SOCIAL CARE AND PUBLIC HEALTH CABINET COMMITTEE

Thursday, 12 July, 2012

9.45 am *

Darent Room, Sessions House, County Hall, Maidstone

**** PLEASE NOTE EARLIER START TIME***

AGENDA

SOCIAL CARE AND PUBLIC HEALTH CABINET COMMITTEE

Thursday, 12 July 2012, at 9.45 am
Darent Room, Sessions House, County Hall, Maidstone

Ask for: **Theresa Grayell**
Telephone: **01622 694277**

Tea/Coffee will be available 15 minutes before the start of the meeting

Membership (13)

Conservative (11): Mr C P Smith (Chairman), Mrs A D Allen (Vice-Chairman), Mr R E Brookbank, Mr N J D Chard, Mrs V J Dagger, Mr K A Ferrin, MBE, Mr C Hibberd, Mr M J Jarvis, Mr J D Kirby, Mr P W A Lake and Mr A T Willicombe

Liberal Democrat (1): Mr S J G Koowaree

Labour (1) Mr L Christie

Webcasting Notice

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UNRESTRICTED ITEMS

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

The Chairman will assume that all Members will read the reports before attending the meeting. Officers are asked to assume the same when introducing reports.

A. COMMITTEE BUSINESS

A1 Introduction/Webcast Announcement

A2 Substitutes

A3 Declarations of Members' Interest in items on today's Agenda

A4 Minutes of the Meeting held on 10 May 2012 (Pages 1 - 8)

A5 Dates of Meetings in 2013

To note that the following dates have been reserved for meetings of this Committee:-

Friday, 11 January 2013
Wednesday, 24 April 2013
Wednesday, 12 June 2013
Friday, 13 September 2013
Friday, 8 November 2013

A6 Chairman's Announcements

B. ITEMS RELATING TO ADULT SOCIAL CARE

B1 Oral Updates by Cabinet Member and Director

Key or Significant Cabinet or Cabinet Member Decision/s for Recommendation or Endorsement

C. ITEMS RELATING TO SPECIALIST CHILDREN'S SERVICES

C1 Oral Updates by Cabinet Member and Director

Key or Significant Cabinet or Cabinet Member Decision/s for Recommendation or Endorsement

D. ITEMS RELATING TO PUBLIC HEALTH

D1 Oral Updates by Cabinet Member and Director

Key or Significant Cabinet or Cabinet Member Decision/s for Recommendation or Endorsement

D2 12/01917 - NHS Health Checks (Decision to be taken by the Cabinet Member for Social Care and Public Health) (Pages 9 - 24)

E. PERFORMANCE MONITORING ITEMS

E1 Families and Social Care Directorate Financial Monitoring 2012 - 13 (Pages 25 - 30)

E2 Public Health Performance (Pages 31 - 36)

E3 Families and Social Care Performance Dashboards 2012/13 (draft) and Business Plan Outturn Report 2011/12 (Pages 37 - 62)

F. OTHER ITEMS FOR COMMENT OR RECOMMENDATION TO THE LEADER, CABINET, CABINET MEMBER/S OR OFFICERS

F1 Update on the Kent Health Commission (Pages 63 - 66)

F2 Kent County Council/Kent and Medway NHS and Social Care Partnership Trust (KMPT) Partnership for Delivery of Social Care to Adults of Working Age with Mental Health Needs (Pages 67 - 78)

F3 Update on the Re-Commissioning of Emotional Wellbeing and Child and Adolescent Mental Health Services (CAMHS) (Pages 79 - 82)

F4 Public Health Transition (Pages 83 - 94)

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
(01622) 694002

Wednesday, 4 July 2012

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.

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KENT COUNTY COUNCIL

SOCIAL CARE AND PUBLIC HEALTH CABINET COMMITTEE

MINUTES of a meeting of the Social Care and Public Health Cabinet Committee held in the Council Chamber, Sessions House, County Hall, Maidstone on Thursday, 10 May 2012.

PRESENT: Mr C P Smith (Chairman), Mrs A D Allen, Mr R E Brookbank, Mr L Christie, Mrs V J Dagger, Mr K A Ferrin, MBE, Mr C Hibberd, Mr M J Jarvis, Mr J D Kirby, Mr S J G Koowaree, Mr P W A Lake and Mr A T Willicombe

ALSO PRESENT: Mr G K Gibbens and Mrs J Whittle

IN ATTENDANCE: Mr A Ireland (Corporate Director, Families and Social Care), Mrs J Imray (Interim Director, Specialist Children's Services), Mr M Lobban (Director of Strategic Commissioning), Mr A Scott-Clark (Deputy Director of Public Health, NHS E & C Kent), Mr M Thomas-Sam (Head of Policy and Service Development), Mrs A Tidmarsh (Director of Older People and Physical Disability) and Miss T A Grayell (Democratic Services Officer)

UNRESTRICTED ITEMS

3. Election of Vice-Chairman
(Item A3)

Mr C P Smith proposed and Mr P W A Lake seconded that Mrs A D Allen be elected Vice-Chairman of the Committee.

Mr S J G Koowaree then proposed and Mr L Christie seconded that Mr L Christie be elected Vice-Chairman of the Committee.

On being put to the vote, Mrs A D Allen was supported by 8 votes to 2 and Mr Christie by 2 votes to 9.

Mrs A D Allen was duly elected Vice-Chairman of the Committee.

4. Minutes of the Meeting held on 29 March 2012
(Item A5)

RESOLVED that the Minutes of the meeting held on 29 March 2012 are correctly recorded and they be signed by the Chairman.

5. Dates of Future Meetings
(Item A6)

RESOLVED that the dates reserved for future meetings of the Committee be noted, as follows:-

Thursday 12 July 2012, 10.00 am
Friday 14 September 2012, 10.00 am

Friday 9 November 2012, 10.00 am
Friday 11 January 2013, 10.00 am
Wednesday 24 April 2013, 10.00 am

6. 12/01905 - Adult Social Care Transformation (Decision to be taken by the Cabinet)
(Item B1)

1. Mr Lobban introduced the report and presented a series of slides which set out the context and key aims of the Transformation model, which, he explained is consistent with the Government's vision for Adult Social Care. He and Mr Ireland highlighted its key aims as:-

- to deliver better outcomes for clients at less cost.
- to ensure available funding is directed to the areas which will achieve the best value for money and greater efficiency while maximising client choice.
- to allow Adult Social Care to fulfil its statutory duties while making a contribution to the £200million deficit faced by the KCC over the next three years. This contribution will need to be substantial as the ASC budget is approximately one-third of the total KCC budget (excluding schools).

He highlighted its key elements and set out the process and timetable for consultation on and implementation of the model and the rationale for asking the Cabinet to agree the Programme Blueprint and Preparation Plan.

2. Mr Lobban and Mr Ireland then answered questions of detail. The comments and views expressed by Members included the following:-

a) the presentation did not make clear or help Members to understand how the Transformation programme fits with the Government's vision for Social Care;

b) to achieve good transformation, it is important to avoid bureaucracy;

c) the number of carers, particularly young carers, in Kent is high and is of great concern;

d) the KCC would need to be able to check on the quality of care being provided to vulnerable clients by care companies;

e) the Transformation programme seems to be a way of disguising cuts, and it is misleading to show aspirations for the future which those proposing them do not have to start work on yet. It supports a political ideology to move away from provision to commissioning;

f) some parts of the programme refer to using the cheapest option when delivering care; the elderly deserve better than the cheapest option;

g) Members appear to have very limited involvement and influence in the process, being involved only in the yearly issuing of contracts and again at a yearly monitoring;

h) the issues raised emphasise the need for people to look ahead and plan for themselves what services they might need and how they wish to access them;

i) provision of adult social care, and particularly preventative services, is a national issue and needs a national scheme to address it. It is good to see this document starting to address this;

j) Kent needs skilled, well-trained care workers to meet the needs of its vulnerable clients. There is insufficient supply of these workers;

k) the emphasis on keeping control of finance is good. Social Services should not be judged solely on its accounts, but it is important to pay attention to accounting, as money saved in one area can be directed to benefit another area;

l) the Blueprint document provides a good route map for future progress;

m) the way in which older people are categorised at present needs to be reviewed. There could be three categories – the fit elderly, the frail elderly and those with Dementia;

n) there are still not enough people taking up Direct Payments; this figure is always a disappointment;

o) priority areas where the KCC must direct spending are preventative services and carers' support;

p) producing the Blueprint is a huge challenge; the courage of those who have drafted the document is to be admired;

q) there is very little mention of Health in the document, but they must play a part in developing service provision. *Mr Scott-Clark explained some of the ways in which Health are involved*; and

r) the document makes no mention of Member involvement but should do. *Mr Gibbens advised that he represents Members on the Transformation Board.*

3. Mr Gibbens said the debate had been very helpful. He noted Members' comments and views and made the following points:-

- the Blueprint is intended as a framework of how KCC will move forward its care provision and approach things differently; the detail will be developed later;
- he assured Members that safeguarding is a key priority in which he takes a strong personal interest;
- the private and voluntary sectors in Kent provide very good services and present the KCC with massive opportunities to explore in terms of service provision;
- there is much concern in the wider community about issues facing carers, and these issues need to be given greater focus. As the Blueprint is developed, it

is important to address the need for more focus on carers, including young carers, and how this can best be achieved;
- Adult Social Care has good connections to Health, who have been engaged in the development of the Blueprint. PCT representatives serve on the various Boards which will take forward the Blueprint;
- he added that he is happy to provide the Committee with an update on the development of the detail of the Plan.

4. The Committee then voted on whether or not it wished to endorse the decision to be taken by the Cabinet.

Endorsement of the decision was agreed by 10 votes to 1

5 RESOLVED that the decision to be taken by the Cabinet, to agree the Adult Social Care Transformation Programme Blueprint and Preparation Plan, be endorsed.

7. 12/01831 - Review of Appledore Reception Centre for Unaccompanied Asylum Seeking Young People (Decision to be taken by the Cabinet Member for Specialist Children's Services)
(Item B2)

This item was considered as urgent business as the papers had not been placed on public deposit with the required five clear days' notice.

Mrs L Totman, Head of Corporate Parenting, was in attendance for this item.

1. Mrs Totman introduced the report, which set out the background and context of the review of the Appledore Centre and the reason for asking the Cabinet Member to agree to delay its closure. She highlighted that, since drafting the report, the costs quoted in paragraph 4 (3) had reduced from £300k to £100k, but £30k was paid to the Youth Service for rent so the cost to KCC was £70k for the Centre to 'tick over' for a few months.

2. Mrs Whittle added that the heightened risk identified by the Kent Safeguarding Children's Board Trafficking Sub-Group had made it obvious that the closure of the Centre should be delayed until after the summer, as previous Olympics had coincided with a rise in unaccompanied children travelling to the host nation. While it is not possible to anticipate what incidents might arise during the summer, it is important to be ready in case the risk becomes a reality.

3. Mrs Totman and Mrs Imray answered questions of detail, explaining the following:-

a) consultees had included Trades Unions, although these had been omitted from the list in paragraph 2 of the report;

b) some staff previously employed at the Appledore Centre have moved to Millbank, retaining the same hours and salary level, which has allowed the KCC to employ fewer agency staff at the latter. Other Appledore staff had moved to work with the Short Breaks units for disabled children;

c) the unit cost of permanent staff rises when there are fewer young people accommodated, so the use of agency staff to supplement permanent staff allows the flexibility to accommodate fluctuations in numbers;

d) the Centre's buildings will be kept in a good condition so it can be opened and be up and running quickly if needed. The resident handyman will remain on site to care for the buildings. A Regulation 33 inspector has visited the Centre and is satisfied with its condition and suitability to accommodate and support young people; and

e) Foster Care remains the ideal option for placing vulnerable young people, but when young people first arrive in the UK they need to be accommodated somewhere in which they can be assessed in safety. Once the children have been assessed, they are placed in foster care.

4. Comments and views expressed by Members included the following:-

a) it is good that the emergency in UASC numbers which had required the Centre to first be opened no longer exists;

b) in closing the Centre, it is important to acknowledge and record the work done there, and the enormous difference it has made to young people's lives; and

c) KCC is duty bound to protect any UASC who might be at risk of trafficking, and keeping the Centre open for the summer is a sensible step.

5. RESOLVED that the decision to be taken by the Cabinet Member for Specialist Children's Services, to approve the delay in closing the Appledore Centre, be endorsed.

8. 11/01747 - Shepway Learning Disability Day Services (Decision to be taken by the Cabinet Member for Social Care and Public Health)
(Item B3)

Ms P Watson, Commissioning Manager, Learning Disability, was in attendance for this item.

1. Ms Watson introduced the report, which set out the background and context of the review of Learning Disability Day Services in Shepway and the reason for asking the Cabinet Member to approve the development of new Community Hubs. She answered questions of detail, explaining the following:-

a) Community Hubs will use buildings which are also used for other purposes and hence are accessible to the wider community, eg leisure centres;

b) existing facilities will run in parallel with new provision while the latter gets up and running, so there will be no gap in provision. When

modernising day services in other areas, this principal has always been strictly adhered to;

c) the questionnaire sent to consultees did not include a specific question which asked if service users wished existing services to remain unchanged, but respondents had the opportunity to comment freely and could express a view; and

d) only eighteen current users access services using Direct Payments.

2. RESOLVED that the decision to be taken by the Cabinet Member for Social Care and Public Health, to develop new Community Hub resources in Shepway, be endorsed.

9. 12/01892 - Amendments to the Charging Policy for Home Care and other Non-Residential Services (Decision to be taken by the Cabinet Member for Social Care and Public Health)
(Item B4)

Miss M Goldsmith, FSC Finance Business Partner, was in attendance for this item, with Mr Thomas-Sam.

1. Mr Thomas-Sam introduced the report, which had been updated since last seen by the former Adult Social Care and Public Health Policy Overview and Scrutiny Committee (POSC) on 30 March 2012, to take account of the comments made by POSC Members at that meeting. He emphasised that change will be very closely monitored, with a further update report being made to this Committee in November 2012. He and Miss Goldsmith and Mr Ireland answered questions of detail, explaining the following:-

a) Members had asked for an indication of the level of income loss which might result from the change. Estimates had been made and are included in the report, but work is still ongoing to identify the numbers of users and assess their eligibility, so it is not yet possible to determine the accuracy of those estimates;

b) Members were assured that, if the removal of some users from charging were to cause a shortfall in income, this would not impact on the level of charges made to other services users; and

c) the assessment process includes a full benefits check to ensure that clients are making optimum use of the benefits which are available to them.

2. RESOLVED that the decision to be taken by the Cabinet Member for Social Care and Public Health, to amend the charging policy for home care and other non-residential services, as previously approved under decision 11/01645, be endorsed.

EXEMPT ITEM

(Open Access to Minutes)

(The Committee resolved that, under Section 100A of the Local Government Act 1972, the public be excluded from the meeting for the following business on the grounds that it involves the likely disclosure of exempt information as defined in paragraph 3 of Part 1 of Schedule 12A of the Act.)

10. 12/01904 - Excellent Homes for All (Decision to be taken by the Cabinet)
(Item E1)

Ms S Naylor, Project Manager, Mr D Weiss, Head of Business Transformation and Programmes, and Ms A Melvin, Principal Accountant (Projects), were in attendance for this item.

1. Ms Naylor introduced the report, which set out the history and context of the Excellent Homes for All project, how it relates to the KCC Strategic policy Framework, the process and timetable for awarding the contract and progressing the project and the reason for asking the Cabinet to agree the delegated authorities set out, the use of the designated sites and to approve the required Authority annual contribution. There are currently two shortlisted bidders, and the preferred bidder will be appointed in October 2012.

2. Ms Naylor, Mr Weiss, Ms Melvin and Mr Ireland answered questions of detail, explaining the following:-

a) as the project was already part-way through the procurement process when the Treasury reviewed and reduced the level of PFI credit (a grant payment which covers construction of a project), the changes which could be made to the project were limited, but some small changes were made to the design and use of communal areas;

b) nomination rights for places are shared by the County Council and its District and Borough Council partners. The contractor running the sites can express a view but cannot override Councils' nominations;

c) the contractor will need to comply with the rents influencing regime when setting rents and service charges. The KCC will ask for rents and service charges to be fixed at an affordable level;

d) although the contract term of the PFI scheme is 25 years, the land 'hand back' period (ie the period after which the property will be handed back to the KCC) is 99 years;

e) PFI is based an outputs and not inputs and it is not possible yet to say how a building contractor will meet environmental concerns (eg in terms of including solar panels, low-flush toilets, etc) but the KCC has specified the need for the buildings to meet the BREEAM 'Good' standard, or the Code for Sustainable Homes Level 3; and

f) units will be a mixture of single- and double-occupancy, to avoid couples having to be separated when only one partner needs support. Keeping couples together is vitally important in terms of their mutual support and emotional wellbeing. If one partner dies, the Housing

Association will consult the surviving partner and work with them to decide on whether to stay on in the double-occupancy unit or move to a single-occupancy unit, when one becomes available. In this respect, the arrangements are the same as those which apply for Local Authority tenants.

3. Comments and views expressed by Members included the following:-

a) the stated cost per unit is very high and does not seem to represent good value for money. The KCC does not seem to be paying a fair or reasonable price. *Officers explained that the unit cost also covers the other facilities provided in a development (such as an on-site shop, restaurant and services for residents' use) as well as the costs of building in features which can adapt to meet residents' future mobility needs. The buildings are required to have a minimum of 60 years' life. It is important also to take into account the spectrum of service needs being met by the scheme and the comparative costs of alternatives, such as residential care*. *It also covers ongoing maintenance.*

b) the explanations above did not convince the speaker that the KCC is paying a fair or reasonable price. To have to justify this spend to the public will be difficult. *Officers explained that the Treasury had looked at the costs very carefully and had been satisfied that they represent good value for public money*; and

c) media coverage of past PFI projects has not been good as costs have risen dramatically during the contract period. *Officers explained that some schemes are better than others but as Kent's current schemes are run by not-for-profit organisations, registered social landlords, etc, they are confident that the Kent schemes are better value than some other ones. The unitary charge will be fixed for the duration of the contract period.*

4. Mr Gibbens commented that he had also been sceptical of the value of PFI projects in the past and is still sceptical of PFIs for schools and hospitals, because the requirements for those services in 25 years' time cannot be known at the outset. Building an Extra Care Sheltered Housing Scheme using PFI is not the same as people will always need housing, even if not at the exact same level of extra care. Extra Care Sheltered Housing is a very good way of meeting the future needs of Kent's ageing population, but building for the future does not come cheaply. He invited Committee Members to visit an Extra Care Sheltered Housing Scheme.

5. RESOLVED that the decision to be taken by the Cabinet, to agree the delegated authorities set out in the report and the use of the designated sites, and to approve the required Authority annual contribution, be endorsed.

Decision 12/01917

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

Meradin Peachey, Director of Public Health

To: Social Care & Public Health Cabinet Committee – 12 July 2012

Subject: NHS Health Checks

Classification: Unrestricted

Summary

With the transfer of locality-led Public Health programmes and services from April 2013 this report explores the possible options for the delivery of NHS health checks next year. The reports seeks the views of this Committee in helping to shape the decision of the Cabinet Member in determining how best to commission and take forward the Health Check programme to give the most benefit to the population of Kent and minimise the risks.

For Decision

The Cabinet Committee are asked to consider this report and either endorse or make further recommendations in shaping the Cabinet Member's decision on the best option in procuring a Kent NHS Health Check Programme in 2013.

Introduction

1. (1) As part of the provisions of the Health and Social Care Act 2012, the County Council will assume statutory responsibility for key elements of the new national public health system from April 2013. This will include the delivery of public health improvement programmes, some of which will be mandatory.

(2) As part of the transition year a key principle has been to involve, where possible, elected Members in decisions that need to be taken this year that will shape delivery post April 2013. So, although the NHS is accountable for all Public Health (PH) programmes until next year, there is the opportunity for KCC to help shape future commissioning and procurement decisions. One of the key programmes for PH is NHS Health Checks, which will be mandated by the Secretary of State to continue from April next year.

(3) It is important to remember that KCC will inherit systems and ways of working in Public Health from two different PCTs and one of the

challenges is to combine the best elements of delivery of two different organisations in to one new system.

NHS Health Checks

2. (1) In 2008 the Department of Health announced that there would be an implementation of "NHS health checks" from April 2009. The programme has been phased with full implementation expected by 2013.

(2) The programme is aimed at patients aged between 40 to 74 years who are being invited for a free health check to assess their risk of cardiovascular disease, including coronary heart disease, stroke, diabetes and kidney disease. All those people that are on relevant disease registers are excluded from the programme.

(3) Circulatory diseases including stroke, diabetes and renal disease as well as heart attack and heart failure account for a third of the deaths in Kent[1]. The Kent Joint Strategic Needs Assessment (JNSA) highlights the importance of the health check programme for the delivery of health priorities across Kent. Cardiovascular disease (CVD) provides a generic term covering all these conditions. In 2007/8 cardiovascular diseases represented 34.6% of the top five causes of death of males in the Kent County Council area and 34.3% of female deaths[2]. Addressing the risk factors for CVD also contributes positively to the prevention of other lifestyle linked diseases such as cancers and dementia.

(4) The health check programme seeks to facilitate improvements in premature mortality from heart disease. The programme will be an important strand in the delivery of the Health and Wellbeing Strategy for Kent which is currently being drafted.

(5) A more detailed explanation of the Health Checks programme is given at Appendix One for information

History of the programme in Kent

3. (1) The programme started in Kent in 2011 but within the NHS locally it was not initially given a particularly high priority nor allocated the full range of resources required to roll out a comprehensive and impactful system. As a result there is a lag in performance which is currently RAG (Red, Amber, or Green) as red. However, by looking to change how the programme is commissioned and delivered, together with the current action plan in place to bring the numbers of people being offered NHS Health Checks in line with national expectations, there is optimism that the effectiveness of the Kent programme will be enhanced and the programme rated Green.

[1] Kent 2011 Joint Strategic Needs Assessment http://www.kmpho.nhs.uk/jsna
[2] We are the people of Kent, 2009 edition.
https://shareweb.kent.gov.uk/Documents/facts-and-figures/people-of-kent-2009-final.pdf

Model of Care

4. (1) The model of delivery of NHS Health Checks is integral to the provision of good primary care and is dependent on GP Practices identifying the cohort of people who are already on a vascular disease register and thus not eligible for an NHS Health Check.

(2) The programme rolls every five years with individuals within the cohort invited for an NHS Health Check once within this timeframe. It involves identification, screening for risk of a vascular event, and referral and treatment for those who are identified as being at risk. People identified at risk will then have there individual risk factors treated, through either GPs referring to various community services (e.g. stop smoking, weight loss) or will initiate medication appropriately such as medicines for treating high blood pressure, or lowering cholesterol. This makes it distinct from a range of current 'health checks' that are offered informally in community settings and in health kiosks. To underline this distinction the term 'NHS Health Check' is used.

(3) The model commissioned in Kent uses General Practice as the building block to deliver NHS Health Checks, with additional commissioning to meet the needs of more vulnerable people, not known to general practice, or through the delivery of NHS Health Checks in other settings e.g. community pharmacy.

Budget for Health Checks

5. (1) The budget identified for health checks across Kent in 2012/13 is some £2.35 million which is the amount that has been modelled as being required to achieve targets. This includes the provision of health checks and the interventions required when someone is identified as being at risk of cardiovascular disease. Currently this resource is within NHS but will transfer to the County Council next year.

(2) The current eligible population ((40-74 year olds) in Kent is some 462,000 and the aim is to undertake some 39,000 or so NHS Health Checks annually. The programme is based on a rolling basis where the target population are tested every five years.

Future delivery of health checks

6. (1) The evidence from the work that has already been undertaken is that Primary Care and particularly General Practice is key to the successful delivery of the programme. The reasons for this are:

1. Primary Care has up to date practice information that can identify the patients that need to be called for a health check
2. GPs need to be involved in the follow-up for effective disease management and continuing care for the patient once a condition is identified

(2) Both Eastern and Coastal Kent and West Kent PCTs currently commission Health Checks on a different basis. Looking ahead to the recommisioning of services in 2013 there is an opportunity to consider the most appropriate alignment of contractual arrangement needs to be aligned across Kent as a whole.

(3) Public Health will continue to use information intelligence to understand areas within the Kent population who may be called but do not attend for an NHS Health Check. This approach would be integral to Kent's Health Inequalities Strategy and Action Plan to identify those people who are less likely to access services and consequently have poorer health.

(4) The success of the programme will also rely on Public Health ensuring that other service providers are able to offer services for those who do not want to attend in GP practices.

Delivery Options

7. (1) Overall, for the purpose of cost and business effectiveness, it is important to move towards a County-wide model of provision. But one which is flexible enough to take in to account local circumstances

(2) Three different options have been considered for the future delivery of NHS Health Checks in 2013/14. These are:

Option 1 - Do Nothing / No Change

Continue with the current contractual set up for West and East Kent. For East Kent this will mean sustaining some 100 or so individual 'Locally Enhanced Service' contracts with Eastern Coastal Kent GPs. For West Kent this would mean holding one contract with a programme provider (who would subcontract with locality providers).

Option 2 – Unify Commissioning Across Kent

The intention would be to unify commissioning across Kent by identifying and using a single programme provider who would have contractual responsibility for overall programme management with the expectation they would manage a range of sub-contracts with potential multiple providers at a locality-level.

Option 3 – Direct Contracting with individual service providers

Public Health would commissions directly with local providers (primarily GPs and community pharmacies) across the whole of the County and using other local provision where are gaps to ensure that everyone is provided for. This could mean holding approximately 300 contracts.

(3) The potential providers for health checks comprise

- Primary care – GP surgeries
- Community pharmacies

- Workplace provision
- Local council provision
- Voluntary sector provision
- Community health provision
- Private sector provision
- Provision in mental health settings
- Provision in offender health settings

Risk and benefit analysis of options

Option 1

- Multiple GP contracts requiring resource and manpower to manage effectively for Kent.
- Complexity of performance management with lags in data flow
- Potential for inequity of provision exacerbated

Option 2

- Potential for one contract and therefore less manpower and resources would be required
- Performance management would be streamlined
- Would enable a high quality and efficient service to be delivered with risks being squarely placed on provider system
- However, if an alternative to Kent Community Health Trust was agreed there would be significant risks. These would be:
    - Requirement to start whole delivery system to be developed from scratch (would depend on who wins the contract)
    - Additional cost in procurement expertise
    - Major risk to delivery of 2012/13 requirements because GP practices would be likely to leave the provision landscape in year should a tender exercise take place as there would be no incentive for them to contribute to a programme that will not include them as a major provider in the future.
    - GPs might not agree to share data with a private provider or do follow-ups for those who are identified as being at risk or requiring clinical intervention
    - Will be at year 3 at the end of first cohort (i.e. behind by further 2 years) in terms of target and delivery of programme

Option 3

- Multiple contracts (approximately 300)
- Significant resource and manpower required to manage
- Currently public health does not have capacity to undertake contract management
- Less money to deliver programmes and provide interventions

The preferred option going forward is Option 2.

Risk and Business Continuity Management

8. (1) There needs to be sufficient resource allocated to ensure that those who are identified as being at risk from cardiovascular disease are able to access other services such as weight and physical activity to enable them to change their lifestyles and improve their health and wellbeing.

(2) There are significant risks to the implementation of the programme.

I. GP engagement – if practices do not sign-up to the programme there will not be universal coverage
II. Governance arrangements for health checks are paramount – unless these are followed patient safety will be a risk
III. The programme needs to be well-co-ordinated otherwise pathways will be fragmented and patients will be identified as being at risk but will not be able to access relevant services
IV. Training needs to be co-ordinated and offered to all those engaged in the programme

Consultation and Communication

9. (1) In taking forward any new proposals for commissioning NHS Health Checks there will be consultation with potential providers on future commissioning proposals when these are being developed.

(2) A public communication strategy is also under development to ensure that the people of Kent have knowledge of how to obtain a health check. This will be a joint venture between NHS Kent and Medway and Kent Community Health Trust. This will facilitate the plurality of providers to communicate effectively with 40-74 year olds across Kent.

Conclusion

10. (1) NHS Health Checks will be a service mandated by the Secretary of State for Health to be provided in Kent by the County Council from April 2013. However, regardless of being mandated or otherwise, Health Checks are an absolutely essential tool in securing strong public health outcomes for Kent.

(2) After a relatively slow start in the roll out of the programme in Kent there is a clear forward momentum in achieving the aspirations behind the programme and increasing the uptake of the service. To be effective the programme needs to be seen on a rolling five-year basis.

(3) To further develop the service, and to accurately reflect future changes in how Public Health is organised, it is proposed to change how the service is managed within the County. The recommendation is that provision will be managed as a County-wide programme through a single supplier. However, the clear intention will be that this supplier will enter in to a number of

sub-contracts with locality providers to provide a plurality of provision. The intention is for service delivery to further evolve to achieve better outcomes.

Recommendations

(1) The Cabinet Member for Adult Social Care and Public Health will be asked to make a decision on taking forward the procurement of NHS Health Checks from April 2013 on the proposed basis of securing a single organisation to programme manage delivery (as set out in option 2 in this report).

(2) Members of the Social Care & Public Health Cabinet Committee are asked to consider and either endorse or make recommendations on the proposed decision to be taken by the Cabinet Member for Adult Social Care & Public Health.

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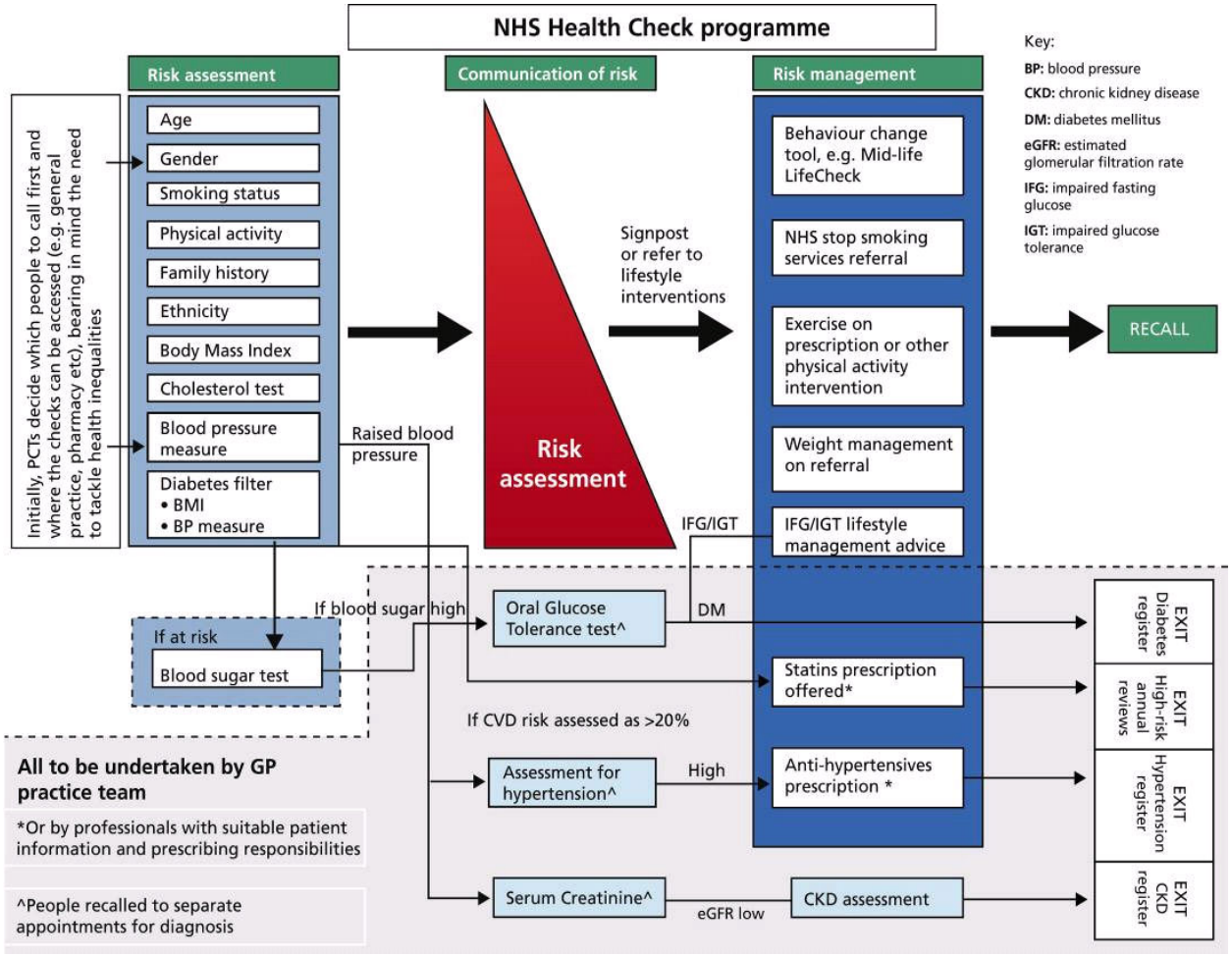
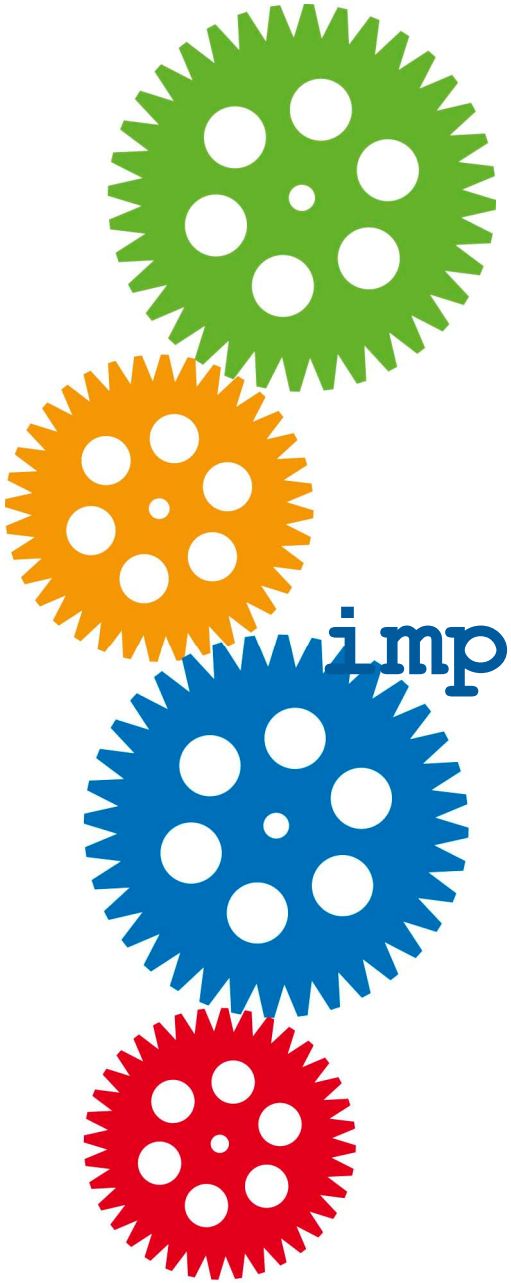
Background Documents

Kent 2011 Joint Strategic Needs Assessment; available from URL: http://www.kmpho.nhs.uk/jsna
We are the people of Kent, 2009 edition. https://shareweb.kent.gov.uk/Documents/facts-and-figures/people-of-kent-2009-final.pdf
The Information Centre. Quality and Outcomes Framework (QOF) for April 2006 to March 2007, England: Numbers of patients on QOF disease registers, and unadjusted prevalence rates. The Information Centre 2008;Available from: URL: http://www.ic.nhs.uk/webfiles/QOF/2006□07/National%20QOF%20tables%202006□07%20□%20prevalence.xls
Several case studies are available on the NHS Health Check website at: http://www.healthcheck.nhs.uk/_CaseStudies.aspx

Appendix One: What the Health Check comprises:

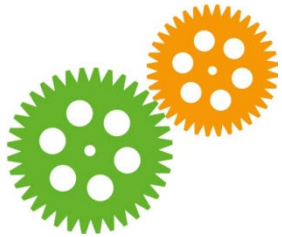


NHS Health Check implementation for Kent



Key milestones for the NHS Health Checks

- NHS Health Checks will be funded from the Public Health budget and responsibility transferred to LAs from April 2013
- Proposed Public Health Outcomes Framework (PHOF) indicator: **"Proportion of eligible people who received an NHS Health Check"**
- Other indicators in PHOF on mortality and morbidity related to life-style issues



Who is a health check for?

All those between 40 – 74 years who are not on disease registers for:

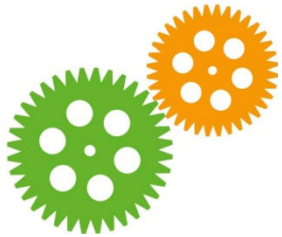
- Diabetes
- Chronic Kidney Disease
- Stroke
- Heart disease

Why do people between 40 – 74 need a check?

The risk of developing heart disease, stroke, diabetes and kidney disease increases with age.

There are other things that make the risk greater:

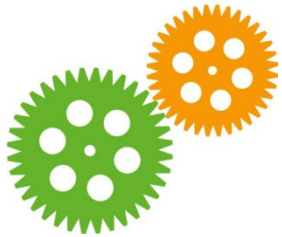
- Being overweight
- Lack of exercise
- High cholesterol
- High blood pressure



What happens at the check?

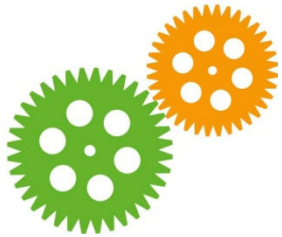
The check is to assess risk of developing heart disease, type 2 diabetes, kidney disease and stroke

- The check takes about 20-30 minutes
- Simple questions about family history and medications are asked
- Records of height, weight, age, sex, ethnicity and blood pressure are made
- A blood sample is taken to check cholesterol levels



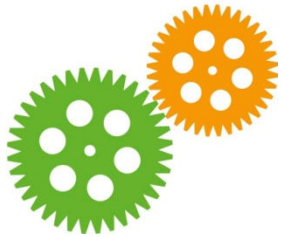
What happens after the check?

- Results are discussed and personal advice given on how to lower risk and maintain a healthy lifestyle
- Some further tests may be needed dependent on the results
- Treatment or medication may be prescribed to help maintain health



Crucial issues to consider for programme

- The programme did not start in Kent until 2011/12 whereas nationally it started in 2009/10
- It is now fully funded for the first time
- It is a five-year rolling programme therefore you cannot expect the programme to be green until after this. One fifth of those eligible are called each year
- GPs absolutely need to be involved in providing the programme. The call/recall element depends on them
- GPs need to follow-up and treat people who are identified as being at risk



Options for delivery next year and beyond

- Continue delivery by West and East models
- Public health to hold separate contracts with each of the GP and other providers
- Procure NHS Health Checks from April 2013 on the proposed basis of securing a single organisation to programme manage delivery

By:	Jenny Whittle, Cabinet Member, Specialist Children's Services Graham Gibbens, Cabinet Member, Adult Social Care and Public Health Andrew Ireland, Corporate Director, Families and Social Care
To:	Social Care and Public Health Cabinet Committee – 12 July 2012
Subject:	**Families & Social Care Directorate Financial Monitoring 2012-13 (covering Adult Social Care & Public Health Portfolio and Specialist Children's Service portfolio)**
Classification:	Unrestricted

Summary:	Cabinet Committee are asked to comment on the first exception financial monitoring report for 2012-13 reported to Cabinet on 9 July 2012.

1. Introduction:

1.1 This is the first report to this Committee on the forecast outturn for Families & Social Care Directorate (Adult Social Care & Public Health Portfolio & Specialist Children's Services Portfolio). Regular reports will continue throughout the financial year.

2. Background:

2.1 A detailed quarterly monitoring report is presented to Cabinet, usually in September, December and March and a draft final outturn report in either June or July. These reports outline the full financial position for each portfolio and will be reported to Cabinet Committees after they have been considered by Cabinet. In the intervening months an exception report is made to Cabinet outlining any significant variations from the quarterly report. In addition, a first exception report for the year is presented to Cabinet in July, which highlights the main issues arising from the previous year's outturn that are expected to have an impact on the coming year. For example, 2012/13 budgets will be based on forecast activity levels in the Autumn 2011 when the budget papers were consolidated prior to Cabinet and County Council approval, but these may well have changed in the final quarter of the year and these revised levels may be expected to continue and therefore impact on the 2012/13 position. There may also be other exceptions which have arisen in the first couple of months of the new financial year. The relevant extracts from this exception report are included in the revenue and capital sections below.

3. Families & Social Care Directorate 2012-13 Financial Forecast - Revenue

3.1 **Table 1**

Portfolio	Forecast Variance £m
Adult Social Care & Public Health	-4.480
Specialist Children's Services	+4.948
Directorate Total	**+0.468**

The main reasons for this variance are detailed below:

3.2 Families & Social Care Directorate:

The initial forecast for Families and Social Care indicates a pressure of £0.468m, +£4.948m within Specialist Children's Services and -£4.480m on Adult Social Care. It should be recognised however that the detailed forecasts with managers of the services are being worked on currently, to ensure that the full monitoring report to Cabinet in September has been constructed on a more firm base. Finance staff, alongside performance colleagues and budget managers, are also currently reviewing all cash limits and affordable levels of activity in light of the 2011-12 outturn and any changing trends in activity that have become apparent since the 2012-13 budget was set. As a result of this exercise and the restructure of Children's Services, requests for virement or for realignment of gross and income cash limits will be submitted as part of the first full monitoring report to Cabinet in September.

Some of the assumptions within this initial forecast are outlined within the separate sections for Specialist Children's Services and Adult Services below:

3.3 Adult Social Care & Public Health Portfolio:

The initial forecast indicates an underspend of £4.480m, which is broadly broken down across the client groups as follows:

	£m
Older People	-1.524
Physical Disability	-1.892
Learning Disability	-0.364
Mental Health	-0.700
	-4.480

a) This initial forecast assumes that all of the savings for Adult Services will be achieved at this stage. Clearly at this early part of the year it is not possible to confirm that every saving will be made on every budget line, but overall it is felt that with the work that is taking place with both procurement and in transformation, that overall across Adult Services these savings will be made.

There is some risk in relation to the savings for Learning Disability and whether this will all be achieved in the way that was originally anticipated. Historically this is an area which has always been under significant financial pressure, it is therefore important that any savings are tracked through the monitoring process and an update will be provided in the Quarter 1 monitoring report to Cabinet in September.

b) The forecasts have mainly been arrived at by assuming that all clients receiving a service in April continue to receive a service all year, at the average unit cost, unless more detailed information is available at this early stage of the year.

c) There are some exceptions to the above assumption in respect of Learning Disability, where known children will be transferring to Adult Services through transition. In these cases an estimate of their likely costs has been included in this forecast.

d) Other budget lines which are not activity driven have been assumed to be either at the same level as 2011-12 outturn or at break-even if that is felt to be the most likely position.

e) Clearly when more detailed forecasts are compiled over the next few weeks, this reported underspend position may change, but at this stage we feel that this is the best estimate, taking into account the 2011-12 outturn position along with the current patterns of activity in the first 2 months of the year.

3.4 Specialist Children's Services Portfolio:

The initial forecast indicates a pressure of £4.948m of which £1.984m relates specifically to the Asylum Service and £2.964m on the remainder of the service. The main reasons for this variance are:

a) +£2.175m Looked After Children: The main area of pressure that is highlighted at this initial stage is in relation to the forecast for looked after children specifically in foster care. The budget was set with significant savings for assumed reductions in the numbers of looked after children. Some of the reduction can already be seen whereby we have significantly less mother and baby placements, and also the average unit cost we are paying for independent fostering placements has reduced. However, it is felt prudent at this stage to assume within the forecast the same number of children as at April for the remainder of the year, at the latest average unit cost, until we have more evidence of further reductions. It is however hoped that as the year progresses and more detailed forecasts are worked on this position will improve.

b) -£0.340m Residential Services: This forecast underspend on residential services reflects the fact that the numbers of children placed in residential care has reduced and that unit costs are also beginning to reduce. However, as with Fostering, no further reductions are assumed in this initial forecast, until further evidence is gathered.

c) +£1.279m Children's Social Care Staffing: A further risk area is in relation to the children's social care staffing budget. As we move towards the full restructure of the Children's teams and permanent appointments are made, it has been necessary to retain some agency staff in the interim. We have also had to set up a new County Referral Unit in advance of the main restructure, this coupled with the extended contracts of agency staff means that at this stage we need to highlight a potential pressure of £1.279m.

d) An area which had significant financial pressures in 2011-12 was that for Legal Services. As a significant increase in budget was made for 2012-13 it is hoped that the costs can be contained within this. There is determination from within Legal Services, the Courts and FSC directorate to improve processes and reduce costs in this area. At this early stage we are fairly confident that the costs will be contained, but this is clearly an area that needs to be monitored closely over the next few months.

e) +£1.984m Asylum: As negotiations continue with the UKBA regarding the funding of Over 18's with appeals rights exhausted and the Gateway Grant it is felt prudent to continue to forecast a pressure based on the funding position as existed in 2011-12. The forecast therefore assumes grant income as per 2011-12 and costs for those children and young people who we are supporting now. It must be acknowledged that this position may move as further discussions take place.

f) The balance of -£0.150m is due to other smaller variances each below £0.1m.

4. Families & Social Care Directorate 2012-13 Financial Forecast - Capital

4.1 **Table 2**

Portfolio	Forecast Variance £m
Adult Social Care and Public Health	-2.398
Specialist Children's Services portfolio	1.851
Directorate Total	**-0.547**

The variance quoted is after having taken any roll forwards from 2011-12 into account. Within the forecast variance, the main projects subject to re-phasing and overall variances are detailed below:

4.2 **Adult Social Care and Public Health portfolio:**

The variance is -£2.398m. Of this -£0.088m is a real variance and there is rephasing of -£2.310m. Projects subject to re-phasing and overall variances affecting 2012-13 are:

- Ebbsfleet (-£0.897m) rephasing and Eastern Quarry (-£0.521m) rephasing. These are both partnership schemes in which a private developer is concerned. Progress depends on the developer's judgement of the best time to begin.

- Dorothy Lucy Centre (-£0.500m) rephasing. The modernisation plan for the Dorothy Lucy Centre has been brought into line with the FSC Transformation Programme which will be reviewing the position of all residential provision. Plans will be developed for the overall Transformation Programme over the next few months with implementation phased according to strategic priorities over the medium term.

- Public Access Development (-£0.278m) rephasing – commissioning of work has been delayed by restructuring.

- Home Support Fund (-£0.114m) rephasing. This rephasing reflects a re-profiling of the commitment.

Overall there is a residual balance of -£0.088m on other projects.

4.3 **Specialist Children's Services portfolio**

The variance is +£1.851m. +£1.851m is real variance. Projects subject to real variances affecting 2012-13 are:

- Multi Agency Service Hubs (+£1.851m) real variance. Latest estimates reflect a pressure of £1.851m in 2012-13. Funding of the overspend is in the process of being resolved, and confirmation is awaited regarding additional funding sources to help ease the pressure.

- Transforming Short Breaks for Disabled Children (-£0.114m). This is a real underspend which is proposed to partially offset the pressure on the MASH projects above.

Overall there is a residual balance of +£0.114m on other projects.

5. Recommendations

5.1 Members of the Social Care & Public Health Cabinet Committee are asked to **COMMENT** on the revenue and capital forecast variances from budget for 2012-13 for the Families & Social Care Directorate (Adult Social Care & Public Health and Specialist Children's Services Portfolios) based on the first exception monitoring to Cabinet.

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

Meradin Peachey, Director of Pubic Health

To: Social Care and Public Health Cabinet Committee – 12 July 2012

Subject: **Public Health Performance**

Classification: Unrestricted

Summary: This report provides an update of Public Health programme performance, including the two programmes highlighted specifically in the NHS Operating framework (Health Checks and Stop smoking Services) and those mandated to be commissioned by Local Authorities from April 2013

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1. Introduction

Part of the NHS reforms is the move of Public Health to the local upper tier Local Authority, and the move to the Local Authority of a ring fenced budget for the commissioning and provision of public health improvement programmes.

This report provides an update of performance of the majority of those programmes through a Public Health performance dashboard where each of the programmes is RAG rated (Red, Amber, or Green) depending on local Kent county performance.

2. Performance of Health Improvement Programmes

The NHS Operating Framework for 2012/13 emphasises two particular elements (NHS Health Checks and Stop Smoking) of commissioning health improvement which are reported here together with key other programmes

The Public Health Performance Dashboard (attached) covers the following programmes:

1. Smoking Quits
2. Health Checks (Mandated service)
3. Sexual Health (Mandated service)
4. National Childhood Measurement Programme (Mandated service)
5. Healthy Schools
6. Breastfeeding Initiation
7. Health Trainers

A further key programme, Healthy weight will be included in future reports; is not reported here as more work will need to be done to agree how we report key performance indicators. Healthy weight is a complex programme where we are commissioning a wide range of services from Health Walks and Health Passport to

weight management services for obese and morbidly obese people along the bariatric surgery pathway.

The dashboard includes the following information for each programme:

- The key performance indicator(s) related to the programme
- The target
- The achievement to date
- A RAG rating
- A short commentary about what the programme is commissioned to provide
- The timeframe the achievement and RAG rating refer to
- An indication of the timeframe the programme functions over and what time lag there is in data reporting.

3. Exception Reports

1. Health Checks

As previously reported to the Policy Overview and Scrutiny Committee, Health Checks have failed to reach the target for 2011/12.
This is due to the fact that 2011/12 was the start-up year for both the East and West Kent services and because the PCTs allocated modest funding which reflected the start position.

For the year 2012/13 PCTs have allocated the full amount of funding to the programme recurrently and we expect to achieve the target for this financial year.

However, it should be noted that the programme is a five year rolling programme with one fifth of the total eligible cohort being invited annually. Therefore it will take five years to achieve full coverage.

Compared with other areas, whilst Kent appears down the lower end of performance, it is better than about 30 or so other PCT areas, five of which are reporting zero offers.

Public Health is working with providers to ensure achievement this year.

2. Smoking Quits

We reported in previous POSC performance reports that the smoking quit performance was on track and envisaged to achieve the target. Unfortunately the combined target was missed by just 103 quitters.

Analysis of the issue which relates to underachievement in the West Kent service relates to a combination of factors including untimely data flows and an unexpected reduction of quits in the last quarter.

Public Health are working with the provider to ensure a recovery plan is developed and implemented to ensure we are not in this position this time next year.

Recommendation:-

4. Members are asked to comment upon the dashboard style performance report and to note performance.

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Background Information: *Nil*

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Kent Public Health Department

Public Health Performance Report Dashboard

	Programme	Target	Achieved	RAG	
1	**Smoking Quits**				
	Nos of people successfully quitting	9,417	9,314	R	2011 to 2012 outturn
	Service delivered by Kent Community Healthcare NHS Trust, target agreed with Public Health and relates to people who have set a quit date and suceesfully quit at the four week follow up				
	Service runs across the financial year, data runs 10 weeks in arrears				
2	**Health Checks**				
	Number of Invites for Health Checks	83,233	32,348	R	
	Number of Health Checks completed	Target for 2012/13			
	Service delivered by numerous providers, with GP practices being the fundamental building block of the programme. The programme is a five year rolling programme for 40 to 74 year old people who are invited for a vascular health check once every five years, except if they are already on a vascular disease register				2011 to 2012 outturn
	Service runs across the financial year, data runs six weeks in arrears				
3	**Sexual Health**				
	GUM Access	95%	98%	G	
	Chlamydia Screening Uptake rate	35%	26.50%	A	
	Chlamydia Screening Positivity	7%	6.25%	A	
	Access to Genito-Urinary Medicine is an important element in reducing the rise in the incidence and prevalence of sexually transmitted disease; the target is 95% of patients offered an appointment to be seen within 48 hours. Chlamydia screening is an opportunistic screening programme targeting sexually active people aged between 15 and 24 years. Emphasis of the programme has been on Uptake rate with a national target of 35% of the eligible population. Emphasis in future years is to be based on positivity ensuring individuals at risk are screened.				2011 to 2012 outturn
	Service runs across the financial year, data runs 8 weeks in arrears				
4	**National Childhood Measurement Programme**				
	Measurement Reception Year	85%	93%	G	
	Measurement Year 6	85%	93%	G	
	The National Child Measurement Programme (NCMP) is an annual programme to measure the height and weight of all children in Reception and Year 6. The aim of the programme is to provide the national statistics on obesity within the two cohorts with a target of measuring at least 85% of eligible children, and to provide direct feedback to parents on their children's healthy weight				2011 to 2012: completion due in July data included to May 2012
	The service runs over the acdemic year, with the service uploading to a national data repository				
5	**Healthy Schools***				
	Achievement of Healthy School Status	98%	97%	A	
	Engagement in the enhancement model	40%	48%	G	
	Healthy Schools is undergoing review with the service currently to look at a future model of delivery which supports reduction in teenage conceptions, reduces young people's smoking and susbstance misuse prevalence, reduction of unhealthy weight together with emotional health and wellbeing*				2011 to 2012: completion due in July
	The service runs over the acdemic year.				
6	**Breast Feeding Initiation**				
	coverage rates (the percentage of ascertainments of breast feeding status)	95%	96%	G	
	6-8 week breastfeeding rates (prevalence)	46%	41%	A	
	Breastfeeding newborn babies is evidenced to improve long term outcomes, for both mother and baby; this target measures both the ascertainment of breastfeeding status and the prevelance of initiation and maintainence of breastfeeding for 6-8 weeks. The 6-8 week target is relatively new and has required detailed work with midwives, health visitors and GP practices to ensure robust reporting				2011 to 2012: completion due in July
	The service runs over the financial year, data runs two months in arrears				
7	**Health Trainers**				
	Number of new contacts	1,400	1,660	G	
	The Health Trainers Programme is commissioned to help people in our most deprived communities to develop healthier behaviour and lifestyles. HTs offer practical support to change individual's behaviour to achieve their own choices and goals. This involve encouraging people to: stop smoking, participate in increased physical activity eat more healthily, drink sensibly and/or practice safe sex. The service not only seeks new clients, but ensures existing clients have personalised written care plans and, where appropraite, are signposted to other services.				2011 to 2012 outturn
	Service runs across the financial year, data runs 6 weeks in arrears				

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By:	Jenny Whittle, Cabinet Member, Specialist Children's Services Graham Gibbens, Cabinet Member, Adult Social Care and Public Health Andrew Ireland, Corporate Director, Families and Social Care
To:	Social Care and Public Health Cabinet Committee – 12 July 2012
Subject:	**Families & Social Care Performance Dashboards 2012/13 (draft) and Business Plan Outturn Report 2011/12**
Classification:	Unrestricted

Summary:	The draft Families & Social Care performance dashboards provide members with progress against targets set for key performance and activity indicators for 2012-13. The report also provides members with a summary outturn position for the Business Plan 11/12.

1. Introduction

1.1 Appendix 2 Part 4 of the Kent County Council Constitution states that:

> "Cabinet Committees shall review the performance of the functions of the Council that fall within the remit of the Cabinet Committee in relation to its policy objectives, performance targets and the customer experience."

To this end, each Cabinet Committee is receiving a performance dashboard.

2. Performance Report

2.1 There are three elements of this report which members are asked to consider:

- The progress in the summary report for the 11/12 business plans, as shown in the report at **Appendix A**. As agreed in the business planning process this is an exception report, coving those elements that have been delayed or cancelled.
- The draft Adult's Social Care dashboard report found at **Appendix B**
- The draft Children's Social Care scorecard report found at **Appendix C.**

2.2 In particular members are asked to note that both the draft dashboard and scorecard are currently used within the Directorate. The children's scorecard is used to support the Improvement Board, and the adult's dashboard is in a transition phase, and will be amended in line with the priorities and objectives of the Transformation Programme in the next few months.

2.3 A subset of the indicators in these performance reports is used within the corporate quarterly performance report, which is submitted to Cabinet.

2.3 As an outcome of this report, members may make reports and recommendations to the Leader, Cabinet Members, the Cabinet or officers.

3. Performance dashboard

3.1 The draft Families and Social Care performance dashboard/scorecard includes latest available results for the key performance and activity indicators.

3.2 The indicators included are based on key priorities for the Directorate, as outlined in the business plans, and include operational data that is regularly used within Directorate. The Adults Social Care dashboard may evolve for as the Transformation Programme is shaped. Cabinet Committees have a role to review the selection of indicators included in dashboards, improving the focus on strategic issues and qualitative outcomes, and this will be a key element for reviewing the dashboard.

3.2 Where frequent data is available for indicators the results in the dashboard are shown either with the latest available month (in most cases May) and a year to date figure, or where appropriate as a rolling 12 month figure.

3.4 Performance results are assigned an alert on the following basis:

Green: Current target achieved or exceeded

Red: Performance is below a pre-defined minimum standard

Amber: Performance is above minimum standard but below target.

3.5 It should be noted that for some indicators where improvement is expected to be delivered steadily over the course of the year, this has been reflected in phased targets. Year End Targets are shown in the dashboards but full details of the phasing of targets can be found in the Cabinet approved business plans.

4. Additional Commentary on Children's scorecard

4.1 The Children's scorecard covers the 44 measures that the Children Service's Improvement Process is looking at but, unlike the Adult's dashboard, does not provide commentary. Consequently additional commentary on the scorecard's 5 broad areas is given below.

4.2 **How much are we dealing with?**
The scorecard shows that, compared to the targets based on high performing authorities, we are receiving slightly few referrals than expected but, of these, a much higher percentage than expected are then progressing to initial assessments and Section 47 investigations. Work is being done to build on best practice to ensure cases progress appropriately through the Central Referral Unit, County Duty Team and with Managers and Practioners in the field. Direction of travel shows the trend is broadly improving.

4.3 **How long is it taking us?**
Performance is generally good with, all but one timescale, now being better than benchmarks based on high performing authorities and direction of travel for all timescales continuing to improve further.

4.4 **How well are we doing it?**
Although performance continues to improve, concerns remains about the percentage of case files judged as adequate and the percentage of children not seen as part of initial assessments. Feedback from case audits is used to inform development in teams and to hold management to account. Additionally, improvements to the Integrated Children's System (ICS) now allows accurate recording of those cases where there is a valid reason for not having seen a child at initial assessment, such as where case complexity warrants moving straight to a core assessment,

4.5 **Are we achieving good outcomes?**
Of the 12 measures, 8 are amber (above minimum standards but below targets based on best performing authorities) but the trend is broadly improving. Work is ongoing to continue this improvement. The remaining 4 measures are red (below minimum standards). However 3 of these reds are reported on year to date figures and so cover just 2 months including April's cohort which differed from the longer term trend. Work is being done to check if this was a one off. Performance in May has returned to the trend for:

- % referrals previously referred in last 12 months (was red, now amber)
- % children with CP Plan for second or more time (still red but improved)
- % LAC placed within of 12 months of decision for adoption (still red but improved)
- % leaving care who are adopted (was red, now amber)

4.6 Concern remains about:

- % of children who had had a Child Protection plan for more than 2 years when deregistered. – As the total number of children with Child Protection plans drops the residual core of those who had had plans for more than 2 years forms a higher % of those being deregistered. Work is being done to ensure that only those children who need to have Child Protection plans remain on them.
- % of children with 3 or more placements in last 12 months. – This is being addressed by Stability Core Groups which are co-ordinating services provided to contain placements where these, or school places, are at risk.

4.7 **Are we supporting our staff?**
Performance is broadly good and trend is marginal although usage of agency staff remains above target. Specialist Children's Services is currently restructuring which will align staffing resources to where they are required and should address this. The use of Agency staff is being closely monitored, particularly the length of time that they have been employed by KCC.

5. Recommendations

5.1 Members are asked to:

a) COMMENT on the outturn summary progress report for the Business Plan
b) COMMENT on the Families & Social Care performance dashboards.

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Families and Social Care.

Outturn Monitoring March 2012

Major Projects and Developments:

In April 2011, Adult Services and Specialist Children's Services were reorganised within the One Council development and are now part of the Families and Social Care Directorate. In consequence some units included in the 2011/12 Business Plan portfolio have moved to other directorates and are not considered in this full year monitoring. These are:

Business Support Unit
Gypsy and Traveller Unit
Kent Supported Employment Unit.
Attendance and Behaviour
Educational Psychology
Special Educational Needs and Resources.

Year end monitoring of 91 projects/objectives now within the Families and Social Care Directorate is as follows:

Delayed or cancelled	**Part Completed and carried forward into 2012/13.**	**Done and an ongoing target within 2012/13.**
7	29	55
7.7 %	31.9%	60.4%

Projects which were delayed or cancelled are as follows:

Project	**Target dates**	**Explanation for delay or cancellation.**
Preparations for the county meals contract re let. All documentation prepared and tendering process started to re let the contract	April 2012	A decision was taken to delay the tendering process for these contracts. This was to ensure consistency with the developing transformation agenda and to avoid a clash with the tender arrangements for the supporting independence service.
Domiciliary and enhanced domiciliary and community support services Tendering process undertaken and contract ready to let in April 2012	April 2012	
Delivery of Valuing People Now in line with National Delivery Plan – the Kent Valuing People Delivery Plan was delayed.	forward into 2012/13	Delayed due to restructure of the Learning Disability Partnership Board and Delivery Group. Also

		Valuing People Now at both a national and regional level has closed down.

Reduction in the number of IFA and P&V placements for adolescent Looked After Children	June 2011	The policy on IFA placements has been revised since the publication of the business plan. The use of an IFA placement can be considered if it is in the best interest of the child, for example to maintain placement stability or reduce the distance of a placement from the home district. Ofsted were complementary about this practice in the recent fostering inspection. A placement strategy action plan, June 2011 – March 2015 has been developed.
Work towards improving the percentage of children adopted by 11% by March 2012		Following a review of the service and an Ofsted inspection, a comprehensive improvement plan has been introduced to reform the adoption service. This includes the appointment of Coram to work in partnership with the council to manage the adoption service and progress the improvement plan.
Children placed for adoption within 18 months of the placement order		
Children and families are supported pre and post adoption to increase placement stability and ensure better outcomes for children		

Illustrations of FSC Contributions to Bold Steps targets in 2011/12:

Bold Steps ambition - To help the Kent economy grow:-
Priority 1: Improve how we procure and commission services

- FSC adult services are continuing to commission 90% of service provision within the independent and voluntary sector in Kent.
- The Good Day programme for people with a Learning Disability has invested in new community based facilities to offer wider choice of day activities.
- Capital and revenue investment was undertaken to enable 130 individuals with very complex disabilities to move into more appropriate community based provision.
- FSC have promoted the development of Locality based consortia of AgeUK voluntary Organisations to deliver more sustainable services and secure local delivery.

Bold Steps ambition - To put the citizen in control:-
Priority 2: Support the transformation of health and social care in Kent
Priority 11: Improve access to public services and move towards a single initial assessment process.
Priority 12: Empower social service users through increased use of personal budgets

- FSC are aligned with other KCC directorates, district councils and other partners to deliver first point of contact and surgery services i.e. OT Clinics through Gateways. Within 2012 a new Gateway was delivered in Sheerness.
- During 2012 FSC let a contract for the County wide provision of short term breaks for older people and their carers. This contract will ultimately provide opportunity for carers or clients to arrange their own breaks directly with providers.
- Progress was made in developing pilot sites for the integration of Health and Social Services teams to provide single points of access for referral and assessment. Further development will offer a county wide application of this model of joint working.
- A first KCC and Kent Community Health NHS Trust appointment was made to manage adult social care and adult community health services across Thanet and Dover localities.
- In Mental Health Services a Living it Well website was launched in collaboration with Sevenoaks MIND to improve ease of access to information.
- In children's services the development of multi-agency hubs to improve access to services and integrated provision.
- The focus on Personal budgets and Direct Payments has led to an increase in service users taking control of their own care packages and added spending power to the social care economy.

Bold Steps ambition - To tackle disadvantage:-
Priority 14: Ensure the most robust and effective public protection arrangements
Priority 15: Improve services for the most vulnerable people in Kent

- Adult Safeguarding has a high priority and within the plan period a series of internal audits were held to identify and improve current practice.
- The Specialist Children's Services restructure will be fully operational by September 2012. The new structure is designed to deliver sustainable improvement.
- A multi agency Central Referral Unit, comprising Families and Social Care (FSC), the Police and NHS, became operational January 2012 to manage referral processes for public protection. The unit has already made a significant impact on improving the consistency of thresholds.
- All cases have an allocated social worker and caseloads are at an appropriate level.
- The Specialist Children's Service has implemented a robust quality assurance framework, this includes the introduction of a Quality Assurance Online Audit program involving all managers. The quality assurance framework is supported by the new Performance Management Framework.
- A new Integrated Children's System has been commissioned and is on target to 'go-live' early 2013

- FSC are committed to working with District Councils and other partners to deliver community budgets to provide a localised impact on disadvantaged neighbourhoods.
- FSC have taken a leading role in developing the Kent Housing Strategy working together with district Councils and Housing providers to focus on the needs of disadvantaged groups such as people with disabilities and older citizens.
- FSC have a strong commitment to improving services for particular disadvantaged groups and have specified new services for people with Autism for which staff are currently being recruited.
- Kent's multiagency Looked After Children strategy was approved in 2011. Kent Corporate Parenting Group is overseeing the successful implementation of the strategy.
- Dedicated Looked After Children teams have been established in each of the 12 districts. These teams are helping drive improvements in service for looked after children.
- The Assisted Boarding pilot has commenced, currently 2 young people have places in 2 of the schools signed up to the scheme, with a further 3 being considered. A well-attended workshop took place in March 2012 to promote the scheme to specialist children's services staff and partners.
- The attainment of Looked After Children at Key Stage 2 and 4 is improving.

Adult Social Care Dashboard

May 2012

Draft

Key to RAG (Red/Amber/Green) ratings applied to KPIs

GREEN	Target has been achieved or exceeded
AMBER	Performance is behind target but within acceptable limits
RED	Performance is significantly behind target and is below an acceptable pre-defined minimum *
⇧	Performance has improved relative to targets set
⇩	Performance has worsened relative to targets set

* In future, when annual business plan targets are set, we will also publish the minimum acceptable level of performance for each indicator which will cause the KPI to be assessed as Red when performance falls below this threshold.

Adult Social Care Indicators
The key Adult Social Care indicators are listed in summary form below, with more detail in the following pages. A subset of these indicators feed into the Quarterly Monitoring Report, for Cabinet, and a subset of these indicators feed into the Bold Steps Monitoring. This is clearly labelled on the summary and in the detail.

Some indicators are monthly indicators, some are annual, and this is clearly stated.

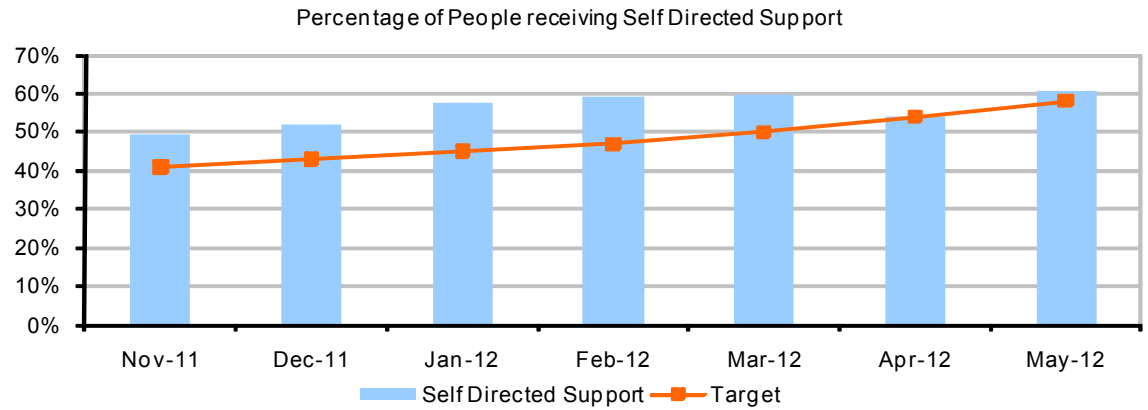
All information is as at may 2012 where possible, with a few indicators still requiring some update, with new targets and indicators being chosen.

In the following months, there will a full set of information.

Summary of Performance for our KPIs

Indicator Description	Bold Steps	QPR	2011-12 Out-turn	2012-13 Target	Current Position	Data Period	RAG	Direction of Travel
1. Percentage of adult social care clients with community based services who receive a personal budget and/or a direct payment	Y	Y	59%	100%	60.90%	12M	Green	↑
2. Proportion of personal budgets given as a direct payment	Y		24.13%	25%	26.29%	12M	Green	↑
3. Number of adult social care clients receiving a telecare service	Y	Y	1032	1050	1042	Cumulative	Amber	↑
4. Number of adult social care clients provided with an enablement service	Y	Y	612	700	560	Month	Red	↓
5. Percentage of adult social care assessments completed within six weeks		Y	76.68%	75%	76.75%	12M	Green	↑
6. Percentage of clients satisfied that desired outcomes have been achieved at their first review		Y	73.6%	75%	75%	Month	Green	↑
7. Proportion of older people who were still at home 91 days after discharge from hospital into reablement/rehabilitation services			85.9%	85%	84.5%	Month	Amber	↓
8. Delayed Transfers of Care	Y		5.04	5.40	5.28	12M	Green	↑
9. Admissions to Permanent Residential Care for Older People			164	145	137	12M	Green	↑
10. People with Learning Disabilities in residential care	Y		1288	1260	1278	Month	Amber	↓
11. Proportion of adults in contact with secondary Mental Health in settled accommodation	Y			75%	86.7%	Quarterly	Green	→

1. Percentage of adult social care clients with community based services who receive a personal budget and/or a direct payment			Green ⇧
Bold Steps Priority/Core Service Area	Empower social service users through increased use of personal budgets	**Bold Steps Ambition**	Put the Citizen in Control
Cabinet Member	Graham Gibbens	**Director**	Anne Tidmarsh
Portfolio	Adult Social Care and Public Health	**Division**	Older People and Physical Disability



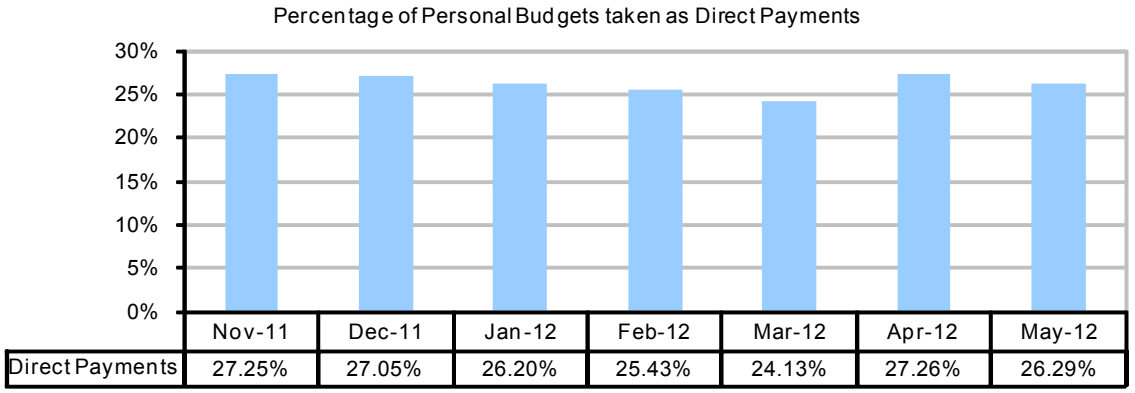
Data Notes.
Units of Measure: Percentage of people with an open service who have a Personal Budget or Direct Payment
Data Source: Adult Social Care Swift client System – Personal Budgets Report

Data is reported as the snapshot position of current clients at the quarter end.

Quarterly Performance Report Indicator
Bold Step Indicator

Trend Data	Nov 11	Dec 11	Jan 11	Feb 12	Mar 12	Apr 12	May 12
Percentage	49.4%	52.2%	57.9%	59.0%	59.7%	54.3%	60.9%
Target	**41%**	**43%**	**45%**	**47%**	**50%**	**54%**	**58%**
Client Numbers	9890	10079	10518	10772	11416	10132	10549
RAG Rating	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN

2. Proportion of Personal Budgets taken as Direct Payments



	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12	Apr-12	May-12
Direct Payments	27.25%	27.05%	26.20%	25.43%	24.13%	27.26%	26.29%

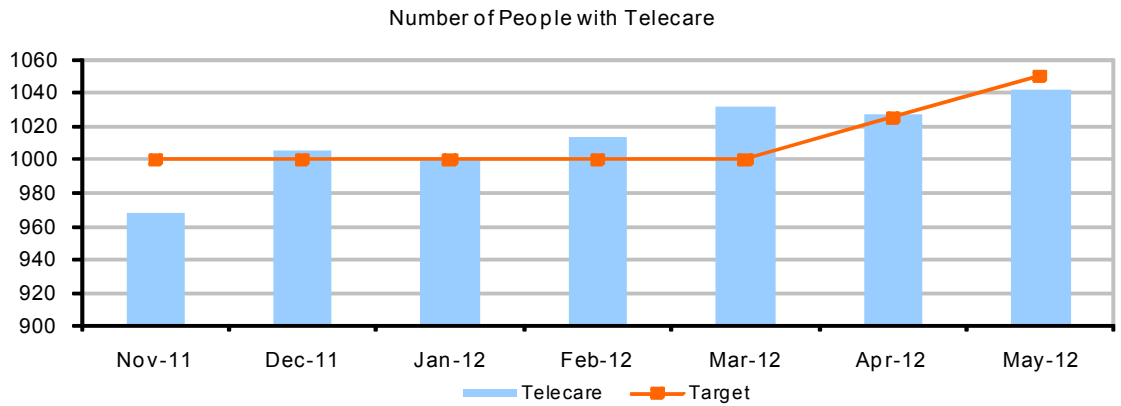
Data Notes.
Units of Measure: Percentage of Personal Budgets taken as a Direct Payment
Data Source: Adult Social Care Swift client System – Personal Budgets & Direct Payments Reports

Bold Steps indicator

Commentary

In line with other Councils and the personalisation agenda, the numbers of people receiving a personal budget continues improve significantly, with a target for all eligible people to have a personal budget for April 2013. The proportion of people who choose to take these as direct payment fluctuates over time and currently stands at just over 26%. Following an internal review, work is now being undertaken to improve the process of providing Direct Payments.

3. Number of adult social care clients receiving a telecare service			AMBER⇧
Bold Steps Priority/Core Service Area	Empower social service users through increased use of personal budgets	**Bold Steps Ambition**	Put the Citizen in Control
Cabinet Member	Graham Gibbens	**Director**	Anne Tidmarsh
Portfolio	Adult Social Care and Public Health	**Division**	Older People and Physical Disability



Data Notes.
Units of Measure: Snapshot of people with Telecare as at the end of each month
Data Source: Adult Social Care Swift client System

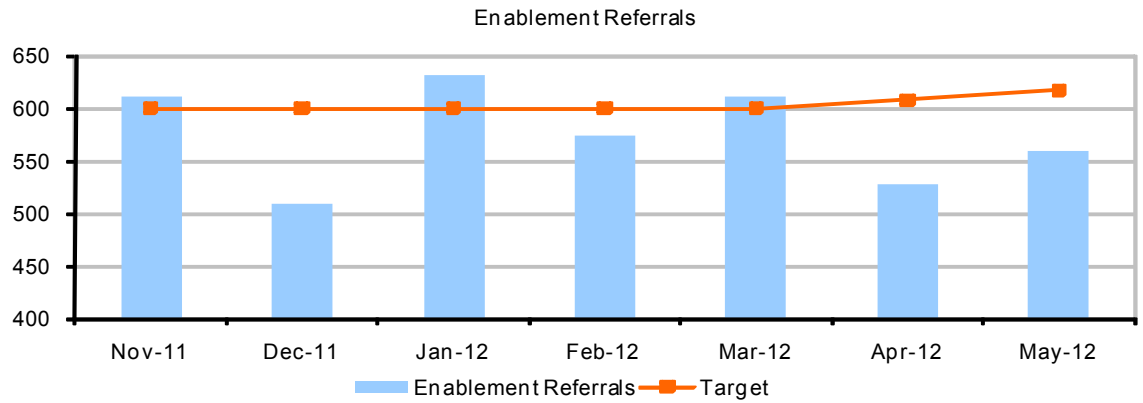
Quarterly Performance Report Indicator
Bold Step Indicator

Trend Data	Nov 11	Dec 11	Jan 12	Feb 12	Mar 12	Apr 12	May 12
Telecare	968	1006	1000	1014	1032	1027	1042
Target	**1000**	**1000**	**1000**	**1000**	**1000**	**1025**	**1050**
RAG Rating	RED	GREEN	GREEN	GREEN	GREEN	GREEN	AMBER

Commentary

Telecare is now a mainstream service and should be offered to all eligible people at assessment and at review as a means for maintaining independence.

4. Number of adult social care clients provided with an enablement service			RED ⇩
Bold Steps Priority/Core Service Area	Empower social service users through increased use of personal budgets	**Bold Steps Ambition**	Put the Citizen in Control
Cabinet Member	Graham Gibbens	**Director**	Anne Tidmarsh
Portfolio	Adult Social Care and Public Health	**Division**	Older People and Physical Disability



Data Notes.
Units of Measure: Number of people who had a referral that led to an Enablement service
Data Source: Adult Social Care Swift client System – Enablement Services Report

Quarterly Performance Report indicator
Bold Steps Indicator

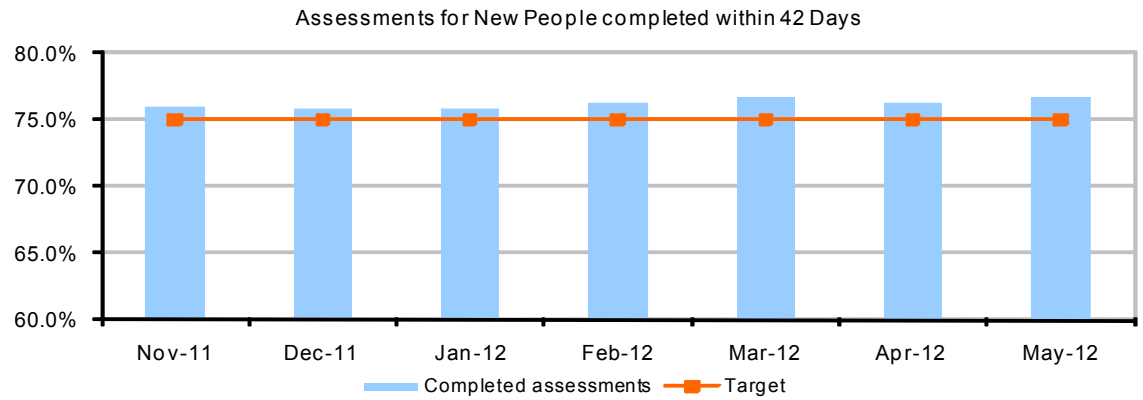
Trend Data	Nov 11	Dec 11	Jan 11	Feb 12	Mar 12	Apr 12	May 12
Enablement Referrals	611	510	631	575	612	527	560
Target	**600**	**600**	**600**	**600**	**600**	**608**	**617**
RAG Rating	GREEN	RED	GREEN	RED	GREEN	RED	RED
% of new Referrals			41.68%	46.78%	45.59%	45.92%	48.21%

Commentary

Enablement has been in place for over a year to support new client referrals to Adult Social Care. Past performance has shown the expected increase in enablement during its early development phase, with continued increases. The last quarter shows increasing numbers of referrals which are now meeting the target level. All the assessment and enablement teams now have enablement services available for their locality.

The target for 2012/13 is for 700 people per month to received enablement.

5. Percentage of adult social care assessments completed within six weeks			Green
Bold Steps Priority/Core Service Area	Empower social service users through increased use of personal budgets	**Bold Steps Ambition**	Put the Citizen in Control
Cabinet Member	Graham Gibbens	**Director**	Anne Tidmarsh
Portfolio	Adult Social Care and Public Health	**Division**	Older People and Physical Disability



Data Notes.
Units of Measure: Percentage of assessments completed within 42 Days
Data Source: Adult Social Care Swift client System – Open Referrals without Support Plan Report

Quarterly Performance Report Indicator

Trend Data	Nov 11	Dec 11	Jan 12	Feb 12	Mar 12	Apr 12	May 12
Completed	76.01%	75.92%	75.85%	76.22%	76.68%	76.30%	76.75%
Target	**75%**	**75%**	**75%**	**75%**	**75%**	**75%**	**75%**
RAG Rating	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN

Commentary

The target for 2012/13 remains 75%, this represents an acceptable balance between timely completion of assessments and the provision of enablement to new people.

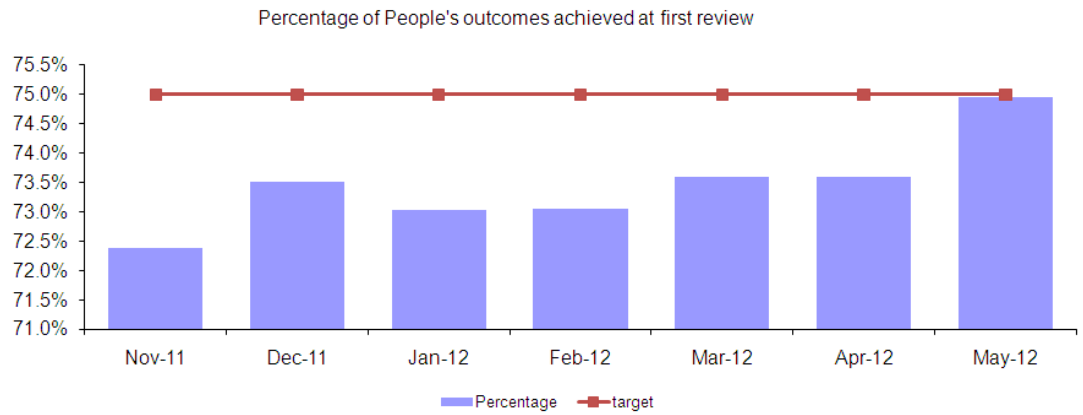
Commentary

This indicator looks at the timeliness of assessments. The aim of the indicator is not to ensure that assessments are completed more and more quickly – this would be detrimental to the individual if the enablement service was ended too soon.

This indicator serves to ensure that we have the right balance between ensuring enablement is delivered effectively and ensuring

5. Percentage of adult social care assessments completed within six weeks	Green
the whole assessment process is timely. To this end we have reviewed the target and would expect 75% of assessments to be within 6 weeks, and would challenge teams who would be either allowing people to spend too much time in an enablement service, or who were pushing people through the assessment process too quickly. Factors affecting this indicator are linked to waiting lists for assessments, assessments not being carried out on allocation and some long standing delays in Occupational Therapy assessments. There are also appropriate delays due to people going through enablement as this process takes up to six weeks and the assessment can not be completed until the enablement process is completed	

6. Percentage of social care clients who are satisfied that desired outcomes have been achieved at their first review			Green ⇧
Bold Steps Priority/Core Service Area	Empower social service users through increased use of personal budgets	**Bold Steps Ambition**	Put the Citizen in Control
Cabinet Member	Graham Gibbens	**Director**	Anne Tidmarsh
Portfolio	Adult Social Care and Public Health	**Division**	Older People and Physical Disability



Data Notes.
Tolerance: Higher values are better
Unit of measure: Percentage
Data Source: Adult Social Care Swift client system

Data is reported as percentage for each quarter.

No comparative data is currently available for this indicator.

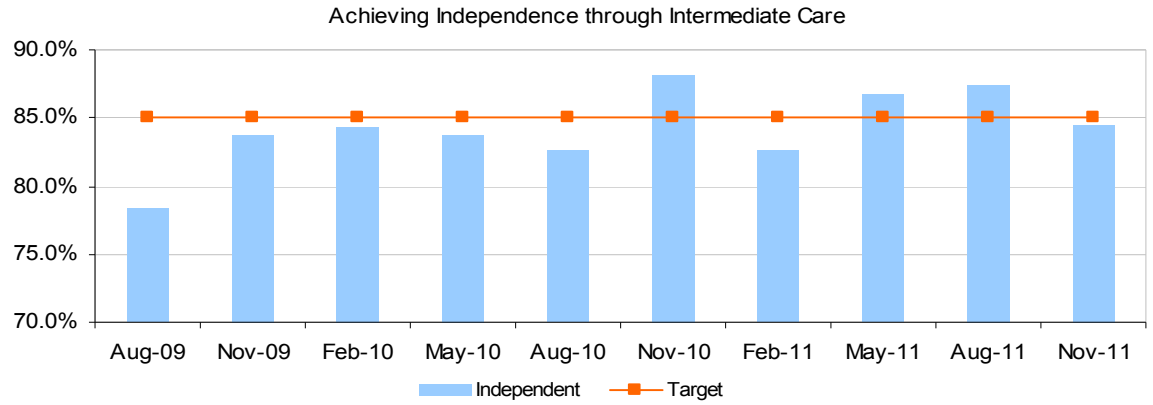
Quarterly Performance Report Indicator

Trend Data	Nov 11	Dec 11	Jan 12	Feb 12	Mar 12	Apr 12	May 12
Achieved	72.4%	73.5%	73.0%	73.0%	73.6%	73.6%	75.0%
Target	**75%**	**75%**	**75%**	**75%**	**75%**	**75%**	**75%**
RAG Rating	**RED**	**RED**	**RED**	**RED**	**RED**	**RED**	**GREEN**

Commentary

The percentage of outcomes achieved has increased from 66% in March 2011 to 75% in March 2012. People's needs and outcomes are identified at assessment and then updated at review, in terms of achievement and satisfaction.

7. Proportion of older people (65+) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services			AMBER ⇩
Bold Steps Priority/Core Service Area	Support the transformation of health and social care in Kent	**Bold Steps Ambition**	Put the Citizen in Control
Cabinet Member	Graham Gibbens	**Director**	Anne Tidmarsh
Portfolio	Adult Social Care and Public Health	**Division**	Older People and Physical Disability



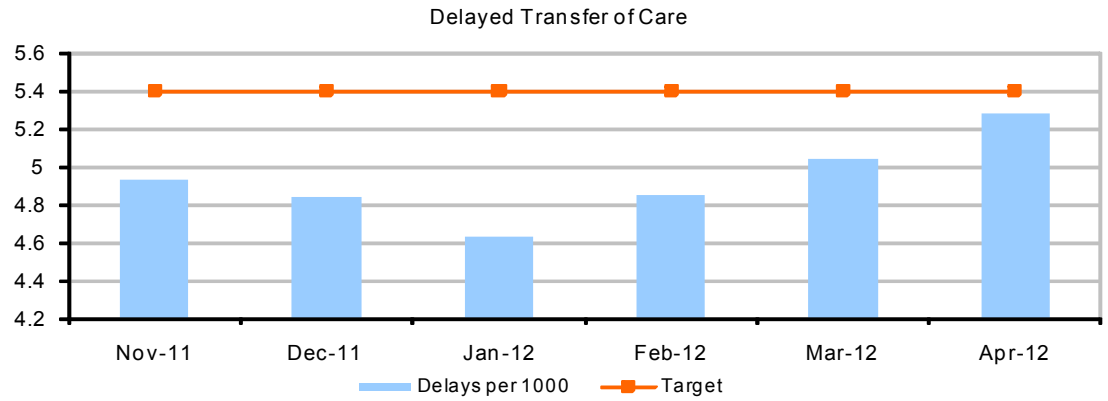
Data Notes.
Units of Measure: Percentage of older people achieving Independence and back home after receiving Intermediate Care following discharge from hospital
Data Source: Manual Data Collection

Trend Data	Aug 09	Nov 09	Feb 10	May 10	Aug 10	Nov 10	Feb 11	May 11	Aug 11	Nov 11
Percentage	78.3%	83.8%	84.3%	83.7%	82.7%	88.1%	82.6%	86.7%	87.4%	84.5%
Target	**85%**	**85%**	**85%**	**85%**	**85%**	**85%**	**85%**	**85%**	**85%**	**85%**
RAG Rating	**RED**	**RED**	**RED**	**RED**	**RED**	**GREEN**	**RED**	**GREEN**	**GREEN**	**AMBER**

Commentary

This indicator identifies where patients are three months after receiving intermediate care and relies on health and social care data being compared. There are about 400 referrals a month which are supported from hospital and into intermediate care. November data has just slipped below the target position.

8. Delayed Transfers of Care			GREEN ⇧
Bold Steps Priority/Core Service Area	Support the transformation of health and social care in Kent	**Bold Steps Ambition**	Put the Citizen in Control
Cabinet Member	Graham Gibbens	**Director**	Anne Tidmarsh
Portfolio	Adult Social Care and Public Health	**Division**	Older People and Physical Disability



Data Notes.
This indicator is displayed as the number of delays per month as a rate per 100,000 population.

Bold Step Indicator

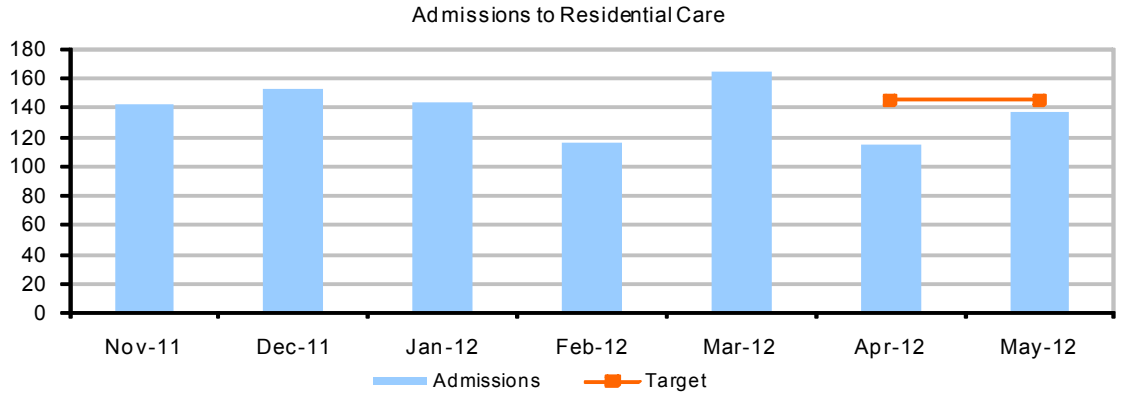
Trend Data	Nov 11	Dec 11	Jan 12	Feb 12	Mar 12	Apr 12
People	4.93	4.84	4.64	4.85	5.04	5.28
Target	**5.40**	**5.40**	**5.40**	**5.40**	**5.40**	**5.40**
RAG Rating	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN

Number of Delayed Discharges

Commentary

Delay transfers can be affected by many factors, mainly client choice and health based reasons. Whilst there are ongoing pressures to find social care placements, these have been eased with support such as intermediate care, and step down beds.

9. Admissions to Permanent Residential Care for Older people			GREEN ⇧
Bold Steps Priority/Core Service Area	Support the transformation of health and social care in Kent	**Bold Steps Ambition**	Put the Citizen in Control
Cabinet Member	Graham Gibbens	**Director**	Anne Tidmarsh
Portfolio	Adult Social Care and Public Health	**Division**	Older People and Physical Disability



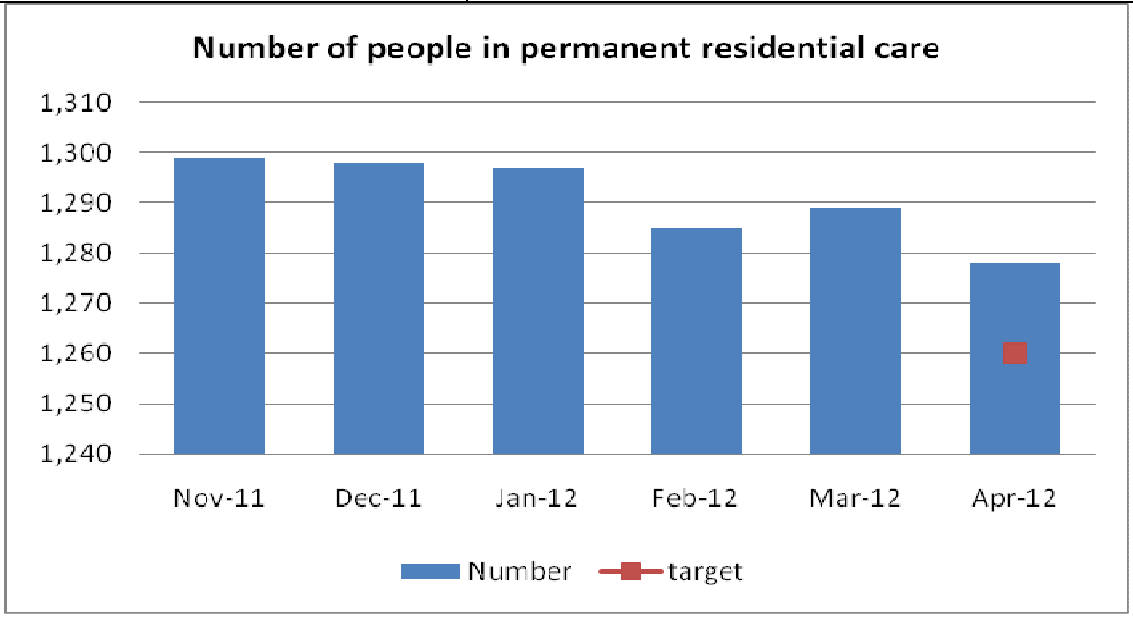
Data Notes.
Units of Measure: Older People placed into Permanent Residential Care per month.
Data Source: Adult Social Care Swift client System – Residential Monitoring Report

Trend Data	Nov 11	Dec 11	Jan 11	Feb 12	Mar 12	Apr 12	May 12
Admissions	142	153	143	116	164	115	137
Target						**145**	**145**
RAG Rating						GREEN	GREEN

Commentary

In 2011/12, there were 2240 new permanent admissions to residential and nursing care, averaging at 186 per month. This was slightly higher than 2010/11. It is clearly an objective to admit fewer people to permanent care, and with the ongoing use of residential panels across the county, it is the intention to keep permanent admissions lower than 145 per month. This also supports the objectives of the transformation programme.

10. People with Learning Disabilities in residential care			AMBER⇩
Bold Steps Priority/Core Service Area	Improve services for the most vulnerable people in Kent	**Bold Steps Ambition**	To tackle disadvantage
Cabinet Member	Graham Gibbens	**Director**	Penny Southern
Portfolio	Adult Social Care and Public Health	**Division**	Learning disability



Data Notes.
Units of Measure: Number of people with a learning disability in permanent residential care as at month end.
Data Source: Monthly activity and budget monitoring.

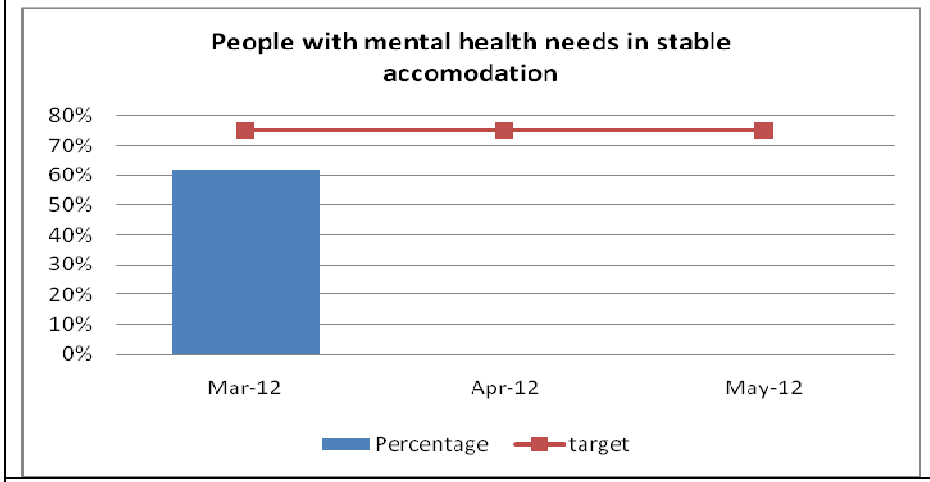
Bold Steps Indicator

Trend Data	Nov 11	Dec 11	Jan 11	Feb 12	Mar 12	Apr 12	May 12
Admissions	**1,299**	**1,298**	**1,297**	**1,285**	**1,289**	**1,278**	
Target						**1260**	**1260**
RAG Rating						AMBER	

Commentary

As part of ensuring that as few people as possible are supported via permanent residential care, more choice is available for people to be supported through supported accommodation, adult placements and other innovative support packages which enable people to maintain their independence. This will continue to be developed as the transformation programme is embedded.

11. Proportion of adults in contact with secondary Mental Health services living independently, with or without support			
Bold Steps Priority/Core Service Area	Improve services for the most vulnerable people in Kent	**Bold Steps Ambition**	To tackle disadvantage
Cabinet Member	Graham Gibbens	**Director**	Penny Southern
Portfolio	Adult Social Care and Public Health	**Division**	People with Mental Health needs



Data Notes.
Units of Measure: Proportion of all people who are in settled accommodation
Data Source: KPMT – quarterly

Bold Step Indicator

Trend Data	Nov 11	Dec 11	Jan 11	Feb 12	Mar 12	Apr 12	May 12
Percentage					75%	86.7%	86.7%
Target						**75%**	**75%**
RAG Rating						**GREEN**	**GREEN**

Commentary

This has been included for the first time, including data from KPMT and will be updated on a quarterly basis. Settled accommodation "Refers to accommodation arrangements where the occupier has security of tenure or appropriate stability of residence in their *usual* accommodation in the medium- to long-term, or is part of a household whose head holds such security of tenure/residence."
It provides an indication of the proportion of people with mental health needs who are in a stable environment, on a permanent basis.

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Scorecard - Kent, inc UASC

May 2012

Indicators	Polarity	Data Period	Current					Previously reported result	Target for 12/13
			Latest Result and RAG Status		Num	Denom	Direction of Travel (DoT)		
HOW MUCH ARE WE DEALING WITH ?									
Number of CAFs completed per 10,000 population under 18	H	Rolling 12 Months	66.0	A	2064	312597	↓	66.7	77.2
Number of Referrals per 10,000 population under 18	T	Rolling 12 Months	468.8	A	14655	312597	↓	504.1	543.7
NI 68 - Percentage of Referrals going on to Initial Assessment	T	YTD	96.7%	R	1683	1740	↑	97.3%	69.5%
Number of Initial Assessments per 10,000 population under 18	T	Rolling 12 Months	440.7	G	13777	312597	↑	462.4	426.1
Number of New & Updated Core Assessments per 10,000 population under 18	T	Rolling 12 Months	425.0	R	13284	312597	↑	434.6	236.0
Number of S47 Investigations per 10,000 population under 18	T	Rolling 12 Months	184.7	R	5775	312597	↑	193.5	106.4
Percentage of S47 Investigations proceeding to Initial CP Conference	T	YTD	27.8%	R	131	471	↑	21.0%	44.5%
Number of Initial CP Conferences per 10,000 population under 18	T	Rolling 12 Months	48.3	A	1509	312597	↑	50.6	42.3
Number of CIN per 10,000 population under 18 (includes CP and LAC)	T	Snapshot	286.0	G	8941	312597	↑	288.6	280.0
Numbers of Children with a CP Plan per 10,000 population under 18	T	Snapshot	25.8	R	808	312597	↓	29.1	30.5
Children looked after per 10,000 population aged under 18 (Excludes Asylum)	T	Snapshot	51.7	G	1616	312597	↓	51.5	47.5
Number of Looked After Children with a CP plan.	L	Snapshot	22	G			↑	32	30
Numbers of Unallocated Cases for over 28 days (Business)	L	Snapshot	0	G			→	0	0
HOW LONG IS IT TAKING US ?									
NI 59 - Percentage of IA's that were carried out within 7 working days of referral	H	YTD	84.4%	G	1420	1683	↑	82.0%	78.8%
Initial Assessments in progress outside of timescale	L	Snapshot	36	G			↑	41	100
(NI 60) - Percentage of Core Assessments that were carried out within timescale	H	YTD	81.7%	A	1453	1778	↑	79.6%	83.2%
Core Assessments in progress outside of timescale	L	Snapshot	55	G			↑	79	100
NI 67 - Child protection cases which were reviewed within required timescales	H	YTD	99.4%	G	628	632	↑	99.3%	98.0%
NI 66 - Looked after children cases which were reviewed within required timescales	H	YTD	98.6%	G	1652	1675	↑	98.3%	98.0%
HOW WELL ARE WE DOING IT ?									
Percentage of Case File Audits judged adequate or better	H	YTD	70.4%	R	131	186	↑	69.1%	85%
Percentage of open cases with Ethnicity recorded (excludes unborn)	H	Snapshot	99.0%	G	8719	8811	↑	97.9%	98%
Percentage of Children seen at Initial Assessment (excludes unborn/progress to strat)	H	YTD	80.3%	R	1186	1477	↓	80.8%	95%
Percentage of Children seen at Core Assessment (excludes unborn)	H	YTD	97.7%	G	1645	1684	↑	96.9%	95%
Percentage of Children seen at Section 47 enquiry (excludes unborn)	H	YTD	93.2%	A	423	454	↓	94.5%	95%
Percentage of Looked After Children aged 5 to 16 with a Personal Education Plan (PEP)	H	Snapshot	90.3%	A	959	1062	↑	84.5%	95%
Participation at Looked After Children Reviews	H	YTD	92.4%	A	656	710	↓	94.1%	95%
Children subject to a CP Plan not allocated to a Qualified Social Worker	L	Snapshot	0	G			→	0	0
Looked After Children not allocated to a Qualified Social Worker	L	Snapshot	0	G			→	0	0
ARE WE ACHIEVING GOOD OUTCOMES ?									
Percentage of referrals with a previous referral within 12 months	L	YTD	27.1%	A	472	1740	↑	29.3%	25.8%
NI 65 - Percentage of children becoming the subject of a CP Plan for a second or subsequent time	T	YTD	22.0%	R	27	123	↑	28.6%	13.4%
NI 64 - Child Protection Plans lasting 2 years or more at the point of de-registration	L	YTD	9.8%	R	26	265	↓	5.6%	6.0%
Percentage of Current CP Plans lasting 18 months or more	L	Snapshot	14.2%	A	115	808	↓	14.1%	10.0%
NI 62 - LAC Placement Stability: 3 or more placements in the last 12 months	L	Snapshot	12.2%	R	219	1798	↓	11.1%	8.1%
NI 63 - LAC Placement Stability: Same placement for last 2 years	H	Snapshot	72.6%	A	318	438	↑	71.6%	75.7%
Percentage of Looked After Children in Foster Care currently placed within 10 miles from home	H	Snapshot	61.4%	A	740	1205	↑	61.2%	65%
LAC Dental Checks held within required timescale	H	Snapshot	87.1%	A	1462	1679	↑	83.8%	90.0%
LAC Health assessments held within required timescale	H	Snapshot	88.5%	A	1486	1679	↑	85.3%	90.0%
Percentage of Looked After Children placed for adoption within 12 months of agency decision	H	YTD	66.7%	R	12	18	↑	61.5%	85.0%
Percentage of Children leaving care who were adopted	H	YTD	12.9%	A	18	140	↑	9.0%	13%
Percentage of Children leaving care who were made subject to a SGO	H	YTD	5.0%	A	7	140	↑	4.5%	6.3%
ARE WE SUPPORTING OUR STAFF ?									
Percentage of caseholding posts unfilled (100% - QSW inc Agency Posts)	L	Snapshot	-1.0%	G			↓	-0.6%	10%
Percentage of caseholding posts filled by agency staff (Agency Staff ÷ Establishment)	L	Snapshot	15.8%	R	67.9	430.6	↓	15.5%	10%
Percentage of caseholding posts filled by Qualified Social Workers (QSW posts exc Agency ÷ Establis	H	Snapshot	85.2%	A	366.9	430.6	↑	85.2%	90%
Average Caseloads of social workers in fieldwork teams	L	Snapshot	19.9	G	434.8	8674	↓	19.9	20

PERFORMANCE SUMMARY

As at 31/05/2012, Kent, inc UASC has 16 indicators rated as Green, 16 indicators rated as Amber and 12 indicators rated as Red. When comparing performance from last month to this month, 28 indicators have shown an improvement, 3 indicators have remained the same and 13 indicators have shown a reduction.

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By: Caroline Davis, Strategic Business Advisor

To: Social Care and Public Health Cabinet Committee 12 July 2012

Subject: Update on the Kent Health Commission

Classification: Unrestricted

Summary

The report highlights the activity, key recommendations and next steps for the Kent Health Commission (KHC) following the launch of its report with the Secretary of State, Rt. Hon Andrew Lansley MP on 14 June

1. The Kent Health Commission (KHC) was established in November 2011 by Paul Carter, working closely with Charlie Elphicke MP, Dover District Council and South Kent Coast Clinical Commissioning Group. The KHC undertook a rapid piece of work to gather evidence on how the transformation of health was being undertaken and where external partners could add value. This was developed into an interim report that was submitted to the Secretary of State for Health in December 2011.

2. Whilst originally the geographic focus of the Kent Health Commission was focussed on Dover district, KHC extended its focus to cover the whole of the South Kent Coast CCG area (Dover, Deal and Shepway) given the importance of aligning future activity with CCG boundaries to promote joint commissioning and integrated provision.

3. The profile of the Kent Health Commission was raised through a number of press articles in the MJ, Health Service Journal and the Local Government Chronicle.

4. The key recommendations of the KHC were:

   - Developing Integrated Commissioning between Health, Social Care and the District Councils, focussing on Long Term Conditions. This will lead to a shift in resources from acute to community, better use of resources and will support the Quality, Innovation, Productivity and Prevention (QIPP) agenda and the Families and Social Care Transformation agenda. Details of savings that can be achieved via this approach will be worked out as the work stream develops.
   - Speeding up the implementation of the Pro-active care programme in Shepway, based on a model delivered on Merseyside, which saw at least an 80% reduction in unplanned hospital admissions and significant decreases in social care expenditure. The first patients are now taking part in the scheme and four other practices are being trained in the approach.

- The South Kent Coast CCG area will be the first CCG in Kent to deliver all three aspects of the Long Term Conditions Plan: Risk Stratification, joint working between health and social care (HASCIP) and Pro-active care. Together these will lead to a change in the way services are both commissioned and provided, leading to a minimum funding shift of 5% from acute to community settings. The model has only just started to be implemented, so it is too early to say accurately what savings might be achieved.
- Will also look at what good community healthcare should look like and how this will be funded as part of discussions with the CCG as it develops its next commissioning plan.

5. An update of the Kent Health Commission report was launched by the Secretary of State for Health, Andrew Lansley on the 14th June. The launch followed a round table discussion between the Secretary of State and the members of the Kent Health Commission. The discussions were wide ranging and covered:

    - Developing the Kent Health Commission into a national showcase.
    - Pilot South Kent Coast as a "Teaching CCG" involving the local training and education sectors in recognition of the difficulty in attracting the very best health and social care professionals to the area.
    - Develop an information pilot to use shared morbidity and other data more effectively to support local healthcare needs, in support of the Department of Health's "Power of Information" strategy and the Patient Knows Best tool.
    - Mainstream the Whole System Demonstrator telecare pilot into a service innovation for others to follow, as part of a broader prevention and enablement programme.
    - Look at models in Birmingham and West Yorkshire as we develop 24/7 rapid response health/social care teams to support vulnerable people in their homes or in the community.
    - Provide further updates on how the Health Commission's recommendations are being put into practice and how improved services are being offered to local people.

6. The next meeting of the Kent Health Commission is on the 12th of July. It will look to progress the activity highlighted above, either as part of mainstream work already underway between the NHS and KCC or, where appropriate commission new work. The KHC will also continue to look at how the money flows between the acute sector, community and social care providers; in particular the savings that might be delivered through integration and focus on preventative activity. It will also continue to examine what good community health could look like as part of a dynamic conversation with GPs as they develop their next commissioning plans.

7. The work of the Kent Health Commission has also fed into other workstreams, including specific work on ICT infrastructure. A letter is being sent to Francis Maude to raise the particular issues around shared ICT infrastructure and the current constraints of the Connecting for Health programme. The work of the KHC has dovetailed well into the work on adult

social services transformation agenda within FSC and the development of the Dover & Shepway Shadow Health and Wellbeing Board.

Recommendation:

8. The Committee is asked to note the report.

Background Documents

- Interim Kent Health Commission Report – December 2011
- Update on Kent Health Commission Report – June 2012

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By:	Graham Gibbens, Cabinet Member, Adult Social Care and Public Health Andrew Ireland, Corporate Director, Families and Social Care
To:	Social Care and Public Health Cabinet Committee – 12 July 2012
Subject:	**KCC/KMPT PARTNERSHIP FOR DELIVERY OF SOCIAL CARE TO ADULTS OF WORKING AGE WITH MENTAL HEALTH NEEDS**
Classification:	Unrestricted

Summary:	This report updates the Cabinet Committee on the new Section 75 Partnership Agreement with KMPT in 2012-13 and sets out the future commissioning intentions for Mental Health services which will affect the Partnership Agreement with KMPT in future years

1. Introduction

(1) Kent County Council has had a Partnership Agreement with NHS organisations to provide mental health services for adults of working age since 2002. In 2006 when KMPT was formed from the merger of the two previous trusts a new section 75 agreement was drawn up which has been in place since.

(2) KCC has circa 280 staff seconded to KMPT. Total KCC investment in mental health is £22.1M, of which £9.25m is the cost of seconded staff and their accommodation. KCC's investment in the Partnership enables the delivery of social care support to adults of working age with mental health needs

2. Review of existing arrangements

(1) KMPT & KCC agreed in 2010 that a number of the aspects of the partnership needed improving therefore KCC, with the agreement of KMPT, commissioned a review of the partnership from an independent organisation. This work commenced in November 2010 and reported in February 2011.

(2) The report highlighted the areas that the partners needed to address. They were reflected into an Improvement Plan that has been monitored for nine months by the Programme Board with exception reports presented to the Partnership Board. KMPT & KCC have shown commitment to the Improvement Plan and have demonstrated improvement highlighted by the review.

3. Budget

(1) The table below details the Mental Health revenue budget for 2011/12 and the outturn for 2009/10 & 2010/11. This clearly demonstrates that the Mental Health budget has been brought under control.

Year	Outturn	Budget	Variance
2009/10	£22,148.7k	£21,749.8k	+ £398.9k
2010/11	£22,481.6k	£21,898.5k	+ £583.1k
2011/12	£21,070.5k	£22,025.3k	- £954.8k

(2) The key reasons for the budget being under control are;

- The monthly complex needs Panel process is an effective way of ensuring that clients are placed in the most appropriate and cost effective placement funded by the appropriate organisation (KCC/NHS).
- A comprehensive RAG analysis identified those ("green" ranked) clients whose needs could be supported by transfers to different services (e.g. from residential care to supported accommodation) or with revised packages of care.
- The KCC Director of Learning Disability and Mental Health has reviewed the mental health budget Recovery Plan at the monthly Divisional meetings. The momentum and more efficient practices from 2010/11 carried through to 2011/12 have had a downward impact on costs.
- Changes to staff teams and the Community Support Service in preparation for the reduction in the Supporting People grant.

4. What is planned over the next year

(1) There are a number of work areas that are underway or planned to start in 2012-13 that will continue to strengthen the infrastructure to deliver social care outcomes, these include:

(a) An ongoing process of auditing safeguarding cases has shown improved outcomes and practice, however KMPT is clear that they have more to do in the continued improvement and scrutiny of their safeguarding practice. The next planned audit is scheduled for June 2012.

(b) KCC & KMPT have agreed to develop an integrated training programme. Currently training departments are looking at commissioned training to develop a joint training strategy that meets the health and social care needs of staff. Work is also underway to start developing a joint competency / capability framework with a social care perspective, due for completion in summer 2012.

(c) KMPT have identified an external consultant to lead on the review of the Approved Mental Health Practitioners (AMHP) service. A project brief has been developed in May 2012 with the outcome to update and produce new practice guidance for AMHPs. The approval process for these will be via the AMHP Good Practice Group.

(d) KMPT are in the process of prioritising the development of a robust system to record and report Fair Access Care Services (FACS). This will include developing a specification for FACS performance monitoring reports to drive up performance.

(e) KCC & KMPT have identified a number of issues with data quality and developing mechanisms to report key performance indicators. Work is in progress to determine the data inputting required onto Rio and SWIFT (health and social care recording systems) to reduce the need for dual data inputting, and ensure we have clear reports to measure performance indicators.

(f) A dedicated lead from both KCC & KMPT has been identified to resolve some of the IT infrastructure issues. Work has already commenced to prepare a hardware survey to improve access to systems, with the aim to improve data quality and reporting. This work is will be completed in the next 3 to 6 months

(g) Joint work is underway to develop a Section 117 Register by July 2012.

(h) A number of KCC seconded staff reviews are planned for summer 2012, including KR11 and admin and clerical staff. The reviews will look at the future structure of KCC staff seconded into KMPT to ensure the structure can meet the demands of the future commissioning intentions.

(i) KMPT are undertaking a number of public engagement events for Foundation Trust Status. The presentation, 3, demonstrates their commitment to delivery quality through partnerships.

5. Section 75 – New KMPT/KCC Partnership Agreement

(1) With the expiry of the existing partnership agreement, the opportunity was present to construct a better Agreement for the establishment of an Integrated Provision arrangement in respect of specified mental health services under Section 75 of the National Health Service Act 2006, that would fit with the changes that are required to deliver a modern mental health service in the spirit of “Live it Well” and government policy.

(2) The new Partnership Agreement will achieve the following:

- Be clearer about what the required social care outcomes are
- Be more specific about the roles and responsibilities on each side, especially those areas where KCC have statutory duties and need to have an active input
- Allow greater flexibility for the delivery of social care in the future
- Be fit for purpose in relation to the requirements of section 75

- Be clear what is required from the Partnership in relation to social care practice standards, secondment arrangements, staffing establishments, performance reporting requirements and terms of reference for the governance structures

(3) However the Council does not have the power to delegate to the Trust the following Functions under the Mental Health Act and remains accountable for them all including those which it does delegate :

- Approved Mental Health Practice (AMHP)
- the Guardianship Register (including approval process)
- Safeguarding
- Social Care

(4) The new Partnership Agreement was discussed in draft form at the Mental Health Partnership Board in March 2012 and was formally signed off by them in May 2012 where it will then go via KMPT / KCC governance for sign off. The process of legal ratification of the S75 agreement is now being undertaken by KCC and KMPT.

(5) The agreement will run for a period of one year in the first instance, with a review after 6 months, following which it can be renewed for further years. This will allow both parties to consider the future direction of the partnership and the future commissioning intentions in the current changeable climate, as detailed in section 6.

6. Future commissioning intentions

(1) The KCC Adult Transformation Plan objective is to move Families and Social Care (Adults) to a position whereby, in 3 years time, it can operate on a budget that is at least £66 million less than it is currently, whilst simultaneously improving the social care outcomes for the people of Kent. Savings of the magnitude required will only be achieved through transformation and radically changing the current investment profile. This requires a high level review of how social care is currently delivered. Service redesign will be achieved by understanding the relationship and interdependencies between our key activities, appraising the options and implementing the changes.

(2) Live it Well" is a partnership between social care Mental Health commissioning and NHS commissioning. Live it Well says that we are changing the emphasis, and redirecting some of the resources, away from secondary, statutory services, closer to, and responsive to, the needs of service users and carers, which is and absolute requirement to make the substantial savings required in the health and social care economy. There are three key drivers that commissioners can use to help deliver the transformation change required within the mental health culture in Kent. These are:

i) Personalisation
ii) Partnerships
iii) Primary Care

(2i) Personalisation

- Over the next 5 years, we will be developing an increased personalisation of services - putting people in charge of their care plans and giving them autonomy over the resources that they need. This is a fundamental change in our relationship with service users and a huge challenge for existing mental health services and their staff.
- In order to move to this more facilitative, less directive way of working with people, more account will need to be taken of the whole person. An independent brokerage service will be developed to ensure an equitable approach to personalisation and a clear and transparent pathway for assessment and fund allocation.

(2ii) Partnerships - a range of providers

- To deliver holistic services in normal, non stigmatising settings (because that is where people live and will choose to have access to services) a range of providers is required. Both the Health and Social Care commissioners are committed to a single strategy that places equal emphasis on health and social care aspects of mental health.
- No one organisation "owns" mental health: Each organisation must be seen as equally important if holistic, non stigmatising services are to happen. This will only work if providers embrace and adopt a culture of partnership working with each other. To achieve the services that people deserve; that will be non-stigmatising and delivered where people choose; we will need a culture of partnership adopted by all stakeholders, including the statutory, voluntary and independent sector.

(2iii) Shifting resources to primary care

- More than 90% of people with mental health problems are treated exclusively within primary care, usually by their GP, without any reference to specialist mental health services (Goldberg and Huxley 1992). It is also estimated that between 25 and 40 per cent of all patients with schizophrenia are managed entirely by GPs, with no input from specialist mental health services (Cohen 1998).

The epidemiological data suggests that services need to be commissioned across the wider mental health economy; and in the places where people live their lives. This means a shift in commissioning resources to primary care settings. The benefit is earlier intervention - people will be able to get access to helpful resources earlier, before their mental health issue becomes bigger. This means developing more services in primary care and at the interface with primary care. In the first year to deliver clusters 1, 2 and 3 and potential future years for clusters 7, 11 and 12 (see diagram on page 6).

The Move to Commissioning through Payment by Results (PbR)

(3) *Equity and Excellence: Liberating the NHS commits* us to introducing the mental health care clusters as the contract currency for 2012-13 with local prices

(Health Of the Nation Outcome Scores HONOS PbR). This means that prices will be agreed between commissioners and providers, and are not set at a national level

(4) KMPT state in their annual business plan that 1800* existing cases will transfer to primary care through clusters 1, 2 and 3 and that GP referrals will fall by 23%. *The figure of 1800 was correct in January 2012, since that time cases have been and continue to be reviewed, and a number of cases have been closed. The actual figure for transfer as of April 2012 would be around 800. This continues to reduce as cases continue to be reviewed.

(5) The following diagram set out a vision for the redesign of delivering mental health services in each of the HONOS PbR. The biggest single change that will be required is a shift of a proportion of the social care resources to primary care in the first year to deliver clusters 1, 2, 3, and potential future years for clusters 7, 11 and 12.

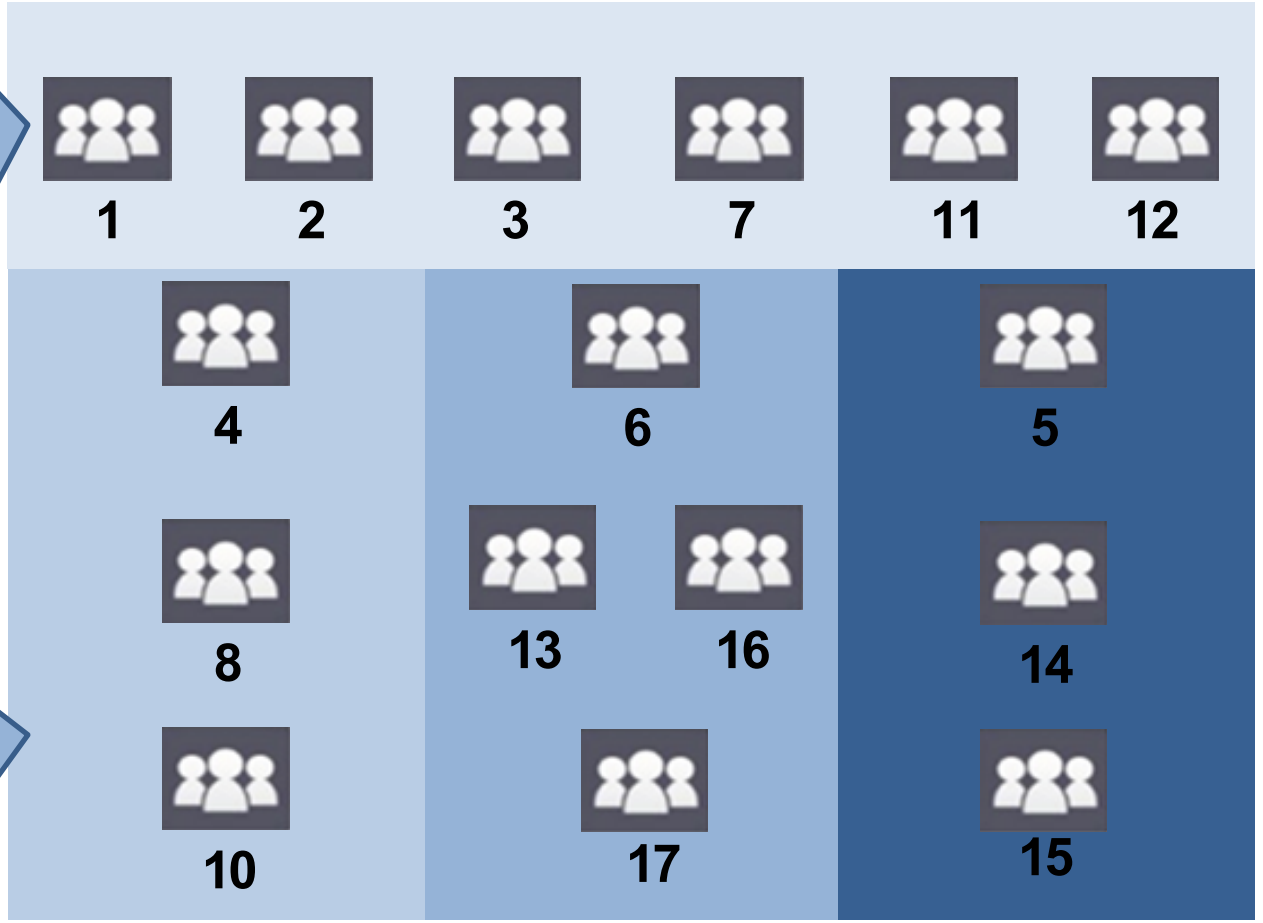
Community Mental Health Service Re-design

TOP HORIZONTAL BLOCK in the diagram represents primary care.

- Each of the numbered icons represents a Mental Health care pathway or 'care cluster'.
- Nationally the clusters are being used to inform PbR implementation.
- Locally we are using this change as an opportunity to improve the quality and efficiency of community Mental Health services.
- We are planning for 6 care pathways to be delivered in a primary care setting (with some shared care arrangements where needed).

THREE VERTICAL BLOCKS in the diagram represent secondary care services.

- **ACCESS** receives new referrals (intake). There will be 3 Access care pathways.
- **RECOVERY** will provide longer term care/support and will have 4 defined care pathways.
- **ACUTE** (CRHT and in-patients) will deliver 3 care pathways.



1 – Common MH conditions (mild)
2 – Common MH conditions (moderate)
3 – Common MH conditions (severe)

7 – Stable mood and anxiety conditions (high disability)
11 – Stable psychotic conditions
12 – Stable psychotic conditions (high disability)

4 – Complex mood and anxiety conditions
8 – Complex personality disorder
10 – Early intervention in psychosis

6 – Enduring mood and anxiety conditions
13 - Enduring psychotic conditions
16 – Dual diagnosis
17 – Assertive outreach

5 – Acute mood and anxiety conditions
14 – Acute psychotic crisis
15 – Acute psychotic depression

(6) From April 2012, work has started to provide the social care resource for clusters 2 and 3 in primary care. Then, after April 2013, delivery of clusters 7, 11 and 12 in primary care will be implemented. Together, this will mean a movement of some staff and resources into new settings.

(7) The commissioning intention is that during 2012, a proportion of social care staff will move to primary care settings where they will start to deliver the social care requirements in that setting. The Improving Access to Psychological Therapies (IAPT) service In Dartford, Gravesham and Swanley is the proposed first locality to adopt the new commissioning model.

(8) It is also proposed that, during 2012, those staff remaining in secondary care settings will concentrate on developing the social care responses in clusters 4, 5, 6, 8,10 and 13. Once these have been established, then, after April 2013, the social care elements of the final clusters 14, 15, 16 and 17 are established.

(9) The Local Authority (KCC) has certain key social care requirements in all clusters, which it needs to be sure are being carried out, in order for it to meet the statutory obligations. From the commissioning perspective, this is also important to ensure that people with mental health problems are not being disadvantaged in relation to the rest of the population.

Clinical Commissioning Groups (CCGs)

(10) Following the Health Bill re-structure, responsibility for the commissioning of secondary care will shift as the National Commissioning Board (NCB) and Clinical Commissioning Groups (CCGs) are established and Primary Care Trusts (PCTs) and Strategic Health Authorities (SHAs) are phased out.

(11) CCGs will be responsible for commissioning the majority of local health services and they will have statutory obligations for obtaining advice from other health and care professionals and involving patients and the public in doing this. They will work closely with their local authorities through Health and Wellbeing Boards to undertake a Joint Strategic Needs Assessment and to then determine their commissioning plans.

(12) The National Commissioning Board, already operating in shadow form as the NCB Authority, will begin to assume its formal responsibilities once it is established (likely to be between July and October 2012). It will have a significant role in supporting and developing CCGs to realise their full potential and that services are developed that will support not only CCGs but also the NHS CB, who will also be responsible for directly commissioning some services like military healthcare, highly specialised services, prison health services, primary care and some public health services. The NCB is hosting commissioning support, during the period 2013 –16, as CCGs become clear about their requirements and are ready to form.

(13) KCC and the Health and Wellbeing Board will have specific roles around the joint commissioning agenda, working in partnership with CCGs. We have a clear role to play both as a key partner in health commissioning but also as a potential partner in, and provider of, commissioning support. In the same way that emerging services from PCT clusters must be clear about their offer and build customer focused and responsive models, so too must we be clear about our contribution and how we can add most value to CCGs.

(14) CCGs are developing within Kent and due to the size of the County and our location to neighbouring boroughs we are expecting different CCG arrangements across the County. As an authority we need to be nimble and swift to respond to the changing climate and the differing requirements of the CCGs to ensure we have services that meet the need of the patient

7. Rationale for continuing the Partnership

1) As detailed in section 3 and 4 of the report, KMPT have demonstrated clear improvements in a number of work areas that were identified in the review and have detailed plans in place to deliver further improvements. There are a number of reasons why it is important to continue with the partnership, as follows;

   a) The key to developing patient centred primary mental health care services is to put the patient's needs at the heart. It is vital that the services we commission and deliver are integrated as peoples needs straddle health and social care. Therefore it is important that KCC and KMPT continue to improve and nurture the integrated service and partnership.

   b) Live It Well, which covers 2010-2015, sets out a vision for promoting mental health and well-being, intervening early and providing personal care when people develop problems, and focusing on helping people to recover in an integrated way. It was developed by the mental health commissioners for Kent and Medway (the three primary care trusts and the two social care directorates), with people who use services, family carers, health and social professionals, voluntary organisations and others. Therefore it is impetrative that KCC continues to support the strategy and its partners.

   c) Following the Health and Social Care Act all NHS Trusts must become, or be part of, an NHS Foundation Trust by April 2014. KMPT have relaunched the Foundation Trust Status application, and currently readiness assessments are taking place. KMPT are excepting to meet with the Strategic Health Authority in August 2012, with an expected referral to the Secretary of State in September 2012. KMPT are committed to delivering partnerships through the FTS process, which is reiterated in their annual business plan, and KCC will want to support them in the FTS process.

d) There are ongoing improvements in the safeguarding practice within KMPT, which was demonstrated in the recent audit. KMPT continues to focus on safeguarding via the comprehensive Improvement Plan. They have strengthened their governance and risk structures and take every opportunity to review practice. The Safeguarding Group continues to hold service lines to account and ensures that safeguarding is on the agenda of all local patient safety and clinical governance meetings.

e) Since summer 2011 both organisations have made concerted efforts, via their leadership teams, to resolve issues about the partnership that members had identified. KMPT now have a new Chairman, Chief Executive Officer and Director of Finance, that have signed up to an annual business plan. Appendix 4, which states their vision; 'The Trust aims to deliver quality through partnership. Creating a dynamic system of care, so people receive the right help, at the right time, in the right setting with the right outcome'. Andrew Ling, KMPT chairman has also met with a number of cabinet members to discuss the future vision of KMPT.

f) The new Partnership Agreement is a clear statement that both orgainsations are committed to the continuous improvement that is required to adapt to the changing climate within health and social care. The Partnership has clear governance arrangements to monitor its effectiveness and will be review after 6 months to ensure it is fit for purpose.

g) KMPT & KCC have a number of joint and independent reviews, as necessary, that are planned over the next year, which will ensure we have the correct structures in place to deliver health and social care outcomes for the future. It is important that both organisations completed the service reviews before looking to change partnership arrangements, otherwise there is the possibility of having to change more than once, which will have a negative impact on patients and staff.

h) Members will be aware that in February 2012 Medway Council withdrew from its partnership with KMPT. We need to learn from the experience of Medway Council withdrawing from the partnership as they have experienced a number of issues and now have a detailed transition plan in place to rectify some of the outstanding issues as a result of a sudden withdrawal. The pace and scale of what Medway need to do has provided KCC with learning that shows the importance of getting the current issues right before we make any significant changes to the partnership.

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i) Due to the introduction of PbR and CCGs the mental health and commissioning landscape is set to drastically change over the next few years. Multi-agency and partnership commissioning for mental health and wellbeing will be required to deliver seamless services. It is

important that the partnership continues whilst we collaboratively understand the needs of the patient and redesign services to meet their needs.

j) KCC & KMPT have jointly developed robust governance arrangements to monitor the partnership, which include the Mental Health Partnership Board, Programme Board, Finance and Performance monitoring via the KCC LDMH Divisional Management Team and the Joint Performance Review Group. This has supported robust performance monitoring and ensured the budget has been brought under control.

k) To deliver the KCC Adult Transformation it will require radically changing the current investment profile high level reviews of how social care is currently delivered. Service redesign will be achieved by understanding the relationship and interdependencies between our key activities, and partnerships, therefore it is important that we work with key partners to deliver the programme.

8. Conclusion

(1) Members will note from the report significant progress has been made on improving the Partnership and work is planned for 12-13 to continue improvements. Although much has been done there are still some concerns in relation to staff morale. However the Mental Health Partnership Board feels confident and assured that the good outcomes will be delivered by the new Partnership Agreement.

(2) The key progress made to date is:

- The re-established Governance structure; with a Programme Board and Partnership Board embedded since July 2011
- The continual high profile for and commitment to the Improvement Plan across both organisations.
- The new Professional Assurance Team, led by the Head of Social Work making significant progress in a number of work areas
- The improved monitoring not only of the Improvement Plan but also the key performance indicators, with a clear joint approach to RIO and Swift
- The improved status of key work streams; including safeguarding and personalisation
- The appointment of a new Chairman at KMPT and a permanent Chief Executive Officer.
- The robust performance management and clear guidelines set out in the new Partnership Agreement permits KCC to have confidence in the future delivery of mental health services within the new commissioning clusters.

(3) Of course close scrutiny and monitoring will need to continue over the next year to ensure progress is maintained.

9. Recommendations

Cabinet Committee members are asked to

a) **NOTE** the revised Partnership Agreement from April 2012 for one year.

b) **COMMENT** on the intended review of the Partnership Agreement in September 2012, whilst we fully assess the impact of the delivery of Commissioning Clusters 1,2 and 3, 7, 11 and 12, the Clinical Commissioning Group and the KCC Transformation (Adults) Plan.

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By:	Jenny Whittle, Cabinet Member, Specialist Children's Services Andrew Ireland, Corporate Director, Families and Social Care Lorraine Goodsell, Associate Director of Commissioning, Child Health and Maternity. NHS Kent and Medway
To:	Social Care and Public Health Cabinet Committee – 12 July 2012
Subject:	**UPDATE ON THE RE-COMMISSIONING OF EMOTIONAL WELL-BEING AND CHILD & ADOLESCENT MENTAL HEALTH SERVICES (CAMHS)**
Classification:	Unrestricted

Summary:	The purpose of this report is to inform and update Members about the progress on the joint commissioning of emotional well-being and Community CAMHS within Kent and Medway.

Introduction

1. (1) In July 2011, Kent County Council Cabinet Members and NHS Kent & Medway agreed to align funding in order to jointly commission new emotional well-being and mental health services for children and young people. This decision was made in response to significant evidence identifying the need to establish a more integrated system that would enable interventions to be delivered to children and young people in a more targeted and timely fashion.

(2) It was agreed that the new services would take the form of an Emotional Well-being Service delivering support within universal settings (Tier 1), alongside a 'Community CAMHS' model comprising targeted (Tier 2) and specialist (Tier 3) mental health services. Each element of service would be aligned to ensure clear pathways for children and young people between the different tiers.

(3) Since then, NHS Kent & Medway have been leading on the procurement of the Community CAMHS model, and KCC has been leading on procurement of the Emotional Well-being Service through its newly established Early Intervention and Prevention Multiple Supplier Framework. *(Please note that the Emotional Well-being Service will be restricted to Kent as Medway will continue to commission its own Emotional Well-being Service).*

Procurement and Evaluation Process

2. (1) During Autumn 2011, specifications and evaluation criteria were developed for both the Emotional Well-being Service and Community CAMHS model, with reciprocal contribution from NHS Kent & Medway and KCC, as well as input from a range of partners, stakeholders, and feedback from children and young people.

(2) An Invitation to Tender for the Community CAMHS model was released in February 2012 and for the Emotional Well-being Service in March 2012.

The two tenders closed in late March and early April respectively. Two consortia bids were received for the CAMHS specification (from an original pool of six providers who had successfully passed the Pre-Qualification Questionnaire) and 14 bids were received for the Emotional Well-being Service.

(3) Evaluation took place during April – May for both services, involving multi-agency colleagues to ensure a holistic assessment process and to underpin the links between the Emotional Well-being Service and Community CAMHS provision. For the CAMHS evaluation, this included a GP panel to assess clinical aspects of the tender, a service user panel, and a sub-group of local authority specialists comprising the Youth Offending Service, Educational Psychology and Specialist Children's Services. Evaluation of the Emotional Well-being Service similarly involved a broad range of colleagues, including the Senior CAMHS Commissioner for NHS Kent and Medway, Preventative Services Managers, and education representatives. A separate financial evaluation was conducted in each case, led by colleagues in KCC and NHS Kent & Medway Finance teams, to assess the viability and value for money presented by each bid. These elements were scored separately and then weighted to give a combined score.

(3) Top-scoring bidders for the Emotional Well-being Service were invited to attend an interview on 29 May 2012, following which a preferred provider was identified.

Preferred bidder – Community CAMHS

3. (1) Following the evaluation process, a preferred provider was identified for delivery of the Community CAMHS model. A recommendation was made to the Kent and Medway PCT Cluster Board on 30 May 2012 to approve the preferred bidder, which was accepted.

Commissioners are in the process of undertaking due diligence with the preferred provider and progressing to contract award in July 2012 when further information will be made available.

Preferred bidder – Emotional Well-being Service

4. (1) The successful bidder for the Emotional Well-being Service is a consortium led by Kent Children's Fund Network (KCFN), who scored higher than any other bidder across the various aspects of the evaluation process including the methodology statements, costings and interview process.

(1) KCFN propose to sub-contract a number of other local VCS organisations to undertake key elements of delivery, including Connexions Kent, Family Action, Avante Partnership, the Big Society Co-operate and Canterbury Christ Church University. The consortia model should allow for a greater set of skills and expertise to be deployed flexibly across the county, and will benefit from the addition of a Student Volunteer Scheme supervised by Canterbury Christ Church University to provide additional capacity.

(2) KCC will hold a single contract with KCFN, who will co-ordinate and performance manage all aspects of delivery from subcontracted parties, and accountability for achievement of the specified outcomes will remain with them.

Transition to new arrangements

5. (1) The contract award is expected to be complete by early July 2012. The new provider will be mobilising the service within Kent over the summer period ready for commencement on 1st September. A key part of the mobilisation process will include a communications campaign to schools, health and community settings, as well as to children, young people and their families, and meetings with existing providers of CAMHS to finalise staffing and operational arrangements.

(2) Contract award for the Emotional Well-being Service took place in late June 2012, and the provider will share the same mobilisation period as that of Community CAMHS, ahead of commencement in September 2012. During this period KCC and NHS Kent & Medway will be facilitating joint discussions between the two new providers to ensure the planned integration of the models.

Recommendation

6. (1) Members of the Social Care and Public Health Cabinet Committee are asked to **COMMENT** on the progress so far with regard to the re-commissioning of an Emotional Well-being Service and Community Child and Adolescent Mental Health Service (Community CAMHS).

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Background Documents: None

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

Meradin Peachey, Director of Pubic Health

To: Social Care and Public Health Cabinet Committee – 12 July 2012

Subject: **Public Health Transition**

Classification: Unrestricted

Summary: This report provides an update on the progress of the transition of the locality-led element of the new national Public Health system to the County Council in April 2013. It also summarises the Government's recent announcements on future Public Health budgets under the new system and explores the implications for the Authority.

For Decision: The Cabinet Committee are asked to consider this report and either endorse or make further recommendations in shaping the Cabinet Member's outline response to the Department of Health's consultation paper 'Healthy Lives, Healthy People: Update on Public Health Funding'.

Introduction

1. (1) This is the latest update to Members of this Committee (which also builds on reports to the now decommissioned Adults Social Care and Public Health Policy Overview and Scrutiny Committee) on the proposals to change how Public Health in England is to be organised and the implications of these changes for the County Council.

Health and Social Care Bill - 27 March 2012

2. (1) The enactment of the Health and Social Care Bill gives KCC, as an upper tier Authority, a new duty "to take appropriate steps to improve the health of the people."

(2) As well as the Act introducing a generic duty, it also requires KCC to undertake a number of specific steps including:

- Establishing a Health and Wellbeing Board
- The development of an enhanced Joint Strategic Needs Assessment (JSNA) under the auspices of the Health and Wellbeing Board
- Commissioning Kent HealthWatch
- Assuming statutory responsibility for some of the key elements of the new national Public Health System
- Appointing (by statute) a Director of Public Health

(3) The Act introduces a new national Public Health system consisting of four elements:

- National Commissioning Board

- Public Health England
- Clinical Commissioning Groups
- Upper Tier Local Authorities

(4) In effect, this means that KCC becomes an integral part of this new national system providing locality-led leadership and oversight of Public Health (PH) in the County, together with responsibilities in delivering some key PH services from the 1 April 2013. To support these new responsibilities the Authority will receive a ring-fenced budget and the transfer of most of the existing NHS staff currently working in PH in Kent.

Public Health Work in 2013 and Beyond

3. (1) It is anticipated the work that will be transferred will include the shaping and delivery of over 20 Public Health programme/services of which, going forward, the following will be mandated from next year:

- Appropriate access to sexual health services (including testing and treatment for sexually transmitted infections, contraception outside of the GP contract and sexual health promotion and disease prevention).
- Steps to be taken to protect the health of the population, in particular giving the local authority a duty to ensure there are plans in place to protect the health of the population.
- Ensuring NHS commissioners receive the Public Health advice they need.
- NHS Health Check assessments.
- The National Child Measurement Programme.

(2) Outside of these mandated services, other services will be discretionary (although the Secretary of State holds reserve powers over the direction of other services) with the Health and Well Being Strategy and the JSNA guiding delivery against these other areas. However, performance will also be judged against the national Public Health Outcomes Framework which will influence the allocation of future resources through the proposed Public Health premium system (see later in this report).

(3) The Act also makes it clear that the Authority has a responsibility for taking appropriate steps to protect the health of the population and to ensure the safety of Public Health services.

The Transition Process

4. (1) It is incumbent on the NHS to identify those exact functions and resources that will transfer to KCC and there are complex sets of Department of Health policies and guidance and reporting arrangements to achieve this. However, given the rate of change within the NHS, a KCC project team has been developed to oversee the transition process and to ensure KCC's best interests are protected. A high level list of programme milestones is attached as appendix 1 for information.

Reshaping the Public Health Team

5. (1) After consultation with KCC, the Director of Public Health (DPH) on behalf of the NHS, has decided to initiate the process of the reshaping of all existing PH staff resources (both NHS and KCC staff) to ensure a better fit with current and future policy frameworks and service priorities. This consultation commenced in mid June with the launch an informal consultation document. This process will last until July followed by formal consultation over the summer. The intention is to make the appropriate appointments or slotting of staff in September/October, with a 'shadow' team in place by October. There are still some negotiations to be finalised, but the expectation is that in total, excluding the DPH there are some 61 posts (not FTEs) in scope (54 posts currently in the NHS, 7 currently employed by KCC). The FTE figure is 46.97 for the NHS and 7 for KCC.

(2) In April 2013, NHS staff will be transferred under TUPE or the Cabinet Office equivalent policy guidelines.

(3) Some of the core principles driving the proposed change include:

- Delivery of the Ambitions set out in Bold Steps for Kent
- Ensuring the safe delivery of Public Health programmes
- An intelligence-led commissioning approach, focusing on areas and groups of greatest need
- A strategic commissioning approach
- An integrated approach to joint commissioning and work both with County Council Directorates and between the County Council and District Councils
- An alignment with sub-County locality arrangements
- Integration with CCGs and other health commissioners
- Ensuring we remain linked to NHS clinical networks so that we can productively advise on health care standards and practice
- Collaborative work with Medway Council
- Tailoring services to population needs and developing a wellness service that address multiple needs and aims to reduce inequalities

(4) As part of the overall informal consultation, staff have been asked to comment on proposals on how the various functions of Public Health might be grouped in the new team. A summary of this is attached as appendix 2 for information.

Finance and Budgets

6. (1) Perhaps one of the more complex aspects of transition is to map and identify the actual budgets that will transfer to the four components of the new Public Health system including the Local Authority. This complexity stems from:

- traditionally Public Health budgets within the NHS have not been clearly delineated from other budgets
- the precise details have yet to be finalised as to which organisation in the new PH system will responsible for exactly what element of each PH programmes and services
- to date, it is historic information that is being used and not contemporary (i.e., it has not been 2012/13 budgets being analysed).

(2) After April 2013, PH will be funded by a new Public Health budget, separate from the budget managed through the NHS National Commissioning Board (NCB) for healthcare. This budget will be made up of:

- ring-fenced grants to upper tier and unitary authorities
- through the NHS National Commissioning Board: and
- Public Health England commissioning or providing services itself
- It has been estimated that in 2012-13 approximately £5.2 billion will be spent on the future responsibilities of the PH system, including £2.2 billion on services that will be the responsibility of local authorities.

Progress to date

7. (1) Initially work focused on establishing the baseline for any budget transfers. This process looked at budget spend 2010/11 and led to the publication in February 2012 of initial figures for each element of Public Health spend by each component of the new system. Under this system the baseline analysis suggested that KCC would receive a transfer of approximately £24 per head (figures adjusted to reflect 12/13 budget estimate). By way of comparison, the predicted local authority spend per head ranged from a high of £117 per head (Tower Hamlets) to the lowest figure of £15 per head (Buckinghamshire). The East Kent PCT figure was £29 per head, West Kent £19 per head. Across the English regions the figures ranged from £27 per head (in the South East and South West) through to £65 per head (London).

(2) Work is currently underway on analysing 2011/12 audited PCT expenditure as an update to the baseline published in February. The Kent and Medway PCT Cluster will make their submissions to the Strategic Health Authority (SHA) for the Eastern and Coastal Kent, and West Kent, PCTs on 9 July so details may be available to update these details by the time of the meeting of this Committee. Submission to the DH and the NHS Commissioning Body Special Health Authority will be made by the SHA on 23\ July.

(3) This process, despite its flaws also highlighted how eclectic the allocations of funding for Public Health have been across the country and between Primary Care Trusts (PCTs).

(4) Work is on-going to challenge the proposed future funding arrangements for the South East Region with the Department for Health.

'Healthy Lives, Healthy People: Update on Public Health Funding'.

8. (1) On the 14 June 2012 the Department of Health published the above paper setting out current Government thinking on the funding of PH post April 2013. In particular it sets out:

- the next steps on moving from the estimates of baseline spending published in February 2012 to actual allocations for 2013-14 that are expected to be published by the end of 2012:
- provides further information on the high level design of the Public Health budget allocation system including the use of a Public Health premium for 2013/14 and:
- conditions on the ring-fenced Public Health grant which state how the grant may be used; including proposals for local authority financial reporting requirements on Public Health spend.

(2) The Department of Health (DH) has yet to fully commit to exactly what level of budgets will be transferred apart from the paper stating that the amount allocated to local

authorities for 2013-14 'will not fall below these estimates in real terms, other than in exceptional circumstances'.

The High Level Design of The Allocation of Public Health Budgets

9. (1) By common consent the budget allocations for PH work varies by an extraordinary amount between and within areas. The Government has proposed that this should be subject to further analysis to derive a more equitable set of allocations across England. They commissioned the Advisory Committee on Resource Allocation (ACRA) to develop a formula for the allocation of the PH budget to local authorities relative to population health need, to enable action to improve population wide health and reduce health inequalities.

(2) ACRA's interim recommendation is based on the use of standardised mortality ratio (SMR) for those aged under 75 years. This is a measure of how many more or fewer deaths there are in a local area compared with the national average, having adjusted for the differences between the age profiles of the local areas compared with the national average.

(3) ACRA also recommended that the formula should include an adjustment for unavoidable differences in the costs of delivering services across the country which are due to location alone, such as higher staff costs, and not need. ACRA recommended that, for consistency, an appropriate Area Cost Adjustment (ACA) based on that used in the local government funding formula should be used. Any ACA however needs to reflect up to date information as far as possible, and it should be noted that the adjustment does occasionally throw up strange results.

(4) However, the update makes it clear that this is an interim recommendation and ACRA have identified some areas needing further work before making its recommendations for the formula for allocations in 2013-14

(5) The Government has said that, although they wish to see progress towards a new system in the allocation of PH resources, it will not commit to an exact timetable (or what they call the 'pace of change'). In part this is understandable as it will still take some time to fully understand the overall resources available and the splits between the various components of the new PH system. The Government has said that it 'will protect investment in each authority in real terms' during the current spending review period. If so, and given there is no predicted increase in overall resources for Public Health it seems likely that it will take several years to move a to a needs-based basis rather than a pattern based on PCT's historic spending.

(6) The paper also considers the proposed use of a health premium (i.e., a reward or incentive for success) but concludes "We recognise that the significant data lag on many of the indicators in the Public Health outcomes framework would mean that if it was paid in 2013-14 we would be rewarding local authorities for decisions taken by PCTs. We are therefore planning to delay the first payments until 2015-16, the third year of local authority responsibility for PH responsibilities".

Conditions on The Ring-Fenced Public Health Grant

10. (1) The PH grant to local authorities will be made under Section 31 of the Local Government Act 2003 and, as with other ring-fenced grants, will carry conditions about how it may be used. Thus, the grant continues to be NHS money.

(2) The government had promised to restrict the conditions on the grant so as to maximise flexibility. That said the draft guidance stretches to 4 sides of text. The core

conditions will centre on defining clearly the purpose of the grant, to ensure it is spent on the Public Health functions for which it has been given, and ensuring a transparent accounting process.

(3) The intention is for the grant to be spent on activities whose main or primary purpose is to impact positively on the health and wellbeing of local populations, with the aim of reducing health inequalities in local communities. Those activities include:

- improving significantly the health and wellbeing of local populations carrying out health protection functions delegated from the Secretary of State;
- reducing health inequalities across the life course; and
- ensuring the provision of population healthcare advice.

(4) The DH intends to test the conditions on the grant further, before finalising them and issuing them with actual allocations for 2012-13.

(5) The update stresses that the preferred distribution of resources is going to take time to perfect and the DH would welcome feedback on how it can be improved in both the short and long term. They expect that the preferred distribution will evolve over the next two to three years. They intend to publish actual allocations for local authorities before the end of 2012.

Next Steps

11. (1) The Healthy Lives, Healthy People: Update on Public Health Funding paper invites comment and feedback and it is important that KCC does respond. In part this will be a technical analysis of the criteria used in ACRA's draft recommendation in distributing resources on a needs basis. This analysis has not yet been completed so I intend, if possible, to provide a verbal update at this meeting.

(2) However, there are also a number of more general or points of principle that should shape a KCC response. These include:

- the under 75s standardised mortality ratio indicator being proposed as the basis for a new system of allocation of funding is positive in that the data is known but it does look limited on its own;
- our current belief that the overall quantum of money spent on Public Health nationally is an under-estimate and the share of that figure that been identified as transferring to local authorities is also undercounted;
- concern over the time it might take to before funding is distributed largely on a needs led basis (i.e., those resources that have been earmarked to be allocated to cover any contingency costs associated with the changes to the NHS);
- querying why the document is silent over any transfer of a proportion of the money saved under the NHS's Nicholson Challenge to the PH budget. These savings have been effectively allocated as a contingency budget to support the overall changes to the NHS;
- concerns over the effectiveness of the area cost adjustment formula that looks like this disadvantages Kent;
- the belief that 2011 Census population details when available should be used and not the Office of National Statistics 2011 estimates;
- An overly prescriptive set of conditions for the proposed ring-fenced grant;

- Observations and comments from this Committee would be very welcome.

Conclusion

12. (1) This report informs the Committee of the progress being made in the transition of PH responsibilities in April 2013. It seeks endorsement by the Committee in the Cabinet Member responding to the 'Healthy Lives, Healthy People: Update on Public Health Funding' document published by Government along the lines set out in paragraph x and incorporating any comments made at this meeting.

Recommendations

13. (1) To note the progress made in the transition of Public Health responsibilities to the County Council in April 2013

(2) To endorse the Cabinet Members intention to formally respond to the consultation by Government on the future of Public Health Funding

Background Documents

Healthy Lives, Healthy People: Update on Public Health Funding
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_134580.pdf

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Appendix 1

INDICATIVE HIGH LEVEL PROJECT MILESTONES

Project Elements	Date
Project Initiation	
Scope, objectives, principles and timescales agreed	June
Stakeholder management and communications plans in place	June
Creating the New Team	
Informal consultation starts	June
Formal consultation launched	July
Final structure published	September
Appointments made	September/ October
In shadow operational form	November
Goes 'live'	April
Finance	
Budgets to be transferred identified and mapped	June
Final verification and quality checking of budgets to be transferred	September
KCC budget build for 2013/14 and business planning cycle starts and runs through to the new calendar year	Summer - March
County Council approves final KCC budgets	February
Ring-fenced Public Health budget transferred to KCC as part of the central Government local authority settlement	April
Cabinet approval of business plans	April
Workforce and HR	
Confirm legal basis of transfer (TUPE or COSOP)	June
Induction and training and development plan developed (transition and post transfer)	September
Confirm and set-up pension arrangements	June and onwards
Enter staff details in to KCC Personnel IT systems	February
Issue new contracts / letters of welcome	February
Contracting and Legal	
Contracts to be transferred identified and mapped	June
Forward procurement plan developed	September
Ability of KCC in using existing NHS contract templates and processes tested	September

Project Elements	Date
Existing contracts terminated, novated, re-tendered as required in line with procurement plan	September to March
Communication and Engagement	
Staff communication plan developed	June
Reporting schedule to KCC political governance framework developed	June
Wider stakeholder transition communication plan developed	July
KCC Public Health communication and engagement plan for post transition developed	October
Launch of new Public Health web site	December
Information Technology and assets	
Existing assets and requirements mapped	June
Forward implementation plan developed	September
IT/IS Training programme implemented	December
Reprovision of KCC equipment or the transfer of NHS owned assets made	February
New KCC IT accounts created	February
Accommodation identified/ provided	February
Information Governance	
Essential and obligatory NHS requirements identified and recorded	July
KCC systems and procedures adapted where necessary	July - March
NHS Information Governance Toolkit assessment submitted by KCC	February
Performance Monitoring and Reporting	
Reporting requirements within and without KCC mapped	September
KCC corporate requirements integrated in to a new PH performance monitoring system	February
New system goes live	April

DRAFT FUNCTION CHART FOR PUBLIC HEALTH

Director of Public Health (statutory appointment)
Member of Corporate Management Team and Corporate Board

Health Intelligence and Operational Research
- Consultant Lead
Needs assessment
Healthcare, Public Health Kent and Medway Health Observatory (joint with Medway)
Epidemiology population analysis
Health Economic
Joint Strategic Needs Assessment
CCG profiles
Annual Public Health report
Long-term conditions risk profiling
Strategic linkages with Public Health England and NHS Commissioning Board

Health Improvement
- Consultant Lead
Needs Assessment
Health Inequalities Action Planning
Commissioning Public Health programmes
Healthy Lifestyles programmes
Programme development – tobacco control, alcohol and drugs, healthy weight, National Child measurement Programme, physical activity, health checks, mental well-being, workplace health, seasonal health
Public Health training
Public Health champions

Health Protection
- Consultant Lead
Needs Assessment
Commissioning sexual health services
Monitoring quality of immunisation and screening programmes and Healthcare Associated Infections
Response to Public Health incidents
Surveillance of infectious diseases
Public Health training
Advice to National Commissioning Board

Business and Commercial Management
Budget and financial management
Business planning and business strategy
Performance management
Partnership and democratic processes
Health and Wellbeing Board
Patient experience
Office administration and support
Contract management
Public Health media and public engagement
Market Development - social enterprise, voluntary

Nominated senior lead to link with current and emerging locality structures and groups including Locality Boards, Community Safety Partnerships, Margate task force and so forth

Partner and Locality working and co-operation, joint commissioning and advice where appropriate across the function with Clinical Commissioning Groups, District Councils, NHS Commissioning Board, other NHS bodies, Public Health England, voluntary and

Wider Kent County Council support to the function
Information and Communications Technology, Personnel, Communications and Engagement, Legal, Procurement, Facilities Management

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