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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

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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.

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## 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 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 Government's 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 2010/11 with 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.

<b>Post Discharge/Reablement 2010/2011</b>	<b>Population</b>	<b>Allocation (£ 000s)</b>
Eastern and Coastal Kent PCT	763, 984	1,021
West Kent PCT	607, 290	812
Total	1,371,274	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.

<b>Winter Pressures 2010/2011</b>	<b>Population</b>	<b>Allocation (£ 000s)</b>
Eastern and Coastal Kent PCT	763, 984	2, 100
West Kent PCT	607, 290	1, 950
Total	1,371,274	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