



## AGENDA

### HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Friday, 8th February, 2008, at 10.00 am      Ask for:      **Paul Wickenden**  
Council Chamber, Sessions House, County      Telephone      **(01622) 694486**  
Hall, Maidstone

*Tea/Coffee will be available from 9:45 am*

#### Membership (17)

- Conservative (12):      Lord Bruce-Lockhart (Chairman),      Mr A R Chell,      Mr B R Cope,  
Mr A D Crowther,      Mr J Curwood,      Mrs S V Hohler,  
Mr G A Horne MBE, Mr R A Marsh, Mr R J Parry, Dr T R Robinson,  
Mr R Tolputt and Mrs E M Tweed
- Labour (4):      Mr M J Fittock (Vice-Chairman), Mrs C Angell, Ms A Harrison and  
Mrs E D Rowbotham
- Liberal Democrat (1):      Mr D S Daley

#### **UNRESTRICTED ITEMS**

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

Item No		Timings
1.	Substitutes	
2.	Declarations of Interests by Members in items on the Agenda for this meeting.	
3.	Minutes - 11 January 2008 (Pages 1 - 14)	10:00- 10:15 am
4.	Local Involvement Network (LINK) update (Pages 15 - 20)	10:15- 10:45 am
<b>PCT Budget and Financial Plans</b>		
5.	Eastern & Coastal Kent Primary Care Trust (Pages 37 - 42)	10:45- 11:45 am

David Meikle, Director of Finance will be in attendance for this item.

**Break 11:45 am-12 noon**

6. West Kent Primary Care Trust 12 noon-  
1:00 pm
- Steve Phoenix, Chief Executive will be in attendance for this item.
7. Date of next programmed meeting – Friday 28 March 2008
- Council Chamber, Sessions House, County Hall commencing at 10:00 am

### **EXEMPT ITEMS**

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

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

**31 January 2008**

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

## KENT COUNTY COUNCIL

---

### HEALTH OVERVIEW & SCRUTINY COMMITTEE

MINUTES of a meeting of the Health Overview & Scrutiny Committee held at Sessions House, County Hall, Maidstone on Friday, 11 January 2008

PRESENT: Mr M J Fittock (Vice-Chairman), Mrs C Angell, Mr A R Chell, Mr A D Crowther, Ms A Harrison, Mr C Hibberd (substitute for Lord Bruce-Lockhart), Mrs S V Hohler, Mr G A Horne, MBE, Mr G Koowaree (substitute for Mr D S Daley), Mr J London (substituting for Mr J A Davies), Dr T R Robinson, Mrs E D Rowbotham, Mr R Tolputt and Mrs E M Tweed

OTHER MEMBERS PRESENT: Mr G K Gibbens, Cabinet Member for Public Health

OBSERVERS: Mr J Cunningham, Ms J Epps, Ms A Evennett, Mr J Fletcher, Mr J Larcombe, Ms M Rogers, Ms P Still, Ms Carole Swann and Mrs F Witherden from the Patient and Public Involvement Fora, Mr C Wanstall and Mrs S Wanstall from the East Kent Mental Health Carers' Forum, Mr T Arnold and Ms M Cheshier and Mr C Chidanguro from Maidstone MIND, Ms L Leonard from Sevenoaks MIND, Mr A Wright from Sevenoaks RETHINK Support Group, Ms M Morland, and Mrs R Lalley, Comprehensive Performance Assessment Inspector

IN ATTENDANCE: Mr P D Wickenden, Overview, Scrutiny and Localism Manager, Dr D Turner, Research Officer to the Health Overview & Scrutiny Committee

#### UNRESTRICTED ITEMS

*(Mr M J Fittock, Vice-Chairman, presiding)*

#### 76. Lord Bruce-Lockhart

The Vice-Chairman informed the Committee that he had spoken to Lord Bruce-Lockhart; he had now started further treatment but was expected to attend a meeting the following week to discuss future work plans for the Committee.

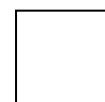
RESOLVED that the Committee's regards be forwarded to Lord Bruce-Lockhart.

#### 77. Urgent Business

(1) The Chairman sought the permission of the Committee to consider the Minutes of the meetings on 9 November, 27 November and 14 December as urgent business, rather than waiting until the next meeting of the Committee, in February 2008. This was agreed by the Committee.

#### 78. Minutes

RESOLVED that the Minutes of the meetings held on 9 November, 27 November and 14 December 2007 were correctly recorded and that they be signed by the Vice-Chairman, subject to:-



- (a) the present Minutes reflecting the Committee's view that it had a right to visit hospitals;
- (b) it being clarified regarding Minute 71 (1) v) of the meeting on 27 November 2007 that the concern expressed about patients' diets related to the issue of patients and visitors bringing into hospitals food that might be of poor quality and could thus compromise the health of patients;
- (c) in response to a question, the Overview, Scrutiny and Localism Manager stated that he would bring to the next meeting information about the proposed Select Committee on Transport and Access to Healthcare.

**79. Mental Health – Kent and Medway NHS and Social Care Partnership Trust and Primary Care Trusts across Kent and Medway**

*(Item 4 – Mr E Millar, Chief Executive, Kent and Medway NHS and Social Care Partnership Trust, Ms L Kavanagh, Director of Commissioning for Adult Mental Health Services and Substance Misuse, Medway PCT, Mr O Mills, Managing Director, Kent Adult Social Services, and Mr P Absolon, Social Care Commissioner for Mental Health, were in attendance for this item)*

(1) The Chairman apologised on behalf of the Committee for the lack of time that Health Service colleagues had been given to respond to the questions they had been sent on mental health.

(2) Mr Millar and Ms Kavanagh gave presentations on mental health services in Kent (attached to these minutes as Appendices 1 and 2) and answered questions from Members:-

- (a) NHS colleagues explained that if a person was already known to the Crisis Resolution Home Treatment (CRHT) service then the service could be accessed directly by a person such as the carer or partner of a service user.
- (b) Members expressed concern about access to out-of-hours services by both service users and carers. NHS colleagues stated that there were clear pathways regarding access to out-of-hours services. As requested previously by the Committee, they were working on a plan regarding access to out-of-hours services by people with less severe conditions. This would be made available to the Committee, and other stakeholders, soon.
- (c) Concern was expressed by Members about whether the CRHT service was actually available 24 hours a day. NHS colleagues stated that the service was available to those who needed it, namely people with serious long-term conditions.
- (d) NHS colleagues explained that the commissioning budget for mental health services in Kent did not include services for people whose primary problem was one of addiction. Substance misuse services were commissioned through the Kent Drug and Alcohol Action Team, a multi-agency partnership led by KCC, which had its own commissioning budget.



- (e) NHS colleagues explained that there was an established process within the NHS for dealing with complaints about services; KCC also had its own complaints mechanism. In addition, there was an ongoing dialogue with carers and service users, allowing them to raise issues of concern.
- (f) Members asked about the National Survey of Investment in Mental Health Services, which had shown that Kent and Medway was at the bottom of the national league table for investment in mental health services in 2005–6. NHS colleagues responded that this financial mapping exercise had concealed differences within Kent and Medway – investment in East Kent had been in line with the national average; but in West Kent and Medway it had been below the average. The results of the mapping exercise for 2006–7 could not be directly compared with those for 2005–6, as the exercise was carried out at Strategic Health Authority (SHA) level, and Kent and Medway SHA had ceased to exist in 2006, when it was merged into the new South East Coast SHA. Further data for the mapping exercise had been submitted in December 2007 and this would be shared with the Committee.
- (g) NHS colleagues stated that they sought to work with service users and carers as much as possible. They had a Carers' Charter; and service users and carers were involved in the commissioning of services.
- (h) It was confirmed that the CRHT service was provided by multi-disciplinary teams, including consultant psychiatrists.
- (i) It was stated that, in some parts of Kent, A&E mental health liaison nurses were employed, with access to CRHTs to make an assessment of a patient if necessary.
- (j) It was confirmed that there were identified police mental health liaison officers, who acted as a point of contact between the police and mental health services.
- (k) The importance of both police and ambulance service personnel getting adequate and consistent training to deal with people with mental health issues was emphasised.
- (l) NHS colleagues said that the SHA had granted the Partnership Trust authority to proceed with a three-month consultation about applying to become a Foundation Trust and this would commence straightaway.
- (m) Members felt that there was a need for more specific proposals for young carers. The Director of Kent Adult Social Services referred to the recently published Young Carers Strategy "Invisible People".
- (n) Members stated that there should be support for carers and families of service users to help them to continue to cope. The importance of carers having assessments of their own needs was emphasised.
- (o) Ms Kavanagh undertook to come back with figures on the number of cases dealt with each year and how many NHS employees were involved in

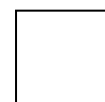


handling those cases. The commissioning teams were developing a five-year commissioning strategy; this would have figures on levels of need and how this was evidenced, and on what the take-up of services was.

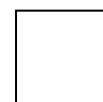
- (p) Members thought that information on how to go about accessing emergency support needed to be made more readily available.
- (q) NHS colleagues explained that they were committed to developing services for early intervention in psychosis.
- (r) It was explained that there was a healthy advocacy service in Kent; and the recent Mental Health Act would mean there would have to be increased investment in advocacy.
- (s) The provision of services for children was raised; it was explained that these services were separately commissioned by the Children's Trust.

(3) Representatives from the Patient and Public Involvement Fora and others were invited to ask questions and highlight issues in relation to mental health services. The Committee heard from Mrs Epps and Mrs Witherden (PPIF representatives), Mr Wanstall (East Kent Mental Health Carers' Forum), Mr Wright (Sevenoaks RETHINK Support Group), Ms Leonard (Sevenoaks MIND), Ms Cheshier (Maidstone MIND) and Ms Morland. A number of points were made, including the following:-

- (a) In relation to the out-of-hours services for emergencies that fell short of the level of crisis needed to trigger CRHT intervention, these services were not felt to be adequate. Professionals should be available to attend if needed. It was extremely difficult in many cases to get a mentally ill person to attend A&E. It was necessary for the services when required to come to the client.
- (b) An assurance was given by NHS colleagues that out-of-hours services would be made as accessible as possible, through all the various pathways that existed.
- (c) A comparison was drawn between the way that the Health Service responded to a mental health crisis situation compared to a physical emergency. It was stated that someone with, for example, a heart attack on a Saturday evening would be in hospital within a short period of time being cared for – whereas if somebody had a psychotic episode, the route to hospital was difficult and convoluted, and it could often take days to get appropriate care.
- (d) There was a perception amongst carers that when a person was psychologically ill, it was often necessary for them to hit "rock bottom" before any help was available and that services tended to be reactive rather than proactive. Often the carer's experience of getting a loved one into hospital was fraught with problems, whatever the route they took. The existence of nine separate pathways into hospital was not necessarily a good thing – a "one-stop shop" approach would actually be more effective, it was suggested.



- (e) The view was expressed that front-line community mental health services were not operating as they should be and that they were not performing to very high standards; but it was hoped that this would improve.
  - (f) Reference was made to the issue of young carers caring for mentally ill relatives and the importance of these carers being assisted and supported by social care services. Mr Mills referred to the strategy for young carers "Invisible People". He stated that the Children's Trust would be working to make sure there was good awareness in schools of pupils who were young carers. The Trust would also make sure that, when somebody was identified with mental health problems, the children in the wider extended family who provided support got an assessment if necessary.
  - (g) The importance of talking therapies was emphasised and an apparent lack of provision in the Medway area was mentioned.
  - (h) The health and safety implications of lone ambulance staff attending a call-out relating to a person with mental health issues were raised.
  - (i) In relation to the role of CRHT services, NHS colleagues stated that these services were fundamentally about avoiding hospitalisation. There was a lot of confusion amongst carers and service users about the role of the CRHT and the assistance they were able to provide in crisis situations.
  - (j) It was stated to be important that the rights of carer and service-user representatives should be recognised.
  - (k) Responding to a question about bed numbers, Mr Millar said that the Partnership Trust had 46 wards in total and promised to make available to the Committee a full beds schedule.
  - (l) A PPIF representative raised the issue of adverse consequences for carers if they criticised services.
  - (m) The often long and drawn-out process of trying to get someone with severe mental health problems "sectioned" was highlighted. A multiplicity of agencies were involved and they needed to work together to achieve a quick, speedy and satisfactory outcome. One of the issues was that the police in these situations would only attend when they had resources available. It was important that colleagues in the Health Service engaged with the police and ambulance service to ensure that adequate assistance was given by the police when it was required.
  - (n) Ms Kavanagh confirmed that, at the South East Coastal Ambulance Trust meeting on 21 January 2008, the availability of appropriate transport for mental health service users was to be raised.
  - (o) The issue of inconsistency in the provision of Care Plans was raised.
- (4) The Overview, Scrutiny and Localism Manager invited PPIF colleagues to share with Health Overview and Scrutiny Members their submissions to the Healthcare



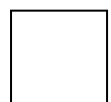
11 January 2008

Commission for the Annual Health Check. He thought the Committee would find this extremely helpful.

(5) The Chairman thanked Health Service colleagues and the representatives of PPIF and Mental Health support organisations for attending.

(6) The Overview, Scrutiny and Localism Manager noted that NHS colleagues had had short notice of the meeting, giving them very limited time to prepare their evidence for the Committee. He stressed the importance of the Committee taking a balanced view and basing its conclusions on all the evidence heard.

(7) It was proposed by Mr Hibberd, and agreed, that the Vice-Chairman, the Conservative Group Spokesman and the Liberal Democrat Group Spokesman should agree a set of recommendations, arising from the evidence heard, and bring them to the next meeting of the Committee (attached to these minutes as Appendix 3).



# KCC - HOSC

11 January 2008

**Erville Millar**  
Chief Executive

Working together we can make a difference

## CRISIS RESOLUTION HOME TREATMENT (CRHT)

- **TEAMS**
  - 3 WEST KENT
  - 1 (LARGE) EASTERN & COASTAL
  - 1 MEDWAY
- **FOR ADULTS WITH SEVERE MENTAL ILLNESS**
- **24 HOURS, 7 DAYS A WEEK SERVICE**
- **ACCESS VIA GP REFERRAL**
- **RAPID RESPONSE**

Working together we can make a difference



## **CARERS**

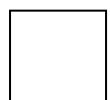
- **CRISIS (CRHT)**
  - ACTIVE INVOLVEMENT OF SERVICE USER, FAMILY & CARERS
- **CARE PROGRAMME APPROACH (CPA)**
  - REQUIRES IDENTIFICATION & INCLUSION OF CARERS IN THE CARE PROCESS
- **CONFRONTATIONAL CONUNDRUM!**
- **TRAINING FOR CARERS**
- **CARERS' CONTRIBUTION TO TRUST GOVERNANCE**
- **CARERS' BREAKS**

Working together we can make a difference

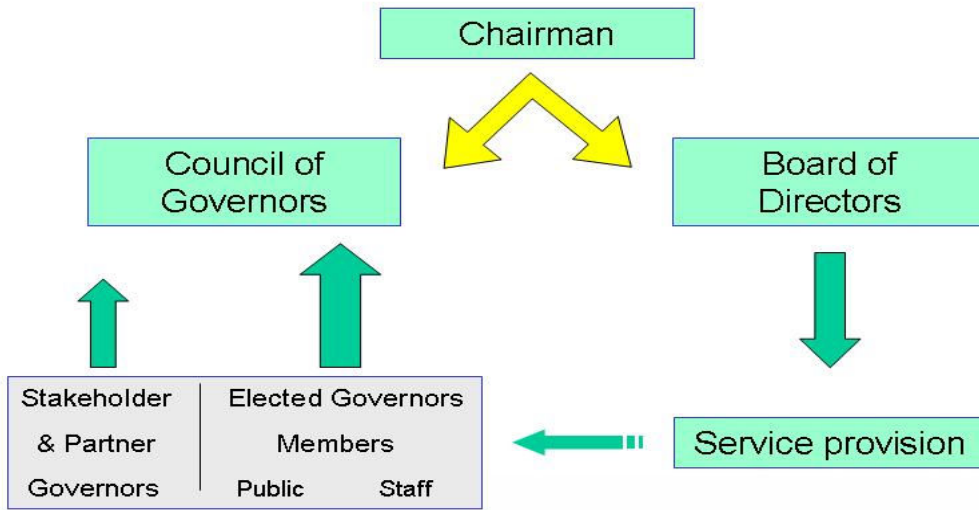
## **SERVICE USER & CARER INVOLVEMENT**

- **TRUST STRATEGIES FOR "INVOLVEMENT"**
- **"CARERS" CHARTER**
- **INFLUENCING:**
  - TRAINING
  - RECRUITMENT
  - CARER SUPPORT GROUPS
  - AUDIT
- **"EMBEDDED" IN EARLY INTERVENTION TEAM**

Working together we can make a difference



## FOUNDATION TRUST - Structure



Working together we can make a difference

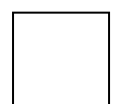
## FOUNDATION TRUST – Proposed Council of Governors

<b>NHS</b>	PCTs	3
	Acute Trust	1
<b>Local Authority</b>	Kent County Council	2
	Medway Unitary Council	1
<b>Partner Organisations</b>	Business Link	1
	Police Service	1
	Prison Service	1
	Academia	1
<b>Voluntary Sector</b>		3
<b>Staff</b>	East Kent / West Kent / Medway	4 (18)
<b>Public</b>	East Kent	7
	West Kent	7
	Medway	5 (19)
<b>Total Number of Governors</b>		37

Working together we can make a difference



11 January 2008

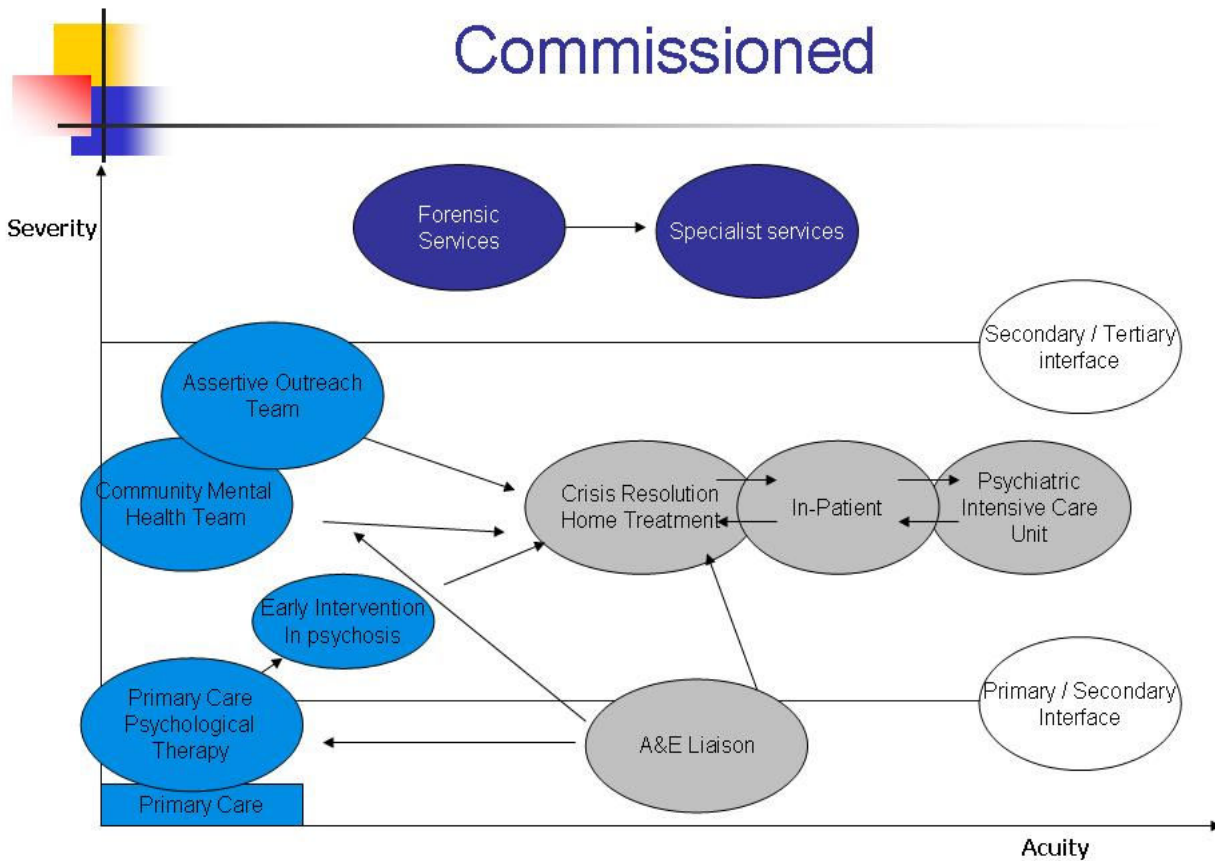


# Kent Health Overview and Scrutiny Committee

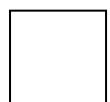
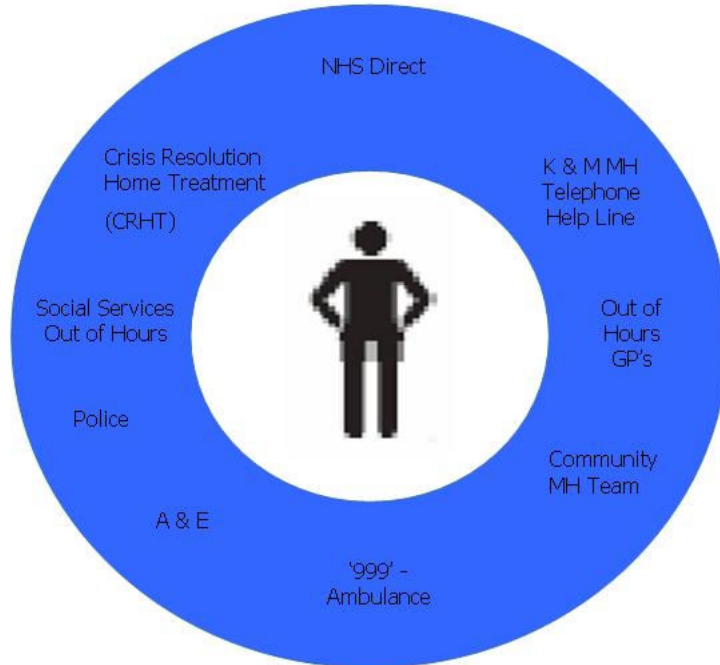
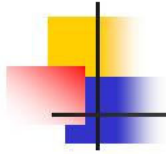


11 January 2008  
Lauretta Kavanagh  
Director of Commissioning for Mental Health  
Kent and Medway PCTs

## Mental Health Services Commissioned



# Access to Support Out of Hours



Recommendations arising from the Health Overview and Scrutiny Committee meeting on 11 January 2008, agreed by the Vice-Chairman, the Conservative Group Spokesman and the Liberal Democrat Group Spokesman:

- a) that the Committee needed to stay abreast of progress on the Action Plan for implementing the recommendations of the Carers in Kent Select Committee report;
- b) that the Committee must keep up-to-date with implementation of KCC's Young Carers Strategy "Invisible People";
- c) that the Committee must decide whether it wished to respond to the consultation on the Partnership Trust's application for Foundation Trust status;
- d) that submitting third-party commentaries for the Healthcare Commission's Annual Health Check was core business for the Committee;
- e) to welcome NHS colleagues' undertaking to provide details about the level of funding for mental health services and how it was allocated, to enable the Committee to identify any gaps;
- f) to request from NHS colleagues a simple explanation of how the various types of mental health service (CRHT, Community Health Mental Health teams, etc.) all fitted together, with a brief summary of the role played by each;
- g) that the Committee should consider the feasibility of a "one-stop shop" approach to hospital admission, which had been mentioned in evidence;
- h) to welcome NHS colleagues' undertaking to provide the Committee with a full beds schedule for all 46 of the Partnership Trust's wards;
- i) to investigate arrangements in A&E departments regarding service users who present with mental health issues, and whether a more consistent approach, based on best practice, was needed;
- j) to look further at the issue of training for GPs, the police, ambulance staff and firefighters as regards dealing with mental health service users;
- k) to examine further the question of out-of-hours services, particularly in respect of service users presenting with less serious conditions, such as personality disorders;
- l) that there was a need to look at the issue of less well-off service users experiencing difficulty accessing services due to lack of transport;
- m) to pursue the matter of providing better information for the public (through means including Kent TV) about mental health services and how to go about accessing them;
- n) to acknowledge the valuable role of the voluntary sector in the mental health



11 January 2008

field;

- o) that an independently chaired event should be arranged for all mental health services stakeholders, including the voluntary sector, to explore how to work together more effectively to improve services across Kent and Medway.

Chairman \_\_\_\_\_

Date \_\_\_\_\_

**Item 4**

To: Health Overview & Scrutiny Committee – 8 February 2008

By: Graham Gibbens, Cabinet Member for Public Health

Subject: Local Involvement Network – an update

---

The purpose of this report is to update Members of the Health Overview & Scrutiny Committee on progress made in establishing a Local Involvement Network for Kent.

---

**1. Background**

- 1.1. Members of the Committee received a comprehensive report at their meeting of the 20 July 2007 setting out the background and forward plans for establishing a Local Involvement Network (LINK) for Kent. Members considered a second report on the progress made at their meeting on the 12 October 2007.
- 1.2. There are essentially two key roles for the County Council in meeting its obligations relating to the establishment of a LINK for Kent:
  - (i) To stimulate wide public interest in LINKs and to encourage debate as to what would make an effective LINK for Kent
  - (ii) To appoint a Host Organisation to set-up and support the creation of a LINK for Kent.
- 1.3. This report updates Members on the current position in satisfying these obligations.
- 1.4. By way of a reminder, the Department of Health (DoH) guidance on LINKs is clear that the “Health Overview and Scrutiny Committee within the local authority has a role in scrutinising how the contracting process was undertaken and ensuring that best value is achieved”.

**2. National Developments**

- 2.1. The Local Government & Public Involvement in Health Act finally received Royal Assent at the end of October 2007. The Act stipulates that a national system of LINKs will be established by the 1 April 2008 to coincide with the abolition of Patient and Public Involvement Forums (PPIFs). This is a very challenging deadline and the Government has acknowledged the need to provide guidance on transitional arrangements if they are required. Unfortunately, the date for the publication of these guidelines is now March.
- 2.2. The DoH has stated that contracts with potential Host Organisations cannot be signed and finalised until the regulations relating to governance and transitional arrangements come into force. It is hoped this does not become problematic.

- 2.3. The letting of the contract to appoint a Host Organisation to set-up and support a LINK for Kent will constitute a 'Key Decision' for the County Council and this has been logged in the Council's Forward Plan.
- 2.4. There is a growing body of information and guidance on LINKs, principally produced by the DoH. This includes a very helpful monthly newsletter a copy of the latest issue will be available at the meeting of this Committee. For those Members wanting to access any of the documentation there is an easy-to-use website:  
  
[www.dh.gov.uk/en/Policyandguidance/Organisationpolicy/PatientAndPublicinvolvement/DH\\_076482](http://www.dh.gov.uk/en/Policyandguidance/Organisationpolicy/PatientAndPublicinvolvement/DH_076482)
- 2.5. The National Centre for Involvement (NCI) has been asked by the DoH to provide further advice, guidance and support. This, it has been promised, will be provided in a variety of ways and we look forward to their support.
- 2.6. Members of the Committee are also reminded that the consultation period on the draft regulations on LINKs closed on 21 December 2007. This Committee submitted a response to the DoH and a separate response went from the County Council.

**3. Funding**

- 3.1. The DoH announced that it would be making £84m available nationally over three years, to support the new system of LINKs and the amount given to each authority was announced on the 6th December.
- 3.2. The amount of funding the DoH will be contributing to the County Council's so-called Area Based Grant – a non-ring-fenced general grant – in recognition of the funding pressures related to LINKs in Kent is as follows:

2008/09	2009/10	2010/11
£492,000	c. £493,000	c. £495,000

- 3.3. The funding is intended to cover:
  - Local Authority contract management costs
  - Host Organisation support function costs e.g. staff, office costs, contract monitoring and evaluation.
  - LINK expenditure budget – e.g. communications, meetings, training, reimbursement of LINK member expenses and specific pieces of work.
- 3.4. In accordance with DoH guidance, it is anticipated that KCC will retain approximately 10% of the funding, in order to cover the costs of managing the contract of the Host Organisation. The issue of where the contract management will sit within KCC is currently under consideration.

- 3.5. Although Kent received one of the largest allocations nationally, we feel that delivering the ambitions that will be set for the LINK for Kent will be very challenging on this budget given the geographic scale of the County.
- 3.6. The Host Organisation will be accountable to Kent County Council – its contract manager – for the support costs. The LINK will be accountable to the public to demonstrate effective spend of its budget. In addition, through the performance management system, the Host will also be accountable to LINK participants.

#### **4. Procurement of the Host Organisation for the LINK for Kent**

- 4.1. Given the high profile nature of this project, and the compelling need for ultimate transparency of the procurement process, ongoing advice is being provided by the Strategic Procurement Unit of the County Council as well as the Director of Law and Governance.
- 4.2. Their advice is that, due to the size of the contract, it is necessary to follow European Unions rules and to advertise in the Official Journal of the European Union (OJEU). The advert was published in the on the 15th December 2007, inviting organisations to express an interest in tendering to become the Host Organisation for the LINK for Kent. The advert was also simultaneously available via the South East Business Portal. Interested parties had until the 21st January 2008 formally to submit their expression of interest in response to the advert. A sufficient number of responses have been received to ensure a healthy competition.
- 4.3. Organisations who have expressed an interest will be sent the full tender documentation including a detailed service specification. Potential tenderers will be set a deadline in which to return their full bid proposal and there will be a formal selection process from which a successful organisation will be appointed. In drafting the service specification the DoH, guidance was used as a base but it also draws heavily on the feedback and comments received to date on what the expectations are on what a LINK for Kent will be like.
- 4.4. The letting of this contract is the responsibility of KCC and will constitute a Key Decision.
- 4.5. The current intention is that the appointment of a Host Organisation will be made by the end of March 2008. However, this will prove a difficult deadline to meet given the need to satisfy EU procurement rules as well as being satisfied that the tender specification and related evaluation criteria are fit for purpose. Once appointed, there will be the need to agree a contract between the Host Organisation and the County Council before the Host can start work in earnest in setting up the LINKs for Kent.

#### **5. Communication and Engagement**

- 5.1. Clearly, it is vital to ensure that as many organisations, groups and individuals as possible are aware of the changes that the creation of a Kent LINKs will bring. It is as important that the views of as many people as possible are used to shape a LINK that is effective and appropriate for Kent. Finally, we must not lose the knowledge and experience of existing groups.

- 5.2. Given the timescales and the budget available (the DoH allocated only £10,000) there has still been an extensive process of communication and engagement although we also recognise that ideally more could have been done. Key actions taken so far has included creating a dedicated LINKs area on the KCC website, commissioning a survey through the Kent Residents Panel, writing and distributing articles through existing newsletters, issuing press releases, writing and circulating a regular newsletter and the more traditional face-to-face methods of organised or attending existing meetings, for example with PPI Forums, District Councils, and County Councillors.
- 5.3. A copy of the Communications and Engagement Strategy, which contains further details of work undertaken, is available on request.
- 5.4. Some of the recurring issues that have been raised include:
- Concerns that Kent will only have one LINK and how that will respond to differing circumstances within the County
  - A desire that existing good practice will be lost in the new arrangements
  - How best to reach the so-called 'hard to reach' groups
- 5.5. The summary findings of these consultations, meetings and surveys will be passed on to the Host Organisation (when appointed) so they can be used in assisting the Kent LINK to set up. This Committee may also be interested in receiving a copy of this work.
- 5.6. A major conference for individuals, carer and user groups and members of key networks and organisations was organised on the 30 January. The conference was hosted by the PPI Forums and run by an external facilitator in order to keep the formation of the LINK independent from KCC.

## **6. Other Local Authority Areas**

- 6.1. As at 30 January 2008, of the 150 local authorities who are appointing a Host Organisation for the LINK in their area, 95 had advertised.
- 6.2. There was a South East regional LINKs meeting on 11 January 2008, at which representatives from local authority areas discussed their present progress. Members at the meeting felt it may be beneficial for LINKs to liaise with adjacent LINKs to ensure cross border efficiencies are achieved. It was also noted that the Host Organisations could make good use of each other, by sharing best practice, and doubling up on things such as training, in order to achieve economies of scale.
- 6.3. Issues that are currently causing some consideration across the South East region include possible transitional arrangements, and the difficulties in being truly inclusive and representative. The latter issue is of particular relevance in Kent, due to the size of the county.
- 6.4. At this regional meeting it became clear that Kent, in common with other areas are now starting to think through how the Host Organisation is supported in setting up each respective LINK. In particular, what may be required in terms of involvement of individuals and existing carer, user and voluntary groups. Other

areas have existing forums and Kent will need to decide how best to manage this process.

## 7. Recommendations

7.1. Members of the Committee are invited to note this report, to consider, and to comment on progress made.

Mary Blanche  
LINKs Lead  
Senior Policy Manager  
Corporate Policy  
01622 694414  
[mary.blanche@kent.gov.uk](mailto:mary.blanche@kent.gov.uk)

Rachel Gardner  
Management Trainee  
Kent Graduate Programme  
Corporate Policy  
01622 696971  
[rachel.gardner@kent.gov.uk](mailto:rachel.gardner@kent.gov.uk)

---

### *Background Documents*

*Report to Health Overview & Scrutiny Committee*                      20 July 2007

*Report to Health Overview & Scrutiny Committee*                      12 October 2007

*The Department of Health guidance documents regarding LINKs:*

[www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_077266](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_077266)

- *Local Involvement Networks Explained - Easy Read*
- *Getting ready for LINKs -Planning your Local Involvement Network*
- *Getting ready for LINKs - Contracting a Host Organisation for your Local Involvement Network*

*The Department of Health newsletters regarding LINKs:*

[www.dh.gov.uk/en/Policyandguidance/Organisationpolicy/PatientAndPublicinvolvement/DH\\_076482](http://www.dh.gov.uk/en/Policyandguidance/Organisationpolicy/PatientAndPublicinvolvement/DH_076482)

This page is intentionally left blank

## Background briefing on PCT budgets

### **The role of Primary Care Trusts**

Primary Care Trusts (PCTs) were established between 2000 and 2002. Their main functions are:

- engaging with their local resident populations to improve health and wellbeing;
- commissioning NHS services for their local resident populations;
- directly providing some primary care (non-hospital) services (“community services”).

Commissioning involves purchasing services from providers:

- NHS Trusts and Foundation Trusts (which provide hospital / secondary care);
- independent primary-care (non-hospital) practitioners (GPs, dentists, pharmacists and opticians);
- providers of primary and secondary care in the independent sector (for-profit corporations and non-profit / charitable / voluntary / “Third Sector” bodies).

Commissioning is more than just administering a set of contractual arrangements with service providers. It amounts to a continuing process (the “commissioning cycle”) that involves:

- planning services (identifying need; determining priorities; managing suppliers; budgeting);
- purchasing services (determining how services are to be provided; identifying providers; negotiating and managing contracts);
- monitoring services (confirming delivery; controlling quantity and quality; ensuring patient satisfaction);
- redesigning services (to ensure that new care pathways take account of changing population needs, and changing health technology and clinical practice).

Community services (such as health visiting) are provided by PCTs through their provider arms – which are increasingly separate from the commissioning arms of PCTs. There are signs that the Department of Health (DoH) would prefer PCTs to move away from directly providing services. Also, it is government policy that, in time, whatever remains of the provider arms of PCTs will become freestanding Community Foundation Trusts, with the same autonomy, commercial freedom and local governance arrangements as hospital Foundation Trusts.

### **PCT budgets**

PCTs control around 80% of the total NHS budget. Each PCT receives annually:

- a capital allocation (Capital Resource Limit), to fund the purchase and replacement of NHS assets that provide benefits for more than a year and have a value greater than £5,000 – such as land, buildings and medical equipment;

- an annual revenue allocation (Revenue Resource Limit) to cover running costs, such as staff pay, and the purchase of goods and services, including drugs.

The bulk of money allocated to PCTs comes in the form of “unified allocations” (or “direct allocations”), which contain revenue allocations to pay for hospital, community and family health services commissioned and provided by each PCT.

These are recurrent allocations, i.e. they are for expenditure that carries on from one year to the next. Most elements of expenditure covered by the unified allocations do not have ring-fenced sums attached to them – so it is down to each PCT to decide how much of its allocation to spend on them. The only exceptions are certain elements of primary care:

- The “global sum”, paid to cover the running costs of GP practices and the provision of Essential Services and Additional Services (and based on the number of patients on each practice’s register), is ring-fenced and must be passed on by the PCT in its entirety.
- Also, there is a minimum for Enhanced Services payments (covering certain specialised services in primary care, such as minor surgery), known as the Enhanced Services Floor.

Unified allocations include non-ring-fenced sums allocated to PCTs to achieve certain public health objectives that were set out in the White Paper *Choosing Health: Making healthier choices easier* (2004).

In addition to their unified allocations, PCTs receive the following recurrent sums:

- money from “Central Budgets” for certain purposes, including the education and training of NHS staff;
- “non-discretionary” funding, which is held by the DoH and “drawn down” by PCTs to reimburse providers of NHS ophthalmic and pharmaceutical (dispensing) services, working under national contracts (theoretically this funding is not cash-limited, as these services are demand-led, but in practice there are budgetary constraints);
- ring-fenced funding for dental services provided by independent practitioners (paid for the last time in 2008–9; thereafter, dentistry will be funded through non-ring-fenced sums included in PCTs’ unified allocations).

PCTs also receive certain non-recurrent allocations, i.e. one-off sums that are earmarked for specific items of expenditure, available for a given period of time (usually one year).

### **Resource allocation formula**

Some elements of the unified allocations relating to primary care are determined by historical arrangements (i.e. how much has been paid previously) or by a performance-related system. The latter is the case in respect of payments made to GPs under the Quality and Outcomes Framework (QOF). Revenue for QOF payments is allocated to PCTs on the basis of expected performance by GPs in hitting targets. If GPs perform better than they were expected to (as has happened to a substantial extent), PCTs have to find the additional funds from within their unified allocations.

However, the remainder of the unified allocations to PCTs (accounting for by far the greater part of the allocations) is informed by the NHS resource allocation formula. This is essentially an instrument for allocating funds to meet the healthcare needs of a given population, within a given (pre-set) budget, over a given time period.

The NHS began using a funding formula in the 1970s, after it was acknowledged that there had been significant geographical inequities in the distribution of NHS funding. The formula has been progressively refined and developed since then, with the core aim of securing equal opportunity of access to healthcare for people at equal risk.

Following the Acheson Report (1998) an additional fundamental objective in allocating NHS resources has been to “contribute to the reduction in avoidable health inequalities”. The formula is thus now intended to help bring about: more equal health outcomes (“vertical equity”), rather than simply equity in access to healthcare services (“horizontal equity”); and social, rather than simply geographical, equity in health.

For each PCT, allocated sums of money are calculated in respect of:

- Hospital and Community Health Services (care provided by NHS acute hospitals, PCTs’ provider arms and independent sector providers);
- Prescribing of drugs by primary-care practitioners (chiefly GP prescribing);
- Primary Medical Services (covering payment for GP infrastructure, i.e. GPs and other practice staff, as well as premises and IT);<sup>1</sup>
- Services for people with HIV / AIDS.

In each of these cases, crude population figures (derived from GP registers and demographic data) are weighted, as appropriate, to make allowance for:

- age- and sex-related need for healthcare;
- additional need (over and above that accounted for by age and sex);
- geographical variations in the unavoidable cost of providing healthcare – covered by the Market Forces Factor (regarding costs of staff, land, buildings and equipment) and the Emergency Ambulance Cost Adjustment.

For this reason, the formula is known as the “weighted capitation” formula.

Account is taken of a wide range of indicators for health need, including some that are perceived to reflect health-related socio-economic circumstances, in order to attempt to address the goal of contributing to the reduction in avoidable health inequalities.

Population estimates produced by the Office for National Statistics (ONS) are taken account of in the formula. However, some areas are experiencing extremely rapid population growth that is not reflected in the ONS statistics – since these are based on observed trends and do not allow for the impact of government policy. In consequence, the 2006–7 and 2007–8 funding allocations included a “Growth Area adjustment”, paid to PCTs in four areas designated by the government as Growth Areas. Among these are the

---

<sup>1</sup> Funding for Primary Medical Services was not included in unified allocations prior to 2006–7.

Thames Gateway (which includes substantial parts of Dartford, Gravesham, Medway and Swale local authority areas) and Ashford.

The resource allocation formula has long been politically controversial, with parties accusing each other of using it, when in power, to direct resources at those parts of the country where their own electoral support is strongest.

Health policy experts have criticised the formula for not taking adequate account of factors including:

- additional costs in rural areas (particularly remote rural areas);
- pockets of deprivation within generally prosperous populations;
- the ageing of the population;
- regional cost variations;
- rapid population growth in certain areas.

The formula was most recently revised in May 2005 and is currently being reviewed again, at the request of the DoH, by the Advisory Committee on Resource Allocation (ACRA).

#### **“Distance from target”**

It is important to note that the actual unified allocation sum paid to a PCT in any given year (the “recurrent revenue allocation”, made up of the “recurrent baseline” – i.e. essentially the previous year’s allocation – plus a “recurrent resource increase”) is not in all cases that yielded by applying the weighted capitation formula (the “fair shares” or “target” figure). Some PCTs are overfunded in relation to the target figure and some are underfunded. The gap between the target figure and the actual revenue allocation in these cases is known as the “distance from target”.

The DoH is committed to ensuring that all these gaps are closed by 2010, by means of adjusting the percentage changes in these PCTs’ funding (“growth funding”), as overall NHS funding increases. How quickly, or slowly, these gaps are closed through this “differential growth” is determined by the DoH’s “pace of change” policy. It is DoH policy that underfunded PCTs in more deprived areas should be brought up to their target level of funding more quickly than those in better off areas. Priority is thus being given to the Spearhead Group of PCTs, which are the 62 PCTs that map onto the 70 local authority areas (20% of the total) with the worst health and deprivation indicators.

#### **Payment by Results**

Services from acute hospitals were previously all paid for under “block contracts”, whereby PCTs stipulated in advance the services to be provided and paid the acute Trust accordingly. These have now substantially been replaced by “cost and volume” contracts. Under these, Trusts are paid for each “spell” of care actually provided, according to a fixed national “tariff”, based on average costs across NHS providers. (There is some adjustment in the tariff to allow for unavoidable differences in costs between regions – using the Market Forces Factor.) This system is known as “Payment by Results” (PbR).

It is intended that the scope of PbR will be extended to cover as much of hospital care as possible (including emergency care) – and, in time, mental health services, community services, ambulance services and specialist (tertiary) services as well.

Under PbR, “underperformance” (lack of patient referrals or insufficient patient throughput) can financially destabilise a Trust. There are thus said to be “perverse incentives” for providers to treat as many patients as they can – despite the national policy of providing more treatment outside hospital settings. Conversely, “overperformance” (treatment of more patients than are specified in a contract) can financially destabilise a PCT.

With Patient Choice, providers of NHS secondary services operate in an increasingly competitive, market-style environment. From April 2008 “Free Choice” will apply, with patients able to choose any provider in England that has been signed off by the Healthcare Commission as meeting minimum standards and is prepared to provide the treatment required at the NHS tariff price.

To ensure that Trusts are adequately compensated for handling more difficult and costly cases, “Healthcare Resource Groups” (HRGs) are used to classify together cases that are clinically similar. However, the limited number of HRGs means that they can only approximately reflect actual case-mixes. There are also concerns about how spells of care are allocated to HRGs – providers will have an incentive to “upcode” (*i.e.* overstate the complexity of a case) or even to “overtreat” (provide more care than is clinically necessary) in order to boost their income. Such practices are known as “gaming” the system.

Another issue associated with PbR is that of “tariff unbundling”. This arises where a PCT and a Trust have to agree how to split a tariff payment in respect of a spell of care that is divided between the Trust and primary care. This situation usually happens where a patient is discharged after hospital treatment into some form of “stepdown” care, because he or she is not yet fully recovered.

When PbR was first introduced, PCTs had their allocations adjusted to ensure their purchasing power remained constant despite any variations between local providers’ prices and national tariff prices. This “purchase parity adjustment” is being phased out and will disappear altogether in 2008–9.

First wave Independent Sector Treatment Centres are not covered by PbR for the period of their initial five-year contracts – they are on “take and pay” contracts that require commissioning PCTs to pay the full value of the contract, regardless of how much work is actually done. However, the government intends that all independent sector providers will in time be covered by PbR.

PCTs do not have legally binding contracts with NHS Trusts – they have only “Service Level Agreements”. Contracts with other providers (including Foundation Trusts and independent sector providers) are, however, legally enforceable.

## **Financial settlements**

In December 2002 a three-year funding allocation for PCTs was announced, covering the years 2003–4, 2004–5 and 2005–6.

In February 2005 PCTs were notified of their recurrent revenue allocations for 2006–7 and 2007–8.

In December 2007 a one-year funding allocation was announced for 2008–9. The reason for announcing a one-year allocation at this point was that the ACRA had requested additional time to finalise its work on the funding formula. Given the importance of getting allocations right, the Secretary of State for Health agreed to give ACRA this extra time. This made it impossible to issue three-year allocations using the new formula in time to allow PCTs to plan for 2008–9 – so a one-year allocation for 2008–9 had to be announced. The DoH plans to announce allocations for 2009–10 and 2010–11 (using the new formula) by summer 2008.

Because the implementation of a revised weighted capitation formula is imminent, the DoH decided to give all PCTs a uniform funding increase of 5.5% for 2008–9, making no allowance for “distance from target” under the old weighted capitation formula.

### **Top-slicing**

PCT funding allocations are passed down through the Strategic Health Authorities (SHAs). SHAs act as a link between the DoH and “frontline” NHS bodies, effectively functioning as the “local headquarters” of the NHS. They performance-manage local NHS bodies on behalf of the Chief Executive of the NHS and, through him, the Secretary of State and Parliament.

In recent years SHAs have “top-sliced” some of the growth funding paid to PCTs as overall NHS spending has increased. This money is temporarily held back by the SHA to be paid to the PCT at a later date (in theory within a three-year allocation cycle). Some of this money has been used by SHAs to mitigate the impact on certain NHS acute hospital Trusts of the Resource Accounting and Budgeting (RAB) rules (which effectively entailed the double-counting of deficits).

In 2006–7 the NHS nationally generated a surplus, chiefly through the creation of a £450m “central contingency reserve” by means of SHAs being obliged by the DoH to hold back part of the allocations from Central Budgets for purposes including the education and training of NHS staff.

Just before the end of the 2006–7 financial year, the DoH (acting on the advice of the Audit Commission) took NHS acute Trusts out of the RAB rules. RAB deductions made in 2006–7 were immediately refunded to the Trusts concerned, using monies from the central contingency reserve.

At the same time, the remainder of the central contingency reserve was made available to SHAs, allowing them to begin returning top-sliced monies to PCTs (beginning with those that have the greatest health need). South East Coast SHA appears to have returned some top-sliced money to PCTs immediately in March 2007 (i.e. within the 2006–7 financial year).

David Turner

Research Officer, Health Overview and Scrutiny Committee

January 2008

## Background briefing on PCT plans

Under *Improvement, Expansion and Reform: The Next Three Years* (2002) all Primary Care Trusts (PCTs) were required for the first time to produce Local Delivery Plans (LDPs) – to cover, in the first instance, the three-year period from 2003–4 to 2005–6 (for which financial allocations were announced in December 2002). These LDPs had to show how each PCT intended to achieve key national targets set out in the NHS Plan (2000) and meet local priorities, while identifying how annual funding allocations were to be used to do so.

Each Strategic Health Authority (SHA) was also obliged to have an LDP, within which was contained the LDPs for each of the PCTs in its area.

LDPs were also produced for 2006–7 and 2007–8, the years covered by the two-year financial allocation announced in February 2005.

Starting in 2008–9 LDPs are replaced by three plans that each PCT is required to draw up as part of its “commissioning cycle”:

- a 5–10-year **Strategic Commissioning Plan**<sup>1</sup> (renewed and developed every three years and updated annually), which outlines the PCT’s longer-term framework for investing in and developing services;
- a three-year **Operating Plan** (renewed and developed every year), which includes a detailed business and commissioning plan, provider plan and financial (including capital) plan for the coming 12 months (with targets, financial and activity schedules, and action plans), and outlines how the PCT plans to achieve the health outcomes and financial goals set out in the Strategic Commissioning Plan;
- an **Organisational Development Plan**<sup>2</sup> (developed every three years and updated annually), which describes the organisational capabilities (in areas such as workforce and governance) needed to deliver the Strategic Commissioning Plan, along with gaps in capability and how they are to be filled.

In some areas PCTs produced an Operating Plan and an Organisational Development Plan for 2007–8, in addition to the LDP for that year.

PCTs are currently developing their plans for 2008–9, in light of the funding allocations announced in December 2007.

In constructing their plans, PCTs must take account of a range of targets and plans at national and local level, including the following:

- **The National Indicator Set (NIS)**

The NIS contains key national outcome indicators (targets) for public services. These indicators are signs of progress and measures of success against aspects of Public Service Agreements (PSAs) and Departmental Strategic Objectives (DSOs). NIS

---

<sup>1</sup> Sometimes called the “Commissioning Strategy Plan”.

<sup>2</sup> Sometimes called the “Organisational Capability Development Plan” or the “Capability Development Plan”.

indicators from April 2008 were set under the Comprehensive Spending Review 2007 (CSR07).

PSAs (first introduced in 1998) are three-year agreements negotiated between government departments (including the DoH) and the Treasury; the latest were set in October 2007 under CSR07 and run from 2008–9 to 2010–11. PSAs describe the key improvements that the public can expect from government expenditure. Each PSA sets out the high-level aims, priority objectives and key outcome-based performance targets of the department concerned.

DSOs represent the fundamental purpose and future direction of each government department (including the DoH). They underpin those PSAs where the department concerned is responsible for delivering outcomes.

- **“Vital Signs”**

The DoH’s outcome indicators in respect of PSAs and DSOs (including those that are not in the NIS) are called “Vital Signs”. A number of these are “shared indicators” that involve at least one other government department.

All PCTs must set targets for “Vital Signs”, based on performance against national best-practice benchmarks and including 10–15 “stretch” targets, to be set at the discretion of the PCT, based upon local needs and priorities.

- **NHS National Operating Framework (NOF)**

The most recent version of the NOF was published in December 2007. This sets out key national targets and priorities for the NHS during 2008–9, including aspects of “system reform” (such as Patient Choice and the increasing the role of the independent sector in the NHS).

- **Local Area Agreements (LAAs)**

The Local Government Act 2000 required each local authority to prepare a Community Strategy (now known as a Sustainable Community Strategy). To facilitate the preparation and delivery of Community Strategies, the Act encouraged the formation of Local Strategic Partnerships (LSPs) – non-statutory, non-executive advisory bodies, matching local-authority boundaries, to bring together the public, private, community and voluntary sectors at the local level.

LAAs are three-year agreements, setting out priorities for a local area, agreed between central government (represented by the Government Office for the region concerned) and a local area – represented by local authorities, LSPs and other key local delivery partners. LAAs are based on Sustainable Community Strategies and are structured around four themes, one of which is “Healthier communities and older people”.

Under the Local Government and Public Involvement in Health Act 2007 local authorities now have a statutory duty to consult on, prepare and agree LAA targets with partners.

The LAA for Kent forms part of the Kent Agreement. The second Kent Agreement, covering 2008–11, is due to be signed off in March 2008.

- **Practice-based commissioning plans of GP practices**

These are set out in the Annual Commissioning Plans of commissioning practices (individually or in “clusters”), which should dovetail with the relevant PCT’s Operating Plan.

- **Joint Strategic Needs Assessment (JSNA)**

Under the Local Government and Public Involvement in Health Act 2007 PCTs and local authorities in each area have a statutory duty to compile a JSNA, connected to the Sustainable Community Strategy / LAA, and to the PCT’s Strategic Commissioning Plan and Operating Plan.

The DoH’s *Commissioning framework for health and well-being* (2007) gives guidance on how to undertake a JSNA. It states that a JSNA “is the means by which Primary Care Trusts (PCTs) and local authorities will describe the future health, care and well-being needs of local populations and the strategic direction of service delivery to meet those needs”.

SHAs, as part of their performance-management function, have the responsibility to ensure that all PCT plans are rigorous, practical and consistent, and will improve the health of the local resident population.

David Turner  
Research Officer, Health Overview and Scrutiny Committee  
January 2008

This page is intentionally left blank

2006-07 baseline allocations

PCT	2006-7 baseline	2006-7 increase	% increase
Ashford	113,464	10,288	9.1
Canterbury and Coastal	195,141	16,547	8.5
Dartford, Gravesham and Swanley	250,539	22,730	9.1
East Kent Coastal	302,930	27,411	9.0
Maidstone Weald	244,335	22,314	9.1
Medway	273,467	30,834	11.3
Shepway	123,618	11,181	9.0
South West Kent	184,886	15,718	8.5
Swale	101,348	15,524	15.3
Eastern and Coastal Kent	836,501	80,951	9.7
West Kent	679,760	60,762	8.9
Kent and Medway total	1,789,729	172,547	9.6

Primary Care Trust Choosing Health allocations (within recurrent revenue allocations), Kent and Medway

PCT		2006-7	2007-8
		£000s	
To 30 September 2006	<i>Ashford</i>	232	327
	<i>Canterbury and Coastal</i>	387	542
	<i>East Kent Coastal</i>	611	852
	<i>Shepway</i>	248	348
	<i>Swale</i>	326	324
<b>Eastern and Coastal Kent (from 1 October 2006)</b>		<b>1,804</b>	<b>2,393</b>
To 30 Sept. 2006	<i>Dartford, Gravesham and Swanley</i>	711	699
	<i>Maidstone Weald</i>	698	688
	<i>South West Kent</i>	519	510
<b>West Kent (from 1 October 2006)</b>		<b>1,928</b>	<b>1,898</b>
<b>Medway</b>		<b>834</b>	<b>826</b>
<b>TOTAL</b>		<b>4,566</b>	<b>5,117</b>

Source: Department of Health

Note:

The number of PCTs was reduced from nine to three on 1 October 2006. Where a new PCT was formed from a merger of several former PCTs, the allocations for the new PCT are the sum of the allocations for its predecessor PCTs in each year.

Primary Care Trust recurrent revenue allocations, Kent and Medway

PCT	2003-4		2004-5		2005-6		2006-7			2007-8			2008-9			
	allocation		allocation		allocation		increase		allocation		increase		allocation		increase	
	£000s	%	£000s	%	£000s	%	£000s	%	£000s	%	£000s	%	£000s	%	£000s	%
To 30 Sept 06	Ashford	85,546	93,528	102,199	24,102	30.9	123,752	10,288	9.1	137,086	13,335	10.8	-	-	-	-
	Canterbury and Coastal	150,208	163,549	177,927	40,291	29.3	211,688	16,547	8.5	231,695	20,006	9.5	-	-	-	-
	East Kent Coastal	234,126	256,544	280,660	67,418	31.6	330,340	27,411	9.0	362,480	32,140	9.7	-	-	-	-
	Shepway	95,502	104,546	114,328	27,255	31.3	134,799	11,181	9.0	148,623	13,824	10.3	-	-	-	-
	Swale	78,399	86,218	94,536	23,302	32.7	116,872	15,524	15.3	133,446	16,574	14.2	-	-	-	-
<b>Eastern and Coastal Kent (from 1 October 2006)</b>	<b>643,780</b>	<b>704,384</b>	<b>769,650</b>	<b>182,368</b>	<b>31.1</b>	<b>917,451</b>	<b>80,951</b>	<b>9.7</b>	<b>1,013,331</b>	<b>95,879</b>	<b>10.5</b>	<b>1,068,679</b>	<b>55,348</b>	<b>5.5</b>		
To 30 Sept 06	Dartford	196,417	214,153	233,267	53,290	29.6	273,269	22,730	9.1	298,896	25,627	9.4	-	-	-	-
	Gravesham and Maidstone Weald	182,029	199,462	218,377	52,360	31.5	266,650	22,314	9.1	292,733	26,084	9.8	-	-	-	-
	South West Kent	141,986	154,808	168,529	38,434	29.5	200,604	15,718	8.5	218,687	18,083	9.0	-	-	-	-
	<b>West Kent (from 1 October 2006)</b>	<b>520,432</b>	<b>568,424</b>	<b>620,174</b>	<b>144,084</b>	<b>30.3</b>	<b>740,523</b>	<b>60,762</b>	<b>8.9</b>	<b>810,316</b>	<b>69,793</b>	<b>9.4</b>	<b>854,576</b>	<b>44,259</b>	<b>5.5</b>	
<b>Medway</b>	<b>208,169</b>	<b>228,675</b>	<b>250,623</b>	<b>61,260</b>	<b>32.4</b>	<b>304,301</b>	<b>30,834</b>	<b>11.3</b>	<b>340,701</b>	<b>36,400</b>	<b>12.0</b>	<b>359,310</b>	<b>18,609</b>	<b>5.5</b>		
<b>TOTAL</b>	<b>1,372,381</b>	<b>1,501,484</b>	<b>1,640,446</b>	<b>387,712</b>	<b>30.9</b>	<b>1,962,275</b>	<b>172,547</b>	<b>9.6</b>	<b>2,164,348</b>	<b>202,072</b>	<b>10.3</b>	<b>2,282,565</b>	<b>118,216</b>	<b>5.5</b>		

Source: Department of Health

Notes:

1. The number of PCTs was reduced from nine to three on 1 October 2006. Where a new PCT was formed from a merger of several former PCTs, the 2006-7 and 2007-8 allocations for the new PCT are the sum of the allocations for its predecessor PCTs in each of those years. For purposes of comparison, equivalent figures are shown for the new PCT areas in respect of years before 2006-7, although this is, of course, anachronistic.
2. Some totals do not tally exactly, due to rounding.

*In-year financial balances of Primary Care Trusts, Kent and Medway*

PCT	2002-3 Annual Accounts Surplus/ (Deficit) £000s	2003-4 Annual Accounts Surplus/ (Deficit) £000s	2004-5 Annual Accounts Surplus/ (Deficit) £000s	2005-6 Annual Accounts Surplus/ (Deficit) £000s	2006-7 Annual Accounts Surplus/ (Deficit) £000s	2007-8 Second Quarter Forecast Outturn Surplus/ (Deficit) £000s	2007-8 Second Quarter Forecast Turnover £000s	2007-8 Second Quarter Forecast Outturn Surplus/ (Deficit) as % turnover
To 30 September 2006	Ashford	104	157	97	-	-	-	-
	Canterbury and Coastal	18	(2,276)	(476)	-	-	-	-
	East Kent Coastal	19	89	920	-	-	-	-
	Shepway	18	410	550	-	-	-	-
	Swale	63	(449)	(3,305)	-	-	-	-
<b>Eastern and Coastal Kent (from 1 October 2006)</b>	<b>169</b>	<b>323</b>	<b>(2,069)</b>	<b>(2,214)</b>	<b>6,615</b>	<b>4,000</b>	<b>1,013,140</b>	<b>0.4</b>
To 30 Sept 2006	Dartford, Gravesham and Swanley	(1,189)	(5,592)	(1,086)	(4,306)	-	-	-
	Maidstone Weald	491	3	(3,714)	261	-	-	-
	South West Kent	131	109	14	(6,446)	-	-	-
	<b>West Kent (from 1 October 2006)</b>	<b>(567)</b>	<b>(5,480)</b>	<b>(4,786)</b>	<b>(10,491)</b>	<b>(15,943)</b>	<b>0</b>	<b>807,569</b>
<b>Medway</b>	<b>9</b>	<b>23</b>	<b>(196)</b>	<b>(2,343)</b>	<b>1,631</b>	<b>3,207</b>	<b>353,141</b>	<b>0.9</b>

Source: Department of Health

Note:

The number of PCTs was reduced from nine to three on 1 October 2006, with two new PCTs being formed from mergers of several former PCTs. For purposes of comparison, balances are shown for these two new PCT areas in respect of years before 2006-7 (amounting to the sum of the balances for

Primary Care Trust recurrent revenue allocations and distances from target, Kent and Medway

PCT	2003-4			2004-5			2005-6			2006-7			2007-8		
	allocation £000s	closing distance from target		allocation £000s	closing distance from target		allocation £000s	closing distance from target		allocation £000s	closing distance from target		allocation £000s	closing distance from target	
		£000s	%		£000s	%		£000s	%		£000s	%		£000s	%
Ashford	85,546	258	0.3	93,528	226	0.2	102,199	200	0.2	123,752	(2,673)	(2.1)	137,086	(2,707)	(1.9)
Canterbury and Coastal	150,208	3,491	2.2	163,549	3,044	1.8	177,927	2,463	1.3	211,688	1,030	0.5	231,695	113	0.0
East Kent Coastal	234,126	(6,706)	(2.6)	256,544	(6,923)	(2.5)	280,660	(7,355)	(2.4)	330,340	(1,942)	(0.6)	362,480	(1,442)	(0.4)
Shepway	95,502	(1,049)	(1.0)	104,546	(1,079)	(1.0)	114,328	(1,140)	(0.9)	134,799	(332)	(0.2)	148,623	(82)	(0.1)
Swale	78,399	(5,256)	(5.9)	86,218	(5,426)	(5.6)	94,536	(5,771)	(5.4)	116,872	(8,261)	(6.6)	133,446	(4,840)	(3.5)
<b>Kent (from 1 October 2006)</b>	<b>643,780</b>	<b>(9,261)</b>	<b>(1.3)</b>	<b>704,384</b>	<b>(10,159)</b>	<b>(1.3)</b>	<b>769,650</b>	<b>(11,602)</b>	<b>(1.4)</b>	<b>917,451</b>	<b>(12,178)</b>	<b>(1.3)</b>	<b>1,013,331</b>	<b>(8,957)</b>	<b>(0.9)</b>
Dartford, Gravesham and Swanley	196,417	4,564	2.2	214,153	3,979	1.8	233,267	3,221	1.3	273,269	(19)	0.0	298,896	278	0.1
Maidstone Weald	182,029	(58)	0.0	199,462	(14)	0.0	218,377	35	0.0	266,650	(1,442)	(0.5)	292,733	(1,253)	(0.4)
South West Kent	141,986	4,467	3.0	154,808	4,155	2.6	168,529	3,624	2.0	200,604	1,265	0.6	218,687	689	0.3
<b>West Kent (from 1 October 2006)</b>	<b>520,432</b>	<b>8,973</b>	<b>1.6</b>	<b>568,424</b>	<b>8,119</b>	<b>1.4</b>	<b>620,174</b>	<b>6,880</b>	<b>1.0</b>	<b>740,523</b>	<b>(195)</b>	<b>0.0</b>	<b>810,316</b>	<b>(285)</b>	<b>0.0</b>
Medway	208,169	(9,635)	(4.2)	228,675	(9,928)	(3.9)	250,623	(10,540)	(3.8)	304,301	(16,187)	(5.1)	340,701	(12,357)	(3.5)
<b>TOTAL</b>	<b>1,372,381</b>	<b>(9,923)</b>	<b>(0.7)</b>	<b>1,501,484</b>	<b>(11,968)</b>	<b>(0.7)</b>	<b>1,640,446</b>	<b>(15,262)</b>	<b>(0.9)</b>	<b>1,962,275</b>	<b>(28,560)</b>	<b>(1.4)</b>	<b>2,164,348</b>	<b>(21,599)</b>	<b>(1.0)</b>

Source: Department of Health

Notes:

1. Allocations from 2006-7 onwards are not directly comparable with those for previous years, as they include funding for Primary Medical Services.
2. The number of PCTs was reduced from nine to three on 1 October 2006. Where a new PCT was formed from a merger of several former PCTs, the 2006-7 and 2007-8 allocations for the new PCT are the sum of the allocations for its predecessor PCTs in each of those years. For purposes of comparison, equivalent figures 3. "Closing distance from target" is the difference between a PCT's weighted capitation target (the funding it should be receiving) and its recurrent revenue allocation (the funding it actually receives) in a given year.
4. Some totals do not tally exactly, due to rounding.

This page is intentionally left blank









**PCT LDP Planning – 2008/09 Process**

**Overview**

1. The Local Delivery Plan (LDP) is the annual planning process that decides which services will be commissioned in the year ahead and how the PCT's money will be spent.
2. Unlike previous years, the business planning process will also incorporate detailed input from Practice Based Commissioners, and will be required to deliver the priorities set out in the Strategic Commissioning Plan (SCP). The SCP will be used as the baseline for assessing whether the Local Delivery Plan is moving the PCT toward its stated strategic aims. Input from Practice based Commissioners will be received from the PbC Management Leads at a workshop on the 30th of November, as well as the availability of PbC Annual Commissioning Plans by mid December.
3. As in previous years, the LDP will look at the services that are needed next year, but will also develop an investment plan for the next three years. As ideas and requirements are developed in the LDP, it will also be possible for them to develop the objectives and timelines set out in the SCP.
4. This paper sets out the process by which the LDP will be managed. Almost all staff within the finance and commissioning directorates will have an input into the development of the LDP at some level, so this year the LDP is being co-ordinated by the PCT's 10 change programmes, who will co-ordinate their own responses to the timetable set out below.
5. As the LDP will ultimately drive the development of the 2008/09 SLA and contracts, it must be managed to a tight timescale and specified activities completed on time. **Change Programme Leads, SIG Leads and PbC Locality Leads will need to ensure they have appropriate internal processes in place to provide the required responses to the timetable set out below.**

**Timetable**

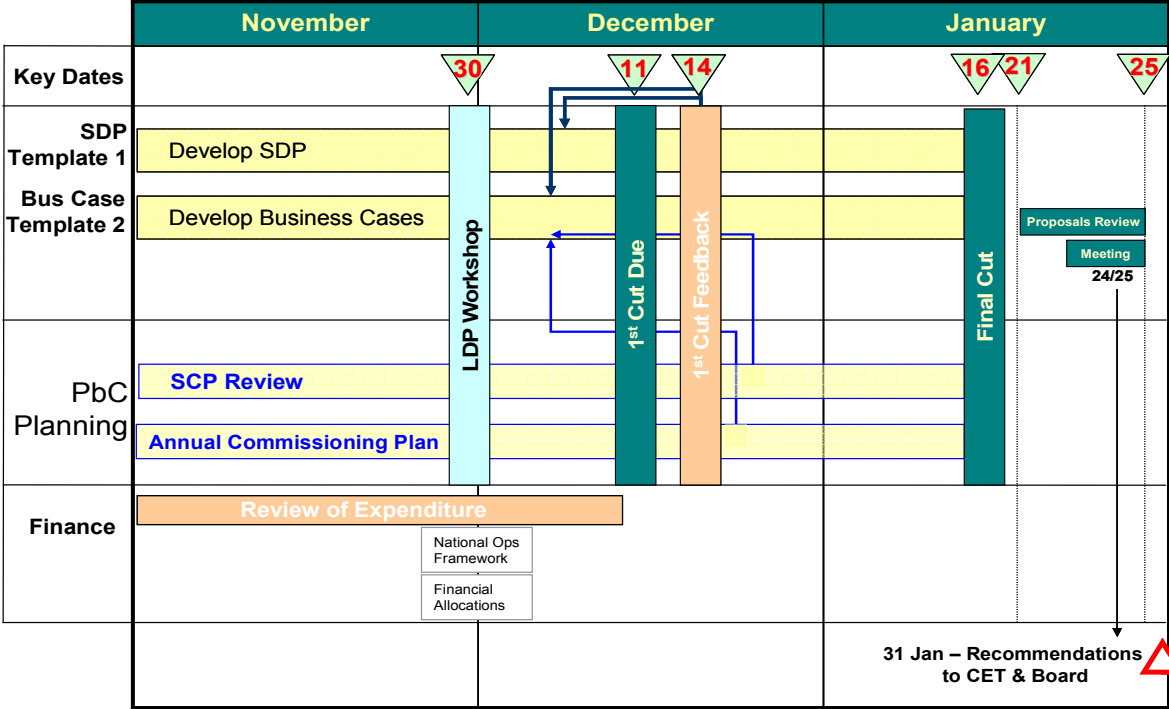
6. The Key Dates for Change Programme Leads are as follows:

November		
December		
		
January		

7. The overarching timetable in more detail is as follows:

- 2 Nov – Launch Event and Input Templates Despatched
- **Nov – 16 Jan:** Practice Based Commissioners develop Annual Commissioning Plans and review the PCT's baseline Strategic Commissioning Plan
- **Nov – 16 Jan:** PCT staff review and complete the Service Delivery Plan template and business case templates
- **30 Nov – LDP Workshop:** Informal Workshop with open discussion of likely PbC input and likely content of service delivery plans and business case bids. If available, an overview of the National Operating Framework and the financial allocations will also be discussed.
- **11 Dec – PbC First Cut:** PbC Commissioners provide a first cut of their Annual Commissioning Plans and their comments on the SCP to the PCT
- **11 Dec – LDP First Cut:** Change Programme Leads submit a first cut of their Service Delivery Plans and Business Case proformas to the LDP Co-ordinating Group
- **14 Dec – LDP Feedback:** The LDP Co-ordinating Group provide feedback to the Change Programmes on their first cut submissions
- **Mid Dec – PbC Direction:** Input from the PbC Commissioners first cut plans shared with the change programmes
- **16 Jan – PbC Final Cut:** PbC Commissioners provide their final cut annual commissioning plans and comments on the strategic commissioning plan
- **16 Jan – LDP Final Cut:** Change programmes submit their final cut service delivery plans and supporting business cases to the LDP Co-ordinating Group
- **24 / 25 Jan – LDP Proposals Review Meeting:** Service Delivery Plans reviewed and change programmes called to present and explain their delivery plans and clarify any points on their business cases
- **31 Jan – LDP proposals to CET and PCT Board**

8. The timetable is also set out here in diagrammatic form.



9. It should be noted by change programme leads that the decisions about funding for the 2008/09 priorities will be based primarily on the templates submitted. The late January review meeting will be to examine delivery plans and to resolve points of clarification. There will be no “Dragon’s Den” style event where funding decisions can be influenced by last minute presentations. Change programme leads are strongly encouraged to ensure that their Service Delivery Plans and Business Case proformas are comprehensive and well prepared.

**What is needed?**

- 10. The timetable above means that Practice Based Commissioners and PCT staff have from the beginning of November until mid January to plan their compile input to the LDP. To bring a common structure to the planning process, two simple templates have been designed and should form the basis of the submission for every change programme.
- 11. The first template is the Service Delivery Plan. This Excel based spreadsheet is intended to create a link between the strategic priorities outlined in the Strategic Commissioning Plan and the delivery plans for each change programme. Clearly, however, some of the change programmes are larger or have been running for longer. The SDP template can, therefore, accommodate some flexibility in how it is completed, but the basic premise of working from strategic priority to measurable actions should be followed.
- 12. The second template is the Business Case Proforma. It should be completed wherever additional funding is needed in the 2008/09 financial year. The SDP template should include a discrete entry for each business case that is to be submitted. Any questions on section 6 of the template regarding finance and

costing should be addressed to the finance department in Templar House. It should be noted that no bids are expected for less than £50,000.

13. Completed templates should be submitted in first cut form by 11 Dec and in final cut form by 16 Jan.

### **Practice Based Commissioning Input**

14. Practice Based Commissioners will have been asked to complete their Annual Commissioning Plans by mid December. In addition to developing their commissioning plans, Practice Based Commissioners are invited to review and comment on the first draft of the Strategic Commissioning Plan, which is in development until the end of the Business Planning Process. These responses are also needed in the Strategy and Planning team by the 14 December.
15. All staff involved in the development of the LDP are invited to attend an informal workshop on 30 Nov. At the workshop, a update from the PbC Management Leads will provide insight into direction of travel for the Practice Based Commissioners. It will also serve as an opportunity for Change Programme commissioners to provide an informal update on their progress and ideas for the LDP. Lastly, finance will provide details on the National Operating Framework and the financial allocations if the information has been received.

***Action: PbC Management Leads, Change Programme Leads and Finance Leads are invited to clear time in their diaries on 30 Nov for the informal workshop.***

### **Business Planning: A New Approach**

16. Rather than 'complete' the strategic commissioning plan at the end of October, and then start work on the delivery plan, the intention is to develop both plans in parallel – with final board sign-off for both at the end of February. Adopting this approach will keep the SCP alive in the minds of those working on the detailed planning for next year, and will ensure that the final version of the SCP reflects the most recent work done within the PCT.
17. This also allows time for Practice Based Commissioners to review a completed draft of the plan, as they will only have been able to provide independent input up until that point. This means that the final SCP will contain a three year plan for investment and divestment which reflects the LDP.
18. There is a further critical difference in the 2008/09 LDP process, which is that there will be no presentations by providers. Rather, all the planning and allocation of funding will be channelled through the change programmes. This means that the change programmes will need to act as the conduits for any provider plans for funding allocation. This is a significant change from the process in previous years and change programme leads are advised to consider what provision for provider engagement will be needed.

### **Governance and Co-ordination**

19. As in previous years, the detail of the LDP will be run by an LDP Co-ordinating Group, lead by the AD Strategy & Planning. The LDP Co-ordinating Group will

be responsible for co-ordinating the planning process for both the developing SCP and the LDP. It will also be responsible for developing communications to PCT staff and PBC commissioners. It will develop the key planning tools like the service delivery templates.

20. Ultimately, the PCT Board will be responsible for agreeing the strategy and allocation of budgets. In preparation for this, the following key roles will be undertaken as follows:

Process Champion	– AD Strategy & Planning
Process Sponsor	– Director of Finance & Commissioning
Process Co-ordination:	– LDP Co-ordinating Group
LDP Sign-Off	– Clinical Executive Team & PCT Board

This page is intentionally left blank