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Date of issue: 14th September 2010

MEETING	**HEALTH SCRUTINY PANEL** (Councillors Walsh (Chair), Davis, S K Dhaliwal, Long, MacIsaac, P K Mann, Plimmer, Rasib and A S Wright)
DATE AND TIME:	THURSDAY, 23RD SEPTEMBER, 2010 AT 6.30 PM
VENUE:	COUNCIL CHAMBER, TOWN HALL, BATH ROAD, SLOUGH
DEMOCRATIC SERVICES OFFICER: **(for all enquiries)**	TERESA CLARK 01753 875018

NOTICE OF MEETING

You are requested to attend the above Meeting at the time and date indicated to deal with the business set out in the following agenda.

RUTH BAGLEY
Chief Executive

NOTE TO MEMBERS
This meeting is an approved duty for the payment of travel expenses.

AGENDA

PART I

AGENDA ITEM	REPORT TITLE	PAGE	WARD
	Apologies for absence.		

sustainable forest

AGENDA ITEM	REPORT TITLE	PAGE	WARD
	CONSTITUTIONAL MATTERS		
1.	Declarations of Interest *(Members are reminded of their duty to declare personal and personal prejudicial interests in matters coming before this meeting as set out in the Local Code of Conduct)*		-
2.	Minutes of the Last Meeting held on 2nd September, 2010	1 - 6	-
	SCRUTINY ISSUES		
3.	Heatherwood and Wexham Park Hospitals Trust- Financial Position and Turnaround Plan *(5 mins response to questions raised at previous meeting; 5 mins update presentation; 10 mins Members questions)*	Verbal Report	All
4.	Externalisation of PCT Provider Arm *(15 mins presentation; 25 mins Member Questions)*	7 - 94	
5.	Proposal to re-site Slough Inpatient Mental Health services to Prospect Park Hospital, Reading (Update by Andrew Millard, Scrutiny Officer) *(20 mins)*	Verbal Report	All
	BREAK		
6.	Full Annual Report of the Slough Safeguarding Vulnerable Adults Partnership Board - April 2009 to March 2010 *(7 mins presentation; 20 mins member questions)*	95 - 156	All
7.	Adult Social Care Commissioning Priorities- Overarching Strategy *(10 mins presentation; 15 mins Member questions)*	157 - 180	All
8.	Member's Attendance Statistics	181 - 182	All
9.	Forward Agenda Plan	183 - 184	All

Press and Public

You are welcome to attend this meeting which is open to the press and public, as an observer. You will however be asked to leave before the Committee considers any items in the Part II agenda. Special facilities may be made available for disabled or non-English speaking persons. Please contact the Democratic Services Officer shown above for further details.

Health Scrutiny Panel – Meeting held on Thursday, 2nd September, 2010.

Present:- Councillors Walsh (Chair), Davis, Long, MacIsaac, P K Mann (arrived 6.38 p.m.) and Plimmer

Apologies for Absence:- Councillors S K Dhaliwal A S Wright

PART I

12. Declarations of Interest

None.

13. Minutes of the Last Meeting held on 22nd June 2010

The minutes of the meeting held on 22nd June, 2010 were approved as a correct record subject to an amendment under Minute No 4- Declarations of Interest, to read that Councillor MacIsaac advised that his family members currently work within the NHS.

14. Strategy for the Implementation of "Putting Me First"- Personalised Adult Social Care Services in Slough

Mike Bibby, Assistant Director, Personalisation, Commissioning and Partnerships, outlined a report to inform, consult and seek the views of the Panel on the draft strategy to implement Personalised Adult Social Care Services in Slough and the key recommendations to be presented to Cabinet for decision.

The Panel had considered a report in February 2010, setting out the national policy agenda relating to the future provision of Adult Social Care Services. On 22nd June, 2010 the Panel received a further presentation on Putting People First and it was noted that Members had been briefed and trained on Putting People First under the compulsory Member training programme on 13th July, 2010. The Panel was advised that this session would be repeated in November, 2010. It was noted that the Cabinet would consider the report in September together with an additional appendix.

The Officer outlined his presentation, setting out the priorities for the implementation of the Putting Me First policy. These included the provision of increased choice and control for service users, enabling people to live independently and the provision of targeted preventative support for carers. The Panel noted the benefits of the strategy which included improvements to customer responses at the first point of contact, improved access to consistent and high quality information, and the provision of a reablement service to promote recovery of individuals and minimise the need for long term care. It was envisaged that the outcome would provide individuals with increased opportunities to make informed decisions about their lives, including how their assessed eligible needs could be met. Information and advice

would also be provided to allow people to make an informed choice and enable them to continue to live in their own homes for as long as possible, thereby reducing the overall costs of long term care.

The Officer discussed the four key components of the National policy, being universal services, prevention and early intervention, choice and control, and social capital. It was noted that many changes would be needed, not only in Adult Social Care Services but also in other parts of the Council and within partner agencies including the NHS and independent sector organisations. The Panel noted the range of options and support that would be available to residents, within the Slough service model, and it was noted that for those not eligible for local authority funded social care and support there would be access to information and advice. This would enable residents to make their own choices or to be signposted to the appropriate services and support available in the community which could be accessed directly. Direct access to community based services including leisure and libraries would be available for all residents and community based preventative services would be targeted at available to those with moderate needs. Where individuals met the eligibility criteria for Adult Social Care a personal budget would be allocated and the person would be able to exercise choice and control over how the budget was used to meet their eligible needs. It was noted that there would be a range of more acute service interventions for eligible people at the point of initial referral or where the person had complex needs.

The Council would continue to work with the PCT and build on existing relationships in the area of urgent care and early intervention. The Panel noted that Telecare services would be increased and that SBC had put forward as a Telecare Accelerator Site. The Putting Me First strategy would also provide access to community services with increased opportunities for access to leisure and life long learning etc. The Officer advised that a report on the review of Day Services would be submitted to the Panel for consideration in October.

The Panel noted that responses for customers would be improved and new commissioning strategies and priorities would be produced. The Officer emphasised that it would be important to change the ways that work was carried out and redesign care management structures and functions, including necessary changes to job roles, the merging of teams, etc, and the improvement of customer responses. The Panel noted that Mental Health Services were not being reviewed in the same way. A new personal needs questionnaire and a revised charging policy which was needed to ensure fairness would be introduced in April 2011 following its presentation to Cabinet. It was noted however, that there would be extensive consultation before its implementation in April 2011. Workforce development would be needed for council staff and partner organisations and there would be a need for cultural change and the establishment of learning and development training needs. Market development would include new commissioning strategies and priorities and close work with partner organisations. There would also be the need for new types of services and contracts/procurement

services. In the ensuing debate Members raised a number of comments/questions including the following:-

- A Member asked the Officer to clarify what was meant by the phrase "Telecare" and was advised that this related to the availability of Careline Services which were situated in the Town Hall. An example of Telecare was where a person could wear a pendant attached to their person and through this they would be able to contact Careline Services in cases of emergency. Another example would be the provision of an alarm which would monitor falls. These services would require workforce development and also working with other partner organisations.
- A Member questioned the ability of My Council to meet the requirement to improve customer responses, particularly with initial customer contact. Jane Wood, Corporate Director of Community & Wellbeing advised that CMT had commissioned a piece of work to look at My Council and clearly there were issues where people were not always able to make contact and receive a timely response. It was felt that the current My Council model was not appropriate to deliver a prompt response at the front end.
- In response to a question relating to the flexibility of market providers, the Officer advised that discussions had been held and it was clear that a number of providers were keenly interested. It was noted that providers would be likely to recruit staff who were flexible in how they delivered required services. It was also emphasised that there would continue to be a high number of individuals who would require continued nursing care.
- A Member asked whether staff who answered telephones would be trained for the job and was advised that the model would require that the caller received a quick response and be passed to the Adult Social Care Team. It was important that the team would be able to commission an immediate response especially in cases of emergency. The Director felt that at present calls were not properly triaged and it was also notable that one-third of all calls received did not require services. It was important that these callers were sign posted elsewhere to improve the efficiency of the system.
- A Member asked what was meant by the reference to the Council's Partners and was advised that this included the PCT, the Voluntary and Community Sectors and other organisations, for example, Age Concern.
- A Member noted that under the current system, people had carers but did not pay for this service and also received an attendance allowance. She asked whether the personal budget would cover both. The Officer advised that the attendance allowance was awarded through the benefits system and that in future the Assessment of Need would identify what the person needed to have to spend. In some cases an individual would not want to manage all of their allocated money.
- A Member asked whether a person was entitled to employ whoever they wished to provide care for them and asked, for example, whether they could use a friend. The Officer advised that there were

restrictions at national level and, for example, a person could not employ a wife or husband. The person was also required to demonstrate that the money would be used to meet their individual needs. In response to a comment that this in effect made the person who received care an employer, the Officer confirmed that this was correct but advice and support would be provided for individuals to go down this route. It was confirmed that in future the attendance allowance would continue to be paid separately.

- In response to the concern expressed by a Member that developing a fairer contribution for Slough was important, the Officer advised that proposals would be brought but these would not amount to a radical overhaul. A policy was currently being drafted and case sampling was being carried out. The Officer acknowledged that it was important to make sure that the system was fair and it was acknowledged that there would be losers. At present 25% of users made use of the direct payments system. It was therefore likely that some people who were not charged at present would be charged in future. National recommendations had stipulated that the policy should be looked at and groups were currently being consulted. Some of those already in receipt of direct payments felt that the system would not be fair and the possibility of introducing the scheme gradually would be considered.
- A Member asked whether it would be useful to work with other neighbouring authorities to create a user-led organisation that could work across several areas and was advised that there had been some discussion with Bracknell Forest Council and the Royal Borough of Windsor and Maidenhead. The Director advised that there were some organisations in London which worked in this way and it was hoped that when the Council went out to tender, such organisations would be attracted.
- In response to a concern regarding the misuse of funds, the Officer advised that this was possible now under the direct payment system and it was important to ensure that there were few loopholes in the new system to prevent this from happening.
- A Member asked how often a persons individual needs would be reviewed and was advised that this would happen at least once each year but it could happen more frequently depending on the persons needs.
- In response to a question regarding the correct use of allocated funds the Officer advised that these were checked yearly but would be scrutinised more closely if it was apparent that there were anomalies.

Resolved –

(a) That the Panel note the information contained within the report and the attached draft strategy document.

(b) That the Panel recognises that reform and improvement to the operation of the Customer Service interface, including My Council will be essential to the successful implementation of Putting Me First, and requests that the Cabinet closely monitor the ongoing

business case for customer services and that the relevant Commissioner take a leading role in any recommendations for change to the service.

15. Members' Attendance Statistics

The Panel noted details of Member attendance.

Resolved – That the report be noted.

16. Forward Agenda Plan

The Panel noted the contents of the forward Agenda Plan and a number of items were added.

Resolved - That the Forward Agenda Plan be noted and that the following items be included:

(1) Heatherwood and Wexham Park Hospitals Trust – Financial Position and Turnaround Plan -23rd September, 2010.

(2) Possible re-siting of Mental Health Services to Prospect Park Hospital – Update Report- 23rd September, 2010.

(3) Heatherwood and Wexham Park Hospitals – Outpatient Booking System (John Wood, Deputy Chief Executive) – 25th October, 2010.

Chair

(Note: The Meeting opened at 6.30 pm and closed at 8.02 pm)

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NHS
Berkshire East

Transforming Community Services and Externalisation of Community Provider Services

Integration of NHS Berkshire East Community Health Services and NHS Berkshire West Community Health with Berkshire Healthcare Foundation Trust: An Executive Summary

1. Background and context

National policy and guidance as well as the Strategic Health Authority's guidance have been used to inform local strategic intent as described in the NHS Berkshire East "Strategic Plan 2009 – 2014". The PCTs are required to pursue a programme of transformation that leads to driving up the quality of delivery with an overall reduction in cost. The focus is therefore on two strands of activity: **reshaping demand for healthcare and reshaping supply which will improve quality and reduce cost to the health economy**; e.g. the commissioners in PCTs have clear strategic intentions to move services from acute hospital settings into the community where they will be delivered as close to people's homes as possible.

Strong, stable and financially sound provider organisations are needed to deliver the commissioning strategies which will drive up quality and drive down cost. PCTs currently have provider arms that are delivering services to the local populations. However, it is recognised that the services delivered by these organisations are done so on a historical basis, both in terms of service type and activity levels. More focus and clarity on the commissioning of these services is required and this is difficult when they are part of the same organisation, with a board that has the dual responsibility of commissioning and service delivery.

This tension is recognised in the national Transforming Community Services Programme, which addresses the "externalisation of the community provider services". This requires the PCT to review the best options for the most appropriate and separate organisational form for a future community service that best suit local need and circumstances. The Coalition Government have confirmed that this separation must be achieved by April 2011.

2. PCT Process for Appointment of Preferred Provider

The Transforming Community Service Assurance and Approvals Process (Department of Health 2010) gave direction that the following organisational forms could be considered:

- Integration with an NHS acute or mental health provider
- Integration with another community based provider
- Social enterprise
- Community Foundation Trust
- Continued direct PCT provision
- Care Trust which includes provision

After informal dialogues with potential providers as well as a series of internal meetings discussing the various options, invitations to bid were sent to Royal Berkshire Foundation Trust, Berkshire Healthcare Foundation Trust and Frimley Park Foundation Trust.

Bids were received from Berkshire Healthcare FT and Royal Berkshire FT. Both organisations were invited to present their case to a panel, consisting of executive directors, non-executive directors, and a full time union officer. The panel recommended to the board that Berkshire Healthcare Foundation Trust should be selected as the preferred provider of community services and the PCT Board approved this recommendation.

3. NHS Berkshire East & West Joint Approach

As described above the issue of externalisation of community provider services is being addressed by all PCTs. NHS Berkshire East and West undertook a similar process and both concluded that Berkshire Healthcare Foundation Trust should be invited to provide community health services for Berkshire. With this in mind the two PCTs agreed to work together to produce a joint business case to support the application to transfer their community services to Berkshire Healthcare Foundation Trust. This transaction will result in provider separation from the PCTs that will support the commissioning strategies to deliver quality, innovation, productivity and prevention.

4. Benefits of Externalisation

Berkshire Healthcare Foundation Trust is seen as a successful organisation that has transformed services, especially for those patients with long term conditions, moving services to the community and significantly reducing reliance on bedded services. They have a track record of sound financial management and have received 'Excellent' for quality of services for the past three years. It is expected that the new "merged" organisation would provide:

- A model of care that enables people to access good information on health issues, promotes healthy life styles and supports people to help and care for themselves.
- A system of care that when a person is unwell seeks to provide as much of their treatment at home or as close to home as possible.
- Integrated care that brings together all the professionals a person may need in one pathway to ensure that organisational boundaries do not impair health outcome.

The immediate benefits on integration are seen to be

- Quality of care will improve, reducing costs, as service delivery is standardised
- Sharing clinical and management infrastructure once the services are safely transferred
- Further integration of children's services
- Merging back office functions and achieving other efficiencies through economies of scale
- As a foundation trust, the new organisation will be able to access capital on the basis of affordability instead of the current system of centrally controlled allocations. This will give the facility to more easily improve equipment and working conditions for staff and patients
- The freedom to invest surpluses into services to support local people is something that has not been available to the community health services providers previously

5. The Joint Business Case and Next Steps

NHS Berkshire East and West have worked together to draft the Joint Business Case. This case covers:

- The Local Context
- Commissioning Strategies
- The Case for the Transaction
- Stakeholder Engagement
- Options Appraisal
- Scope of the Transaction
- The Integrated Organisation
- Affordability
- Achievability

An initial transaction project plan has been developed. The key next steps are:

- The Business Case will be reviewed by the SHA as part of the assurance process.
- At the same time, the business case will be forwarded to the Competition and Cooperation Panel for their assessment. It is expected that this business case will follow their 'fast track' process.
- Staff engagement events are scheduled over the next few months
- Regular progress reports will be provided to each PCT board and the Joint Strategic Commissioning Board

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NHS Berkshire West

NHS Berkshire East

Transforming Community Services
Joint Business Case for NHS Berkshire East and NHS Berkshire West

Integration of NHS Berkshire East Community Health Services and NHS Berkshire West Community Health with Berkshire Healthcare Foundation Trust

23rd August 2010

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EXECUTIVE SUMMARY

NHS Berkshire East and NHS Berkshire West, with their colleagues in the Unitary Authorities and Practice Based Commissioning consortia commission services for 919,422 people. Services come from a variety of providers in acute hospital settings with community services mainly commissioned from the provider arms of each PCT.

The commissioning strategies for both PCTs set out the strategic direction for services to be provided, where appropriate, closer to home within an integrated primary community and social care framework.
To deliver this strategic direction, the commissioners plan to transform community services.

National policy for *Transforming Community Services* stressed the need for the "externalisation" of community services from commissioning bodies. This strategic intention was reiterated in the *Revision to the Operating Framework* stating "separating PCT commissioning from the provision of services remains a priority. This must be achieved by April 2011."

Following a period of engagement with key stakeholders both PCT boards agreed that the services currently provided by them should be transferred to another organisation who could meet a series of tests that had been set nationally and locally and that an options appraisal should be carried out to identify a preferred provider(s).

The options appraisal for each PCT independently indicated that Berkshire Healthcare Foundation Trust (BHFT) should be appointed as the preferred provider and at this point the two PCTs agreed to work together to produce a business case for the safe transfer of services to this new provider.

The business case sets out the benefits of the transaction and specifically the opportunities that an acquisition by Berkshire Healthcare Foundation Trust brings.

Berkshire Healthcare Foundation Trust is a successful organisation providing mental health and learning disability services and has transformed services, especially for those patients with long term conditions, moving services to the community and significantly reducing reliance on bedded services. The trust has made this transformation in conjunction with the commissioners and, importantly, with primary care clinical support, and has worked with the GPs and Local Authorities to ensure that new services and pathways meet their needs and the needs of their patients. BHFT have a track record of sound financial management and have received 'Excellent' for the quality of their services for the past three years. The transfer of community services to this organisation will ensure;

- A model of self care that enables people to access good information on health issues, that promotes healthy life styles and supports people to help and care for themselves.
- A system of care that provides treatment at home or as close to home as possible.
- Integrated care across physical and mental health services within a primary and community care base.

The services planned to transfer to BHCT take with them a total of 2,861 staff (2,218 whole time equivalent) and a total budget of £110.9m. These changes will more than double the income of the trust and almost treble the number of staff that it employs. This will require a change of focus for the new organisation and it is currently reviewing the board arrangements.

The successful transfer to Berkshire Healthcare Trust is dependent on a number of factors including approval by the SHA, the Competition and Cooperation Panel and Monitor. It will also be dependent on a successful staff TUPE consultation.

The transfer of staff and services to Berkshire Healthcare Foundation Trust will happen under TUPE (transfer of undertaking, protection of employment) rules which will protect staff employment rights. As Berkshire Healthcare Trust is an NHS organisation, staff pension rights are also protected. This protection of staff terms, conditions and pay will provide reassurance to staff and help with retention ensuring business continuity during the transition and early implementation period.

The business case sets out in detail the significant benefits of the transaction including patient, staff, technological and financial benefits. Examples of patient benefits are highlighted in the table below

Features	Outcomes	Benefits	Possible KPI
Integrated Community Teams	• Ability to support patients in the community and in their own homes for longer. • Earlier discharge for acute patients • More streamlined and 'seamless' care • Reduction in the hand-offs between health agencies	• Reduction in acute admissions • Improved patient experience • Reduction in patient assessments • Improved patient choice	o % patients treated at home o Average Length of Stay, acute o Response time for referrals
Integrated Community Teams – End of Life	• Rapid response teams • Comprehensive and integrated support • Support for patient choice	• Delivers choice for patients and carers • Prevents unnecessary acute admissions • Improves patient experience • Reduces cost	o Response time for crisis intervention o % EoL pathway deaths in a community setting o % reduction in deaths soon after an acute hospital admission o % of patients on Liverpool Care Pathway
Integrated Community Teams – Self-care	• Provides a vehicle for delivery of self care • Easy access to support services and onward referral as appropriate	• Professional and effective delivery of self-care programmes • Timely intervention and crisis prevention as appropriate	o % of Self-care programmes established with patients o number of unscheduled interventions
Integrated Community Teams – Prevention	• Effective means of delivering prevention agenda • Strong infrastructure and existing links to other agencies	• Coordinated delivery of the prevention/Public Health agenda • Reduction in the level of health interventions required • Cost reduction	Existing measures for areas such as: o Diabetes o Smoking Cessation o Obesity
Integrated Community	• Greater scope for management of the	• Coordination of the patient journey	o Number of end to end

Teams – Pathway Management	entire pathway • Berkshire Healthcare Foundation Trust capable of managing the entire pathway through sub-contracting arrangements	• Seamless care • Reduction in 'hand offs' • Cost reduction • Improved patient experience	Care Pathways developed and managed o Patient satisfaction surveys and complaints
Integrated Community Teams – Focus on LTC	• Innovative approach to the management of LTCs • Specific mental health support for patients in this area	• Patients maintained and supported in their own home or care home • Provides a holistic approach	o Non-elective admissions

This is a large transaction which requires close project management to ensure it is completed by 1st April 2011. The trust has allocated £1m and a dedicated project manager as part of their overall change management programme. The project will be overseen by a transaction project board which will have representation from each of the organisations, including that of non executive directors to ensure board assurance of the viability and robustness of the project.

Approvals have been received from

- NHS Berkshire East and NHS Berkshire West at a joint board to board meeting on 8th June 2010 and individually at their board meetings on 23rd June and 22nd June respectively
- The board of Berkshire Healthcare Foundation Trust has discussed the proposed transfer of services from the PCTs to them at each of their board meetings during 2010. This has also been discussed at their Council of Governors. A final decision will be made by the board once the Monitor process has been completed.

The business case is now submitted to the SHA for approval prior to submission to the Cooperation and Competition Panel

An Integrated Business Plan and Long Term Financial Model are being prepared for Monitor assessment and a forward date of January has been agreed with Monitor. The due diligence process is underway and the integrated business plan is being prepared.

1. INTRODUCTION

This document is the jointly produced business case compiled by Berkshire East and Berkshire West Primary Care Trusts to support the application to transfer Community Services to Berkshire Healthcare Foundation Trust.

This business case has been discussed by the PCT boards individually and together during a board to board meeting. Both boards are assured that the transfer of staff and services to Berkshire Healthcare Foundation Trust will bring improved quality and service integration, across primary, community, mental health, acute and social services, giving clear quality and financial benefits.

The business case provides high level details of the transaction. Detailed proposals for service transformation will be contained in the developing 5 year integrated business plan.

The business case sets out the context, and the commissioning strategies that led to the selection of a preferred provider for the acquisition of the community provider arms of the two PCTs. The process of selection is described and the benefits case is set out for the transformation of community services by the preferred provider.

Approval of this transaction will result in provider separation from the PCTs that will:

- Leverage key strengthens from the preferred provider to deliver the transformation required from the commissioning intentions
- Deliver the quality and financial benefits case

2. STRATEGIC CONTEXT

2.1 National Policy

National policy for *Transforming Community Services* stressed the need for the "externalisation" of community services from commissioning bodies. This strategic intention was reiterated in the *Revision to the Operating Framework* stating "separating PCT commissioning from the provision of services remain a priority. This must be achieved by April 2011."

2.2 Local Context

2.2.1 Health Needs

Berkshire is a relatively affluent area with many health indicators better than the national average. However there are significant pockets of deprivation with associated health problems notably in Reading and Slough, which are some of the most challenging nationally.

The PCTs have a registered population of 919,422 people. Of these approximately 13% are over 65 and 23% under 16. The joint strategic needs assessments in both the east and the west of the county have identified that the long term conditions of pulmonary disease and diabetes are likely to increase significantly over the next few years. Both PCTs identify smoking, obesity, dementia and alcohol misuse as priority areas for improvement.

The PCTs commissioning strategies respond to the following challenges;

- Health Inequalities – The need to target communities where health outcomes are substantially poorer than the rest of Berkshire and the national average, and where local residents do not readily have access to the right healthcare. Whilst this is particularly the case for Reading and Slough, it is acknowledged that there are pockets of inequalities in the more affluent areas of the county.
- Demographics - The population of Berkshire is rapidly changing. In common with other parts of the UK; there is an expected increase of 85% in the numbers of people aged 85 and over in the county by 2026.
- Delivering care closer to home – There is a quality and financial imperative to ensure that care can be provided in or close to home and under the control and direction of the individual and their carers.
- Quality and Personalisation – Improving quality remains at the core of the PCTs' objectives, both in terms of outcomes and the patient experience. Coupled with this is the drive to deliver genuinely personalised care tailored to the individuals needs and responsive to their demands.
- Finance - Pressure on budgets across the NHS and social care are expected to increase. Radical change is necessary to ensure that the quality of services and

patient outcomes are not compromised as the financial growth allocations to the NHS and local councils reduce over the coming years.

2.2.2 Financial Considerations

The PCTs financial plan is underpinned by four core assumptions:

- The need to recognise and manage the cost of providing core primary and secondary care services in a very challenging economic environment and in a way that allows for increased and improved access and choice, demographic change and new technological developments.
- The desire to increase the commissioning of integrated whole care pathways that result in an appropriate and proportionate shift of activity closer to home and which offer the right mix of quality, safety and value
- The need to make long term commitments to targeted health promotion and prevention work, where that work can be shown to avoid future costs and demand on services
- The expectation that we will continually seek to provide best value for money through strong internal management, effective contracting and procurement, the development of the local provider market and transformation in the way health and care services are provided in Berkshire.

3. COMMISSIONING STRATEGIES INCLUDING THE TRANSFORMATION OF COMMUNITY SERVICES

3.1 Commissioner organisation

Health and social care services in Berkshire are commissioned by NHS Berkshire East, NHS Berkshire West and the 6 Unitary Authorities: Bracknell Forest, Reading, Royal Borough of Windsor and Maidenhead, Slough, West Berkshire and Wokingham each of which has its own strategic priorities based on the needs of its population. There are twelve "GP Localities" or practice base commissioning consortia across Berkshire – 7 in the West PCT and 5 in the East – who will be increasingly at the forefront of commissioning decisions.

3.2 Population Feedback

When producing their commissioning strategies, the commissioners have engaged with local people across the communities in Berkshire about the future of service provision, the impact of the ageing population, the need for preventing the onset of disease and the impact of the economic climate. There is also regular "real-time" feedback from patients that is heard and acted upon.

Common themes have arisen from those conversations – local people want:

- More emphasis on prevention with better communication and information for people on their health and how to keep well
- To be treated out of hospital and close to home when ever possible
- Responsibility and management of their own care and help for those who most need it when they need it. For example heart disease, diabetes and pulmonary disease
- A focus on tackling disease and its causes:
    - Smoking
    - Childhood obesity
    - Alcohol and drug misuse
- Partnerships between care providers so that services are seamless and more closely aligned with GP services.

3.3 Vision for improved services

Working with local people using these themes and taking into account the needs of the Berkshire populations, the commissioners have developed a vision for improved health and services (Appendix 1):

- In the East: *Improving the Overall Health of our Population and reducing inequalities*

- In the West: *Keeping People Well and Out of Hospital*

As a provider of services delivered mainly in the community and recognising the need for prevention, Berkshire Healthcare Foundation Trust has the vision of *Helping People be well and stay Healthy*

The fundamentals of these visions are the same and collectively the 3 organisations are agreed that their vision for community based services in Berkshire is: *Improving Peoples' Health and Keeping Them Well*

In delivering the commissioning strategy and achieving the ambitious outcomes there will be implications for Berkshire providers. This strategy will lead initially to a plateau and then a reduction in the level of activity within the acute sector and a continuation in the shift of health care from acute bed based to community provision.

At the same time community services will see a dramatic change in their role as they become more closely integrated across the system, providing an ever increasing range of sub acute services. They will also be instrumental in the developing role of primary care in managing and treating patients at home.

To achieve this ambition, there needs to be a transformation in service design and delivery across all services and care pathways. Providers will need to work together across the health and social care economy to ensure that pathways are fully integrated and supported by flexible services.

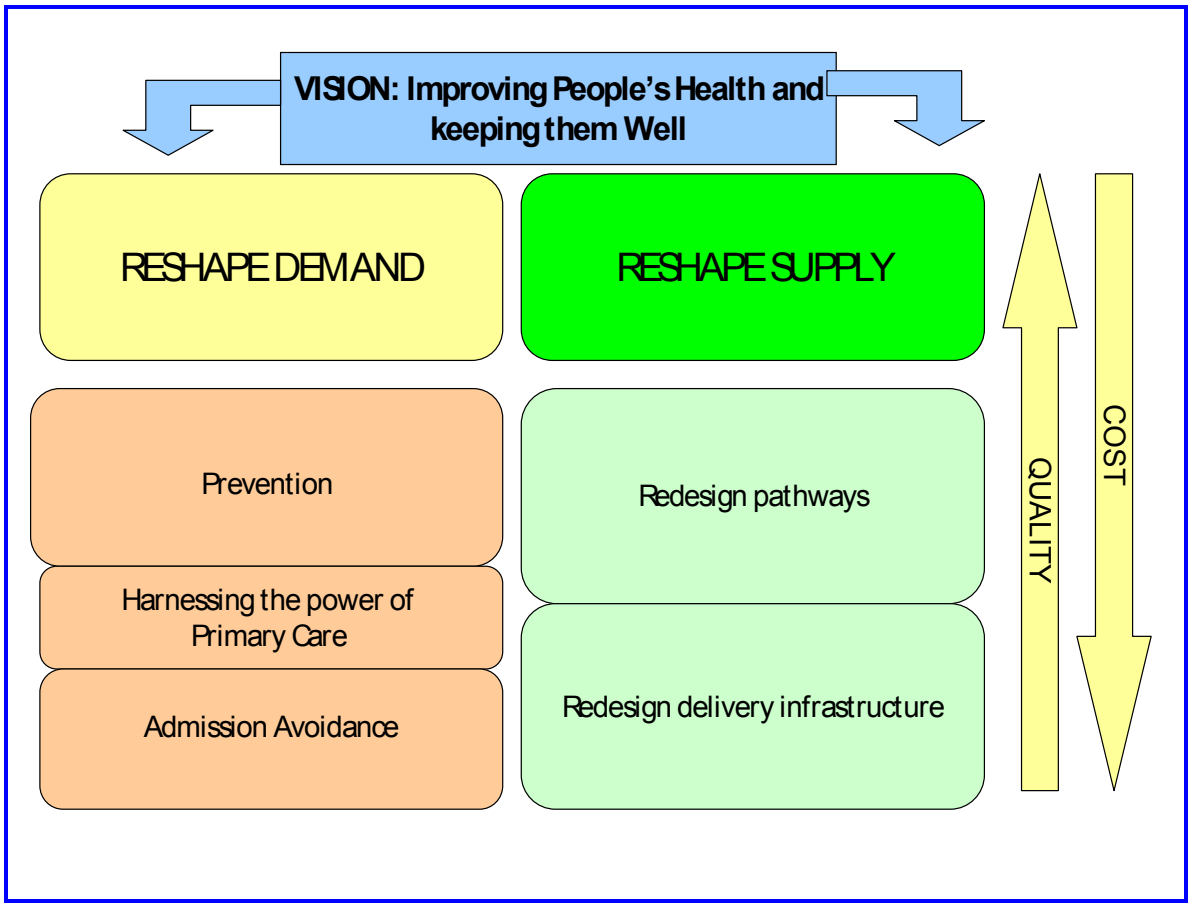
There will be drive by both PCTs to secure value for money from all contracts while improving service quality. This will also encourage providers to work more closely together to improve the patient care pathway.

In order to manage the consequences of this direction NHS Berkshire East and NHS Berkshire West, including their practice based commissioners and local authorities, are working collaboratively with NHS Buckinghamshire and the major providers on a programme to determine the future arrangements for acute services: Care for the Future. This programme is clinically driven and reviews and defines the future arrangements for acute care in four areas: urgent care, planned care, long term conditions and end of life, and maternity and paediatric services. This programme supports the PCTs and providers in mapping out a clinical and financially sustainable range of services that address the needs of the communities.

The development of community based care is a strong component of this work and requires significant service transformation in a short timescale.

3.4 Programme for Transformation

Given the challenges the PCTs face as leaders of the local NHS and with responsibility for overseeing the management of the local health care system, the PCTs will pursue a programme of transformation that leads to an overall reduction in cost, while driving up the quality of delivery. Each PCTs' strategy is to maximise the productivity of existing services and invest in new services that will enable disinvestment opportunities elsewhere in the system. This will be achieved by encouraging, developing and supporting a range of willing, innovative and competent providers who are able to deliver services within a constrained financial envelope.
The focus is therefore on two strands of activity: **reshaping demand for healthcare and reshaping supply which will improve quality and reduce** cost to the health economy.



Reshaping Demand for Healthcare

This will be achieved by:

- Prevention: commissioning initiatives to improve health and wellbeing and prevent ill health so that over time, the health of the population improves and therefore the disease burden and cost burden reduces
- Harnessing the Power of Primary Care: Working with Practice Based Commissioning (PBC) to reduce referrals into secondary care and commission services which increase the number of patients managed in primary care. Implementing the PCTs' Primary Care Strategy and driving up quality and productivity in primary care through the implementation of Practice Profiles and a robust approach to the contracting of primary care.
- Admission avoidance: Commissioning programmes which identify at risk patients, monitor their health and provide health interventions to ensure that they remain at home (for example Case Management)

Reshaping supply
There are two key strands to the PCTs' approach in this area:

- Integration of community services and
- Reconfiguration of acute services

In conjunction with the clinicians, the local GPs, the Local Authorities and the patients & carers, the commissioners will:

- Redesign care pathways: Each specialty and pathway will be reviewed and transformed to enable more care to be provided in a community or primary care setting. This will improve quality for patients, ensuring that care is clinically and cost effective and evidence based. This will involve setting thresholds and intervention rates for some procedures.
- Redesign delivery infrastructure: This will be achieved by implementing market interventions such as competitive tendering, competitive dialogue, consolidation of provision and vertical and horizontal integration to redesign the way that services are provided introducing new providers in to the market to drive up quality and productivity and stimulate innovation.

It is increasingly clear that the PCTs will not be able to address the new challenges in isolation. Each PCT has well developed relationships with its local acute trust and unitary authority partners and the integration of local services to maximise efficiency will be a key part of their strategy.

3.5 Transforming Community Services

During 2009/10 both NHS Berkshire East and Berkshire West have reviewed their commissioning strategies and set out their initiatives for improving health outcomes (Transforming Community Service Strategies Appendix 1). Although there are some differences which reflect the differing priorities of local communities, there are a significant number of strategies that are working to deliver the same aims. These are summarised in table 1 below and further details of the goals and initiatives of each PCT are given the PCTs' strategic plans in Appendix 2.

Table 1: Strategies to Support improved healthcare focused in the Community

East	West	Synergy of outcome	Common initiatives	Other initiatives	Outcome indicator
Staying Healthy	Health and Wellbeing and reducing health inequalities	Improved health promotion; early intervention innovative and targeted health promotion. Greater joint working with local partners LSP Reducing inequalities	Smoking Obesity IAPT	East High risk CVD Social marketing TB West Alcohol Sexual Health	Smoking Quitters Yr 6 obesity Redn inequalities Alcohol admissions Teenage pregnancy CHD controlled blood pressure. Diabetes controlled blood sugar. Increase in life expectancy
Improving Access	Acute Care Closer to Home	Clinically led pathway redesign Better management of access and referrals Improved productivity in primary care Achieving best practice in care	Peer Pathology MSK Urology Dermatology Gynaecology Stable Glaucoma	East Cardiology Oral Surgery Diabetes West DMARDS Endoscopy ENT	Access Access in 1° care 18 weeks – admitted and non admitted by specialty Diabetes controlled blood sugar CHD controlled blood pressure.
Preventing Crisis Providing Support	LTC and rehab	Excellence in access to unscheduled care Greater application of information and technology to improve outcomes Supporting people coming out of hospital Re enablement	Single point access Risk stratification Rapid assessment Telehealth Community teams focused at LTC eg COPD End of Life care	East Urgent Care Intermediate care Stroke West Rehab – cardiac pulmonary Falls	A&E 4 hr Stroke TIA Stroke % time on unit Alcohol admissions COPD rehabilitation and mortality

East	West	Synergy of outcome	Common initiatives	Other initiatives	Outcome indicator
		Supporting people at home rather than being admitted to hospital hieving best practice in re	Neuro rehab Dementia	Home oxygen Com IV	
	Children and Young People	Improved support for children in the community Investing in a future for children	Children's continuing Care	West Sexual Health CAMHS East Breast feeding Paed hosp at home	Teenage pregnancy CAMHS Breastfeeding initiation rates Immunisation
System Alignment		System management Strategic Alignment Management of Demand Improved Quality and Productivity Integrated services Enabling NHS staff including clinicians to bring about change	Care for the Future Next Generation Care Workforce Market Management OD COM and CES	East Quality and Productivity in community services; Mental Health Services and acute e.g. pathology	18 weeks QIPP productivity targets

4 MARKET APPROACH

4.1 Current Structure

The current market structure is a large market share held by a few providers, emphasising the requirement for commissioners to manage choice and develop the market where this would improve outcomes for patients.

Berkshire is well positioned to provide choice due its favourable location bordering Oxfordshire, Buckinghamshire, Wiltshire, Hampshire, Surrey and London providing plenty of opportunity for Commissioners to engage with other Providers. The PCTs are committed to promoting a diverse but well managed local market of health care provision. Our approaches to market management, strategic relationship management and contract management are designed to achieve these aims and are discussed in the next section.

Some of the key features of the current local health care market are summarised below.

4.1.1 Community Services

The PCTs commission community health services from five providers: Berkshire West Community Health, Berkshire East Community Health Services, Hampshire PCT, Oxfordshire PCT and Buckinghamshire PCT. The PCTs provider arms are the majority providers for community health services to their populations. Details of the PCT provider arms are shown at appendix 3.

Other community providers that border the PCTs' geography include Swindon PCT, Surrey PCT and several London providers.

The PCTs now have formal contracts in place with their own provider arms. These include performance standards, service specifications, quality and information metrics. The standard national community contract is used for both providers.

4.1.2 Acute services

Two NHS providers, Royal Berkshire Hospitals NHS FT and Heatherwood & Wexham Park Hospital NHS FT, hold a prominent position in the local market and are the provider of choice for most local patients, though to the south, Frimley Park Hospital NHS FT is a significant and growing provider of care. The PCTs are similarly the single largest commissioner of services from the Trusts.

There are a number of other local providers in acute care in particular, who feature as the provider of choice for some patients. This is particularly the case in certain parts of the PCTs geographical patch. These providers are Oxford Radcliffe Hospitals NHS Trust, Swindon and Marlborough NHS Trust, Basingstoke and North Hampshire NHS Foundation Trust (BNHFT), Buckinghamshire Hospitals Trust (BHT) and Royal Surrey Hospital Trust.

Within the local patch, there are a number of Independent Sector providers offering acute services, including Reading ISTC and Dunedin Hospital in the West and Princess Margaret Hospital in the East.

The PCTs commission a range of tertiary services with specific providers, most notably trusts in Oxfordshire and London.

Berkshire West PCT holds a total of 28 contracts with NHS Trusts and Foundation Trusts, while Berkshire East holds 16 contracts plus specialist contracts with for example, London Hospitals.

Both PCTs have robust approaches to supporting patient choice with patients stating high levels of satisfaction in the choice survey. Whilst both PCTs collaborate with their major providers to improve quality both organisations have also tendered out services in the past where there have been significant concerns in terms of quality and cost e.g. dermatology. In addition through PBC there is an increasing range of Tier 2 services set up as alternatives to secondary care which have replaced some traditional outpatient and day care activity. These include ophthalmology, dermatology and gynaecology. It is the PCTs' intentions to continue to extend the range and variety of services that they commission for their populations which will lead to further choice.

4.1.3 Primary Care

There are a large number of providers in the primary care field, reflecting local accessibility and a high level of diversity in the market. The standard of primary care provision is generally high with GP practices scoring very highly against the Quality and Outcomes Framework (QOF).

Community Pharmacists play a key role in delivering patient care in the PCTs. In Berkshire, a number of interventions are commissioned from community pharmacists, including smoking cessation, weight management, drug misuse and emergency hormonal contraception.

There is a network of Optometrists in the patch, ensuring that patients have access to professional eye care services supporting prompt identification of health issues which require onward referral through agreed referral pathways.

The PCTs are also looking to strengthen the commissioning of primary care to ensure that the transformation of this sector keeps pace with the transformation of acute and community services to deliver the scope and scale of change required.

As echoed across the country there is sub-optimal access to dental services due to lack of capacity in the market. To address this and stimulate the market the PCTs are both currently involved in a wide ranging procurement process to support the implementation of the national dental access programme. This procurement is being managed across 5 PCTs in the Thames valley.

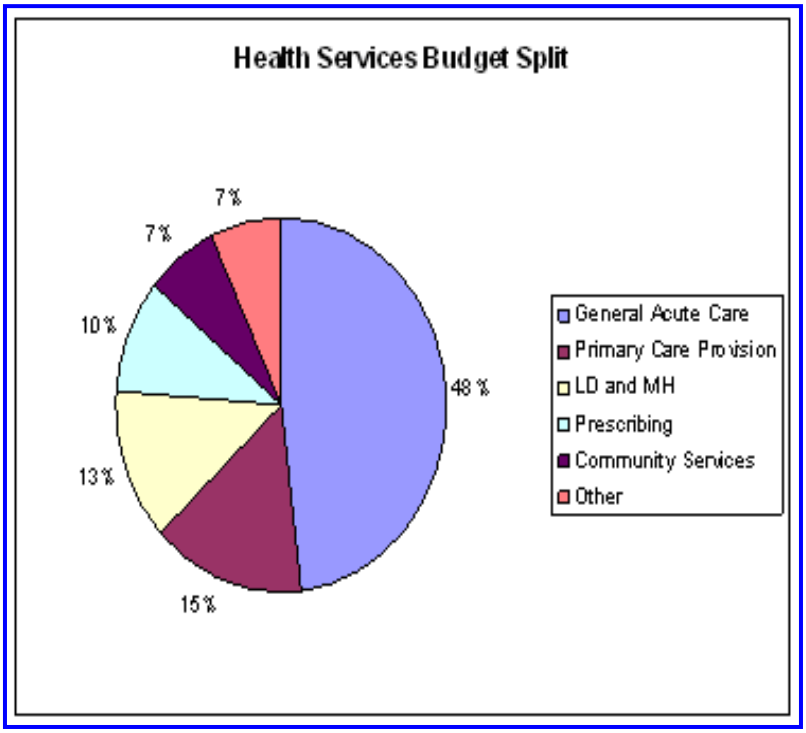
Similarly the PCTs have also purchased additional services in General Medical Practices through procurement, for example the extended access practices. These

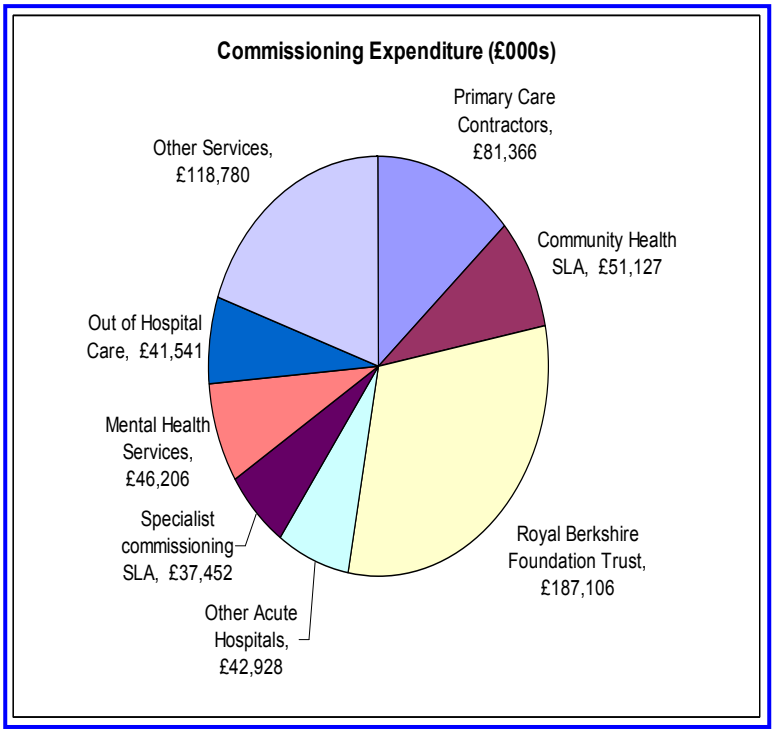
initiatives have resulted in both private and NHS providers being awarded the contracts.

4.2 Contracts

The apportionment of expenditure by each PCT is shown at figure 1 below:
Figure 1

NHS Berkshire East ***NHS Berkshire West***





4.3 PCTs current approach and track record of market development

The PCTs both on their own and through PBC have already established a track record of service redesign and of introducing new providers into the local healthcare market. A range of approaches and market management iniatives have been adopted in delivering new services. The work covered to date includes:

- Local enhanced services - e.g. methotrexate, Chlamydia screening
- Primary care based provision e.g. community gynaecology, community heart failure
- Integrated provision between secondary care and GP/Private partnership – e.g. Dermatology
- Community based independent sector - dexa scanning, oral surgery, ophthalmology

- APMS contract through open procurement - GP led health centre provision – with solutions ranging from private company and GP consortium to NHS provision
- voluntary sector - drugs counselling and treatment , foot care

The approach is now governed through the individual PCT's market management and procurement frameworks. The aim of appropriate market management is to use transparent, open and fair market management practices enabling the commissioners to identify, manage and develop a market of high quality healthcare providers able to deliver safe and evidence based services with an appropriate balance between plurality, patient choice, sustainability and value for money. The objectives of market management:

- Support the delivery of the PCTs' Strategic Plans and achievement of the goals
- Ensure that there are clear guidelines to help manage the process, and encourage competition and co-operation amongst suppliers
- Limit any legal issues that may arise via non compliance with national and international procurement rules
- Deliver value for money (VfM) for the PCTs and the community they serve
- Increase patient choice in line with the NHS Constitution
- Use the opportunities within the national contract to improve the quality of care within the market as it exists

In summary, the commissioners will develop the market to make health care:

- More accessible
- More efficient
- More responsive

4.4 Provider landscape

The delivery of the PCTs' strategic intentions will lead to changes in the provider landscape in the future. There are likely to be shifts between providers, shifts within providers (in place or type of service for example) or the introduction of new providers.

The PCTs recognise that there is more to do in relation to fully understanding the full provider landscape. However, they are aware from experience that the response from the market is different dependent on the service/sector that is being tested. For example, there has recently been an overwhelming response to the tender document for primary dentistry provision across the county while there were more limited responses for an integrated community based dermatology service. The market development framework provides a good indication of which types of providers are likely to respond to which service or sector and this will be enhanced by the information available from the Commissioning Enablement Service (CES) as that is developed further. This information is used to agree the most appropriate

procurement route for that development. As part of the procurement process, opportunities for providers to test their ability to respond, to introduce themselves to commissioners and to learn more about potential future market testing, are provided through open days and informal meetings.

The PCTs work strategically with their main providers to assure and improve the quality of services. However in order to drive these quality improvements, there is a need to ensure that there is healthy, managed competition in the healthcare market. This is one of the reasons that the PCTs are committed to ensuring that there is a genuine choice of provider available for the Berkshire population.

4.4.1 Choice

One of the market interventions the PCTs will use in stimulating change and improvement is ensuring that Patient Choice is well understood by patients and able to be exercised. Each PCT has a developed choice and access strategy, the development of which takes this concept further and contains specific plans to improve choice take-up. The range of options includes plans for:

- The full roll-out of Choose and Book to cover all GP practices,
- Development of choice support for patients through an assessment centre plus initiatives to promote awareness of choice amongst patients, and particular BME groups.
- Consideration of how to improve patient awareness and take-up of choice in non-acute services, such as in primary care and dentistry.

An important part of the PCTs' approach to Choice is increasing the availability of alternatives to acute care, in settings which are not acute hospitals and in locations closer to home where possible and appropriate. Some of this work has already been developed as described above.

For patients at the end of life, important steps forward have already been taken in promoting choice of place of death by implementing a range of changes to the services, appropriate to the needs of individual populations. NHS Berkshire East have undertaken a significant piece of work around this subject and it now forms part of the PCT's 2010/11 work programme. Berkshire West has implemented a community based 24/7 nursing service for this client group which has been an important step forward in this respect as it offers a real alternative to unplanned admissions to hospital and giving patients who want to die at home the ability to realise this choice.

4.4.2 Cross-organisational approaches

The PCTs are also promoting alternative models of provision to facilitate service transformation that increasingly cut across organisational boundaries. Recent examples include new community geriatricians funded by the PCT but employed by

the acute Trust to support the reduction of avoidable non elective admissions amongst older people, realignment of community based consultants to support the reconfiguration of services for long term care in the community, and extended services provided by GP s with specialist interest.

4.4.3 Acute reconfiguration

Alongside the drive to commission more services in primary and community-settings, there is clear scope, as medical technology and expertise develops, for services traditionally provided in specialist centres or as tertiary-only interventions to be shifted into local acute settings. The PCTs work through clinical networks, such as the Cancer Network and the Cardiovascular Network to progress these issues. Inter-provider cooperation at speciality level is likely to be a key feature of local commissioning and delivery plans, to enable the development of centres of excellence and to ensure sustainable services. With increasing sub-specialisation in some specialities, this is likely to be the recurring pattern in some services e.g. the development of the vascular and new cardiac services

4.5 PCT assessment of short to medium term market structure for community services

In constructing the strategic objectives for service segments in their Transforming Community Services Strategies, the PCTs have used market analysis tools to determine at a high level the likely market interventions that would achieve strategic aims. This assessment has considered the existing market structure, consideration of the ease of market entry and the balance with safe and sustainable service delivery through the right number of providers for the activity available. The PCTs recognise the need to consider the Any Willing Provider model for community services as well as services moved into the community from secondary care, as set out in the refreshed national procurement guidance.

For community services the short term assessment is that the market for community health services is largely limited to existing providers. This is in the main a result of most service redesign leading to the letting of contracts, being focused on transference of tariff based secondary care into community settings and community services operating under block contracts.

The PCTs recognise that for this to change for community health services, a move away from block contract arrangements to tariffs for services and greater clarity on the risks between health and social care commissioners where the same resource delivers services to both will need to be addressed.

As the market interventions to deliver strategic objectives are highly influenced by the state of the current market, these will be refreshed annually as part of the PCTs market development plan. In the medium term the PCT assessment is that the strategic objectives to deliver integrated models of working will lend themselves to new provider models and partnerships between existing and new providers. It is likely

that GPs will further consider their role in provision or partnering in provision of community services and it is likely that the provider sector brought into the market to provide previous secondary care activity will mature to expand their scope into community services.

4.6 Risks related to market interventions

There are clear risks to commissioner and existing and new providers in enacting market interventions and it is paramount that business cases for change consider the mitigation strategies and that the demonstrable and measurable patient benefit is balanced with these risks. The PCT role as system manager will be to ensure that the implications of market intervention on the structure of supply (services) are considered so that patient safety is not affected through organisational change. The risks for the provider in this transaction are related to the partial or total loss of services and any stranded overheads or detrimental impact on the organisations ability to manage its financial position.

The risks to the commissioner are both financial and operational in the risk of moving away from block contract and fixed (capped) expenditure for services, and the potential increased transactional costs of managing more providers. There is also the risk that new market entrants do not attract enough activity to remain viable and that provision is lost from the market.

The risks to new market entrants, in particular smaller Any Willing Providers, is that they may find themselves competing with larger organisations with greater economies of scale to offer commissioners and that there is no guaranteed income for the costs they will have to put in place to operate. The PCTs will ensure that procurement approaches and information does not preclude market entrants on the basis of size or experience in bidding for NHS community services.

4.7 Commissioning Intentions and implications for market development

Both PCTs produced a Healthcare Services Procurement Framework (Appendix 4), highlighting the considerations and decision trees required where procurement is taking place, in the environment of internal and external rules and regulation on the procurement process.

This transaction encompasses the transfer of the PCTs' provider arms to Berkshire Healthcare Foundation Trust, but that does not mean that the services are in any way immune to market testing or competition and the creation of additional patient choice.

The PCTs will be placing a three year contract with the new provider for all services, except where specific circumstances apply. An agreed principle to effect safe transfer and maintain service stability while transformational activities take place is that no notice will be served in the first year of the contract. The PCT rationale for supporting this principle is that the business case development and state of the

current market do not suggest that market interventions in year one will be required to effect commissioning intentions. This is balanced with a principle of transparency of how efficiencies will be delivered to all commissioning stakeholders and a process for all service specification development to transform service delivery to include all commissioning stakeholders.

There are a number of services where funding streams are non-recurrent or where commissioning intentions or service reviews may require a market intervention in the first year of the contract. In those instances, contractual notice will be served to the existing contract before the contract commences with Berkshire Healthcare Trust. A full set of these circumstances will be included within the full commissioning intentions due for completion by mid September.

Commissioning Intentions will focus on outcomes to encourage innovation in existing service delivery and when new services are put to the market.

The PCTs will be detailing the potential community investment where plans to disinvest in secondary care and provide alternatives in the community are intended. These areas of community investment will individually through business case development consider the appropriate procurement approach, and will lend themselves to a developing community provider market.

5 OPTIONS FOR ORGANISATIONAL FORM

5.1 Overview

The PCTs were aware that a service driven commissioning strategy would not deliver a definitive answer on the future organisational form of their Provider arms. Later guidance firmly established the prioritisation of robust strategic commissioning plans that pass the Quality, Innovation, Prevention and Production (QIPP) test ahead of the development and assurance of the proposals for future organisational form. However, it was recognised that the transformation would, to a great extent, depend on the availability of high quality, sustainable and flexible community provision if the challenges were to be met.

5.2 Options Appraisal process

When making the decision on the future provider of community services, the PCTs were aware that there were two parallel processes in play, one to move an appropriate collection of services to another external organisation with a transaction, and the second to continue market interventions for individual categories through the normal strategic sourcing approach.
The first of these was a management process that sought provision in the first instance from the NHS or local authorities. Although this process was not deemed as procurement a robust and transparent selection process was put in place. In parallel with this process individual categories of care have continued to be subject to market interventions as planned.

The Transforming Community Service Assurance and Approvals Process (DH 2010) gave direction that the following organisational forms could be considered:

- Integration with an NHS acute or mental health provider
- Integration with another community based provider
- Social enterprise

Also but not expected to be the norm and partnered by strong commissioning

- Community Foundation Trust
- Continued direct PCT provision
- Care Trust which includes provision

It was noted by each organisation that timings of market interventions are critical in assessing the impact on staff should the management transaction result in another move for staff following the market intervention.

5.2.1 Options

Broadly 8 options were considered;

1	**Do nothing and remain as a directly provided organisation**
	The PCT boards noted that the TCS guidance makes clear that PCTs should concentrate on being commissioning organisations. It was anticipated by the Department of Health that Directly Provided Organisations would not be the norm, and would need to pass stringent tests including being able to demonstrate the provision of exceptionally good services that are sustainable and support pathway change, in the presence of commissioning of the highest standard. This latter was defined in the operating framework; 'by April 2011 all PCTs are expected to have attained a 'green' rating for governance, and at least seven out of 11 competencies in each PCT should be rated 3 or above. PCTs should also be on trajectory to deliver agreed improvements in health outcomes' All decisions made by the PCT Boards were to be assured by the Strategic Health Authority and it was recognised that it was the view in South Central that PCTs should focus their efforts on becoming world class commissioners. In addition, it was unlikely that DPO proposals would meet the DH tests (appendix 5). This option was therefore not considered any further.
2	**Merge the two provider arms of Berkshire East PCT and form a Community Foundation Trust**

	The boards noted that the TCS guidance set out that Community Foundation Trusts were likely to be an option for very few areas. It was expected that if there were any CFT proposals in addition to the original 6 pilots, these would be 'strong proposals' and at an advanced stage of preparedness. It was recognised that neither of the provider arms were at this stage of planning or preparedness. In addition the boards were mindful of the management costs associated with establishing new organisations in the current financial climate. This option was therefore not considered any further.
3	**Form a social enterprise for delivery of the provider arm**
	In NHS Berkshire West 2 small sections of community nursing had expressed interest in forming social enterprises but no formal 'Right to Request' was received by the PCT. There had been no interest shown in this model in NHS Berkshire East. Overall, staff who had attended engagement events to discuss TCS had shown no support for social enterprise. The boards also noted that setting up a social enterprise was not possible within the timescales given for TCS and that this option was not supported by staff side colleagues. This option was therefore not considered any further.
4&5	**Integrate with an acute hospital trust or mental health care trust (FTs)**
	It was noted that this is the option most likely to be achieved within the timescale set for TCS, especially as the Foundation Trusts (Royal Berkshire Hospital, Berkshire Healthcare and Frimley Park) are performing well. Integration with any of the organisations would allow the local NHS to better align local goals and transfer or integrate care across all pathways. Heatherwood and Wexham Park was not considered at this time as the trust was not considered to meet the DH tests (appendix 5) The other 3 Foundation Trusts were likely to meet the Department of Health tests and would be marketable to staff who would maintain their terms and conditions including access to the NHS pension. It would also enable staff to remain within the NHS, an issue that has been raised as being important to them. However, it was noted that a wholesale transfer of services to one organisation might mean that service transformation, for example integration across care pathways, might have to take place at a later stage with a potential second move for staff. In addition there were concerns that if services were moved to an acute organisation, there is a possibility of staff being 'pulled' into the hospital setting during times of

	crisis leaving community services short staffed. If the destination for services was the same as that for Berkshire East/West, there could be some economies of scale leading to financial savings. The NHS organisations would meet the DH tests and additional principles required by the board.
6	**Integrate with local authority(s)**
	This option may have been harder to achieve within the timescales, especially as there will be the need for full member support in each of the councils. While staff terms and conditions will transfer with them, pensions will have to transfer to the local government scheme and access to the NHS pension scheme will be lost. There is staff and staff side support for this option although not as strong as that for integration with an NHS trust. It is recognised that this option may not be delivered within the timescales and that a transfer of services to an NHS organisation may be needed while the arrangements for joint commissioning leading to service transformation are put in place. Local authorities have the lead for children's services, via the Children's Trust. Integrating children's services with one or more local authority enable integrated care across a pathway and provide a more seamless service for those children and their families. In Reading and Wokingham, Health Visitors and to some extent, School Nurses, work as members of integrated teams with a joint manager. Some services are too small to be split into three organisations, for example Children's Physiotherapy, and a 'hosting' arrangement would need to put in place where staff are employed by one authority and provide services across all three. This is already in place for some council run services such as the Joint Legal Team. However, the councils have no history or expertise in delivering health services and measures to ensure clinical supervision and clinical governance would need to be firmly embedded as part of the transfer process.
7	**Integrate with another community provider (e.g. Voluntary Organisation, GP practice, Limited Liability Partnership set up around a PBC group)**
	Local Practice Based Commissioning Groups have organisations associated with them to enable service delivery and interest in providing some services has been shown by these organisations. There were no community providers who would meet the DH tests and

	enable delivery of a new organisational form within the timescales laid down in guidance.
8	**Managed dispersal of services along patient care pathways**
	NHS Berkshire West had been in discussions with PBC leads and local authorities in some areas about the development of integrated care organisations. However, none of the organisations alongside the PBC consortia or the local authorities were in a position to take the services from 1st April 2011. The PCT was keen to ensure that the integration agenda should not be lost and for this reason, services were 'bundled' along patient care pathways • Services to support admission avoidance, patients with long term conditions and rehabilitation • Services to support health and well being • Services for children and families to enable NHS organisations to bid to provide certain elements of care

5.2.2 Outcome

Options 4 and 5 were considered by both PCTs and NHS Berkshire West also considered options 6 and 8. However, there were no bids for individual care pathway 'bundles' and none of the local authorities were in a position to acquire services for children and their families within the timescales. Therefore, options 4 and 5 were those considered further by the PCT.

NHS Berkshire East

Invitations to bid were sent to Royal Berkshire Foundation Trust, Berkshire Healthcare Foundation Trust and Frimley Park Foundation Trust. The major acute trust for the PCT was experiencing financial and performance difficulties and was therefore not invited to bid.

Bids were received from Berkshire Healthcare FT and Royal Berkshire FT. Both organisations were invited to present their case to a panel, consisting of executive directors, non executive directors, and a full time union officer. Following the presentation (appendix 6) by each provider, the panel questioned the bidders further on their presentations.

The panel recommended to the board that Berkshire Healthcare Foundation Trust should be selected as the preferred provider of community services and the board approved this recommendation.

NHS Berkshire West

Invitations to bid were sent to Royal Berkshire Foundation Trust and Berkshire Healthcare Foundation Trust. Opportunities were given for the organisations to submit questions to the PCT. Following this period, Royal Berkshire Foundation Trust decided not to proceed with a bid to provide any services and Berkshire Healthcare Trust submitted a bid to provide all services.

Berkshire Healthcare Foundation Trust was invited to present their case to a panel comprising executive directors, non executive directors, representatives of adult and children's services from the UAs, representative from LiNKS and the chair of staff side.

Berkshire Healthcare Foundation Trust was able to assure the panel that they would be able to safely transfer staff and services within the necessary timescale and that they were best placed to support their provider staff in achieving the vision for community services.

The panel recommended to the board that Berkshire Healthcare Foundation Trust should be selected as the preferred provider of community services and the board approved this recommendation.

When identifying the preferred provider the PCTs asked that the organisations demonstrate their overall approach to partnerships, staff, safeguarding, patients and carers, quality, safety and clinical governance, change and improvement of practice - developing models of care, economics and benefits of integration.

In response to each PCT, Berkshire Health Care Foundation Trust demonstrated their alignment with a shared vision and goals for community services (appendix 6) and ability to deliver the strategies and objectives of the commissioners in addition to the Department of Health tests.[1] (appendix 5).

It was therefore agreed that the services and staff of the provider arms of both PCTs would transfer to Berkshire Healthcare Foundation Trust on 1st April 2011, subject to approval by the Cooperation and Competition Panel and Monitor.

Discussions between West Berkshire District Council, community nurses and the Newbury and Community Practice Based Commissioning Group have been taking place and will continue to ensure that the development of integrated working continues in the writing of the new service specifications and agreements with Berkshire Healthcare Foundation Trust. Wokingham Borough Council has also expressed an interest in integrating services with those it provides for people with long term conditions and rehabilitation needs, within an arms length body. Discussions will continue with these groups and Berkshire Healthcare Trust to achieve this ambition. The commissioners will use contractual methods to avoid multiple TUPE for staff..

5.3 Stakeholder engagement

5.3.1 Overview

[1] Transforming Community Services Assurance and Approvals Process

Stakeholders have been engaged at all steps of the process, beginning with the development of the commissioning strategies based on the joint strategic needs assessment, the transforming community services strategy and options for the provision of provider services . They have participated in the assurance checks of the proposals that came to the PCTs and were part of the selection process for the preferred provider.

5.3.2 Public

When developing the commissioning strategies, each of the PCTs embarked on a period of public consultation. Details of the outcome of this consultation is summarised in section 3 above.

The commissioning strategy and Transforming Community Services has also been discussed at the board meetings in public in both PCTs and also at the Health Network in NHS Berkshire West and the Health Panel in NHS Berkshire East.

As this process is considered as a management transaction and not a service change, there has been no formal public consultation as part of this process. However, there will continue to be dialogue with and engagement of key public and patient involvement groups, especially patient panels attached to GP practices, to discuss future service changes.

5.3.3 Staff

Both PCTs recognise the important role of staff in delivering services to patients and enabling service transformation.

Across Berkshire staff engagement events for community services were held before a decision was made on the preferred provider. There was staff side presence at these events.

Large staff engagement events had been held over the last twelve months, which have all had a representative from the Department of Health's Transforming Community Services' team to present.

Further staff engagement events have been held following the decision on preferred provider and more are planned following approval of the business case. The planned engagement events will have representatives from the PCT provider organisations, Berkshire Healthcare Foundation Trust and staff side representatives.

Each provider has a Joint Staff Consultative Committee (JSCC) and, following discussion with full time officers, an event has been planned for these committees to meet together at the beginning of August. Transforming Community Services has been and will remain a standing agenda item for the JSCCs in the PCTs. Formal staff side responses to the proposal are attached at appendix 7. Staff side representatives were present at both panels that were held to assess the proposals from prospective providers.

During the staff engagement events that were held as part of this process, staff indicated that their preference in terms of employment and continuity of service delivery was for a transfer to another NHS organisation. The final decision on a preferred provider has honoured this preference and will cause little disruption in terms of employment and TUPE. The acquiring trust works to Agenda for Change and Whitley (for non AfC staff) and has policies similar to the two PCT providers. The recruitment function used by the providers is part of the shared service organisation hosted by the BHFT and all three organisations have the same payroll provider.

Engagement with staff will continue through the transaction process and beyond by face to face meetings, the use of IT such as 'podcasting', surveys and one to one meetings with individuals. Frequently asked questions have been added to the intranet sites and a briefing on what it means to work in a Foundation Trust is being prepared for the intranet site.

There will also be a full formal consultation process. This is discussed more fully later in this document.

5.3.4 Practice Based Commissioning Leads

Practice based commissioning (PBC) leads for each of the consortia are members of the Clinical Executive Committee in both PCTs and attend the board workshops where commissioning strategies and Transforming Community Services are discussed.

Discussions were held with each of the PBC leads about Transforming Community Services and the commissioning strategy in both PCTs. PBC leads were, in the main, supportive of a transfer of services to another NHS organisation but were clear that they would want to work with that organisation to progress the agenda for integration of service delivery.

The PCTs have established a Collaborative Commissioning Group who will negotiate the actual transfer of services, service specifications and future contract. Membership of this group includes practicing GPs who are members of PBC consortia, along with representatives of public health and the unitary authorities.

5.3.5 Directors of Children's Services and the Local Safeguarding Children's Boards

Involvement with local authority partners have been achieved through attendance at board workshops and discussions at the joint commissioning forum.
In addition to their attendance at the board workshops, separate discussions were held with the Directors of Children's Services in each of the Unitary Authorities (UAs) in recognition of the lead role that they play. Each authority agreed that the long term vision would be to work toward children's services being integrated into the Children's Trust, providing an opportunity for integrated services to work together in a different way. However, it was agreed this was not possible in the short term and

that in the interim (2 years) the Children's Trust will jointly commission services from the preferred provider, Berkshire Healthcare Foundation Trust

A summary of this conversation and subsequent letter are at appendix 8.

In NHS Berkshire West, the Director of Children's Services for Wokingham UA was a member of the panel, on behalf of his colleagues, that met to assess the bid from Berkshire Healthcare Foundation Trust. Directors of Children's Services from each of the UAs are also members of the Collaborative Commissioning Group who are negotiating the transfer of services and ongoing contract. This will ensure that there is robust engagement and development of joint commissioning in the agreement of new service specifications.

There are 6 Local Safeguarding Children's Boards (LSCBs) - 3 in the west of Berkshire and 3 in the east. Those in the west have a single Chair Transforming Community Services has been discussed at various meetings and the Chairs have been informed of the outcome of the selection process. A paper is going to the next round of LSCB meetings with details of the next stages. The LSCBs are content with the transfer of services to Berkshire Healthcare Foundation Trust and view this as a mechanism for greater engagement of both adult and children's mental health services in the safeguarding agenda.

5.3.6 Health Overview and Scrutiny Committees (HOSCs)

In the west of Berkshire, papers on the proposed organisational change were sent to each of the Health Overview and Scrutiny Committees. These were presented and discussed at two of the HOSCs, and the third felt that there was no need for it to be consulted at this time. Neither of the HOSCs who discussed the issue felt that there were issues for them to influence at this time.
In the east of the county a paper was presented to Bracknell Forest, Slough and the Royal Borough of Windsor & Maidenhead HOSCs. No adverse comments were received from any of these bodies.

Papers will be presented for discussion to each HOSC during the next round of meetings with details of the ongoing process.

5.4 Board approvals

The PCT boards came together on 8th June 2010, to discuss the business case, after having discussions in workshop mode on an individual basis.
Formal sign off of the business case by NHS Berkshire East was at their meeting on 23rd June 2010 and NHS Berkshire West was at their meeting on 22nd June 2010.

6. PREFERRED PROVIDER; BERKSHIRE HEALTHCARE NHS FOUNDATION TRUST

6.1 Overview

The Department of Health and the SHA set out a series of tests for commissioners to assess organisational form proposals for the delivery of community services (appendix 5). Berkshire Healthcare Foundation Trust was assessed against these as part of the 'bidding' process by both PCTs. The benefits case is detailed later and the commissioners and provider are working on an integrated business plan that will set out in significant detail how this transaction will ensure commissioner requirements are met.

Berkshire Healthcare NHS Foundation Trust was established on 1 April 2001 to bring together 4 predecessor organisations into a single entity to provide specialist mental health services to the population of Berkshire. Following the successful integration of services into joint teams with the 6 Local Authorities and the closure of a large Psychiatric Institution (Fair Mile Hospital) into a modern PFI hospital in Reading, the Trust became a Foundation Trust on 1 May 2007.The Trust provides mental health and learning disability services and commissions inpatient services for service users that cannot be treated within Trust services.

The Trust has a PFI hospital in Reading with three additional in-patient sites across east Berkshire. The Trust operates from around 30 sites across the county, providing input into functions which include primary care and Reading prison. They employ approximately 1800 WTE staff. Their early objectives were to modernise the portfolio of services in accordance with Government policy. This included managing the closure of a large Victorian asylum, developing a PFI hospital as replacement, externalising a significant proportion of learning disability services to the independent sector and developing new services to reflect the requirements of the national Service Frameworks.

The Trust has a commitment to genuine user involvement, which can be evidenced not just in Board appointments but full involvement in planning, recruitment and evaluation of services and systems. There is a highly effective and integrated governance system within the organisation which has generated a number of unique approaches to service improvement on which other organisations

The transfer of staff and services to Berkshire Healthcare Foundation Trust from the provider arms of NHS Berkshire East and NHS Berkshire West doubles the size of Berkshire Healthcare Foundation Trust in financial terms and almost trebles the size in staffing terms. Initially there will be a combined budget of £110.9m and 2861 staff (2218 wte) and a wide range of services transferring into Berkshire Healthcare Foundation Trust. Full details are provided in appendix 3. In order to achieve the safe transfer of staff and services, it is intended to move both provider arms into Berkshire Healthcare Foundation Trust as business units, with their current clinical structures. During 2011/12 the strategy will developed leading to a period of organisational change.

However, there will be immediate quality benefits and economies of scale in support functions and there will be an immediate restructure of these functions, including human resources, and finance to deliver an element of management cost savings

6.2 The benefits of BHFT

There are very strong strategic reasons for selecting Berkshire Healthcare Foundation Trust as the preferred partner for Berkshire East and Berkshire West Community Health Services. There is a very firm strategic 'fit' that encompasses the whole range of business activities and transformational opportunities. These are summarised below.

6.2.1 Community Based Services

Berkshire Healthcare Foundation Trust has extensive experience of delivering community based mental healthcare through integrated teams and has a much reduced reliance on hospital based services. The Berkshire Healthcare Foundation Trust and Community Health Services partnership offers the opportunity for skills and knowledge transfer across the disciplines. This will enable staff to provide a more holistic assessment of both physical and mental wellbeing.

6.2.2 Service Model

Berkshire Healthcare Foundation Trust proposes a service model that is based on integrated locality teams, supported by a single point of contact and an expanded role for case management. This approach is entirely consistent with the work being undertaken as part of the Care for the Future programme described previously and the Trust's internal Next Generation Care Programme, which will build a collaboration model with other partners within the system.

6.2.3 Complementary 'Fit'

Berkshire Healthcare Foundation Trust has no overlap or duplication of services with either of the community providers. Similarly there is little in the way of referral relationship between the organisations. This makes the merger entirely complementary. Whilst there will be a reduction of one community provider, choice is not affected or constrained by restrictive referral practices.
There are many similarities in approach between the current community provider organisations, the FT and the commissioning intentions. These include:

- a vision of care close to people homes as a driving force to improve quality and reduce cost,
- plans to help people stay well, improve people's ability to manage their own care and understand how to manage their illness if they have a long-term condition,
- the importance of working with primary and acute care together with local authorities to deliver a joined up system of healthcare, strong community competency and a plan to share areas of good practice, learning from each

other and building a strong first class system of health promotion, prevention and sustainable care outside of hospital

6.2.4 Integration and Change Management

Berkshire Healthcare Foundation Trust has a very strong track record of delivering change. Over recent years they have managed the creation of an entirely new organisation through the merger of four predecessor organisations, the formation of a shared services provider and the achievement of Foundation Trust status. All of this has been achieved without compromising service delivery or performance.

6.2.5 Performance and Stability

Berkshire Healthcare Foundation Trust has performed consistently well since the trust was formed in 2006. In 2009 Monitor gave the trust the following risk ratings:

- Finance 3
- Governance Green
- Mandatory Services Green

The trust has produced a financial surplus for the past three years. This is indicative of a stable organisation. The Trust has successfully delivered a significant level of efficiency savings over the last 4 years, ensuring the generation of I & E surpluses in each financial year as shown in table 4 below:

	O6/07 £000	07/08	08/09	09/10	10/11	11/12	12/13
Annual Turnover (excl BSS)	85,296	85,102	88.099	91,119	87,800	86,200	84,800
Actual Savings	10,225	2,232	1,899	2,787	4,200	4,000	5,000
% turnover	11.9%	2.62%	2.15%	3.06%	4.83%	4.83%	5.9%
Surplus generated	2,225	3,361	1,483	1,115			
Annual health check	Good	Excellent	Good				
Monitor	-	4	3				

Key themes of the Trust's savings plans during this period have included:

- Asset rationalisation and fixed cost reductions (savings in 4 years ~£4.5m)
- Operational efficiency (savings ~£7.5m)

- Reduction in staff turnover, recruitment lead time and sickness / absence rates (savings ~£1m)
- Improved procurement (savings ~£1.2m)

The trust has had consistent scoring in the Healthcare Commission/Care Quality Commission ratings for quality of services with Excellent for the past 3 years.

In addition the Trust is host to Berkshire Shared Services which provides a wider range of finance, facilities and health informatics than is usually seen in NHS shared service organisations and has been particularly successful. These non-clinical services enable the organisation to have strong expertise in the services provided.

6.2.6 Quality

Berkshire Healthcare Foundation Trust can point to real success in terms of improving quality. This has been manifest through Monitor and the Care Quality Commission assessments. The trust has been one of the most successful mental health trusts at reducing reliance on bedded service and improving the level of services in the community. They have low levels of delayed discharges and had no cases of C Difficile or MRSA Bactareamia last year and have none to date this financial year.

6.2.7 Partnership Working

Partnership working has been integral to the success of Berkshire Healthcare Foundation Trust. As a mental health provider it is well used to collaborating across the system with health, social care and third sector providers. This collaborative working has demonstrated reduced reliance on acute beds with more services being delivered in the community and will be enhanced through the Next Generation Care Programme. (Appendix 9)

6.2.8 Foundation Trust Status

The merger with Berkshire Healthcare Foundation Trust provides a fast track opportunity for both community providers to achieve Foundation Trust status, within a robust and stable organisation.

6.2.9 Innovative practice

The most recent innovation is within the Trust's Next Generation Care Programme aimed at improving quality and reducing cost. The Trust is targeting a recurrent saving of £12m by 2013/14 through this Programme. The Programme seeks to provide:

- A single point of access
- Reduction of inter team referrals and multiple assessments
- Excellent Inpatient Services

A major strand of the Programme is considering the use of widely used technologies in clinical application with the aim of increasing access to services.

Examples of how this will be achieved are:

- Email and *Skype* for interactions between clinicians and patients

- Social network technology for virtual groups and peer support
- On-line self assessment and self help tools

This use of technology is an innovation that can easily be transferred into Berkshire Community Health Services, improving quality and reducing cost. Berkshire East and Berkshire West Community Health services have already been very successful in achieving productivity gain through their Service Transformation Projects. Through this integration, Berkshire Healthcare Foundation Trust hopes that further gain can be achieved by sharing some of these technological innovations.

Other key innovative practice includes;

- The Healthy Living Group has improved socially inclusive practice within the Community Mental Health Team by positively tackling health issues in tandem with mental health issues. This has also forged a more strategic and stronger link with primary care. By offering health checks, blood tests and advice on diet and smoking, early signs of conditions such as diabetes and coronary heart disease can be detected. The programme combines advice, education, session plans and input from fields such as psychology, exercise, smoking and nutrition. In 2007 NHS Innovations South East supported the Healthy Living Group in compiling the sessions onto a CD ROM. Pavilion have published the work of this group in 2009 and it is being promoted at a National Level.
- Qb-Test system which is used to assess Attention Deficit Hyperactivity Disorder (ADHD) in children and young people. It provides objective measures of hyperactivity, inattention and poor impulse control which are the three core signs of ADHD. Adding objective measures to the assessment helps clinicians to arrive at a more precise and accurate diagnosis. A special protocol used in conjunction with the Qb-Test is helping clinicians identify very early which children would benefit from taking stimulant medication for ADHD. This should prevent children and young people starting stimulant medication when they do not need it. Parents, children and young people appreciate the easy-to-read test feedback which shows if the medication is effective.

7. BENEFITS CASE

7.1 Preferred Provider

The benefits associated with the preferred provider are set out in section 6.

7.2 Overview

High Quality Care for All set the tone and direction for healthcare by establishing quality as the "Organising Principle for the NHS"[2]. *Our Vision for Primary Care* went

[2] NHS Next stage Review, Dept of Health July 2008 (High Quality Care for All)

further in establishing a commitment based on: "creating modern, responsive community services of a consistently high standard"[3]

This will demand a total transformation of service provision built upon principles of:

- Quality – outcomes, patient experience and safety
- Innovation – in service design and delivery
- Community care – maximising the care delivered in a community setting and minimising acute admissions
- Value and Productivity – providing optimum value for money for the tax payer
- Choice – creating viable options for patients to choose their healthcare provider.
- Prevention – promoting healthy living and self care
- Collaboration – across the full range of health and Social Care

This has to be achieved in the environmental context of:

- Growth in demand
- Significant demographic change
- Greater patient expectation
- Technological and Pharmaceutical development
- Likely funding constraints
- Major organisational change
- Changing policy environment

Delivery will require radical transformation in community provision especially within Primary Care Trust (PCT) provider services, who are key to care being delivered in a community setting. These providers will need to build organisations that are flexible enough to innovate and respond, whilst being robust enough to deliver the quality and value required.

The integration with Berkshire Healthcare Foundation Trust will provide the base for community services that are robust, flexible and stable enough to deliver the type of care demanded

Berkshire Healthcare Foundation Trust begins from a strong position in terms of the quality of the services that are currently provided, and the management team, staff, policies and procedures that underpin that solid performance. They have a track record of delivering quality. The trust was rated 3 stars and then Good by the HCC and has also been rated Good for Quality of Care for the last two years.

7.3 Patient Experience

Berkshire Healthcare Foundation Trust and the two community providers use real time data collection technology to collect real time patient feedback. This will be exploited in the future to monitor patient experience in a wider range of services, particularly where the services have changed as a result of the merger.
Collectively the new models of care will:

[3] NHS Next stage Review, Dept of Health July 2008 (High Quality Care for All)

- Promote standardisation of complex care
- Deliver national clinical standards of care
- Reduce inappropriate steps in the patient journey
- Reduce morbidity and mortality
- Deliver care closer to home
- Reduce unplanned episodes of care
- Reduce length of hospital stay
- Improve outcomes

7.4 Create cash releasing efficiency gains

The immediate benefit of the merger of a physical and mental health provider is the opportunity to take a holistic approach to person centred care. The impact on mental health of physical conditions and vice versa, is well documented. The integration of teams will allow for both dimensions of the patients needs to be met quickly and more easily.
Integration provides great benefits to the individual. People with complex physical and mental health needs are often subjected to multiple assessments, disruption in their home through repetitive visits and multiple interventions. Integration of services can effectively reduce the number of visits that people receive and lessen the number of times that individuals have to repeat their personal details.

The proposed partnership between Berkshire Healthcare Foundation Trust and Berkshire East and Berkshire West Community Health Services offers an excellent opportunity to rapidly develop an integrated care service model. The overarching service model will support the delivery of treatment along clinical care pathways, as determined through the commissioning intentions and service specifications. The pathways that will most benefit from the integrated model are those for patients with complex needs such as long term conditions and the elderly, but the service structure and resulting efficiencies will benefit all patients.

The proposed integrated care service model, for the new organisation, will actively drive performance of operational efficiency and in doing so it will reduce the need for secondary care. This will be achieved by pro-actively supporting patients at home and providing an alternative to secondary care when assessment and treatment are required. This work is being further developed in the Next Generation Care programme, which is seeking to use alternatives such as Skpe, telemedicine and SMS messaging to support patients with long term conditions to self care.

Berkshire Healthcare Foundation Trust uses the Care Programme Approach to managing patients. With its emphasis on assessment of the needs of the whole person and the development of a programme of care that meets all a client's needs, it provides a structured approach to care planning. The system features:

- Systematic arrangements for the assessment of health and social care needs, together with an assessment of the degree of risk

- A care coordinator appointed to keep in close contact with the service user, carer(s) and GP, and to monitor and co-ordinate care by all the professionals and agencies involved.
- A written care plan
- Regular review and monitoring of the service users' needs and progress against the care plan

Together with a Single Point of Access and technological support, this offers an opportunity to streamline care and ease the pathway 'hand offs' which are so often a cause of frustration to patients and carers. The availability of call centre staff and equipment through the medical out of hours service provided by NHS Berkshire West Community Health will enable this to be further developed.

As part of its submission Berkshire Healthcare Foundation Trust provided a high level model for Community Services (Appendix 6) and this will be detailed further in the integrated business plan.. The service specifications being developed by the Collaborative Commissioning Group will ensure that integration across the health and social care economy takes place.

7.4.1 Integrated care

Berkshire Healthcare Foundation Trust provides a full range of mental health services to children, adolescents, adults and older people across Berkshire. The trust has a strong track record of service delivery evidenced by its continued success in improving the quality of care and its ability to repeatedly win new business from outside of the county boundaries.

The integration of the community provider organisations with Berkshire Healthcare Foundation Trust doubles the size of the organisation in terms of finance and trebles it in terms of workforce. The basis of this transaction is therefore that of a true partnership between organisations for the benefit of patients and enablement of the commissioners' strategic intentions.

The aim of the new organisation will be to integrate the delivery of care for people in Berkshire across all sectors; primary, community, acute and social care in order to:

- Improve the experience of service users
- Reduce reliance on secondary care
- Reduce length of stay in acute hospitals

7.4.2 Integrated Working

As a provider of mental health care, Berkshire Healthcare Foundation Trust has clearly recognised the role that the PCTs partners and commissioned services will play in making the vision a reality, through the transformation of local health and social care services. To this end the trust has been instrumental in the development of the Next Generation Care programme.

This builds on a strong track record, with the Trust already having established systems and infrastructure to ensure that they operate in partnership with other health and social care organisations. This includes:

- Agreed policies and procedures in place to ensure delivery of seamless care, and the process for dissemination of policies to staff.
- Integrated health and social care teams with joint management structures
- Primary electronic database to capture all patient information
- Implementation of the Care Programme Approach (CPA)
- Clear guidelines to set up contractual agreements to support partnership working with other organisations

7.4.3 Reduced Admissions

Berkshire Healthcare Foundation Trust delivers services through a combination of Integrated Community Teams, focus on long term conditions and case management. It is recognised that when delivered together these things markedly reduce the need for hospital admissions. For patients this will mean an altogether more satisfactory experience of care. Case managers in the community health services use predictive modelling to build and manage their caseloads, reducing the number of patients who need to be admitted to acute hospital setting. Interqual audits are now being used to ensure that patients receive the correct level of care. Berkshire Healthcare Foundation Trust is used to using the same approach and has achieved great success in this area, significantly reducing mental health admissions, while building improved community services. This is an area where shared learning between the integrating organisations will bring great benefits to patients.

7.4.4 Reduced Length of Stay

For patients who require an acute hospital admission, integrated health and social care teams will support early discharge. Community Hospitals will provide an alternative to admission and the necessary step down and rehabilitation to support discharge. Berkshire Healthcare Foundation Trust can point to significant success in this area with a reduced reliance on hospital beds, improved integrated community services and the development of innovative technological interventions through Next Generation Care.

7.5 Care Group Specific Benefits

7.5.1 Children with Complex Needs

The partnership will be advantageous with regard to children's services. There is a natural "fit" between the organisations' children's services and they already work closely together. The strengths of the newly forming organisation are:

- Greater coherence throughout the system
- Care co-ordination for children through Common Assessment Framework and Teams Around the Child
- One child, one plan

- Integrated care pathways
- Timely access for children to any service
- Seamless interface with local authorities
- Opportunities for skills and knowledge transfer and sharing of good practice

Though the pathways that will derive most benefit from the integration of services are those for children with complex needs, all children will benefit from the efficiencies and improved access to services.

The integrated service will be underpinned by robust safeguarding policies, procedures and practice which are supported by information sharing and integrated pathways. All three organisations are party to the Berkshire Safeguarding Children Procedures. Each organisation currently has a safeguarding function, which is larger in the community providers, and there will be benefits derived from combining these. In BHFT the executive director responsibility for safeguarding will sit with the Director of Nursing.

7.5.2 Older People

Frequently older people who come into contact with community services and Berkshire Healthcare Foundation Trust, have mental and physical health issues and often needs are not properly addressed nor care coordinated. The integrated service model will use a single point of contact and an individual care plan. This will support the holistic approach by addressing both needs simultaneously.

7.5.3 People with Long Term Conditions

Long Term Conditions are commonly associated with a range of complications that add complexity to the care of patients. Many of these patients have co-morbidities which can lead to uncoordinated care provision as care pathways may be disease specific. The effective management of patients suffering from long term conditions will benefit from a coordinated integrated approach.

The methodologies developed by mental health services over the past decade particularly care planning and care coordination, can enable significant improvements in the quality and efficiency of care, including reduced requirement for hospital admission. Bringing together the expertise of Berkshire Healthcare Foundation Trust with Community Health Services into an integrated model, will improve the management of patients with long term conditions.

7.6 Public Health

The Creation of a new organisation through the merger of Berkshire Healthcare Foundation Trust and the community providers gives an unprecedented opportunity to deliver a service model which takes account of public health priorities. The Coalition Government's determination that public health will have a heightened profile in the commissioning of health and social care adds emphasis to this dimension in the new organisation's design.

In practice, a public health perspective will be evidenced by application of the following criteria in planning, priority-setting and designing community services:

- Prevention of illness, improvement in health, and associated reduction of demand for services
- Tackling health and social inequalities, and prioritising the needs of vulnerable populations, such as those in Reading Young Offenders Institution
- Services to improve the sexual health of young people and to reduce teenage pregnancy rates
- Addressing the health impact of environmental issues
- Continuing the fight against infectious diseases
- Managing the quality of prescribing and medicines management
- Engagement of all relevant agencies in collaborative delivery of health and social care
- Involvement of the public in improving their own health and wellbeing.

An eventual model of integrated locality teams, providing joined up physical, mental and social care to individuals and families, will improve early recognition of illness, support self-management in long term conditions, and thereby improve outcomes. In conjunction with other services and agencies these teams will support public education and the active promotion of self-care. Integration and development of established specialist teams and workers e.g. for the homeless, travellers, sex workers, prisoners, will improve access to integrated health and social care for the most vulnerable and marginalised populations in this county.

Innovative collaboration with other community providers such as community pharmacists, community dentists, schools and colleges will be developed further in order to extend the range of facilities in which health interventions and health care are provided, but also to deliver these in novel ways which engage more people in healthy behaviours. The PCTs and the trust have adopted social marketing methodologies to extend participation in health promoting activities such as smoking cessation. These will be extended to include the use of new communication technologies which are adopted readily by younger people, such as face-book, twitter and Skype, to promote health awareness and illness prevention, early identification of illness, reduced and improved medicines use, self care and de-stigmatisation.

7.7 Safety & Clinical Effectiveness

Each of the organisations has a patient safety strategy and structure to support delivery against this. Whilst it is planned to initially have 3 business units in the newly formed organisation, there would be alignment of key committee and working group structures with integration of key functions and departments to support this.

In addition to the quality schedule within the contract, the provider CQUIN, which are intended to demonstrate improvement in the safety, quality and effectiveness of services have been set in each of the individual contracts this year. A portion of the

Trust's income will be reliant on achieving CQUIN. In future contracts with the new provider, CQUIN will be focussed on areas where there has been organisational or commissioning concern or there are national targets. Setting of CQUIN in this way will ensure continued safety of services during organisational change and service transformation.

There will be alignments of the clinical governance functions, focusing on the integration and establishment of areas that encompass clinical risk, audit, safety, infection control, complaints, PALs, business continuity, claims, medicines management and emergency planning which will form part of a more developed transition plan and lead on to one Governance framework The integration of the 3 organisations gives greater capacity to ensure that safety and clinical effectiveness is well managed and that lessons learned from incidents are shared and implemented through the organisation.

Berkshire West Community Service and Berkshire Healthcare Foundation Trust have been assessed against NHS Litigation Authority (NHSLA) requirements and have achieved Level 1. Berkshire Healthcare Foundation Trust has a CQUIN target to achieve level 2 this financial year. Berkshire East Community Health Services chose not to be assessed for this last year and plans to have an assessment later this year. Berkshire West Community Service will not have a reassessment this close to the transfer to the new organisation. Given this, the status of NHSLA for Berkshire Healthcare Foundation Trust once the transfer takes place needs to be clarified. Discussions are therefore taking place between the commissioners and the trust about the CQUIN requirements.

It is important that patient safety and continuity of services are maintained during the transitional period and post transfer. Staff will TUPE into the new organisation with existing policies and procedures meaning that there will be no change for staff to adapt to at the same time as they are changing organisations. However, over time it is expected that there will be assimilation of policies and procedures with the new organisation adopting those which demonstrate best practice. The organisational development plan that will be developed for the transaction will include the necessary training and development for staff in any new or amended policies and procedures.

Each of the organisations is registered with the CQC without conditions.

Berkshire Healthcare Foundation Trust has a track record for quality of care achieving 'Excellent' for quality of services, for the third year in the Healthcare Commission assessments.

In addition to the NHSLA and CQC standards, Berkshire Healthcare Foundation Trust was 'approved with excellence' in the Royal College of Psychiatrists ECT Accreditation Service, which was launched to assure and improve the quality of the administration of ECT

Several of the Trust's Wards have gone through this rigorous process for the Royal College of Nursing Centre for Quality Improvement (CCQI) established Accreditation for Inpatient Mental Health Services (AIMS) to promote better standards of care within acute mental health inpatient wards and have all been successful.

A networking and communication plan is being developed for the patient safety and quality teams in order to develop a joined up approach to the transition and service development. This will enable the sharing of good practice and ensure that care is based on models of care designed on evidence instead of organisational structure. Specialist skill and expertise can be accessed across organisations resulting in less duplication and sharing of good practice.

Serious untoward incidents are reported to the SHA using STEIS. Each of the organisations involved in the transaction has their SUIs monitored by the PCT. Commissioners sit on each of the relevant provider patient safety and quality meetings so that they are assured that SUIs are managed effectively and that learning is disseminated as a result of the root cause analysis. The PCTs will continue to monitor and performance manage the SUIs that are reported by providers, requiring, through the contracts, improvement through learning.

This monitoring of SUIs and provider response to the outcomes of root cause analyses will continue to inform commissioning actions when trends are spotted. For example, the commissioners have recently instigated a review of maternity services at a local acute hospital as a result of a trend appearing.

In addition to the presence of commissioners at the patient safety and quality meetings, the commissioners will continue with ad hoc visits to organisations in response to soft or hard intelligence, including information about complaints or PALs enquiries.

The transfer of services to Berkshire Healthcare Foundation Trust will lead to:

- Removal of duplications and increasing the effective and efficient use of Infrastructure and resources including the consolidation and standardisation of investigation skills of senior clinical staff.
- Sharing of good practice and clinical learning relating to the physical and psychological impacts that have contributed to SUI's and specialist skills and expertise can be accessed by teams in different care settings.
- Delivering care based on evidence models rather than organisational structure.
- Patient/client should see no difference to the delivery of service initially but the aim of a more seamless approach will enhance the reduction in risk of SUI's. .

- A broader range of senior clinicians involved in leading service, including nurse consultants, medical consultants, therapy leads etc. to provide strong leadership and deliver change.

NHS Berkshire East and NHS Berkshire West provider arms have low rates of healthcare associated infections and have met the targets in the quality schedules of their contracts. There is a very low incidence in Berkshire Healthcare Trust.

Each organisation has an infection prevention and control service that supports staff with education, training and support. This service is led by a Director for Infection Prevention and Control (DiPC) who is directly accountable to the board. In the west, a multi agency partnership has been established across health, social care and the independent sector to work as a community with good results.

Bringing these functions together will produce some economy of scale and greater capacity leading to:

- A review of the targets and development of joint approaches to contribute to the reduction as a community economy.
- Delivery of the Infection Control Programme and audit plan.
- Review of the existing Infection Control Committees as part of a more detailed transition plan with one integrated committee as the outcome.
- Expertise of staff being shared including the sharing of best practice examples.
- Smoother flow of information along patient pathways will improve safety and clinical care.

Moving to single Infection control standards in all community provider areas will avoid confusion among staff, patients and carers.

In terms of infection control, in 2009-10, the trust had no cases of C-Diff and no cases of MRSA bacteraemia. There are no reported cases of either C-Diff or MRSA bacteraemia so far this year.

7.8 Benefits afforded by foundation trust status

Being part of a foundation trust brings significant benefits to the patients, carers and staff who receive and delivery community services that were not available to them as part of the PCT. These benefits include:

- Ability to become a member of the foundation trust - Those living in communities served by an NHS Foundation Trust can become a member of that organisation. The membership community of Berkshire Healthcare Foundation Trust is made up of patients, carers, local people and staff, with also having the option to become a member.

- More local ownership of community health services as the governor membership changes to reflect the new organisation. This will strengthen local

ownership of and responsibility for hospital and other health services as major decisions are informed by active participation from members based in the local communities.

- Local communities and staff working on the front line can therefore have more say in the management and provision of com unity services in their area. This in turn will enable Berkshire Healthcare Foundation Trust to direct services more closely to communities, with freedom to develop new ways of working so that services more accurately reflect the needs and expectations of local people.

7.9 Staff Benefits

Staff will have the opportunity to innovate in response to commissioning strategies. A move to the Foundation Trust environment offers staff exciting opportunities to use their talents, enthusiasm and skills to take more control in delivering services responsive to the needs of the communities and people they serve. An environment that encourages choice and competition will be a further enabler. Local clinicians are ideally placed to make such responses, and Berkshire Healthcare Foundation Trust has shown that it has the viability and sustainability to help them successfully secure contracts.

The opportunities for training and development will be enhanced. The transaction plan includes the mapping of structures and processes across the three organisations. This will enable early identification of synergies and variance. It will also show where there are opportunities for harmonisation of processes and structure to produce economy of scale.

All of the organisations have training posts for a range of professionals at pre and post registration levels, including rotational programmes. The larger organisation brings greater capacity in terms of the:

- number and types of teaching placements
- size of training budget and the flexibilities this brings
- ability to negotiate more effectively with Higher Education Institutions for courses and in house training
- greater ability to bid for research and teaching possibilities which will enhance the learning opportunities for staff

7.10 Technology benefits

Each of the organisations uses Datix to manage complaints, risks, incidents and claims. The trust is currently using DatixWeb and both PCTs will begin using this system prior to the transfer of services in April 2011. DatixWeb promotes the reporting of incidents by allowing any member of staff who has access to the intranet to follow the progress of the root cause analysis investigation and see the lessons learned as an outcome. It then enables managers to complete the investigation of incidents

and provide analysis. Managers and staff are able to take ownership of incidents and incident reporting by producing and sharing reports. The system also allows wider understanding of trends and makes sharing from incidents easier.

Each of the organisations use balanced scorecard reports to assure their boards of performance across a range of issues including patient safety and quality. During the transition period these reports will be reviewed and a new integrated report produced for the board to approve in readiness for the new organisation. This will also form the basis for the production of a quality account for the organisation.

Berkshire Shared Services provides IT, Estates, Finance and recruitment support to the three non-acute Trusts in Berkshire. The Health Informatics Service (HIS) is a core component of BSS and delivers a range of IT and Information services as outlined below.

The Berkshire HIS is a multi-disciplinary organisation that provides specialist services to:

- NHS Berkshire West
- NHS Berkshire East
- Berkshire Healthcare NHS Foundation Trust

The three organisations share the same infrastructure, utilising a shared data 'CoIN' network (appendix 10) and two corporate data centres. These data centres are based at either ends of the county and provide the entire file, print, application and mail services for the organisations. The disparate locations of the data centres provide resiliency in case of site failure and all data is automatically backed up at the opposite data centre in real time.

This shared approach to the IT requirements of the local health community provides economies of scale; removing duplication of systems by providing the services required on a single instance of the system. Due to the use of Virtualisation technology, there is the ability to create and manage a variety of virtual servers in the data centres, thereby reducing hardware costs. Each system is accessible from any of the networked sites leading to the largest number of remote users in the NHS, enabling staff from any of the organisations to work from their normal base, home, meeting rooms or patients' homes.

Latest figures from the NHS benchmarking show that the IT service provided in Berkshire is in the lowest quartile of costs and the top quartile of performance.

The common infrastructure is used by commissioners and providers. However, there are a number of systems that are specific to the individual provider arms. 9 of the 21 provider specific systems are scheduled to be replaced by RiO and therefore consideration is being given to those systems that will remain. Some of the smaller systems are based around Access and Excel applications and therefore could provide a security risk in their use. These will be considered for replacement in line

with potential national products. Other systems (such as the Kodak R4) system are in use in both PCT provider services. Planning should be undertaken to look at the continued use of these systems to ensure that adequate funding is in place as part of the annual capital programme.

The three organisations will be using RiO to deliver the Care Records Service and are in the process of deployment, with a completion date of 2011. Currently, integration of community and mental health RiO systems is not included in the national contract. To ensure that the correct performance reports are being generated to satisfy the requirements of the commissioners, the trust board and Monitor, common data sets for the services must be aligned before they are submitted to Secondary User Service (SUS). This work is made substantially easier as we have a single data warehouse, managed by BSS HIS, that collates and presents the data.

7.11 Benefits Summary

The Transforming Community Services Commissioning strategy was firmly rooted in each of the PCTs existing Five Year Strategies which were updated towards the end of 2009. These strategies have provided the rationale and impetus for this transaction. It is the strategic aims and objectives of these strategies that the outcomes and benefits of the transaction are designed to support.
The identification of measurable benefits for the transaction are at an early stage and are set out below with proposed key performance indicators.

Summary of Key Outcomes required from the transaction and measurements

Features	Outcomes	Benefits	Possible KPI
Integrated Community Teams	• Ability to support patients in the community and in their own homes for longer. • Earlier discharge for acute patients • More streamlined and 'seamless' care • Reduction in the hand-offs between health agencies	• Reduction in acute admissions • Improved patient experience • Reduction in patient assessments • Improved patient choice	o % patients treated at home o Average Length of Stay, acute o Response time for referrals
Integrated Community Teams – End of Life	• Rapid response teams • Comprehensive and integrated support • Support for patient choice	• Delivers choice for patients and carers • Prevents unnecessary acute admissions • Improves patient experience • Reduces cost	o Response time for crisis intervention o % EoL pathway deaths in a community setting o % reduction in deaths soon after an acute

Features	Outcomes	Benefits	Possible KPI
			hospital admission o % of patients on Liverpool Care Pathway
Integrated Community Teams – Self-care	• Provides a vehicle for delivery of self care • Easy access to support services and onward referral as appropriate	• Professional and effective delivery of self-care programmes • Timely intervention and crisis prevention as appropriate	o % of Self-care programmes established with patients o number of unscheduled interventions
Integrated Community Teams – Prevention	• Effective means of delivering prevention agenda • Strong infrastructure and existing links to other agencies	• Coordinated delivery of the prevention/Public Health agenda • Reduction in the level of health interventions required • Cost reduction	Existing measures for areas such as: o Diabetes o Smoking Cessation o Obesity
Integrated Community Teams – Pathway Management	• Greater scope for management of the entire pathway • Berkshire Healthcare Foundation Trust capable of managing the entire pathway through sub-contracting arrangements	• Coordination of the patient journey • Seamless care • Reduction in 'hand offs' • Cost reduction • Improved patient experience	o Number of end to end Care Pathways developed and managed o Patient satisfaction surveys and complaints

Features	Outcomes	Benefits	KPI and Indicators
Integrated Community Teams – Focus on LTC	• Innovative approach to the management of LTCs • Specific mental health support for patients in this area	• Patients maintained and supported in their own home or care home • Provides a holistic approach	**Integrated Community Teams – Focus on LTC**
Integrated Community Teams –Single Point of Access	• Patients follow simple and consistent journey • Health and social care professionals have a single point of contact and referral	• Simplifies the process for health and social care professionals • Reduces delays and misdirected referrals • Improves the experience for the patient	o % of patients referred through single point access o Patient experience measures o % reduction in delayed transfers of care
Holistic Care	• Physical and mental needs addressed concurrently • Early identification of issues in both patient groups • Skills and knowledge transfer across the disciplines	• Reduction in secondary care admissions, particularly for mental health • Ease of referral between physical and mental health client groups • Single assessment • Access to patient records • Improved quality of care and experience	o Level of secondary care admissions o % Reduction in Secondary care activity
Holistic Care – Out of Hours	• Co-location and easy access to health support out of hours services	• Reduction in admissions into secondary care • Early intervention • More efficient use of resources and cost reductions	o Level of secondary care admissions o % reduction in emergency admissions out of hours
Care Programme Approach	• Consistent approach to patient care • A proven quality approach to case management from an experienced provider • Appointment of care coordinator • Clear lines of accountability for treatment planning and management	• Clear and consistent treatment plans • Named individual with responsibility for individual patient care • Dedicated management of the individual care plan • Streamlined and simplified process • Reduced	o % of patients with a completed care plan o % of patients with a designated care coordinator o Reduction in SUIs o Patient

		bureaucracy and assessments • Seamless care • Consistent clinical quality • Improved patient experience	satisfaction measures o % reduction in emergency admissions for a basket of HRGs o
Features	**Outcomes**	**Benefits**	**KPI and Indicators**
Community Hospitals	• 'Hub and Spoke' system for movement of patients into a sub acute setting of care • Provision of treatments traditionally carried out in an acute setting	• Shift of activity from acute sector • Wider range of acute/sub acute services available locally • Improved access • Reduced acute activity • Improved intra-agency cooperation • Reduction in Delayed Transfers of Care	o Level of acute activity o Range of interventions provided o Level of delayed transfers of care o Average length of stay
Children's Services – Integrated services	• Teams closely located and linked • Rapid integration • Improvement of existing links to local authority • Creation of individual care plans • Single point of access • Common Assessment Framework	• Easier access for children and their families • Early discharge and reduced lengths of stay in secondary care • Clarity for referrers on the range of services available • Consistent care planning • Accountability for care planning and management	o Speed of integration o % of patients with individual care plans o Average length of stay o Referral to treatment times
Children's Services – Improved Safeguarding	• Integration and strengthening of Community Health and Berkshire Healthcare safeguarding functions • Single and secure electronic care record • Reduction in patient 'hand offs' • Improvements in Berkshire Healthcare through community health expertise	• Improved safeguarding • Greater intra-agency cooperation • Earlier intervention • Safety through seamless care	o Level of SUIs o Patient/carer experience measures o Learning from Serious Case Reviews
Technological Innovation – Predictive	• Identification of high risk patients • Prioritisation of work	• Focus of resources • Crisis avoidance • Admission avoidance	o % of unscheduled admissions to

Modelling	load • Early intervention	• Cost reduction	secondary care o Length of stay
Technological Innovation – Electronic Care Record	• Proven solution • Delivery of a single trust wide care record • Accessible to all appropriate clinical personal • Available through a variety of technological solutions	• Reduction in assessments • Safer treatment • More effective use of resources • Supports flexible working	o % of clinical staff able to access records o % of patients with electronic record

8 FINANCIAL BENEFITS CASE

8.1 Overview

Both commissioners have a plan of pathway redesigns that will enhance the patient experience which will begat savings, disinvestments and investments related to the QIPP agenda and include savings against: specifics

- Community Provider productivity and efficiency
- Long term conditions
- Acute care closer to home
- Management of referrals to secondary care
- Unscheduled care

The transformation of community services and collaborative working expected from this transaction will support this agenda.

The transaction involves the transfer of all clinical services from NHS Berkshire East, and the majority of services from NHS Berkshire West (palliative care services being transferred separately to Sue Ryder). This section outlines the financial case for the transfer. At the point of transfer, the financial impact will be cost neutral to the Berkshire Commissioners, with significant real terms reductions accruing to the Commissioners over time through the service redesign and operational synergies. These exceed current tariff efficiency assumptions by approximately one third and are summarised in the table below.

Total Savings & Efficiencies	2011/12 £'m	2012/13 £'m	2013/14 £'m	2014/15 £'m	Total £'m
(Upside Scenario)					
Efficiencies (3.5%)	-3,333	-3,269	-3,194	-3,142	-12,938
Addional Savings	-2,100	-1,950	-1,250	0	-5,300
Annual Savings	-5,433	-5,219	-4,444	-3,142	
Cumulative Savings	-5,433	-10,652	-15,096	-18,238	
Total Finanical Benefit	-5,433	-16,085	-31,181	-49,419	
(Downside Scenario)					
Efficiencies (4.5%)	-4,275	-4,141	-3,998	-3,886	-16,300
Additional Savings	-2,100	-1,950	-1,250	0	-5,300
Annual Savings	-6,375	-6,091	-5,248	-3,886	
Cumulative Savings	-6,375	-12,466	-17,713	-21,600	
Total Finanical Benefit	-6,375	-18,840	-36,554	-58,153	

The starting point for the financial analysis has been the 2010/11 financial envelope for the two PCT Community Service operations. Mental Health services already commissioned from Berkshire Healthcare Foundation Trust (BHFT) have been excluded. The Trust also hosts Berkshire Shared Services (BSS), and the analysis includes estimates of support services costs (facilities, IT and financial services) for the Community Services operations; support costs relating to the Commissioners' operations are excluded. The analysis builds on the proposals submitted by BHFT and also highlights additional areas where the PCTs will be looking to secure further benefits.

The financial analysis and the draft contractual terms being discussed with BHFT are aligned with the planning assumptions underpinning the PCTs' Strategic Plans for 2010/14. It is recognised that some assumptions may need to be refined in the light of changing policy objectives from the new Government which will be reflected in the Operating Framework for 2011/12 and future years. But the underlying national financial position has not altered, and therefore the overarching assumption that the NHS has to manage resources much more effectively to meet increasing demands is still correct.

8.2 Financial Track Record of Berkshire Healthcare Foundation Trust

The Trust has had a track record of generating annual financial surpluses since becoming a Foundation Trust in May 2007, and has delivered significant financial savings each year.

	2007/08 £'m	2008/09 £'m	2009/10 £'m	2010/11 £'m	2011/12 £'m	2012/13 £'m
Annual turnover (excl BSS)	85.1	88.1	91.1	*87.8*	*86.2*	*84.8*
Savings Delivered						
Actual	2.2	1.9	2.8	*4.2*	*4.0*	*5.0*
% of Turnover	2.62%	2.15%	3.06%	*4.83%*	*4.64%*	*5.90%*
Surplus Generated	3.3	1.5	1.2	*0.7*	*0.5*	*0.5*
Annual Health Check	Excellent	Good	Good	-	-	-
Monitor Rating	4	3	3	-	-	-

Key themes in the Trust's savings plans have included:

- Asset rationalisation and fixed cost reductions
- Operational efficiency savings
- Reduction in turnover and sickness / absence
- Improved procurement

In anticipation of significantly reduced funding for mental health services in a period where demographic pressures are likely to increase demand particularly for older peoples services, the Trust has been proactively working with partners on its "Next Generation Care Programme" through which increased use of technology (such as Skype, social networking and online assessment) will improve access to services whist reducing cost.

The Trust's track record combined with its innovative approach gives confidence in its ability to integrate Community Health Services and redesign services whilst delivering significant savings for commissioners.

8.3 Planning Assumptions

In preparing Strategic Plans for 2010/14, the PCTs have assumed that 2010/11 is the last year of real terms financial growth for PCTs. The Operating Framework indicated that in future years funding allocations will only increase in line with inflation. It has also been announced that some activities currently funded directly by the Department of Health will be transferred to PCTs, and other funding streams will be dramatically reduced or stopped altogether. The local planning assumption is that these pressures will negate any inflation uplifts received. In reality therefore, this means the cash available for services in 2010/11 will not in increase – all pressures from inflation, growth in demand and other service improvements will have to be fully met from within existing budgets.

Planning assumptions for tariffs / payments for community services are in line with those recommended by South Central Strategic Health Authority and are for a net reduction in tariff of 1% or 2% starting from 2011/12 onwards, as shown below.

	Up-side			**Down-side**		
Year	**Gross %**	**Efficiency %**	**Net %**	**Gross %**	**Efficiency %**	**Net %**
2011/12	2.5	(3.5)	(1.0)	2.5	(4.5)	(2.0)
2012/13	2.5	(3.5)	(1.0)	2.5	(4.5)	(2.0)
2013/14	2.5	(3.5)	(1.0)	2.5	(4.5)	(2.0)

2014/15	2.5	(3.5)	(1.0)	2.5	(4.5)	(2.0)

The announced pay freeze for public sector staff suggests the gross 2.5% may be too high. The draft Heads of Terms with BHFT reflects the downside assumption, with an agreement that 4.5% efficiency is applied (or Operating Framework percentages if greater).

8.4 Current Arrangements

For 2010/11 there are 2 service level agreements in place covering community service es with lead commissioning arrangements for each. The total value is £97.4 as follows:

West Berkshire Community Health Services	£54.3m
East Berkshire Community Health Services	£43.1m
Total Contract Value	£97.4m

It should be noted that that these figures include:

- non recurrent resources for specific schemes – these will be removed from the recurrent contract envelope for 2011/12;
- part year investments – for which the full-year effects will need to be incorporated in future years;
- overheads for community health services based on current accounting arrangements – some of these staff and non-pay costs are charged directly to these services (eg finance and HR staff employed by community health), but many are recharges. The methodology and accuracy of these recharges (some of which are based on 2006 activity levels) are currently being reviewed to ensure appropriate sums are included. This apportionment will also form part of the commercial negotiations with BHFT;
- management costs for community health. As reported in the 2009/10 draft accounts, these were £2.7m for Berkshire East and £4.3m for Berkshire West;
- funding for responsibilities currently allocated to community health staff. For 2011/12 onwards the figures in the business case for Berkshire West have been adjusted to exclude the direct costs of palliative care (which are being transferred to Sue Ryder) but to include Community Teams for People with Learning Disabilities. There may be other minor changes (for example in 2010/11 Berkshire West Community Health holds the full budgets for learning and development, part of which will need to revert to the commissioner in 2011/12), but these changes will not have a material impact on the overall transaction.

8.5 Benefits from the New Organisation

The transfer of £97m of community health services in April 2011 will more than double the value of services commissioned from BHFT, to £175m. It is expected that the merger of three organisations will create efficiencies and synergies in service delivery which would be difficult to achieve independently, including:

- from the patient perspective, a more seamless management of physical and mental health needs;
- the ability to move to an integrated management structure within localities;
- improved integration and partnership working with local authorities and GPs, with a reduction in the number of organisations and access points which have to be navigated, duplication of meetings etc;
- avoiding duplication of back office services (whist significant economies are already achieved between BHFT and the PCTs in Berkshire through having a Shared Service for facilities, finance back-office and IT), additional synergies will be achieved through combining HR, finance front-office, information, PALs and other support teams;
- a shared and consistent approach to technological innovations, with reduced acquisition, implementation and running costs;
- a reduction in commissioning and contract management costs for the PCTs.

These have been factored into commissioner assumptions in two ways – through delivery of the general efficiency factors in the overall planning assumptions and through the realisation of additional savings as outlined in PCT QIPP plans and the proposals submitted by BHFT. Delivery of the efficiency requirements anticipated in the planning assumptions would be significantly more challenging if the three organisations continued to operate independently.

The tables below shows the expected value of commissioned services using both the downside and upside planning assumptions.

UP-SIDE	**2010/11**	**2011/12**	**2012/13**	**2013/14**	**2014/15**
	£'m	**£'m**	**£'m**	**£'m**	**£'m**
Gross	96.9	97.5	94.9	91.2	89.8
Non Recurrent Adj		-0.8			
Uplift	3.3	2.4	2.3	2.3	2.2
Efficiency	-3.3	-3.3	-3.3	-3.2	-3.1
Transfers in/out of contract	0.0	-1.5			
Developments	0.8	1.2	0.7	0.7	
Alignment with PCT Plans/ BHFT Proposal	-0.3	-2.1	-2.0	-1.3	0.0
Cost of Redundancies		1.5	-1.5		
Total Berkshire	**97.5**	**94.9**	**91.2**	**89.8**	**88.9**

DOWN-SIDE	**2010/11**	**2011/12**	**2012/13**	**2013/14**	**2014/15**
	£'m	**£'m**	**£'m**	**£'m**	**£'m**
Gross	96.6	97.2	93.5	88.8	86.4
Non Recurrent Adj		-0.8			
Uplift	3.3	2.4	2.3	2.2	2.2
Efficiency	-3.3	-4.3	-4.1	-4.0	-3.9
Transfers in/out of contract	0.0	-1.5			
Developments	0.8	1.0	0.6	0.5	
Alignment with PCT Plans/ BHFT Proposal	-0.3	-2.1	-2.0	-1.3	0.0
Cost of Redundancies		1.5	-1.5		
Total Berkshire	**97.2**	**93.5**	**88.8**	**86.4**	**84.6**

The figures can also be split by PCT as shown below:

NHS Berkshire West (Upside Scenario)	2010/11 £'m	2011/12 £'m	2012/13 £'m	2013/14 £'m	2014/15 £'m	Reduction by 2014/15 £'m	%
Community Health (West)	53.0	50.7	49.3	48.3	47.9	-5.1	-10%
Community Health (East)	1.9	1.9	1.8	1.8	1.8	-0.1	-4%
Total	**54.9**	**52.6**	**51.2**	**50.2**	**49.7**	**-5.2**	**-9%**
NHS Berkshire East (Upside Scenario)	**2010/11 £'m**	**2011/12 £'m**	**2012/13 £'m**	**2013/14 £'m**	**2014/15 £'m**	**Reduction by 2014/15 £'m**	**%**
Community Health (West)	1.4	1.3	1.3	1.3	1.3	-0.1	-4%
Community Health (East)	41.2	41.0	38.8	38.3	37.9	-3.3	-8%
Total	**42.6**	**42.3**	**40.1**	**39.6**	**39.2**	**-3.4**	**-8%**
Grand Total	**97.5**	**94.9**	**91.2**	**89.8**	**88.9**		

Notes:

1) The figures for "Alignment with PCT Plans" identify the additional savings above the -3.5% or -4.5% tariff efficiency assumptions.

2) £1.5m of the reduction for Community Health (West) between 2010/11 and 2011/12 relates to the net effect of the Palliative Care and CTPLD Transfers

3) All figures exclude CQUINS

Further details are contained in appendix 11

8.6 Additional Opportunities

8.6.1 Reducing Reliance on Secondary Care

The QIPP Plans for both PCTs outline an ambitious agenda for redesign of patient pathways to enable patients where appropriate to be treated in lower cost settings at or closer to home. BHFT has considerable experience in providing care that minimises the need for people to be in hospital (which has also been evidenced though a 25% reduction in mental health beds since 2002).

Considerable investment has already been made by the PCTs in redesigning community health services to manage patient closer to home – examples in the past two years have included community matrons and case managers, community IV services, intermediate care and falls prevention services. Many of these services are still developing their caseloads, and the full financial benefits will not be seen until 2011/12 and beyond. Similar approaches have already been adopted by BHFT in the treatment of mental illness, and commissioners are expecting that this experience will yield further benefits from these schemes.

QIPP Plans for 2011/12 include a range of further opportunities, particularly for people with long terms conditions and dementia. Commissioning plans assume that these developments will be market tested, but the skill base, capacity and economies of scale created by combining both community health services will

make BHFT a strong player in the local market. Whilst it cannot be guaranteed that BHFT will win this additional work (equally strong combined providers are being formed in Hampshire and Oxfordshire), some success seems likely.

This business case does not attempt to quantify the additional savings in secondary care costs, as the do not derive directly from this transaction

8.6.2 Mental Health Services

The 'Shaping the Future' report commissioned by the SHA from McKinseys identified a range of opportunities in Mental Health which both PCTs have taken into consideration in their QIPP planning assumptions

These efficiencies primarily relate to mental health services not currently within the scope of the BHFT contract (such as high cost out of area placements, acquired brain injury patients and some continuing care costs). These efficiencies total (cumulatively) some £4-5m by 2013/14 for both PCTs, and the two organisations are currently exploring how these services and the related savings can best be incorporated into the proposed Mental Health contract for 2011/12 onwards. For example, NHS Berkshire East have in principle agreement that failure to deliver this level of efficiency would create a "hanging debit" to be recovered from further efficiencies within the core mental health or community health services for the Berkshire East area.

8.6.3 Rationalisation of NHS Estate

Although the current guidance is that premises remain in the ownership of the commissioner, across the total NHS property portfolio (including premises currently owned or leased by BHFT), there is the potential for infrastructure cost savings which will be reflected as an overall reduction to the costs of the services provided.

BHFT are eager to review the estates infrastructure and there are a number of locations primarily supporting community health services which offer opportunities for redevelopment as outlined in the draft PCT Estates Strategies. However these changes would be substantial, long term, and require careful development of detailed business cases which are outside the scope and timescale of this specific transaction.

A system wide approach to estates rationalisation will be adopted, as the cost savings in the provider will not necessarily be a saving to the PCT who may be left with the residual costs. The PCTs will therefore agree a set of business rules to determine how savings / residual costs are shared to ensure that service efficiencies can be realised. Similar business rules will be applied to more modest estates opportunities, such as district nursing accommodations. Service specifications will be define the commissioners' location requirements.

8.7 Integration Costs

As part of the proposals submitted to the PCTs, BHFT have identified a budget of £1m in 2010/11 for the costs of integration. This does not require additional funding from

the PCTs. This covers due diligence work, legal and contractual negotiation and the transition costs into one organisation. If costs are in excess of this amount, all three organisations will agree a way forward.

PCTs recognise that there may be additional one off costs over and above the £1m, and have both put aside £0.5m in anticipation of additional costs.

8.8 Redundancy Costs

A provisional estimate of redundancy costs has been included (£1.5m in 2011/12), with the expectation that this falls equally between the PCTs. This is a cost which BHFT cannot assess or budget for without full access to TUPE staff details. These costs will also be considered as part of the overall negotiations on service efficiencies (if redundancies are significantly greater, the PCTs would expect to see the "benefit" of any redundancies reflected in higher savings in future years).

It is expected that redundancies will be managed to a minimum though normal HR change management processes for staff at risk (including any pooling arrangements across South Central as a result of the re-organisation of the NHS in line with the principles as laid out in the white paper "Equity and Excellence: Liberating the NHS").

8.9 Risks

The table below identifies the key financial risks in the transaction:

Risk	Mitigation	Likelihood / Value
Integration Costs exceed the amounts provided by BHFT and PCTs	Costs to be monitored by Project Board. Additional costs to be shared between organisations.	Medium £500k *50% = £250k
Synergies are not being generated due to the complexity of the new organisation, as well as the large geographical area covered and the need to manage relationships with 6 Unitary Authorities.	BHFT are already experienced at collaboration with Unitary Authorities, and have track record of bringing together multiple providers to deliver integrated services. Commissioners will be actively promoting this direction of travel, and supporting BHFT to ensure the new organisation is given the opportunities and environment to deliver the synergies.	Medium £500k *50% = £250k
Key stakeholders such as local authorities or GPs don't support the service redesigns proposed by BHFT, and therefore expected savings are not delivered.	Service specifications are being jointly developed with stakeholders which BHFT will have to operate within. PCT commissioners will be actively promoting approved business cases to ensure BHFT is given the opportunities and environment to deliver the savings. Engagement events with local authorities and GP consortia underway.	Low £1m *25% = £250k

Due diligence identifies financial risks in current community health services, such as 2010/11 savings not being delivered recurrently on loss of income from non-PCT contracts held by community health	Some non-recurrent savings are to be expected, particularly when transformational changes have been difficult in a period of uncertainty prior to transfer. However this increases the size of the opportunity for BHFT.	Medium £2m *50% = £1m
Due diligence identifies financial risks in maintenance or replacement of physical assets	Liability will be dependent on the precise ownership arrangements. All estate has been maintained to meet at least minimum standards and regular upgrading of IT environment. Current liability rests with commissioner, and specific pressures will be considered on a case by case basis. Also, BHFT access to external funding sources.	Not yet quantified
Viability of new organisation is impacted by level of savings required and/or ability to reconfigure services.	At point of transfer, PCTs will be transferring financially viable entities to BHFT. Whilst the primary responsibility to ensure ongoing viability (without cross-subsidisation of services) rests with BHFT, if this is not possible there will need to be discussion with commissioners on the service and / or financial implications. The proposals from BHFT identify a range of short and longer term efficiencies which should ensure the ongoing viability of the new organisation whilst reducing costs to commissioners.	Medium £2m *50% = £1m
Impact of commissioners de-commissioning services from BHFT.	There may be opportunities where under utilised capacity may be offered to the private sector, other health economies, or repatriation of activity currently undertaken 'out-of-area'. Draft Heads of Term indicate that services will not be decommissioned (unless agreed by all parties) in first 24 months, and provides 6-month protection on some overhead costs post decommissioning.	Dependent on scale of decommissioning.
Additional service developments are not	At point of transfer, PCTs will be transferring financially viable entities to BHFT, therefore viability is not	BHFT's Integrated Business Plan will outline the Trust's

awarded to BHFT.	dependent on successful winning of new business. These will only pose a risk if the full year impact of a development is not honoured. It would be expected that the new organisation will continue to work in partnership with the commissioners in developing services to meet the health needs of the local communities. Whilst new business cannot be guaranteed, the PCTs proposals to transfer significant elements of acute care to closer to home suggests significant opportunities for BHFT.	assessment of this risk / opportunity.
Current planning assumptions for tariffs are incorrect.	It is anticipated that the downside planning reduction of 4.5% year is most likely. If inflationary pressures increase or funding reduces, the commissioners would expect BHFT to be activity identifying further efficiencies to mitigate the position. This may involve consultation on changes to the scope of services offered.	Medium £900k for an additional 1% efficiency requirement
Demographic pressures cannot be contained within the financial envelope of the block contract for community health services	PCT overall financial plans assume that in addition to raw population numbers, demographic pressures and increasing patient demand for healthcare will increase costs by 2.2% pa. QIPP plans have been developed to address this financial pressure. If BHFTs own initiatives are unable to meet rising demand within existing contractual envelopes, PCTs will consider funding based on appropriate business cases.	High £2m pa*75% = £1.5m
Overheads are not fully identified or accounted for, giving rise to potential "stranded overheads" for the commissioners	The local health economy has experienced a number of re-organisations and has historically sought to manage overhead and shared service costs in such a way that individual organisations are not disadvantaged. Business rules will be developed to support this approach with the new organisation.	Low £500k *25% = £125k

9 DELIVERING THE TRANSACTION

9.1 Overview

Given the size of this transaction, dedicated project management support has been provided by Berkshire Healthcare Foundation Trust and this is supported by senior management time from each of the provider arms. A programme structure has been set up to ensure that the transaction is fully governed, with links back into the PCT boards.

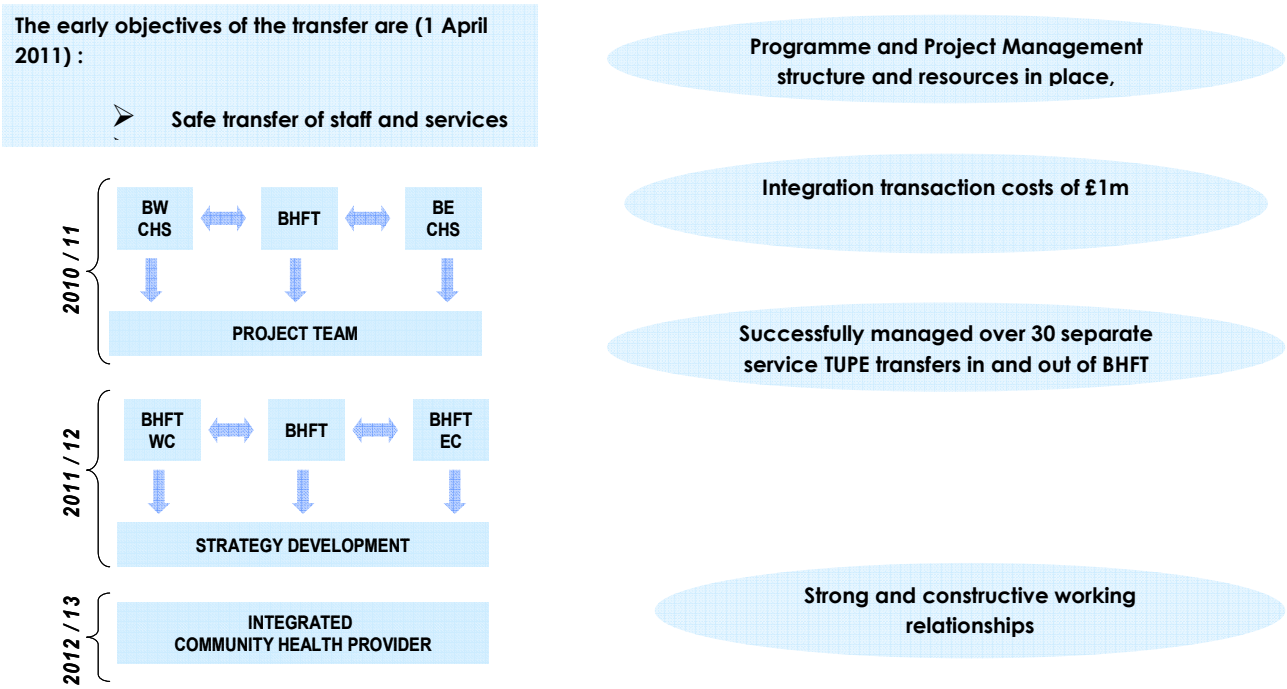
The objectives of the transfer are made up of two distinct elements:

1. The successful delivery of the strategies – commissioning objectives
    - To improve self care and keep people healthy
    - To ensure that people can access services and have care delivered closer to home
    - Integration of services across care pathways to support people with long term conditions and prevent crisis
    - Improve support to children in the community
    - Be an active partner in the integration and realignment of the system

2. The safe and smooth transition of services: - transactional objectives
    - Safe transfer of services and staff
    - Business continuity
    - Producing economies of scale and reduction in management and transaction costs

The initial structure will recognise the need for safe transfer of services and staff as the highest priority through a divisional approach working towards a fully integrated service within 3 years and provides real stability to current community services. During the first year of the new organisation, work will be carried out on a sustainable strategy and structure for the future (figure below)

Mobilisation and Safe Transfer



The size of the transaction impacts on Berkshire Healthcare Foundation Trust as an organisation as its focus will change from single speciality services (i.e. Mental Health and Learning Disability) to multiple specialist services. This will require a change of focus by the Board and Council of Governors and new skills may be required.

Berkshire Healthcare Foundation Trust, NHS Berkshire East and NHS Berkshire West have already done a great deal to provide the optimum landscape to achieve qualitative improvements. By working together, considerably more could be achieved as complementary skills are brought together to further to enhance the quality of services.

In particular some service gaps could be addressed by for example;

- Limited out of hours provision can be improved by bringing together the 24/7 services from each organisation, sharing infrastructure and learning;
- Improving case management and the currently limited psychological support for people with long term conditions.

9.2 The Contract

A collaborative commissioning group with membership from both PCTs and their PBC leads, public health and local authorities (adults and children's services) has been formed to develop the service specifications, which will be outcome based, for the new organisation to ensure that service transformation takes place and the commissioning strategies are enabled. This group will have accountability back to the respective PCT boards.

The service specifications are likely to require two contracts with the new organisation: the national community services contract and the national mental health contract; as there is no other suitable nationally agreed contract form.

NHS Berkshire East and NHS Berkshire West have lead contracting arrangements with a number of providers and it is expected that this will continue with the new organisation. The lead contracting arrangements are yet to be finalised.

9.3 Risks and Constraints

The key constraints to the successful delivery of the transaction and subsequent transformational change are:

- Maintenance of CQC registration without conditions by all 3 organisations to ensure a successful registration for the new organisation
- Resource capacity – The PCTs are entering into this transaction at a time of reduced management and finance resources. In addition to the transaction focus has to be maintained on:
    - Maintenance of the safety and quality of patient care.
    - Delivery of the QIPP savings that have been identified for each organisation
    - Delivery of strategic objectives that support the QIPP programme
    - Maintaining staff morale through the change process
    - Achieving management savings targets while releasing management capacity to focus on the transaction

- Timescales – the transaction must be delivered by 1st April 2011 or substantial progress has been made towards this. Achievement of this is subject to a number of dependencies that are outlined below.

- Decisions on estates and other assets – the commissioners will retain ownership of the estate and other assets. However, the level of asset ownership has not yet been decided, particularly around IT. There is a risk that service transformation will not take place if some IT assets are not passed to the provider.

- Challenging financial climate – all organisations are aware of the financial challenges tghat will be faced over the next few years and the service transformation that is needed to ensure financial viability
- Assessment of risk around the transfer of staff including TUPE, staff consultation and other workforce issues related to the transaction

9.4 Dependencies

The success of the transaction is dependent on a number of internal and external processes:

9.4.1 Internal dependencies

- Capacity to deliver - the transaction is dependent on the capacity and capability of the 3 organisations to meet the challenging timescales for implementation. This has been addressed by the allocation of dedicated financial and human resources by Berkshire Healthcare Trust. Each of the organisations has also allocated senior management time, including HR and finance, to the project. The transfer of staff and services will be managed through a project structure which is detailed below.
- Transfer of IT licences, software etc – as this transaction is between organisations who commission their IT services from Berkshire Shared Services this is not seen as an issue, as described in section 9 below.

- Good change management processes to ensure retention of staff during the transition process. Change management, communications and culture are discussed in more detail in section 9 below.

- Satisfactory outcome from the TUPE consultation with staff – the TUPE consultation with staff will be timetabled into the project plan to allow sufficient time for staff to be fully consulted and this is discussed in more detail in section 9 below.

9.4.2 External dependencies

- Continued support from PBC and other clinicians that this is the preferred option to meet the commissioning intentions.
- Approval by the SHA and DH for this process to proceed

- Approval by CCP – informal discussions have been held with the CCP who have indicated that this transfer can be handled through the fast track process. However, should further examination of the case by the CCP indicate that a full process is needed; the time required has to be built into the implementation plan
- Completion of the Monitor assurance process to meet the timescales - a full assurance process is required due to the size of this transaction and has been arranged with Monitor to commence in November, allowing sufficient time for completion in line with the transfer date.
- Approval by Berkshire Healthcare Foundation Trust board following the Monitor assurance process
- Meeting the requirements of any new national policy following the recent White Paper and subsequent consultation documents
- Agreement from Unitary Authorities in relation to Children's Services and that joint commissioning arrangements meet their needs

9.5 Transfer of the Workforce

9.5.1 Impact on staff

The transfer of Community Health Services, from Berkshire East and Berkshire West to Berkshire Health Foundation Trust has been communicated to staff in all three organisations. The transfer is planned to take effect on 1st April 2011 followed by a year of planning the integration and transformation of the combined units. As the three organisations are integrated into one, this is likely to mean changes in organisational structures and roles, ways of working and culture (values and behaviours). Staff may feel concerned about job security or changes to their terms and conditions of employment as well as negative about have to work in a different way. There is likely to be a protracted period of uncertainty for staff about the nature, scale and timing of changes and what it means for them personally. Negativity towards change and uncertainty about its personal impact could result in poor staff morale and motivation. This is turn could result in increased staff turnover, a lowering of productivity and the loss of key knowledge expertise and skills. It could also make it more difficult for the Trusts to attract and retain high calibre staff to fill vacancies. Poor staff morale could also have an adverse effect on service users and carers. Staff negativity if not minimised and contained could be a risk to Trusts' performance and reputations and the patient / carer experience.

The greatest concern for staff and their representatives will be about job security / stability and changes to terms and conditions of employment. Staff should be reassured that the transfers will be implemented in line with TUPE Regulations (See section #).

To manage staff commitment and expectations throughout the process of mobilisation, transfer, transition and transformation, the organisations will provide clear information on the rationale and personal benefits of change, the process for managing change and the opportunities for staff involvement. Staff will be consulted about the proposed changes and how it affects them personally at the earliest opportunity. Managers will be trained and equipped to support the change process, particularly facilitating communications and engagement activities. All three trusts will co-ordinate their strategies and plans for staff engagement and communication, ensuring messages are consistent, clear, timely and are delivered through a variety of media to meet the different needs and preferences of staff in all three organisations. The trusts will explore a range of options including: Regular question and answer sessions with senior management; Team briefings by direct line managers; One-to-one meetings; confidential employee assistance/counselling services; and websites, newsletters, telephone and email helplines.

To continue the positive consultations and engagement so far achieved with Staff Representatives, the current consultative process will be developed to achieve greater integration and coherence. This consultative machinery will allow for a more efficient and speedy discussion about proposed organisational changes as well as the review of policies relevant to the implementation of change.

A review of processes and systems impacting on staff will be reviewed to ensure duplication and inconsistency are minimised. This will include reviewing: HR systems (ESR, Payroll and workforce planning tools); HR policies; Payroll; Pension; Occupational Health Provision which is linked to Health and Wellbeing initiatives; recruitment and redeployment processes. To help ensure continuity of services, Appraisals, PDPs and objective setting will be reviewed to ensure quality and performance are maintained, whilst providing personal support during a period of significant change. This will help where there are changes in line management, and will avoid the risk of staff being unclear of their role, the direction of the organisation and their contribution.

9.5.2 TUPE Regulations

A plan will be put in place for the transfer of staff in line with TUPE regulations and to ensure safe transfer of staff and services. This will include:

- Meaningful, timely consultations with staff involving the Trusts' respective JSCCs
- Due diligence and the provision of required information on individual staff
- Obtaining the necessary warranties and indemnities
- The handling of staff consultations for those outside of Agenda for Change
- The transfer of personal and occupational health files, CRB checks, professional registration information and Certificates of Sponsorship
- The carrying over of accrued untaken holiday, PAYE deductions, expenses, claims, loans, lease cars.

9.5.3Trade Union View

The community services organisations have conducted several engagement events to seek views from staff and trade union representatives on the options of organisational form. Both panels making the decision on the future redeployment of provider services included a full time officer. The proposal to integrate community health services has been well received by both full time officials and local staff side members within all three organisations. It was noted that this option was likely to be least disruptive for patient services and also for staff who will retain their NHS terms and conditions of employment and pension. Formal sign off of the decision to transfer services to Berkshire Healthcare Foundation Trust is shown from each staff side chair at appendix 7.

9.5.4 Governance and Organisational Capability

Workforce planning will help facilitate the safe transfer of staff and services during mobilisation achieve planned efficiencies and realise the benefits of transformation. It will also help minimise unnecessary severance costs. The three organisations will need to work closely together to develop a comprehensive workforce plan for the next three to five years. There will be synergies in services and benefits from working together, particularly with the two community services of Berkshire joining with Berkshire Healthcare Foundation Trust and it will be a priority to plan the workforce composition/skill mix to meet new ways of working, care pathways and service redesign, increased productivity, quality and value for money. Workforce planning in relation to the transformation agenda within the community providers is already underway and will continue during the mobilisation period with opportunities to work with and share good practice with partners.

The organisations will work together to ensure coherence in pre and post transfer workforce plans: recruitment, redeployment, training and development and service redesign. There will be opportunities to improve recruitment and training plans that link with workforce planning more strategically and proactively. It will be important to ensure workforce plans in the new organisation and the wider health economy are linked to the workforce implications of increased care in the community and an all degree nursing workforce, as well as the potential for the Assistant Practitioner role and Apprenticeships.

9.5.5 Compliance with Statutory and Government Workforce Policy Obligations

The new organisation will ensure the consistency of existing Single Equality Schemes and work towards compliance with the Equality Bill. Strategies and plans that link to the NHS Constitution rights and pledges will be reviewed in each of the integrating organisations to ensure that the principles are consistent, become embedded in the new organisational form and are focussed at Board level. Agenda for Change terms and conditions apply to all three organisations. The integrating organisations will ensure that there is consistency and equality in the application of the terms and conditions as well as equality of the job evaluation processes during the transitional period and the new organisation will ensure that this continues post integration.

Agreement in managing Very Senior Manager pay will be required through individual consultation. Consistency of approach to the Vetting and Barring scheme and Professional Registration validation will be required. CQC registration and monitoring as well as NHSLA levels will be transferred and plans in place to amalgamate. Consideration will be given to the current levels of NHSLA compliance.

9.5.6 Children's Services

Services from the two community providers will transfer into the new organisation with their management structures to initially form separate business units to ensure safe transfer and continuity o f services. This includes some management posts that are held jointly with a local authority in the west.

The community providers and the trust all have a senior post with responsibility for services to children and their families. These posts in NHS Berkshire West and Berkshire Healthcare Foundation Trust have recently become vacant and discussions are underway as to how these could best be filled on a temporary basis while new structures are decided upon.

Within the Trust, the Director of Nursing is the nominated board lead for safeguarding supported by a full time safeguarding manager. Each of the community providers and Berkshire Healthcare Foundation Trust are committed, with the 6 local councils and the local acute FT, to the Berkshire Child Protection Procedures which clearly identify roles and responsibilities. The Named Nurse teams in each of the community providers will transfer to Berkshire Healthcare Foundation Trust, strengthening the child protection function that is already in place.

9.5.7 Workforce Planning

As part of the integrated workforce planning process, commissioners will engage with the new organisation during contract negotiation and monitoring to ensure that a workforce plan that addresses the need for service transformation is in place.

Both community providers have had service transformation programmes in place that have led to changes in the workforce. These plans will move forward into the new organisation to form part of the overall workforce plan.

It is recognised that there is a need to ensure that staff are adequately and appropriately trained and developed in any new skills needed to deliver transformed services. The larger organisation gives greater capacity for pre and post registration training in all areas. There is greater flexibility for student placements and rotations.

As part of the workforce plan, the trust will be clear on the arrangements that it will have with local Higher Education Institutions and the Strategic Health Authority in its education contract management role. This is work that will be done during the transition period and will form part of the implementation plan.

9.6 Rentals and leases

Rental and lease agreements for all services currently provided by the PCTs and for those in Berkshire Healthcare Foundation Trust are managed by Berkshire Shared Services. These arrangements will continue but all leases and rental agreements for space outside of PCT premises will move to Berkshire Healthcare Foundation Trust. Those PCT provided services that currently occupy a PCT owned building will be subject to lease arrangements which will be negotiated during the transaction process and confirmed in the transfer document.

Contracts with organisations other than the PCTs who are involved in this transaction will be reviewed during the transaction process and will be confirmed in the transfer document. This transfer of contracts may need to be reviewed if they are legally binding.

The transfer document will also have details of any outstanding liabilities and complaints which the PCTs are aware of in relation to their provider arms.

9.7 Governance

9.7.1 Overview

A project board' consisting of executive and non executive members of all 3 provider organisations 'has been formed to oversee the effective management of the project. This board is supported by a project team with representation, including clinical representation, from each of the organisations. Terms of references were agreed at the first Programme Board meeting on 11th June 2010.

Transaction Project Board

Non Executive Directors x 3	BHFT (Chair), NHS BE and BW
Chief Executive	BHFT
Managing Directors x 2	BE CHS, BW CS
Finance Director	BHFT
Senior Responsible Officer (Deputy CEO)	BHFT
Berkshire Healthcare Foundation Trust Company Secretary	BHFT

Transaction Project Team

Deputy CEO (SRO)	BHFT
Deputy Finance Directors x 3	BHFT, BE CHS, BW CH
HR x3	BHFT, BE CHS,BW CH
Project Manager	BHFT
Director of Business Strategy x2	BE CHS, BW CH
Clinician x 2	BE CHS, BW CH
Berkshire Healthcare Foundation Trust Company Secretary	BHFT

To ensure safe and effective transfer, a collaborative commissioning group comprising PCT commissioners, PBC leads, public health consultants and senior representatives of adult and children's social services has been formed. This group has accountability back to each of the relevant boards. It will ensure that service specifications are developed to ensure service transformation, in line with the aspirations of the PBC consortia and local authorities. It is recognised that there may be tensions between the aspirations of these new commissioners to health and the available funding. To ensure that these are dealt with appropriately and to assure boards, non executive directors are key members of the group.

The group is currently reviewing and redesigning care pathways that cross acute, primary, community and social care pathways. It will then design the specifications for community and mental health services, which detail the service transformation that is needed to move care from acute to community settings, driving up quality and reducing costs.

The service specifications will contain the key performance indicators against which the new joint community contract will be let and against which the new organisation will be performance managed.

NHS Berkshire West will be the lead PCT for this new joint community contract.

The programme management of the transaction is being led by Berkshire Healthcare Trust (the acquiring organisation). The trust is aware of the timescales that this programme has to be delivered in and the external dependencies that it has. It forms part of an overall transformation programme that the trust has in place and is managed through the Portfolio Office. The Deputy Chief Executive is the Senior Responsible Officer.

A significant amount of pre-transition work has been occurring to ensure that staff understand the strategic reason for change, ensuring that they have been aware of the appropriateness of this integration and that they outcome will be beneficial. A further round of communication with all major stakeholders is planned as part of the project plan. To ensure that this communication is robust, the same across all organisations and at an appropriate level of language, Berkshire Healthcare Foundation Trust is securing the services of a specialist organisation.

9.7.2 Programme Controls

Controls will be employed to ensure that the programme is following the scope and objectives as agreed in the Programme Initiation Document (PID). Care will be taken to ensure the programme is producing the required outputs in accordance with the plans and resources allocated to it and that quality controls are applied on a regular basis.

The key locus of direction and control for the programme will be the Programme Board. The Board will receive from the Programme Team, regular highlight reports and issues/exception reports as required. In addition, the Programme Lead will submit progress/update reports to the Trust Board (Programme Sponsor). The Managing Directors for the community services will also report to their board equivalent and ensure that the overall PCT Boards are able to monitor progress.

The Finance & Investment Committee will be involved at each stage of the process regarding methodology and findings. A report will be prepared for the Finance & Investment Committee at a frequency and in a format to be agreed.

The Risk Management Programme is shaped by Trust policy and the arrangements are those detailed in the original Programme Initiation Document. Each Programme Project maintains a Risk and Issues Log and the Senior Responsible Owners report exceptions to the Programme Lead to report in turn to the Programme Board. Significant risks are included in the overall Programme Risk Log and as necessary, within the Trust Risk Register.

9.7.3 Quality Assurance

Arrangements for quality assurance will be as per those defined within the original Programme Initiation document (11). Quality assurance is the Programme Board's responsibility and a product of its monitoring function. In addition, the quality group will continue to act as a quality assurance for the work and products of the individual Programme Projects.

9.7.4 Business Continuity

All organisations are aware of the need to maintain focus on service delivery and the need to achieve financial savings during this process. A full business continuity plan is being developed and will be presented to the project board and organisational boards when completed.
Managers in the community health services, especially HR managers, learned many lessons from the last major reorganisation of their services, *Commissioning a Patient*

Led NHS, and these will be used to ensure that business continues effectively. For example, an early restructure of the HR functions is being considered to ensure that HR managers are able to effectively support managers and their staff through the change process.

The transfer of staff and services with their current structures on 1st April 2011, into business units within the trust will help to avoid major disruption at the time of organisational change. Once a new vision, strategy and structure is agreed on, staff will be supported through the organisational change policies, which will transfer with them.

9.7.5 Enabling the integration of Cultures

In the case of Berkshire Healthcare Foundation Trust, NHS Berkshire East Community Health services and NHS Berkshire West Community Health, there are many shared cultural values which render the organisations culturally compatible. These factors include:

- Each organisational vision is similar
- Being part of the NHS which staff have highlighted as being important to them
- Providing community services
- Being committed to the delivery of high quality and safe services

The organisations also have the benefit of having worked together, especially at a clinical level as many of the patients are shared. The organisations also share support services through Berkshire Shared Services, including those that staff see as most important such as payroll and recruitment.

These key areas of cultural definition such as values, organisational structures, system control and the symbolism of working for the NHS, delivery quality care to patients, provide a sound foundation. However, each of the organisations operates independently and there will be subtle differences in approach that will require managing. These will be identified through joint meetings of management and staff and by bringing together the three Joint Staff Consultative Committees.

Key aspects will contribute to ensuring that the cultures come together including proper management of the organisational transformation. This means:

- Establishing a prompt, effective and efficient delivery
- Forming a powerful guiding coalition
- Creating a vision
- Communicating the Vision
- Empowering others to act on the vision

- Planning for and creating short term wins
- Consolidating improvements and producing still more changes
- Institutionalising new approaches

The communications and engagement strand of the project will support these ideals. The HR leads for all organisations have worked on the initial risks that a transaction of this size may experience. There is recognition that meaningful communication and engagement with staff is one of the critical success factors for this transaction.

9.7.6 Legal Strength

The Trust is a successful Foundation Trust with a strong consistent track record of delivering high quality services and meeting financial targets. Established as an NHS Trust on 1 April 2001, the Trust had delivered the closure of a large institution into a modern PFI by April 2003, achieved Foundation status on 1 May 2007, and received "excellent" for the quality of services from the Healthcare Commission (now Care Quality Commission) for the past 3 years. It is registered unconditionally with the Care Quality Commission and has a sound rating with Monitor.

Berkshire Healthcare Foundation Trust is governed through a Council of Governors responsible for appointing the Chair and Non -Executive members of a Board of Directors. The Board of Directors, through the Chair are responsible for appointing a Chief Executive. The Chief Executive is responsible for appointing the Executive Directors. The Trust's Constitution determines the structure of the Board of Directors and is as follows:

A Non-Executive Chairman
A maximum of eight other Non-Executive Directors
A maximum of seven Executive Directors
Of the Executive Directors there must be:

- Chief Executive and Accountable Officer
- Finance Director
- Medical Director
- Nurse Director

The current Board of Directors is as follows:

- Chair
- Non- Executives
- Chief Executive
- Deputy Chief Executive
- Acting Director of Finance
- Medical Director
- Nurse Director
- Operations Director

(The Director of Human Resources is a member of the executive Committee but not a Board Director.)

The trust recognises that the make up of its board and board of governors as well as the executive team will need to significantly change to reflect that the combined community services represents over 50% of the contracted value for the new organisation. There are currently two non executive director posts vacant. These are being held by the trust who wishes to fill them with people who have experience of being on a community services board. In addition, an induction programme is being arranged for the current executive and non executive directors to enable them to better understand the services that are transferring. This will also enable the current board to gain a fuller understanding of the changes that will be needed for the new integrated organisation.

Berkshire Healthcare Foundation Trust has long and varied experience of working in partnership with others and providing 'joined up' care. For example they have:

- 12 integrated community teams with 6 Local Authorities, with managers appointed jointly with the local authorities
- policies and procedures integrated with statutory partners
- Care delivered jointly with the voluntary sector e.g. memory clinics (Age Concern,
  Alzheimer's Society) and carers groups (Princess Royal Trust)
- Provision of A&E and paediatric liaison in conjunction with a local acute foundation trust
- Services delivered in conjunction with the independent sector e.g. Priory Group, PFI partner.

The benefits of these schemes enable the Trust to:

- Bring together multiple providers to deliver integrated services
- Share good practice, learning from each other and the know how to make partnerships work
- Recognise the skills and expertise of other organisations to lead

10 NEXT STEPS

Full details of the initial transaction project plan are shown at appendix 12. Key next steps are:

- SHA approval is expected at their board meeting in September.
- At the same time, the business case will be forwarded to the Competition and Cooperation Panel for their assessment. It is expected that this business case will follow their 'fast track' process.

- The project board and project teams have started to meet and workstreams are underway.
- Work has started on the integrated business plan which will contain more detail about how services will respond to the changing commissioning and public health agendas and how service transformation will be achieved through the merging of organisations
- Staff engagement events scheduled for the end of June/beginning of July in both NHS Berkshire East Community Health and NHS Berkshire West Community Health have been held. These have been followed up with technological solutions such as podcasts. Further engagement events are planned for September.
- A staff survey using Survey Monkey is planned to ensure that communication is happening in the most appropriate ways. Frequently asked questions will continue to be updated on the relevant intranets.
- Regular progress reports are being provided to each PCT board at their meetings, both in terms of the service transfer and the new commissioning arrangements
- The collaborative commissioning group will continue to meet to develop the service specifications and contracts. PBC, public health and local authority commissioners are influential members of this group.

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SLOUGH BOROUGH COUNCIL

REPORT TO: Health Scrutiny Panel **DATE:** 23rd September 2010

CONTACT OFFICER: Derek Oliver, Assistant Director, Community and Adult Social Care

(For all enquiries) 01753 875753

WARDS(s) ALL

PORTFOLIO Health and Wellbeing

Full Annual Report of the Slough Safeguarding Vulnerable Adults Partnership Board (April 2009 to March 2010).

1. Purpose of Report

To represent the first full report of the Slough Safeguarding Vulnerable Adults Partnership Board, that sets out the work of the Board between April 2009 and March 2010 and the context in which the Board is operating.

2. Recommendations

The Panel is requested to:

a) Note the content of the full report of the Slough Safeguarding Vulnerable Adults Partnership Board

b) Comment on the developments made by the Board during the period set out in the report, and the priority actions for 2010/2011 as stated in the detail of the report.

c) Note the Annual Report will now be reported to Scrutiny Panel on an annual basis, with an additional half year progress update.

d) Note that the legal framework for regulated social care changes on 1st October 2010 with the implementation of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009

I. Key Priorities

Ensuring effective multiagency strategic partnerships lead the development of improved safeguarding arrangements and practice, and will contribute to the following Council and partner agency key priorities as defined in the Sustainable Community Strategy:

a) Community Cohesion – celebrating diversity, enabling inclusion

The role of the Slough Safeguarding Adults Partnership Board is to take strategic leadership of the safeguarding agenda. It is to increase awareness, understanding, reporting of and protection from abuse and neglect of vulnerable adults, who due to age, disability, frailty and long term illness are amongst the most isolated, excluded and vulnerable people living within our communities.

b) Community Safety – being safe, feeling safe.

Safeguarding adults is about protecting people from significant harm and who are unable to protect themselves. The desired outcome is that people *feel safe* and *are safe*. The work of the Board will contribute to and are included in the wider safer communities, crime and disorder agenda and endorsed by the LSP.

c) Health and Wellbeing – adding years to live and live to years.

The key component of the Slough Safeguarding Adults Partnership Board is for all agencies and organisations, statutory, independent sector and third sector to work collaboratively and collectively with local people to tackle abuse and neglect. The experience of abuse or neglect has a significant impact on a person's health and wellbeing. The misuse of power by one person over another by its very nature will impact upon a person's physical and emotional health and independence. Neglect can prevent a person who is dependent on others for their basic needs exercising choice, control over fundamental aspects of their lives, causing humiliation and loss of dignity.

II. Other Implications

a) Financial

The Board is working collaboratively to maximise the use of resources available to each partner member and explore opportunities to pool resources to improve awareness of safeguarding, joint working practices, and outcomes for local vulnerable people.

b) Human Rights Act (HRA) and other Legal Implications

'Abuse is a violation of an individual's human and civil rights by any other person or persons'', No Secrets (DH 2000).

The working principle of the Board is that:

''Peoples' human and civil rights should be protected, and they have a right to be able to live their lives without fear of abuse or intimidation, in an environment where individuality, independence, privacy and personal dignity are respected''.

c) Workforce

It is the responsibility of all agencies and organisations, statutory or otherwise, to ensure that their respective workforce is appropriately trained and deployed to identify and respond to the risk of abuse and neglect, and that each organisation's operational and human resource policies and procedures promote and protect the public through safe recruitment and working practices.

The work of the Slough Board includes workforce development and in particular address the improvements required to ensure safe practices and increase workforce awareness, understanding and competency.

5. Supporting Information

Background

5.1 The Department of Health document 'No Secrets'[1], was the first document to provide guidance to Councils with social service responsibility, Health, the Police and partner organisations on protecting vulnerable adults. Identifying social services departments as holding the 'lead' co-ordinating responsibility for adult protection services, the guidance advised Councils to establish local multi-agency Adult Protection Committees (now called Safeguarding Boards) and to develop and implement multi-agency policies and procedures to protect vulnerable adults from abuse.

5.2 In response to 'No Secrets', the Councils of Berkshire and related agencies revised and updated local procedures into a single Berkshire-wide document and established two multi-agency safeguarding boards, East and West, to oversee the workings of the procedures and to develop and improve local multi-agency safeguarding practices.

[1] No Secrets (March 2000) Guidance on Developing and Implementing Multi-Agency Policies and Procedures to Protect Vulnerable Adults from Abuse' (March 2000)

5.3 The Slough Safeguarding Vulnerable Adults Partnership Board came into being in April 2009 following agreement that each unitary authority should have its own sovereign board. The Board has consolidated its role since. In particular it has worked on improved partnership working and awareness across the many agencies in Slough and where appropriate East Berkshire. The work has included:

- Local strategic leadership, necessary to deliver required safeguarding standards and performance improvements at a local level.
- Strengthened multi-agency and partner strategic planning and joint working.
- Shared strategic priorities that promote the health and wellbeing of vulnerable residents, and support the local crime reduction and community safety agenda.
- An agreed safeguarding strategy, compiled by all agencies, and supported by a strategic delivery plan, that is overseen and monitored by partners and that reflects locally agreed priorities.
- Connectivity and accountability to the LSP

5.4 'No Secrets' sets out the requirement for local Safeguarding Boards to publish an annual report, to be endorsed through each statutory agency's governance committee. In addition the constitution of the Slough Board states that the Board will report to Health Scrutiny Panel twice a year to discuss safeguarding issues.

5.5 The report being presented to Panel provides the first full year report of the Slough Safeguarding Vulnerable Adults Partnership Board. An interim report for the first six months between April 2009 and October 2009 was presented to Health Scrutiny Panel in February 2010.

5.6 The first year of the Board has been extremely busy, based upon the Board establishing its role and developing and implementing its work plan, as well as responding to issues that have arisen. The full report of the Board builds upon the interim report and provides a full year overview. It sets out:

- The development of the new Board arrangements.
- The strategic priorities identified, defined and scoped by the partnership
- Progress against these priorities
- The priority actions of the Board in 2010/11
- Case examples of good practice
- The statistical profile of safeguarding reports to Adult Social Care services.

The details of the work of Board as summarised above are set out in the full report attached.

5.7 Concurrently with the development of the Board, and implementation of its work plan, regulated health and social care services that vulnerable people of Slough use have been preparing to be compliant with the new Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

5.8 Residential, domiciliary care and some other services have been required to be registered with the Care Quality Commission (CQC) in accordance with the Care Standards Act 2000. This includes services which Slough Borough Council Commissions and some which it provides.

5.9 With effect from 1st April 2010, some health services have, for the first time, been required to be registered with CQC. With effect from 1st October 2010, social care services referred to in paragraph 5.8 (i.e. residential and domiciliary care services) and other designated services (including those providing supported living services and intermediate care services) have to be registered in accordance with the new regulations. All SBC in-house services will have submitted their applications in accordance with the process. All services SBC contracts with will also have had to have done this to continue to supply services to Slough.

6.0 Appendices

'A' - Slough Safeguarding Vulnerable Adults Partnership Board-Annual Report April 2009 to March 2010

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APPENDIX A

SLOUGH SAFEGUARDING VULNERABLE ADULTS PARTNERSHIP BOARD

ANNUAL REPORT

APRIL 2009 TO MARCH 2010

Final

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INTRODUCTION

Councillor Chrissy Small, Commissioner for Health & Wellbeing

Whichever way we look at it, abusing a person who is unable to protect him or herself because of frailty, illness or a disability, is simply wrong.

Abuse of people, who for no fault of their own are 'vulnerable' and may be dependant on others for their care and support, takes many different forms. Abuse can be about the exploitation of a person's pension or benefits by someone on whom they are dependant. It could involve causing physical harm when a person is too frail or unwell to defend or protect his or herself; it is as much about not doing the right thing, where someone is intentionally failing or neglecting to provide the right care. Abuse can and often does happen behind closed doors where we least expect or imagine it to be happening. It is for these reasons, I believe that we must all work together to tackle abuse and quickly raise the alarm when we believe it is happening.

Building upon our half year interim report published in February 2010, I am now delighted to introduce the first full year report of the Slough Safeguarding Vulnerable Adults Partnership Board. The Partnership Board has been set up to promote the voice of people who are unable to speak out because they are vulnerable and improve the way local agencies and services work, together, to protect them from abuse and harm.

It has been a busy first year and this report sets out the work undertaken so far, the challenges and achievements, and the improvements put in place to help safeguard our most vulnerable residents. As the Commissioner for Health & Wellbeing and the Older People's Champion it has been a pleasure being a member of the Board over the past year and seeing what has been achieved.

I look forward to being part of the Board in the year ahead and I know that by working together we will achieve even more.

If you want more information about anything in this report please do not hesitate to contact Derek Oliver (Assistant Director: Community and Adult Social Care) at Slough Borough Council, Town Hall, Bath Road, Slough, SL1 3UQ

Or visit our website http: www.slough.gov.uk/services/17702.aspx

REMEMBER ADULT ABUSE IS WRONG.
If you have a concern that someone is being abused call 01753 690444 or The Emergency Duty Team (out of hours) on 01344 786543

If you wish to report anti social behaviour in your neighbourhood contact the Anti Social Behaviour Hotline on 01753 875298

KEY MESSAGES

Nick Georgiou, Independent Chair Slough Safeguarding Vulnerable Adults Partnership Board

This is the first full Annual Report of the Slough Safeguarding Vulnerable Adults Partnership Board, building on the interim report published in February this year. Whilst some of this information is familiar, this full report represents a full overview of the year from the 1st April to 31st March 2010.

The Board has to ensure that at a time of increasing pressure on public bodies the agencies continue to build their partnership working in Slough to safeguard vulnerable people. We have built a good base and in this report you will see good examples of the agencies working together in both individual cases and in the way they have responded to particular situations.

As a Board we have now developed a work plan of the priorities for the partner agencies to ensue that our Safeguarding strategy and actions are both directed and sustained over the next three years.

Although Slough Borough Council has the lead responsibility for ensuring that safeguarding is effectively delivered in the borough, I want to emphasise that the Board is an independent body and that my role is to challenge all the agencies, individually and collectively to promote strong partnership working and best practice.

The Board's primary responsibility is to ensure that the agencies working in Slough, statutory and independent sector, develop together a clear strategic direction and strong and clear policies and procedures to ensure as strong and effective safeguarding practice for Slough's citizens as possible. We have made a good start in delivering this but this is work that requires constant vigilance and application, I want to promote this further as the Board progresses.

Nick Georgiou

EXECUTIVE SUMMARY

Jane Wood, Strategic Director Community & Wellbeing

It has been an important first year of the Slough Safeguarding Vulnerable Adults Partnership Board. Established in the spring 2009, with the full support of the Leader of the Council, Commissioner for Community and Wellbeing, and Cabinet Members, The Board quickly identified ways in which local safeguarding arrangements could be strengthened, to better protect the most frail and vulnerable residents in our communities.

The Board, consisting of senior members of the Council, Local Health Services, Thames Valley Police, LINks and local Voluntary Sector Services, has met regularly since April 2009, to share ideas and agree the improvements to be made, and has successfully appointed its first Independent Chair, Nick Georgiou, to guide the Board in its work.

Working together is paramount. There are many reasons why a vulnerable person may need to be safeguarded from abuse, exploitation or harm, and abuse can take many different forms and occur in different settings, often hidden from direct view.

Increasing awareness of abuse and information about how to report a concern is essential to safeguarding. But safeguarding is not only about abuse. It is also about tackling poor standards of care and protecting our most vulnerable residents from situations such as repeated anti social behaviour particularly where this threatens the person's safety and wellbeing. Tackling these issues requires that agencies and support services share the same objectives, work in a coordinated way, and operate to agreed standards and arrangements.

This, the first full annual report of the Board summarises the measures taken during its first year. The report identifies the improvements that have been made to local safeguarding arrangements and the impact these improvements are beginning to deliver to local practice. These include:

- Increased awareness of abuse
- Increase in the number of staff in local services trained to identify and report safeguarding concerns
- Improved working arrangements between safeguarding services and community safety teams
- Strengthened responses to poor care practice

The above have all contributed to more vulnerable people being identified during the year, and supported through the appropriate multi agency responses; this has been more so than in any previous years

The achievements in 2009-2010 provide a firm basis on which to make further improvements in the year ahead. There is still much to do and the Board's priority areas for improvement for the second year will be no less important than in the first.

SETTING THE SCENE

The report, 'No Secrets (2000)', set out guidance to local authorities and other statutory agencies relating to the protection of vulnerable adults. This was landmark guidance. Key recommendations included the setting up of Adult Protection Committees (now called Safeguarding Boards) to oversee the strategic leadership of the protection of vulnerable adults and that these committees or Boards should produce an annual report:

> *"Lead officers from each agency should submit annual progress reports to their agency's executive management body or group to ensure that adult protection policy requirements are part of the organisation's overall approach to service provision and service development". (DH 2000, Section 3.13)*

Slough Borough Council has the lead responsibility for co-ordinating multi-agency procedures that address allegations or suspicions of the abuse of vulnerable adults, as well as leading the Safeguarding Board arrangements. Work with local agencies ensures that effective processes and appropriate support is offered to an individual should they be the subjected to abuse or at risk of it.

In 2008 The Department of Health undertook a consultation on the review of 'No Secrets', at a national policy level to strengthen safeguarding awareness and practice. The review identified the need for more powers and duties for Councils and statutory agencies and the possibility of new legislation to better establish safeguarding. Slough Borough Council and local organisations in the Borough participated in the consultation. The formal outcome of this key review is expected to be available in 2010. At the time of this report the new government has made no reference to this policy area.

The Slough Safeguarding Vulnerable Adults' Partnership Board has previously produced an Interim report covering April 2009 through September 2009. This report is the first fill annual report of The Board covering a twelve months period 1st April 2009 to 31st March 2010.

ABOUT THE BOARD

Strategic Leadership, Governance & Priorities

The Slough Board – An Overview

Up until 2009, there were two Safeguarding Boards covering the six Councils across Berkshire:

- East Berkshire Safeguarding Board (Slough, Bracknell Forest and Windsor & Maidenhead)
- West Berkshire Safeguarding Board (West Berkshire, Reading and Wokingham)

Slough, like other Councils was concerned to strengthen leadership and accountability for safeguarding at a local level. Following discussions across the east of Berkshire and with the then Commission for Social Care Inspection (now Care Quality Commission), the 3 East Berkshire local authorities agreed that boards should be convened, within each local authority area. The Slough Safeguarding Vulnerable Adults Partnership Board came into being in April 2009.

It is important to emphasis that the Board is independent of all the statutory agencies represented on it. It is the responsibility of the Independent Chair to promote joint strategies and working between these agencies and their partners in the independent sector in their delivery of purposeful and effective safeguarding practice to protect and support the citizens of Slough.

The Board has three main functions:

- Ensuring common policies, interpretation of safeguarding and consistent identification and action on safeguarding practice
- An information sharing function to disseminate national, regional and local developments in respect of Adult Safeguarding to local organisations and the people they serve.
- Setting and owning the strategic direction for multi-agency developments and improvements in practice across services in adult safeguarding work;

How The Board Links To Key Governance Structures And Forums

With the new Board came new governance and reporting arrangements. The Slough Safeguarding Adults Partnership Board reports to the following:

- The Safer Slough Partnership and Health and Well Being Partnership Delivery Group

- Sub groups of the Local Strategic Partnership, and to the Health Scrutiny Panel.

These groups consist of senior officers from health, the Police, and voluntary sector representatives, and lead the implementation of agreed strategic priorities.

The Health Scrutiny Panel is made up of ward Councillors of the Council, nominated by the Council's political parties and provides political scrutiny and public accountability for the Board's work.

Terms of Reference

Under the Terms of Reference of the Board *(see Annexe page 32*) each agency and organisation representative is accountable for the work programme of the Board, acting on behalf of a service area or the organisation they represent. The constituent organisation the member represents further monitors and endorses the work through their relevant executive board or committee within their own organisation. The Slough Safeguarding Board has developed links with other important partnership boards and operational groups, which support the development and championing of improvements in safeguarding practice in other key areas of community activity (e.g. Anti-Social Behaviour Repeat Victims Group).

The Board has engaged with its counterparts in Windsor and Maidenhead and Bracknell Forest to establish a network across East Berkshire on shared issues such as staff training, commissioning, and the Berkshire Safeguarding Procedures. This will ensure consistency of approach for larger organisations that operate across local authority boundaries for example, NHS Berkshire East, Berkshire East Community Health Services, Heatherwood and Wexham Park NHS Foundation Trust, Berkshire NHS Foundation Trust and Thames Valley Police.

Early Work Of The Board

The Board agreed to meet every six to eight weeks in the first year, in order to develop the necessary momentum to establish and implement it's work programme, identify areas for improvement and define strategic priorities.

The Board has agreed a set of **Quality Standards** *(Annexe Page 51 & 52)***.** These set out the proposed standards by which the Board and representative organisations will operate in developing multi-agency strategic leadership and in the delivery of safeguarding practice by front line staff.

An **Independent Chair,** Nick Georgiou, was appointed in July 2009, and formally took over chair at the Board meeting on 9th October 2009.

Since its inception the Board has also discussed and explored important safeguarding issues. This has assisted the Board to shape and define local safeguarding priorities. Key topics have included:

- The implications of No Secrets and the No Secrets Review
- The role of the new Safeguarding Team
- Lessons learnt from national inquiries into safeguarding incidents and its relevance to inform improved practice in Slough.
- The engagement of professional staff and interested parties in safeguarding
- The relationship of safeguarding with community safety
- The promotion of safeguarding awareness across all communities

In addition the Board has been appraised of key issues in the locality and has contributed to the Law Commission national consultation on the legal reform of adult social care, which includes adult safeguarding.

Board Membership

The Board strives to ensure that its membership provide strong leadership and a clear focus on tackling priority areas for improvement in safeguarding arrangements for vulnerable people across the borough.

For a full list of board membership please see Appendix 1

REVIEW OF ACHIEVEMENTS FOR 2009 - 2010

The Board has identified its shared priorities for improvement.

As a Board, four priority areas for improvement have been identified and four sub-groups set up. These are:

- Governance and Quality Assurance (Lead - Slough Borough Council)
- Community Safety and Crime & disorder (Lead - Slough Borough Council via LSP Partnership Deliver Group)
- Workforce development and public awareness (Lead - Slough Borough Council)
- Commissioning (Lead – East Berkshire PCT)

Governance and Quality Assurance : Work to date

Much of the work in this area has been undertaken through Slough's Safeguarding Improvement Plan, although the oversight of this work is being incorporated within the work of the Governance and Quality Assurance subgroup of the Board.

The focus is on improving operational responses, practices and standards, and monitoring and performance reporting arrangements across all agencies.

The sub group has developed the Quality Standards in Safeguarding – Strategic Principles (page 51). This sets out the standards by which all agencies will work. Both Windsor and Maidenhead and Bracknell Forest Safeguarding Adults Partnership Boards have adopted this document. Slough Borough Council has also developed a Summary of Practice Standards (page 52) setting clear principles by which teams of social work staff will respond to safeguarding alerts. Berkshire East Community Health Services have developed complementary practice guidance for its own staff, and Heatherwood and Wexham Foundation NHS Trust have developed procedures and guidance on safeguarding to support staff and working practices in the acute hospital setting.

Significant work has also been undertaken across Slough Borough Council and NHS Berkshire East Trust in dealing with safeguarding cases in residential and nursing care homes. This has been in response to concerns about care standards. Working alongside the enforcement team of the CQC (Care Quality Commission) safeguarding interventions have been implemented in 5 nursing and residential homes with a view to improving the quality of care practice and the quality of life of service users.

The example below summarises the interventions of Slough agencies to address safeguarding concerns to improve care quality, in one home.

CASE EXAMPLE 1:

This case illustrates the importance of sustaining people in the community in their own tenancies. The right to choice and control over living arrangements is a key part of personalisation agenda.

D is a person with learning disability living in his own tenancy in block of flats where there had been 3 burglaries in two weeks. Safeguarding process engaged police, community safety team, housing association and support provider to ensure that security was improved. This involved local neighbourhood warden patrols, individual safety / security advice and the building and gardens had cover and foliage cut back to deter opportunistic burglaries. As a result there have been no further incidents and service users feel more secure in a block of flats they enjoy living in.

Safeguarding Achievements for 2009-2010:

- Written procedures that reflect and formalise best practice in responding to care providers where quality standards are a cause for concern and could impact upon the safeguarding of individuals being care for.
- Review of Serious Untoward Incidents, Critical Incidents, and Safeguarding procedures to ensure the delivery of learning to practice within clinical and social care settings.
- The establishment of a greater individual user or patient perspective on safeguarding process; where people feel safer and know where to turn for help.
- The publication of the Board's Interim Annual Report and full report
- The development and implementation of a more outcome orientated safeguarding process into local practice that better reflects the views of service users who have been involved in the safeguarding process.
- Improved strategic links across neighbouring councils to consolidate local practice standards and learning
- Substantially improved liaison across other placing boroughs during safeguarding alerts and process
- Investment in key council wide, cross cutting community initiatives that firmly establish the role of safeguarding across the community
- A significant local media campaign to engage the public with safeguarding

Community Safety, Crime and Disorder

In the Interim report of January 2010, three emerging themes were identified by the Community Safety, Crime and Disorder subgroup of the Safeguarding Board. These are:

- Working with people who have chaotic lifestyles and present challenging behaviours along with safeguarding concerns.

- Ensuring the protection of vulnerable adults who have a neighbour with a chaotic lifestyle or who are victims of anti social behaviour

- How to increase understanding by local residents of the impact of challenging behaviour and hate crime on vulnerable people.

Findings from national serious case reviews (SCR's) involving high risk individuals living in the community makes clear the need for the Slough safeguarding sub group to dovetail it's work programme with the work of community safety, victim support services and the Safer Slough Partnership; the ultimate aim being to put in place practical steps that help agencies to work more effectively together in identifying and reporting safeguarding concerns.

Achievements for 2009-2010 include:

In conjunction with Safer Slough partners, the sub group has:

- Increased support for victims: appointment of an Anti Social Behaviour (ASB) Victims' Champion to work as a member of Slough's Community Safety Services. This new role will support victims of ASB and get people in touch with other services in the Borough that may also be able to provide support, for example Age Concern, MENCAP, Crossroads Care for Carers and Women's Aid.

- Rolled out multi-agency case meetings to respond to concerns about 'chaotic tenants'. These meetings include representation from the Slough Safeguarding Team to ensure safeguarding issues are identified and responded to as appropriate.

- Improved joint working arrangements: a new multiagency task group has been set up to develop better joint working between agencies with a particular focus on improving responses and support to people who are vulnerable and experiencing repeated incidents of anti-social behaviour. The Service Manager of the Safeguarding Adults Team is a member of this group.

- Supported training of Community Safety Workers: provided safeguarding awareness training to services working within the community safety, crime and disorder arena. This includes Community Wardens, CCTV staff, and staff working in the Drug Action Team.

- Revised Policies and Procedures: to include vulnerable adult definitions and safeguarding referral protocols within relevant 'community safety' policies and procedures for example the anti social behaviour (ASB) policy.

- Extended multi-agency case meetings held for ASB cases: these have been extended to include concerns relating to tenants and who may present safeguarding concerns to themselves or others. This has resulted in early

identification and prevention in instances where a vulnerable person(s) is involved or affected, as the example below illustrates.

- Improved information to workers: on the range of services that can support people who are victims of ASB and how to raise an alert to the Safeguarding Team.

- Promoted regular safeguarding input on the local multi-agency risk and public protection strategic meetings

In addition the sub group is:

- Supporting Thames Valley Police in their work to improve training of police officers across the force.

- Designing public information about the services available in the Slough area and how to contact them, particularly for people who are vulnerable and are experiencing hate crime and anti social behaviour. This will be available later in 2010.

The Safer Slough Partnership has also:

- Continued to sponsor the Hate Crime Initiative. A project designed and delivered across local schools to promote zero tolerance of hate crime against people because of their frailty or disability. The project has worked with over 870 young people in 4 schools across Slough, in excess of 100 students accessing further education, 175 member of our community and 185 people who use learning disability services

- Established a third party reporting site, for people to report incidents of hate crime and bullying.

Workforce Development and Public Awareness

A major programme of staff development and training in safeguarding commenced for all staff across the Borough, within Slough Borough Council and partner organisations. During 2009-2010 in excess of 930 staff have been trained directly by Slough Borough council. Further to this in excess of 2200 NHS staff have received an appropriate level of adult safeguarding training.

The Board has endorsed the Slough Borough Council Safeguarding Adults Workforce Development Strategy. The strategy sets out the training available to staff from all agencies that support adults who may be at risk of abuse. A synopsis of the training programme is set out on page 54.

In addition, all Slough Borough Council Elected Members have received training as part of their mandatory training programme. NHS Berkshire East is delivering awareness training to its Executive and Non Executive Directors of their Board. Work is in hand to combine Council Member training with the Primary Care Trust training and achieve an integrated training programme across both agencies.

During the period of this report a significant amount of work has been undertaken to raise public awareness of adult safeguarding and to inform the public of the appropriate actions to take should they identify a concern. There have been two distinct phases of the campaign:

- In July 2009 there was a campaign to highlight the issue of adult abuse. The campaign focused on using 'advertising' space on local buses, to communicate the issue to the general public. There was an increase of 33% in the number of alerts received compared to the previous year.

- The second phase of the campaign was in February 2010 when information materials were distributed to over 250 locations across the borough; this was complemented by articles in the local printed media and on local radio. Both phases of the campaign were supported by the use of member organisations internal communications systems.

CASE EXAMPLE 2:

This case concerns the financial abuse of a senior member of the Community living in a local care home.

A family friend was taking money from the person. The recent safeguarding publicity had raised the local profile of where people should go for help. The person made her concerns known to the home manager who then contacted the Slough AS team. At the safeguarding meeting the family friend actually confessed to taking the funds and the police are taking action accordingly. The person has had her funds protected by local financial safeguarding arrangements where she has consented to help from local care home staff.

Nationally it is recognised that adults who may be at risk of abuse or neglect still largely goes unreported or is hidden from sight. The success of the two phases of the publicity campaign has contributed significantly to this increase.

Achievements for 2009 - 2010 include:

- In excess of 2500 people who support adults who may be at risk of harm have received adult safeguarding training

- Integrated training opportunities across the agencies, to promote improved joint working practices.

- The development of bespoke training for providers of services that support adults who may be at risk of abuse.

  - The two phases of the public awareness campaign which included the use of local radio, local media and web based information printed.

Commissioning

It is important that local commissioning arrangements across the health and social care economy are properly informed by the principles of safeguarding. Therefore the Board established this group to lead on this area of work on behalf of Slough. However it was agreed that the group take a collaborative approach across Berkshire East, making good use of existing Berkshire wide networks such as Berkshire Contracts Group, Berkshire Monitoring Officers Group and the ADASS commissioning and contracts group.

The group is developing its revised terms of reference that will reflect the following objectives:

- Ensure that adult safeguarding requirements are clearly set in contracts for commissioned services, including updated legal and policy guidance.
- Ensure that monitoring mechanisms are well articulated and fulfilled.
- Agree what sanctions will be in place should the above be breached
- Agree joint approaches wherever possible
- Agreeing a process for sharing concerns
- Agree the role of lead commissioners with regards to safeguarding adults who may be at risk of harm
- Agree how a collective response to safeguarding concerns in commissioned services would be taken
- Agree a shared commissioning policy on acceptable quality ratings for purchase of registered Care
- Agree what the joint organisational response should be to safeguarding issues in commissioned services. This to include a description of the responsibilities for taking remedial action and the triggers for action.
- Develop co-ordinated care governance processes including the development of a formal method of risk assessment.

The Contribution and Achievements of the Partners

The work undertaken separately and together, by each of the Slough partner agencies and organisations, is of paramount importance to the wellbeing of vulnerable people and improvements that can be made to local safeguarding arrangements.

The section below summaries some of the work undertaken by local services and the work planned for the forthcoming year.

NHS Organisations.

Slough is served by four NHS Trusts. Heatherwood and Wexham Park Hospitals NHS Foundation Trust, which provides acute hospital inpatient services. Berkshire Healthcare NHS Foundation Trust which provides both community and in-patent mental health services and Berkshire East Community Health Services, which provides community based health services. NHS Berkshire East commissions all healthcare services across the east of Berkshire. Slough is also served by South Central Ambulance Service NHS Trust

Achievements for 2009 - 2010 include:

- In excess of 2200 Slough based NHS staff have received adult safeguarding training commiserate to their job role.
- Increase in the number of alerts being raised by NHS staff working within single agency settings.
- Launch of internal Safeguarding steering groups within NHS organisations to lead organisational developments.
- Appointment of Non Executive Board member lead for both Adult and Children's safeguarding.
- Development of both Core and Quality Contracts to ensure they are 'safeguarding compliant'.
- Review of internal governance arrangements within trusts to ensure that safeguarding activity is captured and reported on, in line with other areas of activity.
- Adoption of the Slough Borough Council Safeguarding documentation
- Berkshire Healthcare Foundation Trust also participated in two audits of safeguarding work within their joint funded services.
- Review of NHS based Safeguarding polices and practice guidance.

Areas of work planned for 2010-2011

- Targeted training for specific wards and health care settings.
- Further increase the safeguarding awareness within specific service areas (to maintain reporting)
- Allocate a Manager within Mental Health Services to lead, on behalf of the Slough locality, on all safeguarding activity to further improve compliance with agreed practice standards.
- Develop a Risk Register within NHS Berkshire East

- Continued implementation of Mental Capacity Act and Deprivation of Liberty safeguards (DoLS) training across healthcare settings.

- To further understand the data set requirements of trusts to evidence the impact of training on alert activity.

- Support the development of Safeguarding within GP practices via specific training (to be implemented during 2010 -2011).

Slough Borough Council and Thames Valley Police

As the lead agency for co-ordinating safeguarding responses and arrangements, Slough Borough Council has benefitted from highly productive local relationships with Slough Police.

Achievements for 2009 - 2010 include:

- 700 members of Slough Borough Council staff have received training during 2009-2010; this covers staff from across the council. Further to this 95% of staff working in the Community and Adult Social Care Division have received adult safeguarding training commensurate to their role.

- The development of a performance management framework to inform senior managers of adult safeguarding activity and compliance with published policy.

- Development of internal performance indicators. The indicators reflect both the timeliness and the quality of safeguarding interventions

- The development of the Safeguarding Team

- Increase in the number of alerts received that related to adults who were at risk of harm from the Indian or Pakistani communities.

As has been previously highlighted the Community Safety, Crime and Disorder group have been working with Thames Valley Police to support the force's understanding of the adult safeguarding agenda. Thames Valley Police currently have a Vulnerable Adult Co-coordinator who supports front line officers and partner agencies to ensure that a robust and effective response is provided by Thames Valley Police. The force also provides an overview of adult safeguarding to all new staff as part of its induction programme.

Areas of work planned for 2010-2011

Thames Valley Police describe the following as priority areas for the coming year.

- Development of Adult Safeguarding Policy.

- Development of referral process.

- Development of workforce training strategy

Voluntary Sector and Board Member Organisations

The Board recognises the value of local partnership working and whilst collectively the Board is responsible for driving the strategic direction of adult safeguarding work, each member organisation is also responsible for its own practice and development. During 2009-2010 Member organisations have made significant progress in their workforce training and in their ability to identify and respond to safeguarding issues.

Slough communities are supported by a large number of voluntary organisations; it would not be possible for all organisations to be represented on the Board. However the Board is keen to ensure that the voluntary sector is represented on the board; Crossroads, Slough Mencap, LINkS and Parvaaz are all members of the Board.

Achievements for 2009-2010 include:

- Training for staff and volunteers across organisations
- Review of recruitment process to ensure they are 'safeguarding compliant'
- Review and publicising organisational safeguarding policy to staff, volunteers and users of services.
- Focussing organisational thinking on adult safeguarding and adults who may be at risk of abuse

Areas of work planned for 2010-2011

- Ensuring all new projects are subject to Equalities Impact Assessments, this includes adult safeguarding issues.
- To fully implement safeguarding policy across organisations
- To further develop working relationships with relevant stakeholders to ensure a joined up response to adult safeguarding issues.
- To further develop organisational recording systems to ensure they capture adult safeguarding concerns.
- To support all institutional members to have an awareness of safeguarding and be clear how to both alert and respond

CASE EXAMPLE IN PRACTICE:

The following case summaries provide examples of the work undertaken by Slough services in response to reported safeguarding concerns. Names and locations have been changed to ensure the anonymity and protection of those affected.

CASE EXAMPLE 1:
The first concerns the allegation of sexual assault by a male resident in a nursing home. The allegation has been investigated by the Police in line with Safeguarding Procedures and is being considered by the Crown Prosecution Service. Significant work, led by the Assistant Director of Community and Adult Social Care jointly with the organisation that runs the home, CQC, the PCT, and Thames Valley Police has been undertaken to safeguard against recurrence of an incident of this nature.

CASE EXAMPLE 2:
The second concerns allegations of financial abuse by care staff in a service supporting people with a learning disability in their own homes. Once reported, the safeguarding investigation identified that financial abuse had taken place. The Police have successfully taken the case to court, with one staff member prosecuted, and 3 other managers dismissed for poor managerial practice and not protecting people appropriately. All practices in the service relating to the handling of tenants' money have been reviewed. Slough Borough Council is now working together to identify other ways the service can be improved.

CASE EXAMPLE 3:
Mr B is a senior member of the local community. Although born in the UK Mr B lived the majority of his adult life in Africa, returning to the UK in his 90's. Mr B lived with his son in a one bed roomed flat and expressed concern to his Social Worker about the manner in which his son supported him and his lack of money. On assessment it was discovered that Mr B had been physically, emotionally and financially abused by his son. Mr B who retained capacity to decide how his needs should be met was supported to move into residential accommodation: this was done in partnership with Thames Valley Police. Following his admission to residential care Mr B requested that the council refer the matter to the Office of the Public Guardian to investigate the mismanagement of the lasting power of attorney. This has resulted in the power being revoked and the matter being referred to the Police for criminal investigation. Mr B continues to be supported through care management and Slough Borough Council will support Mr B to manage his finances.

CASE EXAMPLE 4:
A Police Community Support Officer (PCSO) reported to Slough Safeguarding Team that a known class A drug user (who was heavily involved in the Slough drug supply and use) was visiting a supported housing scheme for vulnerable people with mental health problems. The care manager's visited the same day and the police spoke to the alleged perpetrator making clear that they knew of her visits and the potential risks she presented to the service users. The support provider worked effectively with the service users on maintaining their personal security. The outcome being that there have been no further problems reported.

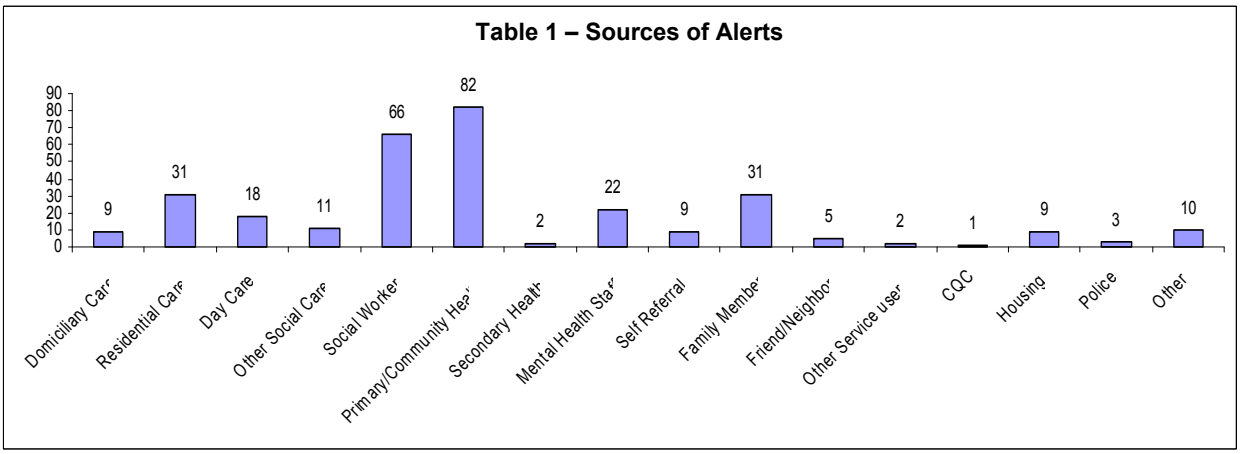
CASE EXAMPLE 5:
Following a contracts monitoring visit to a provider care home, concerns were raised about staff practice within the service. Following a strategy meeting the provider produced an improvement plan to address staff failings and in doing so uncovered more poor practice (staff sleeping on duty) that eventually led to disciplinary procedure and suspension. The service has significantly improved that Slough contracts and adult services' team are regularly monitoring.

SUMMARY OF SAFEGUARDING ADULTS DATA

Local authorities are invited to submit Adult Safeguarding activity data to the Department of Health (DH) on a half yearly basis. Slough has volunteered it's own returns which helps compare local activity and practice across comparator authorities. The first return covered October 2009 – March 2010 and the DH are yet to publish any information regarding the submitted returns. This statistical information has been broken down into three key areas of activity.

- Information relating to alerts
- Timeliness of response
- Outcome for the individual and alleged perpetrator

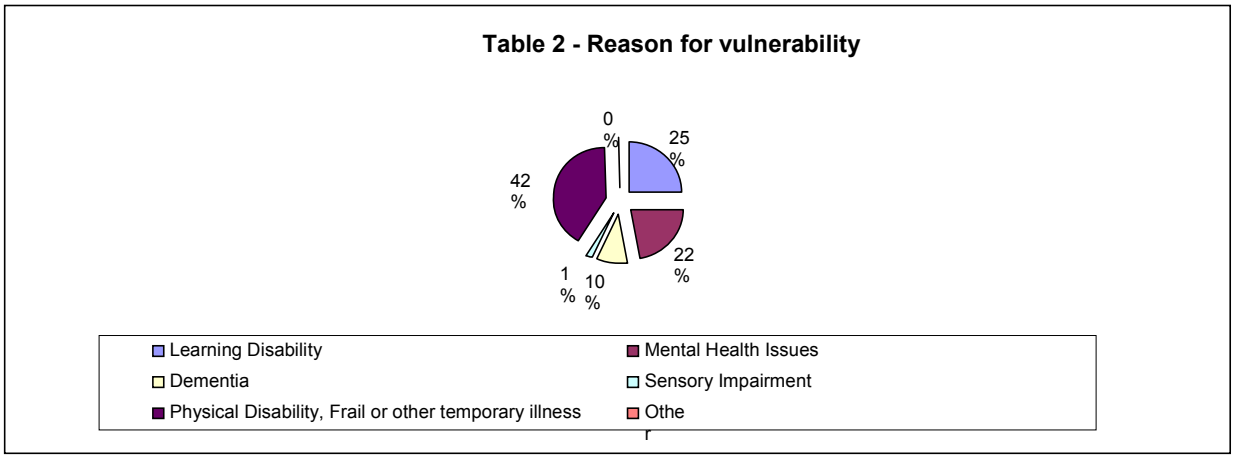
Info relating to alerts/referrals



This table identifies the source of alerts and demonstrates that 77% of all alerts are from either NHS or Social Care staff; this demonstrates the impact of the workforce development strategy that SBC has launched in partnership with the NHS and other statutory agencies. However there are pockets of under-reporting within these groupings particularly domiciliary care staff and numbers of referrals from Secondary health are also low, further interrogation of this data is required to fully understand why this is. However it is positive to note that 31% of all referrals came from the NHS.

15% of all referrals come from local citizen's (i.e. self referral) family, friends or neighbours. This shows the impact of the publicity campaign undertaken by SBC during 2009-2010.

It should be noted that current systems do not allow multiple sources of referral to be recorded for the same service user. This may well explain the low numbers from CQC and the Police.



Citizens with a physical disability or age related frailty make up 42% of people subject to safeguarding alerts. This is as expected as this particular group of citizens is the largest group of people supported by Adult Social Care Services. People with a learning disability are statistically over represented when compared to the overall referrals received. However due to the complexity of need within this group of people it is unsurprising that they are highly represented. Nationally there has been an under reporting of safeguarding concerns for people with mental health issues, however in Slough 32% of alerts relate to people with a mental health issue (including dementia) this is a positive figure and again is evidence of the partnership working, between both the statutory and voluntary sectors, as well as the due seriousness with which mental health services in Slough have engaged with the Safeguarding agenda

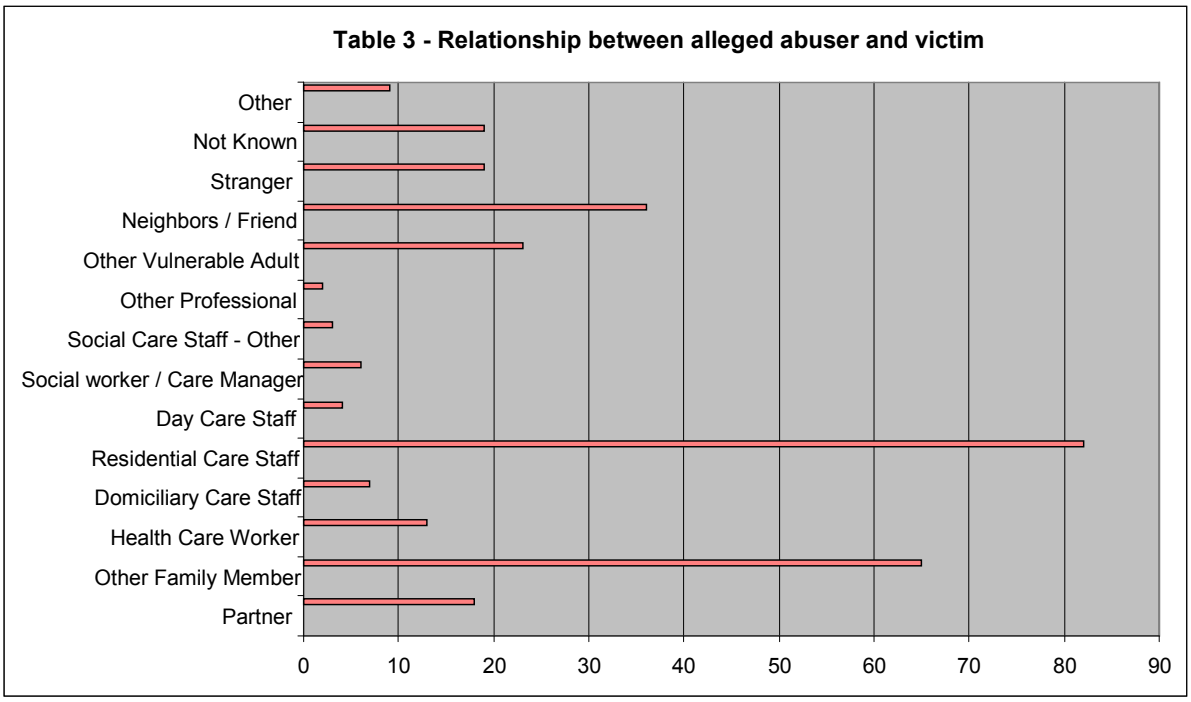


Table 3 demonstrates that the largest group of alleged perpetrators is paid staff within residential care. Statistically, this is likely to be as a direct result of the 5 safeguarding interventions undertaken by Slough Borough Council, CQC and Thames Valley Police, in major residential providers.

27% of alleged abusers were in a personal or family relationship with the 'victim'. This indicates that closer links with Domestic violence services are required to ensure that the rate of repeat victimization dose not increases.

The fourth largest group of alleged perpetrators is strangers. This underlines the need to continue in the development of our links between Safeguarding and community safety.

The current level of reporting from the domiciliary care sector appears lower than would be expected. This may be due to current systems not being able to record more than one source of alert per services uses and it is often the case that people in the community are receiving support from a number of difference agencies. However further work is required with domiciliary care providers to gain reassurance that robust systems are in place to raise safeguarding alerts where needed.

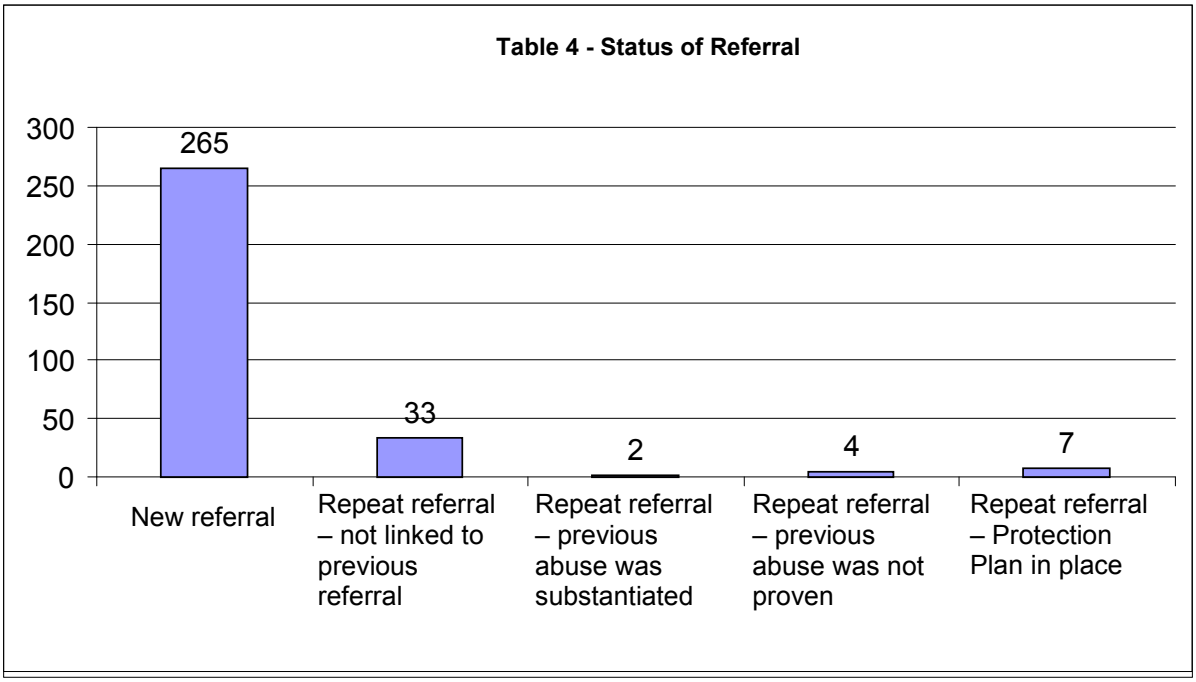
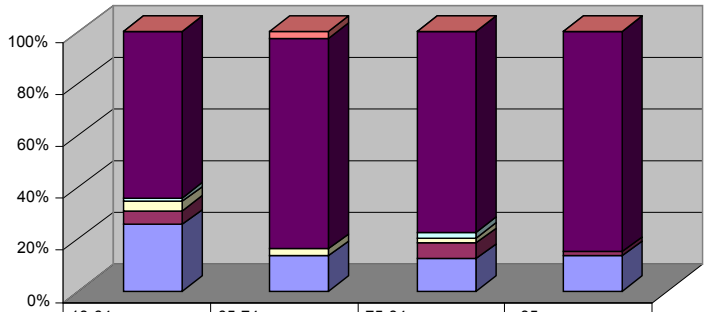


Table 4 demonstrates that 85% of safeguarding alerts were new (i.e. the adult at risk of harm or abuse has not been subject to safeguarding procedures before). Of the remaining referrals, 4% were linked to a previous referral or where a protection plan was in place but had not removed the risk of repeat incidents of abuse. Therefore this information suggests that 96% of safeguarding interventions had successfully removed or reduced the safeguarding risk.

Table 5 - Ethnicity of Victim by Age



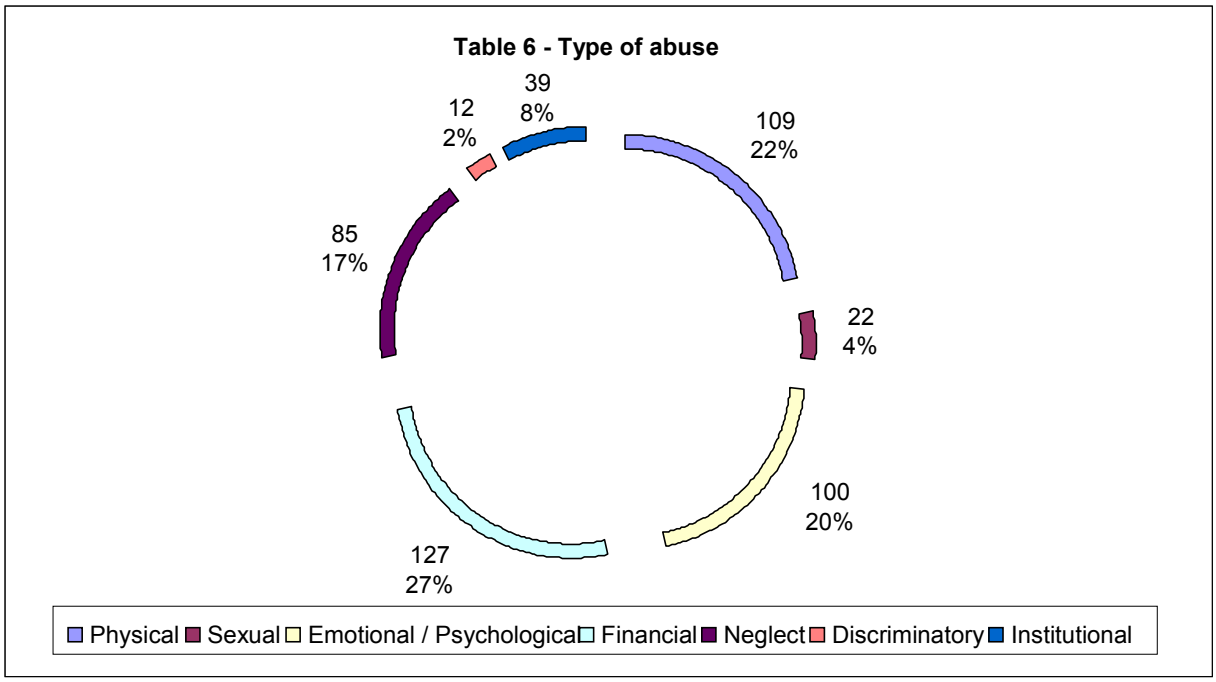
	18-64 age group	65-74 age group	75-84 age group	85+ age group
Other	0	1	0	0
White	108	30	38	51
Not Stated	2	0	1	0
Mixed	6	1	1	0
Black /Black British	9	0	3	1
Asian/Asian British	43	5	6	8

Detailed analysis of this table has been undertaken to ensure that it is accurate and possible to compare it to the 2001 census for the Slough Area. Whilst there is concern locally regarding accurate census data not take into account the transient nature of the slough population, it is the only available validated source of local population broken down by age and ethnicity. Furthermore the number of alerts received is statistically low compared to the general population and therefore exact comparisons will not be possible.

However broadly speaking the percentage of alerts by age group and ethnicity are in line with the results of the 2001 census with the exception of the Asian/Asian British grouping for the ages of 18-74, which are slightly lower than expected, but this is only by the equivalent of 4 alerts.

Those who described the ethnicity as either Black/ Black British or Asian/Asian British are over represented within the 75-84 age group are over represented but by the equivalent of 3 alerts for each group.

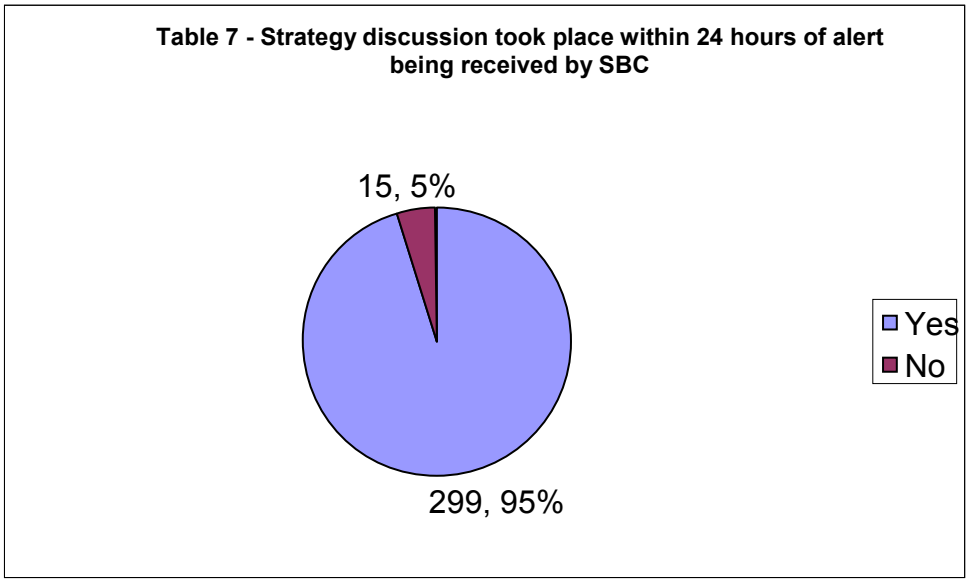
Statistically there is an over reporting for people over the age of 85 who describe their ethnicity as Asian or Asian British and this equates to 5 alerts. Following analysis of the figures this is linked to the concerns within some 5 regulated services that the Council and statutory partners have responded too.



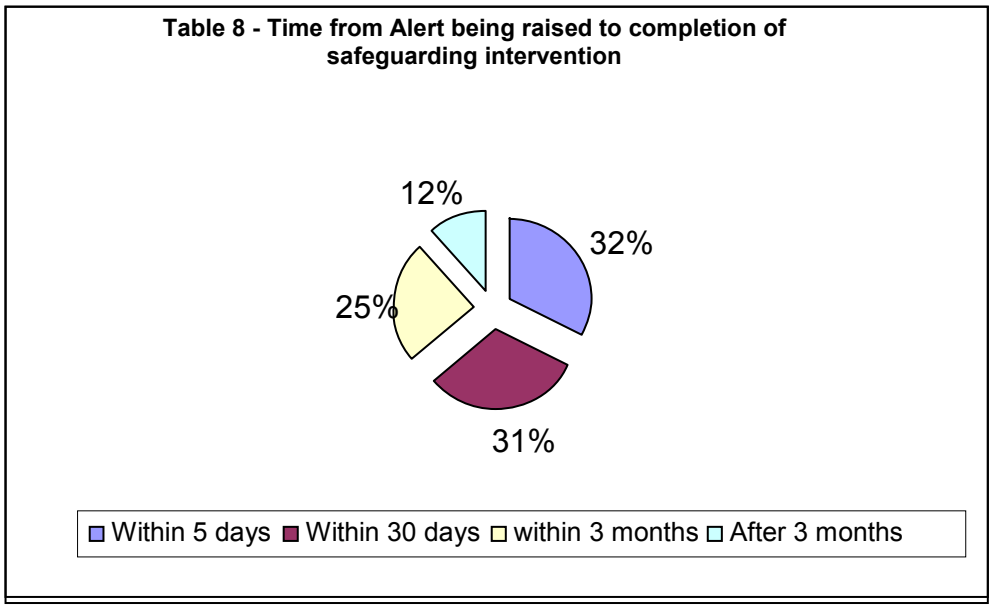
It is not possible to undertake comparison with other years due to this being the first full year of this data being provided in this format. The DH data return may well provide useful comparisons across other Local Authorities. However when comparing the data with the interim annual report (covering the first 6 months of this report) there are some slight changes. In the first 6 months of this report 11% of alerts were in relation to institutional abuse. However over the whole year this figure is only 8%. Clearly the biggest category of abuse is financial abuse, which totalled 27%. However it should be noted that one safeguarding issue involving multiple service users had a disproportionate impact on this category.

Emotional abuse is the next highest category followed by physical. This may well be due to the fact that multiple categories of abuse can be recorded; statistics show that over a third of all victims were subjected to more than one form of abuse.

Timeliness of Response



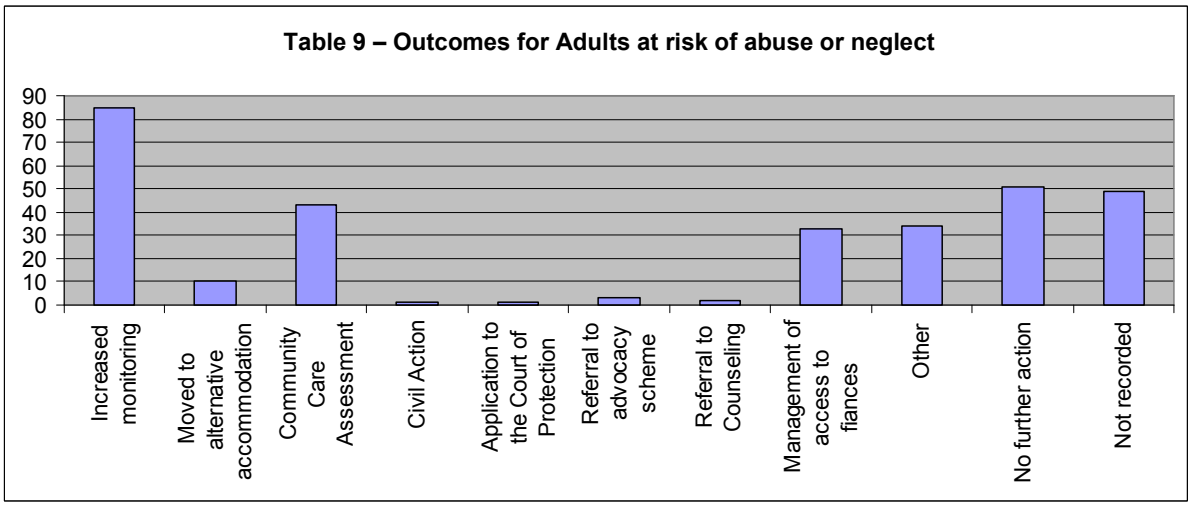
This information shows the priority that safeguarding alerts are given and the timelessness of the decision making process. The report evidences that on 95% of occasions staff held a strategy discussion within 24 hours of receiving the alert. The strategy discussion is the first opportunity for critical scrutiny of the presenting concern by qualified and experienced staff to and senior operational managers to ensure that the appropriate response is provided.



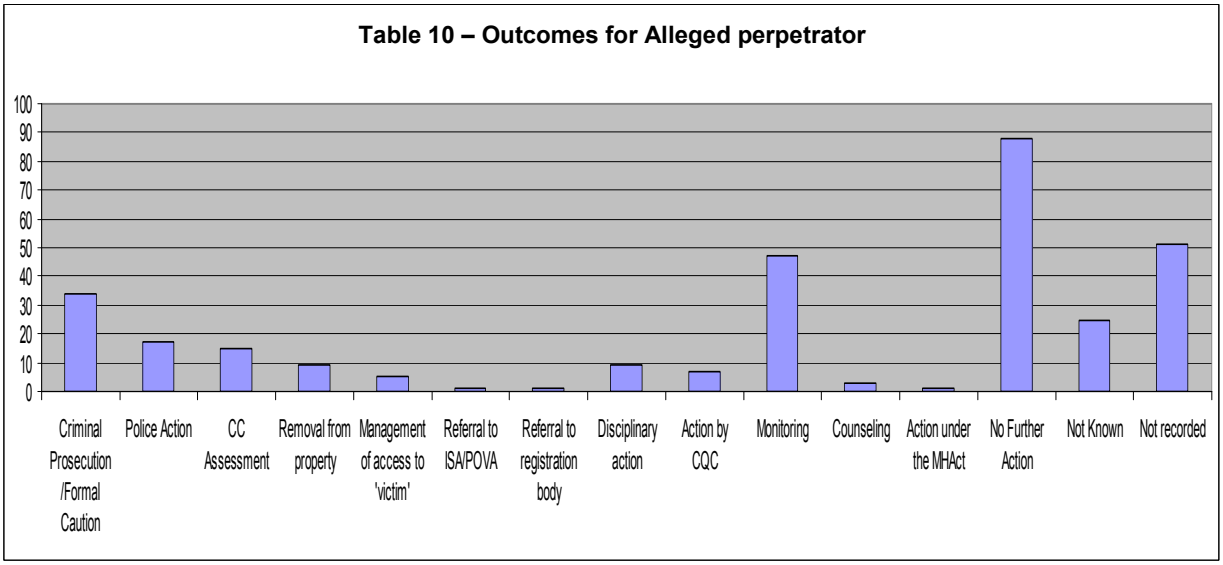
The overall objective of the safeguarding process is to support the individual to remain or regain their autonomy and safety as soon as possible. It is not desirable to see interventions remaining open for prolonged period of time, as this would indicate that the risks have not been reduced to an acceptable level.

It is positive to note that 63% of safeguarding interventions are completed within 30 days, and that only 12% of interventions lasted longer than 3 months. In part this may well be due to other process (i.e. criminal justice system, disciplinary processes or complexity of issue in focus).

Outcome for the individual and perpetrator



Increased monitoring or a community care assessment contributes to 43% of outcomes for vulnerable adult. This is positive as it indicates that support continues to be provided to the vulnerable adult and their social network. Furthermore it is also positive to note that there is a limited reliance on moving the vulnerable person to alternative services. The largest category of abuse is financial. A significant amount of work has been done by professionals involved in safeguarding interventions to manage access to vulnerable adult's finances. The report for "no further action," indicates that further work is needed to ensure that appropriate alerts are passed through the safeguarding process where there are clearly defined risks and a measurable outcome.



16% of perpetrators have been referred to the criminal justice system. This is encouraging and is indicative of the close working relationship between Slough Borough Council and local Police colleagues. Further to this 15% of perpetrators access to a vulnerable adult is being monitored, with a further 5% receiving a community care assessment. Again this is a comparatively positive figure as it is demonstrates practitioners working collaboratively with perpetrators to reduce or remove the risk of further indicants of abuse whilst supporting the individuals to continue with the relationship.

The positive working relationship practitioners have developed with the area CQC inspector is also evidenced by the number of outcomes being achieved by CQC. 3% of alleged abuser had disciplinary actions taken against them however it should be remembered that 37% of alleged abusers were paid staff. It is the case however that only one outcome can be recorded per perpetrator so if a staff member has been subject to criminal prosecution then it may well be that it shows up in that column rather than the disciplinary action.

Further work is needed with staff across the Council and in partner organisations to improve identification and reporting of safeguarding concerns within non health and social care services. Again this is particularly crucial in light of personalisation where individuals will have greater access to universal services rather than being in receipt of directly provided services from statutory agencies. The issue of individual

confidence in local service providers is a key element of successful, local brokerage and market development. However all local authorities need to work up viable procedures for enabling both eligible and self funding service users to make use of providers who have had some sort of checking.

PLANNED PRIORITIES FOR 2010 - 2011

KEY STRATEGIC THEME	KEY AREAS OF WORK
1. Prevention	Develop a common definition and understanding of safeguarding and it's relationship to community safety.
	Public Information about support services for vulnerable people who are victims of the anti-social behaviour of others will be made available in a range of formats and languages.
	Develop a safeguarding prevention strategy common to all key partners.
2. Risk	Raise awareness of safeguarding and choice with vulnerable people who are self funders or who have statutory funded support delivered through a personalised route
	Work across agencies and through the safeguarding partnership to develop a comprehensive approach to safeguarding and personalisation, embracing positive risk-taking that balances risk and personal choice.
3. Partnership Working	Build on existing partnership arrangements to develop strong links with organisations Berkshire wide or at a local level that promote the safeguarding agenda.
	Develop processes for sharing and collection of safeguarding information across partner organisations.
	The Board supports and empowers partner organisations to develop robust safeguarding arrangements and the development of a lead safeguarding role.
4. Supporting the safe delivery of support to vulnerable people	Development and adoption of common safeguarding standards for contract documentation
	Agreement of triggers for intervention and de-escalation
	Working with domiciliary care providers to gain reassurance that robust systems are in place to respond to safeguarding alerts where needed.
	Host an annual Safeguarding Conference to engage providers of services, users of services, people directing their own support and other relevant stakeholders in the safeguarding agenda

KEY STRATEGIC THEME	KEY AREAS OF WORK
5. Improving Awareness and Community Engagement	Improve public awareness of the Board's role.
	Development of targeted and general public awareness campaigns to achieve engagement across all communities.
	Working specifically with Slough's diverse communities to raise the profile of safeguarding and how communities can seek support, advice and assurance on issues of concern.
	Continue with information and publicity campaigns to ensure that all citizens of Slough are provided with accessible information that empowers them to keep safe and raise concerns if they need to.
	Work with health colleagues & GPs to improve awareness, identifying early signs of safeguarding or abuse
	Development of service user engagement to better inform safeguarding developments and responses through experts by experience
6. Workforce Development	Review of current Workforce Development Strategy to ensure that it is applicable to all agencies, professionals and practitioners that support or work with vulnerable adults who maybe at risk from harm
	Workforce Development Strategy to reflect changes in support delivery through personalisation so safeguarding principles are maintained
	Review and validation of training across all partners to measure its impact in the delivery of improved outcomes and safe support to vulnerable people.
	Better engagement of private, not for profit and voluntary sector services in awareness training programmes, its development and validation.
	Identify the developments required to improve opportunities for joint training between agencies, better engagement of care organisations in training and specially tailored training.
	Develop and implement a combined training package for Council Members, NHS Berkshire East Executive and Non Executive Directors and Constituent Board Members Committee Members to achieve an integrated training programme across all agencies.

KEY STRATEGIC THEME	KEY AREAS OF WORK
7. Improved processes, actions and delivery of the Board's work	The Board will consolidate its sub group structure to deliver on strategic themes and ensure cross agency engagement in the safeguarding agenda
	Work to formulate and publish necessary processes that aid partnership working and deliver the Board's work (e.g. Serious Case Review, Serious Untoward Incidents etc)
	Review the Berkshire Safeguarding procedures to ensure they are fit for purpose.
	Engagement in the review the Berkshire Safeguarding procedures to ensure they remain fit for purpose.
	Ensure the Board monitors and drives performance and is appraised of standards across Berkshire to enable meaningful comparisons

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SLOUGH SAFEGUARDING PARTNERSHIP ADULTS BOARD

TERMS OF REFERENCE

1. BACKGROUND
Why do we need a Slough Safeguarding Adults Board?

1.1 The Department of Health document "No Secrets" (March 2000)[1] recommended the establishment of Adult Protection Committees to oversee multi-agency scrutiny of the protection of vulnerable adults from abuse. Until 2008 Windsor & Maidenhead, Slough and Bracknell have operated an East Berkshire wide Safeguarding Adults Board.

1.2 On-going developments and work with government regulators - Commission for Social Care Inspection (CSCI) - reinforce that the statutory lead for Safeguarding remains with each local authority. To meet this requirement and be responsive to its local population, Slough along with the other unitary authorities, will have its own Safeguarding Adults Board from 2009.

2. PRINCIPLES AND AIMS OF THE BOARD
The context in which the Board will work

2.1 It is recognised and accepted that all adults:

- Have the right to live their life free from violence, fear and abuse.
- Have the right to be protected from harm and exploitation
- Have the right to independence, which involves a degree of risk.
- Have the right to be listened to, treated with respect and taken seriously.

2.2 The role of all statutory agencies, their partners, carers and users of services within the Borough of Slough have a duty to ensure that these principles are upheld and take action where these rights are infringed.

2.3 The Safeguarding Adults Partnership Board (The Board) recognises and adopts the approach to adult protection as specified under "No Secrets", the Mental Capacity Act and other related legislation and policy. In line with the key principles set out in the Berkshire Policy and Procedures (p12), member organisations of The Board will:

[1] No Secrets (March 2000) Guidance on Developing and Implementing Multi-Agency Policies and Procedures to Protect Vulnerable Adults from Abuse' (March 2000)

- Reaffirm their commitment to a policy of zero tolerance of abuse within each of their member organisations.

- Take seriously the duty placed on public agencies under Human Rights legislation to intervene proportionately to protect the rights of citizens.

- Act on the principle that any adult at risk of abuse or neglect should be able to access public organizations for advice, support and appropriate protection and care interventions, which enable them to live without fear and in safety.

- Recognise that except where the rights of others would be compromised, citizens have a right to make their own choices in relation to safety from abuse and neglect. Interventions will be based on the presumption of mental capacity unless it is determined that an adult does not have the ability to understand and make decisions about his or her own personal well-being and safety.

- Recognise the right to privacy. Information about an adult who may be at risk of abuse and neglect will only be shared within the framework of the Safeguarding Adults Information – Sharing Protocol.

- Recognise their public duty to protect the human rights of all citizens including those who are subject of concern but who are not covered by the Safeguarding Adults Procedures. This duty falls on each of the Board's member organisations who will offer signposting, advice and support, as appropriate to their organizations.

2.4 The Board is positively committed to opposing discrimination against people on the grounds of race, religion, gender, age, disability, marital status or sexual orientation

2.5 The role of The Board will be to work as a multi-agency group that has:

- Strategic and operational leadership and stewardship in maintaining these principles, working as a multi-agency group
- Effective strategic governance of safeguarding at senior management level across partner organisations
- Public accountability for safeguarding arrangements and outcomes.
- Informs and support East Berkshire and cross boundary safeguarding arrangements.
- Addresses poor practice, robustly acting in ensuring these principles are maintained, taking actions wherever and whenever necessary.

3. OBJECTIVES
What will the board do

3.1 As a multi-agency Board of senior representatives, the Board will carry out the follow key functions:

- Oversee the development of effective interagency policies & procedures for safeguarding and promoting the welfare of these adults within the Slough Borough

- Provide support and guidance to communities and organisations to ensure that in Slough we are actively identifying and preventing the circumstances in which neglect and abuse occurs, promoting the welfare and interests of vulnerable adults.

- Develop a robust overarching strategy for Safeguarding in Slough, within which all agencies set their own strategy and operational policy.

- Raise awareness, knowledge and understanding of abuse and neglect in order that communities and organisations know how to respond effectively and coherently where issues arise

- Engage and encourage dialogue with Borough Partnerships (within Slough and where appropriate across Berkshire) with responsibilities for the safety and welfare of all adults so that we are all able to respond effectively to vulnerable adults.

- Ensure that vulnerable adults who use services we provide or commission are safe and their care and treatment is appropriate to their needs.

- Ensure that each organisation has systems in place that evidence that they discharge their functions in ways that safeguard vulnerable adults

- Become a Board that together learns and shares lessons from national and local experience and research

- Develop systems to audit and evaluate the impact and quality of safeguarding work that enables for continuous improvement of interagency practice, including lessons learned from practice

- Develop and maintain a strong and evolving network of stakeholders including vulnerable adults, their carers and advocates.

- Promote best practice in prevention and investigation by learning from and contributing to national research and policy development, ensuring that this is acted upon.

- Undertake joint serious case reviews where a vulnerable adult when it is confirmed or there is strong evidence to suggest that an adult has died, been significantly harmed or put at risk as a result of abuse or neglect

- Ensure coordinated and timely operational processes, for identifying and investigating any incidents of abuse and protect vulnerable people.

3.2 In order to achieve these objectives, organisations and agencies agree to:

- Work together on the prevention, identification, investigation and treatment of alleged suspected or confirmed abuse of vulnerable adults

- Ensure that vulnerable adults have the same rights as others in the prosecution of criminal offences and pursuit of civil remedies

- Develop and implement policies and procedures within a multi agency framework to protect vulnerable adults;

4. MEMBERSHIP
Who will attend

4.1 The core membership of The Board will be:

- Commissioner (Elected Slough Borough Council Member) - Health and Wellbeing
- Commissioner (Elected Slough Borough Council Member) - Opportunities and Skills
- Strategic Director Community & Wellbeing (DASS)
- Assistant Director, Community & Adult Care
- Thames Valley Police - Public Safety Unit
- Head of Service, Green and Build (Community Safety & Safer Slough Partnership)
- Assistant Director, Learning, Skills and Cultural Services
- Director Berkshire East PCT
- Assistant Director, Heatherwood & Wexham Park Foundation Trust
- Assistant Director Berkshire Mental Health Foundation Trust
- Assistant Director Housing Strategy/People First
- Royal Berkshire Fire and Rescue Service
- Commission of Social Care Inspection – Lead Inspector for Safeguarding
- Age Concern - Chief Executive,
- Mencap - Chief Executive,

- East Berkshire MIND - Director
- Berkshire Care Association
- Slough Cross Roads Care Scheme - Chief Executive,
- South Central Ambulance Service
- Crown Prosecution Service
- Local Involvement Networks (LINks)

4.2 Appendix 1, "Statement of Commitment", sets out the role, function and responsibilities of being a Board Member.

4.3 ***Constituent Agencies***: Partner organisations will recognise the importance of securing effective leadership by nominating persons who are of seniority to be Board members, acting on their behalf.

4.4 ***Co-opted members***: As determined and required by the Board, it may co-opt other members as necessary. This will include:

- Senior lead for Safeguarding, and Safeguarding Co-ordinator to support the work of the board (NB these posts are under review and development).
- Chairs and nominated members of the Slough Safeguarding Partnership working groups, and other subgroups of The Board.
- Secretariat support for The Board, to be provided by the Directorate of Community and Well Being, Slough Borough Council.
- Named officers, speakers, and organisations relevant to achieving the key priorities of the Board.

All attendees will be invited in a consultative capacity.

4.5 ***Observers:*** Subject to the approval of the Chairperson, the Board may agree to observers being in attendance.

4.6 ***Chair and Vice-Chair:*** The Director of Adult Social Services retains the statutory responsibility for the functioning of The Board. The Slough Safeguarding Adults' Partnership Board will appoint an Independent Person as Chair, who will act with impartiality and will not be a member of The Board. The person appointed will occupy the 'office' for two years. A Vice Chair will be agreed as necessary.

5. GOVERNANCE

5.1 The Board will report to the Safer Slough Partnership (subgroup of the Local Strategic Partnership) to the Health Scrutiny Panel every six months or more frequently if required. (See Appendix 2)

5.2 The Chairperson of the Board will be responsible for ensuring that an annual report of the Board is prepared concurrent with the municipal year and made publically available

5.3 The annual report shall be made published on the Council's website. It is the responsibility of all partner agencies to present the Annual Report to their respective senior management teams and constitute decision making body within 3 months of the report publication.

6. RELATIONSHIP TO OTHER BOARDS

How the Board and other groups and forums link up

6.1 The Board will ensure that there are appropriate representatives on the following boards and forums to represent and champion safeguarding:

- Slough Safer Neighbourhood Partnership
- Slough Children's Safeguarding Board
- Slough Domestic Violence Forum
- Slough DAAT
- MAPPA
- Slough Mental Health Local Implementation Team
- Slough Older Peoples, Physical Disability, Learning Disability and Carers partnership boards.
- The individual Partnership Boards for Older People; Physical Disability; Learning Disability; Carers.
- Health and Wellbeing Policy Development Group
- East Berkshire Joint Commissioning Board

6.2 It is the role of representatives to identify matters significant to the achievement of local safeguarding developments, represent the views and priorities of the Board, and report back milestones and outcomes.

7. BOARD SUBGROUPS AND REFERENCE GROUPS

7.1 The following shall be established as subgroups groups of The Board, with the Chair and membership recommended by The Board (and may be redefined as necessary by the Board):

- Workforce Development and Training Subgroup
- Communications and Public Awareness Subgroup
- Performance and Audit Subgroup

7.2 The subgroups will be accountable to the Board. Work undertaken will be commissioned by the Board and progress against targets set and outcomes will be reported to the Board. The role of the groups will include:

- To consider new practice, policy and procedural issues and to propose and initiate appropriate action plans to address those issues.
- To analysis data and compile and present to the Board a quarterly quantitative and qualitative performance report.
- To consider the resource implications of safeguarding and make recommendations to the board.
- To set up time-limited task groups or individuals to undertake specific tasks on policy, procedure and practice matters as necessary.
- To evaluate information presented through statistics, user surveys, DoH inspections, etc, and propose alterations to policies, procedures and practice to the Board for approval.
- To review procedures in partnership with the East Berkshire partners
- To monitor the effectiveness of public information and communication regarding adult protection and to find ways of communicating to all.
- To monitor the effectiveness of training in increasing awareness, and in improving the effectiveness of protection planning and safeguarding interventions.
- To seek and collate the views of user and care stakeholders to inform best practice.

7.3 In addition, the Board will establish two reference groups for the purpose of capturing feedback from key stakeholders and informing developments:

- User and Carer Experience Reference Group
- Provider Reference Group

8. FREQUENCY OF BOARD MEETINGS & MEETING MINUTES

8.1 The Board will meet at least 4 times in every year at such times as may be determined by the Chairperson. Dates will be set a year in advance.

8.2 The Board will nominate subgroups to meet more regularly on behalf of the Board. Representatives of the major constituent agencies will be nominated to serve on the subgroups.

8.3 Minutes of the meetings of The Board shall be taken by a secretary of the Directorate of Community & Well-Being, Slough Borough Council.

8.4 The Chairperson of the meeting shall move that the minutes of the previous meeting shall be approved as a correct record.

8.5 Minutes of the Board and the Annual Report will also be forwarded to the Chairs of the following strategic planning forums, to advise on issues arising and inform cross strategic planning as set out in 6.1 above:

9. SERIOUS CASE REVIEW (SCR)

9.1 It will be the responsibility of the Board to set up a serious case review investigation and review panel, for serious case incidents occurring within the Borough boundary. The Board will elect the independent chair to the SCR panel, agree panel membership to be of sufficient seniority and expertise, and define and agree the terms of reference for the review.

9.2 The Board will receive interim and final reports of the SCR panel and agree actions to be taken to implement the SCR findings and recommendations. The Board will monitor implementation of agreed actions and share lessons learned with members of the East Berkshire Safeguarding Board.

9.3 The Chair of the Board and Strategic Director Community and Wellbeing will present the review findings, recommendations and agreed actions to Health and Social Care Scrutiny Panel

Appendix 1 - Statement of Commitment

Appendix 2 – Confidentiality Statement (To be finalised)

Appendix 3 – Structure of Board within the wider governance framework

Serious Case Review Protocol (In development) will be added when completed

APPENDIX 1 - STATEMENT OF COMMITMENT

Each member of the Slough Safeguarding Partnership Board (The Board) gives a commitment to the following:

Representation

Represent an agency, organisation or representative group of people with full authority.

In doing so to raise issues on their behalf, contribute to discussion and debate and ensure a dissemination of information back to that representative group, agency or organisation.

To ensure that the representative group, agency or organisation they represent engages with the Safeguarding and Adult Protection agenda and embeds safe practice in their organisation, agency or representative group ensuring positive leadership and stewardship of the issues

Values

Upholding the values statement of the Board as set out in the Terms of Reference, ensuring that vulnerable adults are protected from abuse, working with partners to safeguard them through strategic leadership within the representative group, agency or organisation they represent

Attendance

To attend every Board meeting or to arrange for a suitable representative to act on their behalf (and who is able to act with full authority) at any meeting they are unable to attend

Developments and Work Programme

To be involved in developments and where necessary contribute to the subgroups of The Board so there is a diverse and richness of input to the work and outputs from The Board

Annual Report

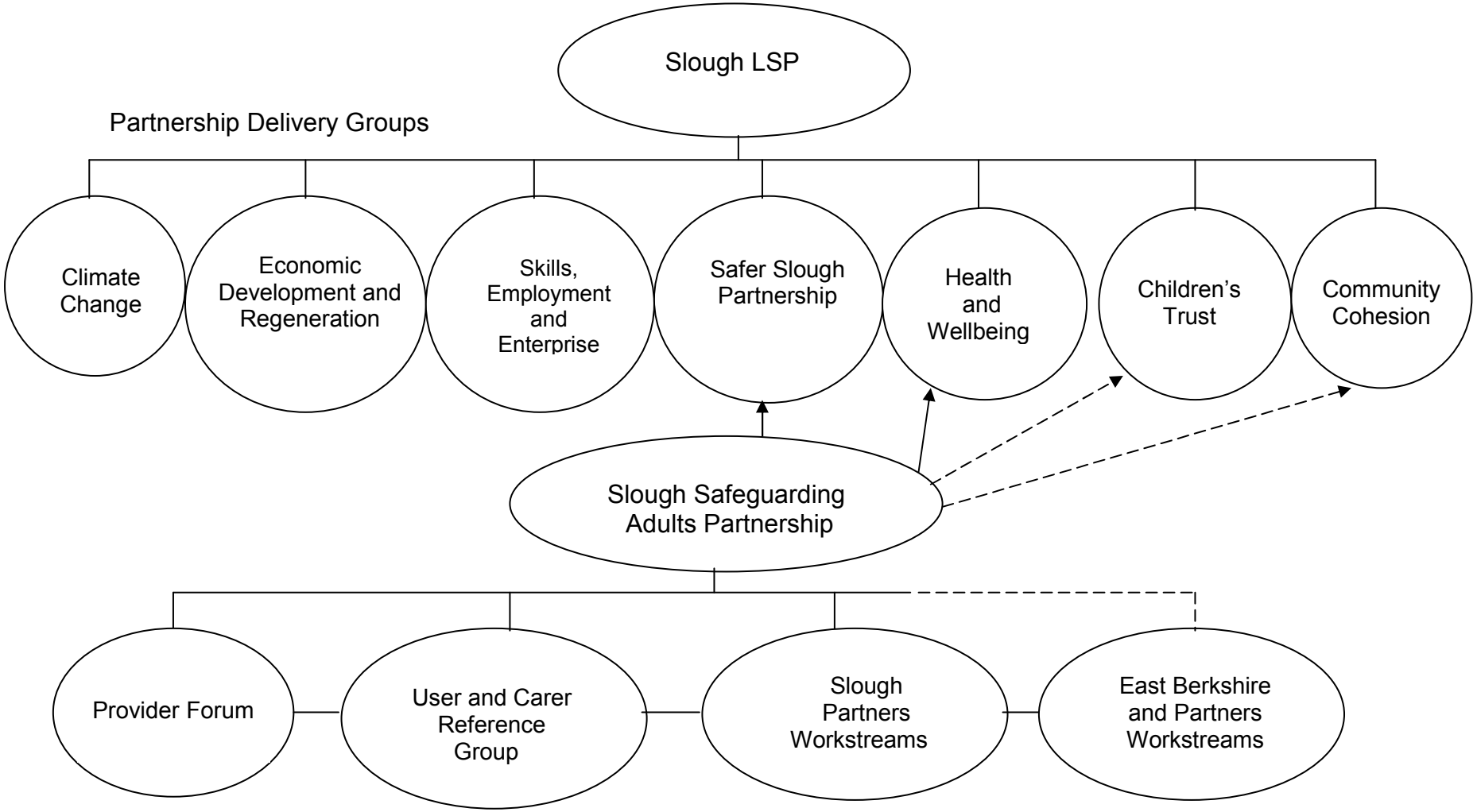
Make a contribution, as necessary, for the Board's Annual Report

APPENDIX 2 - CONFIDENTIALITY STATEMENT

The Board is convened under “no secrets” guidance and will conform to equal opportunities and anti discriminatory criteria. All people attending must respect the confidentially of the issues discussed and in particular where case examples are discussed these issues are confidential and should not be disclosed to other people without the expressed permission of the Chair.

It is noted that for wider learning information discussed at The Board does need to be shared within the wider community but this must always be done retaining anonymity in relation to named individuals, services or agencies. Where board members are uncertain as to what can be shared this needs to be determined at The Board and agreed as part of the minutes.

APPENDIX 3 – RELATIONSHIP TO SLOUGH LOCAL STRATEGIC PARTNERSHIPS



CONSTITUTION OF THE SLOUGH SAFEGUARDING ADULTS PARTNERSHIP BOARD

1. AIMS AND OBJECTIVES

1.1 The Safeguarding Adults Partnership Board of Slough is a multi-agency initiative to serve the local population. The aims of the Board are to:-

- Ensure robust strategic partnerships and leadership arrangements for safeguarding adults in Slough.
- Provide effective governance of safeguarding at senior management level across partner organisations, and public accountability for safeguarding arrangements and outcomes.
- Inform and support East Berkshire and cross boundary safeguarding arrangements.

1.2 The desired outcomes of the Slough Safeguarding Adults Partnership Board are complementary to the strategic aims set out in Berkshire Safeguarding Adults Policy and Procedures 2008 (A5, p11). The outcomes include:

- A Slough partners safeguarding vulnerable adult strategy.
- Local partnership plans that deliver agreed strategic priorities.
- Coordinated and timely operational processes, for identifying and investigating any incidents of abuse, and that protect vulnerable people.
- Development of preventative measures to lessen the likelihood of abuse
- Robust protection planning through effective joint working arrangements
- A competent workforce
- Effective monitoring and performance management systems and the delivery of performance improvement.
- Raised awareness and reporting of all forms of abuse amongst the general public, service users, and voluntary workers, as well as those within member organizations
- Involvement of service users in the development of policy and practice
- Positive outcomes for service users, and improved quality of life as a result of safeguarding activity
- A framework for continuous improvement of interagency practice, including lessons learned from practice.

1.3 Working principles. The Board recognises and adopts the approach to adult protection as specified under national policy in “No Secrets”, the Mental Capacity Act and other related legislation and policy. In line with the key principles set out in the Berkshire Policy and Procedures (p12), member organisations of the Slough Safeguarding Adults Partnership Board:

- Recognise that it is every person’s right to live their life free from violence and abuse.
- Reaffirm their commitment to a policy of zero tolerance of abuse within each of their member organizations.
- Take seriously the duty placed on public agencies under Human Rights legislation to intervene proportionately to protect the rights of citizens.
- Act on the principle that any adult at risk of abuse or neglect should be able to access public organizations for advice, support and appropriate protection and care interventions, which enable them to live without fear and in safety.
- Recognise that except where the rights of others would be compromised, citizens have a right to make their own choices in relation to safety from abuse and neglect. Interventions will be based on the presumption of mental capacity unless it is determined that an adult does not have the ability to understand and make decisions about his or her own personal well being and safety.
- Recognise the right to privacy. Information about an adult who may be at risk of abuse and neglect will only be shared within the framework of the Safeguarding Adults Information –Sharing Protocol.
- Recognise their public duty to protect the human rights of all citizens including those who are subject of concern but who are not covered by the Safeguarding Adults Procedures. This duty falls on each of the Board’s member organizations who will offer signposting, advice and support, as appropriate to their organizations.

The Safeguarding Adults Partnership Board is positively committed to opposing discrimination against people on the grounds of race, religion, gender, age, disability, marital status or sexual orientation

2. MEMBERSHIP

2.1 The core membership of the Safeguarding Adults Partnership Board is as follows:

Commissioner, Health and Wellbeing
Commissioner, Opportunities and Skills
Strategic Director Community & Wellbeing (DASS)
Thames Valley Police
Head of Service Green and Build (Community Safety & Safer Slough Partnership)
Assistant Director, Health and Social Care
Assistant Director, Learning, Skills and Cultural Services
Director Berkshire East PCT
Assistant Director, H&WPH Foundation Trust
Assistant Director Berkshire Mental Health Foundation Trust
Assistant Director Housing Strategy/People First
Senior Officer Royal Berkshire Fire and Rescue Service
Regulation Inspector, Commission of Social Care Inspection
East Berkshire MIND - Director
Chief Executive, Age Concern
Chief Executive, Mencap
Representative Berkshire Care Association
Chief Executive, Slough Cross Roads Care Scheme.

2.2 Selection of Members by Constituent Agencies

All partner organisations will recognise the importance of securing effective co-operation by nominating persons who are of seniority. The nominee will have sufficient authority to speak on their agency's behalf and make key strategic decisions to a level set out in this constitution and commit resources where required.

Nominations for membership to the Board will be made in writing to the Chairperson of the Board. Membership of the Safeguarding Vulnerable Adults Partnership Board will be reviewed annually.

2.3 Attendance by non Board Members:

As determined and required by the Board:

- Head of Service (Safeguarding), and Safeguarding Co-ordinator to support to work of the board.
- Chairs and nominated members of the Slough Safeguarding Partnership working groups.
- Secretariat support for the Slough Safeguarding Adults Partnership Board, to be provided by the Directorate of Community and Well Being, Slough Borough Council.
- Named officers, speakers, and organisations relevant to achieving the key priorities of the Board.

All attendees will be invited in a consultative capacity.

2.4 Observers

Subject to the approval of the Chairperson, the Board may agree to observers being in attendance.

2.5 Chair and Vice-Chair

a) The Slough Safeguarding Adults Partnership Board will make appointments to the Chair and Vice-Chair. The persons elected will occupy the 'office' for two years.
b) The Chairperson and Vice-Chairperson shall not be an *officer* of Slough Borough Council.

3. DECISION MAKING OF THE BOARD

3.1 Members of the Safeguarding Adults Partnership Board of Slough will have delegated to them by their agency or organisation, authority to make decisions in relation to:

- Strategic development of Safeguarding in Slough.
- Policy, procedure and practice in adult protection.
- Performance management and improvement.
- Workforce, to include the commitment of staff and time and other resources as required.
- Governance arrangements, to include regular reporting of the Boards work programme, and safeguarding performance and activity data, through respective agency or organisation. governance and public accountability arrangements.
- Investigations under serious case review arrangements.

3.2 Decisions and recommendations made by the Board will be reached by consensus where at all possible. Where this can not be achieved the Chair will invite members to vote.

3.3 It is recognised by all members that some key decisions proposed by the Board may require resolution by the organisations constitute decision making body. For example, Cabinet, NHS Board.

4. GOVERNANCE

4.1 The work of the Slough Safeguarding Adults Partnership Board will report to the Safer Slough Partnership , subgroup of the LSP and to the Health Scrutiny Panel 6 monthly, or more frequently if required.

4.2 The Chairperson of the Board will be responsible for ensuring that an annual report of the Board is prepared concurrent with the municipal year.

4.3 The annual report shall be made published on the Council's website. It is the responsibility of all partner agencies to present the Annual Report to their

respective senior management teams and constitute decision making body within 3 months of the report publication.

5. RELATIONSHIP TO THE EAST BERKSHIRE SAFEGUARDING ADULTS PARTNERSHIP BOARD

5.1. The East Berkshire Safeguarding Partnership Board consists of members from the three East Berkshire Councils, Heatherwood and Wexham Park NHS Foundation Trust, East Berkshire Primary Care Trust, Berkshire Mental Health NHS Foundation Trust, Thames Valley Police and partner agencies, and established to:

- Compile and review the Berkshire Multi-agency Safeguarding Procedures.
- Ensure the effective workings of the multi-agency procedures.
- Identify shared training needs.
- Identify lessons learned and share good practice.
- Act as a consultative forum.
- Make recommendations to the East Berkshire Councils and partner agency bodies for decision.

5.2 The responsibility for the appointment of the Chair of the East Berkshire Safeguarding Adults Partnership Board rests with the Director of Adult Social Services of the Borough Council in conjunction with the Directors of Adult Services for Bracknell Forest Council, and The Royal Borough of Windsor and Maidenhead.

5.3 The nominated Slough Lead Officer on East Berkshire Safeguarding Adults Partnership Board representing the Council, will also be a non voting member of the Slough Safeguarding Vulnerable Adults Partnership Board and support the work of the Board.

5.4 A progress report on the work of the East Berkshire Safeguarding Adults Partnership Board will be made by the Lead Officer and be a standing item at each Slough Safeguarding Adults Partnership Board.

5.5 The Slough Safeguarding Adults Partnership Board will receive and consider all recommendations, and other matters for decision, referred by the East Berkshire Safeguarding Adults
Partnership Board and that require local ratification in line with the constitution of the Slough Safeguarding Vulnerable Adults Partnership Board.

5.6 Minutes of the East Berkshire Safeguarding Adults Partnership Board will be circulated to members of the Slough Safeguarding Adults Partnership Board and visa versa.

6. RELATIONSHIP TO OTHER BOARDS

6.1 The Slough Safeguarding Adults Partnership Board will ensure that there are appropriate representatives on the following boards and forums to represent and champion safeguarding:

- Slough Safer Neighbourhood Partnership
- Slough Children's Safeguarding Board
- Slough Domestic Violence Forum
- Slough DAAT
- MAPPA
- Slough Mental Health Local Implementation Team.
- Slough Older Peoples, Physical Disability, Learning Disability and Carers partnership boards.

6.2 It is the role of representatives to identify matters significant to the achievement of local safeguarding developments, represent the views and priorities of the Board, and report back milestones and outcomes.

7. FREQUENCY OF MEETINGS & MEETING MINUTES

7.1 The Slough Safeguarding Adults Partnership Board will meet at least 6 times in every year at such times as may be determined by the Chairperson.

7.2 The Board will nominate subgroups to meet more regularly on behalf of the Board. Representatives of the major constituent agencies will be nominated to serve on the subgroups.

7.3 Minutes of the meetings of the Slough Safeguarding Adults Partnership Board shall be taken by a secretary of the Directorate of Community & Well-Being, Slough Borough Council.

7.4 The Chairperson of the meeting shall move that the minutes of the previous meeting shall be approved as a correct record.

7.5 Minutes of the Board and the Annual Report will also be forwarded to the Chairs of the following strategic planning fora, to advise on issues arising and inform cross strategic planning:

- Slough Safer Neighbourhood Partnership
- Slough Children's Safeguarding Board
- Slough Domestic Violence Forum
- Slough DAAT
- MAPPA
- Slough Mental Health Local Implementation Team
- Slough Older Peoples, Physical Disability, Learning Disability and Carers partnership boards.
- East Berkshire Safeguarding Adults Partnership Board

8. LEGAL ADVICE

8.1 A Legal Adviser will be provided by Council when appropriate. The Adviser will normally attend meetings of the Board and the Subgroups only when required.

8.2 It may be appropriate for non Council Board members also to seek legal advice from and on behalf of the agencies and organisation they are representing.

9 BOARD SUBGROUPS AND REFERENCE GROUPS

9.1 The following shall be established subgroups groups of the Slough Safeguarding Adults Partnership Board (and may be redefined as necessary by the Board):

- Workforce Development and Training Subgroup
- Communications and Public Awareness Subgroup
- Performance and Audit Subgroup

9.2 The Chair and Members of these subgroups will be nominated by the Slough Safeguarding Adults Partnership Board and may also be members of the East Berkshire Safeguarding Partnership Board Working Committee or Subgroups.

9.3 The subgroups will be accountable to the Board. Work undertaken will be commissioned by the Board and progress against targets set and outcomes will be reported to the Board. The role of the groups will include:

- To consider new practice, policy and procedural issues and to propose and initiate appropriate action plans to address those issues.
- To analysis data and compile and present to the Board a quarterly quantitative and qualitative performance report.
- To consider the resource implications of safeguarding and make recommendations to the board.
- To set up time-limited task groups or individuals to undertake specific tasks on policy, procedure and practice matters as necessary.
- To evaluate information presented through statistics, user surveys, DoH inspections, etc, and propose alterations to policies, procedures and practice to the Board for approval.
- To review procedures in partnership with the East Berkshire partners
- To monitor the effectiveness of public information and communication regarding adult protection and to find ways of communicating to all.
- To monitor the effectiveness of training in increasing awareness, and in improving the effectiveness of protection planning and safeguarding interventions.
- To seek and collate the views of user and care stakeholders to inform best practice.

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9.4 In addition, the Board will establish two reference groups for the purpose of capturing feedback from key stakeholders and informing developments:

- User and Carer Experience Reference Group
- Provider Reference Group

9.5 To avoid duplication the views of statutory sector stakeholders for example care managers, the police and health practitioners will be captured through the East Berkshire Partnership Board and related working committee.

10. SERIOUS CASE REVIEW

It will be the responsibility of the Board to set up a serious case review investigation and review panel, for serious case incidents occurring within the Borough boundary. The Board will elect the independent chair to the SCR panel, agree panel membership to be of sufficient seniority and expertise, and define and agree the terms of reference for the review.

The Board will receive interim and final reports of the SCR panel and agree actions to be taken to implement the SCR findings and recommendations. The Board will monitor implementation of agreed actions and share lessons learned with members of the East Berkshire Safeguarding Board.

The Chair of the Board and Strategic Director Community and Wellbeing will present the review findings , recommendations and agreed actions to Health and Social Care Scrutiny Panel

QUALITY STANDARDS IN SAFEGUARDING - STRATEGIC PRINCIPLES -

Protecting vulnerable people in our community and those people who use community care services is a top priority for Slough Borough Council (SBC) and its partners. We will all aim to provide support that is professional, sensitive and timely through the following:

1. PARTNERSHIP WORKING AND LEADERSHIP

- All agencies in Slough will work together in partnership to protect and safeguard vulnerable adults from abuse and will respond accordingly if an alert is forthcoming
- The Safeguarding Board will have strategic oversight of safeguarding work, ensuring agencies work and fulfil a collective responsibility. Members of the Board will take responsibility for their organisation's active contribution to the work plan of The Board.
- Safeguarding Adults is a whole council priority within SBC, with strategic leadership and management from Elected Members and Senior Officers across the council.
- SBC will lead the safeguarding adults' process through a multi-agency Safeguarding Board.
- SBC and partner agencies will ensure that all staff:
  - Have the appropriate skills, knowledge and training relevant to their role
  - Be service user focussed in their response
  - Provide safe support and appropriate responses when abuse is identified
  - (NB Staff refers to all officers who deliver services for the council and those who work in partner agencies be they direct employees, volunteers or contract workers.)

2. BY WORKING TO PROTECT

- The safety and wellbeing of the vulnerable adult is paramount and we will respond promptly, effectively and proportionately, ensuring that the person is safeguarded appropriately.
- When support is needed, it will be accessible, provided by people with expertise and knowledge and provided in a timely way.
- All allegations of abuse received will be taken seriously, action will be taken to protect those at immediate risk of harm and that their needs are addressed.
- Written records will be kept and standards of record keeping will be consistent and of good quality.
- There will be scrutiny and performance management of the safeguarding process to provide systematic support for managers. This will involve a robust analysis of the quality of the service and practice

3. BY INVOLVING THE PEOPLE THAT USE OUR SERVICES

- Information will accessible and be available when needed, and will be adapted by learning from the experience of people who use it.
- We will listen to the people during and after any safeguarding issue, and respond accordingly to the issues they raise.
- When a safeguarding issue is resolved, we will follow up with the service user and carer afterwards to ensure we learn by their experience and inform them of any outcomes.
- Independent support (including advocacy) will be offered to any person involved in a safeguarding process.
- There is an allocated staff member from the council that will act as the link person throughout any safeguarding process.

QUALITY STANDARDS IN SAFEGUARDING

A SUMMARY OF PRACTICE STANDARDS IN ACTION IN SLOUGH BOROUGH COUNCIL

TIMELINESS OF RESPONSE

- All alerts will be risk assessed and issues of urgent concern will be acted upon immediately.
- Immediate risk assessments and protection plans will be put in place upon referral.
- All alerts will be responded to within 24 hours.
- A multi agency strategy meeting will take place within 5 days.
- Assessment and planning process will take place within 28 days.
- All protection plans reviewed within 6 weeks.

ALLOCATION OF CASE WORKER

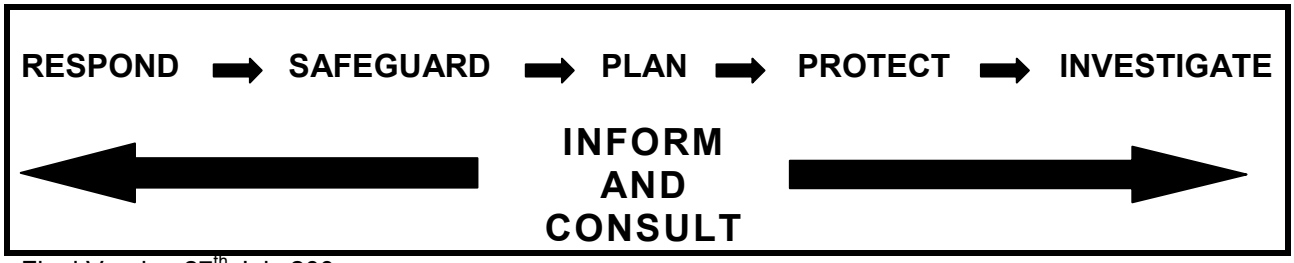
- All cases will be assigned a case worker, who will remain the same worker through the process, and will only change in exceptional circumstances.
- The case worker will speak to the person subject of an alert within 4 hours of picking up the referral.

ALLOCATION OF MANAGER

- A Manager will be assigned to oversee practice within the case.
- The manager will monitor the case through regular supervision with the case worker and ensure adherence to policy, standards and that the Audit/Quality Assurance tool is completed as the case progresses.
- All case files will be audited by the Manager and random samples will be audited by the Head of Service.

WORKING WITH USERS AND CARERS

- The service user and carer will be kept informed of all issues promptly and regularly.
- Carers and/or advocates will be informed where the service user needs assistance to understand the process and actions being taken.
- There will be a process agreed by the Case Worker at the outset of the referral as to how users and/or carers/advocates will be kept updated on progress, information and outcomes and this will be recorded on the file so consistency is maintained should another person need to pick up the case



Final Version 27th July 200

SUMMARY OF WORKFORCE TRAINING STRATEGY

LEVEL ONE – COMPETENCY OUTCOMES

- Recognise an Adult who may be Vulnerable to being abused
- Recognise evidence and indicators of abuse
- Recognise factors which may increase the risk of abuse
- Report concerns about abuse using appropriate systems
- Work in a manner that minimises the risk of vulnerable adults being abused
- Understand the principles and values which underpin all safeguarding adults activity

Target audience

- Staff at all levels, Service users, carers and volunteers

LEVEL TWO – COMPETENCY OUTCOMES

- Understand and use Berkshire Multi-agency safeguarding adults policy and procedures as well as local processes
- Understand the different roles and responsibilities of all agencies involved in investigations
- Engage in a positive way to the multi agency approach to safeguarding adults
- Monitor existing and identify new risks during the investigation
- Conduct investigative/assessment activity
- There are two levels of training – general and specialist.

Target audience

- Those who work regularly with community care service users/carers to identify and assess and address concerns

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LEVEL THREE - COMPETENCY OUTCOMES

- Make sound and consistent decisions as part of implementation the safeguarding policy and procedures
- Co-ordinate the safeguarding decision making assessment/investigation and protection planning process
- Chair and convene safeguarding adults meetings or discussions
- Effectively risks assess and manage any actions as part of the safeguarding adult's process, particularly at all stages of safeguarding adult's procedures.

Target audience

- Those with particular responsibility for safeguarding adults – managers.

Currently the training programme focuses on paid staff; however, plans are being developed to ensure that information is available in a range of formats and settings to people who use health and social care services. One of the methods of delivering this will be structured awareness rising sessions.

GLOSSARY

Abbreviation	Explanation
DMT	Adult Social Care Divisional Management Team
CASSR	Council with Adult Social Services responsibility
CMHT	Community Mental Health Team
CMHT (E)	Community Mental Health Team for Older Adults
CSWT	Community Social Work Team
CQC	Care Quality Commission
CTPLD	Community Team for People with a Learning Disability
DAAT	Drug and Alcohol Action Team
LSCB	Local Safeguarding Children's Board
MARAC	Multi Agency Risk Assessment Conference
MAPPA	Multi Agency Public protection Arrangements
Mental Health LIT	Mental Health Local Implementation Team
SSVAPB	Slough Safeguarding Vulnerable Adults Partnership Board

Appendix 1

The Board membership consists of senior officers from the statutory agencies serving Slough communities, and representatives from local voluntary sector organisations with key interests in and responsibilities for working vulnerable adults. Two local Councillors are also substantive members of the Board. A representative from the Care Quality Commission and LinKs and a non executive of the Berkshire East Primary Care Trust Board attend in an observer or advisory capacity.

Membership of the Board from 1st April 2009 to 31st March 2010 comprises:

Independent Chair	
Commissioner (Elected Slough Borough Council Member)	Health and Wellbeing
Commissioner (Elected Slough Borough Council Member	Opportunities and Skills
Strategic Director Community & Wellbeing (DASS)	Slough Borough Council
Assistant Director, Community & Adult Social Care	Slough Borough Council
Service Manager (Safeguarding and Governance)	Slough Borough Council
Detective Inspector of Public Protection	Thames Valley Police, Berkshire East Base Command Unit
Head of Service, Green and Built (Community Safety & Safer Slough Partnership)	Slough Borough Council
Assistant Director, Learning, Skills and Cultural Services	Slough Borough Council
Assistant Director – Adults and Older People	Berkshire East Primary Care Trust
Deputy Director of Nursing	Heatherwood & Wexham Park Foundation Trust
Assistant Director of Operations	Berkshire Healthcare NHS Foundation Trust
Chief Executive	People First (Almo)
Local Area Manager	Care Quality Commission
Chief Executive	Age Concern
Chief Executive	Slough Mencap
Director	East Berkshire MIND
Scheme Manager	Slough Cross Roads Care Scheme
Clinical Development Manager	South Central Ambulance Service
Development Manager	Local Involvement Networks (LiNKS)
Project Manager	Parvaaz
Safeguarding Adults Lead	East Berkshire Community Health Services
To be confirmed	*Royal Berkshire Fire and Rescue Service*

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SLOUGH BOROUGH COUNCIL

REPORT TO: Health Scrutiny **DATE:** 23rd September 2010

CONTACT OFFICER: Mike Bibby – Assistant Director, Personalisation, Commissioning & Partnerships – 01753 875800

Su Davy – Joint Commissioning Manager – 01753 5864(For all enquiries)

WARD(S): All

PART I
FOR COMMENT & CONSIDERATION

NEW ADULT SOCIAL CARE COMMISSIONING STRATEGY

1 Purpose of Report

1.1 To inform, consult and seek the views of Scrutiny Panel Members on the Draft Commissioning Strategy for Adult Social Care;

1.2 To inform Panel of key recommendations to be presented to Cabinet for decision to implement the strategy

2 Recommendation(s) / Proposed Action

2.1 That Panel notes the information contained in this report and the attached draft commissioning strategy.

2.2 That Panel considers and comments on the draft strategy

3 Community Strategy Priorities

3.1 Implementation of the Adult Social Care commissioning strategy will contribute to the delivery of Community Strategy priorities in a number of ways:

Community Cohesion

- Promotes involvement in community activities;
- Reduces inequalities and promotes fair access to high quality services.

Health and Wellbeing

- Help people make positive informed choices;
- Intervene early to tackle serious health issues and promote healthier life styles;
- Maintain a person centred approach to service provision;

- Provide effective and tailored services for adults to allow them to live independent, socially inclusive lives;
- To work, often with other agencies, to provide support for improved health including early intervention

Community Safety

- Improve public information and help people have an active role;

- Within the overall provision of support and care services to ensure that the most vulnerable are protected and safeguarded.

4 **Other Implications**

(a) Financial

The total gross budget in 2010/11 for adult social care and Supporting People to fund externally provided services is £25,732,000. This is through a combination of contracted services, grant funding underpinned by service level agreements and 'spot' purchased care packages for individual service users.

The table below illustrates the current pattern of funding

		£	£
Supporting people			3,970,000
Block purchased services			
	Residential / Nursing	7,651,000	
	Domiciliary	2,111,000	9,762,000
Community based services			
	Advice and support (e.g. advocacy, carers support etc)	467,000	
	Care and respite (e.g. day care, lunch clubs, respite for carers etc)	716,000	
	Living at home (e.g. meals service, handyperson, equipment loans)	660,000	
	Out and about (e.g. transport etc)	56,000	1,899,000
Spot purchased services			
	Residential / Nursing	9,500,000	
	Domiciliary	265,000	
	Day Care	336,000	10,101,000
Total budget - externally commissioned services			**25,732,000**

There are savings identified in the medium term financial plan relating specifically to commissioning and supporting people which total £924K for the period 2011/12 to

2013/14. A further £100K in 2011/12 is identified relating to residential care block commissioning. In addition measures arising from changes to commissioned services will also contribute to other agreed savings plans.

Future commissioning activity will be funded from within agreed cash limits.

(b) Human Rights Act and Other Legal Implications

Commissioning of new services and the termination or extension of existing contracts will be carried out in accordance with relevant legislation and guidance including the council's constitution.

Contracts and service level agreements will be put in place for all commissioned services.

(c) Equalities Impact Assessment

An Impact Assessment will be carried out on the final strategy prior to formal approval and implementation.

Equalities Impact Assessments will also be completed for specific de-commissioning / commissioning actions.

(d) **Workforce**

There will be no workforce implications for the council arising from the implementation of the commissioning strategy with the necessary work being undertaken within the existing staffing arrangements.

However, as a consequence of the decommissioning and commissioning activities there will be workforce implications for provider agencies.

5 Background:

5.1 The local authority commissions services from a range of provider agencies in the private, voluntary and community sectors to deliver adult social care services.

5.2 There are significant developments to the way that adult social care services are to be delivered arising from the implementation of 'Putting Me First' – the strategy for the implementation of personalised adult social care services in Slough. The type of services that will be commissioned and the resulting contracts will need to change to support the delivery of more person-centred services.

5.3 The draft Commissioning Strategy for Adult Social Care identifies the key priorities for commissioning in coming years to support the delivery of 'Putting Me First'.

5.4 The challenging financial climate and the reduction in resources available to local authorities make it more important than ever that robust, coordinated and effective commissioning arrangements are in place to ensure the availability of high quality and cost effective services which deliver improved outcomes for residents while making the best use of available resources.

5.5 The changes that will result from implementing the commissioning strategy will have significant impacts on current provider organisations as the range of services commissioned will change. Some existing services will be de-commissioned while others may change in terms of the nature of the service and who provides it as a result of re-commissioning. There will also be changes to the nature of contracts for service provision.

5.4 **Detail**:

5.4.1 **Development of the Commissioning Strategy for Adult Social Care**

The local authority commissions a wide range of agencies to provide adult social care services to the residents of Slough. These include services and support that form a part of an individual's care package to meet eligible needs following a Fair Access to Care assessment, as well as preventative community based services which can be accessed directly. Services such as Supported Housing and Floating Support are commissioned and funded through the Supporting People programme. The commissioning strategy covers all these services and relevant funding.

The services are provided by private and voluntary sector or not for profit organisations. The currently commissioned services in Slough have developed over time resulting in a historical pattern of generally 'traditional' services.

Commissioning takes place in a variety of ways dependent on the funding source and the price or volume of the service provided. In some cases formal tender processes governed by legislation, including European Union procurement guidelines, apply which result in formal contractual arrangements covering a number of years. In other cases grant funding is provided on an annual basis, these being underpinned by Service Level Agreements.

In addition to these arrangements, individual support for service users is 'spot' purchased from private and voluntary sector agencies.
The council is in the process of finalising policy, protocols and best practice guidance relating to commissioning which will be adopted when implementing this strategy. These will include proportionate, consistent and transparent arrangements for the commissioning and subsequent monitoring of commissioned services. Outcomes which are clearly defined and measurable will be set out for each commissioned service and where possible and appropriate funding will be agreed for a defined number of years dependent on performance. Services commissioned will deliver agreed priorities.

5.4.2 **Why do we need to make changes?**

There are significant issues which have been taken into account in developing the Commissioning Strategy for Adult Social Care for Slough. These include:

- The development of person centred social care services through the Slough "Putting Me First" programme.

- Significantly reduced resources as a result of the national financial climate, including reductions in public sector resources, the extent of which is not yet fully known.

- Savings already agreed within the medium term financial plan.

- Increased partnership working to meet needs and deliver agreed priorities, both with other organisations and within the “One Council” approach.

- Demographic information including data on current and future needs

These factors mean that commissioned adult social care services have to be reshaped to deliver flexible services which are responsive to individual needs and choice and to ensure that they are targeted appropriately to meet the needs of vulnerable people. Commissioning also has to ensure that services deliver agreed priorities and make the best use of available resources.

The way that services are commissioned and procured by the local authority will also need to change. For example, contracts with provider agencies are likely to move away from block contract arrangements with fixed and guaranteed volumes to more flexible framework agreements. Guaranteeing the flow of business to providers will be far more challenging than in the past and will require those services to adapt.

5.4.3 **Commissioning principles and priorities:**

The Commissioning Strategy sets out the priorities and principles for the commissioning of adult social care services over the next three years.

We will promote, develop and commission care and support that:

- Is innovative and flexible in times of change and responsive to the needs and risks of our most vulnerable residents.

- supports and enables people to live independently within their own communities for as long as is possible and appropriate.

- Achieves agreed outcomes and promotes choice and control in the planning and delivery of those outcomes.
- Is delivered to defined measurable and controllable quality standards.

- Demonstrates continuous effectiveness and efficiency to make the best use of the resources available to the Council.

Key priority areas for commissioning to deliver agreed objectives and priorities have been identified and are set out in the strategy. These are:

- Advice and Information across all care groups including carers;

- Brokerage and advocacy across all care groups for those who meet the adult social care eligibility criteria;

- Assistive technology for all care groups;

- Support and respite for carers;

- Dementia services to ensure they are more accessible for those under the age of 75 and are more community based;
- Residential, nursing and dementia care services reconfigured to reflect future demand;
- Day opportunities for older people reviewed and re-commissioned to enable greater choice and independence;
- Community based mental health services focusing on promoting independence and choice;
- Domiciliary care services to deliver greater independence for older and disabled people by encouraging people to do things for themselves, rather do things for them;
- Remodelled meals service
- Support for substance misuse and HIV clients commissioned in partnership with other Council service areas
- Community transport
- Emergency alarm response service
- supported independent and 'extra care' type housing schemes for people with more complex and challenging needs; including those with mental health problems, physical disabilities, sensory loss, learning disabilities and autism.
- Shared Lives schemes to include a greater number of people who are at risk of social isolation and/or losing their independence.
- Supported living services for people with learning disabilities to enable service users to move from residential care to community based provision and for those placed outside the Authority to return to live as independently as possible within Slough.
- Work and employment opportunities for people with a learning or physical disability.

5.4.4 **What impact will the commissioning strategy have?**

Implementing the new commissioning strategy will impact in a number of ways.

These include:

- Ensuring the provision of services that deliver agreed priorities
- A focus on promoting independence and where possible reducing the need for long term care
- Enabling service users to have greater choice and control over the support they receive

- Improving outcomes for local residents
- Making best use of the resources available

There will also be significant impacts on current provider organisations as the range of services commissioned will change.

Some existing services will be de-commissioned, while others may change in terms of the nature of the service and who provides it as a result of re-commissioning. There will also be changes to the nature of contracts for service provision.

Difficult and challenging decisions will have to be made as the strategy is implemented and new and different services commissioned while others decline.

5.4.5 **Implementing the strategy:**

The changes that will need to be made in the range of services provided and the contracting approaches adopted will take time to implement. It will be important that this work is carried out in a planned way to maintain stability within the market during the transitional period.

A detailed plan is being developed which sets out the actions needed in relation to all existing externally purchased services, including those where new contracts are required. This will include de-commissioning of some services and re-letting of contracts on a new basis. The programme will identify in more detail the timescales for commissioning and decommissioning of services. It is not possible to forecast the cost of individual contracts at this stage.

It is anticipated that the major part of the programme will be delivered in the next 18 months, with completion by April 2012. As many of the Councils contracts would normally expire in the next year, it may be necessary for some existing contracts to be extended while new arrangements are put in place in line with the detailed programme.

There will be extensive and on-going engagement and consultation with key stakeholders including service users, carers and provider agencies throughout the implementation of the strategy. This will include discussions at relevant Partnership Boards, the regular Providers forum and other events.

The Commissioning Strategy will be presented to Cabinet in October 2010 with a recommendation that Cabinet resolve to agree the identified priorities and the commissioning and tendering of these services.

6. Conclusion

The draft adult social care commissioning strategy sets out the priorities for coming years.

The strategy has been developed to reflect and respond to changing demographic needs, the developments in the provision of adult social care services as a result of ‘Putting Me First’, and the prevailing financial climate.

Delivering the strategy will involve a complex programme of work over the next two years. This will have significant impacts on current provider organisations as the range of services commissioned will change. There will also be changes to the nature of contracts for service provision.

Delivery of the strategy will ensure that commissioned services deliver the council's agreed priorities and deliver high quality and cost effective support which make the best use of available resources. The services commissioned will improve outcomes for local residents and support the delivery of person-centred support that enables people to live independently in their own homes for as long as possible.

Health Scrutiny Panel is asked to:

- note the information contained in this report and the attached draft commissioning strategy.
- consider and comment on the draft strategy

7. Appendices Attached

Draft Commissioning Strategy for Adult Social Care - August 2010;

8. Background Papers

1 Slough Borough Councils Strategic Commissioning Framework – June 2010;

2 Joint Strategic Needs Assessment for Slough - October 2009;

3 Joint Commissioning Strategy for Slough 2007 – 2015.

4 Putting People First (PPF) DoH December 2007;

5 Our Health, Our Care, Our Say DoH 30 January 2006;

6 PPF related Circulars issued in January 2008, March 2009 and March 2010.

Slough Borough Council

Draft Commissioning Strategy for Adult Social Care

August 2010

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2 INTRODUCTION

2.1 Purpose of the New Commissioning Strategy

2.1.1 Slough Borough Council is committed to following a Strategic Commissioning approach to achieve better outcomes for residents and improved value for money for the council.

2.1.2 This Strategy identifies the commissioning priorities for adult social care. Based on strategic commissioning principles and best practice it proposes specific actions to transform social care and the range of services commissioned.

2.1.3 There are substantial changes taking place in the provision of public services, and these affect the council's commissioning activities which seek to ensure the provision of appropriate services and improved value for money. The programme to implement this strategy is being undertaken in the context of:

- The development of person centred social care services through the Slough "Putting Me First" programme;
- Significantly reduced resources as a result of the national financial climate, including reductions in public sector resources, the extent of which is not yet fully known
- Increased partnership working to meet needs of local residents and deliver agreed priorities, both with other organisations and within the "One Council" approach.

2.1.4 These factors mean that adult social care and commissioned services have to be reshaped to deliver flexible services which are responsive to individual needs and choice, and that they are targeted appropriately to meet the needs of vulnerable people. Commissioning also needs to ensure that services deliver agreed priorities and make the best use of available resources

2.1.5 The way that services are commissioned and procured by the local authority will also need to change. For example, contracts with provider agencies are likely to move away from block contract arrangements with fixed and guaranteed volumes to more flexible framework agreements. Guaranteeing the flow of business to providers will be far more challenging than in the past and will require those services to adapt.

2.1.6 Strategic commissioning is a major tool in the transformation process. Implementing the strategy will:

- Ensure the provision of services that deliver agreed priorities
- Focus on promoting independence and where possible reducing the need for long term care
- Enable service users to have greater choice and control over the support they receive
- Improve outcomes for local residents
- Make best use of the resources available

2.2 Strategic Commissioning – Overview

2.2.1 Strategic commissioning requires a broad appreciation of needs and service requirements, supported by detailed data. These are the starting points for analysis and decision making, and eventually obtaining improved services from high quality providers.

2.2.2 The diagram (right) illustrates the commissioning cycle and the approaches that have been and will be applied in developing and implementing this strategy.

2.2.3 A new Commissioning Strategy for Adult Social Care is needed to reflect and respond to current and predicted changes in policy and the financial climate.

Institute of Public Care

2.2.4 This strategy accommodates, amongst other things, requirements for more flexible person centred services and more rigorous control of value for money, quality and eligibility

2.2.5 The Commissioning Strategy will be maintained over time and in addition to providing the context for purchasing and contracting it will facilitate broader thinking about the opportunities for innovation in purchasing, joint commissioning with partners and engagement with providers.

2.3 Developing the New Commissioning Strategy

2.3.1 In developing the new Commissioning Strategy for adult social care a number of key factors have been reviewed and analysed. These include:

- Demographic data identifying the current and projected population profile and needs of Slough. Much of this information has been taken the Joint Strategic Needs Assessment for Slough, October 2009. There are marked disparities in health and well being in parts of the Borough. As resources are to be scarcer services will need to be more focused and targeted. Strategies must be evidence based, rather than merely repeating current practices and historical patterns of funding and service provision.

- The introduction of person centred adult social care services including personal budgets. The key priorities of the 'Putting Me First' strategy for Slough are:
    - Increasing choice and control for service users
    - Urgent Care, early intervention and prevention
    - Enabling people to live independently
    - Enhancing Citizenship & Access to community based services
    - Improving Customer responses
    - Providing targeted preventative support and support for carers
    - Ensuring personal safety and high quality service provision

  The delivery of the strategy will require providers and contracting arrangements capable of offering a range of innovative services, with the flexibility that will be required to increase personal choice.
- Ongoing financial remodelling by the Government to reduce public expenditure. The Government's emergency budget announced in June 2010 resulted in an initial impact of £3.322million on the Council and various cost reduction measures have been introduced across the council, including in adult social care, to respond to these pressures. Further measures which are likely to reduce resources available to local authorities will become known in October 2010 as a result of the Government Spending Review (covering 2011/12 to 2014/15).
- Consultation with service users, carers and partner agencies is a continuing activity for all client groups. Topics such as 'Putting Me First' and reductions in resources have been discussed at these events and the information gathered and analysed when drawing up this strategy.
- A workshop involving social care senior managers, representatives of specialist client areas and NHS Berks East was held in August 2010 which has informed the development and content of this strategy.

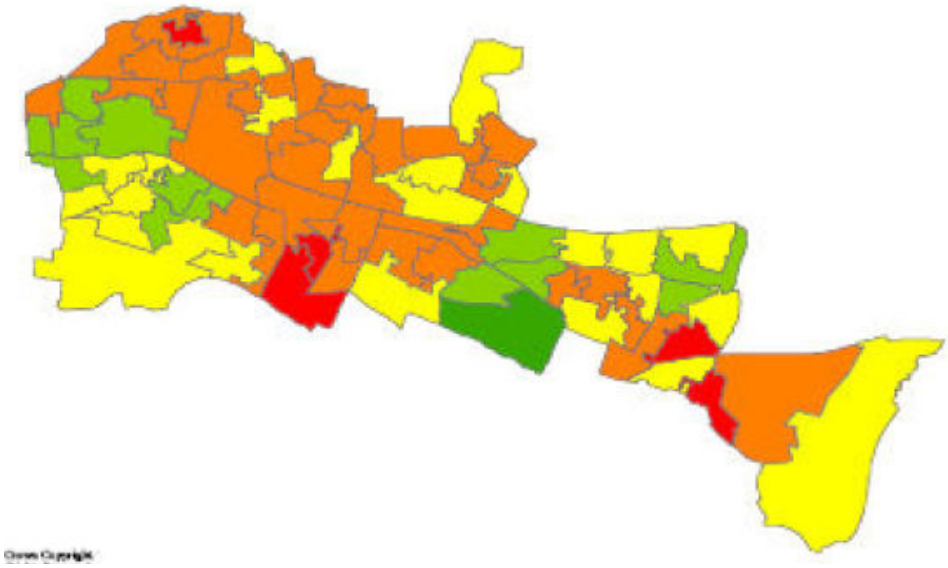
3 NATIONAL AND LOCAL GUIDANCE AND RESEARCH

3.1 Demographics and Trends – identifying needs

The collection and consideration of demographic data within the planning stage of the strategic commissioning cycle must be rigorous in order to establish the necessary evidence base to inform commissioning. There are a number of significant underlying issues and problems affecting residents. Some of the key factors are:

- Whilst Slough has an active local economy, average earnings of the resident population are relatively low.
- The size of the Borough's population is a matter for debate, as the 2001 census figures are believed to significantly undercount the number of people living in Slough. Government allocation of resources to Slough is based on the census figures.
- The estimated true population figure is around 130,000. Population density is over ten times the national average and at least three times that of other Unitary Authorities in Berkshire East.
- Projections for older people imply negative growth compared to the other council areas in Berkshire East and against national trends.

- Almost 40% of residents are from black or minority ethnic communities. The greatest number are of Indian origin with other significant Pakistani, African and Polish groups. 75 languages are spoken in the Borough.
- There are high birth rates, particularly in families that originate from commonwealth and Eastern European countries.
- Among those of working age, expected population growth will place demands on services and carers of people who have learning difficulties, long term conditions or mental health problems.
- 44 lower super output areas[1] across Slough are within the fifth quintile (i.e. the most deprived) within the NHS South Central region; five of these are in the most deprived quintile nationally (see the red areas below).



- There are several unsatisfactory housing infrastructure issues in the Borough, with market prices beyond the local average earnings and high levels of rented property, including many Houses in Multiple Occupation (HMO).
- There are poor standards in some parts of the rented sector (e.g. use of outbuildings for residential purposes) and a large number of HMOs are in poor condition, particularly in Chalvey, Upton and Central wards.
- A higher proportion, 30% (24% nationally), of houses in some areas of the Borough would not meet the 'Decent Homes' standard. Thermal inefficiency is a large problem.
- Within the overall demand for housing there is an identified requirement for housing with flexible support for those with learning disabilities. The numbers of people with learning disabilities in residential care are comparatively high.
- There are comparatively high number of people with mental health problems in residential care
- Referral rates in relation to Safeguarding have increased steadily from 190 (2007/2008) through to 314 (2009/2010).
- In respect of long term conditions, in 2009/10 adult social care services in Slough supported 3215 people with a physical disability or temporary illness, 1105 people with a mental health problem of which 95 were over 65 and had dementia and 300 people with learning disabilities.

[1] Lower super output areas are small areas, below ward level, for which census statistics are analysed by the Office of National Statistics.

- During the same period a total of 1029 carers were registered; 661 were caring for people aged 18-64 and an additional 368 cared for people over the age of 65. 562 were caring for those with a physical disability; 261 for those with mental heath problems and 101 for those with a learning disability.
- The Joint Strategic Needs Assessment for the Borough includes a prediction that the number of men and women with dementia in the Borough is projected to rise from 822 people in 2009, to 1,195 in 2021.
- The levels of tuberculosis in Slough are high.

3.2 'Putting Me First' – Personalised Adult Social Care service in Slough – developments in policy

3.2.1 In December 2007 the document '*Putting People First* – A shared vision and commitment to the transformation of Adult Social Care' was published by the Government. It sets out the vision and policy direction for Adult Social Care for future years.

The concept of 'Personalisation' is at the core of 'Putting People First'. This means that people with adult social care needs will:

- have choice and control over the support they receive
- benefit from safe services which promote independence, well-being and dignity

A specific 'Putting Me First' strategy has been developed to implement these changes in Slough.

3.2.2 The aims and objectives of the 'Putting Me First' strategy will:

- Further develop joint working with NHS partners to deliver co-ordinated services to support recovery and to prevent admissions to acute hospital care
- Improve customer responses at the first point of contact and assist people in making their own choices through access to high quality information
- Support the development of services in the community which change the historic pattern of provision and provide a range of alternative support options that deliver to the council's priority objectives
- Deliver efficiencies by streamlining processes
- Focus on promoting independence and where possible reducing the need for long term care
- Give service users greater choice and control over the support they receive
- Provide better integration of adult social care service users in the community through increased use of services such as leisure, adult education, libraries and community centres
- Promote more active engagement of people in their communities

These improvements to services will enable more vulnerable and disabled residents to:

- Have increased opportunities to make informed decisions about their lives, including how their assessed eligible needs could be met
- Have good information, advice and support to inform their choices
- Continue to live for as long as possible in their own homes, avoiding the need for residential or nursing care
- Have increased opportunities to make a positive contribution to their communities and neighbourhood

And, as a consequence of the improvements, we will:

- Support more people to live at home for longer
- Reduce the costs of long term care
- Deliver efficiencies through changes to working systems, structures and patterns of service delivery

The 'Putting Me First' strategy recognises that as personal budgets are more widely introduced and people begin to exercise greater choice and control over the support they wish to receive, it is highly likely that gaps in the current market of services available will begin to appear.

There is a need to develop more flexible, responsive and user focused services within the market. This will mean that, in addition to the development of new types of provision, many existing services will need to change or be decommissioned.

The contractual arrangements for commissioned services will also need to develop and become more flexible. Flexible framework agreements will be introduced to facilitate service user choice.

There will be difficult and challenging decisions to be made concerning the future commissioning intentions and priorities for social care support as new ways of working and new services are developed while others decline, and it will be important that this work is carried out in a planned way to maintain stability within the market during the transitional period.

3.3 Finances and funding:

The current financial climate will have significant impacts on commissioning activities. Resources available to local authorities and other public sector bodies are decreasing, though the full scale and timings of these reductions are not yet known. The decline in resources as a result of Government policies has to be seen alongside already agreed local financial policies and initiatives. Among the main issues are:

- The government has set a target for public sector services to find approximately 25% savings in the next four years;
- During 2010/11 the Council is negotiating with voluntary sector providers who are in receipt of council funding in excess of £10,000 (including social care) to achieve a 4% reduction. This is in response to reductions in central government funding to councils already introduced during 20010/11.
- There are agreed financial saving proposals for 2011-12 through to 2013-14 relating to commissioning activity
- There are a number of other restrictions and possible reductions which may impact on the resources which the Council has available such as the freeze on Council tax.
- Further details of financial implications for local authorities will be come clear when announcements are made in the Government Spending Review (covering 2011/12 – 2004/15) on 20th October 2010.

4 FUTURE DEMAND

4.1 Based on the known demographics and trends set out above, Slough has to respond to a wide and varied range of needs, across the spectrum of social care.

4.2 Whilst the Authority does not have the high proportion of elderly people that is common in other areas, it does have particular issues such as areas of marked deprivation (and consequent related health needs and lower life expectancy) and high levels of mental health problems.

4.3 The nature of Slough's population requires responses which are appropriate to meet the needs of diverse communities.

4.4 Preparing to address future demands at the strategic level is best achieved by the development of a dynamic commissioning environment, where need is assessed on a cyclical basis. This will include implementing robust processes and analysis of information to ensure the commissioning and provision of appropriate support services.

5 MARKET ANALYSIS:

5.1 Current service provision in Slough has grown up over a number of years, with the result that there is a historical pattern of mainly 'traditional' services procured from a limited market. Not all these developments have been led or driven by the council's strategic priorities.

5.2 During the past 18 months the council's commissioning team has been working closely with providers to establish firm relations which will facilitate the commissioning and development of the services required to meet identified and agreed strategic priorities.

5.3 Work has also been undertaken to profile in detail commissioned services in terms of the range of current provision and the resource commitments.

5.4 This work will form the basis for reviewing existing service commitments and remodelling service provision. It shows that in 2010/11, £25,732,000 is available for externally commissioned services for adult social care and Supporting People services.

5.5 The table below gives a high level breakdown of the current pattern of spending

		£	£
Supporting people			3,970,000
Block purchased services			
	Residential / Nursing	7,651,000	
	Domiciliary	2,111,000	9,762,000
Community based services			
	Advice and support (e.g. advocacy, carers support etc)	467,000	
	Care and respite (e.g. day care, lunch clubs, respite for carers etc)	716,000	
	Living at home (e.g. meals service, handyperson, equipment loans)	660,000	
	Out and about (e.g. transport etc)	56,000	1,899,000
Spot purchased services			
	Residential / Nursing	9,500,000	
	Domiciliary	265,000	
	Day Care	336,000	10,101,000
Total budget - externally commissioned services			**25,732,000**

6 COMMISSIONING PRIORITIES

6.1 Strategic Approach

6.1.1 The creation of this Strategy has provided the opportunity to look at and review all externally provided services to consider how services may be remodelled to meet the changes required by the introduction of 'Putting Me First' and to ensure value for money.

6.1.2 This strategic approach will also assist the Council in working closely with provider agencies to develop the market in the future.

6.1.3 Some existing services will be de-commissioned while others may change in terms of the nature of the service and who provides it as a result of re-commissioning.

6.1.4 There will also be changes to the nature of contracts for service provision

6.2 Commissioning Strategy Statement

6.2.1 This commissioning strategy sets out the priorities for adult social care over the next three years. It provides details on how we intend to respond to the changing needs of individuals within their local community. It emphasises a shift in the way we work to one that puts the individual at the centre of our approach. In doing this when commissioning all services we will focus on key 'outcomes' for each individual that address risks to their independence, safety, rights, choice and autonomy.

6.2.2 We will promote, develop and commission care and support that:

- Is innovative and flexible in times of change and responsive to the needs and risks of our most vulnerable residents;
- supports and enables people to live independently within their own communities for as long as is possible and appropriate
- Achieves agreed outcomes and promotes choice and control in the planning and delivery of those outcomes;
- Is delivered to defined measurable and controllable quality standards;
- Demonstrates continuous effectiveness and efficiency to make the best use of the resources available to the Council.

6.2.3 The following approaches will underpin our commissioning work:

Reviewing current traditional forms of support:
We will:

- decommission and re-commission services that are unable to deliver person centred outcomes
- commission services which deliver the council's priorities and the objectives of this strategy

Empowering service users and carers:
We will:

- develop person centred approaches which respond appropriately to individuals' needs and preferences.

- support an individual's right to maintain, support or restore as appropriate their independence
- recognise service users' rights to exercise choice and control over decisions which affect their lives.
- Protect individuals from physical, sexual, psychological, financial abuse and neglect and acts of omission
- acknowledge and support the role of unpaid carers so that they can continue performing their caring roles.

Addressing risks to independence:
We will:

- establish integrated, inclusive and seamless responses that promote positive outcomes for vulnerable people.
- Commission flexible and accessible services which are tailored to individual circumstances and choice.
- focus on assisting individuals to identify the risks to their independence, and jointly determine strategies to minimise those risks as appropriate.

Safeguarding:
We will:

- implement common safeguarding standards in contract and service agreement documentation
- require commissioned services and their staff to be appropriately trained in safeguarding
- require up to date Criminal Records Bureau checks to have been completed for all relevant staff in commissioned services
- Ensure compliance in commissioned services with safeguarding policies and procedures
- Monitor compliance with safeguarding requirements

Improving commissioning approaches:
We will:

- maximise opportunities for increased partnership working to achieve better and quicker responses to individual need.
- identify, plan and develop joint approaches to improve the health, social care and wellbeing of the residents within the resources available to us.
- Collect and analyse of demographic and other data, to ensure an evidence based approach to commissioning. .

Shaping the market:
We will:

- build on current market shaping strategies through the use of well established contracting processes
- consolidate effective working relationships with social care providers.
- involve providers positively in planning and commissioning processes
- use a mix of publicly and self funded services where appropriate and improve access to universal services, where these contribute to support needs.
- work cooperatively, to enhance the transparency and flexibility of relationships across market sectors to establish a more sustainable mixed economy of care
- improve quality responses and outcomes for service users

Promoting workforce development:
We will:

- facilitate workforce planning in partnership with the private sector, third sector and other key stakeholders to promote a coordinated workforce approach within the local market.
- assist adult social care staff to become appropriately skilled, trained and qualified to perform the range of responses and functions required in the future
- target funding that sustains the

Sustaining the environment:
We will:

- raise awareness of environmental issues and promote best practice standards to assist the reduction of waste and harmful emissions that impact on the local environment and public health.
- encourage providers of adult social care to achieve more output with fewer resources by reducing consumption, reusing or re-cycling wherever possible and reducing the impact of travel to improve the environment.

Continuously improving responses:
We will

- develop frameworks that specify the range of quality thresholds that promote best practice and meet the expectations of service users, carers and key stakeholders.
- ensure that quality frameworks promote autonomy, choice, independence and empowerment
- ensure that providers demonstrate value for money, economic viability and capacity and ability for continuous improvement
- maintain effective arrangements for monitoring and review.

Integrated living:
We will:

- focus on providing housing support options that enable individuals to maintain their independence, functioning and quality of life in the community
- explore options for the development of ‘extra care’ type housing schemes for people with mental health and learning disabilities which will reduce the numbers in residential care

6.3 Priorities

The reductions in available resources, changes in needs and the introduction of personal budgets giving services users more choice and control mean that adult social care services have to be reshaped to respond to these issues. Future provision will need to be different.

In order to deliver our objectives and priorities, the services below will be developed and commissioned during the period up to March 2012:

- Advice and Information across all care groups including carers;
- Brokerage and advocacy across all care groups for those who meet the adult social care eligibility criteria;
- Assistive technology for all care groups;
- Support and respite for carers;
- Dementia services to ensure they are more accessible for those under the age of 75 and are more community based;
- Residential, nursing and dementia care services reconfigured to reflect future demand;
- Day opportunities for older people reviewed and re-commissioned to enable greater choice and independence;
- Community based mental health services focusing on promoting independence and choice;
- Domiciliary care services to deliver greater independence for older and disabled people by encouraging people to do things for themselves, rather do things for them;
- Remodelled meals service
- Support for substance misuse and HIV clients commissioned in partnership with other Council service areas
- Community transport
- Emergency alarm response service
- supported independent and ‘extra care’ type housing schemes for people with more complex and challenging needs; including those with mental health problems, physical disabilities, sensory loss, learning disabilities and autism.
- Shared Lives schemes to include a greater number of people who are at risk of social isolation and/or losing their independence.
- Supported living services for people with learning disabilities to enable service users to move from residential care to community based provision and for those placed outside the Authority to return to live as independently as possible within Slough.
- Work and employment opportunities for people with a learning or physical disability.

6.4 Programme Plan

6.4.1 The general principles for commissioning externally funded services are being applied to existing contracts that will have to be modified, taking into account the focus on ensuring links with agreed priorities, increasing service user choice and control and delivering increased efficiencies and value for money.

6.4.2 A detailed plan is being developed which sets out the actions needed in relation to all existing externally purchased services, including where new contracts are required.

6.4.3 This will include de-commissioning of some services and re-letting of contracts on a new basis. The programme will identify in more detail the timescales for commissioning and decommissioning of services. It is not possible to forecast the cost of individual contracts at this stage.

6.4.4 It is anticipated that the major part of the programme can be delivered in the next 18 months, with completion by April 2013. As many of the Councils contracts would normally expire in the next year, it may be necessary for some existing contracts to be extended while new arrangements are put in place in line with the detailed programme.

6.4.5 There will be extensive and on-going engagement and consultation with key stakeholders including service users, carers and provider agencies throughout the implementation of the strategy. This will include discussions at relevant Partnership Boards, the regular Providers forum and other events.

7 BACKGROUND DOCUMENTS

7.1 Slough Borough Councils Strategic Commissioning Framework – June 2010;

7.2 Joint Strategic Needs Assessment for Slough - October 2009;

7.3 Joint Commissioning Strategy for Slough 2007 – 2015.

7.4 Putting People First (PPF) DoH December 2007;

7.5 Our Health, Our Care, Our Say DoH 30 January 2006;

7.6 PPF related Circulars issued in January 2008, March 2009 and March 2010.

MEMBERS' ATTENDANCE RECORD 2010/11

HEALTH SCRUTINY PANEL

COUNCILLOR	22/06	02/09	23/09	25/10	09/12	08/02	21/03
Davis	P	P					
S K Dhaliwal	P	Ab					
Long	Ap	P					
MacIsaac	P	P					
P K Mann	Ap	P*					
Plimmer	P	P					
Rasib	P	Ab					
Walsh	P	P					
A S Wright	P	Ap					

P = Present for whole meeting
Ap = Apologies given
P* = Present for part of meeting
Ab = Absent, no apologies given

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HEALTH SCRUTINY PANEL
WORK PROGRAMME 2010/2011

Agenda Items	Final deadline for Reports	Agenda Despatch	Date of Panel Meeting
• NHS White Paper, Lise Llewellyn, Chief Executive , Berkshire East PCT • Heatherwood and Wexham Park Hospitals- Outpatient booking system (John Wood, Dep Chief Exec) • Proposals for Hospital Avoidance & Reablement Services (joint presentation, Derek Oliver and Viki Wadd) • Hospice/Palliative Care Policy (Viki Wadd) • Outcomes and Recommendations for review of Adult Social Care Day Services (Geoff Elford) • Joint East Berkshire Health Overview and Scrutiny Committee- Car Parking Review (Andrew Millard)	**Wednesday 13 October 2010**	**Friday 15 October 2010**	**Monday 25 October 2010**
• Drug and Alcohol misuse in the Borough (the effect on health services and how this is being tackled) • Joint Strategic Needs Assessment • Charging Policy for Adult Social Care (Mike Bibby and Andrew Smith) • Adult Social Care-Performance Management (Jane Wood)	**Friday 26 November 2010**	**Tuesday 30 November 2010**	**Thursday 9 December 2010**

• Male Cancers/ Cervical Cancer Screening (Asmat Nisa, NHS Berkshire East)			
• White Paper on LAs & Public Health Provision (new arrangements) • Access to NHS Dentistry (particularly Orthodontics) • User Led Organisation and Universal Services (JW)	**Wednesday 26 January 2011**	**Friday 28 January 2011**	**Tuesday 8 February 2011**
	Wednesday 9 March 2011	**Friday 11 March 2011**	**Monday 21 March 2011**
Unprogrammed • Effects of economic downturn on mental health of population (ref: O and S Cttee 25/02/10) • Tuberculosis update report (June 2011-Asmat Nisa) • White paper on public health (possible January, 2010) (JW)			