.gov.uk

Background Information: *Nil*

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