ADULT SOCIAL SERVICES AND PUBLIC HEALTH POLICY OVERVIEW AND SCRUTINY COMMITTEE*

Thursday, 7th April, 2011

10.00 am

Council Chamber, Sessions House, County Hall, Maidstone

NB - on the assumption that the County Council will approve the new Committee structure and titles at its meeting on 6 April 2011, this agenda uses the new title.

AGENDA

ADULT SOCIAL SERVICES AND PUBLIC HEALTH POLICY OVERVIEW AND SCRUTINY COMMITTEE

Thursday, 7 April 2011 at 10.00 am **Council Chamber, Sessions House, County Hall, Maidstone**	Ask for: Telephone	**Theresa Grayell** **(01622) 694277**

Tea/Coffee will be available 30 minutes before the meeting

Membership (13)

Conservative (11): Mrs A D Allen, Mr R Brookbank, Mr C J Capon, Mrs P T Cole, Mr N J Collor, Mr J M Cubitt, Mrs V J Dagger, Mr M J Jarvis, Mr J E Scholes, Mr C P Smith Mr C T Wells

Labour (1): Mr G Cowan

Liberal Democrat (1): Mr S J G Koowaree

Webcasting Notice

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By entering the meeting room you are consenting to being filmed and to the possible use of those images and sound recordings for webcasting and/or training purposes. If you do not wish to have your image captured then you should make the Clerk of the meeting aware.

UNRESTRICTED ITEMS

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

The Committee has the option of breaking for lunch and continuing its business afterwards, if the weight of business dictates. The timing of the meeting will be determined on the day by the Chairman.

Item No

A. COMMITTEE BUSINESS

A1 Introduction/Webcasting

A2 Membership - the Committee is asked to note its new Membership, shown above

A3 Substitutes

A4 Election of Vice-Chairman

A5 Meeting Dates for 2011. The Committee is asked to note the dates of its meetings for the remainder of 2011:-

Thursday 7 July, 10.00am
Tuesday 20 September, 10.00am
Tuesday 10 November, 10.00am
All meetings will be held at County Hall

A6 Declaration of Members' Interest relating to items on today's agenda

A7 Minutes of the last Adult Social Services Policy Overview and Scrutiny Committee meeting on 12 January 2011 (1 - 14)

A8 Chairman's Announcements

A9 Oral updates by Cabinet Member, Director of Public Health and Interim Corporate Director, Families and Social Care

B. PRESENTATION

B1 White Paper on Public Health (all Members will be invited to attend)

C. ITEMS FOR SCRUTINY

C1 KASS Debt Position February 2011 (15 - 24)

D. PUBLIC HEALTH ITEMS

E. ITEMS FOR CONSIDERATION

E1 'No Health without Mental Health' - the new Government Strategy for Mental Health (25 - 28)

E2 Care Quality Commission - Annual Performance Assessment Improvement Plan (29 - 38)

E3 Think Local, Act Personal (39 - 44)

E4 A Summary of The Operating Framework for the NHS in England 2011/2012, including Funding Allocations and Local Activity in Kent (45 - 122)

E5 Non-Residential Charging Policy Changes (123 - 142)

E6 Adult Social Services Budget Forecast Report 2010/2011 (143 - 174)

E7 Core Monitoring (175 - 194)

E8 KCC's Performance Management Framework (195 - 198)

F. ITEMS PLACED ON THE AGENDA BY MEMBERS

F1 Savings Monitoring Report

G. SELECT COMMITTEE WORK

G1 Update on Select Committee Work (199 - 200)

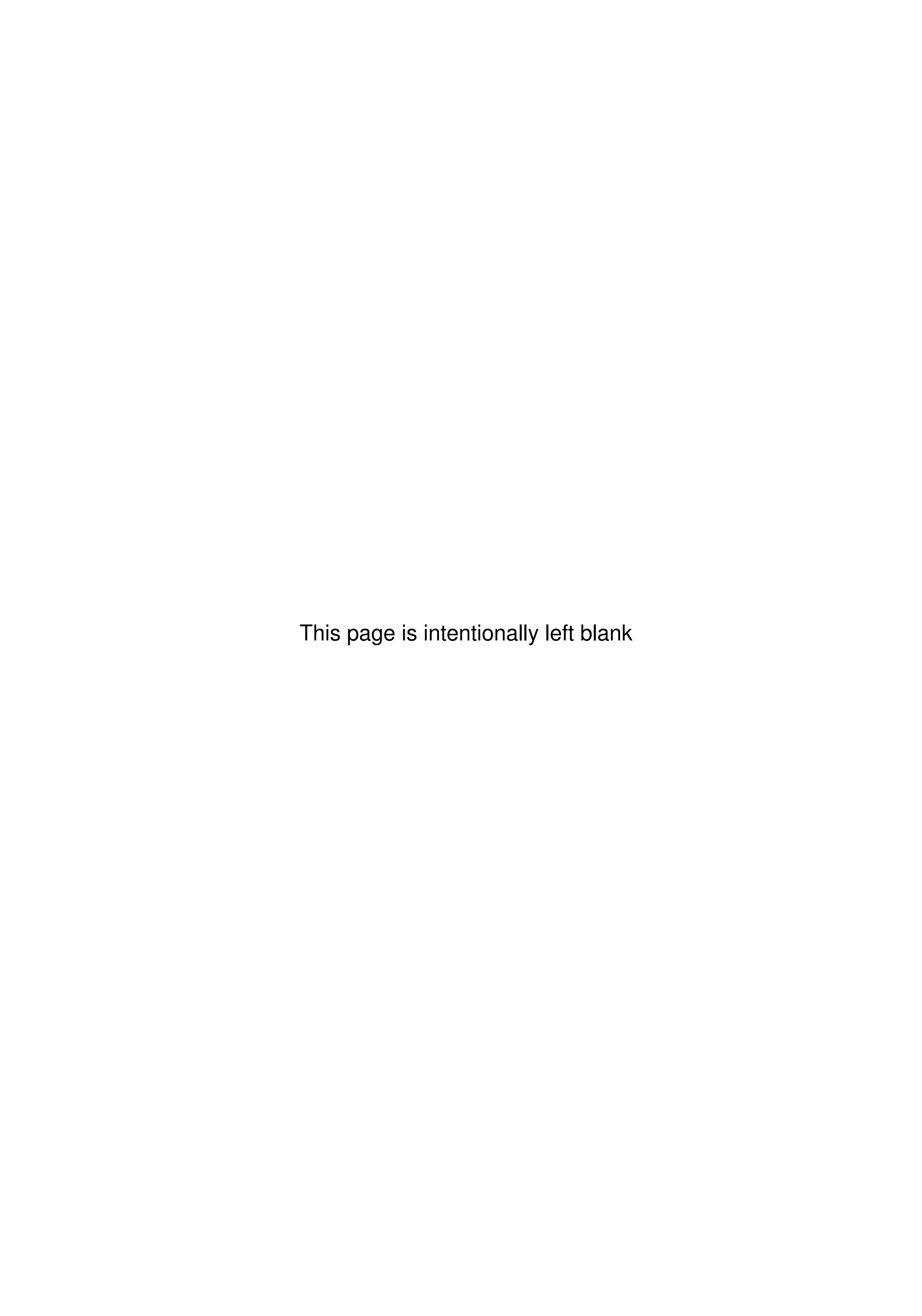
EXEMPT ITEMS

(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

30 March 2011

Please note that any background documents referred to in the accompanying papers may be inspected by arrangement with the officer responsible for preparing the relevant report.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KENT COUNTY COUNCIL

ADULT SOCIAL SERVICES POLICY OVERVIEW AND SCRUTINY COMMITTEE

MINUTES of a meeting of the Adult Social Services Policy Overview and Scrutiny Committee held in the Council Chamber, Sessions House, County Hall, Maidstone on Wednesday, 12 January 2011.

PRESENT: Mr P W A Lake (Chairman), Mr K H Pugh (Vice-Chairman), Mrs A D Allen, Mr L Christie, Mrs P T Cole, Mr J M Cubitt, Mrs V J Dagger, Mr C Hibberd (Substitute for Mr N J Collor), Mr M J Jarvis, Mr S J G Koowaree, Mr J E Scholes, Mr C P Smith and Mr M J Whiting (Substitute for Mr R Brookbank)

ALSO PRESENT: Mr M J Angell, Mr G Cowan, Mrs T Dean, Mr G K Gibbens, Mr P J Homewood, Mr R J Lees, Mr J F London, Mrs J Rook, Mr R Tolputt and Mr J N Wedgbury. In addition, Mr R Brookbank attended the later part of the meeting as a local Member.

IN ATTENDANCE: Mr O Mills (Managing Director - Adult Social Services), Mrs M Howard (Director of Operations), Mrs A Tidmarsh (Director of Commissioning and Provision - East Kent) and Miss T Grayell (Democratic Services Officer)

UNRESTRICTED ITEMS

101. Minutes of the meeting held on 16 November 2010
(Item A4)

RESOLVED that the Minutes of the meeting held on 16 November 2010 are correctly recorded and they be signed by the Chairman.

Matters Arising
Two items, 'Think Local, Act Personal' and 'Capable Communities and Active Citizens', on which future reports had been offered in the Director's oral update, had not been able to be reported back yet as the first was still in preparation and the second was still in consultation. Reports on both of these, and on the Public Health White Paper, will be submitted to the POSC's April meeting.

102. Chairman's Announcements
(Item A5)

1. The Chairman reported the receipt of an announcement from the Group Managing Director, Katherine Kerswell, which listed the first tier appointments under Change to Keep Succeeding, and he read out the appointments related to the POSC; Mrs Howard had been appointed as Director of Learning Disability and Mental Health and Mrs Tidmarsh as Director of Older People and Physical Disability.

2. The announcement also included notice of some officers who would be leaving the Council in the Spring of 2011, once the new structure had been completed. These included Mr Mills, Miss Highwood, Director of Strategic Business Support, and Mrs Huntingford, Transforming Social Care Lead Officer.

3. Mr Mills confirmed that he would be very active in setting up the new KASS structure but advised Members that this was the last POSC meeting at which he would be present. He thanked Members for their support, both individually and as a Committee, in maintaining a constructive dialogue with his officer team, and for their 'critical friend' role in scrutinising the Directorate's work. He also thanked his officer colleagues for the quality of reports which the Committee received, which had helped them to understand and scrutinise issues.

4. The Chairman thanked Mr Mills for his work as Director of Operations and then Managing Director in leading KASS to achieve national recognition for its pioneering policy development and service delivery. Mr Christie, Mr Koowaree, Mrs Allen, Mr Jarvis and Mr Angell also thanked Mr Mills for his guidance and support of them personally through their political careers and in helping them to address problems brought to them by local residents.

5. Mr Gibbens added that many people across Kent had reason to appreciate Mr Mills' leadership of a service which had consistently received good ratings from national regulators and has a good reputation nationally. He had heard first hand from SECASS and ADASS contacts that Mr Mills was respected and well thought of among his peers. He also remembered and paid tribute to Mr Mills' support and guidance to him as a new Cabinet Member.

103. Cabinet Member's and Director's Update (oral)
(Item A6)

1. Mr Gibbens gave an oral update on the following:-

   a) *District Partnership Groups* meet in each district every three months to address issues raised by people with Learning Disabilities. Mr Gibbens explained that he is actively involved in these groups and encouraged Member colleagues to become involved as champions for people with Learning Disabilities. He asked that any Members interested in taking on this role contact him.

2. Mr Mills then gave an oral update on the following issues:-

   a) *CQC Annual Performance Assessment*: KASS had developed an Action Plan to address, over the next six months, the areas which were marked as needing improvement, and the POSC would need to oversee the delivery of this;

   b) *NHS changes*: The changes currently being made to the NHS are the largest since its launch 1948, and would be far-reaching. The government announced on 4 January that £162m had been made available nationally, which would be transferred from the PCTs for social care to benefit the NHS. In 2011/12 a further £648m nationally will be transferred to social care but this was not shown in the current budget book as KASS did not yet have access to it. The National Operating Framework for 2011/12 had been published, which sets out the clustering of PCTs which will mean the amalgamation of the three

Kent PCTs to tackle winter pressures until the end of March. Separately, a new combined Community Services NHS Trust will be established from 1 April which will combine the two PCT provider services and will be the Foundation Trust. The POSC would have further updates on both these issues at future meetings; and

c) *Change to Keep Succeeding:* Work on the new structure was continuing and there was much detail still to be worked through. East and West Kent would no longer be covered separately, and the new senior management posts being established under CKS would cover the whole of the county. Support Services were to be centralised and would no longer come under KASS line management. Members expressed concern at how well this would work, and asked for future reports on the bedding-in of the new structure so they could monitor very closely the effectiveness of the new arrangement, in particular the finance function.

104. Adult Social Services Budget Forecast Report 2010/11 and Kent Adult Social Services Debt Position, November 2010
(Item B1)

Miss M Goldsmith, Directorate Finance Manager, was in attendance for this and the following item.

1. Miss Goldsmith introduced the report and said that she hoped to balance the KASS budget at the end of the financial year. The extra NHS funding, announced in the oral update, would certainly help with this. The pattern of debt in two consecutive months had been influenced, firstly by a technical failure of the invoicing system and then by the postal backlog caused by the bad weather, both of which had affected the ability to issue and process invoices. The pattern was expected to normalise, however, in the current billing period.

2. In discussion, and in officers' response to questions asked by Members, the following points were highlighted:-

a) a decrease in the number of older people entering permanent residential care had at first been a very small difference, but the pattern had since repeated and so had been factored in as a trend;

b) none of the debt written off in the period had related to any client currently receiving services, but was old debt and related mostly to clients who had deceased and whose estates did not contain sufficient funds to clear the debt;

c) delayed transfers carried no direct financial cost to the local authority, but did have an indirect cost in terms of staff time and involvement. The main cause of delayed transfers used to be a delay in arranging social care packages, but in the last two years this had changed to being mainly health-related delays; and

d) the general pattern of reducing debt (taking into account the temporary change outlined above) had demonstrated that bringing the debt recovery and management service in-house a year ago has had a positive effect. However, this service, along with other support services, would be centralised under CKS, and the POSC would need to monitor this very closely to ensure that debt management did not suffer as a result.

3. RESOLVED that the information given in the report and in response to Members' questions be noted, with thanks.

105. Draft Revenue and Capital Budgets 2011/12 and Medium Term Financial Plan, 2011 - 2013
(Item B2)

The Chairman secured the Committee's agreement to consider this item as urgent business, as the papers could not be placed in the public domain with the required five clear days' notice, due to the late publication of the draft budget.

1. Miss Goldsmith introduced the report and she and Mr Mills and Mrs Howard responded to comments and questions from Members. The issues highlighted were as follows:-

a) KASS headings in the published budget book showed net budget reductions in some service areas. Some of these had been caused by the end of some specific grants including Transforming Social Care Grant. Some payments to the voluntary organisations were time limited, specifically whilst this grant funding existed. No cuts to specific voluntary organisations are proposed other than for this reason;

b) KASS had strategies in place to address these reductions, as well as ways to generate income, and these are listed on pages 89 and 90 of the budget book;

c) the ongoing increase in the number of clients using Direct Payments to buy services would lead to reduced expenditure on residential services;

d) the KCC was previously expecting to lose £5m of funding (a reduction of 50% from the former level) when the Preserved Rights formula changed, but this expected loss had not materialised. Similarly, other funding which the KCC had feared would move from specific grants to formula funding had not changed;

e) Members expressed the opinion that the layout of the budget book made it difficult to follow, and some entries did not show enough detail to give a helpful picture. Miss Goldsmith undertook to advise Members outside the meeting of specific details requested; and

f) the headings presented in the budget represented the headlines only, and if these were agreed by the Council in February, the detail of the budget would then be worked out, using the Fairer Charging guidance.

2. RESOLVED that the information given in the report and in response to Members' questions be noted, with thanks.

106. Risk Management - Revised Directorate Risk Register
(Item C1)

Mr N Sherlock, Head of Planning and Public Involvement, was in attendance for this and the following two items.

1. Mr Sherlock introduced the report and answered questions from Members. Points arising in comments and questions were as follows:-

a) the shaded chart on page 51 of the meeting papers would be clearer if it were to include numbers to identify the intensity of risk. Numbers would be generated by multiplying the likelihood by the impact and entering the numerical value in the column where the two lines intercept. Alternatively, the boxes currently shaded in greys could contain the words High, Medium and Low;

b) due to the way in which risks are identified, it is difficult to say how KASS risks compare in severity to those of other Directorates. For instance, 'financial' risk would include all financial risk across all Directorates and would not allow those specific to KASS (eg client debt) to show up individually. Some risks are also common to, or shared by, more than one Directorate. Members were advised, however, that KASS did not have any more 'High' rated risks than any other Directorate;

c) all change and transition generates some level of risk, and Members asked that future risk management reports to the POSC highlight and take full account of the risks arising from the Change to Keep Succeeding restructure, in particular the concerns which have been expressed about centralising the KASS finance function, so Members can monitor the impact of this change; and

d) public expectations of service delivery, particularly in relation to increasing demand for services, is managed by ongoing liaison with public bodies such as Links.

2. RESOLVED that:-

a) the information in the report and given in response to questions be noted, with thanks; and

b) future risk management reports to the POSC highlight and take full account of the risks arising from the Change to Keep Succeeding restructure, in particular the concerns which have been expressed about centralising the KASS finance function, so Members can monitor the impact of this change.

107. Core Monitoring, September 2010
(Item C2)

1. Mr Sherlock introduced the report and he and Mr Mills responded to comments and questions from Members. The issues highlighted were as follows:-

a) the figures currently presented were collected in September 2010, but figures for December would be available very soon and would be shared with Members as soon as possible. It was expected that the December figures, when available, would show that KASS had met its target; and

b) there were two ways of measuring progress in establishing personal budgets; the National Indicator NI 130 and the new ADASS indicator. Of these, the latter was the most helpful in the way it measured performance and gave a more realistic picture of progress as it counted only those using a personal budget for ongoing rather than one-off service provision.

2. RESOLVED that the information given in the report and in response to Members' questions be noted, with thanks.

108. Care Quality Commission - Annual Performance Assessment Report for Adult Social Care 2009/10
(Item C3)

1. Mr Sherlock introduced the report and said how proud he was of KASS achieving such an excellent result in a period of major change. Mr Mills added that the Directorate had made steady progress over recent years and scored more 'Excellent' and 'Good' ratings each year.

2. Members agreed and added their thanks and congratulations. Mr K Pugh proposed and Mr C Smith seconded that Members' sincere congratulations be passed to all KASS staff on achieving another excellent performance result despite the major change and upheaval.

Agreed without a vote

3. Mr Sherlock, Mr Mills and Mrs Howard answered a number of questions from Members, and the points arising from comments and questions were as follows:-

a) the six areas for improvement identified in the report were now the subject of an action plan, and progress on this would be reported to and monitored by the POSC, as mentioned earlier in the meeting in the Director's oral update; and

b) Members commended the way in which KASS reports its performance information, as reports include commentary on the outcomes of its performance for the people of Kent and do not rely solely on presenting figures and graphs. Members particularly appreciated this full and rounded information and asked that it be continued in future reports.

4. RESOLVED that:-

a) the information given in the report and in response to Members' questions be noted, with thanks;

b) Members' thanks and congratulations be passed to all KASS staff on achieving another excellent performance result despite major change and upheaval; and

c) KASS performance monitoring reports continue to include commentary on the outcomes of its performance for the people of Kent, so Members have a full and rounded picture.

109. Age Concern Update
(Item C4)

Mrs A D Allen declared an interest in this item as the Chairman of Dartford Age Concern.

Mrs L Hardware, Policy Manager, was in attendance for this item.

1. Mr Mills introduced the report and, with Mrs Hardware, Mrs Howard and Mrs Tidmarsh, responded to comments and questions from Members. Points highlighted were as follows:-

a) Mrs Howard and Mrs Tidmarsh are closely involved with Age Concern's County Advisory Group, which is next due to meet in February;

b) a three-year agreement/contract between KCC and Age Concern had been entered into. Due to the uncertainty of future budgets, funding would be reviewed each year rather than set for the whole three-year period;

c) Members were advised that Age Concern branches would be allowed to monitor their own performance, helped by the KCC, and expressed concern that this joint monitoring arrangement was not made clear in the report;

d) it was still the intention of Dartford, Gravesham, Northfleet, Swanscombe and Darenth Valley Age Concerns to merge, but progress had not been as rapid as hoped. Mrs Allen confirmed that the Dartford, Gravesham and Swanley group would be meeting twice in January, its main concern being to move forward steadily and be thorough with its arrangements; and

e) the current changes were planned and had started to happen before the national merger in 2010 of Age Concern and Age UK, and one of the new groups' earliest tasks would be to work through the implications of the merger.

2. RESOLVED that the information given in the report and in response to Members' questions be noted, with thanks.

110. Update on NHS Changes
(Item C5)

Ms S Smith, Policy Officer, was in attendance for this item.

1. Mr Mills introduced the report, which had been requested to keep the POSC updated on the rapid and complex changes going on in the NHS and the far reaching implications of them for the KCC. He and Ms Smith responded to comments and questions from Members. Points highlighted were as follows:-

a) the plan is that all NHS provider organisations become Foundation Trusts by 2014. All Trusts need to have Governors with a connection to the locality, and will work with GPs' consortia. The new organisations will be large and complex but work locally;

b) Members expressed concern and disappointment that they had not been given the opportunity to take part in the consultation or contribute to the development of the new vision. Mr Mills sympathised and reassured Members that no decision on the detail of the new arrangements would be taken until statutory guidance had been received;

c) The Chairman offered to set up a meeting to allow any ASSPOSC Member who wished to comment the opportunity to do so by the next consultation deadline in February, and undertook to advise Members of the date of this meeting;

d) it was suggested that an innovative way of engaging Members in the consultation would be to have a 'virtual panel' in which Members receive emailed updates on latest developments between the POSC's formal meetings; and

e) Members expressed concerns about the suitability and effectiveness of the new arrangements and whether or not the model was the right one.

2. RESOLVED that:-

a) the information given in the report and in response to Members' questions be noted, with thanks;

b) further updates be made to the POSC, in the same style, starting with the April meeting of the POSC; and

c) the Chairman look into setting up some arrangements for consultation and information sharing between POSC meetings and advise Members of an arrangement.

111. Older Persons Modernisation
(Item C6)

Mr R Brookbank, Mr G Cowan, Mrs T Dean, Mr P J Homewood, Mr R J Lees, Mr J F London, Mrs J Rook, Mr R Tolputt and Mr J N Wedgbury were present for this item as local Members.

Mr D Weiss, Head of Public Private Partnerships and Property Team, Mrs C Holden, Project Manager/Better Homes Active Lives PFI Contract Manager, and Ms J Barnes, Head of Provision – Modernisation (Older People – West Kent), were in attendance for this item.

During discussion on The Limes in Dartford, Mr Brookbank declared an interest as the Chairman of Darent Valley Age Concern.

1. Mrs Howard introduced the report and the officers who had worked on the modernisation programme and were in attendance at the meeting to respond to Members' questions. She presented a series of slides which set out the background and rationale for the proposals, listed the services currently provided at each of the eleven premises, summarised the outcomes of the consultation and the recommendation relating to each of the premises, on which the Cabinet Member for Adult Social Services would later be taking a decision.

2. The Chairman invited Members to comment and ask questions of detail on any of the premises. No comments were made about the Dorothy Lucy Centre or Cornfields, but points arising in relation to the other premises were as follows:-

WAYFARERS

a) the staff who would transfer when a new provider took on the centre would do so under the TUPE regulations, and would transfer over on their existing terms and conditions and a comparable pension scheme as at present. The KCC would need to seek assurance that a prospective purchaser would be able to cover these costs, but this commitment does not appear to have been an obstacle for the 14 prospective purchasers who had declared an interest in the Centre. These costs would be set out in the details of the contract between KCC and the new provider.

BLACKBURN LODGE

a) the partnership arrangements proposed for this centre would consist of the KCC working closely with a partner provider, to commission from them the range of services at a quality and cost that the KCC requires; and

b) assurances were sought that the new provision proposed would meet the needs of the people of Sheppey, that the new build would be located on Sheppey, that it would provide new services not currently available there, and that no client would be transferred from the existing premises until the new provision was up and running.

DOUBLEDAY LODGE

a) the comment that no services would close until there were replacements in place also applies to Doubleday Lodge, so that provision for the people of Swale was not compromised.

KILN COURT

a) the comment that no services would close until there were replacements in place also applies to Kiln Court, so that provision for the people of Swale was not compromised;

b) all the expressions of interest received for all homes had been from UK-based companies; and

c) the aspiration was to re-build the home with partners, and good expressions of interest had been received, but if no partnership could ultimately be established, the plans for the home would be reviewed and an alternative proposal selected. This new proposal would then be subject to a fresh consultation process.

BOWLES LODGE

a) PFI proposals are required to have an outline business case in order to get the support of government and the confidence of bidders, as the latter have to take on a lot of risk upfront. Working up a new PFI proposal at a particular site took two years, and considering an alternative site suggested in the consultation was not viable at this point;

b) under 'Excellent Homes for All', Extra Care Housing (ECH) provision had the potential to accommodate clients with some mix of needs, including mental health and learning disabilities; and

c) premises nearby which could offer similar services are Westview at Tenterden and Hartley House at Cranbrook, which is planned to be extended. These premises might be suitable for some clients who are currently at Bowles Lodge. New day services will also need to be developed locally. Because of the particular circumstances at Bowles Lodge and the range of local replacement services needed, a closure date of January 2012 is recommended

MANORBROOKE

a) assessment of eligibility and allocation of ECH places was the responsibility of the KCC and District Councils, via the Joint Strategic Needs Assessment, and both would have to agree on placements. ECH would usually aim to accommodate clients with a range of needs – often about one-third each of high-, medium- and low- dependency. Although the new ECH would not be open until some 18 months after

the closure of Manorbrooke, some of the current residents of Manorbrooke might wish to move back to the site to live in ECH.

LADESFIELD

a) no resident should experience any financial detriment from the re-provision of services, and KCC was working with residents and their families to address this issue and place residents in homes which best meet their needs at a cost-effective price. If a dispute were to arise between the KCC and a resident or their family, an independent arbiter would be sought.

THE LIMES

a) KCC expected to move ahead with the agreed proposals promptly but taking every care, and Members were assured that the KCC was fully committed to ensuring that suitable alternative services were in place before closing any premises. Intermediate care beds would be developed at Gravesham Place in early 2011, and day care for those who use it (most for only one or two days a week) could be purchased using personal budgets, as well as utilising other local opportunities;

b) Members were assured that the KCC had thought through its proposals very carefully, to address current issues and prepare for future care needs, making the best use of the resources available. KCC was confident of being able to purchase suitable respite care from the Private and Voluntary sector; and

c) although one local group, as part of the consultation process, suggested an ongoing alternative use of the site, no more details had been forthcoming during the consultation process.

SAMPSON COURT

a) concern was expressed that homes in the proposal had not all been treated equitably, with some being proposed for one course of action and not seeking any alternatives, but officers explained that, although alternatives were not actively sought, those suggested had been evaluated against the four key objectives for the modernisation programme;

b) to bid for a PFI scheme in an area, KCC would need the support of the local District housing department, and Dover District Council wanted a PFI scheme in Dover rather than in Deal. The KCC was exploring the possibility of ECH in Deal;

c) Sampson Court had not been built specifically to take emergency admissions from Health and did not plan for this, but any spare beds available at any one time had been used for such emergency admissions;

d) Sampson Court had been refusing any new admissions for permanent placements since the start of the consultation period in June 2010, as the KCC had taken a decision not to place any new resident in a home while the future of that home was uncertain;

e) the KCC had chosen PFI rather than borrowing from the Public Works Loan Board (PWLB) as the costs would be covered by government PFI credits. These were not index-linked, so could not increase during the life of the loan, and, as such, the KCC had secured a good deal. If the KCC had borrowed from the PWLB it would have had to pay interest on the loan; and

f) the heating and hot water system at Sampson Court had been upgraded in 2009/10 at a cost of £135,000, but this investment had insured that residents had the best quality and most comfortable environment possible. Planned investment of this sort lessened the chances of needing to make unplanned, emergency investments later, and possibly needing to close a home while urgent work is carried out.

GENERAL COMMENTS

a) it was accepted that provision needed to change to meet future demands, but disappointment was expressed by some Members over the consultation process and the apparent lack of consideration given to the alternatives proposed during the consultation;

b) a number of concerns about staffing issues were also expressed, including the implied lack of relief staff employed in the Private and Voluntary sector to cover sickness, and the number of redundancies expected among the staff currently employed at the premises concerned; and

c) Extra Care Housing as a concept is welcomed, but its success depends on where it is placed, and what choices are left for those who are not eligible for it. Extra Care Housing should be an addition to Residential Care and not an alternative to it.

3. Mr L Christie proposed and Mr S J G Koowaree seconded, that the following recommendation be added; 'that the Cabinet Member take serious account of the results of the consultation, examine carefully the alleged claim that in-house provision costs the KCC twice as much as Private and Voluntary provision, and look carefully at whether or not serious independent consideration was given to alternative proposals arising from the consultation'.

Agreed without a vote.

4. The Cabinet Member, Mr Gibbens, confirmed that he was happy to accept this suggestion and would respond in writing to Mr Christie.

5. The issue had been called in by the Cabinet Scrutiny Committee, which would be calling witnesses to address it on 19 January about four of the homes – Bowles Lodge, Ladesfield, Wayfarers and The Limes - and any other Member who wished to

call a witness to speak on any other of the homes was invited to do so by the Chairman of the Cabinet Scrutiny Committee, Mrs Dean.

6. RESOLVED that:-

a) the information given in the report and in response to Members' questions be noted, with thanks; and

b) the Cabinet Member take serious account of the results of the consultation, examine carefully the alleged claim that in-house provision costs the KCC twice as much as Private and Voluntary provision, and look carefully at whether or not serious independent consideration was given to alternative proposals arising from the consultation.

112. Treatment of Jointly-owned Property in the Residential Charging Assessment
(Item D1)

The Chairman secured the Committee's agreement to consider this item as urgent business, as the papers could not be placed in the public domain with the required five clear days' notice.

Mrs P Huntingford, Transforming Social Care Lead Officer, Ms C Grosskopf, Policy Officer, and Mrs J Marsh, Directorate Exchequer Officer, were in attendance for this item

1. Mr L Christie said he had asked for the item to be added to the POSC agenda to allow full discussion of an issue on which the Cabinet Member was shortly to take a decision.

2. Mrs Huntingford introduced the report and explained that the change in policy had been made to address an inequity in the way home owners were treated. The change KCC had decided to make had a firm legal basis, as the KCC was obliged to maximise its income so it could provide maximum services to those who needed them.

3. Cases were complex and each had to be considered on its own merits, requiring a balance of judgement. The change in policy could bring in potential annual income of £500,000 to £1million, and it was hoped that the first year's income could be between £250,000 and £500,000.

4. Mrs Huntingford responded to comments and answered questions from Members. The points highlighted were as follows:-

a) the principal of the policy change was accepted, but it was suggested that a review needed to be included to take account of circumstances in which the value of a home had reduced below the value of the care package, ie when the client would become eligible for KCC funding;

b) it was also suggested that a review of the policy change be undertaken after one year to allow Members to monitor the cost of it as set against

the income it generates, to evaluate the cost-effectiveness of it. This suggestion was generally supported;

c) if a client were purposefully to dispose of their property to avoid it being considered in the funding assessment, this would count as 'deprivation of assets' and the KCC could treat the assets as still belonging to the client. If the transfer had been made in the last six months, the KCC could seek redress from the recipient of the assets, but if the transfer had been made years ago, it would be difficult for KCC to prove that the intention had been to avoid contributing towards care; and

d) the policy change would apply only to new clients entering KCC-funded residential care, and not to existing residents.

5. RESOLVED that:-

a) the information given in the report and in response to Members' questions be noted, with thanks; and

b) a review of the policy change be undertaken after one year to allow Members to monitor the cost of it as set against the income it generates, to evaluate the cost-effectiveness of it.

113. Pat Huntingford

Members thanked Mrs Huntingford sincerely for her advice and support over many years and paid tribute to her work as a senior member of the KASS management team. Mrs Huntingford thanked Members for their comments.

114. Update on Select Committee Work
(Item E1)

RESOLVED that the information given in the report be noted, with thanks.

By:	Graham Gibbens, Cabinet Member Adult Social Care and Public Health Oliver Mills, Managing Director Kent Adult Social Services
To:	Adult Social Services and Public Health Policy Overview and Scrutiny Committee - 7 April 2011
Subject:	**KASS DEBT POSITION FEBRUARY 2011**
Classification:	Unrestricted

Summary: To update this Committee on the current position of the KASS Social Care & AR Debt position as at February 2011

Introduction

1. (1) It was previously agreed that a regular report be presented to update this Committee on the latest debt position for Kent Adult Social Services (KASS).

Summary Position

2. (1) The overall debt for KASS as at February is £43,879k, of which £24,044k is not yet due for payment, leaving an amount due for payment of £19,835k.

(2) There are two types of invoicing arrangements used by KASS, both of which are through Oracle Accounts Receivables. This report will primarily deal with the client related debt, but will give a general overview of the other debt.

(3) The sundry debt due for payment is:

Health	£5,886k
Sundry	£493k
Total	£6,379k

(It should be noted that the majority of monies owed by Health are secured through legal agreements)

(4) The client billing debt is currently £17,877k, of which £13,455k is due for payment.

Analysis of Client Related Debt

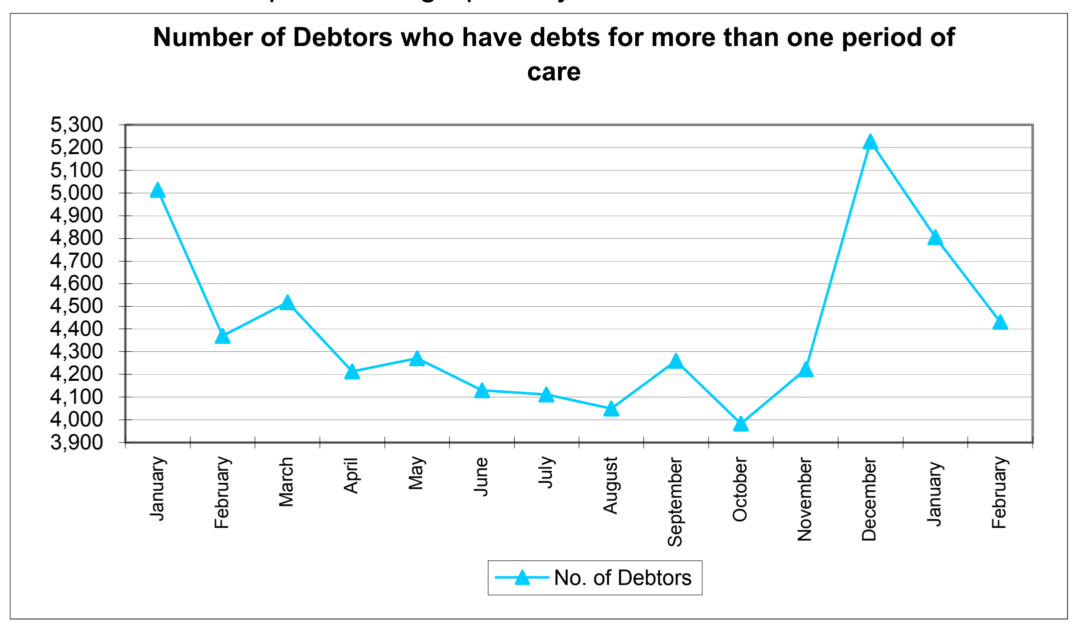
3. (1) The £17,877k client related debt is made up of 12,659 individual debtors, with an average debt of £1,412 each. This compares with £17,531k and 12,753 debtors, with an average of £1,341 each, reported to Adult Social Services POSC in January. The debt for both months is broken down as follows:

Type	January ASSPOSC (Nov debt) (£000)	April ASPHPOSC (Feb debt) (£000)	Change (£000)
Residential	14,990	15,347	+357
Domiciliary	2,467	2,471	+4
Health Contributions	74	59	-15
Total	17,531	17,877	+346

(2) Of the 12,659 debtors, 8,227 (65%) only have a current debt which is not yet due, i.e. all previous invoices have been paid and the only amount to be paid relates to the most recent period of care. This therefore means that 4,432 (35%) have debt for prior periods of care. The following table shows how the number of debtors has changed since January 2010:

Month	No. of Debtors (1)	Change (2)	Change since January (3)
Jan 2010	5,014	-	
Feb 2010	4,369	-645	-645
March 2010	4,519	+150	-495
April 2010	4,213	-306	-801
May 2010	4,271	+58	-743
June 2010	4,130	-141	-884
July 2010	4,112	-18	-902
Aug 2010	4,049	-63	-965
Sept 2010	4,260	+211	-754
Oct 2010	3,983	-277	-1,031
Nov 2010	4,223	+240	-791
Dec 2010	5,227	+1,004	+213
Jan 2011	4,805	-422	-209
Feb 2011	4,432	-373	-582

This information is presented graphically as follows:



(3) Of the £17,877k only £13,455k is actually due for payment, invoices having only just been dispatched for the remaining £4,422k. Clients and health have 28 days to pay their invoices.

(4) The £13,455k can be broken down between secured and unsecured debt as follows:

	£K
• Unsecured – ongoing clients	£5,793k
• Unsecured – terminated/ deceased clients	£1,056k
Total Unsecured	£6,849k
• Secured with legal charges	£6,559k
• Health contributions	£47k
Overall Total of due debt	£13,455k

Aged Analysis of Unsecured Due Debt

4. (1) Appendix 1 shows an analysis of Unsecured Debt that is due for payment comprising both Ongoing and Terminated/Deceased Debt. The appendix compares the current position with the position reported last time. Overall the amount of Unsecured Debt that is Due for payment is up £108k from last time which is disappointing.

Analysis of *Ongoing* Unsecured Debt (including Not Yet Due)

5. (1) Appendix 2 shows an analysis of all Unsecured Debt for those debtors who have debts relating to prior periods of care as well as the invoice for the most recent period of care. The appendix includes due and not yet due amounts relating to Ongoing clients, broken down into bands by the value of debt, the number of debtors and the average debt per debtor. The appendix also shows the figures reported last time, together with movement.

Secured Debt

6. (1) During 2009 we carried out a full review of all debts secured by legal charges on clients' houses. This review has ensured that the estimated valuation of the properties are not less than the value of the deferred debts, and if so 100% provision has been allowed for.

(2) Of the 4,432 debtors with an outstanding debt 235 of these are secured by a legal charge. The total value of debt for this group is £6,905k which works out at an average of £29,832 each.

Unsecured Deceased/Terminated Debt

7. (1) Of the 4,432 debtors with an outstanding debt, 496 are either deceased or are now no longer receiving a chargeable service. The total value of debt for this group is £1,058k which works out at an average of £2,134 each.

Bad Debt Provision

8. (1) As at the end of 2009-10 the total bad debt provision for client related debt was £3,972k. This is calculated by looking at the value of all of the debts under various debt categories of those secured and unsecured. It also takes into account the age of the debt.

(2) Generally the percentages for the main categories used are as follows:

Unsecured - ongoing (under 6 months) - 5%
Unsecured - ongoing (over 6 months) - 60%
Unsecured - terminated (under 6 months) - 33%
Unsecured – terminated (over 6 months) - 75%

(3) The general provision, which was £2,006k at the end of 2009-10, covers all debts, secured, unsecured and health. This provision is re-calculated on a monthly basis, and any required changes are forecast within the revenue monitoring.

(4) In addition to the general provision that is calculated as described above we also allow for specific provisions, which at the end of 2009-10 amounted to £1,966k. These relate to individual named clients for which we believe there is a high risk of the debt not being paid. This is reviewed during the course of the year to see if any payments have been made.

Write Off's

9. (1) In 2008-09 £362k of client related debt was written off and this amount was similar in value to that in previous years; there was also £17k of sundry debt written off. However in 2009-10 £421k of client debt and £109k of sundry debt was formally written off. To date in 2010-11 £228k of client debt and £9k of sundry debt has been written off.

Recommendation

10. (1) Members are asked to **NOTE** and **COMMENT** on the content of the report.

Michelle Goldsmith
Directorate Finance & e-Commerce Manager
01622 221770
(VPN: 7000 1770)

Background documents: None

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Aged Analysis of Unsecured Due Debt - comparison from January to April report Appendix 1

	Under 6 months			Over 6 months			Over 1 year			Total		
	Jan £000	April £'000	Change £000	Jan £000	April £'000	Change £000	Jan £000	April £'000	Change £000	Jan £000	April £'000	Change £000
Unsecured – ongoing client debt	3,226	2,983	-243	1,021	1,144	123	1,623	1,666	43	5,870	5,793	-77
Unsecured deceased/ terminated Client debt	134	220	86	222	233	11	515	604	89	871	1,057	186
Total unsecured client debt	3,360	3,203	-157	1,243	1,377	134	2,138	2,270	132	6,742	6,850	108

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Analysis of Ongoing Debt (including Not Yet Due)

Appendix 2

Value of debt	Last Report (Jan ASSPOSC)			This month (April ASSPOSC)			Change		
	No. of Debtors	Total of Debt (£000	Average debt (£)	No. of Debtors	Total of Debt (£000	Average debt (£)	No. of Debtors	Total of Debt (£000	Average debt (£)
Above £25,000.01	25	1,034	41,360	26	1,002	38,538	1	-32	-2,822
£10,000.01 - £25,000.00	95	1,418	14,926	90	1,338	14,867	-5	-80	-60
£5000.01 - £10,000.00	199	1,390	6,985	193	1,320	6,839	-6	-70	-146
£1,000.01 - £5,000.00	1,120	2,510	2,241	1,095	2,446	2,234	-25	-64	-7
£1000.00 and below	2,095	656	313	1,732	812	469	-363	156	156
Totals	3,534	7,008	1,983	3,136	6,918	2,206	-398	-90	-2,878

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By: Graham Gibbens, Cabinet Member, Adult Social Care and Public Health
Oliver Mills, Managing Director, Kent Adult Social Services

To: Adult Social Services and Public Health Policy Overview and Scrutiny Committee - 7 April 2011

Subject: **"NO HEALTH WITHOUT MENTAL HEALTH" – THE NEW GOVERNMENT STRATEGY FOR MENTAL HEALTH**

Classification: Unrestricted

Summary: To advise Members of the new Government strategy for mental health published on 2 February 2011; and the implications for local implementation.

Background

1. (1) Between 1999 and 2009 mental health services were driven by the National Service Framework for Mental Health. This was very much a target-driven approach, particularly in relation to delivering new crisis and home treatment teams and reducing the use of inpatient treatment. It brought much new investment into mental health.

(2) In 2009 "New Horizons" was published. This set out a direction for mental health services that was more aspirational, with the aim to "create flourishing and connected communities through the promotion of well-being and resilience and the reduction of inequalities". It set out new ideas for delivering services, through primary care initiatives, personalisation and developing partnerships across statutory bodies. However it was difficult to quantify and measure the changes it said were desirable.

(3) The Government considered a revision of New Horizons was needed which would set out a simplified and clearer picture with identified outcomes. As a result, on 2 February 2011 the Government published "No Health without Mental Health", its cross-government, all-age strategy for mental health.

No Health without Mental Health

2. (1) "No Health without Mental Health" is a strategy that has been actively coordinated across Government departments to ensure joint working and integration between health and social care, with outcomes that reflect this unified approach. It sets out six shared objectives to improve the mental health and well-being of the nation, and to improve outcomes for people with mental health problems through high quality services.

(2) These objectives support the Government's aims of ensuring similar opportunities for choice and control about treatment for people in mental health as in physical health; safeguarding, keeping people from harm; and understanding the interconnections between mental health and accommodation, employment, and the criminal justice system. There will be increasing emphasis on improving access to talking therapies, especially in primary care, and greater focus on early intervention.

(3) However the strategy has been published at a time of great structural change and a pressured financial situation. The strategy also furthers the case for the extension of Payment by Results (PbR) into mental health. To deliver the key objectives effectively will require the combined use of current resources for mental health, working together across health, social care and voluntary and independent sectors.

The Six Key Objectives

3. (1) **More people will have good mental health** - more people of all ages and backgrounds will have better wellbeing and good mental health, and fewer people will develop mental health problems – by starting well, developing well, working well, living well and ageing well.

(2) **More people with mental health problems will recover** - more people who develop mental health problems will have a good quality of life – greater ability to manage their own lives, stronger social relationships, a greater sense of purpose, improved chances in education, better employment rates and a suitable and stable place to live.

(3) **More people with mental health problems will have good physical health** - fewer people with mental health problems will die prematurely, and more people with physical ill-health will have better mental health

(4) **More people will have a positive experience of care and support** -care and support, wherever it takes place, should offer access to timely, evidence-based interventions and approaches that give people the greatest choice and control over their own lives, in the least restrictive environment, and should ensure people's human rights are protected

(5) **Fewer people will suffer avoidable harm** - people receiving care and support should have confidence that the services they use are of the highest quality and at least as safe as any other public service.

(6) **Fewer people will experience stigma and discrimination** - public understanding of mental health will improve and, as a result, negative attitudes and behaviours to people with mental health problems will decrease.

Measuring Outcomes

4. (1) Progress against the objectives above will be measured through indicators within the outcomes frameworks relating to the NHS, Public Health and Adult Social Care services. Many will be a shared responsibility between Health and Adult Social Care. The indicators are described in the following high level "domains".

(i) **NHS Domains**

- Preventing people from dying prematurely
- Enhancing quality of life for people with long-term conditions: employment for people with mental illness and quality of life for carers
- Helping people to recover from episodes of ill-health: emergency readmissions within 28 days of discharge from hospital
- Ensuring that people have a positive experience of care through patient experiences of community mental health services
- Treating and caring for people in a safe environment and protecting them from avoidable harm

(ii) **Public Health Domains**

- Health protection and resilience: protecting the population's health from major emergencies and remaining resilient to harm
- Tackling the wider determinants of ill-health: tackling factors that affect health and wellbeing
- Health improvement: helping people to live healthy lifestyles and make healthy choices
- Prevention of ill-health: reducing the number of people living with preventable ill-health
- Healthy life expectancy and preventable mortality: preventing people from dying prematurely

(iii) **Adult Social Care Domains**

- Promoting personalisation and enhancing quality of life for people with care and support needs
- Preventing deterioration, delaying dependency and supporting recovery
- Ensuring a positive experience of care and support
- Protecting from avoidable harm and caring in a safe environment

(2) Each of these domains has outline performance indicators attached to them. Many are shared between Health and Social Care. Most will be captured through existing data collection, although there will be a need for close cooperation and information sharing between agencies.

Links to Local Strategy

5. (1) "Live it Well" – the strategy for improving the mental health and wellbeing of people in Kent and Medway 2010 to 2015 - was presented to Members at the Adult Social Services Policy Overview and Scrutiny Committee of 30 March 2010. It set out the strategy for delivering Kent's mental health services for the next 5 years as a more personalised approach which focuses on prevention, health and wellbeing and improving access and reducing discrimination and stigma.

(2) The Live it Well strategy is very compatible with the aims of "No Health without Mental Health". Indeed the same phrase "No Health without Mental Health" was used to set the tone of the Live it Well strategy in the public summary booklet which was distributed widely in Kent and Medway last year.

Implications for Kent

6. (1) In Kent we are well placed through our current commissioning relationships to deliver the key themes of "No Health without Mental Health". The current performance management arrangements led by the PCT team, together with the social care performance monitored by the KCC Mental Health Commissioning and Contracting Team, mean that we are already collecting most of the indicators suggested by Government.

(2) The next two years will be challenging, particularly with the move to GP commissioning consortia in April 2013. It is important that Kent's investment in mental health in the new arrangement remains committed to achieving Kent's ambitions for early intervention; improved access to services through Gateways and primary care; and increased personalisation.

(3) "No Health without Mental Health" requires an integrated approach to commissioning mental health services which will result in seamless service provision. Kent is already in a joint strategy with Health in delivering the commissioning of mental health across health and social care outcomes, both for secondary care services and with the voluntary sector: this is a strength which should help with the transition to GP commissioning over the next two years.

(4) Kent has recently undertaken a review of the partnership agreement with the main mental health provider in Kent, the Kent and Medway NHS and Social Care Partnership Trust (KMPT), with the aim of re-aligning some elements of the partnership. The outcome of this review will be reported to Members in the near future. This is an opportunity to ensure that the resource Kent commits to this partnership is re-structured in a way which will ensure the social care elements of "No Health without Mental Health" are delivered effectively, in a seamless way with the rest of the local mental health economy.

Recommendation

7. (1) Members are asked to NOTE the new Government strategy for mental health and the implications for Kent: and to APPROVE the continuation of our joint commissioning strategy with Health.

Lead Officer:

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Social Care Commissioner for mental health
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Background documents: None

By: Graham Gibbens, Cabinet Member, Adult Social Care and Public Health
Oliver Mills, Managing Director, Kent Adult Social Services

To: Adult Social Services and Public Health Policy Overview and Scrutiny Committee – 7 April 2011

Subject: **CARE QUALITY COMMISSION – ANNUAL PERFORMANCE ASSESSMENT IMPROVEMENT PLAN**

Classification: Unrestricted

Summary: In January 2011 the Care Quality Commission Annual Performance Assessment was presented to the Committee. The Annual Performance Assessment identified some Areas for Improvement. This report presents the Action Plan which is being implemented by the Directorate to address these areas.

Introduction

1. (1) On 12 January 2011, the Adult Social Services Policy Overview and Scrutiny Committee received a report presenting the Care Quality Commission (CQC) Annual Performance Assessment (APA) of Kent Adult Social Services for the year 2009/10. This was published at the end of November 2010 and was presented to Cabinet on 10 January 2011.

(2) Although in the main the services this assessment applies to cover the Kent Adult Social Services Directorate, it does cover some services now managed within the Communities Directorate such as KDAAT (Kent Drug & Alcohol Action Team).

(3) Overall the Annual Performance Assessment rated Kent as 'performing well'. Six key areas for improvement were identified. This report presents the detailed improvement plan which is being implemented to address these areas.

Policy Context

2. (1) the six areas for improvement identified were:

- Improve reporting of activity across the twelve local district councils associated with the delivery of major adaptations.
- Ensure all individuals in receipt of a care package provided by the council receive an annual review.
- Ensure that by April 2011, 30% of eligible individuals are in receipt of a Personal Budget.
- Improve data quality to ensure that Adult Protection cases are audited and closed on SWIFT promptly.

- Develop solutions to evidence a clear picture of uptake of safeguarding training in the independent sector.
- Develop an effective and sensitive way of obtaining feedback from people who have been the subject of safeguarding alerts.

(2) The detailed improvement plan addressing these areas is attached as Appendix One of this report.

3. (1) On 3 November 2010, the Minister of State for Care Services, Paul Burstow, announced that the CQC will no longer conduct an Annual Performance Assessment of councils' commissioning of care under the existing framework. The discontinuation of the Annual Performance Assessment took place with immediate effect and there will be no CQC Annual Performance Assessment for 2010/2011.

(2) As a result of this decision there is currently no national performance framework to evaluate Social Services across the country. Furthermore, CQC are not currently actively monitoring our progress in addressing the areas of improvement. Despite this, the Directorate is focused on the delivery of the action plan as it identifies some extremely important areas and the plan is being monitored closely by the Senior Management Team. Both the Leader and the Group Managing Director have taken a keen interest in the progress of the improvement plan and are being updated regularly.

(3) Given the importance it is proposed that the Committee play a role in monitoring the improvement plan and suggest we report progress on a 6 monthly basis.

Recommendations

4. (1) Members are asked to:

(a) NOTE the report and Improvement Action Plan, and
(b) AGREE the proposed monitoring cycle

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Background documents:
Adult Services and Public Health Policy Overview and Scrutiny Committee 12 January 2011, Item C3 "Care Quality Commission – Annual Performance Assessment Report for Adult Social Care 2009/10"

Areas of Improvement 10/11 Action Plan

1. Outlined below is the Action Plan which has been developed following the 09/10 Annual Performance Assessment by the Care Quality Commission.
2. The actions from this plan will be monitored closely by the Kent Adult Social Services Strategic Management Team (SMT) and progress will be reported on a regular basis through the established reporting processes.

Leadership

Recommendation		Measurable Indicator	Desired Outcome	Timescale	Lead (s)	Actions to date
1.	The council remains unable to report activity across the twelve local district councils associated with the delivery of major adaptations. Data presented for nine of the twelve district councils indicates an average completion time that is more than twice that of similar councils. This is an area of activity the council must seek to address, if it is to fully understand the impact of service delivery and the impact on the outcomes for individuals.	▪ Activity reported on an agreed basis across twelve local district councils	1. Consistent performance monitoring mechanism in place to facilitate reporting. 2. Kent performance matches similar councils.	April 2011	Lead Officer: Margaret Howard	1. In Kent, KASS is responsible for the assessment for major adaptations to an individual's home to support independent living through Disabled Facilities Grants. The twelve District Councils then deliver the recommended works and provide data on completion. 2. Extensive work has been carried out, looking at how other Local Authorities record and report activity and the timescales used. This work shows that there is no consistency of reporting across councils with social care responsibilities. CQC have been contacted for clarity regarding this indicator. 3. We are able to report activity for all twelve District Councils and do monitor and review the financial costs of the projects and the outcomes for people. There are some differences in how District Councils record and report activity. 4. Work is underway to get consistency across Kent in how activity is recorded and reported. Partners are in agreement with this objective. 5. The timeline for this process is below:

Milestone date	Activity
January – March 2011	Consult/agree report content with partner LAs
April 2011	Implement reporting practice with partner LAs
June 2011	Joint Management Groups (JMG) report on 1st quarters performance
June 2011	County wide DFG Forum meet to review outcomes
September 2011	JMG report on 2nd quarters performance
December 2011	JMG report on 3rd quarters performance
December 2011	County wide DFG Forum meet to review outcomes
March 2012	JMG report on 4th quarters performance
April 2012	Review plans for coming year

Increased Choice and Control

<table>
<tr><th colspan="2">Recommendation</th><th>Measurable Indicator</th><th>Desired Outcome</th><th>Timescale</th><th>Lead (s)</th><th>Actions to date</th></tr>
<tr>
<td>2.</td>
<td>As a result of the restructure of staff teams and localities and implementation of SDS an increasing number of individuals in receipt of a care package provided by the council did not receive an annual review during the year. This is an area of activity the council must address so that it can be assured the needs of concerned individuals remain appropriately addressed.</td>
<td>▪ Increase in reviews completed (75%+)</td>
<td>1. Individuals in receipt of a support package provided by the council receive an annual review.</td>
<td>April 2011</td>
<td>Lead Officer: Margaret Howard</td>
<td>1. Each locality has a specific action plan in place to address the issue. Within these action plans, a range of strategies have been implemented and these include:

• Brokers carrying out reviews where the cases are less complex
• Prioritising high cost community care clients
• Pilot of a clinic model to undertake assessments and reviews
• Robust performance management, including focusing on data quality and recording processes. Regular reports are scrutinised at Area Management Teams as part of a risk management approach

2. Additionally, countywide the following further initiatives have been undertaken:

• A long term review team has been established, with dedicated workers to carry out reviews in residential homes and for people in receipt of Direct Payments. This has been very successful and has taken account of reviews up to the end of 2010
• Designated review workers identified
• Sessional workers employed to address the overdue reviews where appropriate

3. The ways in which we work have had to change to mirror the implementation of Self Directed Support, offering people choice and control over their services and their own support plan. This of course has an impact on the review process which has to work at the pace of the individual client and the choices they make.

4. The table below illustrates the number of Reviews to be completed by the end of the year.

<table>
<tr><th></th><th>Clients in receipt of a service</th><th>Reviewed so far</th><th>Target for year end</th></tr>
<tr><td>County total</td><td>39,768</td><td>21,641</td><td>29,826</td></tr>
</table>
In 2009/10 Kent’s review rate was 76%, and the target for all people in receipt of a service to have an outcome focussed review this year will be 75%+, in line with the Department of Health banding for optimal performance for the old review indicator.
(Not all people currently in receipt of a service will be eligible for a review, for example if they are new to Social Care. Based on Department of Health definitions, 100% can not be achieved)</td>
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Recommendation		Measurable Indicator	Desired Outcome	Timescale	Lead (s)	Actions to date
3.	The use and take up of SDS is increasing, overall, although performance is below the average of similar councils. To enable individuals to maximise their personal choice and control the council must deliver on its plan to enable 30% of eligible individuals to benefit from the use of SDS by April 2011.	▪ Continued increase of Personal Budgets and take up of Direct Payments ▪ Performance compared to similar councils ▪ Performance against Putting People First (PPF) Milestones	3. By April 2011, 30% of eligible individuals are in receipt of a Personal Budget (PPF Milestone 2)	April 2011	Lead Officer: Margaret Howard	1. Kent Adult Social Services continues to be on target to meet the PPF Milestone 2, that by April 2011, 30% of eligible individuals are in receipt of a Personal Budget. 2. As of 11 February 2011, 6490 people were allocated a Personal Budget and within the current definition, this represents 27% of eligible individuals. 3. Allocating a Personal Budget to new clients is now mainstream activity in KASS. Latest developments include: • From 4 October 2010 Mental Health teams started to provide Personal Budgets to all new clients • Existing Mental Health clients have been offered Personal Budgets at review from January 2011 • Further development work is planned for the allocation of Personal Budgets to carers • A joint pilot with health is underway to test the effectiveness of personal health budgets • Systems are being enhanced so that service users can access and manage information about their services and personal budgets and it is easier to record information about personal budgets (Mysupport systems) • An Individual Service Fund project for older people began in January 2011 • The allocation of Personal Budgets to existing clients through the outcome focussed review and support planning process Data quality and inputting continues to be scrutinised. SMT regularly review progress and have put into place additional oversight for the final 3 months.

Maintaining Personal Dignity and Respect

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<tr><th colspan="2">Recommendation</th><th>Measurable Indicator</th><th>Desired Outcome</th><th>Timescale</th><th>Lead (s)</th><th>Actions to date</th></tr>
<tr>
<td>4.</td>
<td>Data provided by the council indicates that 42% of cases are not closed within the council's own standard of six months. The council must ensure that cases open for more than six months are reviewed and closed in order to assure partners and the public that outcomes for people at risk are effectively managed and the council is promoting good safeguarding practice.</td>
<td>Work to review cases open for more than six months
▪ Fewer % of cases not closed within six months
▪ Completed paperwork evidences that reviews have taken place where cases are open for more than six months

Process in place to determine cases concluded but not closed on SWIFT
▪ Cases are audited and closed on SWIFT promptly.</td>
<td>1. Reduction in % of cases not closed within six months.

2. Cases open for more than six months continue to be reviewed and paperwork demonstrates reviews have taken place.

3. When cases open for more than six months are closed, cases continue to be audited and this is evidenced in the paperwork. Following the audit, cases are closed on SWIFT.

1. Processes are in place to ensure that when cases are concluded, the cases are closed on SWIFT in a timely manner.</td>
<td>Ongoing

Ongoing</td>
<td>Lead Officer: Anne Tidmarsh</td>
<td>1. Review of Cases
All cases opened for more than six months are reviewed
Reasons for cases being open and active for more than six months include:
• Post abuse care planning and implementation
• Several cases can be open in one residential home where the Adult Protection has been kept open, often to facilitate information sharing and ongoing review by the Safeguarding Co-ordinator
• Adult Protection kept open in order to facilitate cross-agency information sharing in order to monitor an ongoing situation of potential abuse
• Complexity of cases

2. Standards
A benchmarking exercise in relation to the closure of safeguarding cases will be concluded in April. Information from other Local Authorities will be used to inform the benchmarking as to what is deemed an acceptable timeframe for closing cases. A standard will be developed to include:
• an acceptable timeframe for closing cases
• timeframes for different parts of the safeguarding process
• future practice changes needed to ensure SWIFT is up to date

3. Data Quality

The majority of cases not closed on SWIFT within six months were not active cases – the case had been concluded and the client was safe, they were waiting to be audited and put on the system as closed.

This was re-affirmed by a Data Quality Audit undertaken by Internal Audit in 2010 which received a substantial assurance rating. The audit acknowledged that despite some delay in closing cases on SWIFT, there was minimal risk to the client.

At Locality Level action plans have resulted in significant improvements outlined below

<table>
<tr><th></th><th colspan="3">July 2010</th><th colspan="3">January 2011</th></tr>
<tr><th></th><th>open</th><th>Awaiting to be closed</th><th>% cases</th><th>open</th><th>Awaiting to be closed</th><th>% cases</th></tr>
<tr><td>total</td><td>1,513</td><td>458</td><td>30%</td><td>1,666</td><td>289</td><td>17%</td></tr>
</table>

4. Process
A key part of the work has been to look at the safeguarding process and to identify ways in which it can be more effective. Outlined are some of the initiatives that have been taken:

A Quality in Care mechanism has been developed separate to the safeguarding process, to address quality in care issues. This has been strengthened by a review of the Contracts Compliance methodology. This will divert a number to cases away from the safeguarding process to a more appropriate and proportionate response.

Locality and District Safeguarding Risk Assessment meetings are held</td>
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Recommendation		Measurable Indicator	Desired Outcome	Timescale	Lead (s)	Actions to date
						regularly. The purpose of these meetings is to share intelligence with multi-agency partners about registered services and to update on progress in safeguarding cases. We are streamlining the safeguarding process using a nationally recognised methodology, LEAN. A scoping exercise is taking place on 4th March 2011 followed by two Rapid Improvement Workshops on 11th March 2011 and the 28th April 2011.

Recommendation		Measurable Indicator	Desired Outcome	Timescale	Lead (s)	Actions to date
5.	Despite a range of strategies to provide safeguarding training, the council is not able to provide a clear picture of uptake in the independent sector. This is an area of activity the council needs to focus on in the future to ensure the quality of outcomes for individuals who use services.	▪ Staff in the independent sector are appropriately trained in safeguarding ▪ All applications for SVA multi-agency training are made via the online application form ▪ Ability to report numbers of staff attending SVA multi-agency training, at which level and from which agency ▪ Ability to evidence outcomes of SVA multi-agency training, including how many people trainers have trained following the course and from which organisations	1. KASS is assured that independent sector providers have an appropriately trained workforce and therefore respond effectively to safeguarding issues.	Ongoing	Lead Officer: Nick Sherlock	1. KASS have contracts with the independent sector to provide a range of services across client groups. The Specifications for these contracts require that staff employed by the independent sector must receive appropriate levels of safeguarding training. The contract also requires providers to have a Policy and Procedure on Adult Protection, in line with the Multi-Agency Adult Protection Policy and Protocols for Kent & Medway. 2. Based on the above specifications all providers will be written to on an annual basis asking them to confirm that they meet these requirements in respect to safeguarding. They will be expected to inform us if they fall below the specifications, outlining a plan to address this. 3. Contracts staff undertake quality assurance visits of the independent sector, based on a risk-assessed approach. Safeguarding training is one of the areas looked at during these visits. Training matrix are looked at to identify how many staff have been trained, at what level and when the training took place. The matrix identifies further training planned for staff. 4. Contracts staff also undertake competency checks, including talking to staff to ensure they know what to do if they have any concerns and supervision records. A shortfall in either area would result in actions being agreed and monitored until it could be evidenced that the actions have been completed. 5. Additional Level 2 courses have been commissioned for KASS staff and the private and voluntary sector to meet demand for this training course. These courses are well attended and further courses are planned for 11/12. 6. 'Training The Trainer' courses are provided for the private and voluntary sector. Recall days are held annually for people who have attended these courses to refresh their knowledge. KASS record attendance at these courses and delegates are also asked to provide information with regards to the numbers of people they have trained following these courses and from which organisations. 7. To improve the access to training and feedback from training an on-line process has been developed with Multi-Agency partners. This will be implemented in April 2011 and will improve the effectiveness of the process and provide better quality of management information. For example this information will be fed into a database which will give patterns of attendance. It can then be, where appropriate, fed into contract teams to support their risk based approach as outlined above 8. A Multi-Agency Training Review has been completed which explores the different options for delivering Safeguarding Vulnerable Adults training, for all agencies including providers. The final report will be presented to the Safeguarding Vulnerable Adults Executive Board on 28 March 2011. 9. Provider forums are used to emphasise the importance of safeguarding training and how it will be scrutinised both on current and future contracts.

Recommendation		Measurable Indicator	Desired Outcome	Timescale	Lead (s)	Actions to date
6.	The council must deliver on its plan to develop an effective and sensitive way of obtaining feedback from people who have been the subject of safeguarding alerts. This will ensure victims of abuse are more directly engaged in the safeguarding process and to inform and improve practice.	▪ Feedback tool forms part of the audit programme	1. Develop tool to obtain feedback from people who have been the subject of safeguarding alerts in an effective and sensitive way. 2. Feedback is used to inform and improve practice.	March 2011 onwards	Lead Officer: Nick Sherlock	1. A feedback tool was developed and piloted in Learning Disabilities in November 2010. Following the pilot, modifications have been made in the delivery of the tool. 2. Based on the feedback received, the questionnaire has been redesigned – encapsulating best practice from other Local Authorities and experiences from safeguarding co-ordinators and people who use services. 3. The above questionnaire will be used by safeguarding co-ordinators in collecting people's views and will be evaluated on a Kentwide basis by the Policy Manager for Safeguarding. This will begin in April 2011. 4. In future case file audits, the feedback tool will be used on audited cases (where appropriate) in order to give a full 360 degree audit of a case. 5. As outlined above, a review of the safeguarding process is planned in March/April 2011 and a key feature of this will be to make sure feedback from those people involved is adequately captured throughout the process.

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By: Graham Gibbens, Cabinet Member, Adult Social Care and Public Health
Oliver Mills, Managing Director, Kent Adult Social Services

To: Adult Social Services and Public Health Policy Overview and Scrutiny Committee – 7 April 2011

Subject: **THINK LOCAL ACT PERSONAL**

Classification: Unrestricted

Summary: The purpose of this report is to provide a briefing for Members on the key components of the Vision for Adult Social Care and the Think Local Act Personal commitment.

Introduction

1. (1) In November 2010, the Care Services Minister, Paul Burstow launched "A Vision for Adult Social Care: Capable Communities and Active Citizens".

(2) The vision sets out how the Government intends to develop a new direction for adult social care and put personalised services and outcomes at the centre of service delivery.

(3) Alongside the vision document, a partnership made up of the Association of Directors of Adult Social Services, the Local Government Association, the Department of Health and other stakeholders has produced a sector wide commitment to personalisation and community based support. The partnership agreement, entitled Think Local, Act Personal, is a statement of intent that makes a link between the government's new vision for social care and builds on the Putting People First Strategy (December 2007) which set out a vision for the transformation of social care.

A Vision for Social Care: Capable Communities and Active Citizens

2. (1) The vision focuses on the Government's commitment to:

- "Break down barriers between health and social care funding to incentivise preventative action;
- Extend the greater roll out of personal budgets to give people and their carers more control and purchasing power; and
- Use direct payments to carers and better community based provision to improve access to respite care".

(2) At the core of the vision is an intention to devolve decision making as closely to the individual as possible and looks to the care sector, working with partners, to promote and deliver this transformation (as evident in the Think Local Act Personal partnership agreement).

(3) The vision is built on seven principles:

(i) Prevention

This relates to empowering people and promoting strong communities to assist people in maintaining independence. Where the state does provide support it is to help people retain and regain independence.

(ii) Personalisation.

This principle sees individuals and not institutions taking control of their care and recognises personal budgets, preferably in the form of direct payments, as a powerful way to give people more control over their own lives. It also recognises that to have real autonomy and choice, people need to have access to good information and advice.

(iii) Partnership

Care and support should be delivered in a partnership between individuals, communities, the voluntary sector and private sectors, the NHS and councils – including wider support services such as housing. The vision is for local councils to play a lead role in their communities to ensure local services are coherent, responsive and integrated.

(iv) Plurality.

The vision recognises that social care already involves a diverse range of providers, including the voluntary and private sectors. However it is thought that more can be done to promote a thriving social market and to stimulate and shape the market (including social enterprises) to develop innovative and creative ways of addressing care needs.

(v) Protection.

The Vision perceives that there should be sensible safeguards in place against the risk of abuse or neglect. It also advocates that Safeguarding is everybody's business. However it also notes that risk should not be an excuse to limit people's freedom.

(vi) Productivity.

Another principle is to seek greater productivity along with achieving efficiencies and value for money at a time of significant financial pressure. The shift is to be away from the centre and top down performance management towards empowered local communities' holding organisations to account for the services they provide based on the experiences of service users and carers.

(vii) People

The vision calls upon the whole workforce, including care workers, nurses, occupational therapist, physiotherapists and social workers, alongside carers and people who use services to lead the changes set out in the vision document. It recognises a need to empower workers and devolve decision making. It also indicates a much more diverse workforce with people working in a variety of settings, some in more integrated services and a variety of types of employing agencies.

(4) The vision makes many references to the role of local councils in making the vision a reality. Key principles of the vision, such as personalisation, prevention and protection are building on the "Putting People First" strategy which commenced a major transformation of Adult Social Care. Where the new Vision is significantly different, is the greater emphasis on localism and empowering people and strong communities.

(5) This approach is a reflection of the shift to localism in other spheres of the public sector. There are numerous examples – pathfinder GP consortia leading NHS commissioning, parents establishing free schools, elected police commissioners, and citizens founding social enterprises to run local services.

(6) A separate but related document to the vision is a DH document entitled Transparency in Outcomes: a framework for adult social care. This document contains proposals for a new approach to quality that is not about "top down performance management where the national government directs and the sector follows, but about recasting this relationship for a new, more decentralised future".

Think Local, Act Personal

3. (1) It is in this context of localism and a new vision for adult social care, that a consortium of key agencies including local government, social care providers and the Department of Health has produced the partnership agreement - Think Local Act Personal, which consolidates lessons learned over the past three years within the new financial context. It makes clear that personalisation and community are the key building blocks of the reform agenda which includes a changing offer from service providers. The partnership agreement explains how councils, service providers, voluntary and community organisations can respond to the Government's vision and make progress happen on the ground.

(2) It advocates continued reform, placing a huge premium on efficient, effective and integrated service delivery alongside partnership working to support the contribution of individuals, their families, carers and the wider community – reducing the need for acute health and care support. Providers –large and small – will need to offer an increasingly flexible and wider range of good value services developed with the people who use them.

(3) A key message is the need for more integrated working between councils, public health bodies and emerging G.P consortia to identify and meet local health and social care needs efficiently, providing more accessible and joined up multi disciplinary arrangements. (See the separate paper on today's agenda regarding the forthcoming changes to the NHS arrangements).

(4) Key themes from Think Local, Act Personal include:

- Promoting prevention and harnessing voluntary and community action, so that people and their communities can play a bigger role in supporting themselves and others, reducing the need for more acute care and health services.
- Actively involving people, carers, families and communities in the design, development, delivery and review of innovative care and support arrangements to maximise choice and independence and utilise the widest range of resources.
- Facilitating a broad range of choice in the local care and support market.

- Ensuring that those people eligible for on going council social care funding receive this via a personal budget (with direct payments as the preferred delivery model for most) allowing them to exercise the same amount of choice and control as those who pay for their own care and support.
- Promote self-directed support to deliver efficiencies and reduce unnecessary processes.
- Ensuring all people have the information and advice needed to make care and support decisions which work for them, regardless of who is paying for that care. This includes help to make the best use of their resources to support their independence and reduce their need for lone term care.

(5) The consortium of organisation that produced "Think Local, Act Personal" has also issued a number of best practice papers to support delivery of the initiative. (This includes papers on building community capacity; market shaping; practical approaches to personalisation and safeguarding; and personal budgets).

(6) This report provides Members with a summary of the key issues contained in the Vision for Adult Social Care and in the Think Local Act Personal initiative. Members might wish to find out more through the following links:

http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_121971.pdf

http://www.puttingpeoplefirst.org.uk/_library/PPF/NCAS/Partnership_Agreement_final_29_October_2010.pdf

The Position in Kent

4. (1) In recent years, KCC Adult Social Services, along with partner organisations has taken significant steps to transform and redesign systems and models of care and support in the county. This has been achieved whilst sustaining a strong performance culture and at a time of demographic change and rising expectations.

(2) Services are more personalised with people having greater choice and control through personal budgets, direct payments and self–directed support. The enablement service, alongside the telehealth and telecare developments and supported living schemes, has allowed people to remain independent whereas in the past they might have become dependent on long term care services.

(3) Kent has also worked over a number of years to develop a flourishing private and voluntary sector – again where possible providing people with a level of choice and flexibility over the services they receive. This includes providing choice, along with information and advice for people who are self-funders.

(4) Although a strong basis has been achieved and needs to be further "bedded in", there are further challenges ahead to continue with the reform agenda, developing and delivering a personalised, community based care and support system with a focus on prevention. This needs to be done in the current financial context with the associated reductions in public expenditure.

(5) Whilst a period of consolidation might seem appealing, this is not an option in the current environment. Members are therefore asked to give their continued support to the change agenda – making a reality of localism, building community capacity, supporting new ways of working, putting the citizen in control through personalisation and tackling disadvantage.

(6) The key messages of Think Local Act Personal, are – in the main – not new ones but they are placed in the realities of the current financial pressures and are consistent with the localism agenda, the Liberating the NHS White Paper (2010), and the Health and Social Care Bill (2011).

Recommendation

5. (1) Members are asked to NOTE and COMMENT on the contents of this report.

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Background documents: None

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By: Graham Gibbens, Cabinet Member, Adult Social Care and Public Health
Oliver Mills, Managing Director, Kent Adult Social Services)

To: Adult Social Services and Public Health Policy Overview and Scrutiny Committee - 7 April 2011

Subject: **A SUMMARY OF *THE OPERATING FRAMEWORK FOR THE NHS IN ENGLAND 2011/2012* INCLUDING FUNDING ALLOCATIONS AND LOCAL ACTIVITY IN KENT**

Classification: Unrestricted

Summary: The purpose of this document is to brief the Adult Services and Public Health Policy Overview and Scrutiny Committee (ASPHPOSC) on the *Operating Framework for the NHS in England 2011/2012* in terms of the impact on health and social care in Kent. This document also seeks to summarise the NHS funding streams which will directly benefit Kent County Council.

Introduction

1. (1) On the 15 December, the Department of Health, published the *Operating Framework for the NHS in England 2011/2012* (see Appendix 1). As part of the new Framework the health service is required to work across organisational boundaries to respond positively to the reforms set out in the *Liberating the NHS White Paper* (2010) and *Health and Social Care Bill* (2011). The Government's ambition for the reform of health and social care is far reaching and the Framework has been developed to ensure that service quality and financial performance are maintained and improved during this time of significant change.

(2) The NHS Operating Framework is a large document which covers a wide range of health priorities. The large scale impact on NHS and Social Care services across the UK is summarised in the following bullet points:

- Deliver £20 billion efficiency savings via the QIPP (Quality, Innovation, Productivity and Prevention) Programme (12 work streams nationally, 16 work streams across Kent). KASS are fully integrated in the delivery of the work stream objectives.
- Phase out Primary Care Trusts (PCTs) (which will cease to exist in 2013) and Strategic Health Authorities (SHAs) (abolished as statutory bodies 2012-13). PCT clusters are now being introduced to allow smooth transition of commissioning responsibilities to GP Consortia.
- The Government will transfer PCT Health improvement functions to Local Authorities (LAs).

- Implement the GP Consortia Pathfinder programme. In Kent the following have been granted 'Pathfinder Status':

  C4 Canterbury

  Dartford, Gravesham and Swanley

  Deal, Ash and Sandwich Health

  Dover

  East Cliff Practice

  Maidstone and Malling

  Thanet

  Whitstable

  (Source: http://healthandcare.dh.gov.uk/gp-consortia-map/
  Correct as of 11 March 2011)

- Drive integration between health and social care by giving PCTs responsibility for securing post-discharge support, with hospitals responsible for any readmissions within 30 days of discharge. PCTs to receive allocation of £70 million in 2010/2011, £150 million for reablement in 2011/12 rising to £300 million from 2012/13.

- PCTs will also receive allocations totalling £648million in 2011/12 to support social care, as well as £162 million 'Winter Pressures' money in 2010/11 and £622 million in 2012/13. Please see section 3 for more details.

For the purposes of clarity and brevity the remainder of this document will focus specifically on those proposals which will impact on Kent County Council, Families and Social Care and Public Health.

Local Impact and the NHS Operating Framework

2. (1) **Health and Social Care Integration Programme**

Within KCC the recent restructure of directorates and posts is leading to the development of a commissioning organisation. This approach ties in with the cost saving requirements of the spending review and general requirement for Local Authorities to think more about how other providers, including social enterprises can deliver some of the traditional LA services. Supporting this re-direction has been the review of commissioning strategies in social care, specifically around older people and what can be done across health and social care to harness some of the good joint commissioning already in place.

KCC has been working with the Kent Communities NHS Trust (est. April 1 2011) and prior to this both East Kent and West Kent Community NHS Trusts, to scope how health and social care integration could be further enhanced. Initial discussion has explored the opportunities around the development of a one-stop health and social care pathway via integrated commissioning strategies and an alignment of resources. This work is in its early stages and a proposal setting out possible models and key enablers will be in final draft in May 2011. This work is being led by the Director of Older Persons and Physical Disability and the Efficiency Team Manager, and will be added to the Directorate Joint Consultative Committee agenda as a standing item due to the possible implications for staff and ways of working.

(2) **Primary Care Trust (PCT) Clusters**

PCT capacity is to be consolidated to create PCT clusters across all regions of the NHS. PCT Clusters will have a single Executive Team and will be in place by June 2011. In Kent, there will be **1 Kent & Medway PCT** to oversee delivery during transition, provide support for emerging GP consortia, develop commissioning support for providers and manage the close down of the old system.

(3) **National Health Service Commissioning Board (NHSCB)**

The National Health Service Commissioning Board will be established in shadow form as a Special Health Authority in 2011/12 and will become fully operational from 1 April 2012. The NHSCB will be chaired by Andrew Lansley, Secretary of State for Health. The NHSCB will appoint a **representative to join each Local Authority's (LAs) Health and Wellbeing Board** for the purposes of participating in the GP Consortia and LA *Health and Wellbeing Strategy* preparation.

(4) **Foundation Trust Status**

The Provider Development Authority (PDA) is to be established by April 2012. The PDA will offer overall governance and performance management to NHS Trusts until they become Foundation Trusts. The PDA to be wound down once there is an established Foundation Trust Sector, estimated April 2014. In Kent the expectation is that the recently established Kent Community Health NHS Trust will achieve Foundation Trust status in April 2013

(5) **Health and Wellbeing Boards**

Local Authorities (LAs) are to take on the function of joining up commissioning for local NHS services, social care and health improvement. This will be achieved via the establishment of the Health and Wellbeing Board and Health Watch Groups. As part of the Health and Wellbeing Boards remit LAs will be responsible for leading Joint Strategic Needs Assessments (JSNA). This arrangement will give LAs influence over NHS commissioning, and corresponding influence for NHS commissioners in relation to public health and social care.

In Kent, **Health and Wellbeing Board 'early implementer status'** has been agreed. The expectation is that as an 'early implementer' KCC will;

- enhance existing partnership arrangements with PCTs in order to lay the foundations for new Health and Wellbeing Boards.
- provide an opportunity for a step change in developing integrated working between health and local government.
- lead a cultural and behavioural change to support a joint approach to meeting local needs

A meeting between KCC and partners took place on the 16 March to focus on the initial structure of the shadow Health and Wellbeing Board. The intention is that by April 2012 a shadow Health and Wellbeing Board will be established in agreement with GP Consortia, the PCT cluster, HealthWatch and District Council partners.

(6) **Public Health**

Each local authority must take such steps as it considers appropriate for improving the health of the people in its area.

This includes:

(a) providing information and advice;
(b) providing services or facilities designed to promote healthy living (whether by helping individuals to address behaviour that is detrimental to health or in any other way);
(c) providing services or facilities for the prevention, diagnosis or treatment of illness;
(d) providing financial incentives to encourage individuals to adopt healthier lifestyles;
(e) providing assistance (including financial assistance) to help individuals to minimise any risks to health arising from their accommodation or environment;
(f) providing or participating in the provision of training for persons working or seeking to work in the field of health improvement;
(g) making available the services of any person or any facilities.

Directors of Public Health will be responsible for key public health functions, using their position within local authorities to tackle the wider determinants of health. *Healthy Lives, Healthy People: Our Strategy for Public Health in England* sets out a mission to create a new public health service with strong local and national leadership. This will include creating a new, dedicated public health service – Public Health England – as part of the DH. Public Health England (PHE) will be formed from existing structures (the Health Protection Agency; the National Treatment Agency for Substance Misuse and the Department of Health) and this will be in place, as part of the Department of Health (DH), by April 2013.

The national budget for public health will be 'ring-fenced' - with a £4bn 'baseline' specifically for public health issues such as issues such as smoking, obesity and alcohol consumption - with part of money going to LAs and part to Public Health England. Actual allocations will not be announced until April 2012 at the earliest. Please note that the consultation on Public Health, including Funding and Commissioning closes on the 31 March 2011. The consultation response is being managed and overseen by KCC's Public Health Policy Department.

(7) **Patient Experience and Choice**

PCTs and providers, working with their partners, should ensure that patient experience and feedback are inherent parts of service design, delivery and improvement.

PCTs must continue to ensure their statutory obligations under the *Duty to Involve* are efficiently and effectively discharged during transition to commissioning by GP Consortia.

By April 2011, all patients referred for an outpatient appointment should be able to choose a named consultant led team. From April 2011, providers will be required to:

- Accept patients who are referred to a named consultant-led team, as long as the referral is clinically appropriate
- List their services on Choose and Book in a way that allows users to book appointments with named consultant-led teams, and

- Publish information about services so that people can use it to make choices about their healthcare, and support people to use this information

PCTs will need to work with GP practices and other stakeholders to make preparations for the introduction of choice (in its fullest sense i.e. Any Willing Provider) to GP practices from April 2012, subject to the policy framework to be published in 2011.

(8) **Commissioning and Contracting**

Commissioners (including GP Consortia and Local Authorities), in developing their local commissioning strategies, should consider how social enterprises and voluntary and community organisations can play a role in terms of scoping and delivering services. Through engagement and interaction it is the Governments view that the ambitions of the Big Society can be realised.

Commissioners, in their role of promoting greater patient choice and control, subject to affordability and quality considerations, should use the introduction of Any Willing Provider to enable greater participation by social enterprises to provide services, alongside other providers. Ultimately, there should be a level playing field for all providers.

The arrangements set out in *Equity and Excellence: Liberating the NHS* are predicted to demand a much more effective use of contracting within the NHS. For 2011/12, the opportunity has been taken to review and simplify the key process clauses in the NHS contracts and to redraft some of the core clauses.

During 2011/12 and 2012/13, the contracts will be subject to fundamental revision to prepare for the needs of GP Consortia and NHSCB. PCTs have been asked to be mindful that the contracts with providers of NHS funded services must have a smooth transition to GP Consortia, and where appropriate, the NHSCB and LAs.

In Kent, SMT Health External has been working with health colleagues to review the governance of the joint section 75 agreements currently in place between KCC and Health. In addition to the contractual considerations around service delivery, SMT Health will also look at how the transfer of responsibilities between PCTs and GP Consortia will be managed in regards to the smooth transition of existing arrangements.

(9) **Quality, Innovation, Productivity and Prevention (QIPP)**

Moving into 2011/12 and beyond, the DH will monitor performance against QIPP requirements via the monthly reporting of QIPP Trackers from SHA leads for each of the QIPP work streams (nationally there are 12 work streams, in Kent there are 16).

The Kent QIPP Programme Office (under the direction of the Director of Productivity and Systems Improvement, Kent and Medway PCTs) and the Kent and Medway QIPP Board, of which the Cabinet Member for Business Strategy and the Director of Older People and Physical Disability are members, has introduced a further 4 work streams, these are Children and Young People, Maternity, Staying Healthy and Mental Health (to include Dementia).

Financial Arrangements

3. (1) Details of 'NHS Support for Social Care: 2010/2011 – 2012/2013' were consolidated in a letter from the Department of Health dated 13 January 2011, see Appendix 2.

(2) The first tranche of money was announced on 5 October 2010. This amounted to £70m nationally for 2010/11with the Kent PCT's receiving £1.833m. This funding was targeted at post discharge and reablement services. Plans have been developed and agreed locally between the PCT's and KCC for the use of this money. Initial focus has been on bed numbers, team resource and the improved utilisation of community services.

Post Discharge/Reablement 2010/2011	**Population**	**Allocation (£ 000s)**
Eastern and Coastal Kent PCT	763, 984	1,021
West Kent PCT	607, 290	812
Total	1,371274	1,833

(3) The post discharge and reablement funding in 2010/11 is followed by a further £150m in 2011/12 and an indicative £300m in 2012/13. Whilst detailed allocations to local level have not yet been published, it would not be unreasonable to expect somewhere in the region of £3.9m and £7.9m respectively for Kent based on the current year allocation.

(4) Further funding was made available for 2010/11 on 4 January 2011 under the banner, 'Winter Pressures Funding'. The national total was £162m and Kent's share is £4.056m. The Department of Health advised that this funding should be transferred to Local Authorities under Section 256 of the 2006 NHS Act. Heads of Agreement have been drafted and are currently with the PCT's awaiting their approval. Once agreed, formal agreements will be drafted. Plans have been agreed locally between KCC and the PCT's for the use of these funds and invoices have been raised to the PCT's.

Winter Pressures 2010/2011	**Population**	**Allocation (£ 000s)**
Eastern and Coastal Kent PCT	763, 984	2, 100
West Kent PCT	607, 290	1, 950
Total	1,371274	4,050

(5) 'Winter Pressures Funding' is replaced in future years as 'Specific PCT allocations for social care'. £648m has been allocated in 2011/12 and £622m in 2012/13 with Kent's share being £16.226m and £15.656m. In common with the 'Winter Pressures Funding', these funds must be transferred to Local Authorities under Section 256 of the 2006 NHS Act. Reference to future years funding has been included in the draft Heads of Agreement.

(6) PCTs will need to work together with LAs to agree appropriate areas for social care investment, and the outcomes expected from this investment. This could include current services such as telecare, community directed prevention (including falls prevention), community equipment and adaptations, and crisis response. The DH would expect these decisions to take into account the JSNA for the local population.

(7) In regards to Public Health budget allocations, from April 2013 Public Health England will allocate ring-fenced budgets, weighted for inequalities, to upper-tier and unitary authorities in local government for improving the health and wellbeing of local populations. The Department of Health is unable to provide information about local authority's actual allocations until April 2012 at the earliest. It is understood that if allocations are determined now (and there is a reduction) then there is a risk that existing services will be destabilised. Please see section 6 of 'Healthy Lives, Healthy People: Consultation on the Funding and Commissioning Routes for Public Health' for further information on proposed funding arrangements.

Conclusion

4. (1) KCC is actively engaged with PCT and SHA colleagues to ensure the smooth transition of services, identification of appropriate areas of investment following the release of the NHS funding and the development of health and social care integrated strategies.

(2) As one of the main bodies for delivering the health and social care integrated commissioning agenda, the Health and Wellbeing Boards impact will reach far and wide across KCC and will require significant joint working with new partners such as GP Consortia and the NHSCB. The pursuit of Health and Wellbeing Board 'early implementer status' supported by a clear KCC vision of structure and purpose is vital if KCC's vision of integration is to be realised.

Recommendation

5. (1) Members are asked to:

(a) NOTE and COMMENT on the contents of the report

(b) NOTE that KCC Officers will continue to keep the Policy Overview and Scrutiny Committee updated on changes to the NHS and the subsequent implications for social care and LAs. Including but not limited to NHS funding investment opportunities, the health and social care integration programme, the Health and Wellbeing Board status and the continued development of the QIPP Programme.

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Background documents: None

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The Operating Framework

for the NHS in England 2011/12

DH INFORMATION READER BOX

Policy HR/Workforce Management **Planning/Performance** Clinical	Estates Commissioning IM&T Finance Social Care/Partnership Working
Document purpose	Action
Gateway reference	15216
Title	The Operating Framework for the NHS in England 2011/12
Author	DH/NHS Finance, Performance and Operations
Publication date	15 Dec 2010
Target audience	PCT CEs, NHS Trust CEs, SHA CEs, Care Trust CEs, Foundation Trust CEs, Local Authority CEs, NHS Trust Board Chairs, Special HA CEs, Directors of Finance, Communication Leads, Directors of Performance.
Circulation list	Voluntary Organisations/NDPBs
Description	This document outlines the business and planning arrangements for the NHS in 2011/12. It describes the national priorities, system levers and enablers needed to build strong foundations set out in Equity and excellence: Liberating the NHS, maintaining and improving quality, while keeping tight financial control and delivering the QIPP challenge.
Cross ref	N/A
Superseded docs	N/A
Action required	N/A
Timing	N/A
Contact details	David Flory NHS Finance, Performance & Operations Directorate Department of Health Richmond House 79 Whitehall London SW1A 2NS
For recipient's use	

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Foreword by Sir David Nicholson KCB CBE

2011/12 will be a very demanding year for the NHS as we take on the challenge of continuing to deliver high quality care for our patients, while beginning in earnest the transition to the new system envisaged in *Equity and excellence: Liberating the NHS*. Our over-arching goal in this period is to build strong foundations for the new system by maintaining and improving quality, by keeping tight financial control and delivering on the quality and productivity challenge, and by creating energy and momentum for transition and reform.

Maintaining and improving quality and outcomes

Our core purpose remains the delivery of improved quality for our patients, by improving safety, effectiveness and patient experience. The NHS Operating Framework sets out the national priorities for 2011/12, including maintaining performance on key waiting times, continuing to reduce healthcare associated infections, and reducing emergency readmission rates.

In doing this, our focus in 2011/12 will be increasingly on improving the outcomes we achieve, in line with the vision in *Liberating the NHS*. The forthcoming *Improving Outcomes Strategy for Cancer* will set out a clear ambition for improving survival rates, while the new measures of quality for ambulance and Accident and Emergency services to be published shortly will concentrate on measures that link to outcomes.

We shall continue to develop the quality framework in 2011/12 in anticipation of the new role of the NHS Commissioning Board in driving quality improvement across the system. NICE will begin work on 31 new Quality Standards next year to add to the 15 already completed or in development. Meanwhile quality accounts will be extended to cover community services for the first time.

Financial control and QIPP

2011/12 is the first year of the new Spending Review period and today's allocations to PCTs confirm the strong financial settlement for the NHS. Given the current economic context, the settlement represents a real vote of confidence in the NHS and a recognition of the pressures we face due to rising demand, changing demography, and new technologies. It is nevertheless a very challenging settlement in historical terms, which is why we must remain focussed on delivery of the £20 billion efficiency savings for re-investment in improving quality across the Spending Review period.

To this end, this NHS Operating Framework sets out how we will maintain tight financial control during 2011/12. PCTs will continue to be required to invest 2 per cent of their budgets non-recurrently in order to create financial flexibility and headroom to support change. The marginal rate of tariff payment for emergency admissions above baseline thresholds will be maintained, incentivising commissioners and providers to work together in an area that is critical to delivering local QIPP plans.

These measures will no doubt create real challenges in some parts of the system, but they are critical to ensuring we maintain a strong financial position to get the new system on the right footing from the outset. We shall continue to support commissioners and providers to make quality and productivity improvements, as we have done through the recent publication of the *NHS Atlas of Variation* and the review of *Back Office Efficiency and Management Optimisation*.

Developing the new system

As well as maintaining a strong grip on the system during 2011/12, we need to make progress on laying the foundations for the new health and social care system. We recently announced the first wave of pathfinder GP consortia, which already cover a quarter of the population. The pathfinder programme will expand across the country during 2011/12, while the new NHS Commissioning Board will be created in shadow form, meaning the foundations of the new commissioning system will be in place by the end of the year.

On the provider side, we shall look to make early progress on completion of the Foundation Trust pipeline and to prepare for the new system of economic regulation. And 2011/12 is also an important transition year for local government as we test the new arrangements for health and wellbeing boards and the new public health service.

This NHS Operating Framework will also create clearer incentives to drive integration between health and social care by giving PCTs responsibility for securing post-discharge support, with hospitals responsible for any readmissions within 30 days of discharge. PCT allocations also include funding of £150 million for reablement and PCTs will receive separate allocations totalling £648 million in 2011/12 to support social care.

Accountability in 2011/12

It is critical that we maintain clear accountability arrangements during 2011/12, even as parts of the new system come into place in shadow form. Strategic Health Authorities will continue to play a key role during 2011/12 and will remain accountable both for delivery of high quality care within available resources, and for making progress on the transition to the new system across their region.

At local level, Primary Care Trusts will remain statutorily accountable in 2011/12 and 2012/13. However, it is unlikely that we will be able to maintain 151 fully functional separate organisations up to the end of that period, particularly if we want to offer capacity to emerging GP consortia. Because of this, and because of the broader drive to reduce running costs across the system, some regions of the NHS have already developed clusters of PCTs. In order to secure the capacity and flexibility needed for the transition period, this NHS Operating Framework therefore set out plans for a managed consolidation of PCT capacity to create such clusters across all regions of the NHS.

This is a broad and complex agenda and a significant leadership challenge for us all. It requires us to keep a firm grip on delivery for today, facing up to issues such as winter pressures and the need to maintain patient safety during a period of organisational change. And it also requires us to begin to build the new system and to bring about the changes set out in *Liberating the NHS*. We must meet these challenges at a time when staff and leaders across the NHS face personal and professional uncertainty about their futures. I do not underestimate the scale of what lies ahead, but I have confidence, based on our track record of delivery, that we can succeed.

Sir David Nicholson, KCB CBE
NHS Chief Executive

1. Overview

A new direction and vision

1.1 The White Paper, *Equity and excellence: Liberating the NHS*[1] was published on 12 July 2010 and outlines the Government's plans for a new direction for the NHS. We have already started an ambitious programme of reforms in the NHS with the *Revision to the Operating Framework for the NHS in England 2010/11*[2], published on 21 June 2010. This Operating Framework for the NHS in England 2011/12 sets out the challenges in implementing the first full year of the transition. 2011/12 is a critical period that requires all parts of the health service to respond positively to the principles and purposes set out in *Equity and excellence: Liberating the NHS*, whilst ensuring service quality and financial performance are maintained and improved.

1.2 On 20 October 2010, the Government announced the details of the Spending Review covering the four years from 2011/12 to 2014/15. This reflected the Government's commitment to protect health with the total health budget increasing by £10.6 billion over four years. Within this, total revenue increases by £11.1 billion with capital falling by £0.5 billion over the same period. That settlement needs to be considered in the context of reducing management costs and Quality, Innovation, Productivity and Prevention (QIPP) productivity gains which will release up to £20 billion more funding into frontline services for patients over the four years. In 2011/12, the settlement includes an explicit provision from health resources of £800 million, which NHS commissioners will have available to spend on measures which support social care and benefit health in agreement with social care commissioners.

1.3 There is extensive work going on across the health service to support the move to a system that is accountable to local people, focuses on outcomes, empowers patients through choice and information, and liberates commissioners and providers. GPs are already moving into shadow consortia arrangements in many parts of the country and we need to learn from them in terms of developing future consortia, there is more regular publication of key information such as infection rates on a weekly basis and the first NHS Outcomes Framework will be published shortly.

1.4 NHS organisations will need to comply with the public sector duties of the Equality Act 2010, due to come into force in April 2011. The NHS Equality and Diversity Council is developing an Equality Delivery System to advise boards on how to maintain progress and demonstrate compliance with the Act.

1 http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_117353
2 http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_110107

1.5 With that backdrop, this NHS Operating Framework for 2011/12 needs to be viewed in the context of three inter-related themes:

- **transition and reform** – what needs to happen in 2011/12 to begin to realise the challenges set out in the White Paper, taking our staff with us;
- **transparency and local accountability** – what we need to involve public and patients in and give them a better understanding of how and where their money is being spent to improve services and strengthen local accountability; and in doing so make a significant contribution to the Big Society; and
- **service quality** – how we deliver on the quality and productivity challenge through securing improvement in those areas where additional funding has been made available, making the wider productivity gains and quality improvement outlined in QIPP, securing re-investment to meet demand and improve quality and outcomes, and taking more responsibility for working together with local authorities.

1.6 These themes are supported by sections in this NHS Operating Framework that set out:

- **finance and business rules** – where the financial and business rules have been developed to reflect the new agenda and tighter fiscal environment; and
- **accountability** – where a single planning process is set out to hold NHS organisations to account for the delivery of service quality and financial sustainability during 2011/12.

Transition and reform

1.7 2011/12 is the year in which we establish the building blocks for the NHS to respond to the White Paper:

- an NHS Commissioning Board will be created in shadow form during 2011/12;
- a programme of pathfinder GP consortia is in place and we shall support the emergence of new pathfinders throughout 2011/12, ensuring that lessons are learned and shared. New arrangements for local authorities will also be tested in this period; and
- SHAs must identify when each of its NHS trusts will become an NHS foundation trust by 31 March 2014 with an identifiable solution for those trusts who need alternative arrangements – the status quo is not an option.

1.8 The NHS has a strong track record of delivery of widescale change. Delivering change while maintaining performance against the QIPP challenge will mean needing to maximise opportunities for:

- flexible local implementation and choice of how new systems operate;
- working together across organisational boundaries;
- supporting current employees through the change; and
- ensuring running costs start and remain low in the new system.

1.9 To support the transition, this NHS Operating Framework sets out our intention increasingly to deliver business through PCT clusters that will in essence work as transition vehicles for:

- overseeing and accounting for delivery;
- direct commissioning; and
- supporting the development of the new commissioning system.

1.10 2011/12 will also be the year when the NHS fully exploits the benefits of the national contract. Contracts must be agreed on time and reflect the needs of the whole health economy, including efficiency savings, with penalties and sanctions activated when the terms of contracts are not being met.

Transparency and local accountability

1.11 In December 2010, the Department of Health will publish a first NHS Outcomes Framework. The NHS Outcomes Framework will include a set of outcome goals that the Secretary of State will use to hold the NHS Commissioning Board to account when it becomes fully operational from April 2012. Data against all indicators in the NHS Outcomes Framework will be made publicly available to allow local people to make informed choices about the services they use.

1.12 In tandem with the NHS Outcomes Framework, there will be a revolution in patient power. NHS commissioners and providers should be publishing information to support local accountability. For example, there is already a requirement for PCTs to publish locally how they are delivering services in line with the *Quality outcomes for people with dementia: Building on the work of the National Dementia Strategy*[3]. That requirement holds – wherever possible commissioners must be accountable to the people they serve, not the centre. Choice will drive service improvements, putting more decision making under the control of patients and their carers. It will be important that services for young people reflect *Achieving Equity and Excellence for Children*[4] so that services are designed around young people from the outset.

3 http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_119827
4 http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_119449

Service quality

1.13 *Equity and excellence: Liberating the NHS* set out a vision for a service that focuses on outcomes rather than processes as its key measure of success and that positions interactions between patients and clinicians, rather than central performance management, as the key agent of change.

1.14 Achieving this change will take time and 2011/12 will be about creating the environment for greater devolution during 2012/13. In doing so, it will require a tighter grip in a limited number of areas during 2011/12 if we are to go into 2012/13 with confidence. Those areas are as follows:

- reform – progress on transition to the new system;
- QIPP – where there will be close monitoring of progress against QIPP key performance indicators, as well as a need to go further on improvements that contribute to quality and efficiency gains;
- maintenance of improvements to date – for instance, in referral to treatment times, where we need to ensure patient confidence in the service being able to treat people within a reasonable time is sustained and encourage waiting times to continue to be reduced at a time of transition; and
- specific improvements in relation to Government priorities – where funding has been identified as part of the Spending Review, for example more health visitors and Family Nurse Partnership schemes.

1.15 Whilst the aim of the reforms is to produce high quality care and better outcomes for patients, we know from the evidence that any organisational change carries a degree of risk. It is important that the NHS takes steps to manage these risks in order to ensure that the significant progress made in improving quality in recent years is maintained and built upon.

1.16 The National Quality Board (NQB) is conducting a review, building on its earlier *Review of Early Warning Systems in the NHS*[5] report, into how best to maintain quality and safety during the transition (Phase 1) and once the new system architecture is in place (Phase 2). The Phase 1 report will be published early in 2011 and will provide further detail on how best to address key questions associated with the transition. These include the need to have a clear strategy for:

- dealing with the potential loss of managerial and clinical talent so as to maintain capacity and capability for quality throughout transition;

5 http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_113020

- ensuring that the voice of patients, as a vital element of the early warning system, remains heard at all times and is not drowned out by other operational or transitional noise;
- bringing key partner organisations together (both local and national) to consider collectively risks to quality both in relation to specific services or provider organisations and, more broadly, across whole health economies;
- delivering a robust and effective handover to successor organisations with appropriate "due diligence" so that there is no loss in corporate memory on issues relating to quality; and
- identifying and tackling any long-standing and intractable quality issues before handing over responsibilities to successor bodies.

1.17 Every board should ensure that they are familiar with and understand the NQB's report *Review of Early Warning Systems in the NHS* (which stands until April 2012). Further guidance on additional resilience measures will be provided in early 2011 as part of Phase 1 of the NQB's review. This will also include advice on how provider boards can strengthen their governance for quality, given that they are ultimately accountable for the quality of services provided within their organisation.

1.18 Phase 2 of the NQB's work will provide further advice as to how the system will operate once the new architecture is fully in place.

Finance and business rules

1.19 The financial position for the NHS where we move from a position of growth to one of more stable settlements makes it all the more imperative that we get the finance and business rules right, in order that the importance of financial control through the transition period is reinforced.

1.20 For 2011/12, the financial framework will require NHS organisations to ensure they gain the maximum benefit when making investment decisions. Running costs will need to be reduced at every level.

Accountability

1.21 *Equity and excellence: Liberating the NHS* set out a challenging agenda in terms of ensuring NHS organisations respond to their local communities rather than being over burdened with central process requirements.

1.22 To support that transition, there will be a single planning and accountability process for 2011/12 that captures the basis on which NHS organisations will be held to account in terms of quality, resources and reform. It is important that the planning and accountability process supports joined up delivery. For example, NHS commissioners need to demonstrate how they can support the challenges in social care. Reduced length of stay in hospital beds can put greater pressure on social care places. That is why we have put the responsibility on PCTs to secure post-discharge support, with hospitals responsible for any readmissions within 30 days of discharge.

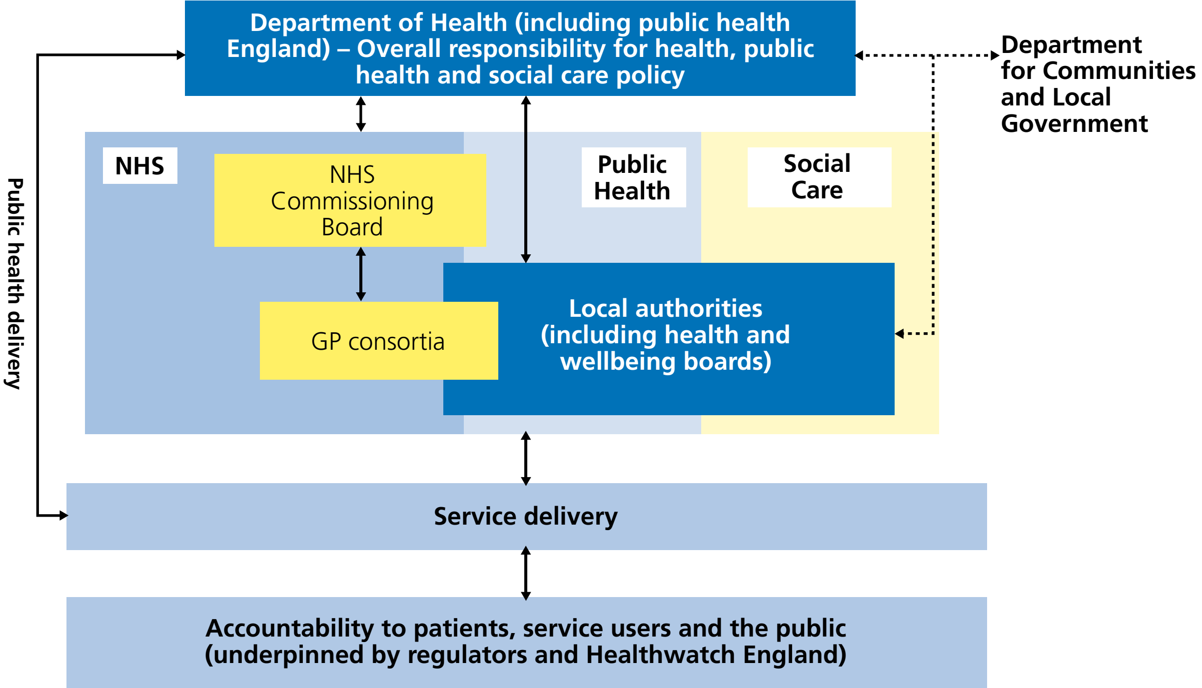
1.23 To ensure NHS organisations can be satisfied that central requests are limited to the minimum necessary to allow them to focus on their local communities, all communications requiring the attention of NHS management in 2011/12 will be consistent with this NHS Operating Framework and include a Gateway reference number.

1.24 This NHS Operating Framework comes at a pivotal moment in the creation of an NHS that is more responsive and better able to reflect the varying needs of the people who require health and care services. This means that a tight grip on finance and performance is called for by all organisations during 2011/12 to support our ambition of greater devolution and liberation during 2012/13 and beyond.

2. Transition and reform

New roles for new and existing organisations

Fig 1: The *Equity and Excellence* system



2.1 *Equity and excellence: Liberating the NHS* set out the blueprint for a new NHS system. 2011/12 is the first full year of the transition to the new system and will require initial changes to be made across all parts of the service. We need to ensure that the current system of accountable organisations is delivering excellent patient care, driving improvements in health outcomes, and improving patient choice and experience within available resources. We need to achieve this in a way that supports the development of the new landscape of organisations, accountabilities and relationships.

2.2 During this transition year, it is essential that organisations continue to fulfil their statutory responsibilities. NHS organisations should ensure that all decisions are taken with due regard to the public sector Equality Duty to ensure that decisions are fair, transparent, accountable, evidence-based and consider the needs and rights of staff and patients.

2.3 SHAs will remain accountable for operational delivery and for leading the transition across their region in 2011/12. They will hold PCTs to account for the delivery of the requirements set out in this NHS Operating Framework both in terms of service delivery and transition to the new arrangements.

2.4 Groups of GP practices, working closely with other health and care professionals, will increasingly take on devolved responsibility for commissioning decisions and consider how best to come together to form prospective consortia.

2.5 PCTs will be undergoing significant change during 2011/12 as emerging GP consortia and the NHS Commissioning Board develop. Without clear action, there is a risk of seeing unplanned loss of capacity and capability in the current commissioning system, notwithstanding the organic development of the new commissioning system. In response to this, and having carefully considered the balance of risks between ensuring continuity of capability and further disruptive change, we have decided that while PCTs will continue to be the statutory unit of accountability during 2011/12, they will increasingly discharge their responsibilities through formal cluster arrangements. In doing so, they need to create space for and support the development of emerging GP consortia.

National level

2.6 Existing accountability arrangements will remain in place at national level during 2011/12, with the NHS Chief Executive remaining accountable for delivery. The NHS Chief Executive will hold the NHS to account for delivery on in-year requirements, QIPP delivery and supporting reform through a single integrated process.

2.7 The NHS Commissioning Board (NHSCB) will be established in shadow form as a Special Health Authority in 2011/12 and will become fully operational from 1 April 2012. When fully established, the NHSCB will be responsible for:

- supporting continuous improvements in quality and outcomes of NHS funded services;
- promoting and extending public and patient involvement and choice;
- ensuring a comprehensive system of GP consortia, supporting them and holding them to account, including working in partnership with local government and other organisations;
- directly commissioning certain services including primary medical care, other family health services, designated services specialised healthcare for those in prison or custody, and some aspects of military healthcare;
- allocating and accounting for NHS resources; and
- promoting equality and reducing inequalities in access to healthcare, in cooperation with Public Health England.

2.8 In 2011/12, the shadow NHSCB will focus its attention on:

- developing its own capability and capacity to ensure that it is fully fit for purpose from April 2012;
- overseeing the development of emerging GP consortia and the associated architecture including systems for authorisation, accountability, intervention and failure; and
- planning for 2012/13.

2.9 To support the implementation of an all foundation trust sector by 1 April 2014, the Provider Development Authority will have been established as a Special Health Authority by April 2012. The Authority will provide overall governance and performance manage NHS trusts until they become foundation trusts. The Authority will be wound down once there is an all foundation trust sector by 1 April 2014.

Regional level

2.10 SHAs will remain accountable at regional level during 2011/12 for operational delivery and the transition to new commissioning arrangements. In doing so, it is essential to ensure that current performance is maintained, and that QIPP delivers the improvement in NHS productivity and service quality set out in local plans. SHAs will oversee the development of PCT clusters and ensure local coherence across the local development of the new architecture, such as relationships between GP consortia pathfinders and local health and wellbeing board early implementers.

Local level

2.11 While PCTs will have a critical role up to April 2013, we do not expect to maintain 151 fully functional separate organisations up to that time, particularly if we want to offer capacity to emerging GP consortia. Because of this, and because of the broader drive to reduce running costs across the system, some regions of the NHS have already developed clusters of PCTs. In order to secure the capacity and flexibility needed for the transition period, we shall undertake a managed consolidation of PCT capacity to create such clusters across all regions of the NHS. Alongside this, staff will be increasingly assigned to emerging GP consortia to support their development.

2.12 The broad role of clusters will be twofold. Firstly, clusters will oversee delivery during the transition and the close down of the old system. In so doing, they will ensure PCT statutory functions are delivered up to April 2013. Secondly, clusters will support emerging GP consortia, the development of commissioning support providers and the emergence of the new system.

In so doing, they will provide the new NHSCB with an initial local structure to enable it to work with GP consortia. In creating clusters, our aim is to maintain the strength of the commissioning system in light of the significant financial challenges ahead.

2.13 Clusters will have a single Executive Team and will be in place by June 2011 at the latest in a form that is sustainable up to April 2013, and potentially beyond that date if the NHSCB chooses. Emerging clusters should be involved in the planning process for 2011/12 in anticipation of their future role. Where clusters are already in place, current geographical coverage will be maintained.

2.14 More specifically, clusters will sustain capacity in the system to:

- maintain and improve the quality and safety of services across their areas through the commissioning and contracting process;
- ensure delivery of 2011/12 and 2012/13 operational plans covering all aspects of operational delivery as set out in Chapter 6 including the development of longer term commissioning provision support in preparation for alternative organisational models beyond 2013;
- oversee management and implementation of medium term QIPP plans;
- oversee the local and regional planning process for 2012/13 and into 2013/14, increasingly involving and handing leadership to GP consortia;
- have oversight of closedown of PCTs;
- oversee commissioning planning, contracting and management for all services in the cluster area not delegated to GP consortia, such as primary care, and nationally and regionally commissioned specialised services;
- ensure governance, proper handling of statutory business, decision making and accountability through PCT boards;
- secure the delivery of PCT statutory responsibilities, ensuring all statutory functions are maintained, with a clear focus on priority issues, such as safeguarding;
- maintain talent and capability, working to retain key individuals through transition, making people available to support new structures and managing staff reductions fairly and effectively;
- ensure GP consortia have access to commissioning support up until April 2013;
- oversee the development of GP consortia during 2011/12, ahead of their authorisation; and

- maintain relationships with local government and other key partners, supporting local work to develop health and wellbeing boards and ensuring joint working is sustained and accelerated.

2.15 In addition, clusters will support the development of GP consortia through offering support, including:

- a development fund of £2 per head to support them in the development of their consortia. This will be resourced primarily from management cost savings realised from the MARS scheme. This should be in addition to, and used alongside, existing PBC funding and can be used flexibly to fund, for example, clinical backfill, training and organisational development;
- a qualified or accredited senior finance manager (this may be shared across consortia);
- an organisational development expert/facilitator;
- an individual with expertise of appropriate governance arrangements/ corporate affairs; and
- a commissioning expert to support the consortium in their assessment of those commissioning activities they will carry out themselves, those where they may choose to act collectively, and/or where they may choose to buy in commissioning support from external organisations both during the transition and beyond.

More detail on the governance arrangements and the process for forming clusters will be set out in the New Year.

2.16 Through cluster arrangements, PCTs must work with consortia to develop their Operating Plans as set out in Chapter 6. QIPP value for money improvement projections should be disaggregated to the level of consortia and developing consortia should be encouraged and supported to take on areas of QIPP delivery for which they are best placed. PCTs should provide support for the consortia development process, and empower consortia to take on new responsibilities when they are ready to do so.

2.17 Support and empowerment provided by PCTs, through cluster arrangements, will include:

- encouraging GP practices to work together to form consortia;
- delegating budgets with a dedicated management resource for consortia ready to take on responsibilities;
- helping consortia to understand and participate in the Joint Strategic Needs Assessment (JSNA) processes, in collaboration with local authority partners;

- creating support teams to provide technical functions that consortia can draw on;
- paving the way for a smooth transfer of existing joint commissioning, pooled budgets and section 75 arrangements; and
- ensuring a partnership approach to the whole commissioning cycle, considering the scope for greater use of joint commissioning where appropriate.

2.18 PCTs will receive specific allocations to support social care. PCTs will transfer this funding to local authorities for spending on social care services to benefit health and to improve overall health and social care outcomes. PCTs and local authorities will need to agree appropriate areas for social care investment and expected outcomes, and will work together in order to achieve these. The Government has recently set out its *Vision for adult social care: Capable communities and active citizens*[6] and updated its carers' strategy, *Recognised, valued and supported: next steps for the Carers Strategy*[7] which should be taken into account when agreeing local investment plans.

General Practice

2.19 All practices should be considering how they will group together into consortia, the objectives of their consortia and the best operating model to deliver these. All practices should ensure that they do this through engagement with their local communities. The support available for the development of GP consortia is set out earlier in this chapter. The Department is considering what support will be needed for leadership development in emerging GP consortia.

6 http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_121508
7 http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_122077

Commissioning transition timetable

Now – March 2011	PCTs to involve GP practices and emerging consortia, with other clinicians, in the 2011/12 contracting round and the broader commissioning cycle from 2011/12 onwards
December 2010	Initial GP consortia pathfinders identified
January – March 2011	Delegated responsibilities of pathfinder consortia confirmed with PCTs
January 2011 – March 2012	Further pathfinders identified and emerging consortia encouraged to become increasingly involved in commissioning and take on increasing delegated responsibilities
In 2011/12	NHS Commissioning Board set up in shadow form as special health authority
June 2011	PCT clustering arrangements in place
April 2012	All GP practices in GP consortia and start of NHS Commissioning Board authorisation of consortia
April 2012	NHS Commissioning Board established, takes over relevant responsibilities
April 2012	SHAs abolished and responsibilities allocated to bodies in the 2012/13 architecture
April 2012 – March 2013	NHS Commissioning Board to work with GP consortia that need further support to be ready to take on full statutory responsibilities
April 2013	Authorised GP consortia take on full statutory responsibilities
April 2013	PCTs abolished

Development of health and wellbeing boards

2.20 NHS commissioners will need to work closely with local authorities to establish shadow health and wellbeing boards. These will be the key vehicle for councils to carry out their statutory responsibilities to lead on integrated working and commissioning across the NHS, public health and social care in collaboration with other local agencies.

2.21 Through the health and wellbeing boards, NHS commissioners and councils, with representatives of public voice through local HealthWatch (currently LINks), will:

- do a Joint Strategic Needs Assessment (JSNA) to understand health and wellbeing needs of local populations, and agree shared priorities;
- using the JSNA, agree a Joint Health and Wellbeing Strategy across NHS, public health, social care and children's services; and
- support individual organisations, including GP consortia in linking their commissioning strategies to the Joint Health & Wellbeing Strategy.

2.22 These arrangements will need to be in place from April 2012, when GP consortia have shadow allocations and local authorities have shadow public health budgets. There will be a network of "early implementers" for health and wellbeing boards, linking closely to pathfinders for GP consortia.

Progression to NHS foundation trust status

2.23 All NHS trusts will become NHS foundation trusts (NHS FTs) by the end of 2013/14. This will include the newly established NHS trusts formed out of PCT provider arms. NHS trusts will be held to account at regional and national level for achieving the updated timetables submitted to the Secretary of State at the end of 2010. It will not be an option for organisations to decide to remain as an NHS trust, rather than become, or be part of an NHS FT. Subject to legislation, by 1 April 2014 all NHS trusts will cease to exist.

2.24 Achieving and sustaining the highest levels of quality and financial performance are a key pre-requisite for NHS FTs going forward and those are the standards that aspirant NHS FTs must meet. For NHS trusts who will have difficulty in reaching NHS FT status in their current form, realistic plans for alternative configurations need to be in place.

2.25 Under the leadership of the National Managing Director for Provider Development, SHAs are leading the development of the FT pipeline and must support NHS trusts to make the transition, making maximum use of options for providing support to help address challenges.

2.26 Following ratification of the timetables submitted to the Secretary of State, in January 2011 NHS organisations will receive advice on:

- the key issues NHS trusts face in achieving NHS FT status;
- the steps required to address those issues; and
- the practical actions that need to be taken, including agreements detailing the key work and timetable for achieving NHS FT status as a stand alone organisation, with an existing NHS FT or a different organisational form.

Transforming community services

2.27 A robust set of data for community services will be developed during 2011/12 and commissioners and providers of community services should make the necessary preparations for their introduction. This includes the accelerated deployment and utilisation of clinical applications to improve data collection and data flow and support reducing hospital admissions and demand management.

2.28 As required in the *Revision to the Operating Framework for the NHS in England 2010/11*, by 1 April 2011 all PCT directly provided community services must have been separated from PCT commissioning functions and the divestment of these services from PCTs completed or substantial progress made towards divestment.

2.29 There should be a level playing field for all providers. Commissioners, in their role of promoting greater patient choice and control, subject to affordability and quality considerations, should use the introduction of Any Willing Provider to enable greater participation by social enterprises to provide services, alongside other providers, starting with community services.

2.30 Commissioners, in developing their local commissioning strategies, should also consider how social enterprises and voluntary and community organisations can play a role both in the delivery of services and, through their expert knowledge, scoping the sorts of services and outcomes that communities want and need. Through this engagement and interaction, commissioners can begin to realise the ambitions of the Big Society.

2.31 The Government has recently announced the introduction of a "Right to Provide" for staff working in many public services. We shall issue guidance setting out how this can be applied to the NHS, creating new opportunities for NHS staff to lead service development and transformation through setting up and leading new social enterprises.

Stronger contracting

2.32 The arrangements set out in *Equity and excellence: Liberating the NHS* are predicated on much more effective use of contracting. PCTs and providers must use standard contracts and activate penalties and sanctions when appropriate.

2.33 All contracts between commissioners and providers must be signed before the start of the financial year. They should balance the needs of the whole health economy, including the delivery of QIPP efficiencies, and support participation in national clinical audits. PCTs need to ensure that contracts allow for providers to take responsibility for managing demand within their own organisations and avoid additional costs being placed on the system. For example, PCTs may identify clinically appropriate follow up ratios for out-patient appointments in certain specialties. PCTs may also use contract sanctions if they are not satisfied about the completeness and quality of a provider's data.

2.34 Standard contracts for acute and mental health service organisations that are integrating their local PCT provider arm services have been developed. These two new contracts will sit alongside the other standard contracts. Guidance has been circulated to SHAs on the use of these contracts when integrating PCT provider arm services.

2.35 For 2011/12, the opportunity has been taken to review and simplify the key process clauses in the contracts and to redraft some of the core clauses to improve clarity.

2.36 During 2011/12 and 2012/13, the contracts will be subject to fundamental revision to prepare for the needs of GP consortia and the NHSCB. The core elements of the contract will reflect the standard terms that providers will be expected to agree if they wish to provide services to NHS funded patients. The detailed service requirements to reflect local needs will be agreed with commissioners.

2.37 A bespoke contract based on the community services contract has been developed for the care homes sector. This one year interim contract, which expires on 31 March 2012, will be reviewed during 2011/12.

2.38 As part of the 2011/12 contracting round and for each of the coming contract years, PCTs should be mindful that the contracts with providers of NHS funded services must smoothly transition to GP consortia, and where appropriate, the NHSCB or local authorities. Guidance on this will be issued with the suite of standard contracts for 2011/12. It is essential for PCTs to involve local GPs, existing practice based commissioning and developing

GP consortia in the development and negotiation of their contracts with providers. Development of the tariff as set out in Chapter 5 will strengthen, in parallel, the options for commissioners to secure value and more responsive and integrated services.

Supporting the NHS workforce

2.39 The NHS remains committed to protecting and improving staff health and wellbeing, and reducing unnecessary sickness absence, as set out in Dr Steve Boorman's Review of NHS health and wellbeing[8].

2.40 High levels of staff engagement will help deliver the quality and productivity challenges organisations face and lead to improved outcomes for patients and better financial management in the NHS. The Department of Health and NHS Employers will make materials available to support organisations in achieving or maintaining high levels of staff engagement, particularly during the transition to the new system infrastructure. This will help in ensuring that unnecessary costs in respect of staffing changes between current NHS organisations and GP consortia are avoided.

2.41 The Centre for Workforce Intelligence will support local employers to take a strategic approach to workforce planning, developing a more flexible and responsive workforce and avoiding inappropriate responses to cost pressures.

Education and training

2.42 *Equity and excellence: Liberating the NHS* signalled a new approach to workforce planning, education and training that should give employers greater autonomy and accountability for planning and developing the workforce, alongside greater professional ownership of the quality of education and training. The Department of Health will publish a consultation document about how to put these principles into action. It will be important for providers, with effective local professional engagement, to work with SHAs and with patients, staff, commissioners, universities and other education providers on the design and implementation of the new framework. Advice on workforce planning, education and training will set out how the new system will develop. Providers will need to work in partnership with SHAs to ensure that suitable local arrangements are in place by April 2012.

2.43 NHS organisations will need to ensure they have in place the key components to underpin medical revalidation, in advance of an assessment of readiness in early 2012/13 to help doctors remain up to date and fit to practise throughout their career.

8 http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_108799

Pay and reward

2.44 The Government has announced a two year pay freeze with effect from April 2011 for those earning more than £21,000. This will help ease pressure on the pay bill as we enter a challenging financial period. Many staff are concerned about their security of employment, particularly over the next two years while we implement the QIPP reforms to release savings. Individual NHS organisations should be working in partnership with local trade unions and staff to redesign services so that they are delivered efficiently and ensure the quality and safety of care. This should include discussions to retain, retrain and redeploy staff wherever possible so as to avoid unnecessary loss of skills. It will be important that unnecessary costs in respect of staffing changes are avoided.

2.45 Proposals being discussed in partnership between NHS Employers and the NHS Trade Unions through the NHS Staff Council would provide staff with significantly improved security of employment in return for foregoing pay increments during 2011/12 and 2012/13 while protecting the integrity of national collective agreement. Any savings released by such proposals would be retained by individual NHS employers to enable them to protect staff from avoidable compulsory redundancies.

2.46 NHS terms and conditions remain competitive but are not always fully appreciated. NHS employers are therefore encouraged to support the maintenance of recruitment, retention, morale and motivation of staff by ensuring they are aware of their overall pay and reward package and the benefits available to them. Plans are in place to introduce total reward statements from 2012 to support this process.

3. Transparency and local accountability

3.1 The reform of organisational structures described in the previous chapter is only one part of the vision for the future NHS. *Equity and excellence: Liberating the NHS* set out a model for the NHS where the outcomes secured by local health services will be much more transparent and understandable by local people. This is part of a fundamental shift in accountability towards local communities, which is at the heart of the reform, creating a revolution in patient power, and enabling informed local discussion and decisions about spending, priorities and improvement. NHS organisations should account clearly for their investment priorities so that the public can understand how money is being spent.

3.2 Early in 2011, we expect to set out a more wide ranging set of proposals on how we intend to support the creation of this revolution in patient power. This NHS Operating Framework sets out some of the mechanisms to support this. Most notably:

- **a new Outcomes Framework for the NHS** – where the focus is on the health improvement achieved;
- **patient experience** – where there needs to be a shift to better collection of and timely action on patient experience and feedback;
- **better information** – where a new information strategy will set out how local commissioners and the people they serve can be better supported in decision making;
- **quality accounts** – which will be extended to cover community services; and
- **local publication** – where there is greater clarity of how expenditure translates into local achievements.

3.3 This transparency and better information will also support choice, allowing patients to make more informed decisions such as where and how they choose to access care. As well as making information more accessible, we shall be extending the range of choices available to patients.

3.4 During this time, *The NHS Constitution for England*[9] remains at the heart of the NHS system. The Government is committed to upholding the NHS Constitution, which codifies NHS principles and values, and the rights and

9 http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_113613

responsibilities of patients and staff. The Government's ambition for shared decision making by patients, their clinicians and carers builds on, and gives better effect to, the principle of involving people in decisions and their care.

A new Outcomes Framework for the NHS

3.5 The first NHS Outcomes Framework will be published in December 2010. From 2012/13, this is the framework that will be used by Secretary of State for Health to hold the NHSCB to account for improving quality and delivering better health outcomes for people using NHS services. The NHS Outcomes Framework for 2012/13 will not set levels of ambition for improvement in 2011/12. These will be negotiated between the Secretary of State and the NHSCB once it is in place. For this coming year, NHS organisations should take heed of the direction of travel towards focussing on outcomes, collecting data and establishing baselines for all indicators wherever possible and, in doing so, identifying how they will improve on quality.

3.6 The NHS Outcomes Framework will consist of a small set of outcome goals or domains, under each of which will sit overarching indicators and a small set of improvement areas. In the future, each domain will be supported by a suite of NICE Quality Standards[10]. These Quality Standards will support the NHS to commission services that will deliver the outcomes set out in the NHS Outcomes Framework by providing authoritative definitions of what high quality care looks like for a particular pathway of care. The NHSCB will use them to inform development of an outcomes framework for GP consortia and associated incentives for high quality commissioning.

3.7 Delivering the priorities set out in this NHS Operating Framework in 2011/12 will put the NHS in the best possible position to deliver better health outcomes and the ambitions that will be set out in the NHS Outcomes Framework for 2012/13 and beyond. There are some areas of priority that will be directly comparable. For instance, the improvements in relation to healthcare associated infection rates sought in 2011/12 will be an improvement area in the NHS Outcomes Framework for 2012/13. Public Health England will work with the NHS through its own outcomes framework to improve health. There are other areas where the requirements in 2011/12, which may be more focused on process or input improvements, will support improvement of outcomes in the future. For instance, progress on the cancer access indicators should support improvements in cancer survival rates.

3.8 The delivery of QIPP improvements will ensure that we have maximised the resources for frontline services so that they are well placed to continue delivering improvements to outcomes.

10 http://www.nice.org.uk/guidance/qualitystandards/qualitystandards.jsp

3.9 The promotion and conduct of research is a core NHS function. Continued research and the use of research evidence in design and delivery of services is key to achieving improvements in outcomes. The NHS Life Sciences Delivery Board affords the NHS the opportunity to work with the life sciences industries and roll out best practice so that it can deliver the financial savings that are being driven by QIPP. For example, the Board's remit to increase access to cost effective innovative medicines and medical technologies will be pivotal to improving quality and realising savings as the NHS evolves into its new structure.

Patient experience and feedback

3.10 Patient experience must be a key arbiter of all NHS services. PCTs and providers should continue to ensure that appropriate systems are in place to capture the views and experiences of patients, service users and carers. This will include use of local and nationally coordinated patient surveys, but also a range of additional approaches or sources that are locally relevant, such as the use of real-time feedback collected at the point of care (eg SMS texting, Patient Experience Trackers, kiosks), use of complaints data and Patient Reported Outcome Measures (PROMS).

3.11 The current PROMs guidance will be revised during 2011 to set out proposals for extending the use, collection and validity of PROMs across the NHS, wherever practicable.

3.12 PCTs and providers should raise awareness of local feedback options available (including, for example, patient ratings or comments on websites such as NHS Choices), encourage feedback, and also demonstrate to the public how their feedback has been used to improve service quality and patient experience through appropriate reporting mechanisms, such as Quality Accounts.

3.13 PCTs should use the intelligence from a range of sources such as those above to understand what matters most to patients in the widest sense (for instance, supporting patients to remain in employment), to ensure patient and staff feedback is acted upon and priorities for local improvement can be identified.

3.14 PCTs and providers, working with their partners, should ensure that patient experience and feedback are inherent parts of service design, delivery and improvement. PCTs should also make arrangements to ensure existing information and insight about local people's needs and preferences is not lost during transition and may be readily picked up and used by emerging GP consortia. PCTs must continue to ensure their statutory obligations under the Duty to Involve is effectively and efficiently discharged during transition to commissioning by GP consortia.

3.15 NHS organisations should consider the Government Buying Standards for food and catering when they are introduced.

Better information

3.16 The information revolution is a key component of the vision set out in *Equity and excellence: Liberating the NHS*. As well as being required to empower patients with more choice, better information and more control over their care, it plays a vital part in enabling effective commissioning for improved quality and productivity of care.

3.17 To support the NHS in planning and achieving this transformation, an Information Strategy will be published in early 2011 that will include more detail about the approach and priorities identified following completion of the public consultation on this topic[11]. Other key reviews, including the fundamental review of data returns and the Quality Information Strategy[12] will inform the Information Strategy.

3.18 In advance of this, a number of issues have already been identified and should be incorporated within plans for 2011/12:

- introduction of PROMS;
- use of real-time patient and service user feedback to improve quality of care;
- consistent use of the NHS number – from 2012/13, use of the NHS number will be linked to contractual payments from commissioners in line with guidance;
- use of digital technology in key areas to support delivery of the QIPP agenda, including:
  - use of telehealth and telecare to help people stay in their own homes;
  - introduction of digital or online services to deliver greater convenience for patients and to free up face-to-face clinical time for those who really need it;
- informatics requirements to support greater integration across local health and social care services; and
- supporting GP consortia in understanding and fulfilling their information needs, including appropriate skills and resourcing requirements.

11 Liberating the NHS – an Information Revolution: a consultation on proposals October 2010
12 National Quality Board Report on Information on the Quality of Services July 2010

Quality accounts

3.19 In 2011/12, NHS providers will need to publish their quality accounts for 2010/11. In doing so they should meet the requirements set out in guidance in relation to:

- the expectations for 2010/11 quality accounts, including likely revisions to regulations and formal guidance; and
- the extension of quality accounts to community services for 2010/11.

3.20 We expect to see providers build on the first year's quality accounts by demonstrating in 2010/11 quality accounts how they:

- perform on the measures that mean most to patients;
- review services and engage with patients, public and governors, in setting priorities for the future; and
- measure performance over time and in comparison with their peers.

Local publication

3.21 Quality accounts play a part in helping local populations understand how NHS services are improving the care that they provide, but they should not exist in isolation. It has not always been apparent to local people how they can understand where a national strategy translates into a local service. With that in mind, for 2011/12 PCTs should publish local plans where appropriate and, specifically, PCTs are required to publish their local plans to deliver both dementia services and services to support carers.

Choice

3.22 The Government is committed to extending the range of choices available to patients. By April 2011, all patients referred for an outpatient appointment should be able to choose a named consultant-led team. The guidance on choice informing providers' obligations under the NHS standard contracts will be amended such that, from April 2011, providers will be required to:

- accept patients who are referred to a named consultant-led team, as long as the referral is clinically appropriate;
- list their services on Choose and Book in a way that allows users to book appointments with named consultant-led teams; and
- publish information about services so that people can use it to make choices about their healthcare, and support people to use this information.

3.23 Following conclusion of the consultation process on choice, further changes to the guidance on choice informing providers' obligations under the NHS standard contracts may follow during 2011 to set out any new obligations with respect to choice as set out in *Equity and excellence: Liberating the NHS*:

- from April 2011, patients should be offered greater choice of treatment and provider in some mental health services;
- during 2011, patients should be offered greater choice in diagnostic testing and post-diagnosis care; and
- during 2011, choice should be introduced in care for long term conditions as part of personalised care planning.

3.24 The commitment to allow patients to choose any healthcare provider for the majority of NHS funded services, as long as the provider can deliver care within the NHS, meeting NHS standards and within the NHS tariff, will be introduced in a phased manner. Guidance on implementation will be published. From April 2011, patients should be able to start to choose any healthcare provider in a range of community services.

3.25 PCTs will need to work with GP practices and other stakeholders to make preparations for introduction of choice of GP practice from April 2012, subject to the policy framework to be published in 2011.

3.26 PCTs should develop and implement plans for shared decision making and information giving and should include these areas in contracts. PCTs should also publish, via *Your Guide* or similar mechanisms, an account of how they have delivered shared decision making and information giving.

Choice in maternity services

3.27 Choice in maternity services is a key Government commitment. Commissioners should use feedback gained from women and their families to ensure that appropriate information is provided for women and their partners so that they can make informed choices about their maternity care from preconception care, through pregnancy and after birth. Providers working in maternity networks are encouraged to use the data items suggested in the maternity and children's dataset to review, inform and plan the provision of care to meet the needs of women. Work will continue to develop the maternity tariff to ensure that money follows a woman's choices.

Personal health budgets

3.28 The Government is committed to expanding the use of personal budgets for service users. As set out in *Equity and excellence: Liberating the NHS*, this includes continuing and developing the personal health budget pilot programme, both extending existing sites and encouraging proposals for additional sites in 2011/12. The learning from the pilot programme will inform wider rollout in 2012. Personal budgets will allow greater integration between health and social care at the level of the individual and give people more choice and control over their care.

4. Service quality

Overall approach

4.1 This is a time of significant change. In 2011/12, we need to create the building blocks of the new architecture for the health and care system and deliver on the first year of the QIPP challenge to realise up to £20 billion in efficiencies for re-investment into services over the next four years.

4.2 The challenge in 2011/12 is to ensure that we effect the necessary changes while maintaining service quality, including the improvements that the NHS has worked hard to deliver to date. Successful transition to the new system will require a tight grip to be maintained on current performance, financial stability and the quality of services.

4.3 As part of this NHS Operating Framework, we have developed a list of key indicators against which PCTs and clusters will be held to account during 2011/12. The list is included as an Annex to this NHS Operating Framework and brings together:

- key performance indicators to support QIPP efficiencies;
- indicators relating to new commitments and reform; and
- clinically relevant indicators from existing measures.

4.4 It is important not to regard these indicators in isolation from each other or from the wider requirements set out in this NHS Operating Framework. For example, QIPP aims to release hospital capacity to allow the better use of community services. The requirement to reduce length of stay needs to be considered in the context of higher day case rates, increased responsibility on acute providers around emergency readmission rates and sufficient care home places. Thus, a PCT could meet its responsibilities to provide post-discharge support by securing additional social care places ensuring that, where clinically appropriate, patients are discharged both quickly and with sufficient capacity to support them outside hospital.

4.5 Through the transparency agenda, the focus is changing with a bigger role for local accountability and quality of services across the board in the NHS, delivering the outcomes that matter to all patients and their carers. At the same time, the Care Quality Commission is empowered to use its judgement to ensure NHS providers are meeting minimum standards and thus assure local people about the safety of their services. In this time of change, the NHS needs to keep a forensic focus on maintaining and improving quality

including patient safety, particularly in relation to older people. Delivery of the priorities in this NHS Operating Framework needs to be achieved alongside the core delivery and safety of services. The work of the National Quality Board will be particularly important to maintain and improve quality during the transition and beyond, as set out in Chapter 1.

Data quality

4.6 The NHS should use the Secondary Uses Service (SUS) as the standard repository for performance, monitoring, reconciliation and payments by April 2012, operating in shadow form from October 2011. During 2011/12, progress on delivery of this will be performance managed and commissioners will be expected to use contract sanctions if they are not satisfied about the completeness and quality of a provider's data.

Quality, innovation, productivity & prevention (QIPP)

4.7 The NHS has been preparing to meet the challenge of driving quality improvements against a much more restricted financial environment since the autumn of 2009. At that stage, it was working on scenarios of either flat real or flat cash funding from 2011/12 onwards, leading to an efficiency challenge of £15-20 billion over three years.

4.8 Three things have changed since those assumptions were made:

i) the Spending Review settlement for the NHS is better than the autumn 2009 assumption, with NHS revenue budgets growing in real terms over the next four years;

ii) the adoption of a pay freeze for most NHS staff for two years, whilst a tough decision, makes a positive impact on the remaining efficiency requirement for the first part of the QIPP period; and

iii) the deeper than originally modelled reductions in management and administration costs, whilst again tough and needing to be realised, make a positive impact on the remaining efficiency requirement.

4.9 Taken together, our assessment is that the prudent response to these welcome improvements is to retain the overall up to £20 billion challenge, but to extend the expected period to the end of 2014/15. This provides further time to produce the longer term change to services described in local QIPP plans, and should ease to some extent the measures required in early phases of local plans. It does not change the need for focus on delivery.

4.10 The single operational plan as set out in Chapter 6 needs to identify how QIPP will be delivered during 2011/12, which will include making the most of

the opportunities presented by the national workstream plans, for instance, the national workstream on long term conditions. This single operational plan should demonstrate how improved quality and outcomes will be delivered within the available resources, how other critical functions will be maintained through the transition and allow for the investment of savings to improve quality and outcomes as demand changes to reflect an ageing and growing population, new technology and ever-higher expectations.

4.11 NHS organisations must continue to ensure that they maximise efficiencies through reducing energy consumption and expenditure in line with guidance.

Reconfiguration

4.12 Changes to services will sometimes be required but must be consistent with the four key tests for service reconfigurations set out by the Secretary of State in May 2010[13]:

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

4.13 PCTs must continue to ensure their statutory duty to consult Overview and Scrutiny Committees about substantial service change is maintained throughout transition. These tests are to support and improve the planning process and reduce the blockages that come from a perceived lack of transparency.

Key new commitments

Health visitors

4.14 PCTs should ensure they develop effective health visiting services, with sufficient capacity to deliver the new service model to be set out in the *Health Visitor Implementation Plan 2011-2015 – A Call to Action*, to deliver the Healthy Child Programme, provide greater support to families and develop local community capacity in support of children and families, working closely with Sure Start Children's Centres and other local services. The Government is committed to developing an expanded and stronger health visiting service as a key element in improving support to children and families at the start of life. This will entail ending the decline in workforce numbers, beginning to increase posts, workforce numbers and training capacity in the short term, and increasing overall numbers of health visitors by 4,200 by April 2015.

13 http://www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Dearcolleagueletters/DH_116442

Family Nurse Partnerships

4.15 The NHS is expected to expand the Family Nurse Partnership programme to improve outcomes for the most vulnerable first time teenage mothers and their children. This licensed programme offers intensive preventive support from early in pregnancy until children are two years old. The Government intends that the current capacity of over 6,000 clients in England at any one time should more than double to a capacity of at least 13,000 by April 2015. PCTs should therefore consider how to maintain existing delivery, alongside planning for an expanded service in appropriate areas.

Cancer Drugs Fund

4.16 As set out in *Equity and excellence: Liberating the NHS,* a new Cancer Drugs Fund will be established. This fund will operate from April 2011 and will help NHS patients get the additional cancer drugs their doctors recommend. £200 million is being provided to the NHS in 2011/12 for this fund and the level of annual funding available will remain constant over the life of the fund. Advice will be provided on the detailed operation of the fund following consultation.

Military and veterans' health

4.17 It is important that SHAs develop and maintain their Armed Forces Networks to ensure the implementation of the Ministry of Defence/NHS Transition Protocol for those who have been injured in the course of their duty, meeting veterans' prosthetic needs and ensuring the implementation of the Murrison Report (*Fighting Fit – A mental health plan for servicemen and veterans*)[14] to improve mental health services for veterans. SHAs must ensure continuity of this work during the NHS transition period. At the same time, there is an expectation that NHS employers should be supportive towards those staff who volunteer for reserve duties.

Services for people with autism

4.18 NHS commissioners and trusts will be required by new guidance, to be issued in December 2010, to take action to assess the needs of people with autism in their areas, then plan and commission services as appropriate to address those needs. This guidance, which is intended to give effect to the Adult Autism Strategy – *Fulfilling and rewarding lives: the strategy for adults with autism in England* [15] will be issued under Section 2 of the Autism Act 2009[16].

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14 http://www.mod.uk/DefenceInternet/AboutDefence/CorporatePublications/PolicyStrategyandPlanning/FightingFitAMentalHealthPlanForServicemenAndVeterans.htm
15 http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_113369
16 http://www.legislation.gov.uk/ukpga/2009/15/contents

Dementia services

4.19 People with dementia and their carers need information to help them understand the range and quality of local services. NHS organisations are expected to make progress on the National Dementia Strategy, including the four priority areas as set out in the implementation plan published in September 2010:

- good quality early diagnosis and intervention for all;
- improved quality of care in general hospitals;
- living well with dementia in care homes; and
- reduced use of antipsychotic medication.

4.20 NHS organisations should also agree with their social care commissioning partners the aspects of the strategy that could be delivered by using section 75 flexibilities.

Support for carers

4.21 NHS organisations should consider *Recognised, valued and supported: next steps for the Carers Strategy*[17] which focuses on four priority areas:

- identifying carers earlier;
- supporting carers to achieve their full education and employment potential;
- personalised support for carers so they can live a full life; and
- supporting carers to remain mentally and physically well.

4.22 It has not always been apparent how funding to support carers has been used in each PCT. The Spending Review has made available additional funding in PCT baselines to support the provision of breaks for carers. PCTs should pool budgets with local authorities to provide carers' breaks, as far as possible, via direct payments or personal health budgets. For 2011/12, PCTs should agree policies, plans and budgets to support carers with local authorities and local carers' organisations, and make them available to local people.

17 http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_122077

Maintaining quality improvements

4.23 To reflect the move to a more outcomes focussed approach, the Revision to the NHS Operating Framework for 2010/11 ended performance management of 18 weeks waiting times and changed the four hour A&E standard. As we move to a transparency and outcomes approach, both of these areas will still be important during 2011/12 but will be approached differently in performance terms.

Referral to treatment times

4.24 Patients' rights to access services within maximum waiting times under the NHS Constitution will continue and commissioners should ensure that performance does not deteriorate and where possible improves during 2011/12. With that in mind, providers should be expected to offer maximum waiting times to patients and there will be monitoring of compliance with this and the 95th percentile of waiting time. The median wait will also continue to be monitored with a view to improvement. The existing cancer waiting times standards support better clinical outcomes and will continue to apply.

Accident and emergency (A&E) services

4.25 Working with the College of Emergency Medicine and the Royal College of Nursing, the National Clinical Director for Urgent and Emergency Care has developed a set of indicators to look at the performance of A&E departments in the round. For 2011/12, the expectation is that there is an improvement in performance across this set of indicators.

4.26 In line with the recommendations made by Professor Sir John Temple in *Time for training*[18] (May 2010) and those of Professor Sir John Collins in *Foundation for Excellence*[19] (November 2010), providers should take opportunities to redesign urgent and emergency care services as increasing numbers of emergency medicine doctors complete their training.

Ambulance services

4.27 Working with ambulance trusts, the National Ambulance Director has developed a set of indicators to provide a broad overview of the clinical quality achieved by ambulance services. For 2011/12, the expectation is that there is an improvement in performance across this set of indicators in ambulance trusts, with all trusts meeting the Category A response time standards.

18 http://www.mee.nhs.uk/PDF/14274%20Bookmark%20Web%20Version.pdf
19 http://www.mee.nhs.uk/pdf/401339_MEE_FoundationExcellence_acc.pdf

Healthcare associated infections (HCAI)

4.28 The NHS has made good progress in reducing MRSA bloodstream and *Clostridium difficile* infections. There is still scope to drive these and other healthcare associated infections (HCAIs) down further. NHS organisations should aim for a zero tolerance approach to all HCAIs and all organisations must identify and adjust plans so that they can operate at the level of the best. NHS providers and commissioners should ensure that their HCAI improvement plans deliver at least the level of performance set by the HCAI indicators.

4.29 Following the extension of mandatory reporting for meticillin sensitive *staphylococcus aureus* (MSSA) and *E. coli* bloodstream infections, organisations must ensure this data is entered in a timely manner. NHS providers and commissioners should set local ambition for these infections by agreeing stretching goals through contracts.

Eliminating mixed sex accommodation (MSA)

4.30 All providers of NHS funded care are expected to eliminate mixed-sex accommodation, except where it is in the overall best interest of the patient, in accordance with the definitions set out in the Professional Letter CNO/2010/3[20].

4.31 From April 2011, all providers of NHS funded care must routinely report breaches of sleeping accommodation, as set out in national guidance, and will attract contract sanctions in respect of each patient affected. Each year, on or by 1 April, all such organisations must declare that they are compliant with the national definition or face financial penalties. PCTs should report to SHAs, on an exception basis, those organisations that have had financial sanctions applied, or those whose compliance status has changed.

4.32 Breaches relating to bathroom / WC accommodation, provision of women-only day areas in mental health units, and “passing through” opposite-sex areas should be monitored and managed through contract performance mechanisms. Where action plan milestones are missed, commissioners may impose financial consequences as set out in the national contract guidance.

20 http://www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Professionalletters/Chiefnursingofficerletters/DH_121848

End of life care

4.33 The NHS should continue to ensure implementation of the *End of Life Care Strategy – promoting high quality care for all adults at the end of life*[21], working to offer patients the choice of where to be cared for as they approach the end of life, and where to die, regardless of their condition. It should ensure that staff are trained for this, including using the e-learning modules available as part of blended learning.

4.34 The QIPP End of Life Care workstream is driving the first two steps on the strategy's end of life care pathway – identifying people as they approach the end of life and planning for their care, including asking about their preferences for care. To make that choice a real option requires implementation of the other strands of the strategy – commissioning the care people want, coordinating care across sectors and training the workforce to provide it. In particular, commissioners need to ensure that adequate 24/7 community services are available in their locality.

Cancer reform

4.35 The NHS will be expected to implement the forthcoming *Improving Outcomes Strategy for Cancer*. Patients should have timely access to diagnosis and treatment and be seen by the right person with the appropriate expertise. In particular:

- commissioners and local providers will need to ensure services are being planned, commissioned and delivered based on the current suite of cancer waiting time standards;
- commissioners and local providers will want to consider the four priority areas for diagnostics for improving earlier diagnosis of cancer and ensure continuity of commissioning and provision is secured in the move to commissioning by the NHSCB and GP consortia:
  - **chest x-ray**: to support diagnosis of lung cancer;
  - **non-obstetric ultrasound**: to support diagnosis of ovarian cancer;
  - **flexi sigmoidoscopy/colonoscopy**: to support the diagnosis of colorectal cancer; and
  - **MRI brain**: to support diagnosis of brain cancer.
- to improve outcomes from radiotherapy treatment for cancer patients, commissioners should develop local plans to ensure that access rates to radiotherapy and the use of advanced radiotherapy techniques, such as Intensity Modulated Radiotherapy are appropriate for their populations;

21 http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_086277

- commissioners should work with their cancer networks on implementation of NICE Improving Outcomes Guidance (IOG). There remain some services that are not yet compliant with some of the IOGs, particularly upper gastro-intestinal, urology, head and neck and haematology; and
- to provide the data needed to assess whether progress is being made on improving survival rates through earlier diagnosis, providers are expected to include staging information in their cancer registration dataset.

Cancer screening

4.36 Screening improves clinical outcomes. Commissioners need to work with their cancer networks to ensure that all screening services are able to:

- continue to take part in the breast screening age extension randomisation project, either screening women aged 47-49 or 71-73, depending on the randomisation protocol;
- ensure that all local centres maintain the two-year screening round for bowel cancer. The extensions begun in 2010/11 should continue and be maintained for 2011/12. Those centres whose end of original round is in 2011/12 should implement extension on completion of the original round. Those whose two-year screening round falls beyond 2011/12 should prepare to expand on completion of the original round; and
- ensure that cervical screening results continue to be received within 14 days. Commissioners should work with their local services and NHS Cancer Screening Programmes to implement HPV testing as triage for women with mild or borderline results, leading to a more patient centred service and major cost savings.

Stroke

4.37 The Stroke Strategy, published in late 2007, is a ten-year programme for implementing high quality stroke care across the care pathway from prevention to long term care and support. Good progress has been made to date including the response to the 2010/11 Accelerating Stroke Improvement programme. There remains scope for improving outcomes by:

- **prevention**: improving diagnosis and treatment of people with atrial fibrillation and ensuring that people who are at high risk of stroke who present with a transient ischaemic attack (TIA) are assessed and treated as emergencies. A best practice tariff is being introduced for out-patient TIA services in April 2011 to support high quality care for this group of patients;
- **acute care**: ensuring all stroke patients are admitted directly to a stroke unit, access timely scanning, and all patients are assessed for thrombolysis, receiving it if clinically indicated;

- **post hospital discharge and longer term care**: for example, developing Early Supported Discharge arrangements and community specialist stroke rehabilitation, with effective reablement support where responsibility rests with the PCT.

Mental health

4.38 The Mental Health Strategy, due to be published in early 2011, will make clear the interdependence of physical and mental health and the need for a balanced approach to investment to achieve improved health outcomes for all age groups. The strategy will encompass the twin objectives of improvement of public mental health and wellbeing, and delivery of high quality patient centred outcomes by health services. Early intervention and prevention should be used further to reduce the likelihood of mental illness developing, including within groups at high risk such as offenders. To support treatment for offenders, NHS organisations should work with local partners to deliver joined up local commissioning of drug services based on the Prison Drug Treatment Strategy Review Group's outcome framework.

4.39 Access to evidence based early intervention services in the community should continue to be available to all young people who need these services. Community teams providing home treatment and acute inpatient services should work together to avoid unnecessary hospital admissions, or unnecessarily long stays, while maintaining high quality care. Subject to the outcome of consultation, we also propose to increase choice and control for many users of mental health services, including introducing *Any Willing Provider* for a range of services.

Increasing access to psychological therapies (IAPT)

4.40 The NHS is expected to continue expanding access to psychological therapy services in 2011/12 as part of the overall commitment to full roll-out of this programme by 2014/15. This will comprise continuing training programmes to develop the workforce and a choice of NICE-approved therapies and delivering the measurable outcomes of patient recovery and improvements in employment.

4.41 In partnership with the NHS, the Department of Health will extend access to talking therapies for children and young people, older people, for people with severe and enduring mental health problems and for people with co-morbid mental and physical health long term conditions.

Safeguarding children

4.42 The findings of the Munro Review of child protection will be completed in April 2011. The response to this review is likely to impact on the way the NHS contributes to safeguarding children. In the meantime and throughout the transition period, the NHS should continue to build on the improvements to date in this area and ensure that statutory duties, as set out in the statutory guidance *Working Together to Safeguard Children*[22], and partnership working arrangements are maintained and handed over to new organisations in good order.

Dentistry

4.43 PCTs should continue to commission improvements in access to NHS dentistry, and seek to improve efficiency through effective management of dental contracts to minimise unnecessary recalls and split courses of treatment. They should work with dentists and other agencies to promote improvements in the oral health of children. As part of the development of a new dental contract, the Department of Health will announce proposals for contract pilots in 2011/12, and seek volunteers to take part. PCTs are encouraged to identify and support potential pilot sites.

Areas for improvement

Healthcare for people with learning disabilities

4.44 The NHS should ensure momentum is maintained in improving care and outcomes for people with learning disabilities, in the light of the *"Six Lives" Progress Report*[23], the Government's response to the 2009 report of the Parliamentary and Health Service Ombudsman and Local Government Ombudsman on health for this group. Using information gathered locally in partnership with people with learning disabilities and their families, PCTs should ensure they are taking action to improve healthcare and health outcomes.

4.45 Findings presented to the Ombudsman suggest particular emphasis should be given to ensuring staff are trained to make reasonable adjustments, communicate effectively and follow the *Mental Capacity Act (2005) Code of Practice*[24] in all their interactions with patients with learning disabilities to ensure full compliance with the law in respect of capacity, consent and best interest decision making. Annual health checks for people with learning disabilities remain an important means of ensuring improved access to health services.

22 http://publications.education.gov.uk/eOrderingDownload/00305-2010DOM-EN.pdf
23 http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_120251
24 http://www.publicguardian.gov.uk/mca/code-of-practice.htm

Children and young people's physical and mental health

4.46 Both the report by Sir Ian Kennedy[25], commissioned by Sir David Nicholson, and *Achieving Equity and Excellence for Children*[26], which sets out how the NHS White Paper relates to children and young people, highlight the need for the NHS to pay greater attention to the needs of children, young people and families in commissioning and delivering services. NHS organisations should consider the issues they raise, particularly in the management of transition throughout 2011/12 and, as identified, pay particular attention to groups with specific needs including disabled children, palliative care, and child and adolescent mental health services (CAMHS), children in care and families with multiple problems.

Diabetes

4.47 All people with diabetes should be offered screening for early detection and, if needed, treatment of retinopathy. NHS commissioners and providers must do more to ensure insulin pumps are available for those people with diabetes that meet the criteria recommended by NICE.

4.48 PCTs should be commissioning the relevant structured patient education to support people newly diagnosed with diabetes and at appropriate points in their life as their condition progresses.

4.49 NHS providers should consider the overall management of inpatients with diabetes in order to reduce their length of stay, improve their experience of care, ensure that they do not develop diabetic foot complications whilst in hospital and that their blood glucose is managed safely. This is particularly relevant to the safe administration of insulin by healthcare professionals.

Sharing non-confidential information to tackle violence

4.50 All acute trusts should share non-confidential information with Community Safety Partnerships in order to support reductions in the number of violence-related attendances in A&E departments.

Violence against women and girls

4.51 In November 2010 the Department published *Improving services for women and child victims of violence: the Department of Health Action Plan*[27]. Women and children who are victims of violence or abuse use all NHS services; in particular primary care, maternity care, genito-urinary medicine (GUM) and mental health services. NHS organisations should ensure that they properly identify these patients and have suitable care pathways in place to ensure that they get the sensitive, ongoing care they need.

25 http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_119445
26 http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_119449
27 http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_122003

Regional trauma networks

4.52 All regions should be moving trauma service provision into regional trauma network configurations in 2010/11. Tariff changes will be introduced from April 2011 that are designed to recompense for the complexity of multiple-injury patients. Designated Major Trauma Centres should be planning the continuous provision of consultant led trauma teams, immediate CT scan options, and access to interventional radiology services for haemorrhage.

Respiratory disease

4.53 The 2010 public consultation on a Strategy for Services for Chronic Obstructive Pulmonary Disease (COPD) in England revealed strong consensus support for the 24 recommendations and PCTs are asked to continue the task of delivery. Diagnosis of COPD is a particular problem with individuals often presenting late with disabling disease. If these patients were identified and managed effectively, the burden of those who progress to severe or very severe disease would be significantly reduced for the NHS as well as for patients and their carers.

Maintaining quality in public health

4.54 *Healthy lives, healthy people: Our strategy for public health in England*[28] sets out a mission to create a new public health service with strong local and national leadership. This will include creating a new, dedicated public health service – Public Health England – as part of the Department of Health. Subject to Parliamentary approval, Public Health England will take on full responsibilities from 2012, including the formal transfer of functions and powers from the Health Protection Agency (HPA) and the National Treatment Agency for Substance Abuse (HTA).

4.55 Directors of Public Health will be responsible for key public health functions, using their position as part of local authorities to tackle the wider determinants of health. Local authorities will have shadow allocations from 2012/13, in anticipation of receiving full allocations from 2013/14.

4.56 The NHS will continue to have a crucial role in public health. Preventing ill health, supporting people with long term conditions, improving access to care for the whole population, reducing inequalities and tackling health emergencies are all key functions of the NHS. NHS commissioners should be working with local authorities on ensuring the healthy living programme is in place. This will involve creating an identifiable health improvement budget, working closely with local authorities and health and wellbeing boards.

28 http://www.dh.gov.uk/en/Publichealth/Healthyliveshealthypeople/index.htm

4.57 In 2011/12, the NHS must continue to lead on improvements to public health, ensuring that public health services are in the strongest possible position when responsibilities are devolved to local authorities. That will involve realising the ambitions of the Big Society though greater involvement of social enterprises in the commissioning of services.

4.58 NHS organisations must continue to maintain performance whilst also managing the transition towards the new commissioning and governance arrangements of the NHSCB and GP consortia and local authority health and wellbeing boards. This is vital in relation to the prevention component of the QIPP challenge.

4.59 NHS organisations will continue to be held to account against the existing public health indicators.

Pharmacy

4.60 It is important that NHS organisations continue to maintain and develop pharmaceutical services, including local enhanced services to meet pharmaceutical needs. Optimising the use of medicines in people with newly diagnosed long term conditions, and targeting of Medicines Use Reviews are areas that SHAs and PCTs should actively engage in. In addition, evidence continues to build for the provision of public health services through community pharmacies, as highlighted in *Healthy Lives, Healthy People: Our strategy for public health in England.*

Emergency preparedness

4.61 Emergency preparedness and resilience across the NHS continues to be a high priority. All NHS organisations, other contracted healthcare providers, local authorities and other local organisations should maintain and test plans and arrangements to deliver an effective response to threats and hazards, including Chemical, Biological, Radioactive and Nuclear (CBRN), conventional terrorism, fuel and supplies disruption, flooding and public health incidents and any impact from climate change. They should have robust and tested command and control systems, as well as meeting their local obligations under the Civil Contingencies Act 2004. PCTs must also ensure that they maintain the current capability and capacity of the existing 12 Hazardous Area Response Teams (HARTs) in Ambulance Trusts now that funding for HARTs is in their allocations.

4.62 It is essential that all NHS organisations have well developed plans in place to manage exceptional surges in activity. Experience from swine flu demonstrated the benefits of robust planning and leadership for NHS resilience more widely and these lessons should be fully embedded in local

plans. In particular, all NHS organisations will need to ensure that they have the necessary plans in place to maintain service provision and meet any additional demands arising from events associated with the Olympic and Paralympic Games in 2012.

4.63 Pandemic influenza remains a serious threat and NHS organisations will wish to ensure that the ability to operationalise and coordinate their pandemic response plans across local areas is maintained and continues to be tested with their local partners. All local plans should be able to deal with a range of potential levels of pressure, from the relatively mild, such as swine flu, through to much more severe pandemics.

Physical activity

4.64 PCTs should engage with local authorities and other partners to support and embed community physical activity initiatives for all ages alongside activity in schools in preparation for the 2012 Games. Implementing the *Let's Get Moving* physical activity pathway will enable GPs and other healthcare practitioners to identify adults who do not currently meet recommended activity levels and support them in being more active. Directors of Public Health, working with local authorities, are encouraged to promote activities that improve the health of all sections of the populations they serve, such as schemes to promote physical activity, building on and complementing 5-A-DAY activity and the *Change4Life* campaign.

NHS Health Check programme

4.65 Whilst improvements continue to be made in managing people with heart disease, stroke, diabetes and kidney disease, the NHS Health Check programme works to prevent these diseases, or spot them earlier, and will significantly contribute to the NHS achieving better outcomes. Most PCTs now have a programme in place and are looking at ways to ensure that it positively contributes to reducing health inequalities. PCTs are asked to continue to progress the implementation of their programmes and ensure that, when doing so, they look at ways to reduce health inequalities from vascular disease. During 2011/12, the results of pilots of health checks for carers will be published, PCTs should consider the findings of this work in the development of NHS health check.

Abdominal aortic aneurysm screening

4.66 Phased implementation of the NHS Abdominal Aortic Aneurysm national screening programme is in progress, with complete coverage planned by the end of 2012/13. PCTs are expected to:

- continue screening for programmes that are currently operational;
- implement screening as planned for the 2011/12 phases; and
- develop a robust implementation plan for 2012/13, ensuring surgery providers fulfil the requirements for implementation of screening.

Fragility fractures in the elderly, especially in women

4.67 The introduction of the best practice tariff for hip fracture in 2010 has proved successful in transforming the care on admission of those who suffer fragility fractures each year. PCTs are also asked to take steps to reduce incidence. The best way to prevent this transformative injury is to recognise precursor or "herald" fractures and give patients a bone health assessment and treatment when they first show clear signs of being at risk.

5. Finance and business rules

Surplus strategy 2011/12 onwards

5.1 During 2010/11, the PCT/SHA sector has continued to deploy the revenue surplus, which has built up over the last few years, while maintaining a strong financial position.

5.2 As we move forward into a period of significant change, the emphasis of the NHS financial strategy will be to ensure that PCTs and SHAs are in the best possible position to implement the objectives of *Equity and excellence: Liberating the NHS*. This will mean that PCTs and SHAs should continue to maintain a strong financial position underpinned by demonstrable financial flexibility.

5.3 In line with current policy, the aggregate surplus delivered in 2010/11 by SHAs and PCTs will be carried forward to 2011/12 and continue to be available to those organisations. In 2011/12, the expected drawdown of surplus will be up to £150 million with the additional expectation that this drawdown will come from the PCT sector surplus. SHAs will determine and agree with the Department of Health the level of aggregate PCT/SHA sector surplus for their area to be delivered in 2011/12 and how that agreed surplus is distributed between their PCTs and themselves.

5.4 The Department continues to require that no PCT will plan for an operating deficit in 2011/12. NHS trust operating deficits will only be accepted where this is part of a planned recovery path agreed with the relevant SHA and the Department.

5.5 In the 2010/11 NHS Operating Framework we introduced the requirement for SHAs to ensure that there was at least 2 per cent non-recurrent expenditure from PCT recurrent resources at a regional level to mitigate financial risk. We shall build on this in 2011/12 and require every PCT to ensure that 2 per cent of their recurrent funding is only ever committed non-recurrently. PCTs will have the discretion to increase this percentage.

5.6 To reinforce financial control in 2011/12, this 2 per cent of recurrent resource will be held by SHAs, with PCTs being required to submit business cases to access the funding that demonstrate the non-recurrent nature of the expenditure proposed. The business case will need to be supported by the SHA Directors of Finance group.

5.7 Any surplus drawn down by a PCT cannot count against the 2 per cent of its resources held by the SHA.

5.8 Building upon and maintaining the non-recurrent expenditure is crucial for both managing the transition and maintaining the financial health of the NHS.

5.9 The utilisation of the 2 per cent of recurrent resources must retain the characteristic of being recurrently uncommitted, ie the related expenditure is a "one-off" or can be stopped in year. Further detail about what should be classified as non-recurrent expenditure will be laid out in the financial planning guidance.

5.10 GP consortia will have their own budgets from 2013/14. They will not be responsible for resolving PCT legacy debt that arose prior to 2011/12. PCTs and clusters must ensure that through planning in 2011/12 and 2012/13, all existing legacy issues are dealt with. During this period we expect developing GP consortia to work closely with PCTs to ensure that financial control and balance is maintained to prevent PCT deficits in those years. This will reduce the risk for GP consortia that they could have responsibility for any post 2010/11 PCT deficit unresolved at the point of PCT abolition.

5.11 It is important that the strong financial position that the NHS has built up over the last few years is maintained, particularly during the period of transition. A key factor in achieving this will be the need to maintain financial control. As such, the Department will require SHAs and PCT clusters to have an increased focus on maintaining strong financial control and good governance during transition.

PCT allocations

5.12 PCTs' recurrent allocations for 2011/12 are published alongside this NHS Operating Framework. In headline terms, average growth in recurrent allocations for PCTs is 2.2 per cent. Minimum growth is 2.0 per cent. 2011/12 PCT recurrent allocations now include funding of £150 million for reablement. Separate allocations to PCTs, outside recurrent allocations, are also published for support for social care, primary dental services, general ophthalmic services and the pharmaceutical services global sum. Total PCT allocations increase by £2.6 billion, ie 3.0 per cent with a minimum increase of 2.5 per cent and a maximum increase of 4.9 per cent. PCT recurrent allocations are based on a revised weighted capitation formula, details of which are also being published.

Running costs

5.13 2010/11 will be the last year for reporting PCT and SHA management costs. In order to prepare for the new system, from 2011/12, PCTs and SHAs will be required to report their running costs. The precise definition for running costs will be included within the financial planning guidance, but in broad terms, the definition will include any cost incurred that is not a direct payment for the provision of healthcare or healthcare related services.

5.14 By 2014/15 the overall running costs of the new NHS superstructure, compared to the running costs of the current NHS superstructure, will decrease by one third. This decrease includes the over 45 per cent reduction in management costs detailed in *Equity and excellence: Liberating the NHS*, in relation to SHA and PCT non provider management costs. The detailed trajectory for releasing the running cost savings will be included within the financial planning guidance.

5.15 In addition, the financial planning guidance will allocate this running costs reduction by region and it will be for SHAs to determine how the target reduction is managed across the region. SHAs should ensure that plans are not limited to simply achieving the target and should aim to go further to ensure all possible efficiencies are realised.

5.16 *The Revision to the Operating Framework for the NHS in England 2010/11* said that we would set out how resources will be released from the infrastructure and running costs of SHAs and PCTs in order to provide a running cost allowance for GP consortia. The expectation is that GP consortia will have an allowance for running costs that could be in the range of £25 to £35 per head of population by 2014/15. We will not determine the exact amount until further work has been undertaken with pathfinders. This work will explore the optimal balance between ensuring sufficient investment in organisational sustainability with maximising resources for front line services. Before this, during their development phase, the running costs will be locally agreed within the running cost envelope for each region.

5.17 In 2011/12, in line with NHS foundation trust reporting, NHS trusts will no longer be required to report on management costs.

QIPP reporting and monitoring

5.18 Moving into 2011/12 and beyond, the Department will monitor performance against QIPP requirements through the single process set out in Chapter 6. This will aid consistency and accuracy, and intends to simplify how reporting on QIPP is progressing at a local, regional and national level.

5.19 Monitoring of efficiencies will focus on several key areas, including those savings which are driven by changes in demand, and those which are cash releasing. Monitoring will also assess the re-investment of these savings.

5.20 Details on the regularity and format of monitoring will be included in the planning guidance.

Capital

5.21 Capital allocations to cover trusts' capital resource limit (CRL) and external financing limits (EFLs) will be based on capital expenditure plans agreed by SHAs, subject to national affordability. The primary source of capital funding will continue to be internally generated cash with additional finance provided through interest bearing loans. As with previous years, any unspent capital allocation in 2010/11 will not be carried forward. There is no expectation that a central capital budget programme for allocation to the NHS will exist in 2011/12. All NHS capital requirements will therefore be handled as part of the planning process.

5.22 In 2011/12, there will be no automatic capital allocation for PCTs, with necessary capital funding for PCTs being granted on a case-by-case basis. Capital funding for community services will follow the regime for NHS trusts, where new community trusts have been created, or the regime applicable for the organisation they transfer into. There are no changes planned in 2011/12 to the capital regimes currently operating in the NHS trust or foundation trust sectors.

5.23 The Spending Review has set a reduced capital envelope for health and social care. Maintenance and essential smaller improvement schemes should not be affected by this reduction and trusts should take account of the effects of investment on ongoing expenditure, with greater scrutiny of economic returns in business cases. The NHS has pledged to provide a clean and safe environment that is fit for purpose, based on national best practice. Therefore, NHS trusts must prioritise urgent backlog maintenance work to deliver this duty. Provision of additional single en-suite rooms needs to be included in considering capital investment to eliminate mixed sex accommodation (MSA), improve patient's privacy and dignity and provide increased isolation facilities for infection control.

Social care

5.24 In 2011/12 PCTs will receive allocations totalling £648 million to support social care. Indicative allocations, totalling £622 million, will also be set out for 2012/13[29]. This is in addition to the funding for reablement services that is incorporated within recurrent PCT allocations of £150 million in 2011/12 rising to £300 million from 2012/13.

29 These allocations are based on the adult social care relative needs formulae, in order to reflect social care need.

5.25 PCTs will need to transfer this funding to local authorities to invest in social care services to benefit health, and to improve overall health gain. Transfers will need to be made via an agreement under Section 256 of the 2006 NHS Act.

5.26 PCTs will need to work together with local authorities to agree jointly on appropriate areas for social care investment, and the outcomes expected from this investment. This could include current services such as telecare, community directed prevention (including falls prevention), community equipment and adaptations, and crisis response services. The Department would expect these decisions to take into account the Joint Strategic Needs Assessment for their local population, and the existing commissioning plans for both health and social care. PCTs should work with local authorities to achieve these outcomes in a transparent and efficient manner, with local authorities keeping PCTs informed of progress using appropriate local mechanisms.

Financial planning guidance

5.27 As part of the single planning process set out in Chapter 6, financial planning guidance will be issued in January 2011 and will include the detailed rules underpinning the financial strategy and the financial plans required for 2011/12.

Tariff

5.28 *The Revision to the Operating Framework for the NHS in England 2010/11* and *Equity and excellence: Liberating the NHS* set out priorities for the development of the payment system. The design and structure of the national tariff for 2011/12 signals the start of a series of changes to be made over the coming years, and has been informed by a number of key priorities:

- Quality and outcomes
- Efficiency and value for money
- Integration and patient responsiveness
- Expanding the scope of the tariff

5.29 The coverage of best practice tariffs, first introduced in 2010/11, will be expanded to cover a number of new service areas, and it is anticipated that this expansion will accelerate in 2012/13 and beyond. Best practice tariffs are designed not only to promote better patient outcomes and experience, but also to deliver gains in productivity and efficiency.

5.30 To drive efficiency further in the tariff we are changing the way in which long stays in hospital are funded by introducing a five-day trim point floor, so that relatively short stays do not attract a long stay payment. In addition, we have set all tariffs 1 per cent below the average as an initial step in pricing policy to set tariffs below the national average level. The change to the calculation of trim points, setting tariffs below the average, and the expansion of best practice tariffs, mean that a 2 per cent efficiency requirement has been "embedded" into the tariff. This has been taken into account when determining the efficiency deflator set out in the pay and prices tariff adjustment.

5.31 The national efficiency requirement in 2011/12 is 4 per cent and the uplift for pay and price inflation is assessed at 2.5 per cent. Consequently, the prices for services outside the scope of the national tariffs should reflect a reduction of 1.5 per cent compared with those of 2010/11 before negotiated and agreed developments. Tariff prices for 2011/12 also reflect the 4 per cent efficiency requirement: 2 per cent is embedded in tariff design with the remaining 2 per cent offsetting the pay and prices uplift resulting in a final tariff adjustment of 0.5 per cent.

5.32 Taking both the 2 per cent efficiency requirement embedded in the tariff design and the 2 per cent general efficiency deflator, off-setting pay and prices uplifts, results in an overall tariff reduction between 2010/11 and 2011/12 of 1.5 per cent. This 1.5 per cent reduction will apply to non-tariff services and is consistent with the current NHS Operating Framework statement that over the next three years tariff adjustments will not be better than 0 per cent.

5.33 In 2011/12 hospitals will not be reimbursed for emergency readmissions within 30 days of discharge following an elective admission, and all other readmissions within 30 days of discharge will be subject to locally agreed thresholds, set to deliver a 25% reduction, where possible. This is to ensure that, wherever possible, hospitals have good discharge arrangements in place to avoid readmissions. PCTs should work with providers, GPs and local authorities to manage the savings arising from non-payment of emergency readmissions to fund reablement and post discharge support.

5.34 Detailed operational guidance on the implementation of this new approach will be contained in PbR Guidance for 2011/12, which will also specify the services that are excluded from this policy.

5.35 PCTs have received £70 million additional funding in 2010/11 to support people for 30 days following discharge from hospital. PCTs were required to develop local plans in conjunction with GPs and local authorities to develop seamless care for patients on discharge from hospital and to prevent

readmission to hospital. PCTs should use these plans as a basis for coordinating activity on post-discharge support from 2011/12 onwards, keeping plans and outcomes under review in conjunction with GPs and local authorities. PCTs will need to work closely with their local authority partners to develop local reablement capacity. The NHS will have £150 million available for reablement in 2011/12 and £300 million each year from 2012/13 to 2015 incorporated within their recurrent allocations in addition to those savings as a result of the change to the readmissions payment policy.

5.36 During 2011/12, the Department will work with early implementers to identify appropriate increases to tariffs that will take effect from 2012/13 to reimburse providers for the cost of reablement and post-discharge support for 30 days following discharge from hospital.

5.37 While there will be limited expansion in the scope of the mandatory tariff in 2011/12, we are making some changes, including the introduction of a number of new outpatient attendance tariffs. We intend to expand the scope more substantially in future years, and as a move in this direction in 2011/12 we shall:

- bring adult renal dialysis into the scope of PbR by mandating a transition path to national prices;
- mandate currencies (but not prices) for contracting for adult and neonatal critical care;
- seek to amend the scope of ambulance service reference cost data collection to underpin currencies for use in 2012/13;
- introduce currencies for smoking cessation;
- mandate a national currency for cystic fibrosis services, which reflects the care that patients receive over the course of a year;
- develop a local currency for podiatry services, based on a simple treatment episode or package of care;
- mandate the allocation of service users to mental health care clusters.

5.38 The development of new currencies and tariffs should be led locally by the NHS, not centrally by the Department. To support this objective, the PbR Development Sites programme will continue throughout 2011/12, harnessing the ideas and expertise of NHS organisations.

5.39 The development and implementation of new currencies and tariffs should support the integration of services where this is appropriate and is in the best interests of patients. Flexibilities will continue to be made available to permit changes to the tariff where there have been changes in service provision.

5.40 Following the review of specialised service top-ups which was signalled in the 2010/11 NHS Operating Framework, changes are being made to the scope and level of top-up payments. Specialist children's and orthopaedic services will continue to attract a top-up, albeit at a lower rate, and two specialist services will become eligible for top-ups in 2011/12; spinal and neurosciences. We have reviewed, and where appropriate amended, the lists of providers that are eligible to receive top-up payments.

5.41 In 2010/11 we postponed plans to move to Healthcare Resource Group version 4 (HRG4) as the payment currency for A&E services. This change will go ahead in 2011/12.

5.42 The 30 per cent marginal tariff rate for emergency admissions, above a contractual baseline, introduced in 2010/11, will continue in 2011/12, as an incentive for providers and commissioners to work together to minimise the number of avoidable emergency admissions to hospital. This policy will again operate on the basis of 2008/09 being the baseline year.

5.43 The flexibilities set out in the 2010/11 NHS Operating Framework will remain largely in place for 2011/12. One new flexibility being introduced in 2011/12 is the opportunity for providers to offer services to commissioners at less than the published mandatory tariff price, where both commissioner and provider agree. Commissioners will want to be sure that there is no detrimental impact on quality, choice or competition as a result of any such agreement.

CQUIN framework

5.44 In 2011/12 we shall extend the CQUIN framework to the new NHS standard contract for care homes. For all standard contracts, the amount that providers can earn will be 1.5 per cent on top of Actual Outturn Value. CQUIN goals should reflect local priorities and those within this NHS Operating Framework, without duplicating specific minimum expectations of providers set out in contract performance and quality requirements. Beyond the first year of a CQUIN scheme, all goals must require the delivery of stretching quality improvements. Transaction costs should be minimised.

5.45 The existing national CQUIN goals on VTE risk assessment and on responsiveness to personal needs of patients must again be included in acute CQUIN schemes with some adjustment to the timings of measurement for 2011/12 and, unless commissioners decide there is negligible room for improvement, they must again be linked to around one fifth of the value of schemes. Commissioners must share agreed schemes on the NHS Institute website.

Extended list of never events

5.46 Care that falls seriously short of basic standards is not acceptable in the NHS. The NHS standard contract extends the list of incidents defined as “never events” – serious, largely preventable patient safety incidents that should not occur if healthcare providers have implemented available, preventative measures. If a provider delivers care that involves a “never event”, then the commissioner of that care will be able to recover the costs associated with that care.

SHA bundle

5.47 The proposed value of the bundle of central initiative budgets devolved to SHAs for local management is £6,243 million, compared with the value of the bundle issued in 2010/11 of £6,246 million. Within this, a limited number of budget amendments have been made, and the funding for a small number of policy programmes has reduced, mostly as planned, whilst others have increased. The most significant of these is the additional funding for prison drug treatment services that reflects a transfer of responsibility from the Ministry of Justice to the NHS.

5.48 Discussions are continuing between the SHAs and the Department to determine the final detail of the bundle, including the impact on the regional running cost limits that will be set out in the Financial Planning Guidance or 2011/12.

5.49 This will be the last year for the SHA bundle. During 2011/12, DH will work with the shadow NHS Commissioning Board and SHAs to agree how the activities currently funded from the bundle will be managed from 2012/13 onwards.

6. Accountability

6.1 In the future, the NHS Commissioning Board will be held to account by the Secretary of State for the outcomes that it delivers. In 2011/12, the accountability arrangements for the NHS need to be strong enough to give the system, at every level, the information to help secure and monitor quality and value for money improvements and to provide assurance that organisations are on track to deliver QIPP and the preparatory steps for the new system.

6.2 Planning arrangements for 2011/12 are about maintaining grip on current performance levels while delivering quality and productivity improvements that will in turn release further funding to frontline services. This is a transition year prior to the NHSCB being fully functional from April 2012 and the expectation is that the NHS will be in a healthy position throughout transition in terms of service quality and financial stability.

6.3 The priorities set out in this NHS Operating Framework need to be planned for in the context of the system levers:

- the NHS Constitution, which secures patient and staff rights;
- the contract, which needs to be the pre-eminent means of doing business between commissioners and providers;
- the Care Quality Commission, who provide regulatory assurance that essential levels of safety and quality are being met; and
- Monitor's Compliance Framework, which ensures that NHS FTs are meeting their terms of authorisation, including delivery against the national priorities set out in this NHS Operating Framework.

6.4 Until responsibilities are formally handed over to new organisations, PCTs, clusters and SHAs and, through them, providers will be held to account for delivering the service, quality and financial requirements set out in this document. Under-performance will trigger proportional action that may include intervention from the centre.

Planning arrangements

6.5 For the NHS accountability arrangements in 2011/12, there should be one integrated plan that brings together all of the key requirements across the areas of quality, resources and reform. Plans will be geographically based, covering a balanced range of measures, rather than functionally based.

6.6 Those plans will evolve from the regional visions and subsequent QIPP plans and set long term expectations over the Spending Review period and the short term delivery commitments and milestones that will track progress towards them. They will need to describe the overall improvements as envisaged over the next four years in terms of quality, productivity, management of resources and the capacity building for the new system.

6.7 The expectation is that each locality will have a clear strategic vision for improvements in quality and productivity, and plans for transition to the new system. Organisations should ensure that their plans support the delivery of the priorities in this NHS Operating Framework.

6.8 In order to meet the quality and productivity challenge and to reform the system, planning needs to focus on the long term agenda. As the plans will outlive the lifespan of SHAs and PCTs, existing and emerging GP consortia should be involved as fully as possible in shaping the development of their PCT's plan. Emerging clusters should also be involved in the planning process.

6.9 PCTs need to ensure their operational plans support wider local arrangements particularly in terms of shared agreements with local authorities and voluntary organisations, and that they take into account the need for consistency with the Joint Strategic Needs Assessment. PCT plans also need to be consistent with the contracts agreed with local providers.

Performance monitoring and assessment

6.10 The annex to this NHS Operating Framework sets out the indicators and milestones to be used for planning and to assess how SHAs and PCTs are delivering on those plans during the year of transition. The indicators and milestones are grouped under three domains:

- **quality**, covering safety, effectiveness and experience;
- **resources**, covering finance, workforce, capacity and activity; and
- **reform**, covering commissioning, provision, partnership building, putting patients first and development of the new public health infrastructure.

6.11 The annex sets out the indicators for central monitoring and within them a small set that will be used actively to judge organisational and system health. There will be further, more detailed technical guidance issued on the definitions underpinning each measure.

6.12 In addition to these indicators, the expectation is that to support the principles of transparency for quality improvement, and the move to an outcomes approach, local analysis, publication and benchmarking should take place where possible for all available performance measures, including:

- existing public health and social care indicators;
- all requirements for publication on NHS Choices;
- local measures for assessing progress on QIPP schemes; and
- measures from the NHS Outcomes Framework when that is published (this will increasingly be the central pillar of NHSCB accountability in the future).

6.13 Organisations should also be aware of and acting upon other national and locally relevant intelligence, such as the CQC's quality and risk profiles.

6.14 This approach requires focus from NHS organisations and the Department of Health in order to streamline data requirements. The Department has initiated a fundamental review of data returns with the aim of culling returns of limited value.

6.15 The Department of Health's External Gateway function[30] serves to ensure all national communications to NHS and social care audiences from the Department are fit for purpose in terms of content and policy governance. This includes compliance with the NHS Operating Framework as well as other key aspects such as ensuring financial affordability and meeting our obligations in terms of better regulation and promoting equality and inclusion. All communications requiring the attention of NHS management during 2011/12 will include a Gateway reference number.

System requirements

6.16 By the end of March 2011, the Department of Health will review the regional plans with each SHA. In doing so, the Department shall apply key assurance tests to the plans to ensure that they:

- represent a long term vision with quality improvement and value for money at their heart;
- are based on robust demand and activity assumptions that support delivery of QIPP over four years;
- provide assurances on the delivery of national priorities, including transition, and reconcile these across all areas of the plan;

30 www.dh.gov.uk/dhexternalgateway

- provide assurances that they are robust in the light of changes to organisational arrangements and have the support of emerging consortia and clusters;
- are consistent with contracts agreed locally with providers; and
- are integrated with shared priorities with local authorities for health, public health, social care and children's services.

Timetable

6.17 We shall collect SHA plans for 2011/12 in two stages. A first, initial draft will be due on 28 January 2011 covering the full scope of the plan and a second and final draft will be due on 25 March 2011.

6.18 A transition assurance process will take place in each region from March to June 2011 where each SHA will be visited by the NHS leadership team to provide assurance on its agenda for quality, productivity and reform.

Annex

Integrated performance measures for national oversight

	Headline measures	Supporting measures
Quality (Safety, Effectiveness & Patient Experience)	• HCAI measure (MRSA & CDI) • Patient experience survey[2] • Referral to Treatment waits (95th percentile measures) • MSA breaches • A&E Quality Indicators (5 measures)[1] • Ambulance quality (Cat A response times) • Cancer 2 week, 62 day waits (2 aggregate measures) • Emergency Readmissions	• MRSA – delivery of objective • VTE Risk assessment • Ambulance quality indicators (all other measures)[1] • Cancer waits (all 9 measures) • Community services • Access to NHS dentistry • PROMS scores • Mental health measures (EI, CR/HT, CPA, IAPT) • Smoking Quitters • Breast screening • Cervical screening test results • Referral to Treatment waits (median wait measures) • People with Long Term Conditions feeling independent and in control of their condition • Emergency admissions for Long Term Conditions • CDI – delivery of objective • % deaths at home (inc care homes) • A&E quality indicators (all other measures) • Stroke indicator • Carers breaks • Staff engagement[2] • Maternity 12 weeks • Low value procedures • Breastfeeding at 6-8 weeks • Bowel screening • Diabetic retinopathy screening • Coverage of NHS Health Checks • Safeguarding
Resources (Finance, Capacity & Activity)	• Financial forecast outturn & performance against plan • Financial performance score for NHS Trusts[3] • Delivery of running cost targets • Progress on delivery of QIPP savings • Acute Bed Capacity • Non elective FFCEs • Numbers waiting on an incomplete Referral to Treatment pathway • Health visitor numbers • Workforce productivity	• Total pay costs • Year to date financial position • Delivery of 2% recurrent headroom • Underlying financial position of PCTs and NHS Trusts • Daycase rate • GP written referrals to hospital • First outpatient attendances following GP referral • Elective FFCEs • Ambulance Urgent & Emergency Journeys • Staff absences • Clinical staff numbers • Redundancy numbers • Total workforce (WTEs) • NHS Trusts Breakeven duty • PCT legacy debt position • Length of stay (Acute and MH) • Delayed Transfers of Care (Acute & MH) • Other referrals for a first outpatient appointment • All first outpatient attendances • A&E attendances • Community activity • Temporary staffing costs • Management numbers
Reform (Commissioner, Provider & building capability and partnership)	• FT pipeline • Transforming Community Services (TCS) successfully achieved • GP Consortia progress and transfer of relevant functions NHS CB/LAs • Establishment of PCT clusters • Choice • Information to Patients • Competition	**Provider development:** % of orgs progressing along pipeline to milestones agreed between SHA, trust and DH % of organisations behind expected position along the FT pipeline by over 3 months. % of organisations behind expected position along the FT pipeline by over 3 months that are in the unsustainable providers categorisation Uptake of community services Right to Request scheme and forecast uptake in Right to Provide % (value) of community and mental health services by PCT subject to Any Willing Provider **TCS:** Extent of completion of TCS programme – separation and divestment of provider services **GP Consortia:** % of GPs (a) in pathfinder consortia and (b) in pipeline to become pathfinders % of PCT commissioning spend delegated to GP practices Running costs per head of pop. delegated from PCTs to consortia for start up costs **NHS CB:** Has SHA completed full analysis of current levels of staffing and arrangements for those region-wide (SHA and PCT) functions, which will transfer to the NHS CB? **Choice:** Bookings to services where named consultant led team was available (even if not selected Proportion of GP referrals to first OP appointments booked using Choose and Book Trend in value/volume of patients being treated at non-NHS hospitals. **Information:** % of patients with greater control of their care records **Capacity & Capability:** Secure leadership capacity in critical posts in PCTs, clusters and SHAs

1 Suites of measures – a drop in performance on a single indicator may not trigger intervention as long as there has been no worsening in performance of the suite overall.
2 Monitored through local data collections as well as national annual survey 3 The finance domain score for NHS Trusts in the NHS Performance Framework.

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To:
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Local Authority Chief Executives
Directors of Adult Social Services

Copy:
Primary Care Trust Directors of Finance
Strategic Health Authority Directors of Finance
Strategic Health Authority Directors of Performance
Deputy Regional Directors
Local Government Association
Association of Directors of Adult Social Services
NHS Confederation

Gateway Number: 15434

13 January 2011

Dear colleagues,

NHS SUPPORT FOR SOCIAL CARE: 2010/11 – 2012/13

We are writing in the light of recent announcements, including those made at the Spending Review and highlighted in A Vision for Adult Social Care[1], about NHS support for social care. PCTs and local authorities have been informed about the separate elements of this support, but this letter sets out for clarity how the different funding streams relate to each other, and the expectations placed on Primary Care Trusts and local authorities in spending these resources.

Support for social care in this financial year

Post-discharge services and re-ablement

On 5 October 2010, the Department announced that an additional £70m would be allocated to PCTs for spending in 2010/11 on services to promote better services for patients upon discharge from hospital.[2] We set out that PCTs should develop local

[1] http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_121508, paragraph 7.1, page 28
[2] Details at: http://www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Dearcolleagueletters/DH_120944 and http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_121508, paragraphs 7.6-7.7, page 29

plans in conjunction with the Local Authority and Foundation Trust/NHS Trusts and community health services on the best way of using this money to facilitate seamless care for patients on discharge from hospital and to prevent avoidable hospital readmissions. It is for local decision how much of this money is spent on NHS services and how much on social care.

A proportion of this funding should be used to develop current re-ablement capacity in councils, community health services, the independent and voluntary sectors according to local needs. Resources can be transferred to local partners, or to pooled budgets, wherever this make sense locally.

We requested that SHAs ensure that each PCT has a local plan including monitoring arrangements, developed with their local authority and local FT/NHS Trusts, in place by the end of December 2010. PCTs should use these plans as a basis for coordinating activity on post-discharge support from 2011/12 onwards, keeping plans and outcomes under review in conjunction with GPs and local authorities.

Winter Pressures Funding

On 4 January 2011, the Department announced a further allocation of £162m to PCTs, for immediate spending on social care services that also benefit the NHS. This funding stream is focused on a broader range of local authority-funded social care services and must be transferred to local authorities to invest in social care services to benefit health, and to improve overall health gain. Transfers will need to be made via an agreement under Section 256 of the 2006 NHS Act.[3]

PCTs need to work together with local authorities to agree jointly on appropriate areas for social care investment, and the outcomes expected from this investment. The Department would expect these decisions to take into account the Joint Strategic Needs Assessment for their local population, and the existing commissioning plans for both health and social care. PCTs should work with local authorities to achieve these outcomes in a transparent and efficient manner, with local authorities keeping PCTs informed of progress using appropriate local mechanisms.

Examples of the kinds of services that could be invested in are:

- additional short-term residential care places, or respite and intermediate care;
- more capacity for home care support, investment in equipment, adaptations and telecare;
- investment in crisis response teams and other preventative services to avoid unnecessary admission to hospital; and
- further investment in reablement services, to help people regain their independence and reduce the need for ongoing care.

Support for social care in 2011/12 and 2012/13

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[3] Further details were contained in a letter to PCT, SHA and local authority Chief Executives: http://www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Dearcolleagueletters/DH_123287

Post-discharge services and re-ablement

The Spending Review and 2011/12 NHS Operating Framework announced further funding to PCTs in financial years 2011/12 and 2012/13 to develop local re-ablement services in the context of the post-discharge support plans submitted to SHAs this December. This funding totals £150m in 2011/12 and £300m in 2012/13, and is contained within recurrent PCT baseline allocations.[4]

This funding is intended specifically to develop current re-ablement capacity in councils, community health services, the independent and voluntary sectors, with the objective of ensuring rapid recovery from an acute episode and reducing people's dependency on social care services following discharge. As with the £70m allocation this financial year, these resources can be transferred to local partners, or pooled budgets established, wherever this make sense locally. Again, it is for local decision how much of this money is spent on NHS services and how much on social care.

From 1 April 2011 there will also be changes to the national tariff which will result in savings for PCTs from the non-payment for certain emergency readmissions to hospital. PCTs will be required to use these savings, alongside the funding of £150m in 2011/12 and £300m in 2012/13, to improve the support available to patients within the 30 days following discharge from hospitals. From 1 April 2012 the responsibility for the care of patients in this period will move to acute care providers and so PCTs will need to work with them, and other agencies to anticipate and prepare for this change. More information is available in the 2011/12 PbR Guidance at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_122717

Specific PCT allocations for social care

The 2011//12 NHS Operating Framework also provided details of separate, non-recurrent PCT allocations for social care, totalling £648m in 2011/12 and £622m in 2012/13. This is funding which has been allocated to PCTs, and which they will need to transfer to local authorities to invest in social care services to benefit health, and to improve overall health gain. Transfers will need to be made via an agreement under Section 256 of the 2006 NHS Act.

It is the Department's clear intention that this funding is used for social care purposes. Local authorities have been informed of the expected transfer from PCTs as part of the 2011/12 and 2012/13 local government finance settlement.[5]

This allocation is in addition to the funding for re-ablement services which is contained within recurrent PCT allocations, as detailed above. It should also be additional to any existing pooled budget or lead commissioning arrangements that a PCT may have with a local authority.

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[4] The 2011/12 NHS Operating Framework can be found at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_122738. Details of the re-ablement funding are on pp. 52-53.

[5] Details can be found at http://www.local.communities.gov.uk/finance/1112/grant.htm. Individual PCT transfers to local authorities are found in the supporting data annex to the consultation on the Transitional Grant for local authorities with the largest reductions in spending power.

As with the £162m of Winter Pressures funding announced for the remainder of the 2010/11 financial year, PCTs will need to work together with local authorities to agree jointly on appropriate areas for social care investment, and the outcomes expected from this investment. The investment may be used to support and maintain existing services such as telecare, community directed prevention (including falls prevention), community equipment and adaptations, and crisis response services. The Department would expect these decisions to take into account the Joint Strategic Needs Assessment for their local population, and the existing commissioning plans for both health and social care. PCTs should work with local authorities to achieve these outcomes in a transparent and efficient manner, with local authorities keeping PCTs informed of progress using appropriate local mechanisms.

New resources for carers breaks' 2011-2015

On 16 November 2010, the Department announced that new resources of £400m would be made available to the NHS over the next four years to enable more carers to take breaks from their caring responsibilities. The NHS Operating Framework 2011-12 made clear that:

"PCTs should pool budgets with local authorities to provide carers' breaks, as far as possible, via direct payments or personal health budgets. For 2011/12, PCTs should agree policies, plans and budgets to support carers with local authorities and local carers' organisations, and make them available to local people."

Summary

The table below summarises the additional funding provided to PCTs in 2010/11 – 2012/13 to support social care services.

Purpose	2010/11 (£m)	2011/12 (£m)	2012/13 (£m indicative)	How the funding should be used
Development of post-discharge support and re-ablement services	70	150	300	To work with local authorities to develop local re-ablement capacity, according to local plans submitted to SHAs in December 2010. Funding may be transferred to local partners or pooled budgets. **It is for local discretion the proportion of spend on the NHS and social care..**
To support social care services	162	648	622	**Funding must be transferred to local authorities**, to spend on social care services which also benefit health. PCTs and local authorities should

				jointly agree how the funding should be spent and the outcomes to be achieved.

As part of the NHS planning process for 2011/12, DH will seek assurances from SHAs that arrangements are in place for funding to be transferred to LAs and that plans have been jointly agreed between NHS organisations and their local authority partners for delivery of services in line with the Operating Framework for the NHS in England 2011/12.

We are clear that this funding provides a unique and excellent opportunity to forge better integrated working between the health and social care systems, for the benefit of patients, service users and carers, as set out in the NHS White Paper, *A Vision for Adult Social Care*, and *Recognised, valued and supported: Next Steps for the Carers Strategy*'. We are committed to ensuring that individuals are supported to regain and maintain their health and independence, and these additional funding streams will enable us, together, to achieve that aim. It is therefore essential that local partners use this opportunity to push ahead with the joint working arrangements detailed in this letter.

Details of the non-recurrent PCT level allocations to support social care services, which are to be transferred to local authorities, are available together with a copy of this letter at:
http://www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Dearcolleagueletters/DH_123460
The webpage also includes further information about re-ablement services and the changes to the tariff.

Yours sincerely,

David Behan CBE
Director General for Social Care, Local Government and Care Partnerships, Department of Health

David Flory CBE
Deputy NHS Chief Executive

By: Graham Gibbens, Cabinet Member Adult Social Care and Public Health
Oliver Mills, Managing Director Kent Adult Social Services

To: Adult Social Services and Public Health Policy Overview and Scrutiny Committee – 7 April 2011.

Subject: **NON - RESIDENTIAL CHARGING POLICY CHANGES**

Classification: Unrestricted

Summary: Proposed amendments to the Domiciliary Charging Policy designed to increase the Directorate's income in line with the Council's Medium Term Plan.

Introduction

1. (1) This report will update Members on the proposed amendments to the Domiciliary Charging Policy designed to increase the Directorate's income and the intention to rename the Domiciliary Charging Policy as the Non - Residential Charging Policy so that it will more accurately reflect the charges that are levied.

Policy Context

2. (1) The legal powers required to charge for non residential services are contained within Section 17 of the Health and Social Services and Social Security Adjudication Act 1983 (HASSASSAA). This gives local authorities the discretionary power to charge.

(2) In 2001 the Department of Health issued statutory guidance on how charging policies should be carried out. This was contained within LAC(2001)32: Fairer charging policies for home care and other non-residential services – guidance for councils with social services responsibilities. The final guidance was issued in September 2003.

(3) In 2009 the Department of Health published 'Fairer contributions guidance: calculating an individual's contribution to their personal budget', with an updated version issued in October 2010. This is a supplement to the 2001 guidance and does not replace the original guidance and its principles still apply.

(4) KASS has a Domiciliary Charging Policy which complies with the 2001 fairer charging guidance and was last changed in October 2007. The policy refers to 'care provided at home' and also states that 'KASS currently charge for personal budgets in line with their existing non-residential charging policy'.

(5) The Directorate publishes annually a public facing document entitled 'Charging for Care Provided at Home (domiciliary care)', a copy of which is given to all service users by Case Management.

(6) Both the 'Domiciliary Charging Policy' and the 'Charging for Care Provided at Home' booklet give the impression that they are about charging for care provided in the home. The Fairer Charging Guidance does refer to Homecare and other non-residential services. In practice, the Directorate raises charges for services that are provided both within and outside of the home, but the current policy and booklet leave that open to challenge and confusion.

Proposed Amendment 1 – Change of Policy Name

3. (1) It is proposed that the Domiciliary Charging Policy is renamed as the Non – Residential Charging Policy and that the Charging for Care Provided at Home should be redrafted to reflect the change.

Proposed Amendment 2 - Increase % of net disposable income taken into account:

4. (1) The charging process basically compares the cost of an individual's care to their net disposable income (ndi) and charges them the lower of the two figures. The ndi is the weekly income that an individual is left with after allowing a statutory amount that the Government has determined they require for day to day living expenses. It is derived from a financial assessment of their means and is effectively the amount of money each week they can afford to contribute to the cost of their care. Currently only 85% of the ndi is taken into account when charging. It is proposed that this is increased to 100% which will deliver additional income in the region of £1.350m per annum.

(2) This will not impact on those people who are already paying the full cost of their service (900) or those people who do not contribute to their care (3300). However, it will impact on those people who are making a contribution to their service (3400).

(3) The last change to this percentage was made in October 2007 when it was increased from 65% to 85%.

(4) This proposal will increase charges for those people contributing to their care by approximately £6 per week although it must be stressed that there is a wide variation of charges so many individuals will experience a greater financial increase.

(5) This proposal should be considered in conjunction with proposed amendment 3 as broadly the same cohort of individuals will be affected by both proposals and practical implementation of both will take place in tandem.

(6) Many local authorities including Medway, East Sussex, Bromley, Buckinghamshire and Croydon already charge at 100% (ndi) with others remaining between 80% and 95%.

Proposed Amendment 3 - Reduce the standard allowance for the Disability Related Expenditure Assessment (DREA):

5. (1) Councils are required to offer a Disability Related Expenditure Assessment to anyone who is in receipt of disability related benefits. The intention is to ensure that the additional cost incurred as the result of an individuals disability or illness are allowed for when calculating their charges. A DREA will consider the additional costs that an individual faces as a result of their disability. These costs are converted into a weekly

value which is deducted from their ndi to give a lower figure available for charging purposes.

(2) KASS has introduced a standard allowance which currently stands at £21 per week, but if anyone feels that their costs exceed this figure they are entitled to an individual DREA. It is proposed that the standard allowance is reduced to £17 per week and it is anticipated that this will deliver additional income of approximately £0.742m per annum. This will increase the charge to those service users who contribute to the cost of their care by £4 per week

(3) This will not impact on those people who are already paying the full cost of their service. However, it will impact on those people who are making a contribution to their service (3400) and it is estimated that it will affect approximately 250 people who are not currently contributing to their care and will face charges of up to £4 per week.

(4) This will affect broadly the same cohort of individuals who are affected by the proposed amendment 2 and will mean an average increase of approximately £10 per week. However, relatively few people will be paying the average charge and it is anticipated that whilst 1600 people will see charges increase by less than £10 per week, some 2000 people would experience increases in excess of £10 per week, with 943 of these seeing an increase of £11.10 per week.

(5) It is understood that about 50% of other local authorities undertake individual DREA assessments with the others having a fixed standard rate of between £8 and £24. However, in order to make a true comparison with Kent it will be necessary to take into account both the DREA and ndi. The levels of DREA and the ndi both having an impact on the level of charge.

(6) We also understand that other local authorities are currently reviewing their policy regarding these levels in the context of the current financial climate.

Proposed Amendment 4 - Charging Mental Health Service Users:

6. (1) It is estimated that 560 Mental Health service users are in receipt of domiciliary services and whilst it is not permissible to charge people who are receiving Section 117 aftercare, it is proposed that the remainder should be charged. It is estimated that additional income in the region of £0.160m per annum could be achieved.

(2) All other service user groups receiving domiciliary care are assessed to contribute to the cost of that care. The introduction of a charge for Mental Health service users ensures equity across service user groups.

Proposed Amendment 5 - Charging for Day Care and Transport to Day Care:

7. (1) Day care is accessed in the following ways:

- KCC provided within residential care homes (older people)
- KCC provided within integrated care centres (older people)
- KCC provided within stand alone day centres (older people)
- KCC provided within ‘day centres’ for people with a learning disability
- KCC commissioned private sector day care
- Voluntary sector day care
- Purchased using a Direct payment

(2) Approximately 2900 people are recorded on the directorate's business system as being in receipt of day care. Of these, 1800 are also receiving a domiciliary package and most of these people will already be making the maximum contribution to their care so their charges will not be affected by this proposal. However some will be paying the full cost of their domiciliary care and therefore could make an additional contribution to their day care.

(3) It is proposed that the cost of day care and the cost of transport to day care are included as part of the cost of service in the charging process and therefore become chargeable services. This will impact on the 1100 people who only appear to be receiving day care services on the directorate's business system and it is estimated that additional income of approximately £0.700m per annum will be achieved.

(4) This proposal will also impact on service users who choose to take their Personal Budget as a Direct Payment and use it for day care services as the current system introduces inconsistencies in the way charging is applied.

Fairer Contributions Guidance – Calculating an Individual's Contribution to their Personal Budget

8. (1) This guidance was issued in July 2009 under Section 7 of the Local Authority Social Services Act 1970, with the requirement for it to be implemented by April 2010.

(2) If the proposed amendments 4 and 5 are agreed then the charging policy will be more equitable and treat every one the same regardless of the service they choose to meet their needs. This will also remove the perverse incentive under the existing policy where some people choose day care as opposed to other more suitable alternatives to meet their needs on the grounds that they will not be charged.

(3) If the proposed amendments 4 and 5 are agreed then this will move the Directorate even closer to a position where 100% of the personal budget will be chargeable.

Implementation

9. (1) Full consultation will be undertaken with service users, their representatives and voluntary organisations and public meetings are also planned.

(2) Adequate preparation is essential in order to properly consult and gather the information to inform any member decision. Therefore it is planned to commence consultation in the summer.

Impact on Individuals

10. (1) An indication of the potential impact on individuals is referred to under the proposed amendments 2 and 4 above. As an individual's charge is directly related to their **individual** financial circumstances it is advisable not to generalise about the impact on individuals from specific examples. However 3 examples of the impact of the proposed amendments 2 and 3 are attached at Appendix 1 for illustrative purposes.

(2) The introduction of charges for Mental Health service users will impact on individuals based on their means. Potentially some service users will pay the full cost of their care, some will make a contribution to their care and some will contribute nothing. Within the current cohort of chargeable service users it is estimated that 12% pay the full cost of their care, 45% make a contribution and 43% receive the service free of charge.

(3) A more complex algorithm will result from the inclusion of day care / transport costs. Many service users will already be receiving another chargeable service and will be contributing their maximum contribution to their care so will see no increase in their charges. Some service users will be in a similar position but will be paying the full cost of their care and these people will see an increase in their charges. A further group of people will only be in receipt of day care/transport services and these people may pay the full cost, may make a contribution or may pay nothing at all.

(4) In line with the existing policy we will consider using discretionary power to apply disregards in cases of exceptional hardship on an individual basis.

Comparison with other Local Authorities

11. (1) Charging Polices vary from authority to authority in respect of the amount of an individual's net disposable income they take into account when assessing the contribution they should pay towards the cost of their care. Kent currently only takes into account 85% of an individual's disposable income which is less than other neighbouring authorities including Medway, East Sussex, Bromley, Croydon and Buckinghamshire who take 100% into account. It is notable that West Sussex, propose to move to 100% from 1st April 2011.

(2) Kent is also proposing to charge people who receive mental health services in line with other local authorities in the south east region.

Financial Implications

12. (1) The following additional income is anticipated in a full year:

Increase % to 100%	£1.350m
Reduce DREA	£0.744m
Charge MH service users	£0.160m
Charge for day care/transport	£0.700m
Total	**£2.954m**

(2) The savings requirement built into the MTFP is £2.9m in a full year with 50%, which equates to £1.45m, required in 2011/12.

Equalities Impact Assessment

13. (1) An Equalities Impact Assessment has been carried out and is attached at Appendix 2.

Recommendation

14. (1) Members are asked to **NOTE** and **COMMENT** on the contents of this report

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Background documents: None

Non Residential charging

Set out below are examples of how three different people would be effected by the proposed changes to the way a Persons contribution is calculated.

- Increasing the percentage of available income taken into account from 85% to 100%.
- Reducing the allowance for Disability Related Expenditure (DREA) from £21 per week to £17 per week.

Example 1

Mr A is an 85 year old Gentleman who lives alone. He receives a State Retirement Pension topped up with Pension Credit and Attendance Allowance.

He has a care package which costs Kent County Council £55 per week.

	Existing Policy	Proposed Policy	Note
Income	£241.95	£241.95	
Less Protected Income Level	£171.69	£171.69	This is the government recommended amount for living costs for a person in these circumstances.
Standard DREA	£21.00	£17.00	This is an additional amount KCC allows to cover any extra living costs associated with having a disability.
Available Income	£49.26	£53.26	This is the maximum amount he can contribute towards his social care costs.
Charge	85% **£41.87**	100% **£53.26**	The actual amount the individual should contribute to their cost of care.

Example 2

Miss F is a 54 year old lady who lives alone and has MS. Her income is made up of contribution based Employment Support Allowance, Disability Living Allowance (DLA) care component and other private income. She also receives a DLA Mobility Component but this is disregarded from the calculation.

She has a care package which costs Kent County Council £216 per week.

	Existing Policy	Proposed Policy	Note
Income	Per week £210.00	Per week £210.00	
Less Protected Income Level	£138.00	£138.00	This is the government recommended amount for living costs for a person in these circumstances.
Housing/Council Tax	£15.00	£15.00	This is an additional allowance for people who are not on means tested benefits and have to pay them. (subject to certain rules)
Standard DREA	£21.00	£17.00	This is an additional amount KCC allows to cover any extra living costs associated with having a disability.
Available Income	£36.00	£40.00	This is the maximum amount she can contribute towards her social care costs.
Charge	85% **£30.60**	100% **£40.00**	The actual amount the individual should contribute to their cost of care.

Example 3

Mrs P is a 50 year old woman who lives with her husband. They are both disabled but only Mrs P receives services from Kent County Council. Mrs P receives Incapacity Benefit and Disability Living Allowance (DLA).

She has a care package which costs Kent County Council £100 per week.

	Existing Policy	Proposed Policy	Note
Income	Per week £157.00	Per week £157.00	
Less Protected Income Level	£104.56	£104.56	This is the government recommended amount for living costs for a person in these circumstances.
Housing/Council Tax	£12.00	£12.00	This is an additional allowance for people who are not on means tested benefits and have to pay them. (subject to certain rules)
Standard DREA	£21.00	£17.00	This is an additional amount KCC allows to cover any extra living costs associated with having a disability.
Available Income	£19.79	£23.79	This is the maximum amount she can contribute towards her social care costs.
Charge	85% **£16.82**	100% **£23.79**	The actual amount the individual should contribute to their cost of care.

Note:-

1. There will of course still be those who pay full cost and as well as those who have no available income and pay no contribution towards their cost of care.

2. Charges will continue to be capped at the lesser of the Persons available income or the cost of the care package

Jeremy Blackman
15th March 2011

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Appendix 2

KENT COUNTY COUNCIL

EQUALITY IMPACT ASSESSMENT (FINAL v2)

Please read the EIA GUIDANCE and the EIA flow chart available on KNet.
This form dated 17/12/2010 supersedes all previous EIA/ CIA forms

Directorate:

KASS

Name of policy, procedure, project or service
For example, Flexible Working policy

Non - Residential Charging Policy

Type
What are you impact assessing, a policy procedure or service?

Policy

Responsible Owner/ Senior Officer
Provide the name of the senior officer or manager responsible for the policy, procedure, project or service

Janice Grant, Senior Policy Manager

Date of Initial Screening
Please provide the date of your initial screening

14th February 2011

Screening Grid

Characteristic	Could this policy, procedure, project or service affect this group differently from others in Kent? YES/NO	Could this policy, procedure, project or service promote equal opportunities for this group? YES/NO	Assessment of potential impact HIGH/MEDIUM/LOW/ NONE/UNKNOWN		Provide details: a) Is internal action required? If yes, why? b) Is further assessment required? If yes, why? c) Explain how good practice can promote equal opportunities
			Positive	**Negative**	
Age	Yes	No Whilst the increases in charges will not be welcomed by service user. They are being levied fairly and equitably. The additional income at a time of reduced budgets will enable KCC to maintain preventative services	High	High	However the impact will deliver equality. The current policy for non – residential services provides that people who are under 65yrs and have a Mental Health need are not charged for any support. Those who are over 65yrs and have a MH need are charged for their support. The proposal will provide that all age groups are treated equitably, but in implementing this there will be a greater impact on people under 65yrs.
Disability	Yes	No Whilst the increases in charges will not be welcomed by service user. They are being levied fairly and equitably. The additional income at a time of reduced budgets will enable KCC to maintain preventative services		High	The introduction of charging for Day Centre provision will impact differently for older people who use day centres and people with an LD who use day centres. This is because of the way day centre provisions have been commissioned and are provided. In the main, KASS knows who is in receipt of day care from KASS where the person has a learning disability, but where the person is over 65yrs recording and commissioning practices vary. Some people over 65yrs will access day care directly and others will access it via KASS, some of those accessing directly will be community care eligible, this may result in unequal application of charging for people over 65yrs.

Gender	No	No			N/A
Gender identity	No	No			N/A
Race	No	No			Any changes to charging will be applied irrespective of the location of provision, so if a person chose to attend day care in a centre which is designed to meet a specific cultural need then the policy would be applied equally. Discretionary disregards will still apply.
Religion or belief	No	No			Any changes to charging will be applied irrespective of the location of provision, so if a person chose to attend day care in a centre which is designed to meet a specific cultural need then the policy would be applied equally. Discretionary disregards will still apply.
Sexual orientation	No	No			N/A
Pregnancy and maternity	No	No			N/A

Part 1: INITIAL SCREENING

Context

Explain how this policy, procedure, project or service relates to a wider strategy

Following an assessment to identify a person's eligibility for social care the person will write a support plan (with help from a Kent Adult Social Services (KASS) worker if required). This will outline any social care support the person might use to help them.

KASS is able to charge for the social care support it provides and so the person will be further assessed to see what, if anything, they may be expected to pay towards their care. KASS is able to do this because of a discretionary power contained within section 17 of the Health and Social Services and Social Security Adjudication Act.

The way Kent works out the contribution a person makes to the cost of their care is described in the Domiciliary Charging Policy. This policy complies with the guidance issued by the Department of Health in 2001, LAC (2001)32: Fairer Charging policies for home care and other non-residential services.

Aims and Objectives

Provide a summary of what the policy, procedure, project or service is trying to achieve and how it will be achieved

In order to continue to provide support to the widest number of people in Kent who are eligible for social care support and to enable KASS to continue to invest in preventative services, we must review all mechanisms open to us to maximise management of the budget.

The current financial situation constraints for local authorities are placed within the national context of savings required by public sector organisations. One of the areas in which KASS is able to influence the budget position is the way it charges for services.

KASS is exploring a range of options which could deliver financial savings, one of those options is to review the non-residential charging policy, and this could potentially increase income by £2.9m (full year effect).

This policy aims to achieve increases in charges in as fair and equitable way as is possible.

Beneficiaries

Set out who the intended beneficiaries?

The review of non –residential charging will enable KASS to continue to provide support to as many people as possible who are eligible for social care. Without making changes to the charging policy it will be necessary for KASS

to make savings in other ways which would include cuts to service provision for some people. It would also mean that KASS would have less money to invest in preventative services and it is through this early intervention that KASS is able to help people to help themselves rather than become more dependant upon more expensive forms of support.

Consultation and data
Please record any data/research and/or consultation you have carried out to inform your screening

An analysis of KASS's client data system SWIFT was undertaken to identify the numbers of people who would be directly affected. This information was supplemented with local intelligence regarding those groups attending KASS funded voluntary sector provision.

Potential Impact
Provide a summary of the results from your initial screening, highlighting where there is any potential positive or adverse impact. If there is no impact on any group or the impact is unknown please state that here.

Adverse Impact:

(1) Increase % of net disposable income taken into account : The charging process basically compares the cost of an individuals care to their net disposable income (ndi) and charges them the lower of the two figures. The ndi is derived from the financial assessment and is the amount of money each week that it is calculated an individual can afford to contribute to the cost of their care. Currently only 85% of the ndi is taken into account when charging. It is proposed that this should be increase to 100% which will deliver additional income in the region of £1.350m per annum. This will not impact on those people who are already paying the full cost of their service (900). However, it will impact on those people who are making a contribution to their service (3300), but will not affect those people who do not contribute to their care (3400)

(2) Reduce the standard allowance for the Disability Related Expenditure Assessment (DREA): Councils are required to offer a Disability Related Expenditure Assessment to anyone who is in receipt of disability related benefits. The intention is to ensure that the additional costs incurred as the result of an individuals disability or illness are allowed for when calculating their charges. KASS has introduced a standard allowance which currently stands at £21 per week, but if anyone feels that their costs exceed this figure they are entitled to an individual DREA. It is proposed that the standard allowance is reduced to £17 per week and it is anticipated that this will deliver additional income of approximately £0.744m per annum after making an allowance for the cost of additional DREA's. This will not impact on those people who are already paying the full cost of their service. However, it will impact on those people who are making a contribution to their service and it is estimated that it will affect approximately 250 people who are not currently contributing to their care and will face charges of up to £4 per week.

(3) Charging Mental Health Service Users: Currently 560 service users in this client group are in receipt of non residential services and whilst it is not permissible to charge people who are in receipt of Section 117 aftercare, it is proposed that the remainder should be charged. It is estimated that additional income in the region of £0.160m per annum could be gained.

(4) Charging for day care and transport to day care: Approximately 2900 people are in receipt of day care. However, 1800 of these are also receiving a domiciliary package and most of these people will already be making the maximum contribution to their care although some will be paying full cost and therefore could make an additional contribution to their day care. It is proposed that the cost of day care and the cost of transport to day care are included as part of the cost of service in the charging process and therefore become chargeable services. This will impact mainly on the 1100 people who only appear to be receiving day care services and it is estimated that additional income of approximately £0.700m per annum will be achieved.
Day care is provided in a range of ways:

- KCC provided within residential care homes (older persons)
- KCC provided within integrated care centres (older persons)
- KCC provided within stand alone day centres (older persons)
- KCC provided with Learning Disability 'day centres'
- KCC commissioned private sector day care
- Voluntary sector day care
- Purchased using a Direct payment

KASS will be able to identify those people who have a learning disability and use day care provisions; for older people the position holds less clarity as some people have been sign posted to access the provision directly and are community care eligible; there are others who access day care directly who are not community care eligible and some who access day care via KASS. It may take a period of time to identify which people over 65years may be required to contribute to the cost of their day care, it will therefore be essential to ensure that any changes to the charging policy for day care are applied equitably for all service groups.

Positive Impact:
The increase in charges will not have a positive impact on the individuals concerned but will enable KASS to maintain preventative services.

JUDGEMENT

Option 1 – Screening Sufficient No

.

Justification:

Option 2 – Internal Action Required YES

There is potential for adverse impact on particular groups and we have found scope to improve the proposal.

In order to gain a better understanding of the impact that this may have on people a 12 week period of consultation will be undertaken with the public as a whole as well as with those individuals who currently receive a non residential service before any changes are made..

This will be undertaken by holding a number of Public meetings as well as writing to those individuals who are currently in receipt of a service funded by KASS.

Voluntary sector providers such as Age Concern will also be provided with letters to send out to those individuals who have been referred by KASS but may not be recorded on SWIFT.

Loop systems will be available at public meetings to assist those with hearing difficulties and letters in easy read versions or large print will also be available if required.

KASS staff will ensure that benefits for individuals are maximised and will also retain the responsibility to assess if there has been an adverse impact on an individual case by case basis and to apply an exceptional disregard if this is assessed as appropriate.

Option 3 – Full Impact Assessment NO
Only go to full impact assessment if an adverse impact has been identified that will need to undertake further analysis, consultation and action

Sign Off

I have noted the content of the equality impact assessment and agree the actions to mitigate the adverse impact(s) that have been identified.

Senior Officer

Signed: Janice Grant

Date: 18th Feb 11

Name: Janice Grant

Job Title:

Directorate Equality Lead

Signed: Keith Wyncoll

Date: 18th Feb 11

Name: Keith Wyncoll

Appendix 2

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By: Graham Gibbens, Cabinet Member, Adult Social Care and Public Health
Oliver Mills, Managing Director, Kent Adult Social Services

To: Adult Social Services and Public Health Policy Overview and Scrutiny Committee - 7 April 2011

Subject: **ADULT SOCIAL SERVICES BUDGET FORECAST REPORT 2010/11**

Classification: Unrestricted

Summary: A report on the forecast outturn against budget for the third quarter for Kent Adult Social Services (KASS)

Introduction

1. (1) This is the fourth report for 2010-11 to this Committee on the forecast outturn against budget for the Adult Social Services Department.

Background

2. (1) Policy Overview and Scrutiny Committees consider the draft Medium Term Financial Plan at their November and January meetings. To enable a more informed discussion, three reports will be presented to the Committee on a regular basis:

a) **Budget Monitoring reports**
A detailed quarterly budget monitoring report is presented to Cabinet, usually in September, December and March, and a draft final outturn report in June. A report for each directorate is annexed to the summary report, and the annex for the Adult Social Services Directorate will be presented to this Committee at the meetings following those Cabinet meetings. This will help inform this POSC about current trends, pressures and management actions in advance of the next year's budget setting

b) **Performance data**
This will be reported at least half-yearly to this Committee.

c) **Outturn report**
Effectively an amalgam of the above two, the outturn report will summarise both the financial and performance information for the whole of the preceding year

(2) Informed by these reports, the POSCs will be in a stronger position to question and comment on the future budget and medium term proposals, as they will be asked to do at the November and January meetings.

(3) A special Budget IMG was arranged for November 2009 to discuss the future Budget and MTP proposals in more detail. At its April meeting the Scrutiny Board recommended that all POSCs need to formulate their arrangements for contributing to the development of the budget so that they are able to have an input at an earlier stage than previous years. In particular POSCs were asked to consider whether the Informal Member Groups set up following the November 2009 meeting should meet regularly between now and December when the draft budget needs to be finalised for formal consultation. As a result three Budget IMGs have already taken place.

Full Monitoring Report for the Third Quarter

3. (1) The full monitoring report for the third quarter for Adult Services as presented to Cabinet on 4 April 2011 is attached at Appendix 1 and this indicates an overall revenue pressure of £225k. This position assumes that all savings identified within the Medium Term Plan will be achieved. The reported position also assumes forecasted savings of £203k from the recently announced moratorium, and savings relating to vacancy management. 'Guidelines for Good Management Practice' are in place across all teams in order to help us manage demand on an equitable basis consistent with policy and legislation. The Guidelines include ensuring all high cost placements and support packages are reviewed, plus a continued analysis and scrutiny of all requests for waiving of third party top ups to the cost of placements, and rigorous on-going panel arrangements. Furthermore the successful promotion and increased use of enablement continues to result in fewer people needing long term support. Robust monitoring arrangements are in place on a monthly basis to ensure that forecasts and expenditure are closely monitored and where necessary challenged.

However even though the Directorate has done everything possible to balance we now believe that the remaining pressure of £225k will not be addressed, primarily because of the impact of the increase in debt over the past couple of months which has required us to put more money into the bad debt provision.

(2) The £225k pressure breaks down as follows:
-£1,106k Older People
+£710k Learning Disability
+£2,025k Physical Disability
+£53k All Adults Assessment & Related
+£1k Mental Health
-£39k Gypsy & Traveller Unit
-£147k Strategic Management
-£1,663k Strategic Business Support
+£29k Other Services
+£362k Specific Grants
+£225k Total

(3) The revenue forecast also allows for the impact of the recent funding allocated to the NHS for joint working with Local Authorities to promote better services for patients leaving hospital (known as Reablement), as well as additional 'Winter Pressure Funding'. These allocations have enabled both the PCTs and

KASS to commission new projects and services, as well as also allowing us to cover some of the additional costs which we would have inevitably had to cover for the anticipated increase due to the winter.

(4) Although the capital forecast reported to Cabinet on 4 April was a variance of -£678k, we are re-phasing £692k into 2011/12 which leaves a real variance of +£14k; the £14k will be covered by developer contributions. Of the £692k being re-phased, £327k of it relates to the Good Day Programme, with a further £111k to the Broadmeadow extension; the remaining £327k comprises a number of projects all below £100k.

Recommendations

4. (1) Members of the Policy Overview and Scrutiny Committee are asked to **NOTE** the latest forecast out-turn for revenue and capital.

Michelle Goldsmith
Directorate Finance Manager
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VPN: 7000 1770
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Background documents: None

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KENT ADULT SOCIAL SERVICES DIRECTORATE SUMMARY
JANUARY 2010-11 FULL MONITORING REPORT

1. FINANCE

1.1 REVENUE

1.1.1 All changes to cash limits are in accordance with the virement rules contained within the constitution, with the exception of those cash limit adjustments which are considered "technical adjustments" i.e. where there is no change in policy, including:

- Allocation of grants and previously unallocated budgets where further information regarding allocations and spending plans has become available since the budget setting process.
- Cash limits have been adjusted since the last full monitoring report to reflect a number of technical adjustments to budget.
- The inclusion of new 100% grants (i.e. grants which fully fund the additional costs) awarded since the budget was set. These are detailed in appendix 2 to the executive summary.

1.1.2 **Table 1** below details the revenue position by Service Unit:

Budget Book Heading	Cash Limit			Variance			Comment
	G	I	N	G	I	N	
	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	
Adult Services portfolio							
Older People:							
- Residential Care	89,156	-34,850	54,306	324	412	736	Demographic pressure; staff cover (in-house); falling income unit cost
- Nursing Care	47,906	-23,294	24,612	-817	-866	-1,683	Forecast activity below affordable level.
- Domiciliary Care	48,671	-11,217	37,454	-278	225	-53	Independent sector activity in excess of affordable offsetting significantly reduced in house activity
- Direct Payments	5,062	-532	4,530	495	-54	441	Demographic pressures
- Other Services	24,650	-7,600	17,050	-624	77	-547	Whole System Demonstrator underspend, uncommitted grant funding
Total Older People	215,445	-77,493	137,952	-900	-206	-1,106	
People with a Learning Disability:							
- Residential Care	72,361	-19,794	52,567	1,575	1,487	3,062	Demographic & placement pressures
- Domiciliary Care	7,827	-1,556	6,271	-610	84	-526	Forecast activity & price below affordable level
- Direct Payments	7,865	-143	7,722	460	-126	334	Forecast activity & price above affordable level
- Supported Accommodation	27,170	-16,496	10,674	275	8	283	Additional cost of non section 256 clients
- Other Services	21,268	-897	20,371	-2,430	-13	-2,443	Release of MDs contingency, uncommitted grant funding, various other savings
Total People with a LD	136,491	-38,886	97,605	-730	1,440	710	
People with a Physical Disability							
- Residential Care	12,526	-1,951	10,575	587	262	849	Demographic and placement pressures
- Domiciliary Care	7,661	-449	7,212	336	16	352	Demographic pressures
- Direct Payments	7,132	-249	6,883	969	-90	879	Demographic and placement pressures
- Supported Accommodation	394	-8	386	94	-18	76	
- Other Services	5,594	-685	4,909	-126	-5	-131	Various savings
Total People with a PD	33,307	-3,342	29,965	1,860	165	2,025	

Budget Book Heading	Cash Limit			Variance			Comment
	G	I	N	G	I	N	
	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	
All Adults Assessment & Related	38,081	-2,809	35,272	201	-148	53	Temporary staff, additional workloads, and recharge income
Mental Health Service							
- Residential Care	6,416	-882	5,534	915	220	1,135	Forecast activity above affordable, increasing S117 clients
- Domiciliary Care	878	0	878	-85	0	-85	
- Direct Payments	606	0	606	-31	0	-31	
- Supported Accommodation	654	-219	435	180	-10	170	Demographic Pressure
- Assessment & Related	9,911	-786	9,125	-469	4	-465	Vacancy management
- Other Services	7,180	-1,157	6,023	-627	-96	-723	Release of contingency and uncommitted funding
Total Mental Health Service	25,645	-3,044	22,601	-117	118	1	
Gypsy & Traveller Unit	662	-333	329	23	-62	-39	
People with no recourse to Public Funds	100	0	100	0	0	0	
Strategic Management	1,222	0	1,222	-147	0	-147	Vacancies
Strategic Business Support	24,695	-2,054	22,641	-1,526	-137	-1,663	Release of uncommitted funds, Vacancy management, external funded posts, management actions
Support Services purchased from CED	6,787	0	6,787	29	0	29	
Specific Grants	0	-9,910	-9,910	0	362	362	Slipped projects needing to roll forward
Total Adult Services controllable	**482,435**	**-137,871**	**344,564**	**-1,307**	**1,532**	**225**	
Assumed Management Action				**0**		**0**	
Forecast after Mgmt Action				**-1,307**	**1,532**	**225**	

1.1.3 **Major Reasons for Variance**: *[provides an explanation of the 'headings' in table 2]*

Table 2, at the end of this section, details all forecast revenue variances over £100k. Each of these variances is explained further below:

1.1.3.1 General Comment

Winter brings an increased level of pressure to the health and social care community. Seasonal variations in illness have historically resulted in increased emergency admissions and length of stay in hospital during the winter months with pressures peaking between December and March. Although the winter peak in demand is generally no worse than summer, the increased demand occurs alongside peaks in seasonal flu, swine flu and norovirus. This will lead to increased pressure for services from KASS and we expect to see increased levels of activity over the next few months, although to a degree this will be offset by expected increases in attrition.

NHS Support for Social Care 2010/11 – 2012/13

Additional funding streams have been allocated to the NHS for joint working with Local Authorities to promote better services for patients leaving hospital, part of which can be used for increasing capacity of current services such as re-ablement (enablement in Kent) and to invest in a broader range of social care services to benefit health and to improve overall health gain.

The first tranche of funding announced was £70m (nationally) for 'post discharge and re-ablement' services in 2010/11 and is targeted at patients leaving hospital. Of this, £1.8m has been made available for Kent and plans have been developed with the two Kent PCT's to utilise these funds. The second tranche of funding, announced in January, included a figure of £150m in 2011/12 and indicative funding of £300m in 2012/13 to continue to develop these services. The actual amount for Kent has not yet been announced, but on a pro rata basis we could expect £3.8m and £7.7m respectively.

Within the second tranche of funding, an additional £162m was designated as 'Winter Pressures Funding' for 2010/11. This funding will be focussed on a broader range of social care services and is expected to benefit health and to improve overall health gain. Of this funding, £4.1m has been allocated to Kent PCT's for 2010/11. Whilst plans have been agreed jointly, the funds must be transferred to KCC under Section 256 of the 2006 NHS Act. Allocations have been made for future years to continue with these services and this funding is referred to as 'specific PCT allocations for social care' with £648m allocated in 2011/12 and £622m in 2012/13. Kent's share of these funds is £16.2m and £15.7m respectively.

Although much of this allocation has allowed both the PCTs and KASS to commission new projects and services to meet this aim, it has also allowed us to cover some of the additional costs which we would have inevitably had to cover for the anticipated increase due to the winter, and therefore our affordable levels of activity for Older People residential, nursing and domiciliary care have increased to reflect the impact of part of this additional funding.

1.1.3.2 **Older People:**

The overall position for services for Older People is a net underspend of £1,106k.

a. Residential Care

This line is reporting a gross pressure of £324k, and an under recovery of income of £412k, leaving a net pressure of £736k. As at December, there were 2,782 permanent clients in independent sector care compared with 2,817 in September, a decrease of 35. The forecast for independent sector residential care is 157,297 weeks against an affordable level of 156,812 which is 485 more than budget. Using the forecast unit cost of £388.80 this increased level of activity generates a pressure of £189k. In addition the forecast unit cost is £1.11 lower than the affordable level, which results in a saving of £174k. Using the forecast unit income of £158.06 this increased level of activity generates additional income of £77k. In addition, the forecast unit income is £6.22 lower than the affordable which results in a pressure of £976k. There is also additional health income secured against this line of £337k, which was not budgeted for. We have now had to allow for a £250k increase to the bad debt provision resulting from the overall increase in debt over the last couple of months.

The overall attrition rate within residential has been low for most of the year however, as expected this has risen recently. The number of clients with dementia continues to cause concern as we have seen a net increase of 58 clients with the number of other residential clients actually reducing by 27 (net). Increased activity within the independent sector also results from not placing clients into permanent care within our own homes whilst the consultation on the modernisation of Older People's care continues; however conversely there will be some reduction in respite care as we seek to maximise the spare capacity in-house for non-permanent placements. It should also be noted that where possible we seek to place people into residential care rather than nursing so there is some off-set of the pressure identified here against that line.

The forecast for Preserved Rights clients is showing minor variances, below £100k on both gross and income.

Internal provision, including integrated care centres, is showing a small forecast pressure of £163k against gross as a result of the continuing need to cover sickness. This pressure has reduced during the year because, as mentioned above, we are not placing anyone permanently in the homes affected by the consultation. There is also a small over-recovery of income of £84k.

This line also includes a £200k under-spend relating to expenditure relating to the modernisation of Older People's care funded through the Social Care Reform Grant which has re-phased to the new financial year. There has also been a corresponding drop in the amount of Specific Grant income forecast for this year as this amount will be rolled forward as a receipt in advance.

b. Nursing Care

This line is reporting a gross saving of £817k, and an over recovery of income of £866k, leaving a net underspend of £1,683k. The number of permanent clients in independent sector placements is 1,372 in December compared to the 1,374 reported in March. The forecast position of 79,696 weeks of care is 1,686 weeks lower than the affordable. The lower than anticipated level of activity results in part from the intention to place people into residential care rather than nursing care. As with residential care the level of attrition remained low over the first six months of the year, although recently this has started to rise as expected. Using the forecast unit cost of £461.75 the reduced level of activity generates a saving of £779k. The unit cost reduced in December because an error in the previously reported figure was discovered, it now stands at £8.26 lower than the affordable which results in a saving of £672k. Using the forecast unit income of £166.03 this reduced level of activity creates a pressure of £280k. In addition the forecast unit income is £7.72 higher than the affordable which results in an over-recovery of £628k

Increased cost and activity for Registered Nursing Care Contribution clients is resulting in a forecast pressure of £466k, however this is completely off-set with additional income from health, meaning a net nil position for this service.

The remaining £168k pressure is due to small pressures, below £100k, against activity and price on Preserved Rights, as well as a £152k increase in the bad debt provision.

c. Domiciliary Care

This line is reporting a gross underspend of £278k, and an under recovery of income of £225k, giving a net underspend of £53k. Domiciliary care continues to be the most difficult to forecast as there is a constant and significant churn in activity; the continuing trend in the number of clients remains volatile and the number receiving a domiciliary care package from the independent sector remains below the average of last year. The number of clients in receipt of a package through the independent sector in December was 6,061 compared with 6,227 clients in March. The forecast position is 2,558,748 hours of care which is 37,372 more than budgeted for. Using the forecast unit cost of £15.393 this increased level of activity generates a pressure of £575k. In addition the forecast unit cost is £0.059 lower than the affordable which results in a saving of £147k. There is also a significant underspend of £577k relating to the in-house domiciliary service as the number of clients remains well below that afforded within the budget. There are also underspends against block contracts, extra care, and enablement, individually below £100k, but together totalling £224k. There is also a £94k increase in the bad debt provision.

Client income is showing a small under-recovery in income of £122k across all domiciliary lines and there is a small under-recovery in other income of £103k.

d. Direct payments

This line is reporting a gross pressure of £495k, and an under recovery of income of £54k. Increasing client numbers mean that the forecast activity is 953 weeks higher than affordable. Using the average weekly cost of £132.58 this additional activity creates a pressure of £126k. The average cost is also £7.04 higher than affordable leading to an additional pressure of £280k. There is also a small pressure on one-off direct payments, e.g. for equipment.

e. Other Services

This line is reporting a gross under-spend of £624k, and an under recovery of income of £77k. £315k of the gross under-spend relates to the Whole System Demonstrator base funding, which was provided because it was expected that the remaining amount of health funding would be insufficient to meet this year's costs. Fortunately the forecast suggests that base budget funding will not now be required in 2010/11, and will instead be funded by the savings found through management actions driving down the cost of equipment & installations. There is also £330k of funding that was identified as uncommitted following a review of all grants in light of potential in-year cuts from Government and this is being used to offset the overall pressure.

1.1.3.3 **People with a Learning Disability:**

The overall position for services for Learning Disabled is a net pressure of £710k. However, as described further on in this section, this position is mitigated by under-spends within Other Services without which the pressure would be over £3m. Services for this client group remain

under extreme pressure, particularly within residential care as a result of both demographic and placement price pressures. This includes the impact of young adults transferring from Children's Services, many of whom have very complex needs and require a much higher level of support. There are also increasing numbers of older learning disabled clients who are cared for at home by ageing parents who will begin to require more support. Cases of clients becoming/ or who could become "ordinarily resident" in Kent continue to be a problem. A client would become "ordinarily resident" when placed by another local authority in Kent and following de-registration of the home, the individual moves into supported accommodation. We have accepted responsibility for a number of clients, and we are still contesting a number of other applications. The issue of ordinary residence has been discussed nationally through the Association of Directors of Adult Social Services as the current system penalises those authorities, such as Kent, who have historically been a net importer of residential clients, and agreement on a voluntary protocol has now been reached, although this has not yet been "signed up to" by all authorities. Each ADASS region will be monitoring sign up to the protocol. This protocol suggests an 18 month period during which financial responsibility hands over, the intention of which is to give the receiving authority sufficient time to plan for the costs of the transferring placements.

a. Residential Care

This line is reporting a gross pressure of £1,575k with an under recovery of income of £1,487k, giving a net pressure of £3,062k. Details of the individual pressures and savings contributing to this position are provided below.

The number of clients has increased from 632 in March, of which 40 were transferred from health under Section 256, to 708 in December, of which 114 are Section 256. The Section 256 clients are part of the overall transfer of responsibility for most Learning Disability placements from Health. Section 256 clients are 100% funded by Health.

The forecast position for independent sector residential care is 37,645 weeks of care against an affordable level of 36,593 which is 1,052 more than affordable. Using the forecast unit cost of £1,223.31 this increased level of activity generates a pressure of £1,287k. In addition the forecast unit cost is £15.73 higher than the affordable which results in a pressure of £576k. This level of activity, using the forecast unit income of £312.27, generates additional income of £329k. However the forecast unit income is £27.34 lower than the affordable which results in a pressure of £1,000k.

For preserved rights, the forecast position is 30,921 weeks of care against an affordable level of 31,414 which is 493 less than affordable. Using the forecast unit cost of £805.38 this reduced level of activity generates a saving of £397k. In addition the forecast unit cost is £0.10 higher than the affordable which results in a pressure of £3k. Using the forecast unit income of £206.67 this reduced level of activity creates an under recovery of income of £102k. In addition the forecast unit income is £19.94 lower than the affordable which results in a pressure of £626k.

There is a £123k pressure on in-house provision, primarily due to the continuing need to cover sickness and absence with agency staff in order to meet care standards, and additional 1 to 1 support being provided. There are also small variances on in-house income lines.

b. Domiciliary Care

This line is reporting a gross under-spend of £610k, and an under recovery of income of £84k.
The forecast position for independent sector provision is 342,196 hours of care against an affordable level of 351,968 which is 9,772 less than affordable. Using the forecast unit cost of £11.14 this reduced level of activity generates a saving of £109k. In addition the forecast unit cost is £0.85 lower than the affordable which results in a saving of £298k. The unit income is £0.40 higher than budgeted for, which results in an over recovery of income of £140k, which is offset by the reduced activity causing a pressure of £8k.

There is also an under-spend against the Independent living scheme, of £180k, however, this is fully offset by a reduction in corresponding income, which is due to a change in Supporting People related activity. There are also small savings on gross, and small under recovery of income on other domiciliary lines including extra care sheltered housing.

c. Direct payments

This line is reporting a gross pressure of £460k, and an over recovery of income of £126k. Forecast activity is 426 weeks above the budgeted level of 34,219 which when multiplied by the average weekly cost of £241.02 results in a pressure of £103k. In addition, the average cost is £14.63 higher than affordable leading to a pressure of £501k. However, this pressure is offset by the recovery of surplus and unused funds from payments made in 09/10 of £291k although there is a further pressure created by additional one-off direct payments, (e.g. for equipment), of £162k. In addition to this, the unit income is £3.60 more than budgeted for, creating additional income of £123k, and the additional activity adds a small amount to this over recovery.

d. Supported Accommodation

The current position is a gross pressure of £275k and a minor under recovery of income of £8k resulting in a net pressure of £283k. The number of clients having increased to 487 in December from 478 in September; the figure was 309 in March and 408 in June. The increase is almost solely relating to the further transfer of clients from Health under Section 256 arrangements. The gross and income cash limits were realigned to reflect this further transfer of clients and 100% funding from Health in quarter 2, and following further transfers, the cash limit has also been realigned this quarter. The current forecast is 711 weeks more than the affordable level of 24,967 creating a pressure of £716k which entirely relates to non-Section 256 clients. This is based on a forecast unit cost of £1,007.95, although within this are three distinct groups of clients: Section 256 clients, Ordinary Residence clients and other clients. Each client group has a very different unit cost, which when combined give the average forecast unit cost stated above. This combined forecast unit cost is £17.72 less than affordable, which reduces the pressure by £442k. Both the affordable and forecast unit costs have increased significantly from last year as a result of the placements transferred from Health under S256 arrangements due to the high cost of these placements.

There are also small variances against group homes and the adult placement scheme.

It should be noted that the Residential Change Strategy is encouraging many small residential providers to move to providing supported accommodation giving people more choice and opportunities to remain within the community rather than live in a residential environment.

e. Other Services

This line is reporting a gross underspend of £2,430k, and an over recovery of income of £13k. The gross underspend includes the release of £830k Contingency held by the Managing Director, as well as £1,005k of uncommitted grant monies used to offset the overall pressure within this client group. There is an underspend of £231k in supported employment, £148k of this is due to some activities being transferred to the private sector and other vacancies being held, with the remaining £83k made up of several other small savings resulting from management actions. This is partially offset by an under-recovery in income of £43k. There is also an under-spend of £202k against day-care and other services. The remaining £162k of the under-spend relates to expenditure funded through the Social Care Reform Grant which has re-phased to the new financial year. There has also been a corresponding drop in the amount of Specific Grant income forecast for this year as this amount will be rolled forward as a receipt in advance.

1.1.3.4 **People with a Physical Disability:**

Overall the position for this client group is a net pressure of £2,025k. Services for this client group remain under pressure as a result of demographic and placement price pressures, and difficulties in forecasting remain, e.g. the number of road traffic accidents.

a. Residential Care

The overall forecast for residential care, including preserved rights clients, is a pressure on gross of £587k and an under recovery of income of £262k. The number of clients in permanent residential care has increased from 222 in September to 229 in December; the number was 218 in June and 222 in March. The forecast assumes 1,071 weeks more than is affordable giving a pressure of £921k. The actual unit cost is £859.39 which is £18.27 lower than the affordable which reduces the pressure by £222k. The additional client weeks add £103k of income to the position however the income per week is less than the level expected which causes a pressure of £339k.

The forecast number of client weeks of service provided to Preserved Rights clients is 110 lower than the affordable level because of increased attrition which is over and above that assumed in the budget. This reduced activity gives an underspend of £91k and the unit cost is lower than the affordable level which further reduces the position by £80k. The reduced activity and a lower average of income per week means an under-recovery in income of £72k.

Increased cost and activity for Registered Nursing Care Contribution clients is resulting in a minor forecast pressure of £53k, however this is completely off-set with additional income from health, meaning a net nil position for this service.

b. Domiciliary Care

This budget is reporting a gross pressure of £336k, and an under-recovery of income of £16k. The forecast position for independent sector provision is 579,216 hours of care against an affordable level of 556,354 which is 22,862 more than affordable. Using the forecast unit cost of £12.59 this increased level of activity generates a pressure of £288k. In addition the forecast unit cost is £0.05 higher than the affordable which adds £28k to the pressure. There are minor variances against the other domiciliary budgets.

c. Direct Payments

This line is reporting a gross pressure of £969k, and an over recovery of income of £90k. Client numbers continue to increase meaning that the forecast activity of 42,887 weeks is 3,421 weeks higher than affordable. Using the average weekly cost of £180.45 this additional activity creates a pressure of £617k. The average cost is also £2.54 higher than affordable leading to an additional pressure of £100k. The forecast for respite, one-off payments and direct payments to carers, i.e. the budget not related to the on-going clients, is £220k over budget with a further £32k relating to an increase in the provision for bad debts.

d. Other Services

This line includes Day Services, payments to voluntary organisations, occupational therapy, services for the sensory impaired. There are small variances on several of these lines, which when combined create a saving of £126k.

1.1.3.5 All Adults Assessment & Related

This line is reporting a gross pressure of £201k, offset by an over recovery of income of £148k, giving a net position of £53k pressure. £105k of the pressure is due to additional staffing costs related to increased workloads at Kent Contact and Assessment Service, however this is being entirely offset by additional recharge income from CFE for these extra resources. The remaining pressure is as a result of the need to engage Locums, temporary and agency staff, which are typically more expensive than permanent staff, whilst permanent recruitment is delayed, and in order to maintain the skill level within Assessment & Related staffing.

1.1.3.6 Mental Health

The overall position for Mental Health is a net pressure of £1k, however there are some significant offsetting variances across the service groups as follows:

a. Residential Care

The forecast for residential care, including preserved rights clients, is a pressure on gross of £915k and an under recovery of income of £220k. The affordable level for non-preserved rights was previously reduced following the decision to realign budgets to reflect the changed priorities in the Directorate to keep clients, wherever possible, within a community based setting such as supported accommodation or via direct payments, rather than residential care; however this change has not happened as quickly as anticipated. The intention to keep clients in the community remains, so budgets have been left as they are rather than adjusted back. The result is a forecast which is 1,370 weeks more than is affordable at a cost of £760k. The actual unit cost is £554.79 which is £5.39 higher than the affordable which adds to the pressure an amount of £48k. We are now also forecasting to add £180k into the Section 117 provision as there have been several significant repayments to clients made this year which have wiped out the existing provision of £148k, and the current expectation is that there will be further claims in the next

couple of years. The forecast also assumes a significant under-recovery in income as an increasing proportion of clients fall under Section 117 legislation meaning that they do not contribute towards the cost of their care. This has added £199k to the pressure.

There are small variances against gross and income for both preserved rights and Registered Nursing Care Contribution clients.

b. Supported Accommodation

The current position is £180k pressure on gross; the forecast of 2,081 weeks is 568 weeks more than budget which at the average cost of £295.24 per week generates a £168k pressure. There is an additional pressure of £12k as the unit cost is £8.03 higher than budget.

c. Assessment & Related

An underspend of £469k on gross expenditure is being forecast which in part results from vacancy management but also from difficulties in recruiting qualified social work staff. Savings also accrue from difficulties experienced in recruiting to senior positions for joint health/social care posts.

d. Other Services

This line is showing an under-spend on gross of £627k following the release of £520k of Contingency and other uncommitted funding held by the Managing Director to offset the overall pressure within this client group. The balance of the under-spend on gross is made up of small variances against day-care, payments to voluntary organisations, and community services.

1.1.3.7 **Strategic Management**

This line is reporting a gross saving of £147k, which is due to vacancy management throughout the management structure, the main part of which was achieved through the Director of Operations post being vacant whilst the recruitment process was undertaken.

1.1.3.8 **Strategic Business Support:**

This line is forecasting a significant underspend of £1,526k against gross expenditure with an over recovery in income of £137k. Of the gross underspend, £250k relates to funding that was declared as uncommitted following a review of all grants in light of potential in-year cuts from Government and this is being used to offset the overall pressure. There have also been significant savings in a number of areas including: £706k of vacancy management through continuing to hold posts vacant and delaying the recruitment process, £163k of printing, stationery, rent and room hire and reduced Girobank charges, and £373k of posts funded externally and not backfilled. The remaining balance is made up of numerous small savings. The over recovery of income is primarily due to £71k of extra income generated for Moving & Handling training, along with numerous other smaller income variances.

1.1.3.9 **Specific Grants:**

This line is now forecasting an under-recovery in income of £362k relating to the roll-forward of income as receipts in advance for expenditure funded through the Social Care Reform Grant which has re-phased to the new year, (£200k within Older Person’s Residential Care and £162k within Learning Disability Other Services as reported in sections 1.1.3.2.a and 1.1.3.3.e respectively).

Table 2: REVENUE VARIANCES OVER £100K IN SIZE ORDER

(shading denotes that a pressure has an offsetting saving, which is directly related, or vice versa)

There are a number of savings referred to in section 1.1.3 above which are below £100k and therefore do not appear in table 2. Therefore overall the net position in table 2 (+£978k) is significantly higher than the overall position presented in table 1 (+£225k)

Pressures (+)			Underspends (-)		
Portfolio		£'000	Portfolio		£'000
KASS	LD Residential Gross Independent Sector Activity higher than affordable	+1,287	KASS	LD Other Gross - uncommitted grant monies	-1,005
KASS	LD Residential Income Independent Sector Unit Income lower than	+1,000	KASS	LD Other Gross - Release of MDs Contingency	-830
KASS	OP Residential Income Independent Sector Unit Income lower than	+976	KASS	OP Nursing Gross Independent Sector Activity less than affordable	-779
KASS	PD Residential Gross Independent Sector Activity higher than affordable	+921	KASS	Strategic Business Support Gross - vacancy management	-706
KASS	MH Residential Gross - P&V activity greater than affordable	+760	KASS	OP Nursing Gross Independent Sector Unit Cost less than affordable	-672
KASS	LD Supported Accomodation Gross - Activity above affordable	+716	KASS	OP Nursing Income Unit income higher than affordable	-628
KASS	LD Residential Pres Rights Income - P&V unit Income less than affordable	+626	KASS	OP Domiciliary Gross In House - Activity below affordable level	-577
KASS	PD Direct Payments Gross Independent Sector Activity higher than affordable	+617	KASS	MH Other Gross - Release of uncommitted funding	-520
KASS	LD Residential Gross Independent Sector Unit Cost higher than affordable	+576	KASS	MH Assessment & related Gross - vacancy management and recruitment difficulties	-469
KASS	OP Domiciliary Gross Independent Sector Activity higher than affordable	+575	KASS	OP Nursing Income increased activity giving rise to increased income from health	-466
KASS	LD Direct Payments Gross Independent Sector Unit Cost higher than affordable	+501	KASS	LD Supported Accomodation Gross - Unit cost below affordable level	-442
KASS	OP Nursing Gross increased cost & activity for RNCC	+466	KASS	LD Residential Pres Rights Gross Independent Sector Activity less than affordable	-397
KASS	PD Residential Income Independent Sector Unit Income lower than affordable	+339	KASS	Strategic Business Support Gross - Posts for which external funding has been secured	-373
KASS	PD Domiciliary Gross Independent Sector Activity higher than affordable	+288	KASS	OP Residential Income - Additional health income	-337
KASS	OP Nursing Income - P&V activity below affordable level	+280	KASS	OP Other Services - uncommitted grant funding	-330
KASS	OP Direct Payments Gross Independent Sector Unit Cost higher than affordable	+280	KASS	LD Residential Income Independent Sector Activity higher than affordable	-329
KASS	OP Residential Gross Increase in Bad Debt Provision	+250	KASS	OP Other Services - Whole System Demonstrator management actions meaning base funding not required for 10/11	-315
KASS	PD Direct Payments Gross additional one offs, respite and payments to carers	+220	KASS	LD Domiciliary Gross Independent Sector Unit Cost less than affordable	-298
KASS	Specific Grant - Social Care Reform Grant re-phasing in OP Residential	+200	KASS	LD Direct Payments Gross - Recovery of unused surplus funds from 09-10 payments	-291
KASS	MH Residential Income - Increased Section 117 clients who do not contribute to costs	+199	KASS	Strategic Business Support Gross - uncommitted grant funding	-250
KASS	OP Residential Gross Independent Sector Activity higher than affordable	+189	KASS	PD Residential Gross Independent Sector Unit Cost less than affordable	-222

Pressures (+)			Underspends (-)		
Portfolio		£'000	Portfolio		£'000
KASS	LD Domiciliary Income In House - Reduction in Supporting People related activity	+180	KASS	LD Other Gross - Savings on Day Care & other services	-202
KASS	MH Residential Gross - S117 provision	+180	KASS	OP Residential Gross - Re-phasing of Social Care Reform Grant funded	-200
KASS	MH Supported Accomodation Gross - Activity in excess of affordable level	+168	KASS	LD Domiciliary Gross In House - Reduction in Supporting People related activity	-180
KASS	OP Residential In House Gross - Staffing issues; maintaining care levels	+163	KASS	OP Residential Gross Independent Sector Unit Cost less than affordable	-174
KASS	LD Direct Payments Gross - additional one off direct payments	+162	KASS	Strategic Business Support Gross - savings found on printing, stationery, room hire & Girobank charges	-163
KASS	Specific Grant - Social Care Reform Grant re-phasing in LD Other Services	+162	KASS	LD Other Gross - Social Care Reform Grant re-phasing	-162
KASS	OP Nursing Gross - Increase to bad debt provision	+152	KASS	LD Other Gross - Transfer of some Supported Employment activities to private sector	-148
KASS	OP Direct Payments Gross Independent Sector Activity higher than affordable	+126	KASS	Strategic Management Gross - Vacancy management	-147
KASS	LD Residential Gross In House - Maintaining care levels and providing additional 1:1 support	+123	KASS	OP Domiciliary Gross Independent Sector Unit Cost less than affordable	-147
KASS	OP Domiciliary Income - under recovery in client income	+122	KASS	LD Domiciliary Income - unit income higher than affordable	-140
KASS	All Adults A&R Gross - additional staffing to cover increased workloads at Kent Contact & Assessment Service	+105	KASS	LD Direct Payments Income Independent Sector Unit income higher than affordable	-123
KASS	LD Direct Payments Gross Independent Sector Activity higher than affordable	+103	KASS	LD Domiciliary Gross Independent Sector Activity less than affordable	-109
KASS	OP Domiciliary Income - under recovery of other income (non-client income)	+103	KASS	All Adults A&R Income - recharge income for additional work undertaken at Kent Contact & Assessment Service	-105
KASS	LD Residential Pres Rights Income Independent Sector Activity lower than affordable	+102	KASS	PD Residential Income Independent Sector Activity higher than affordable	-103
KASS	PD Direct Payments Gross - unit cost higher than affordable	+100			
		+13,317			**-12,339**

1.1.4 **Actions required to achieve this position**:

The forecast pressure of £225k assumes that the savings identified within the MTP will be achieved and the Directorate remains confident that these savings will be achieved. The reported position also assumes forecasted savings of £203k from the recently announced moratorium.
'Guidelines for Good Management Practice', also referred to below, are in place across the Directorate, and these, together with vacancy management, have significantly reduced the overall pressures. However even though the Directorate has done everything possible to balance we now believe that the remaining pressure of £225k will not be addressed, primarily because of the impact of the increase in debt over the past couple of months which has required us to put more money into the bad debt provision.

1.1.5 **Implications for MTFP**:

The MTFP assumes a breakeven position for 2010-11.

The significant issues for the KASS portfolio arising from 2010/11 budget monitoring are related to demography and this has been addressed in the 2011-13 MTFP.

It is assumed that the demographic pressures for KASS are likely to be £8.7m per year in the 2011-13 MTFP. This is based on detailed calculations, on trends over the past year of increased clients and complexity. Clearly this will be reviewed on an on-going basis as part of the monitoring process.

1.1.6 **Details of re-phasing of revenue projects**:

No revenue projects have been identified for re-phasing.

1.1.7 **Details of proposals for residual variance**: *[eg roll forward proposals; mgmt action outstanding]*

Although the KASS Directorate remains committed to delivering a balanced outturn position by the end of the financial year, as stated above in 1.1.4 we now believe that this is unlikely and we will end the year with a £225k overspend. KASS has 'Guidelines for Good Management Practice' in place across all teams in order to help us manage demand on an equitable basis consistent with policy and legislation. The Guidelines include ensuring all high cost placements and support packages are reviewed, plus a continued analysis and scrutiny of all requests for waiving of third party top ups to the cost of placements, and rigorous on-going panel arrangements. Furthermore the successful promotion and increased use of enablement continues to result in fewer people needing long term support. Robust monitoring arrangements are in place on a monthly basis to ensure that forecasts and expenditure are closely monitored and where necessary challenged.

1.2 CAPITAL

1.2.1 All changes to cash limits are in accordance with the virement rules contained within the constitution and have received the appropriate approval via the Leader, or relevant delegated authority.

The capital cash limits have been adjusted to reflect the position in the 2011-14 MTFP as agreed by county council on 17 February 2011, any further adjustments are detailed in section 4.1.

1.2.2 **Table 3** below provides a portfolio overview of the latest capital monitoring position excluding PFI projects.

	Prev Yrs Exp £000s	2010-11 £000s	2011-12 £000s	2012-13 £000s	Future Yrs £000s	TOTAL £000s
Kent Adult Social Services portfolio						
Budget	4,176	6,749	13,366	5,868	6,045	36,204
Adjustments:						
- December re-phasing		-395	395			0
- Virement to CMY		-28				-28
Revised Budget	4,176	6,326	13,761	5,868	6,045	36,176
Variance		-678	692	0	0	14
split:						
- real variance		+14				+14
- re-phasing		-692	+692			0

Real Variance	**0**	**+14**	**0**	**0**	**0**	**+14**
Re-phasing	**0**	**-692**	**+692**	**0**	**0**	**0**

1.2.3 Main Reasons for Variance

Table 4 below, details all forecast capital variances over £250k in 2010-11 and identifies these between projects which are:

- part of our year on year rolling programmes e.g. maintenance and modernisation;
- projects which have received approval to spend and are underway;
- projects which are only at the approval to plan stage and
- Projects at preliminary stage.

The variances are also identified as being either a real variance i.e. real under or overspending which has resourcing implications, or a phasing issue i.e. simply down to a difference in timing compared to the budget assumption.

Each of the variances in excess of £1m which is due to phasing of the project, excluding those projects identified as only being at the preliminary stage, is explained further in section 1.2.4 below.

All real variances are explained in section 1.2.5, together with the resourcing implications.

Table 4: CAPITAL VARIANCES OVER £250K IN SIZE ORDER

			Project Status			
portfolio	Project	real/ phasing	Rolling Programme	Approval to Spend	Approval to Plan	Preliminary Stage
			£'000s	£'000s	£'000s	£'000s
Overspends/Projects ahead of schedule						
			+0	**+0**	**+0**	**+0**
Underspends/Projects behind schedule						
KASS	LD Good Day Programme	phasing			-327	
			0	**-0**	**-327**	**-0**
			-0	**-0**	**-327**	**-0**

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1.2.4 **Projects re-phasing by over £1m**:

None

1.2.5 **Projects with real variances, including resourcing implications:**

The real variance of £0.014m is to be covered by developer contributions.

1.2.6 **General Overview of capital programme**:

(a) Risks

There are no current risks

(b) Details of action being taken to alleviate risks

1.2.7 **PFI projects**

The £44.3m investment in the PFI Excellent Homes for All project also represents investment by a third party. No payment is made by KCC for the assets until they were ready for use and this is by way of an annual unitary charge to the revenue budget

	Previous years	**2010-11**	**2011-12**	**2012-13**	**TOTAL**
	£000s	£000s	£000s	£000s	£000s
Budget		22,300	22,000		44,300
Forecast		22,300	22,000		44,300
Variance					

(a) **Progress and details of whether costings are still as planned (for the 3rd party)**

Overall costings still as planned.

(b) **Implications for KCC of details reported in (a) ie could an increase in the cost result in a change to the unitary charge?**

The unitary charge is not subject to indexation as the contractor has agreed to a fixed price for the duration of the contract. Deductions will be made during the contract period if performance falls below the standards agreed or if the facilities are unavailable for use.

During the contract period if one of the partners proposes a change that either results in increased costs or a change in the balance of risk, this must be taken to the Project Board for agreement. Each partner has a vote and any decision resulting in a change to the costs or risks would need unanimous approval.

1.2.8 **Project Re-Phasing**

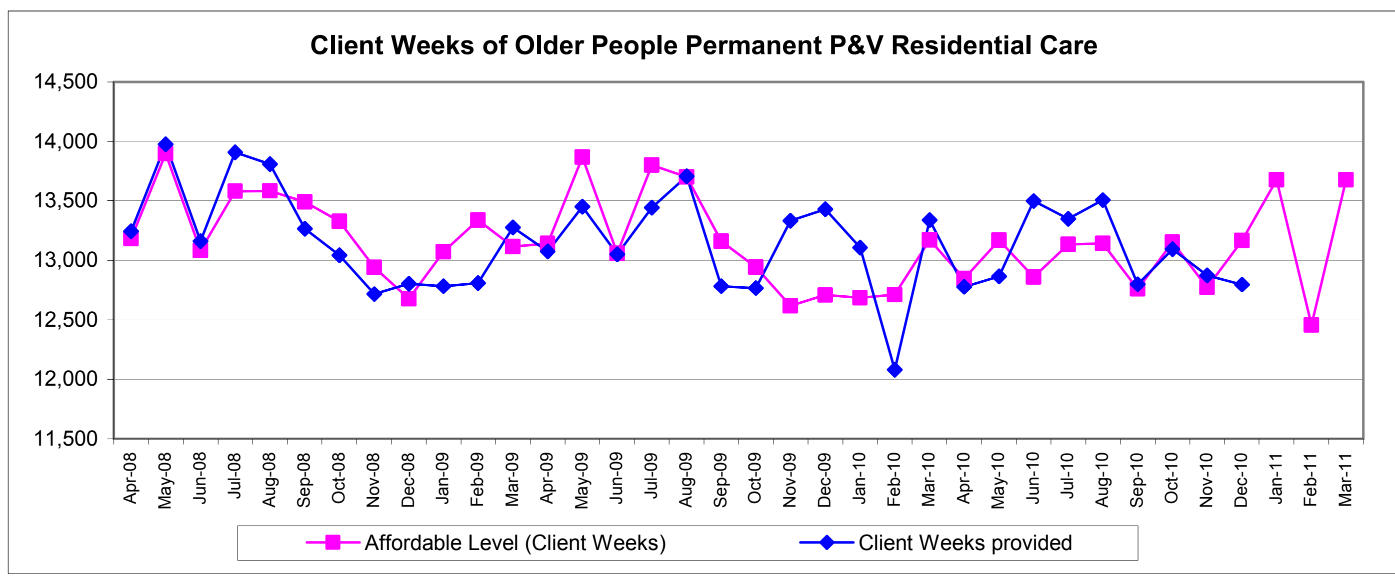
Cash limits are changed for projects that have re-phased by greater than £0.100m to reduce the reporting requirements during the year. Any subsequent re-phasing greater than £0.100m will be reported and the full extent of the rephasing will be shown. The proposed re-phasing is detailed in the table below.

	2010-11	2011-12	2012-13	Future Years	Total
	£'000	£'000	£'000	£'000	£'000
Broadmeadow Extension					
Amended total cash limits	+1,718	+38	0	0	+1,756
re-phasing	-111	+111		-20	-20
Revised project phasing	**+1,607**	**+149**	**0**	**-20**	**+1,736**
LD Good Day Programme					
Amended total cash limits	+452	+3,325	+1,600	+1,521	+6,898
re-phasing	-327	+327			0
Revised project phasing	**+125**	**+3,652**	**+1,600**	**+1,521**	**+6,898**
Total re-phasing >£100k	**-438**	**+438**	**0**	**-20**	**-20**
Other re-phased Projects below £100k	-254	+254			
TOTAL RE-PHASING	**-692**	**+692**	**0**	**-20**	**-20**

2. KEY ACTIVITY INDICATORS AND BUDGET RISK ASSESSMENT MONITORING

2.1.1 **Number of client weeks of older people permanent P&V residential care provided compared with affordable level**:

	2008-09		2009-10		2010-11	
	Affordable Level (Client Weeks)	Client Weeks of older people permanent P&V residential care provided	Affordable Level (Client Weeks)	Client Weeks of older people permanent P&V residential care provided	Affordable Level (Client Weeks)	Client Weeks of older people permanent P&V residential care provided
April	13,181	13,244	13,142	13,076	12,848	12,778
May	13,897	13,974	13,867	13,451	13,168	12,867
June	13,084	13,160	13,059	13,050	12,860	13,497
July	13,581	13,909	13,802	13,443	13,135	13,349
August	13,585	13,809	13,703	13,707	13,141	13,505
September	13,491	13,264	13,162	12,784	12,758	12,799
October	13,326	13,043	12,943	12,768	13,154	13,094
November	12,941	12,716	12,618	13,333	12,771	12,873
December	12,676	12,805	12,707	13,429	13,167	12,796
January	13,073	12,784	12,685	13,107	13,677	
February	13,338	12,810	12,712	12,082	12,455	
March	13,114	13,275	13,172	13,338	13,678	
TOTAL	**159,287**	**158,793**	**157,572**	**157,568**	**156,812**	**117,558**

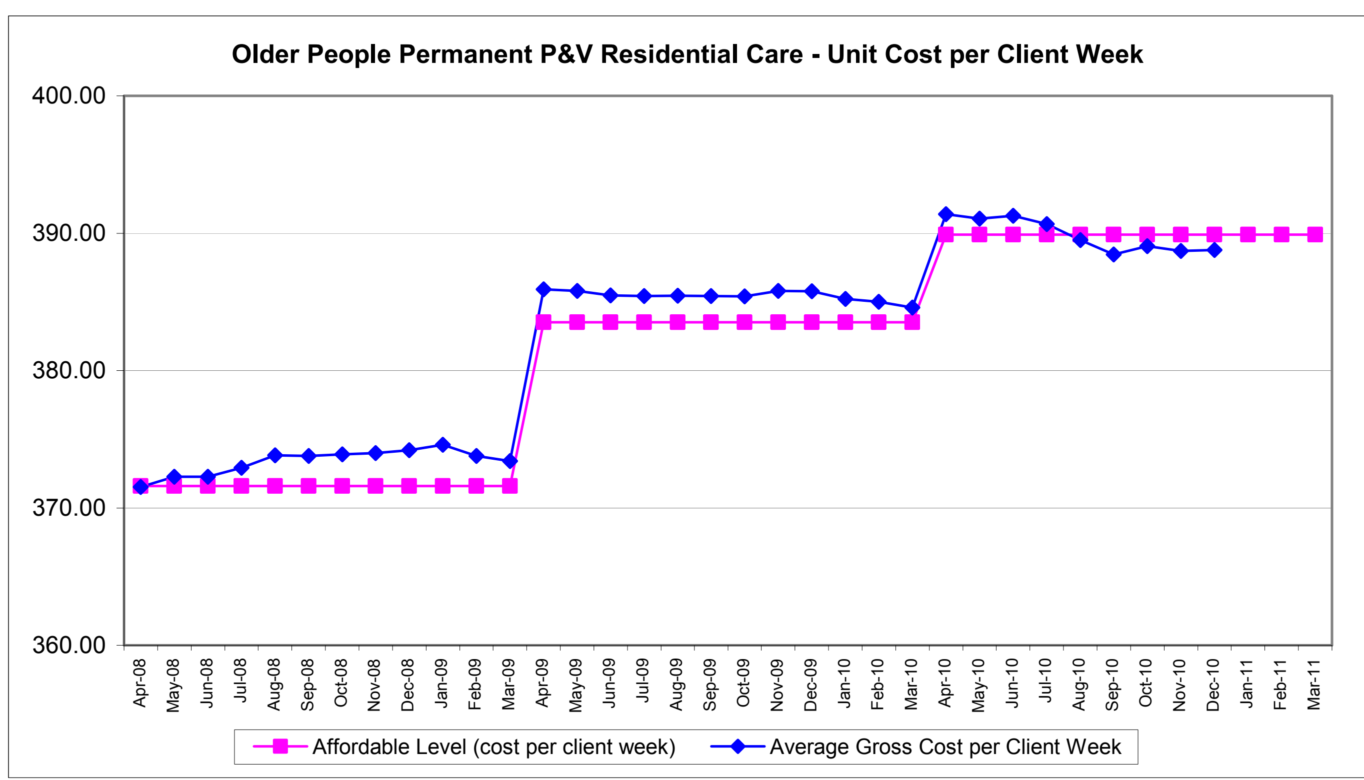


Comments:

- The affordable level for the period January to March has been adjusted since the last quarter to reflect the additional winter pressures and re-ablement funding from health referred to in section 1.1.3.1.
- The above graph reflects the number of client weeks of service provided as this has a greater influence on cost than the actual number of clients. The actual number of clients in older people permanent P&V residential care at the end of 2008-09 was 2,832, at the end of 2009-10 it was 2,751 and at the end of December 2010 it was 2,782. It is evident that there are ongoing pressures relating to clients with dementia. During this year, the number of clients with dementia has increased from 1,195 in March to 1,253 in December, and the other residential clients have decreased from 1,556 in March to 1,529 in December.
- The current forecast is 157,297 weeks of care against an affordable level of 156,812, a difference of +485 weeks. Using the forecast unit cost of £388.80 this increase in activity increases the forecast by £189k, as highlighted in section 1.1.3.2.a.
- To the end of December 117,558 weeks of care have been delivered against an affordable level of 117,002; a difference of +556 weeks.

2.1.2 **Average gross cost per client week of older people permanent P&V residential care compared with affordable level**:

	2008-09		2009-10		2010-11	
	Affordable Level (Cost per Week)	**Average Gross Cost per Client Week**	**Affordable Level (Cost per Week)**	**Average Gross Cost per Client Week**	**Affordable Level (Cost per Week)**	**Average Gross Cost per Client Week**
April	371.60	371.54	383.52	385.90	389.91	391.40
May	371.60	372.28	383.52	385.78	389.91	391.07
June	371.60	372.27	383.52	385.47	389.91	391.29
July	371.60	372.94	383.52	385.43	389.91	390.68
August	371.60	373.84	383.52	385.44	389.91	389.51
September	371.60	373.78	383.52	385.42	389.91	388.46
October	371.60	373.91	383.52	385.39	389.91	389.06
November	371.60	374.01	383.52	385.79	389.91	388.72
December	371.60	374.22	383.52	385.76	389.91	388.80
January	371.60	374.61	383.52	385.20	389.91	
February	371.60	373.78	383.52	385.01	389.91	
March	371.60	373.42	383.52	384.59	389.91	

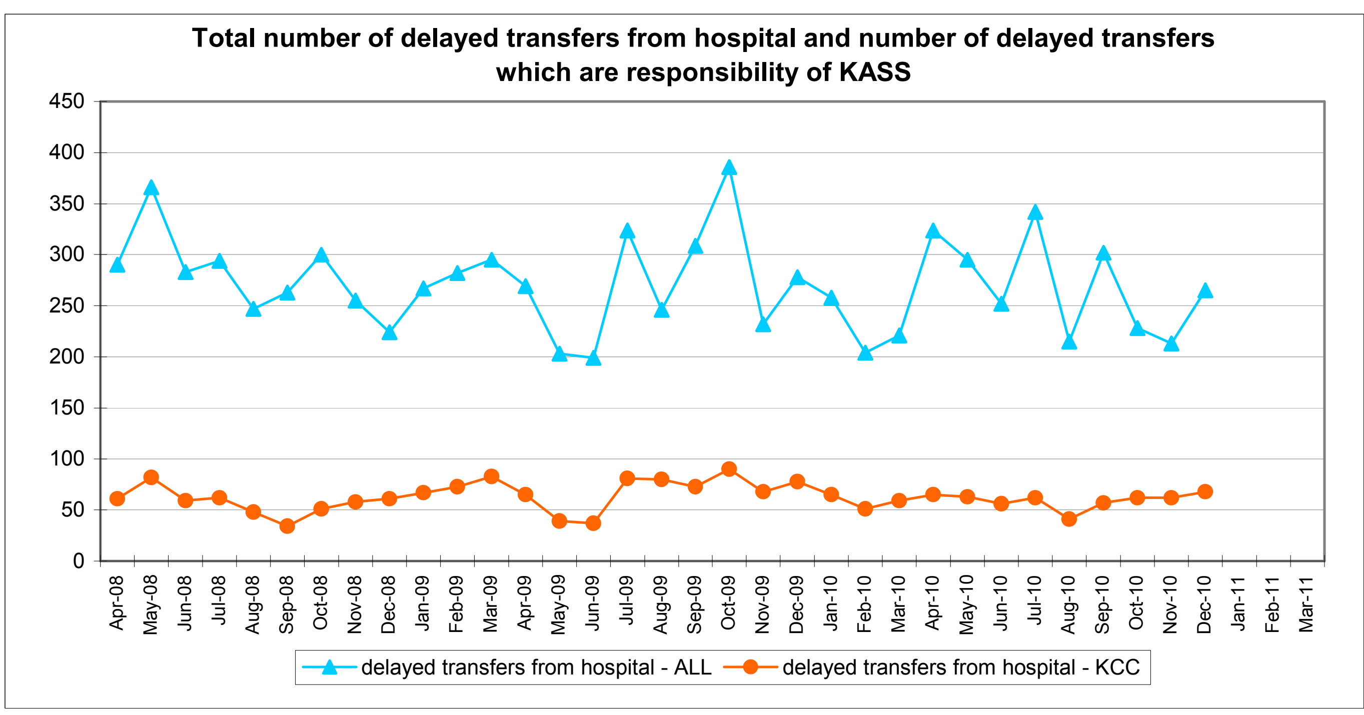


Comments:

- The forecast unit cost of £388.80 is lower than the affordable cost of £389.91 and this difference of £1.11 creates a saving of £174k when multiplied by the affordable weeks, as highlighted in section 1.1.3.2.a

2.1.3 **Total of All Delayed Transfers from hospital compared with those which are KASS responsibility**:

	2008-09		2009-010		2010-11	
	ALL	KASS responsibility	ALL	KASS responsibility	ALL	KASS responsibility
April	290	61	269	65	324	65
May	366	82	203	39	295	63
June	283	59	199	37	252	56
July	294	62	324	81	342	62
August	247	48	246	80	215	41
September	263	34	309	73	302	57
October	300	51	386	90	228	62
November	255	58	232	68	213	62
December	224	61	278	78	265	68
January	267	67	258	65		
February	282	73	204	51		
March	295	83	221	59		



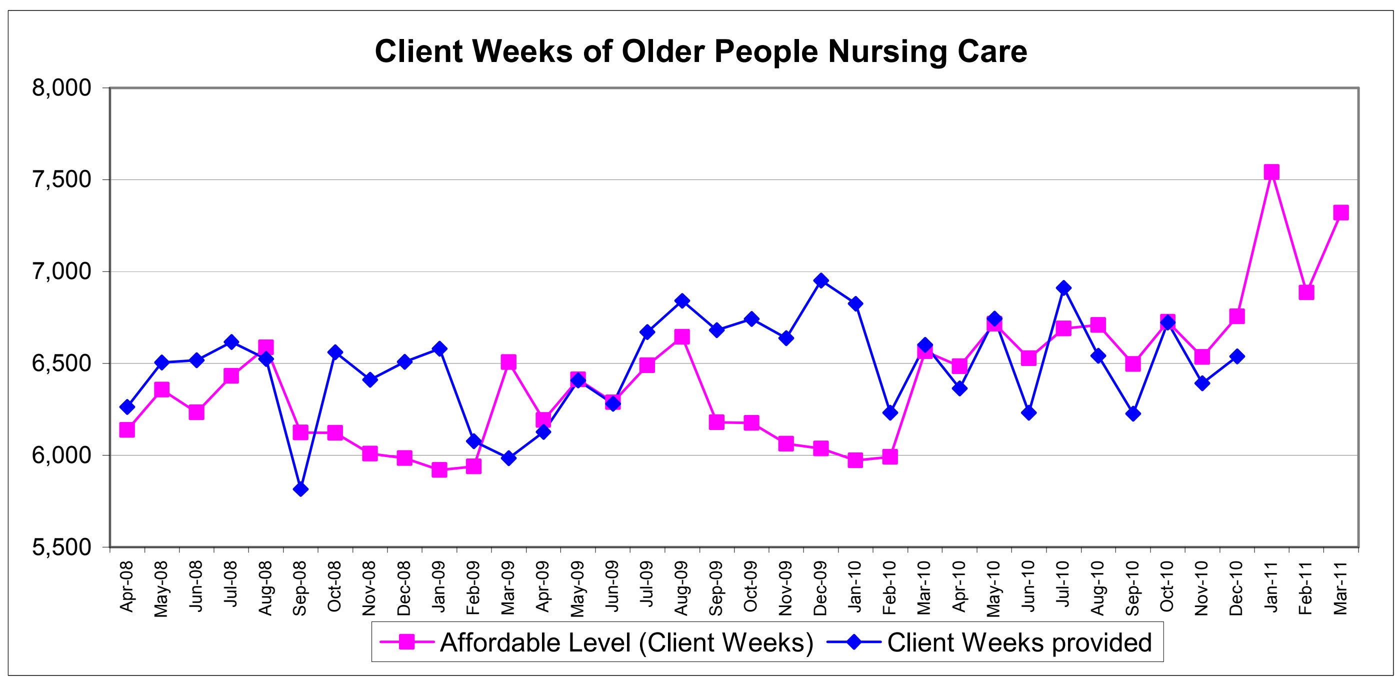
Comments:

- The Delayed Transfers of Care (DTCs) show the numbers of people whose movement from an acute hospital has been delayed. Generally, the main reasons for delay are 'Patient Choice' (just over 25%), with the reasons 'Awaiting non-acute NHS care' and 'Awaiting assessment' being the next highest (approx. 19% each). This figure shows all delays, but those attributable to Adult Social Services, and therefore subject to the reimbursement regime, are a minority. There are many reasons for fluctuations in the number of DTCs which result from the interaction of various different factors within a highly complex system across both Health and Social Care.

- This activity information is obtained from the KASS hospital teams who monitor delayed discharges on a weekly basis and validate the figures with the Hospital Trust.

2.2.1 **Number of client weeks of older people nursing care provided compared with affordable level:**

	2008-09		2009-10		2010-11	
	Affordable Level (Client Weeks)	Client Weeks of older people nursing care provided	Affordable Level (Client Weeks)	Client Weeks of older people nursing care provided	Affordable Level (Client Weeks)	Client Weeks of older people nursing care provided
April	6,137	6,263	6,191	6,127	6,485	6,365
May	6,357	6,505	6,413	6,408	6,715	6,743
June	6,233	6,518	6,288	6,279	6,527	6,231
July	6,432	6,616	6,489	6,671	6,689	6,911
August	6,586	6,525	6,644	6,841	6,708	6,541
September	6,124	5,816	6,178	6,680	6,497	6,225
October	6,121	6,561	6,175	6,741	6,726	6,722
November	6,009	6,412	6,062	6,637	6,535	6,393
December	5,984	6,509	6,037	6,952	6,755	6,539
January	5,921	6,580	5,973	6,824	7,541	
February	5,940	6,077	5,992	6,231	6,885	
March	6,507	5,985	6,566	6,601	7,319	
TOTAL	**74,351**	**76,367**	**75,008**	**78,992**	**81,382**	**58,670**



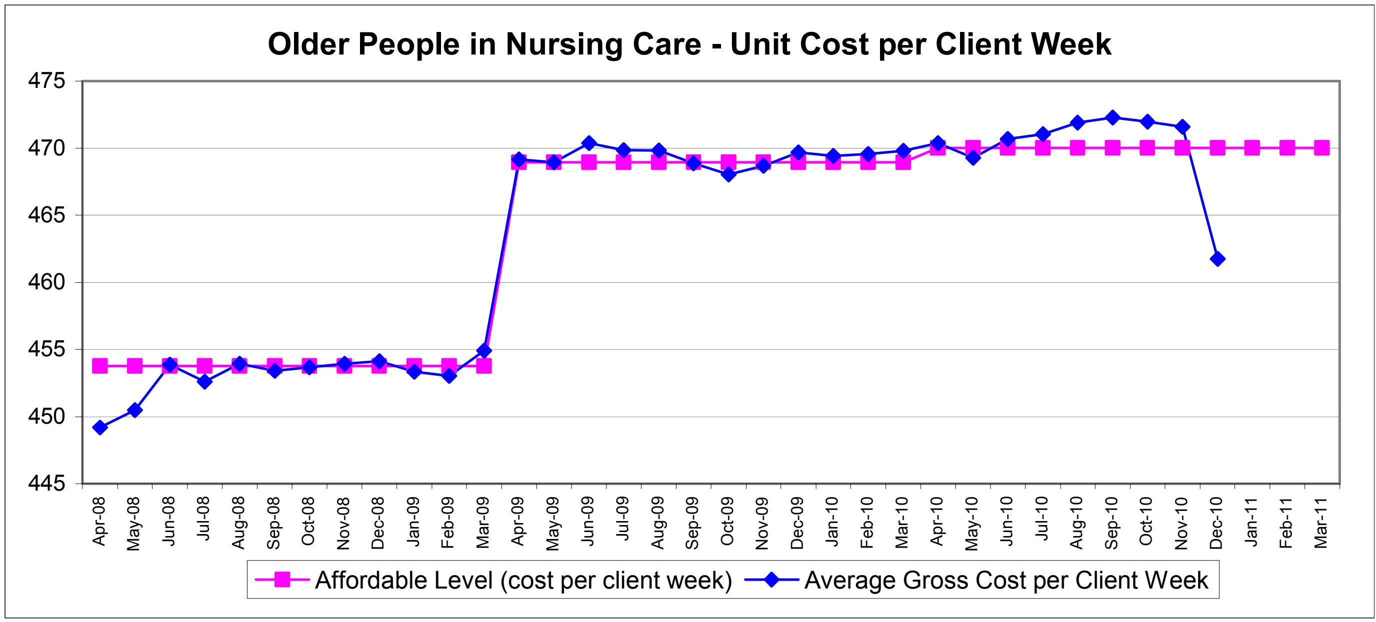
Comment:

- The affordable level for the period January to March has been adjusted since the last quarter to reflect the additional winter pressures and re-ablement funding from health referred to in section 1.1.3.1.
- The above graph reflects the number of client weeks of service provided as this has a greater influence on cost than the actual number of clients. The actual number of clients in older people nursing care at the end of 2008-09 was 1,332, at the end of 2009-10 it was 1,374 and at the end of December 2010 was 1,372. In nursing care, there is not the same distinction between clients with dementia, as with residential care.
- The current forecast is 79,696 weeks of care against an affordable level of 81,382 a difference of -1,686 weeks. Using the forecast unit cost of £461.75, this reduction in activity reduces the forecast by £779k, as highlighted in section 1.1.3.2.b.
- To the end of December 58,670 weeks of care have been delivered against an affordable level of 59,637, a difference of -967 weeks.
- There are always pressures in permanent nursing care which may occur for many reasons. Increasingly, older people are entering nursing care only when other ways of support have been explored. This means that the most dependent are those that enter nursing care and consequently

are more likely to have dementia. In addition, there will always be pressures which the directorate face, for example the knock on effect of minimising delayed transfers of care. Demographic changes – increasing numbers of older people with long term illnesses – also means that there is an underlying trend of growing numbers of people needing nursing care.

2.2.2 **Average gross cost per client week of older people nursing care compared with affordable level**:

	2008-09		2009-10		2010-11	
	Affordable Level (Cost per Week)	**Average Gross Cost per Client Week**	**Affordable Level (Cost per Week)**	**Average Gross Cost per Client Week**	**Affordable Level (Cost per Week)**	**Average Gross Cost per Client Week**
April	453.77	449.18	468.95	469.15	470.01	470.36
May	453.77	450.49	468.95	468.95	470.01	469.27
June	453.77	453.86	468.95	470.37	470.01	470.67
July	453.77	452.61	468.95	469.84	470.01	471.03
August	453.77	453.93	468.95	469.82	470.01	471.90
September	453.77	453.42	468.95	468.88	470.01	472.28
October	453.77	453.68	468.95	468.04	470.01	471.97
November	453.77	453.92	468.95	468.69	470.01	471.58
December	453.77	454.13	468.95	469.67	470.01	461.75
January	453.77	453.33	468.95	469.42	470.01	
February	453.77	453.02	468.95	469.55	470.01	
March	453.77	454.90	468.95	469.80	470.01	

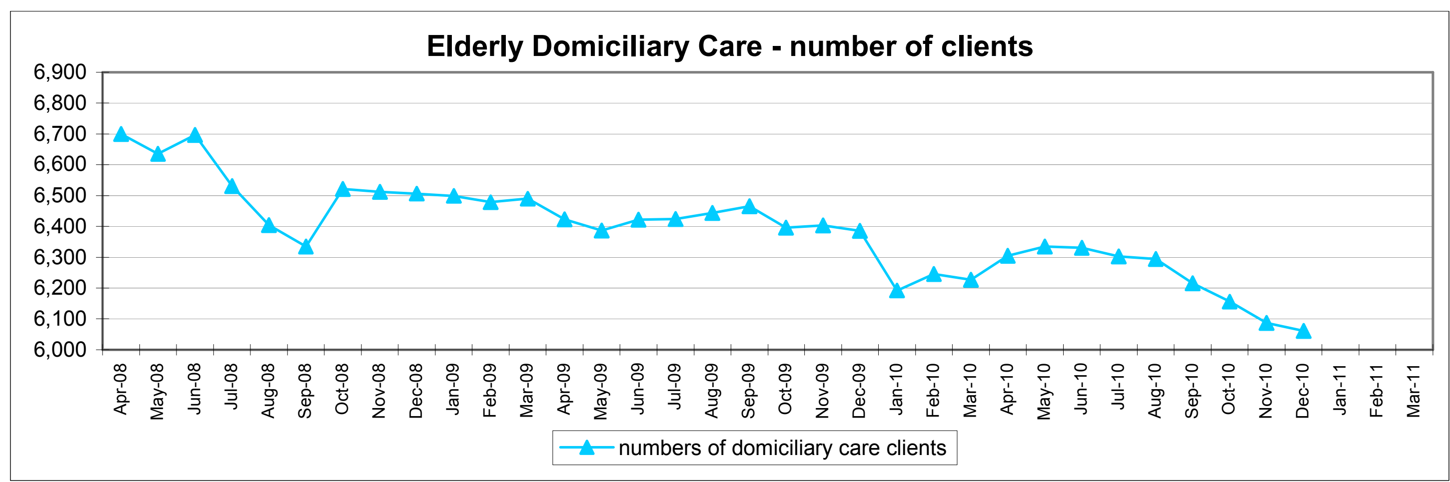


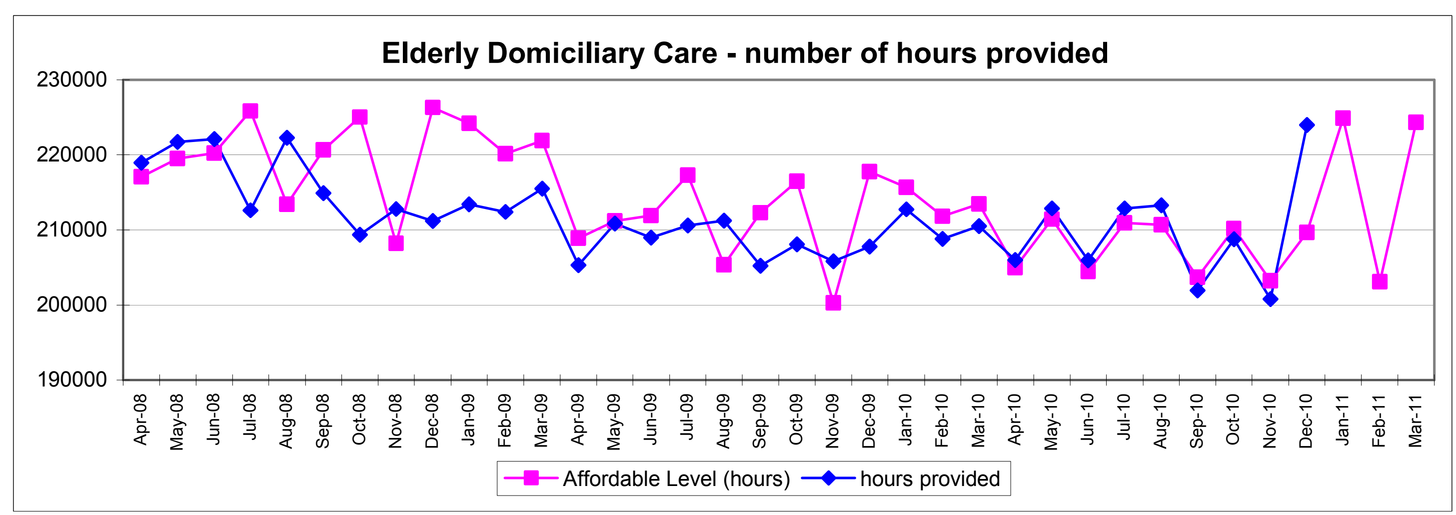
Comments:

- As with residential care, the unit cost for nursing care will be affected by the increasing proportion of older people with dementia who need more specialist and expensive care.
- The forecast unit cost of £461.75 is lower than the affordable cost of £470.01 and this difference of £8.26 reduces the position by £672k when multiplied by the affordable weeks, as highlighted in section 1.1.3.2.b
- The unit cost has reduced significantly in December due to an error identified in the previously reported figure.

2.3.1 **Elderly domiciliary care – numbers of clients and hours provided**:

	2008-09			2009-10			2010-11		
	Affordable level (hours)	hours provided	number of clients	Affordable level (hours)	hours provided	number of clients	Affordable level (hours)	hours provided	number of clients
April	217,090	218,929	6,700	208,869	205,312	6,423	204,948	205,989	6,305
May	219,480	221,725	6,635	211,169	210,844	6,386	211,437	212,877	6,335
June	220,237	222,088	6,696	211,897	208,945	6,422	204,452	205,937	6,331
July	225,841	212,610	6,531	217,289	210,591	6,424	210,924	212,866	6,303
August	213,436	222,273	6,404	205,354	211,214	6,443	210,668	213,294	6,294
September	220,644	214,904	6,335	212,289	205,238	6,465	203,708	201,951	6,216
October	225,012	209,336	6,522	216,491	208,051	6,396	210,155	208,735	6,156
November	208,175	212,778	6,512	200,292	205,806	6,403	203,212	200,789	6,087
December	226,319	211,189	6,506	217,749	207,771	6,385	209,643	223,961	6,061
January	224,175	213,424	6,499	215,686	212,754	6,192	224,841		
February	220,135	212,395	6,478	211,799	208,805	6,246	203,103		
March	221,875	215,488	6,490	213,474	210,507	6,227	224,285		
TOTAL	**2,642,419**	**2,587,139**		**2,542,358**	**2,505,838**		**2,521,376**	**1,886,399**	





Comment:

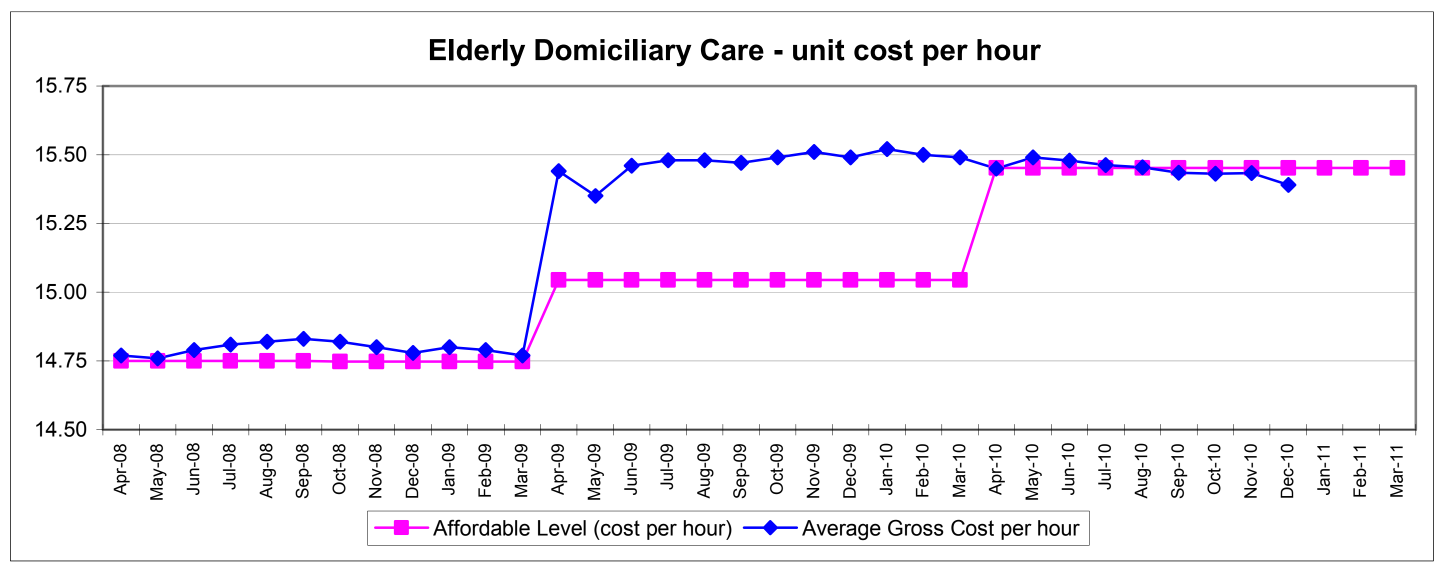
- The affordable level for the period January to March has been adjusted since the last quarter to reflect the additional winter pressures and re-ablement funding from health referred to in section 1.1.3.1.
- Actual hours of care have been updated for previous months to reflect late data entry and provides a more accurate trend.
- Figures exclude services commissioned from the Kent Enablement At Home service.
- The current forecast is 2,558,748 hours of care against an affordable level of 2,521,376, a difference of +37,372 hours. Using the forecast unit cost of £15.393 this additional activity increases the forecast

by £575k, as highlighted in section 1.1.3.2.c. We are expecting an increase in permanent clients in the final quarter of the year, which explains why the year to date (YTD) appears low when compared to this forecast.

- To the end of December 1,886,399 hours of care have been delivered against an affordable level of 1,869,147, a difference of +17,252 hours. The higher figures in July and August follow a trend in previous years where the figures for the summer months appear to peak and then drop again.
- While the number of clients receiving domiciliary care has been decreasing over the past two years, this trend appears to have slowed, and flattened out as the number of clients forecast is now 6,194 133 more than the current figure of 6,061. In addition, the intensity of care appears to have increased such that clients are receiving more hours per week on average than in previous years as a result of the implementation of Self Directed Support (SDS) within the Directorate.

2.3.2 **Average gross cost per hour of older people domiciliary care compared with affordable level**:

	2008-09		2009-10		2010-11	
	Affordable Level (Cost per Hour)	Average Gross Cost per Hour	Affordable Level (Cost per Hour)	Average Gross Cost per Hour	Affordable Level (Cost per Hour)	Average Gross Cost per Hour
April	14.75	14.77	15.045	15.44	15.45	15.45
May	14.75	14.76	15.045	15.35	15.45	15.49
June	14.75	14.79	15.045	15.46	15.45	15.48
July	14.75	14.81	15.045	15.48	15.45	15.46
August	14.75	14.82	15.045	15.48	15.45	15.45
September	14.75	14.83	15.045	15.47	15.45	15.44
October	14.75	14.82	15.045	15.49	15.45	15.43
November	14.75	14.80	15.045	15.51	15.45	15.43
December	14.75	14.78	15.045	15.49	15.45	15.39
January	14.75	14.80	15.045	15.52	15.45	
February	14.75	14.79	15.045	15.50	15.45	
March	14.75	14.77	15.045	15.49	15.45	

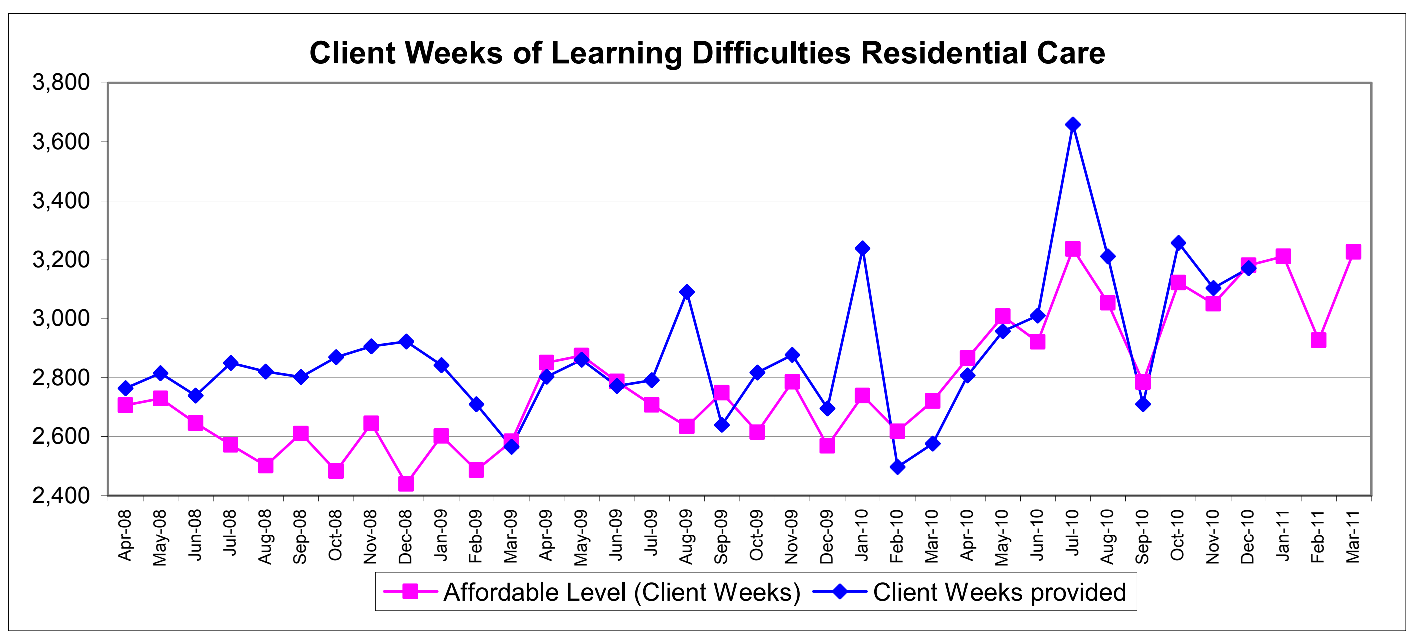


Comments:

- The forecast unit cost of £15.393 is slightly lower than the affordable cost of £15.452 and this difference of £0.059 creates a saving of £147k when multiplied by the affordable hours, as highlighted in section 1.1.3.2.c

2.4.1 Number of client weeks of learning difficulties residential care provided compared with affordable level (non preserved rights clients):

	2008-09		2009-10		2010-11	
	Affordable Level (Client Weeks)	Client Weeks of LD residential care provided	Affordable Level (Client Weeks)	Client Weeks of LD residential care provided	Affordable Level (Client Weeks)	Client Weeks of LD residential care provided
April	2,707	2,765	2,851	2,804	2,866	2,808
May	2,730	2,815	2,875	2,861	3,009	2,957
June	2,647	2,740	2,787	2,772	2,922	3,011
July	2,572	2,850	2,708	2,792	3,236	3,658
August	2,502	2,821	2,635	3,091	3,055	3,211
September	2,611	2,803	2,750	2,640	2,785	2,711
October	2,483	2,870	2,615	2,818	3,123	3,257
November	2,646	2,906	2,786	2,877	3,051	3,104
December	2,440	2,923	2,569	2,696	3,181	3,171
January	2,602	2,842	2,740	3,238	3,211	
February	2,487	2,711	2,619	2,497	2,927	
March	2,584	2,565	2,721	2,576	3,227	
TOTAL	**31,011**	**33,611**	**32,656**	**33,662**	**36,593**	**27,888**

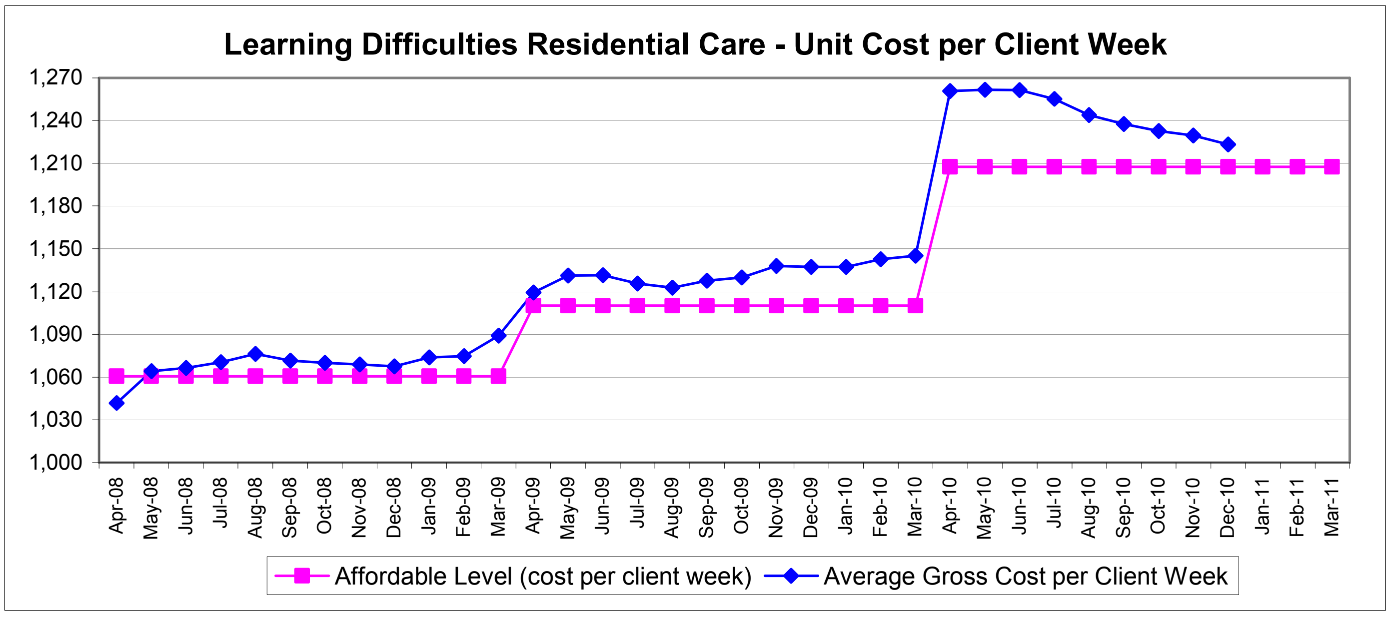


Comments:

- The above graph reflects the number of client weeks of service provided as this has a greater influence on cost than the actual number of clients. The actual number of clients in LD residential care at the end of 2008-09 was 640, at the end of 2009-10 it was 632 and at the end of December 2010 it was 708 of which 114 are S256 clients.
- The current forecast is 37,645 weeks of care against an affordable level of 36,593 a difference of +1,052 weeks. Using the forecast unit cost of £1,223.31 this additional activity adds £1,287k to the forecast, as highlighted in section 1.1.3.3.a. We are expecting an increase in both permanent clients, and non permanent episodes in the remaining months of the year, which explains why the year to date (YTD) appears slightly low when compared to this forecast.
- To the end of December 27,888 weeks of care have been delivered against an affordable level of 27,228, a difference of +660 weeks.

2.4.2 Average gross cost per client week of Learning Difficulties residential care compared with affordable level (non preserved rights clients):

	2008-09		2009-10		2010-11	
	Affordable Level (Cost per Week)	Average Gross Cost per Client Week	Affordable Level (Cost per Week)	Average Gross Cost per Client Week	Affordable Level (Cost per Week)	Average Gross Cost per Client Week
April	1,060.70	1,041.82	1,110.15	1,119.42	1,207.58	1,260.82
May	1,060.70	1,064.19	1,110.15	1,131.28	1,207.58	1,261.67
June	1,060.70	1,066.49	1,110.15	1,131.43	1,207.58	1,261.46
July	1,060.70	1,070.50	1,110.15	1,125.65	1,207.58	1,255.21
August	1,060.70	1,076.27	1,110.15	1,122.81	1,207.58	1,243.87
September	1,060.70	1,071.59	1,110.15	1,127.79	1,207.58	1,237.49
October	1,060.70	1,070.02	1,110.15	1,130.07	1,207.58	1,232.68
November	1,060.70	1,068.95	1,110.15	1,137.95	1,207.58	1,229.44
December	1,060.70	1,067.59	1,110.15	1,137.28	1,207.58	1,223.31
January	1,060.70	1,073.71	1,110.15	1,137.41	1,207.58	
February	1,060.70	1,074.67	1,110.15	1,142.82	1,207.58	
March	1,060.70	1,089.10	1,110.15	1,145.12	1,207.58	

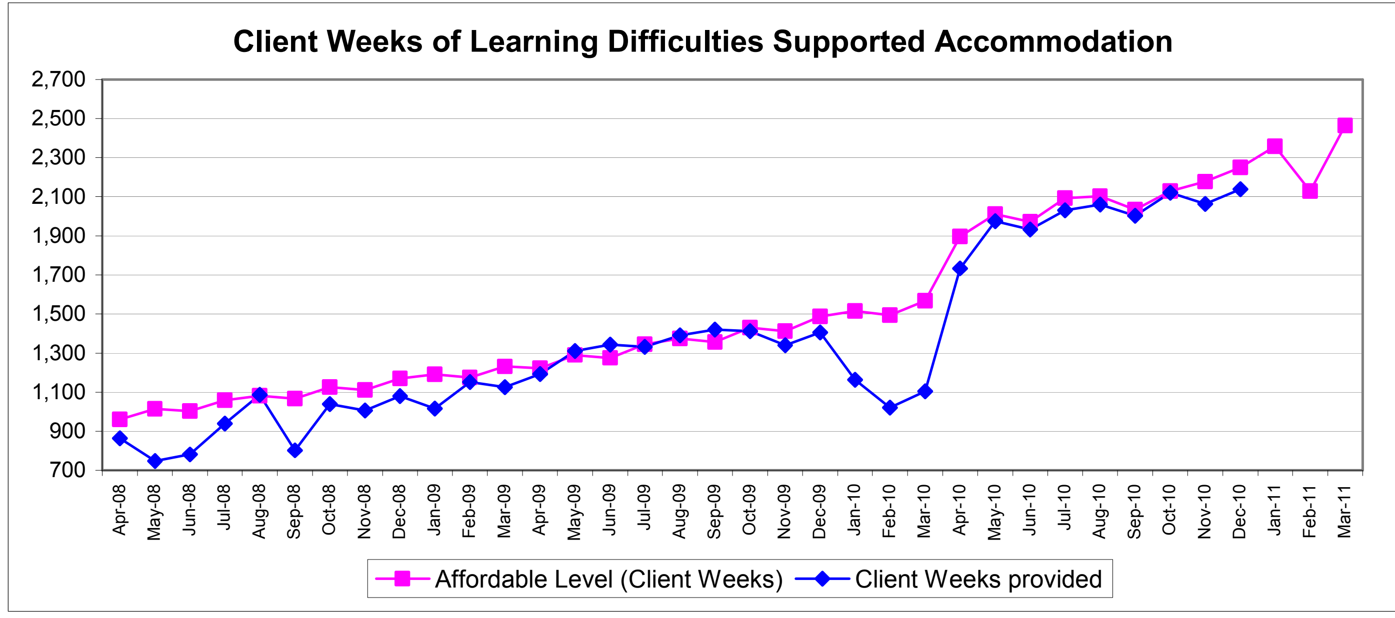


Comments:

- Clients being placed in residential care are those with very complex and individual needs which makes it difficult for them to remain in the community, in supported accommodation/supporting living arrangements, or receiving a domiciliary care package. These are therefore placements which attract a very high cost, with the average now being over £1,200 per week. It is expected that clients with less complex needs, and therefore less cost, can transfer from residential into supported living arrangements. This would mean that the average cost per week would increase over time as the remaining clients in residential care would be those with very high cost – some of whom can cost up to £2,000 per week. In addition, no two placements are alike – the needs of people with learning disabilities are unique and consequently, it is common for average unit costs to increase or decrease significantly on the basis of one or two cases.
- The forecast unit cost of £1,223.31 is higher than the affordable cost of £1,207.58 and this difference of £15.73 adds £576k to the position when multiplied by the affordable weeks, as highlighted in section 1.1.3.3.a

2.5.1 **Number of client weeks of learning difficulties supported accommodation provided compared with affordable level:**

	2008-09		2009-10		2010-11	
	Affordable Level (Client Weeks)	**Client Weeks of LD supported accommodation provided**	**Affordable Level (Client Weeks)**	**Client Weeks of LD supported accommodation provided**	**Affordable Level (Client Weeks)**	**Client Weeks of LD supported accommodation provided**
April	960	865	1,221	1,192	1,841	1,752
May	1,014	747	1,290	1,311	1,951	1,988
June	1,003	782	1,276	1,344	1,914	1,956
July	1,058	939	1,346	1,333	2,029	2,060
August	1,081	1,087	1,375	1,391	2,034	2,096
September	1,067	803	1,357	1,421	1,951	2,059
October	1,125	1,039	1,431	1,412	2,080	2,119
November	1,110	1,006	1,412	1,340	2,138	2,063
December	1,169	1,079	1,487	1,405	2,210	2,137
January	1,191	1,016	1,515	1,163	2,314	
February	1,174	1,151	1,493	1,021	2,088	
March	1,231	1,125	1,567	1,105	2,417	
TOTAL	**13,183**	**11,639**	**16,770**	**15,438**	**24,967**	**18,229**



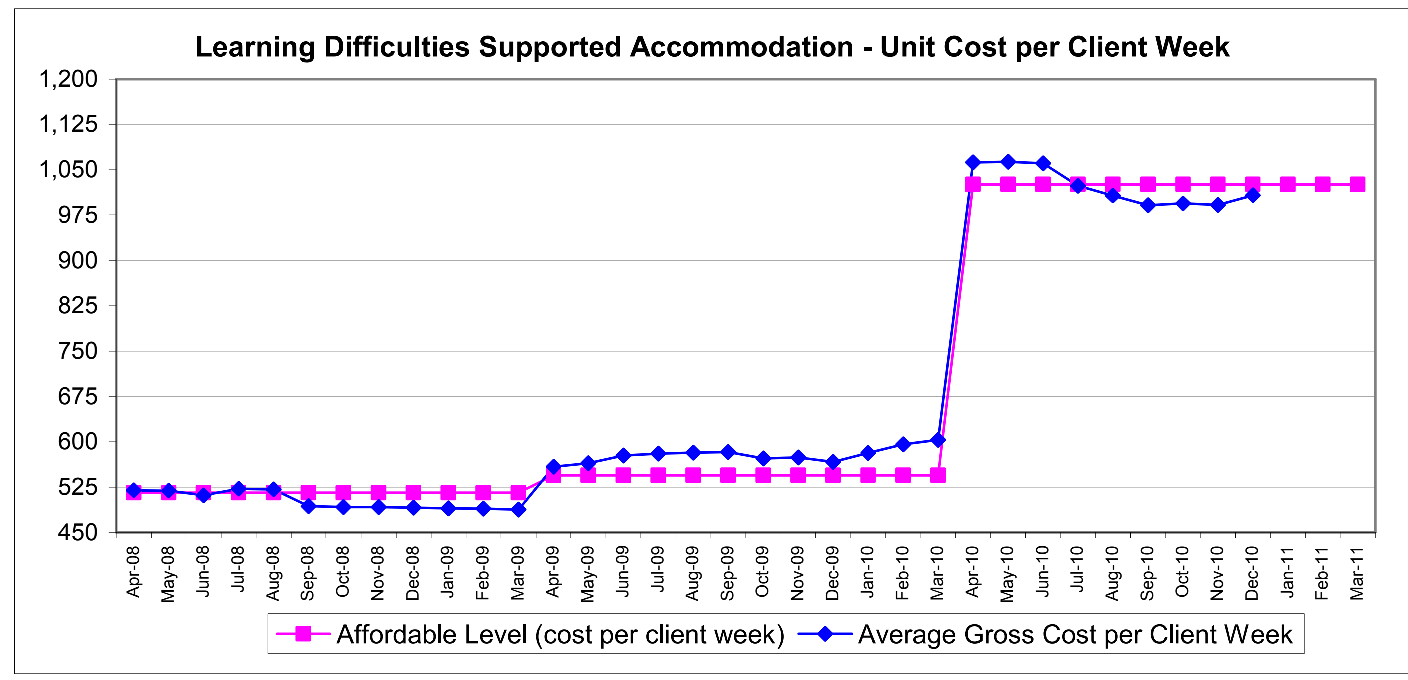
Comments:

- The affordable level of weeks has been amended to reflect the additional transfer of S256 clients and their funding from Health. It also now includes Ordinary Residence clients. The overall weeks have been increased to reflect the latest average hours per week for clients in receipt of supported living. This service is counted in hours rather than weeks and the process for converting to weeks for this report uses the latest average hours per week.
- The above graph reflects the number of client weeks of service provided. The actual number of clients in LD supported accommodation at the end of 2008-09 was 233, at the end of 2009-10 it was 309 and at the end of December 2010 was 487. This increase is almost solely due to S256 clients.
- The current forecast is 25,678 weeks of care against an affordable level of 24,967, a difference of +711 weeks which relates entirely to non-S256 clients. Using the forecast unit cost of £1,007.95 this increased activity creates a pressure of £716k as highlighted in section 1.1.3.3.d.
- To the end of December 18,229 care have been delivered against an affordable level of 18,148 a difference of +81 weeks. The year to date looks low compared to forecast and affordable as there are approximately 1,000 weeks included within the forecast relating to Ordinary Residence clients who have yet to show within the year to date activity. The forecast assumes that we take responsibility for the majority of these clients from April 2010 but they will only appear in actual activity once responsibility is confirmed.

- Like residential care for people with a learning disability, every case is unique and varies in cost, depending on the individual circumstances. Although the quality of life will be better for these people, it is not always significantly cheaper. The focus to enable as many people as possible to move from residential care into supported accommodation means that increasingly complex and unique cases will be successfully supported to live independently.

2.5.2 **Average gross cost per client week of Learning Difficulties supported accommodation compared with affordable level (non preserved rights clients)**:

	2008-09		2009-10		2010-11	
	Affordable Level (Cost per Week)	Average Gross Cost per Client Week	Affordable Level (Cost per Week)	Average Gross Cost per Client Week	Affordable Level (Cost per Week)	Average Gross Cost per Client Week
April	515.41	519.60	544.31	558.65	1,025.67	1,062.38
May	515.41	519.40	544.31	564.49	1,025.67	1,063.22
June	515.41	511.10	544.31	577.33	1,025.67	1,060.59
July	515.41	522.30	544.31	580.27	1,025.67	1,023.90
August	515.41	521.40	544.31	581.76	1,025.67	1,007.58
September	515.41	493.33	544.31	583.26	1,025.67	991.20
October	515.41	491.85	544.31	572.59	1,025.67	993.92
November	515.41	491.47	544.31	574.24	1,025.67	991.56
December	515.41	490.83	544.31	566.87	1,025.67	1,007.95
January	515.41	489.75	544.31	581.53	1,025.67	
February	515.41	488.90	544.31	595.89	1,025.67	
March	515.41	487.60	544.31	603.08	1,025.67	

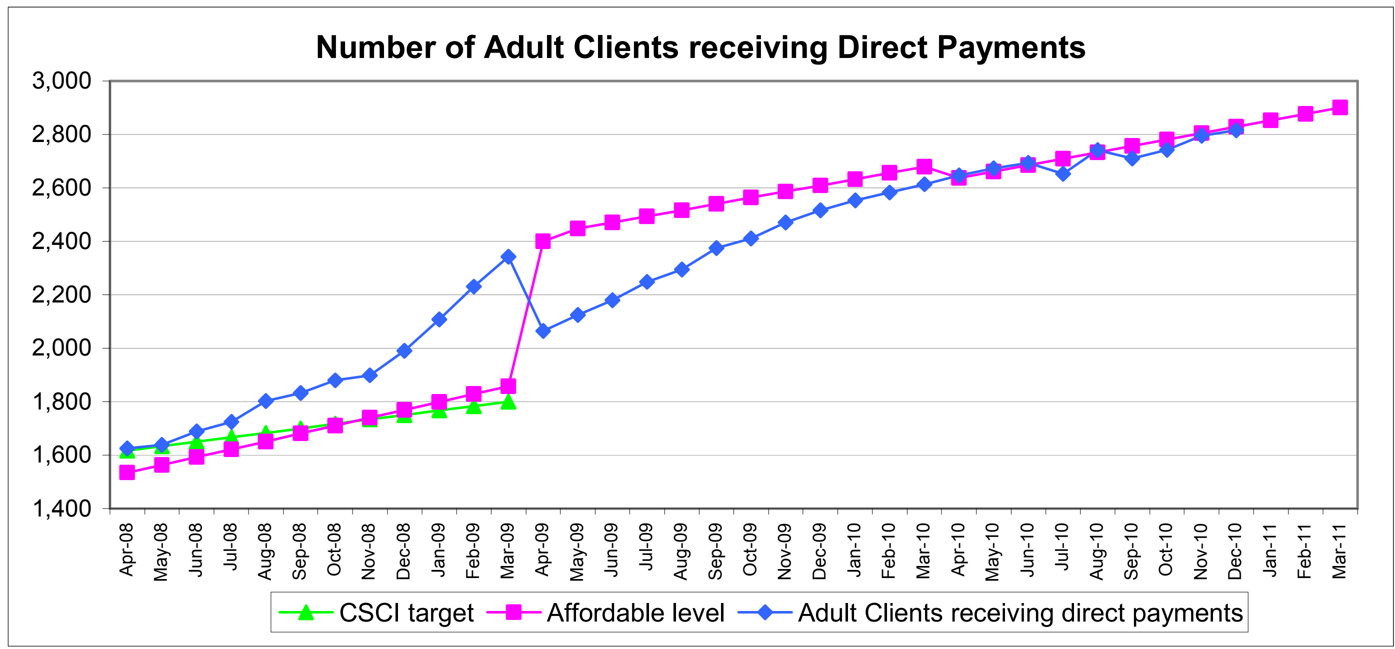


Comments:

- The affordable unit cost has been changed again in Quarter 3, to reflect the inclusion of new S256 clients and their funding, transferred from Health.
- The forecast unit cost of £1,007.95, which is lower than the affordable cost of £1,025.67. This difference of -£17.72 creates a saving of £442k when multiplied by the affordable weeks, as highlighted in section 1.1.3.3.d. As referred to in section 1.1.3.3.d, there are three distinct groups of clients: Section 256 clients, Ordinary Residence clients and other clients. Each group has a very different unit cost which are combined to provide an average unit cost for the purposes of this report.

2.6 **Direct Payments – Number of Adult Social Services Clients receiving Direct Payments:**

	2008-09			2009-10		2010-11	
	CSCI Target	Affordable Level	Adult Clients receiving Direct Payments	Affordable Level	Adult Clients receiving Direct Payments	Affordable Level	Adult Clients receiving Direct Payments
April	1,617	1,535	1,625	2,400	2,065	2,637	2,647
May	1,634	1,564	1,639	2,447	2,124	2,661	2,673
June	1,650	1,593	1,689	2,470	2,179	2,685	2,693
July	1,667	1,622	1,725	2,493	2,248	2,709	2,653
August	1,683	1,651	1,802	2,516	2,295	2,733	2,741
September	1,700	1,681	1,832	2,540	2,375	2,757	2,710
October	1,717	1,710	1,880	2,563	2,411	2,780	2,742
November	1,734	1,740	1,899	2,586	2,470	2,804	2,795
December	1,750	1,769	1,991	2,609	2,515	2,828	2,815
January	1,767	1,799	2,108	2,633	2,552	2,852	
February	1,783	1,828	2,231	2,656	2,582	2,876	
March	1,800	1,857	2,342	2,679	2,613	2,900	



Comments:

- The activity being reported is as per the Department of Health definition for counting Direct Payments, which includes anyone who has received a Direct Payment during the preceding 12 months, but includes only those that are ‘on-going’. i.e. in April the figures include clients who have received an on-going Direct Payment between 1st May 2009 and 30th April 2010, and the December figures includes clients who have received an on-going Direct Payment between 1st January 2010 and 31st December 2010. This compares with what was reported last year.

3. SOCIAL CARE DEBT MONITORING

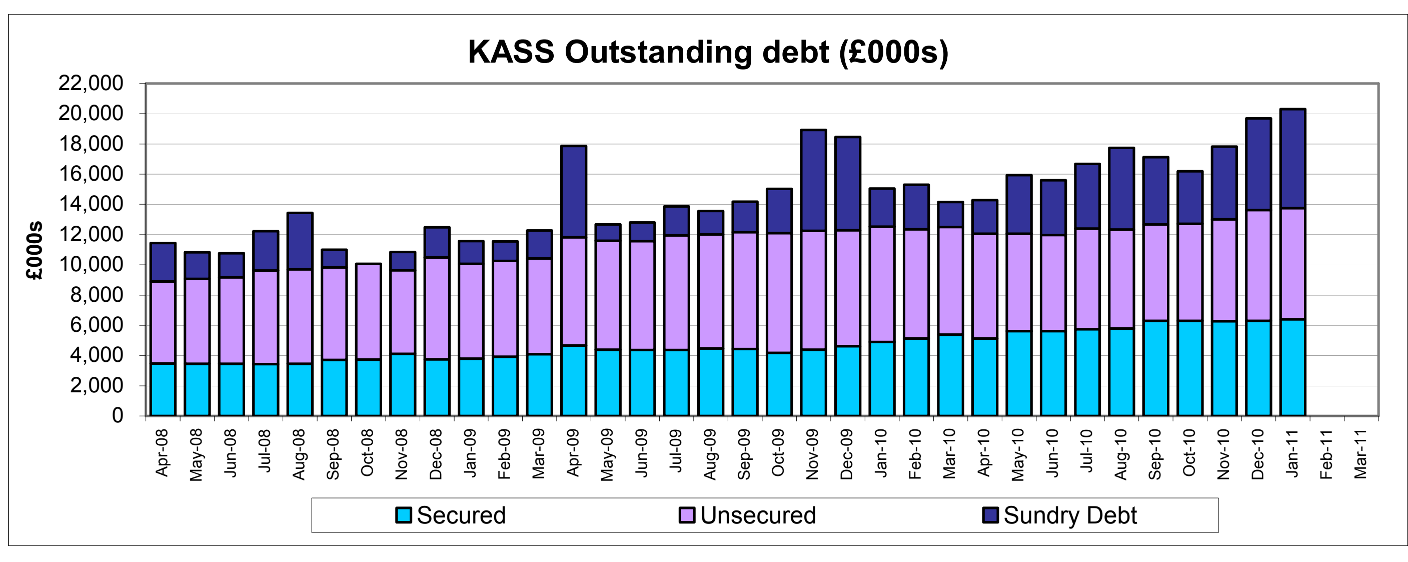
The outstanding due debt as at the January 2011 was £20.313m compared with October's figure of £16.200m (reported to Cabinet in November) excluding any amounts not yet due for payment (as they are still within the 28 day payment term allowed). Within this figure is £6.560m of sundry debt compared to £3.489m at the end of October. The amount of sundry debt can fluctuate for large invoices to health. Also within the outstanding debt is £13.753m relating to Social Care (client) debt which is an increase of £1.042m from the last reported position to Cabinet in November (October position). The following table shows how this breaks down in terms of age and also whether it is secured (i.e. by a legal charge on the client's property) or unsecured, together with how this month compares with previous months. For most months the debt figures refer to when the four weekly invoice billing run interfaces with Oracle (the accounting system) rather than the calendar month, as this provides a more meaningful position for Social Care Client Debt. This therefore means that there are 13 billing invoice runs during the year. It also means that as the Directorate moved onto the new Client Billing system in October 2008, the balance will differ from that reported by Corporate Exchequer who report on a calendar month basis, apart from the period November 2008 to March 2009, when the figures are based on calendar months, as provided by Corporate Exchequer, because reports at that time were not aligned with the four weekly billing runs. From April 2009 the debt figures revert back to being on a four weekly basis to coincide with invoice billing runs. The age of debt cannot be completed for the months between November 2008 and March 2009 as the switch to Client Billing meant that all debts transferring on to the new system became "new" for purposes of reporting therefore it was not possible to show ageing until April.

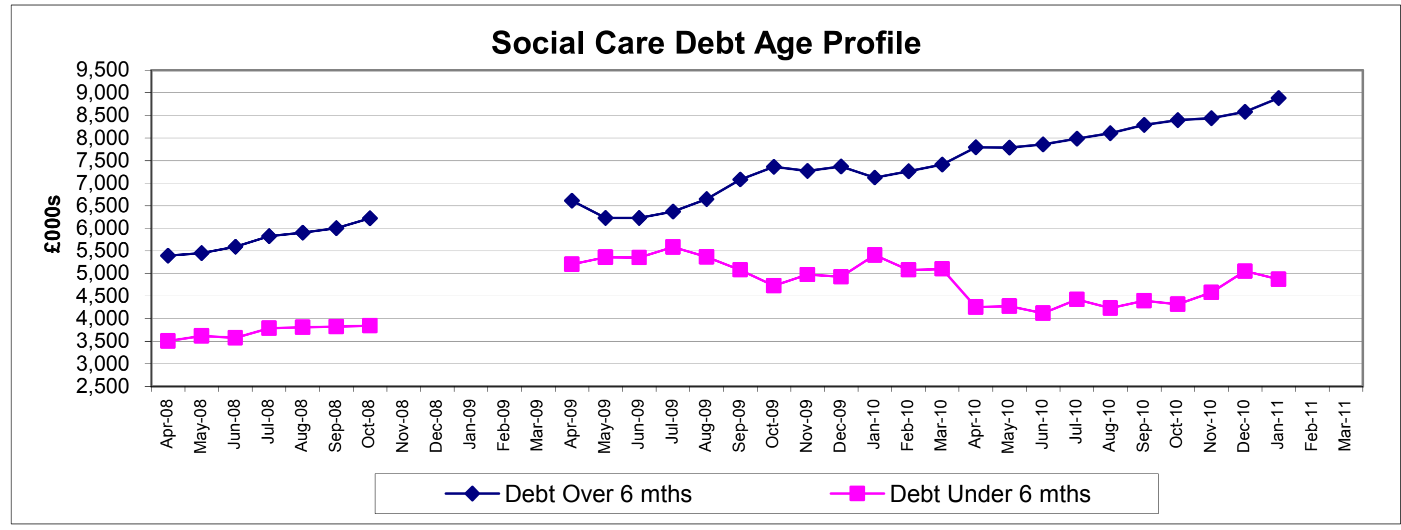
Now that the full client debt monitoring and recovery function has been fully integrated into KASS, we have been able to develop bespoke reports that accurately reflect the ageing of Social Care debt. This has therefore meant that since April there has been some slight changes to how debt is categorised between that which is over six months and that which is under six months and this has resulted in slightly more debt being classed as over six months.

			Social Care Debt				
Debt Month	**Total Due Debt (Social Care & Sundry Debt) £000s**	**Sundry Debt £000s**	**Total Social Care Due Debt £000s**	**Debt Over 6 mths £000s**	**Debt Under 6 mths £000s**	**Secured £000s**	**Unsecured £000s**
Apr-08	**11,436**	**2,531**	8,905	5,399	3,506	3,468	5,437
May-08	**10,833**	**1,755**	9,078	5,457	3,621	3,452	5,626
Jun-08	**10,757**	**1,586**	9,171	5,593	3,578	3,464	5,707
Jul-08	**12,219**	**2,599**	9,620	5,827	3,793	3,425	6,195
Aug-08	**13,445**	**3,732**	9,713	5,902	3,811	3,449	6,264
Sep-08	**11,004**	**1,174**	9,830	6,006	3,824	3,716	6,114
Oct-08	*	*	10,071	6,223	3,848	3,737	6,334
Nov-08	**10,857**	**1,206**	9,651			4,111	5,540
Dec-08	**12,486**	**2,004**	10,482			3,742	6,740
Jan-09	**11,575**	**1,517**	10,058			3,792	6,266
Feb-09	**11,542**	**1,283**	10,259			3,914	6,345
Mar-09	**12,276**	**1,850**	10,426			4,100	6,326
Apr-09	**17,874**	**6,056**	11,818	6,609	5,209	4,657	7,161
May-09	**12,671**	**1,078**	11,593	6,232	5,361	4,387	7,206
Jun-09	**12,799**	**1,221**	11,578	6,226	5,352	4,369	7,209
Jul-09	**13,862**	**1,909**	11,953	6,367	5,586	4,366	7,587
Aug-09	**13,559**	**1,545**	12,014	6,643	5,371	4,481	7,533
Sep-09	**14,182**	**2,024**	12,158	7,080	5,078	4,420	7,738
Oct-09	**15,017**	**2,922**	12,095	7,367	4,728	4,185	7,910
Nov-09	**18,927**	**6,682**	12,245	7,273	4,972	4,386	7,859
Dec-09	**18,470**	**6,175**	12,295	7,373	4,922	4,618	7,677
Jan-10	**15,054**	**2,521**	12,533	7,121	5,412	4,906	7,627
Feb-10	**15,305**	**2,956**	12,349	7,266	5,083	5,128	7,221
Mar-10	**14,157**	**1,643**	12,514	7,411	5,103	5,387	7,127

Debt Month	Total Due Debt (Social Care & Sundry Debt) £000s	Sundry Debt £000s	Social Care Debt				
			Total Social Care Due Debt £000s	Debt Over 6 mths £000s	Debt Under 6 mths £000s	Secured £000s	Unsecured £000s
Apr-10	**14,294**	**2,243**	12,051	7,794	4,257	5,132	6,919
May-10	**15,930**	**3,873**	12,057	7,784	4,273	5,619	6,438
Jun-10	**15,600**	**3,621**	11,979	7,858	4,121	5,611	6,368
Jul-10	**16,689**	**4,285**	12,404	7,982	4,422	5,752	6,652
Aug-10	**17,734**	**5,400**	12,334	8,101	4,233	5,785	6,549
Sep-10	**17,128**	**4,450**	12,678	8,284	4,394	6,289	6,389
Oct-10	**16,200**	**3,489**	12,711	8,392	4,319	6,290	6,421
Nov-10	**17,828**	**4,813**	13,015	8,438	4,577	6,273	6,742
Dec-10	**19,694**	**6,063**	13,631	8,577	5,054	6,285	7,346
Jan-11	**20,313**	**6,560**	13,753	8,883	4,870	6,410	7,343
Feb-11							
Mar-11							

* In October 2008, KASS Social Care debt transferred from the COLLECT system to Oracle. The new reports were not available at this point, hence there is no data available for this period. The October Social Care debt figures relate to the last four weekly billing run in the old COLLECT system.





- The age of debt cannot be completed for the months between November 2008 and March 2009 as the switch to Client Billing meant that all debts transferring on to the new system became “new” for purposes of reporting therefore it was not possible to show ageing until April (i.e. once these debts became 6 months old in the new system).

By: Graham Gibbens, Cabinet Member, Adult Social Care and Public Health
Oliver Mills, Managing Director, Kent Adult Social Services

To: Adult Social Services and Public Health Policy Overview and Scrutiny Committee – 7 April 2011

Subject: **CORE MONITORING**

Classification: Unrestricted

Summary: The purpose of this report is to inform the Policy Overview and Scrutiny Committee of the key areas of performance as reported to Cabinet on 4 April 2011

Introduction

1. (1) An extract from the third Core Monitoring report for 2010/11 is attached (Appendix 1) and this provides information for the third quarter of the year up to the end of December 2010.

(2) 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. The index and summary are also included to give Members the full context and wider overview of performance across the County Council.

Core Monitoring

2. (1) The Core Monitoring process is corporately led and considered to be an important step in helping to manage the overall performance of the authority. It is intended to contain the most important information which the Corporate Management Team and Cabinet Members need to be informed of.

(2) Publication of the Core Monitoring report on the external web site is also an important element of our transparency agenda.

Future Reports

3. (1) A new Performance Management Framework, based around Bold Steps for Kent, is being developed for 2011/12.

Recommendation

4. (1) Members are asked to NOTE and COMMENT on this report.

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Kent County Council

Core Monitoring Report

Presented to Cabinet
4 April 2011

Extract for Adult Services and Public Health Policy Overview and Scrutiny Committee 7 April 2011

Including Information up to the end of December 2010

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Index

Description	Previous Status	Current Status
Key to interpreting the data		
Overall Summary of Performance		
Council-wide Indicators		
Contact Kent : calls answered within 20 seconds	Green	Green
Gateways	Provided for information only	
Complaints		
Staffing numbers (FTE)		
Staffing age profile	Amber	Amber
Staffing equalities – disability	Amber	Amber
Staffing equalities – ethnicity	Amber	Amber
Staff turnover	Information only	
Staff sickness absence	Amber	Amber
CO2 emissions from KCC non-schools estate	Amber	Amber
CO2 emissions from schools	Red	Red
Children, Families and Education		
Commentary		
Foundation Stage pupil attainment	Amber	Green
Key stage 2 attainment – all children	Red	Red
Key stage 2 attainment – looked after children	Red	Amber
GCSE results – all children	Amber	Amber
GCSE results – children with free school meals	Red	Red
GCSE results – looked after children	Amber	Red
Young people not in education, employment or training	Green	Green
Secondary schools inspections	Green	Green
Primary schools inspections	Red	Red
Early years and childcare providers inspections	Amber	Green
Schools in special measures	Amber	Amber
SEN assessments	Amber	Amber
Pupil exclusions	Amber	Amber
Pupil absence – secondary schools	Amber	Amber
Children's social services - referrals	Amber	Red
Children with child protection plan	Red	Red
Number of looked after children (LAC)	Green	Amber
Asylum service – young people now aged 18+	Red	Red
LAC placed by other local authorities	Red	Red

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Description	Previous Status	Current Status
Social worker vacancies	Amber	Amber
Kent Adult Social Services		
Commentary		
Direct payments/Personal budgets	Amber	Amber
Older people in residential care	Amber	Amber
Older people in nursing care	Amber	Amber
Domiciliary care for older people	Amber	Amber
Learning disability residential care	Red	Red
Environment, Highways and Waste		
Commentary		
Household waste tonnage	Amber	Amber
Recycling/composting	Amber	Amber
Municipal waste taken to landfill	Green	Green
Congestion - Maidstone	Amber	Amber
Freedom pass	Amber	Amber
Routine highways repairs within 28 days	Red	Amber
Pothole repairs – average repair time	Red	Red
Streetlight faults repaired - KCC	Green	Amber
Streetlight faults repaired - UKPN	Red	Red
Road traffic casualties	Amber	Green
Communities		
Commentary		
Library visits	Amber	Amber
Library book issues	Red	Red
KCC apprenticeships	Green	Green
New entrants to the youth justice system	Red	Amber
Young offenders in education, employment and training	Amber	Amber
Adult education enrolments	Green	Green
Drug users leaving treatment free of dependency	Green	Green
Supporting People – people achieving independent living	Amber	Amber
Appendix		
Comparative benchmarks		

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 they receive, 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

Kent Adult Social Services

Annual Performance Assessment Outcome

The Care Quality Commission (CQC) published their Annual Performance Assessment of all adult social services in November 2010. Kent Adult Social Services (KASS) was awarded an overall performance rating of 'performing well' and was judged as 'excellent' in three out of seven outcomes and 'performing well' in the remaining four outcomes. The directorate has been awarded an overall performance rating of 'performing well'. An action plan is being implemented to focus on those areas that were highlighted in the report as needing further development.

Future of Older Person's Service Provision

A decision has been made about the future of in-house older people's services following extensive consultation and scrutiny by members of the council, and has been widely publicised. We are working with each individual service user and their carers to plan any change at a pace appropriate to them and with staff to support them through the formal processes.

Transforming Services: Self Directed Support

In October we set out proposals for the future of social care in Kent. These proposals will help us deliver the aims of "Bold Steps for Kent" and will reshape the organisation so that it can deliver personalisation, increased choice and control, at a time of reduced resources and increased demand.

Our proposal is that by 2014/15 we will be a strategic and joint commissioning organisation, contracting services from a range of providers. We will provide a role of
market shaping and we will also provide quality assurance and financial oversight of commissioned services. We will aim to put the citizen in control by encouraging and enabling more people to self manage the services they receive from the funding we provide. We will retain a strong role in
safeguarding vulnerable adults and will provide a 'fully managed' service where a 'safety net' is assessed as necessary.

Safeguarding

We received a judgement of performing well in safeguarding (maintaining personal dignity and respect) in our annual CQC performance assessment. Alongside this judgement our Cabinet member wanted to be assured that quality of practice and continuous improvement were embedded across the directorate. An independent audit of safeguarding case files has been commissioned. Senior

Managers and elected Members will be presented with the findings and an action plan will be developed from recommendations made.

NHS Support for Social Care 2010/11 - 2012/13

Additional funding streams have been allocated to the NHS for joint working with local authorities to promote better services for patients leaving hospital, part of which can be used for increasing capacity of current services, such as enablement, and to invest in a broader range of social care services to help improve health.

The first tranche of funding announced was £70m (nationally) for 'post discharge and enablement' services in 2010/11 and was targeted at patients leaving hospital. Of this, £1.8m has been made available for Kent and plans have been developed with the two Kent primary care trusts (PCTs) to utilise these funds. The second tranche of funding, announced in January, included a figure of £150m in 2011/12 and indicative funding of £300m in 2012/13 to continue to develop these services. The actual amount for Kent has not yet been announced, but on a pro rata basis we could expect £3.8m and £7.7m respectively.

Within the second tranche of funding, £162m was designated as 'Winter Pressures Funding' for 2010/11. This funding will be focussed on a broader range of social care services to improve general levels of health. Of this funding, £4.1m has been allocated to Kent PCTs for 2010/11. Whilst plans have been agreed jointly, the funds must be transferred to Kent under Section 256 of the 2006 NHS Act. Allocations have been made for future years to continue with these services and this funding is referred to as 'specific PCT allocations for social care', with £648m allocated in 2011/12 and £622m in 2012/13. Kent's share of these funds is £16.2m and £15.7m respectively.

Mental Health

‘Live It Well’, a mental health strategy for the next five years was launched in October. It sets out how KCC, PCTs and local partners across Kent and Medway plan to develop Kent’s mental health services with a more personalised approach, which focuses on prevention, health and wellbeing, improving access and reducing discrimination and stigma.

Learning Disability

We continue to transform services for people with a learning disability. In 2009 the responsibility and funding for the commissioning of social care for adults with a learning disability transferred from the National Health Service to KCC. We are now at the end of this process and 440 people have been transferred. From

2011, KCC will be responsible for the commissioning, contract and review of all social care services in Kent for people with a learning disability.

Service Demand

Demand on services continues to increase. Referrals represent the incoming demand on the council. Early indications for 2010/11 are that referral rates will increase by 3.2%. During the first 6 months of 2010/11 there were 17,281 referrals.

Personal Budgets and Direct Payments

We continue to be on target to meet the Putting People First national target that by April 2011, 30% of eligible individuals will be in receipt of a Personal Budget.

As at 31 December 2010, 6,430 individuals were in receipt of a Personal Budget. This is good progress and an increase from 5,200 people as at 30 September 2010.

Residential and Nursing care

Generally we are seeing a reduction in the numbers of older people moving into residential care. This reflects the impact that our preventative services are having in supporting people to remain independent and stay at home for as long as possible.

However there is an increase in demand for residential care for people with dementia.

The increase of clients with dementia is also resulting in a rise in the number of clients and weeks of care provided for people aged 65 in nursing care. However Kent has historically maintained a lower level of usage of nursing care than the national average and for this quarter the numbers have been stable.

The number of clients with a learning disability moving into residential care has increased from 632 in March to 707 in December. This includes those transferring from the NHS as described above and reflects the growing numbers of people with complex conditions who are living longer. These individuals often have very complex and individual needs which make it difficult for them to remain in the community, in supported accommodation/supporting living arrangements, or receiving a domiciliary care package and are often placements which attract a high cost.

The Impact of Preventative services

The continued development and rollout of preventative services is reducing the demand for traditional services such as domiciliary and residential care. The number of people who continue to receive a service are fewer, but with a higher level of need.

Enablement, intermediate care, telecare and telehealth and increased take up of direct payments as well as further development of voluntary sector provision are providing effective alternatives.

The recent evaluation of the outcomes of the Kent Telehealth Pilot reported:

- an estimated average saving of £1,878 per patient over a six month period in 2006/7
- a reduction in unscheduled hospital appointments and A&E visits
- improved quality of life with more independence and peace of mind.

In response to these findings assistive technology services will be mainstreamed. We are working closely with the NHS to ensure that telehealth is embedded in to care pathways as a standard. Plans to integrate telecare and telehealth equipment in to the Community Equipment Stores (a partnership between Health and Social Care) will be in place by early spring.

Percentage of clients with community based services, excluding carers, who received direct payments and/or a personal budget	Amber

Result for 12 months ending

National Average — KCC Actual

Higher result is better	Mar 08	Mar 09	Mar 10	Dec 10 Provisional
KCC Result	4.3%	6.3% ↑	9.9% ↑	16.3%↑
National average	4.4%	5.6%	11.3%	N/a
RAG Rating	●	●	●	●
Number of clients	1,680	2,350	3,910	6,430

2009/10 was the first year of significant roll out of Self Directed Support with new clients being offered Personal Budgets for the first time.

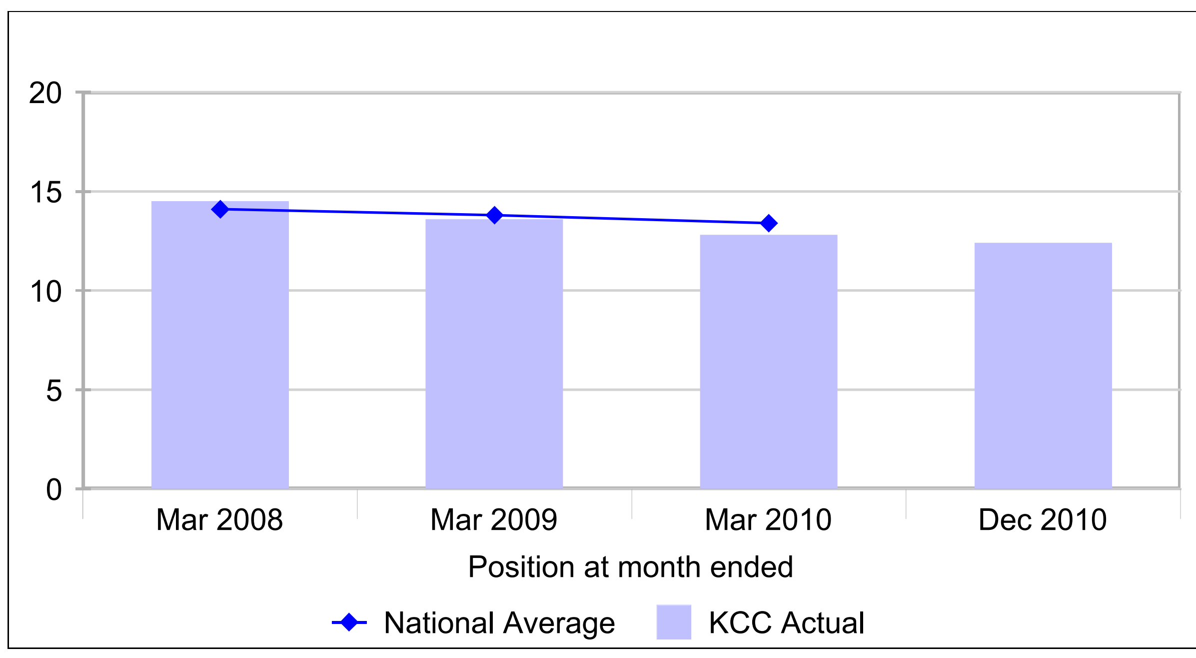
Kent has seen continued increases in take up of Personal Budgets during the nine months from April to December 2010. The December position of 6,430 clients compares to the September position of 5,200 clients.

There is a national target of 30% take up of personal budgets by April 2011. Although the numbers above seem some way behind this target, actions are in place to substantially increase this number in the final quarter of the year. Numbers are continuing to rapidly increase since December and the target is likely to be met.

Data Notes:

- The indicator shown is different from the previous national indicator which included carers.
- Previous year data and national benchmarks are taken from the National Adult Social Care Intelligence Service.
- Client data rounded to nearest 10.
- The indicator measures all clients receiving a service in the year and is not just a snapshot of clients at a given date.

Older people supported in residential care, permanent placements per 1,000 people aged 65 and over	Amber



Lower result is better	Mar 08	Mar 09	Mar 10	Dec 10 Provisional
KCC Result	14.5	13.6 ↑	12.8 ↑	12.4 ↑
National average	14.1	13.8	13.4	N/a
RAG Rating	●	●	●	●
Number of clients	3,500	3,350	3,240	3,140

The long term trend for the total number of clients aged over 65 in residential care continues to show a decline with Kent showing a similar fall and rate of provision to national levels.

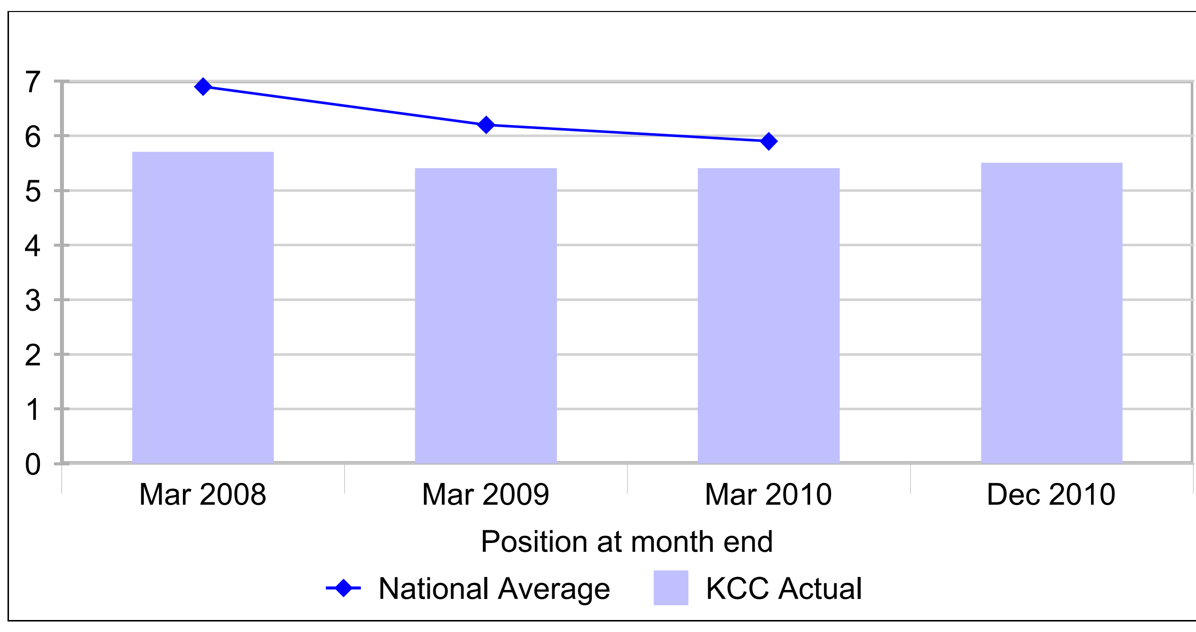
The number of clients placed in permanent independent sector residential care at the end of December was 2,782 up from 2,751 in March 2010 (excluding preserved rights clients).

There are also ongoing pressures relating to clients with dementia and the number of clients with dementia in independent sector provision increasing from 1,195 in March to 1,255 in December.

Data Notes:

- Previous year data and national benchmarks are taken from the National Adult Social Care Intelligence Service.
- Data includes all clients whether placed in in-house provision or with external providers.
- Client data rounded to nearest 10.

Older people supported in nursing care, permanent placements per 1,000 people aged 65 and over	Amber



Lower result is better	Mar 08	Mar 09	Mar 10	Dec 10 Provisional
KCC Result	5.7	5.4 ⬆	5.4 ↔	5.5 ⬇
National average	6.9	6.2	5.9	N/a
RAG Rating	★	★	●	●
Number of clients	1,390	1,340	1,370	1,390

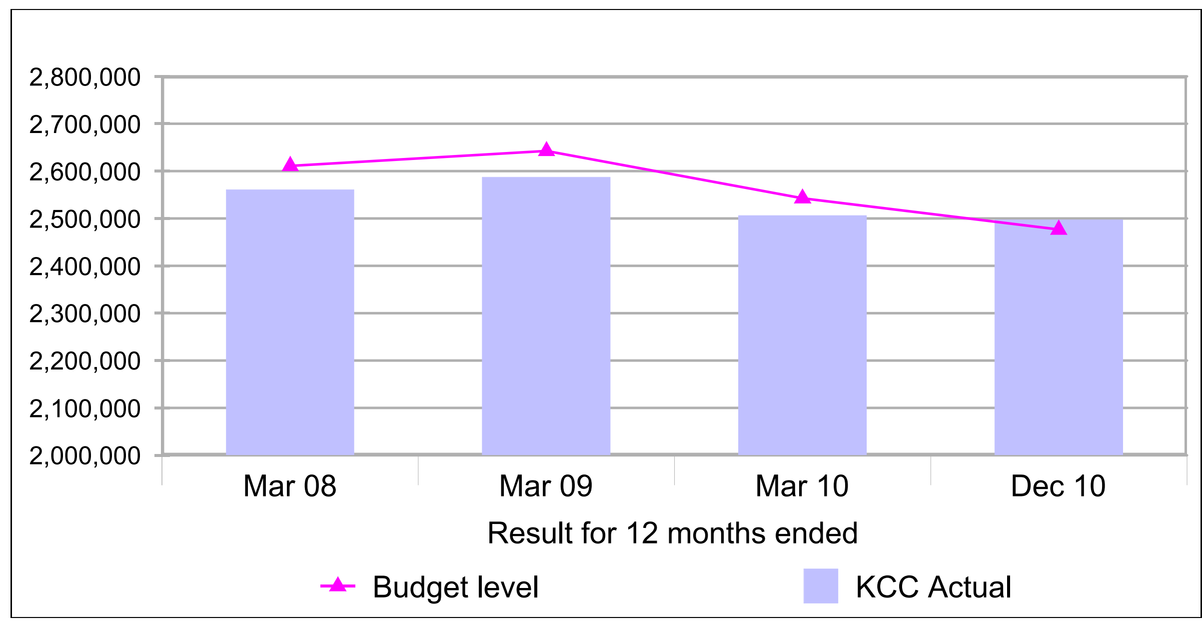
The number of clients aged over 65 in permanent placements of nursing care increased in the first quarter of the financial year (to 1,420) but have been reducing since. The levels remain slightly above those seen in the previous 2 years.

Kent has historically maintained a lower level of usage of nursing care than the national average, although the national average has been reducing significantly in the last few years.

Data Notes:

- Previous year data and national benchmarks are taken from the National Adult Social Care Intelligence Service.
- Data includes all clients whether placed in in-house provision or with external providers.
- Client data rounded to nearest 10.

Hours of independent domiciliary home care funded by KCC and provided to people aged 65 and over	**Amber**



Lower result is better	Year ended Mar 08	Year ended Mar 09	Year ended Mar 10	Year ended Dec 10 Provisional
Hours care provided (000's)	2,561	2,587 ⬇	2,506 ⬆	2,497 ⬆
Budget level	2,611	2,642	2,542	2,477
RAG Rating	●	●	●	●
Number of clients	6,740	6,490 ⬆	6,230 ⬆	6,060 ⬆

Client numbers with externally provided domiciliary provision were 6,060 in December which is down from 6,230 in March. The number of hours of care provided in the last 12 months however has only slightly reduced. Currently the hours provided are 0.8% over the amount provided for in the budget.

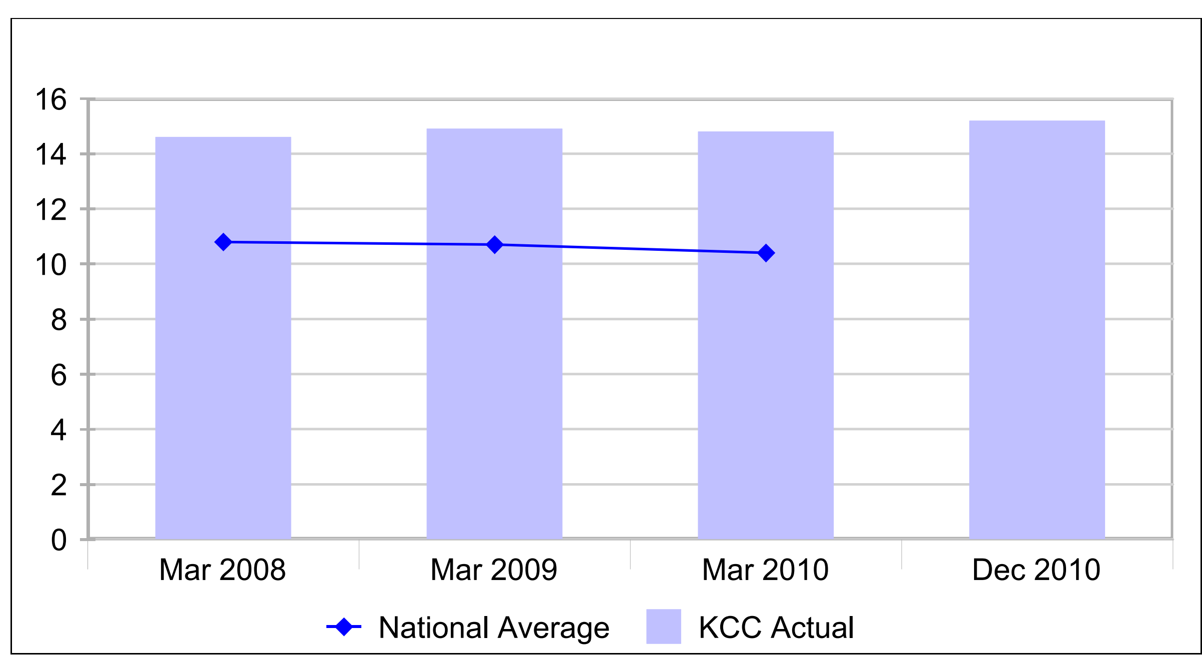
The number of hours of externally purchased domiciliary care has decreased since 2008/09 and this was expected due to other services being provided such as intermediate care, telecare and telehealth and increased take up of direct payments as well as further development of provision through voluntary sector provision.

In addition, with the introduction of enablement, more people are able to return home with minimal or no care package. However, although the numbers of people who continue to receive a service are fewer, those that do may receive a more intensive care package.

Data notes:

- Client data rounded to nearest 10.

Adult clients with learning disability supported in residential care, per 10,000 population aged 18 to 64	**Red**



Lower result is better	Mar 08	Mar 09	Mar 10	Dec 10 Provisional
KCC Result	14.6	14.9 ⬇	14.8 ⬆	15.2 ⬇
National average	10.8	10.7	10.4	N/a
RAG Rating	▲	▲	▲	▲
Number of clients	1,230	1,260	1,250	1,290

Demographic pressures and the NHS transfer continue to impact on Learning Disability Services, particularly residential care.

In addition, Kent has a higher than average proportion of preserved rights clients, which will impact on any benchmarking analysis. These are clients who have been in long term care, some of whom would have been placed in Kent from other parts of the country. Responsibility for these clients transferred from government to local authorities some time in the past and government provides a specific grant to meet the costs of care for these clients.

The number of clients in residential care excluding those with preserved rights at the end of December 2010 was 707, up from 632 in March. This includes NHS transfer figures.

Data Notes:

- Previous year data and national benchmarks are taken from the National Adult Social Care Intelligence Service.
- Client data rounded to nearest 10.

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

To: Adult Social Services and Public Health Policy Overview & Scrutiny Committee – 7 April 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: Adult Social Services and Public Health Policy Overview and Scrutiny Committee - 7 April 2011

Subject: **UPDATE ON SELECT COMMITTEE WORK**

Classification: Unrestricted

Summary: This report updates Members on current and future Select Committee work and invites suggestions for future Select Committee Topic Reviews.

Current Select Committee Review Work

1. The following reviews are either underway or preparing to start:-

Dementia – This POSC is the 'parent' committee for this review. The Select Committee held its first meeting in January to elect Mrs T Dean as its Chairman, and held a briefing and training session to give Members an understanding of the issue. A focus group made up of professionals also met for the first time in January, with the aim of feeding into the review's terms of reference and scope. Visits to day centres, care homes, dementia cafés and meetings with peer support groups, carers and people with dementia took place through February. Hearings will take place through March and early April and will include two sessions themed around carers' support. A number of organisations have offered to undertake small pieces of work and engagement which will feed into the review, and these are still being discussed. The Select Committee will meet in June to take stock of its findings so far, receive further input from the focus group and identify any further evidence needed, prior to drafting its report over the summer to go to full Council in December 2011.

The contacts in Democratic Services for this Select Committee are: Research Officer Sue Frampton (01622 694993) and Democratic Services Officer Christine Singh (01622 694334).

Educational Attainment of Pupils and Schools in Areas of High Deprivation – The Select Committee held its first meeting in early February to elect Mr C T Wells as its Chairman and agree its terms of reference and scope. Informal briefings, then hearings and visits, will take place through May, June, July and possibly September. It is not yet possible to say when the review will submit its final report to full Council. A revised timetable will be prepared for consideration by the Scrutiny Board in April.

The contacts in Democratic Services for this Select Committee are: Research Officer Pippa Cracknell (01622 694178) and Assistant Democratic Services Manager Denise Fitch (01622 694269).

The Student Journey – This review cuts across Regeneration and Economic Development POSC and the new Customer and Communities and Education, Learning and Skills POSCs. The Select Committee was awaiting the completion of the Wolf review of vocational education, published last week, before it starts its work proper, but much research and planning is already going on to put together an innovative programme for this review. It is anticipated that the first meeting of the Select Committee will take place late in April, to elect a Chairman, the Chairman Designate being Mr K Smith, and agree its terms of reference and scope. The timetable of the review is still under discussion and will be reported to the Scrutiny Board in due course. It is possible that the review will submit its final report to the full Council in April or May 2012.

The contacts in Democratic Services for this Select Committee are: Research Officer Gaetano Romagnuolo (01622 694292) and Democratic Services Officer Theresa Grayell (01622 694277).

Suggestions for Select Committee Topic Reviews

2. If Members have any suggestions of topics they would like to put forward for consideration for inclusion in the future topic review work programme, they should contact the Democratic Services Officer for this POSC.

Recommendation:-

3. Members are asked to note the review work currently underway and advise the Democratic Services Officer of any topics which they would like to put forward for consideration for inclusion in the future Select Committee Topic Review Work Programme.

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Democratic Services Officer

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Background Information: *Nil*