By: Roger Gough - Cabinet Member for Business Strategy, Performance and Health Reform

To: Corporate Policy Overview and Scrutiny Committee – 13th January 2012

Subject: NHS and Public Health Reform – For information

Classification: Unrestricted

Summary: The transition of public health to the local authority and the reforms to the NHS are progressing in Kent. Radical changes to commissioning of services and public accountability of services are becoming a reality. By April 2012 most of the new system should exist in shadow form ready to assume full responsibilities when the PCTs are abolished in April 2013. This report summarises the current position of the key elements of the reforms.

Introduction

1. (1) The Health and Social Care Bill is still before Parliament but is expected to be passed in early 2012. It requires the Primary Care Trusts to be abolished by April 2013 with most of their commissioning functions transferring to groups of GPs in Commissioning Consortia and, for Public Health, to the upper tier local authority. Shadow arrangements are being established to be operational from April 2012. Key elements of the reforms include Public Health, Local HealthWatch, Health and Wellbeing Boards, and the Clinical Commissioning Groups themselves. In Kent we have also established the Kent Health Commission, designed to develop models for working with CCGs at a local level to improve the commissioning and provision of services.

Public Health Transition

2. (2) The transition of public health to local authorities is progressing. Factsheets clarifying government thinking and intentions have been issued including further detail on government expectations of how local authorities will use their new responsibilities and the Operating Model; for Public Health England but we still await important DH guidance on key issues such as budget allocations, the workings of the Health Premium, the Outcomes Framework we will be expected to work towards and workforce transfer.

(3) The budget allocation will initially be based upon the identified spend by the PCTs for last year but there will also be an allocation formula calculated with reference to the population characteristics of the area. If the formula allocation varies from the historical spend the budget will be adjusted in the following years.

Workforce Transfer

3. (1) 55 Staff have been aligned to KCC management under the Memorandum of Understanding agreed by County Council in September. These are Public Health Specialists, Consultants and associated staff. The general principles that should apply to the transfer have been outlined in a DH Concordat between the NHS and local government but the detailed guidance on how the transfer is to be effected is still awaited.

(2) Work has begun to identify the best configuration of staff within the property estate of the NHS and KCC that may become available.

Local Health Watch

4. (1) Local HealthWatch Kent is designed make a reality of the Health and Social Care Bill's ambition of "no decisions about me without me". It will enable the public to help shape and influence health and social services. It will also provide an opportunity for health and social care commissioners to understand, and respond to, the public's concerns about the services that are commissioned for them – and the standards to which they are delivered.
Local HealthWatch will have the following functions:

- **Citizen Engagement** – Local HealthWatch will actively engage communities in a dialogue about their health and social care needs to make sure that services act upon feedback and can demonstrate that they have done so.
- An **Information and Signposting service** for health and social care to support choice.
- An **NHS Complaints Advocacy Service**. Local Health Watch will support people to speak out and give those who want it an opportunity to get more involved in a range of different ways.

(2) In Kent we commissioned the Centre for Public Scrutiny to assess our readiness to establish Local HealthWatch. The recommendations from this report are now being implemented.

Kent Health and Wellbeing Board

5. (1) Kent is part of the national Health and Wellbeing Board early implementer programme, which aims to establish Health and Wellbeing Boards ahead of the timetable laid out in the Health and Social Care Bill. In developing the Health and Wellbeing Board, Kent County Council has held a

number of workshops and meetings. Following on from the Full County Council meeting held in July 2011, the shadow Kent Health and Wellbeing was established, meeting on a bimonthly basis, (the first meeting was held on the 28th September), with Cllr Roger Gough as the Chairman. The HWB is attended by all 8 of the Clinical Commissioning Groups.

(2) The adult Social Care and Public Health POSC received an update report on the development of the Kent Health and Wellbeing Board on the 10th November 2011.

(3) The HWB is currently focussing on the Joint Strategic Needs Assessment, Joint Health and Wellbeing Strategy and the emerging CCG commissioning intentions.

Integration of Health and Social Care

6. (1) Kent County Council and the NHS in Kent are working together to deliver integrated adult community health and social care. A programme board has been established (the Health and Social Care Integration Programme (HASCIP)) and a delivery plan has been produced. Initial work is already underway in Swale, Dover and Maidstone/Malling areas.

Kent Health Commission

7. (1) Following on from a number of discussions, the leaders of Kent County Council and Dover District Council along with Charlie Elphicke MP and the South Kent Coast Clinical Commissioning Group established the Kent Health Commission.

(2) Its core purpose is to develop a visionary model that demonstrates how the Government's health and care reform agenda can empower GPs and commissioners to deliver better quality care, improve health outcomes and improve patient experience through working with GPs in Dover district as a pilot area.

(3) The Health Commission has outlined a phased approach to its work; Phase 1 (November – December 2011) to produce an interim report to be presented to Andrew Lansley by Christmas, outlining our initial findings and our proposals to tackle them; followed by a full report in early January 2012. Phase 2 will then be scoped based on the initial findings, and will look to use some of the resources available from the NHS re-ablement funding to fast track investment in integrated health and social care needs for the South Kent Coast CCG amongst other activity (to be planned).

(4) The Commission met on three occasions to consider evidence from local GPs, local NHS providers, the PCT Cluster, national providers and the voluntary and community sector.

(5) In order to ensure the independence of the Commissions work and findings, it has worked with both MHP and Localis (specialist health policy and

localist/local government think tanks) to facilitate the discussions with key players and to produce the interim findings and Phase 1 report.

(6) The Health Commission submitted its interim findings to the Secretary of State for Health, Andrew Lansley on the 20th December.

(7) Key to the Health Commissions work is the need to ensure that there is a 5% shift in resources from the Acute Sector (Hospitals) to the Community Sector, to enable patients to be treated in the right place at the right time. Kent's approach has been recently supported in comments made by Mike Farrar (Chief Executive of the NHS Confederation), who has warned "of a potential loss of confidence in the NHS unless political and healthcare leaders make a compelling case to the public for changes to the delivery of services...to let go of the outdated hospital-or-bust model of care…to shift resources into community based services, early intervention and self care". This is being acted on in Kent through both the Kent Health Commission and Health and Social Care Integration Programme.

Development of Clinical Commissioning Groups

8. (1) The Health and Social Care Bill (and subsequent guidance) sets out the responsibilities and time table for the establishment of Clinical Commissioning Groups, to be led by GPs, with the aim of commissioning 70-80% of the health care services that the population that it covers will need (the other areas not commissioning by the CCG will be commissioned by the National Commissioning Board). CCGs will take on formal responsibilities for commissioning from April 2013, and will be running in shadow form from April 2012. It is the stated intent of the Kent and Medway PCT Cluster to delegate the full CCG budget to CCGs from April 2012.

(2) CCGs are being supported in their development by the Kent and Medway PCT Cluster. Their November 2011 Board papers provided an update on the delegation of budgets to CCGs and the steps that need to be undertaken.

(3) Until April 2013, CCGs will be committees of the PCT Board. PCTs will be abolished from April 2013, with residual support for CCGs, including the Commissioning Support Infrastructure, will be provided by the local arm of the National Commissioning Board.

(4) There are currently 8 CCGs in Kent, and it is unclear at this time if there will be further mergers of CCGs in order that they are big enough to be able to afford adequate commissioning support (each CCG will have £25 per head of population for management overhead costs, the K&M PCT cluster has reduced its management overhead costs over the last 12 months down to that level).

(5) The Kent Health and Wellbeing Board will be part of the consultation process to agree the size and boundaries of the CCGs in Kent;

they will also be part of the on going process of monitoring the CCGs and ensuring that they CCG Commissioning Intentions take into account the Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy.

Recommended that the content of the report be **noted**

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