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Date of issue: Tuesday, 24 January 2012

MEETING	**HEALTH SCRUTINY PANEL** (Councillors Chohan, Davis, Long, Munawar, Plimmer, Rasib, Sharif and Strutton, 1 Labour Vacancy)
DATE AND TIME:	WEDNESDAY, 1ST FEBRUARY, 2012 AT 6.30 PM
VENUE:	FLEXI HALL, THE CENTRE, FARNHAM ROAD, SLOUGH, BERKSHIRE SL1 4UT
DEMOCRATIC SERVICES OFFICER:	TERESA CLARK
(for all enquiries)	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

AGENDA

PART I

AGENDA ITEM	REPORT TITLE	PAGE	WARD
	Apologies for absence.		
	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)		

AGENDA ITEM	REPORT TITLE	PAGE	WARD
2.	Membership of the Panel and Election of Chair	1 - 2	All
3.	Minutes of the Last Meeting held on 8th December, 2012	3 - 10	All
	SCRUTINY ISSUES		
4.	Member Questions *(An opportunity for Panel Members to ask questions of the relevant Director/ Assistant Director, relating to pertinent, topical issues affecting their Directorate – maximum of 10 minutes allocated).*		
5.	National Health Service and Public Health Reform *(15 Mins Presentation- 45 Mins Questions)*	11 - 42	All
6.	Heatherwood and Wexham Park Hospitals NHS Trust: Operational Finance-Update *(15 Mins Presentation-45 Mins Questions)*	43 - 46	All
7.	Stroke Services in Slough-Presentation by Dr McGlynn *(10 Mins Presentation- 15 Mins Questions)*		All
8.	East Berkshire Mental Health Inpatient Services *(10 Mins Presentation- 20 Mins Questions)*	47 - 102	All
9.	Consideration of reports marked to be noted/for information (if any) *(The Panel will consider any reports marked to be noted/for information and determine whether future scrutiny is considered necessary: maximum of 5 minutes allocated).*		
10.	Forward Work Programme	103 - 104	All
11.	Attendance Record	105 - 106	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.

AGENDA ITEM 2

SLOUGH BOROUGH COUNCIL

REPORT TO: Health Scrutiny Panel **DATE:** 1st February 2012

CONTACT OFFICER: Teresa Clark, Senior Democratic Services
(For all enquiries) (01753 875018)

WARD(S): All

PART I
FOR DECISION

MEMBERSHIP OF THE PANEL AND ELECTION OF CHAIR

1 **Purpose of Report**

To advise the Health Scrutiny Panel that following her appointment as Commissioner for Opportunity and Skills, Councillor PK Mann has resigned from the Panel. Appointment to the resulting Labour vacancy will be made by Council at its meeting on 31st January.

2. **Recommendations**

The Panel is requested to appoint a new Chair for the remainder of the Municipal Year.

3. **Community Strategy Priorities**

Effective, transparent and equitable democratic and decision making processes are an essential pre-requisite to the delivery of all the Council's priorities.

4. **Other Implications**

The recommendations within this report meet legal requirements. The proposals have no workforce implications and any financial implications have been reflected within the approved budget. There are no Human Rights Act implications.

5. **Supporting Information**

5.1 The Leader of the Council appointed Councillor P K Mann as Commissioner for Opportunity and Skills in place of Councillor F Matloob with effect from 23rd December 2011.

5.2 A member of the executive cannot sit on Overview and Scrutiny Committee or its Panels. The resignation of the Chair has resulted in the requirement to elect a new Chair to the Panel.

6. **Background Papers**

Council Constitution.

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Health Scrutiny Panel – Meeting held on Thursday, 8th December, 2011.

Present:- Councillors P K Mann (Chair), Davis, Long, Plimmer, Sharif and Strutton

Also present under Rule 30:- Councillor Walsh

Apologies for Absence:- Councillor Munawar and Rasib

PART I

105. Declarations of Interest

None.

106. Minutes of the Meetings held on 13th October and 18th October, 2011

The Minutes of the Meetings held on 13th October and 18th October, 2011 were approved as a correct record.

107. Member Questions

None were received.

108. Joint Strategic Needs Assessment - Progress Report and Presentation

Ms Asmat Nisa Consultant in Public Health and Assistant Director, Public Health Directorate, NHS Berkshire East stated that the Primary Care Trust and the Council had a statutory duty under the Local Government and Public Involvement in Health Act (2007) to undertake a Joint Strategic Needs Assessment (JSNA). Members were reminded that the JSNA was the process that identified current and future health and wellbeing needs in light of existing services and informed future service planning taking into account evidence of effectiveness. The JSNA identified the health and wellbeing needs and inequalities of the local population.

Ms Nisa, presented Scrutiny Panel Members with an overview of the JSNA for 2011. Members were reminded of the JSNA 2010 findings and informed of the key health issues that had emerged over the past 2 years and areas that remained a concern. It was noted that one of the priority needs outlined in the 2010 JSNA related to tuberculosis and that a number of measures had been taken to address those concerns.

The Panel was informed that although the 2011 population figures were due to be published by the Office of National Statistics in 2012, it was evident that the Slough population had increased over the years and was skewed towards a younger population in comparison to other local authorities in the south-east. Population projections showed that the greatest predicted rise was within the 30-34 year olds and 10-14 year olds. A contributing factor to the

increase in population figures was due to an increase in birth rate within Slough, which was higher than any of its neighbouring local authorities. It was noted that Slough had the fifth highest fertility rate in the UK and the highest in the south-east.

Ms Nisa outlined the priority needs for Slough for 2011 and noted that key differences from 2010 priorities included areas relating to TB and HIV, mental health, sexual health, looked after children and reducing childhood and adult obesity.

Key findings from the JSNA exercise were highlighted and included:

- New insights into current and projected needs of vulnerable groups based on the local Government Improvement and Development JSNA data inventory published in August 2011. A key gap in the projected needs of those with physical disability had been identified by commissioners and the new projections will inform future commissioning.
- Detailed population density maps for planning services have yielded insights into how the provision of age-specific services can be improved
- An update on population growth with insight into the optimum modelling of future migration to inform the planning of school places and housing
- An update on changes in prevalence of GP registered patients with long term conditions – mental health, diabetes and coronary heart disease were the ones that were statistically higher and adult obesity
- Identification of wards with significantly higher rates of emergency admissions.

Members were also informed of areas JSNA products in development which included a guide to accessing underlying data set and templates with hyperlinks to:

- Detailed templates and datasets for each theme
- A summary of the top ten priorities
- An extract of SHAPE population density information for planning
- A powerpoint of the key findings for each area
- Service templates for key social care and health services to aid future commissioning decisions.

Details of the next steps and prioritisation planning were outlined for Members information. It was noted that now that the data had been collated appropriate planning needed to be carried out with regard to services that needed to be provided more effectively and which areas needed to be targeted due to limited resources.

In the ensuing discussion a number of questions were asked. A Member asked what impact GP triage had had on hospital A&E visits. Dr Angela Snowling, Co-author of the Slough JSNA 2011 stated that whilst this information was not available at the moment a number of options were presented to individuals in terms of looking at alternative rather than attending

A&E. This included using the NHS telephone line and Walk In Centre. It was noted that A&E admissions in Slough remained at a significant higher rate than the national average for England and the reasons why would be investigated further at a working group. A Member queried whether there was any direct correlation between those wards that had a higher rate of hospital admissions and wards within which individuals were not registered with a GP. Dr Snowling stated that whilst there was a direct impact on individuals not registering with GPs and increase in the number of A&E visits, a New Entrants Service had been developed, informing individuals of where services other than the hospital could be accessed.

In response to how the priorities within the JSNA would be monitored, Ms Nisa stated that a detailed action plan for each area would be produced which would monitor outcomes and services provided. A partnership approach in dealing with these issues was critical and key performance indicators would measure what had been achieved.

A Member commented that poverty was the underlying cause of many of the issues and Dr Snowling stated that the issue had been addressed through debt management, training back into work and equipping people with skills and that this had been a very effective service within Slough.

It was noted that the electronic copy of the JSNA would be available in January 2012 on the local authority website.

Resolved – That the report and update be noted.

109. Future of Mental Health Inpatient Services - Progress Update on Additional Engagement and Consultation Activity

Bev Searle, Director of Joint Commissioning, NHS Berkshire outlined the results of the additional engagement work agreed by NHS Berkshire and Berkshire Healthcare NHS Foundation Trust (BHFT) in July. Members were reminded that an alternative means of providing Mental Health In-patient Services for East Berkshire patients had been sought for a consideration time and that there was clear consensus that the existing arrangements on three separate sites, in accommodation which does not allow for single rooms, en-suite facilities and safe access to outside space was not an acceptable standard of provision for patients and was likely to compromise clinical outcomes. It was submitted that the number of people requiring mental health in-patient services had continued to decline and with the benefit of additional community services and improvements in quality and productivity it was likely that this trend would continue. The proportion of people receiving mental health services who required inpatient services was growing smaller, but there was a corresponding growth in acuity and the level of risk presented. This added further wait to the requirement for specialist environment to ensure that patients needs were met effectively.

Additional engagement work undertaken had confirmed a good level of understanding of the case for change amongst stakeholders. However, it was

clear that for some stakeholders concern remained about the distance of Prospect Park Hospital in Reading both for patients and their families, the nature of any transport support available and the planned community service development.

The anticipated benefits of the service were detailed and included:

- The new service would provide both an early intervention and a basis for longer term recovery work which would result in fewer admissions and a reduced length of stay for this client group.
- Individuals would experience a preferred method of service delivery much more capable of meeting their needs.
- The children of people who use the service were likely to experience a happier, more secure upbringing, therefore there was a reduced likelihood of local authority care and a decrease from the probability that they would themselves experience future problems.
- There was an anticipated reduction in the use of GP, Ambulance and A&E time because of less medication to stress them self-harming.
- Increased opportunity for individuals to find pathways into work and other positive ways to contribute to the town's society.

Members were reminded that the cost of a new build facility on the Upton site was previously estimated at approximately £21 million, which would require borrowing above the level of reserves held by BHFT. A new build on Wexham Park site would also approximately cost the same. It was explained that the cost of changes required to Prospect Park Hospital would be between £5-6 million. This funding was already available within the BHFT budget, having been built up over a number of years, as a one-off sum to support anticipated necessary changes to inpatient services. Members were informed that consideration of all options needed to be in the context of the savings plan that BHFT was already embarking on, in order to meet demand and continue to provide effective services. However, any additional investment required or loss of currently identified savings would impact on community service provision.

Members were asked for their views prior to a meeting of the BHFT Cluster Board which was scheduled for January 2012.

The Chair of the Panel stated that, in her view, the Panel could not make an informed opinion without all the information and facts being presented to Members. It was noted that information regarding the financial viability for each of the options needed to be detailed and presented to the Scrutiny Panel. In addition, it was submitted that a decision could not be made whilst the 'Shaping the Future' consultation was ongoing.

A number of Members also expressed concern that they had been led to believe that the Prospect Park facility was ready to move in but it had now transpired that a significant amount of money needed to be spent at Prospect Park and that some services would be outsourced. Furthermore, the report

that had been presented to the meeting did not reflect the concerns that the Panel had expressed on a number of occasions.

A Member sought clarification with regard to the budget allocated for transport to and from Prospect Park. Ms Searle confirmed that the identification of a £100K recurrent budget to provide transport solution would be available on an annual basis. Members stated that it would not be possible to provide BHFT with an informed response prior to their Cluster Board meeting in January 2012.

It was agreed that Ms Searle would present a detailed report outlining all options available against a number of criteria, including impact on community services, financial options, impact on clinical outcomes and impact on accessibility.

Resolved – That a report detailing all possible options with regard to the provision of mental health inpatient services to be provided to a future meeting of the Health Scrutiny Panel.

(The meeting was adjourned for 5 minutes).

110. Slough Safeguarding Vulnerable Adults Partnership Board (April 2010 to October 2011)

The Chair welcomed Nick Georgio, the Independent Chair of the Slough Safeguarding Vulnerable Adults Partnership Board to the meeting.

Ged Taylor, Interim Assistant Director Community and Adult Social Care outlined detailed relating to the Slough Safeguarding Vulnerable Adults Partnership Board, summarising the improvements made in the period April 2010 and September 2011.

Members were informed that safeguarding related to reducing harm experience by a vulnerable person by the abusive actions of others. Safeguarding was everybody's business and was about taking action to raise awareness that abuse of vulnerable people was wrong.

The Board's priorities for the period 2011 – 2014 were outlined as:

- Awareness and community engagement
- Prevention
- Risk and choice and control
- Safe delivery of care services
- Partnership working
- Workforce development
- Improved processes and delivery of the Board's work.

It was highlighted that the Board's work had focused on effective strategic leadership, which was necessary to deliver required safeguarding standards

and performance improvements at a local level. Multi-agency planning and joint working was strengthened to better respond to abuse and neglect.

Members were informed of the progress and achievements that had been made in Slough, which included:

- "Don't Suffer in Silence" – card campaign which was publicised and distributed across public and voluntary services in the Borough.
- "Stop It Now" campaign established to increase awareness of hate crime experience by people of with learning disabilities.
- Risks presented to over 70 victims of anti-social behaviour were monitored and supported by agencies as a direct result of joint working.
- Regarding a serious incident at a private Nursing Home, the Board commissioned an independent chair to convene a review of the circumstances surrounding the incident (Serious Case Review)
- 380 Safeguarding Awareness Training places were made available through the Council's Safeguarding Training Programme
- Working arrangements between safeguarding services and community safety teams improved.

It was highlighted that the number of repeat referrals had reduced significantly to 3% compared to 12% in the previous year. However, referrals from statutory agencies had increased, particularly from the health sector, which now formed 37% of the total number of referrals. Concerns raised by family members also fell slightly although this figure remained higher than the Regional average. Self referrals and referrals from neighbours remained largely unchanged. Responding to whether the Local Authority should be concerned in an increase in the number of referrals, it was stated that this should be viewed as a positive measure as potential matters were being identified and there was a greater awareness of issues amongst professionals.

The future priorities for the Board were outlined and included developing a specialist service for hidden vulnerable groups and working with GP's to ensure their readiness to undertake their new statutory responsibilities in 2013.

A number of detailed questions were asked by Members. It was explained that Safe Place Schemes were being developed and involved providing support to people who were feeling vulnerable when they were out in the community. The scheme worked with the support and commitment of local businesses where a Safe Place sticker was displayed in the window, identifying them as a place where a vulnerable person could, in an emergency, receive immediate short-term help and contact be made on their behalf to the police or carer as required. Members were informed that the scheme was being piloted in Langley and if successful would be rolled out across the borough.

Resolved – That the report be noted.

111. Consideration of reports marked for information

None were received.

112. Forward Work Programme

The programme was updated as follows -

- East Berkshire NHS Car parking review to be listed as unprogrammed.

Resolved – That the report be noted.

113. Attendance Record

Resolved – That the Members attendance record be noted.

114. Date of Next Meeting - 1st February, 2012

The date of the next meeting was noted.

Chair

(Note: The Meeting opened at 6.30 pm and closed at 9.40 pm)

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SLOUGH BOROUGH COUNCIL

REPORT TO: Health Scrutiny Panel **DATE:** 1 February 2012

CONTACT OFFICER: Jane Wood, Strategic Director of Community and Wellbeing
Tracy Luck, Head of Policy and Communications
(For all enquiries) (01753) 875518

WARD(S): All

PART I
FOR COMMENT AND CONSIDERATION

NATIONAL HEALTH SERVICE AND PUBLIC HEALTH REFORM

1 Purpose of Report

To update the Panel on the NHS and public health service changes which form part of the Health and Social Care Bill, currently being considered by Parliament.

2 Recommendations/Proposed Action

That the Panel:

I. Consider and comment on the reforms so far and their implications for Slough.
II. Comment on the formation of the Shadow Health and Wellbeing Board and its terms of reference (to be considered by the Cabinet on 14 February).
III. Request officers to provide a further report when guidance is received from the government on the relationship between the Health and Wellbeing Board, the Council's Cabinet and Overview and Scrutiny.

3 Sustainable Community Strategy Priorities

The SCS, which was refreshed in 2011, sets out the strategic objectives and priorities for the borough until 2028:

- Economy and Skills
- Health and Wellbeing
- Housing
- Regeneration and Environment
- Safer Communities

All of these priorities form the wider determinants of health and contribute to the wellbeing of the people of Slough. The SCS will in future be monitored by the Health and Wellbeing Board.

4 Other Implications

(a) Financial – it is proposed that a ring-fenced grant (made under section 31 of the Local Government Act 2003) will be allocated to councils to fund public health services. 'Shadow' budget allocations will be made this year before allocations for the 2013/14 financial year.

(b) Risk Management – some aspects of the changes will require the development of a risk plan, particularly in relation to the transfer of staff from the PCT to the local authority, but this will need to be developed when the model of service provision is agreed.

(c) Human Rights Act and Other Legal Implications – the additional statutory requirements placed on local authorities introduced by the Bill are set out in the report. The progress of the Bill, its Royal Assent in due course and the publication of Regulations under the Act , together with any further guidance issued by the Department of Health will need to be reviewed and will continue to direct and shape the further work required by the Local Authority.

(d) Equalities Impact Assessment – an EIA will be required when the public health service delivery model is agreed and when specific proposal such as Local HealthWatch procurement are developed.

(e) Workforce – the public health forms will include the transfer of public health staff, including the Director of Public health to top tier local authorities in April 2013. The implications of this for Slough, which currently shares a Director of Public Health with the other two East Berkshire local authorities is set out in the report.

5 Background Information

5.1 The Health Scrutiny Panel received a report on NHS and public health reform at their meeting on 8 February 2011, following the publication of the White Papers 'Equity and Excellence: Liberating the NHS' and 'Healthy Lives, Healthy People'. During the past year the Health and Social Care Bill (the Bill) has been published and is currently being considered by Parliament.

5.2 The Bill has major implications for the local health system and the relationship between that system and local government. In particular it provides for the:

- Abolition of PCTs and the establishment of Clinical Commissioning Groups (CCGs), led by GPs, to commission health services locally;
- Transfers responsibility for public health to local government;
- Requires councils to establish Health and Wellbeing Boards.

5.3 The Bill devolves power and responsibility for the commissioning of NHS Services:

- The role of the Secretary of State will change to one of strategic direction setting and holding the NHS to account.
- GPs will get responsibility for commissioning a wide range of healthcare services, with some exceptions. The Bill allows GPs to join together in consortia, and to commission services in the ways that they judge will deliver the best outcomes for patients

- A new National Commissioning Board will support CCGs. The Commissioning Board will set health outcomes, allocate and account for NHS resources, authorise the establishment of consortia, and have powers of direction over consortia in specified areas and circumstances (such as risk of failure). It will also commission specific services (for example, primary medical services and national specialised services) and will oversee the work of consortia.
- Strategic Health Authorities (SHAs) are to be abolished from April 2012 and Primary Care Trusts (PCTs) from April 2013.
- The Foundation Trust model will be reformed with an aim to support all NHS Trusts to become foundation trusts by 2014.

Creates a new role for Local Authorities in Public Health:

- Public Health England (PHE) will be the national public health service.
- Local authorities will be given responsibility for health improvement currently carried out by Primary Care Trusts (PCTs)
- Directors of Public Health (DsPH), jointly appointed by councils and PHE, will have a leading role in discharging local authorities' public health functions.
- Health and Wellbeing Boards (HWBs) will be statutory in every upper tier local authority and will be required to bring together GP consortia, DsPH, children's services, adult social services and others. The HWBs will have a statutory responsibility to develop a 'joint health and wellbeing strategy' that both local authority and NHS commissioners will be required to have regard to.

Sets up new accountability and scrutiny arrangements:

- Health Watch England will be established as the national voice of patients and the public. Local Involvement Networks (LINks) will be replaced by local Health Watch organisations.
- 'Monitor' will be transformed into the economic regulator for health and adult social care services. Along with the Care Quality Commission, Monitor will licence providers.
- The National Institute for Health and Clinical Excellence (NICE) and the Information Centre will be enshrined in primary legislation for the first time to maintain their independence.

5.4 There was considerable opposition by health professionals following publication of the Bill and this led to the government's "pause" and recommendations by the Future Forum, most of which were incorporated into the 363 amendments to the Bill published at the end of August 2011. There is a developing agenda in relation to public health and therefore some degree of uncertainty about particular aspects. The report attempts to set out what is currently known but that uncertainty means that many questions are still to be answered.

5.5 **Responsibilities of Clinical Commissioning Groups (CCGs)**

5.5.1 The CCGs will:

- Be responsible for managing their combined budget and deciding how best to use these resources to meet the healthcare needs of the patients for whom they are responsible.

- Have the freedom to decide which aspects of commissioning activity they undertake themselves, and which require collaboration across several consortia, for instance through a lead commissioner. In some cases, commissioning will be permitted to take place at a sub-consortium or practice level.
- Decide commissioning priorities to reflect local need, supported by a national framework of quality standards, tariffs and national contracts established by the board. It will be a requirement for priorities to reflect need as set out in the Joint Strategic Needs Assessment (JSNA).
- Become increasingly influential in driving up the quality of general practice and be expected to intervene in the first instance where there are concerns that an individual practice is causing wasteful or ineffective use of NHS resources.
- Be the responsible commissioner for any patients registered within constituent practices – and those in the area who are not registered with a practice.
- Develop arrangements to hold constituent practices to account.

5.5.2 **Proposed funding of Consortia**

Practice-level budgets will be calculated on the basis of registered patient numbers within the consortia boundary and allocated directly to consortia. Consortia commissioning budgets will include a maximum management allowance to reflect costs associated with commissioning. Consortia may choose to commission services from one or more constituent practice over and above the primary care services they have a duty to provide. Further work will be taken forward to allow this while guarding against conflicts of interest.

5.5.3 **What is happening in Slough?**

A single CCG has been established, coterminous with the Council's boundaries. The Strategic Director of Community and Wellbeing is a member of the CCG Panel and has a vote. Appointments to the board were made by interview and the chair was selected by the CCG. The CCG has held a number of meetings and has agreed terms of reference. It has also agreed conflict of interest procedures. The CCG has started to review performance and finance issues, for example what Slough is spending e.g. from elective surgery to prescriptions. This has led to some trailblazing work for example controlling the overspending prescriptions budget. It is also working with the PCT to develop new health pathways. The Slough CCG is looking at federation options with others CCGs. It may be that the Health Scrutiny Panel would want to request a presentation by the CCG on their work at a future meeting.

5.6 **Health and Wellbeing Boards**

5.6.1 The core aim of the Health and Wellbeing Boards (HWBs) is to improve efficiency, secure better care and, ultimately, ensure better health and wellbeing outcomes for the local population. The Boards are expected to integrate commissioning across NHS, public health and social care services, breaking down divisions between the NHS and local authorities by bringing together those who commission services across the NHS, public health, social care and children's services to plan services for their area, and encouraging them to work in a more integrated way.

5.6.2 The Boards will have responsibilities for ensuring that the current and future needs of the local population are understood and best served by health and social care commissioners and providers. They will assess local needs and develop a shared strategy for how best to address them, providing a strategic framework for local commissioning plans. They will be expected to facilitate democratic patient and carer input into the commissioning of local services and give communities more say in health and social care services for local people. They will do this by including elected representatives and patient representatives (via the local HealthWatch once it is in place) in shaping the strategic direction of health and social services in their area, and by acting as the forum for holding those responsible for commissioning decisions to account.

5.6.3 The role envisaged for HWBs has been strengthened as a result of the Government's 'listening exercise' as part of its 'pause' earlier in the year. In response to Future Forum recommendations, the Boards will have a stronger role in addressing wider health determinants, promoting joint commissioning and integrated provision between health, public health and social care. There will also be a new duty on the Boards to involve users and the public, and a requirement for CCGs to involve HWBs as they develop their commissioning plans, with HWBs having the authority to refer commissioning plans back to the Clinical Commissioning Consortium or the NHS Commissioning Board if they are not satisfied that the plans are in line with the JSNA or Joint Health and Wellbeing Strategy (JHWS) (although HWBs will have no veto rights).

5.6.4 Specifically, the Boards will:

- Produce the JSNA and JHWS;
- Be responsible for ensuring that the CCGs commissioning plans align with the joint strategy;
- Play a role in the annual assessment of CCGs and in the initial authorisation process;
- Be required to involve users and the public in the JSNA and JHWS.

5.6.5 Statutory requirements

HWBs are a statutory requirement; every upper-tier local authority is required to lead on developing a HWB in their locality and to establish a Shadow HWB by April 2012. These will become fully constituted bodies under forthcoming legislation in April 2013.

There are a number of specific statutory requirements that relate to the governance, membership and functions of HWBs:

- The legislation will require the Boards to be established as a committee of the council, with local government legislation being amended to reflect the proposed membership of them;
- The minimum core membership will be prescribed, namely:
    - At least one councillor;
    - The directors of adult services, children's services and public health;
    - A representative of the local HealthWatch organisation;
    - A representative of each relevant CCG;

    - And, for some purposes, a representative of the NHS Commissioning Board;
- They will have a duty to involve users and the public in the commissioning of local health and social care services;
- They will have a duty to promote joint commissioning and integrated working between the NHS and local government;
- The legislation sets expectations that HWBs are involved throughout the NHS commissioning process, so commissioning plans (CCGs and others) are in line with the JHWS;
- The JHWS, which the HWB are expected to produce, will be a statutory requirement for both local authorities and CCG;
- The JSNA, which the HWBs are expected to produce, will be a statutory requirement for both local authorities and the CCG, and the HWB will be required to demonstrate that due regard has been given to the findings of the JSNA;
- NHS and local authority will be required to consult with HWB and have regard to the JSNA and JHWS when drawing up their annual commissioning plans;
- Legislation gives HWBs a role in the annual assessment of CCGs (and a non-statutory role in their initial authorisation).

5.6.6 **What is happening in Slough?**

Last summer the council commissioned the consultancy Shared Intelligence (Si) to assist in developing the Council's response to the public health reforms. Specifically in relation to the formation of a Health and Wellbeing Board, Si developed draft terms of reference, suggested membership and an outline work programme.

Building on the Si work a Shadow HWB has been formed and has held a planning meeting and a first working meeting. Si's work emphasised the particular circumstances of Slough, where the wider determinants of health, including housing, skills and crime are of importance (as clearly evidenced in the refresh of the JSNA). It was therefore agreed that the Shadow HWB would replace the former Local Strategic Partnership as it will act as the umbrella partnership for the borough and retaining the LSP would have led to duplication. The terms of reference of the Shadow HWB are attached as **Appendix 'A'**. The Shadow HWB will be considering a name for the board which reflects its wider responsibilities.

Also attached as **Appendix 'B'** is a document called "Operating principles for health and wellbeing board" prepared jointly by the Department of Health and Local Government Association, amongst others, which sets out some useful information, including success criteria for boards.

The Shadow HWB has been developing a sub structure and has agreed that the Children's, Safer Slough, Skills, Employment and Enterprise, Community Cohesion, and Climate Change Partnerships will sit below the Board and report into it. A reformed Health and Wellbeing Sub Group will also be set up to deal with the detailed specific health work which the HWB will need to delegate to a delivery group.

The membership of the Shadow HWB has been agreed to reflect the need to ensure work is coordinated on the wider determinants of health and is chaired by Councillor Robert Anderson, Leader of SBC. In addition to the statutorily required members

includes representatives from Thames Valley Police, the business and voluntary sectors and the Royal Berkshire Fire and Rescue Service. It will be important for this range of partners to play an active part in delivering the aims of the HWB, for example domestic violence is known to have a significant impact on both the health and wellbeing of adults and children in Slough and a number of partners will be able to contribute to a response and prevention.

It will be important for the Health Scrutiny Panel to establish how it will work with and scrutinise the HWB. The Panel will scrutinise the Board's strategic policy development and performance outcomes. This relationship should be developed during the Shadow HWB stage. To facilitate this the minutes of Shadow HWB meetings will be made available to Health Scrutiny Panel Members.

6. Public Health

6.1. From April 2013 top tier local authorities will have a statutory responsibility to employ a DPH jointly with PHE. DsPH will lead local public health efforts: this role can be shared with other councils if agreed locally. In this joint arrangement DsPH will be professionally accountable to the Chief Medical Officer (CMO) and part of the Public Health England professional network. They will also be accountable to the council and HWB for local delivery and outcomes.

6.2 The DPH as a public health specialist will be responsible for all the new public health functions of local authorities, including any conferred on local authorities by regulation. The Health and Social Care Bill will in addition make it a statutory requirement for the DPH to produce an annual report on the health of the local population, and for the local authority to publish it. DsPH will also be statutory members of health and wellbeing boards, and will wish to use the boards as the key formal mechanism for promoting integrated, effective delivery of services. There is an expectation, though not a requirement that the DPH will report to the Chief Executive and be seen as the lead officer for Members to contact on health matters. Specifically the DPH will:

- Be the principal adviser on health matters including needs assessment and priority setting
- Be responsible for the reduction of health inequalities and disease prevention including interventions, commissioning, and provision
- Ensure evidence based commissioning: GP, primary care, secondary , specialist - care and pathways
- Ensure the provision of health protection and emergency preparedness/response, including infections/control
- Be responsible for workforce development – whole system.

6.3 DsPH tasks will include:

- Developing an approach to improving health and wellbeing locally, identifying need, promoting equality and tackling health inequalities and monitoring outcomes
- Providing and using evidence relating to health and wellbeing informing the role, functions and outcomes of the HWBs
- Advising and supporting GP consortia on the population aspects of NHS services and evidence based commissioning including integrated pathways

- Collaborating with local partners on improving health and wellbeing, including GP consortia, other local DsPH, local businesses and others.

6..4 The proposed division of responsibilities for the commissioning of public health functions is set out in **Appendix 'C'**.

6.5 **What is happening in Slough?**

6.5.1 The transfer of the DPH and their staff to local authorities is relatively straightforward in areas where the DPH's remit is coterminous with the upper tier authority (e.g. county councils and London boroughs). However, currently Slough shares a DPH with the other East Berkshire councils (Bracknell Forest and Windsor and Maidenhead). A further complicating factor is that prior to abolition of the PCTs in April 2013, the East and West Berkshire PCTs have been clustered together with a joint management structure (although currently retaining two DsPH).

6.5.2 The Council has been examining different models of managing public health in consultation with partners, including the PCT and with other Berkshire local authorities. As mentioned in paragraph 5.6.6 the Shared Intelligence consultancy has been providing advice to the council about the public health transition and this has included development of workforce options. The three options developed are to have a public health function dedicated to Slough, to share a function with the East Berkshire councils or all of the Berkshire councils or a hybrid model with a shared DPH and some other functions with some dedicated Slough staff.

6.5.3 A cross-Berkshire group convened to progress the transition but decisions will depend on the value of the grant to local authorities. Guidance was issued to PCTs at the end of 2011 and outline transition plans need to be produced by 27 January.

7. **Local HealthWatch**

7.1 Local HealthWatch will become operational in April 2013 (this is a recent postponement from October 2012). Local authorities will be responsible for facilitating the development of an effective local HealthWatch which provides opportunities for people to have their say about the quality and development of their local health and adult social care services, particularly to influence the commissioning of services and to scrutinise them.

7.2 The functions of local HealthWatch will include:- signposting, advice and information giving, assisting with complaints, community networking, intelligence work on national and local statistics in order to inform the commissioning overview functions and assist patients in their choices, enter and view, and possibly advocacy. Local HealthWatch will need the resources to support all of these functions and to support the training of volunteer members carrying out monitoring visits, inspections, enter and view and participating in Health and Wellbeing Board and a wide range of influencing activities in relation to commissioning.

7.3 Local HealthWatch will provide a single point of contact, by connecting people to the right NHS and social care advice and advocacy services, and by helping people to find information that will enable them to choose the services they need and require. It will support people to speak out and give those who want it, an opportunity to get more involved in a range of different ways.

7.4 Local HealthWatch will not be a 'network' like the LINk. It will be a "body corporate", so at some point, Local HealthWatch may need to be set up as a charity, company or similar body, which means that it:

- will be an organisation in its own right, and no longer 'just' a network overseen by volunteer groups
- may appoint its own staff
- will have to produce its own annual accounts
- will have standards provided by a national HealthWatch organisation, HealthWatch England, against which Local HealthWatch organisations can be measured.
- will be subject to the Equality Act 2010. (It is not yet clear what the implications of this will mean, but it may be that Local HealthWatch will have to demonstrate how it is meeting its obligations under the Equality Act, by engaging with all the different sections of the community.)

7.5 It appears that Local HealthWatch will be led by local members or volunteers, and that paid staff will be there to support volunteers, as is the current situation with LINks. The Health and Social Care Bill talks about Local HealthWatch 'members'. It is not clear exactly how HealthWatch will define 'members', but it is possible that the Department of Health considers that Local HealthWatch organisations will be run and 'owned' by a board of members, similar to charity trustees or health board non-executive directors. Some parts of the Bill suggest that Local HealthWatch members might be paid. The Bill it also states that Local HealthWatch members must be "representative of local communities" and this will be challenge for a diverse area like Slough.

7.6 There continues to be considerable uncertainty about the formations of LHW. Local authorities are expected to set up an organisation to meet local needs but there is no recommended procurement route or recommended specification, although there will be consultation on what a 'good' LHW looks like.

7.7 Local Authorities must make arrangements to establish a Local HealthWatch a contract. Local authorities will fund Local HealthWatch in the same way that they fund the LINks: i.e. they will put together specifications for Local HealthWatch and put this out for organisations to bid for. They will then performance manage the contracts, and can terminate them if they think the performance of the Local HealthWatch is unsatisfactory. The Health and Social Care Bill says that local authorities may possibly make HealthWatch arrangements 'directly with the Local HealthWatch'. There is debate about what this means, as how can local authorities make arrangements with a body that does not yet exist? In theory, what could happen is that groups of local volunteers might get together and form an organisation (such as a social enterprise or charity) and then bid for the Local HealthWatch contract. However, as such groups would have no experience of tendering then it is hard to see how this could work.

7.8 Local HealthWatch will be funded from money from central government. The amount for each local authority will be different based on need and is not ring-fenced and will roughly equate to the current LINk budget plus 65% of the Patient Advisory Liaison Service (PALS) local budget. There will also be additional funding in 2013 if Local HealthWatch is successful in bidding for the complaints advocacy (currently Independent Complaints Advisory Service or ICAS) work that local authorities will have to commission.

7.9 The following functions will transfer from PALS to Local HealthWatch:

- Providing information about the NHS and help with health related enquiries
- Helping resolve concerns or problems patients have when using the NHS
- Providing information about the NHS complaints procedure and how to get independent help to make a complaint
- Signposting patients to agencies and support groups outside the NHS
- Informing people about how to get more involved in their own healthcare and the NHS locally
- Improving the NHS by gathering feedback about services and experiences for people who design and manage services
- Identifying problems or gaps in services and reporting them to NHS Trusts.

It is not yet clear what will happen to PCT PALS staff contracts.

7.10 **What is happening in Slough?**

Work has now started to develop a Local HealthWatch model that will meet the needs of local people. There will be close working with the Slough LINk to learn from their experience. We will be reviewing our consultation and engagement arrangements, what has worked well, looking at gaps and involving GPs.

8. **Next stages**

The current Department of Health timetable is:

Early 2012
PCT outline transition plans prepared
Letter about Directors of Public Health appointments
Public Health outcomes framework published
Building the PHE People Transition Policy document published
Public health workforce strategy consultation launched
Shadow local authority allocations for 2012/13 announced
LGG HR Guidance
Sender's HR guidance

March
Local transition plans agreed

April
Chief Executive PHE designate starts

Early summer
PHE People Transition Policy including terms and conditions

2013

April
Public Health England established

9. **Background Papers**

None other than statutory publications

APPENDIX A

Slough Shadow Health and Wellbeing Board (Board's name to be agreed)

Terms of Reference

Purpose of the Shadow Health and Wellbeing Board (HWB)

- To act as a high level strategic partnership to agree on the priorities that will improve the health and wellbeing and reduce the inequalities of the residents of Slough.
- To deliver the statutory functions placed on Health and Wellbeing Boards once the Health and Social Care Bill is established in legislation.
- To act as the umbrella partnership for the borough and oversee the implementation of the priorities in the Sustainable Community Strategy.

To do this the **objectives** of the Shadow HWB will be to:

1. Understand the health and wellbeing needs of Slough's population;
2. Provide a strategic overview of health and wellbeing across Slough to ensure that services are focused in the right place, including developing a strategy for how health, public health, social care and children's services can work together to address identified needs;
3. Deliver the Board's duty to promote joint commissioning and integrated provision, by bringing together a wider range of resources across NHS, social care, public health and other related services;
4. Give the public a voice in shaping health and wellbeing services in Slough, and provide a key forum for public accountability of NHS, public health, social care and other commissioned services that are related to health and wellbeing in Slough; and
5. Prepare for the transition to a fully constituted Health and Wellbeing Board which his ready and able to take on the statutory duties and powers and responsibilities that will be set out for it in the Health and Social Care Bill.

Main functions and responsibilities

Understanding needs and priorities:

- Produce the Joint Strategic Needs Assessment (JSNA);

Strategy development:

- Drawing on the JSNA, agree and produce a new joint Health and Wellbeing Strategy (JHWS) that spans the NHS, public health, social care and tackles other determinants of health such as crime & disorder, housing, climate change, skills and transport. The JHWS will provide a high-level summary of how the health and wellbeing needs of the community are being addressed, which commissioners will need to have regard of in developing commissioning plans for health care, social care and public health;
- Retain a strategic overview of the work of commissioners to further the Board's strategic objectives.

Joint commissioning and integrated provision:

- Consider the wider determinants of health and wellbeing and link with a range of agencies that can help improve health and wellbeing outcomes for all groups in Slough;
- Promote joined-up working and integrated commissioning plans across the NHS, social care, public health and other related services which may have an impact on the health and wellbeing of individuals (for example housing, transport, skills, climate change);
- Encourage organisations commissioning health or social care service provision (clinical commissioners, adult and children's social care commissioners and public health commissioners and other related services) to work together in a more integrated manner;
- Guide and oversee the establishment of effective joint commissioning arrangements, led by GP Consortia;
- Provide advice to the NHS Commissioning Board in authorising and assuring CCGs;
- Support the development of CCG commissioning plans;
- Promote integrated provision and partnership working, joining up social care, public health and NHS services with wider local authority services;
- Refer commissioning plans back to the Clinical Commissioning Consortium or the NHS Commissioning Board if they are not in line with the JSNA or JHWS;
- Lead on the development of pooled budget arrangements, where relevant.

Public accountability:

- Involve local people - through councillors and patient representatives - in influencing the strategy for health and well-being in their area;
- Lead the development of HealthWatch forums for public and patient engagement and involvement.

Preparing for transition to fully constituted Health and Wellbeing Board:

- Make recommendations on the constitution and governance of the Health and Wellbeing Board and any changes required to existing boards and structures in order to implement the proposed changes;
- Deliver a work-plan for the shadow board that that will ensure the necessary relationships, structures and processes for the Health and Wellbeing Board are developed and secured by April 2013;
- Take on any interim new and transferred powers; and responsibilities pending the formal constitution of the Board.

Membership

The Shadow Health and Wellbeing Board will comprise the following but kept under review as requirements are clarified in the legislation and as the Board's priorities are developed and agreed:

- Leader of the Council
- Cabinet member for Health and Wellbeing
- Chief Executive of SBC
- The Directors of:
    - Adult Social Services
    - Children's Services
    - Public Health

- Representative of Slough Clinical Commissioning Group
- Representative from Slough's LiNK, pending establishment of HealthWatch
- Representative of the NHS Berkshire (PCT)
- Local Police Area Commander
- Representative of the Royal Berkshire Fire and Rescue Service
- Representative of local businesses
- Representative of the voluntary and community sector

Governance

In line with the Health and Social Care Bill, the Health and Wellbeing Board will be a committee of the local authority from April 2013. Until that time formal decision-making responsibility will continue to rest with the Council's Executive (the Cabinet and its Members) and the relevant governance bodies of the local health services until new legislation is enacted.

The Shadow HWB will also need to establish a relationship with the Health Scrutiny Panel.

The requirements are as follows, but will be kept under review as requirements are clarified in the legislation:

Decision making

Decisions at meetings will be achieved by consensus of those present. If a vote is required, the Chair will have a casting vote.

Quorum

The quorum for the Board will comprise of one third of its total membership or five members, whichever is the greater. If fewer members attend a meeting than this figure it will be deemed inquorate. Matters may be discussed but no decisions taken.

Urgent decisions

If an urgent decision is required which cannot wait until the next meeting, a special meeting can be arranged. If this is not practical, then the Chair, in discussion with the Vice-Chair, may take a decision. The decision will be reported to the next scheduled meeting.

Frequency and timing of meetings

Meetings will be held bi-monthly, commencing at 5.00 p.m. unless otherwise agreed.

Meetings

Meetings of the Shadow HWB will be held in private.

Agendas

Agendas and associated papers will be circulated five working days before a meeting is held. The HWB will develop a forward plan setting out programmed agenda items for the year ahead.

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Royal College of General Practitioner

ADCS Leading Children's Services

RSPH Royal Society for Public Health

NHS Confederation

Department of Health

nhsalliance

solace

Local Government Improvement and Development

Operating principles for health and wellbeing boards

Laying the foundations for healthier places

The partners

The following organisations jointly developed and endorse the operating principles for health and wellbeing boards contained in this paper.

The Association of Directors of Children's Services
www.adcs.org.uk

The Department of Health
www.dh.gov.uk

The Local Government Group
www.local.gov.uk

The NHS Alliance
www.nhsalliance.org

The NHS Confederation
www.nhsconfed.org

The Royal College of General Practitioners
www.rcgp.org.uk

The Royal Society for Public Health
www.rsph.org.uk/en/about-us/policy-and-projects/projects/health-and-wellbeing-boards-.cfm

Solace
www.solace.org.uk

The British Medical Association also contributed to the development of these principles.

Contents

Introduction and purpose

The Health and Social Care Bill 2011 currently establishes health and wellbeing boards as committees in upper-tier local authorities*, responsible for encouraging integrated working and developing Joint Strategic Needs Assessments and joint health and wellbeing strategies. The proposed health and wellbeing board membership includes:

- at least one councillor from the local authority
- the director of adult social services
- the director of children's services
- the director of public health
- a representative of the local HealthWatch
- a representative of each relevant clinical commissioning group
- other persons or representatives the local authority or health and wellbeing board thinks appropriate.

The director of public health will be the principal advisor on health and well-being to elected members and officials in the local authority.

National organisations representing the membership of health and wellbeing boards developed a set of principles for establishing the boards at an event in July 2011 (see page 12 for a full list of all participating organisations).

The resulting operating principles and accompanying narrative in this paper are designed to support the effective establishment and functioning of health and wellbeing boards. They are, we hope, a realistic and practical response to supporting health and wellbeing boards. They are neither perfect nor 'the end of the story', and this paper is not a definitive description of the legislation that will underpin health and wellbeing boards as there is a lot of potential for boards to operate effectively in different ways, driven by local needs, assets, relationships between partners, context and decisions. However, the principles are intended to help board members consider how to create really effective partnerships across local government and the NHS.

> 'The principles are intended to help board members consider how to create effective partnerships across local government and the NHS'

The operating principles can be used:

- flexibly at different levels
- during different stages of board development
- to guide new ways of working and local operating frameworks
- as a guide or a useful prompt to monitoring progress
- to support the development of local principles or standards by health and wellbeing boards themselves.

The principles can be used as part of a self-assessment process. They will not be used as a performance measure by the Department of Health, Public Health England or others, but health and wellbeing board members may find them useful in assessing the extent to which their boards are developing and working effectively.

*Although health and wellbeing boards will be set up as committees of local authorities, the Health and Social Care Bill 2011 has a clause that enables the disapplication of legislation that relates to those committees – such as legislation covering voting processes and terms of membership, among other issues. This recognises that health and wellbeing boards are unusual in comparison to normal s102 committees in having officers, clinical commissioning groups and local HealthWatch representatives sit on them.

Context

Health and wellbeing boards will be a key part of complex health and local government systems and contexts. Some of the issues they will face are outlined below.

Structures

Health and wellbeing boards will be established as committees of upper-tier local authorities. The way they will be structured is different from previous joint/partnership arrangements. As well as the intention to further develop effective working between upper-tier local authorities and health partners, it is hoped there will be opportunities for greater joint working across the tiers of local government as a result of the new system. Recognising the complexity of the system will be important to ensure that it is able to function effectively. Health and wellbeing boards should not be considered islands cut off from other areas. They will need to work with other health and wellbeing boards regionally and with the national structures such as the NHS Commissioning Board and Public Health England. They will also need to build credibility and trust with local communities.

Relationships

The success of health and wellbeing boards will depend on building constructive relationships between board members, the NHS, local government and partners, including the voluntary sector, communities and other bodies in lower-tier local authorities.

Funding

Resources are scarcer now than in recent years. A ring-fenced public health budget will be transferred to local authorities. The Government's comprehensive spending review to address the national budget deficit has resulted in substantial cuts to local authority budgets, and the NHS has to find 4 per cent efficiency savings each year until 2015. Health and wellbeing board members, local authorities and clinical commissioning groups will have to make difficult decisions about resources issues. Board members will need to work together to take collective responsibility for using limited resources to address the priority needs outlined in the Joint Strategic Needs Assessments and joint health and wellbeing strategies.

'There will be opportunities, through pooled budgets, to address key priorities such as families with complex needs. Local areas will be able to consider how best to use collective budgets across agencies to improve agreed outcomes'

Successful boards are likely to comprise of partners who do not withdraw from joint working to protect their own budgets or attempt to shift costs from one part of the system, which might significantly affect another part. Local areas will not be forced to pool budgets across local government and the NHS, but there will be opportunities, through pooled budgets, to address key priorities such as families with complex needs. Local areas will be able to consider how best to use collective budgets across agencies to improve agreed outcomes.

Methods for funding local areas may vary. Much funding comes through local government and the NHS, but some comes direct from central government and it may be difficult for health and wellbeing boards to influence this spending at a local level.

However, health and wellbeing boards can also seek to influence wider public spending locally. For example, tackling worklessness is an important part of improving health outcomes not only for individuals in employment but also for their wider family. As well as working with employers, health and wellbeing boards will have the opportunity to work with programme providers and Jobcentre Plus, who each have discretion to target resources at partnership working.

Outcomes

Outcomes linked to health and well-being priorities, as identified in the joint health and wellbeing strategy, are an integral part of each of the principles and should underpin the work of the health and wellbeing boards, in particular the commissioners of health, public health, well-being and social care. The boards should be focused on improving outcomes when setting strategies and making decisions. They should have a process for reviewing whether outcomes have changed as a result of agreed actions, taking into consideration the long-term nature of achieving many public health outcomes.

Broader determinants of health

Tackling health inequalities is a major priority for health and wellbeing boards. An approach that identifies needs and assets in the Joint Strategic Needs Assessment and the joint health and wellbeing strategy may be more effective in treating/preventing illness than one which focuses solely on needs. Addressing the structural, material and relational barriers to individuals and communities achieving their potential will significantly contribute towards tackling health inequalities. Health and wellbeing boards can lead this.

> ‘Addressing the structural, material and relational barriers to individuals and communities achieving their potential will significantly contribute towards tackling health inequalities’

Accountability

Although members of health and wellbeing boards will be formally accountable to different parts of the system, they will have a shared responsibility for developing and contributing to the delivery of the joint health and wellbeing strategy. Citizen involvement should be integral to the health and wellbeing board and seen as everybody’s business. Having councillors on the health and wellbeing board means that the actions boards take to achieve these aims will have some democratic legitimacy, but this is not the same as accountability.

Accountability of clinical commissioning groups will come through assessment by the NHS Commissioning Board, lay people on clinical commissioning group boards and duties to involve, consult and publish an annual report. Although clinical commissioning groups will be accountable to the NHS Commissioning Board for financial performance, quality of services, health outcomes and governance, they will also have a collective responsibility as members of the board for delivering their part of the joint health and wellbeing strategy.

Accountability of local authorities will come through their overview and scrutiny function and through local HealthWatch. Health and wellbeing boards in their entirety will be accountable to communities, service users and

overview and scrutiny committees. All board members will also have incentives to deliver on shared objectives to improve efficiency.

Self-assessment

These principles can be used as part of a self-assessment of progress. Self-regulation and improvement will be an important part of health and wellbeing boards' own governance systems and operational culture, such as how transparent, inclusive and accountable they are. Health and wellbeing boards will need to adopt a 'learning approach' to evaluate how well they operate, their collective impact on improving outcomes, and a process for identifying the most effective ways of sharing learning. Some health and wellbeing boards may find it useful to impact assess existing or new strategies, policies and service developments to ascertain how they impact upon the wider determinants of health.

Commissioning and provision of services

Health and wellbeing boards will have an opportunity to define and communicate locally what choice for health and public services means and what is possible. The Government said in its response to the NHS Future Forum report in June 2011 that health and wellbeing boards will act "as the vehicle for lead commissioning." Local areas will have to prioritise according to need. They might consider choice to be about having the best possible services available and accessible locally. Local communities' voices need to be heard and acted upon regarding the design, delivery and evaluation of services. Patient and public involvement through HealthWatch and other channels (such as clinical commissioning groups and overview and scrutiny) will be

> 'Patient and public involvement will be essential to ensuring high-quality and effective services are commissioned and delivered'

essential to ensuring high-quality and effective services are commissioned and delivered.

Providers of services have specialist knowledge which is required when devising Joint Strategic Needs (and assets) Assessments and joint health and wellbeing strategies. While some health and wellbeing boards do not intend to directly commission services, others will have far more direct oversight of the commissioning of council services and of joint commissioning. Whatever they decide their role is in relation to commissioning, they will lead on strategy and governance issues relating to the joint health and wellbeing strategy. Furthermore, they will play a leading role in developing new, integrated ways of working across the NHS, public health, social care and the whole of local government to improve local health and well-being outcomes. Conflicts of interests for all parties need to be managed. Involving providers in key processes can be done in a variety of ways, for example, through a stakeholder forum, and will be important to improve the quality of services and outcomes.

The health and wellbeing board will need to think about how it ensures capacity building takes place. This could be in relation to enabling patient and public involvement to operate effectively, for example, through HealthWatch and other ways, how services respond to personalisation, or how the board can enable communities to build capacity in a 'Big Society'/community development context.

Operating principles

1. To provide collective leadership to improve health and well-being across the local authority area, enable shared decision-making and ownership of decisions in an open and transparent way

What success might look like	Prompts to assist with putting the principles into practice
Effective political and public leadership for health and well-being locally. Leaders: • take collective responsibility for engaging communities, professionals and patients, as well as public, private and voluntary sectors, to develop and deliver a shared vision for improving and protecting health and well-being • are working together in transparent, inclusive and accountable ways • take and communicate difficult decisions • learn lessons from past experience and the experience of others • oversee development of joined-up ways of working • develop a shared vision and agreed outcomes • agree a process for resolving disputes.	• Are strong governance procedures for the health and wellbeing board in place and operating well? • Is there a culture of transparency, trust, respect and understanding between health and well-being board members? • Is it clear how commissioning plans will address the Joint Strategic Needs (and assets) Assessment and achieve the outcomes of the joint health and wellbeing strategy? • Are health and wellbeing board members open and transparent about concerns, identifying potential conflicts straightaway and having ways of dealing with them? • Are health and wellbeing board members leading the culture changes required within the system? • Are difficult decisions, such as reconfiguration issues, being tackled and communicated clearly? • Are lessons being learnt from past local experiences and building on success of current partnership arrangements? • Are health and wellbeing board members applying good practice to join up ways of working between health and local government services? • Does the health and wellbeing board provide high-quality leadership so that health and well-being outcomes for the whole population are improved?

2. To achieve democratic legitimacy and accountability, and empower local people to take part in decision-making

What success might look like	Prompts to assist with putting the principles into practice
Health and wellbeing boards: • operate transparently • in partnership with HealthWatch, fully engage patients, service users and communities and the third, public and private sectors to influence the work of the board, in particular the Joint Strategic Needs (and assets) Assessment and joint health and wellbeing strategy • support communities to find their own solutions to improving and protecting health and well-being • demonstrate professional, clinical and democratic legitimacy for joint decisions.	• Is the health and wellbeing board operating openly, transparently and in accordance with the Nolan Principles of Public Life*? • Are there clear lines of accountability for health and wellbeing board members and partners? • Are the Joint Strategic Needs (and asset) Assessment and the joint health and wellbeing strategy and services being co-designed and commissioned in collaboration with and with engagement from communities as well as third, public and private sector organisations? • Are services and organisations involving people, including children and young people, in the planning and delivery of services? • Are relevant measures of success service user-generated? • Are individuals and communities being appropriately engaged in order to release capability and capacity to finding their own solutions to improve local health and well-being (bearing in mind that other parts of the system such as central government have a role to play at improving the public's health)? • Does the health and wellbeing board have a process to involve communities in evaluating whether it has been successful in delivering priority outcomes identified in the joint health and wellbeing strategy?

*Selflessness, integrity, objectivity, accountability, openness, honesty, leadership (see **www.public-standards.gov.uk**)

3. To address health inequalities by ensuring quality, consistency and comprehensive health and local government services are commissioned and delivered in the area

What success might look like	Prompts to assist with putting the principles into practice
Health and well-being outcomes are improving and health inequalities are reducing as a result of: • commissioning effective health and well-being services across the NHS and local government • addressing the wider determinants of health by including education, housing, transport, employment and the environment in the joint health and wellbeing strategy • influencing cross-sector decisions and services to have positive impacts on health and well-being. There is strong collaboration and partnerships and clear links between local statutory (such as local safeguarding boards) and non-statutory bodies (for example, children's trusts or voluntary group forums). The needs of unregistered patients and vulnerable groups are being addressed and there is a clear focus on children and young people as well as adults.	• Are health and well-being outcomes improving and health inequalities reducing? • Are there examples where local government and NHS services have joined-up working arrangements (such as the use of integrated commissioning arrangements or teams)? • Is it the norm for services and organisations to work together? • Are there clear links between statutory and non-statutory bodies? • Do service users experience services that are joined-up and that offer seamless and continuous care? • Are services timely and responsive to individual and community needs? • Are the needs of unregistered patients, vulnerable groups, children and adults being met? • Does the joint health and wellbeing strategy address the wider determinants of health (for example, a broader approach than simply health and social care services, working with wider partners particularly voluntary organisations) and place emphasis on prevention and early intervention? • Are equalities and human rights acts honoured and a quality equity audit carried out?

4. To identify key priorities for health and local government commissioning and develop clear plans for how commissioners can make best use of their combined resources to improve local health and well-being outcomes in the short, medium and long term

What success might look like	Prompts to assist with putting the principles into practice
The health and wellbeing board ensures the plans of local and regional commissioners are aligned to meet the agreed priorities in the joint health and wellbeing strategy. The Joint Strategic Needs Assessment is a meaningful, asset-based and high-quality process and the outputs provide the evidence to develop the joint health and wellbeing strategy. Decisions are based on research, public and patient input and robust evidence. Partners work together to jointly agree best use of resources. Resources are used effectively, fairly and sustainably. Relevant data and information is collected in order to measure progress. Action is taken when monitoring indicators show plans or initiatives are not working. Innovation and research is supported to improve current and protect future population health and well-being.	• Is the health and wellbeing board adaptive or responsive to change in, for example, demography, workforce requirements or level of resources available? • Do health and well-being partners work well together or operate individually? • Do health and wellbeing board partners have a shared understanding of what resources are available locally to improve health and well-being? Is there a consensus on how these resources can best be utilised to improve outcomes? • Are resources being used effectively and efficiently, ensuring value for money? • Are health and wellbeing board partners taking a flexible approach to allocating resources in support of whole systems thinking to improving health and well-being? • Are decisions driven by independent and robust evidence? • Were all health and wellbeing board members, local communities and external stakeholders meaningfully engaged in the Joint Strategic Needs (and assets) Assessment and joint health and wellbeing strategy processes? • Does the health and wellbeing board maintain an adequate balance between addressing immediate and longer term priorities for improving health and well-being outcomes, and reducing health inequalities? • Do all members of the health and wellbeing board have a shared understanding of the population health and well-being needs according to the Joint Strategic Needs (and assets) Assessments and are they committed to delivering the joint health and wellbeing strategy? • Does the health and wellbeing board monitor progress on outcomes and take action when indicators show plans or initiatives are not working? • Are research and innovative initiatives funded in your area? • Are initiatives and partnerships evaluated on their effectiveness and efficacy? • Does the health and wellbeing board have access to appropriately qualified, skilled and knowledgeable workforce to carry out its public health responsibilities?

Conclusion

Health and wellbeing boards are the vehicles by which the NHS, local government and local communities work together effectively to improve services and population health and well-being. They offer a real opportunity to address health inequalities by identifying priorities for health and local authority commissioning and by focusing resources on improving health and well-being outcomes.

These principles have been developed by the national organisations representing the proposed members of the health and wellbeing boards, and represent their shared commitment to making the new system work.

Health and wellbeing boards must be accountable to the local community. They must also empower local people to take part in decision-making.

Key to their success will be collective leadership and the way in which board members work together. Getting it right will lay the foundations for healthier communities and more sustainable public services.

For more information on the issues covered in this paper, contact Nicola Stevenson, Senior Policy and Research Officer, NHS Confederation at nicola.stevenson@nhsconfed.org

Further information

The following documents and links provide additional resources to assist with developing health and wellbeing boards.

Wistow G: *Integration this time? Liberating the NHS and the role of local government*. LGID, March 2011
www.idea.gov.uk/idk/aio/27388110

Where next for health and social care integration? NHS Confederation discussion paper, June 2010
www.nhsconfed.org/Publications/Pages/health-socialcare-integration.aspx

Bambra C, Blackman T, Hopkins T, Hunter DJ, Marks L, Perkins N: *Partnership working and the implications for governance: issues affecting public health partnerships*. NIHR, March 2011
www.sdo.nihr.ac.uk/projdetails.php?ref=08-1716-204

The NHS Constitution for England
www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_113613

Accountability works. Centre for Public Scrutiny, 2010
www.cfps.org.uk/what-we-do/publications/cfps-general/?id=128

Board Assurance Prompt – Health and Wellbeing Boards, Good Governance Institute, September 2011
www.good-governance.org.uk/Downloads/2011%20Aug%20Health%20Well%20Being%20Board%20BAPMM.pdf

National learning sets to accelerate development of health and wellbeing boards
http://healthandcare.dh.gov.uk/learning-sets

Local Government Group, National Learning Network for Health and Wellbeing Boards
www.communities.idea.gov.uk/comm/landing-home.do?id=10113659

Health and wellbeing boards: making them work. The King's Fund
www.kingsfund.org.uk/current_projects/health_and_wellbeing_boards_making_them_work/health_and_wellbeing.html

The Joint Strategic Needs Assessment: a vital tool to guide commissioning. NHS Confederation, July 2011
www.nhsconfed.org/Publications/briefings/Pages/joint-strategic-needs-assessment.aspx

Acknowledgements

Representatives from the following national organisations attended the event in July 2011. We are grateful for their participation.

The Association of Directors of Adult Social Services

The Association of Directors of Children's Services

The Association of Directors of Public Health

The British Medical Association

The Centre for Public Scrutiny

The Department of Health

The Faculty of Public Health

The Family Doctor Association

The Local Government Group

The National Association of Links Members

The National Association of Primary Care

The National Quality Board

National Voices

The NHS Alliance

The NHS Confederation

Regional Voices

The Royal College of General Practitioners

The Royal Society for Public Health

We would also like to thank the representatives from the following local organisations who attended the event in July 2011. These representatives provided specific contributions in relation to their own local contexts which helped to frame discussions.

Bridgewater Community Healthcare NHS Trust

Knowsley Council

London Borough of Hammersmith and Fulham

NHS Hampshire

Operating principles for health and wellbeing boards

At an event held in July 2011, a number of national organisations developed a set of operating principles to support the effective establishment and functioning of health and wellbeing boards.

These operating principles are designed to be a realistic and practical response to supporting health and wellbeing boards. They are intended to help board members consider how to create really effective partnerships across local government and the NHS.

Further copies or alternative formats can be requested from:
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APPENDIX C

Proposed Division of Responsibilities for the Commissioning of Public Health Functions

Weighing and measuring of children	Local authority (LA)
Dental public health	LA
Fluoridation	LA
Medical inspection of school children	LA
Infectious disease	Public Health England (PHE) with support from LA
All sexual health services	LA (apart from contraceptive services and screening which will be commissioned by NHS Commissioning Board)
Immunisation	NHS Commissioning Board plus LA to commission school programmes such as HPV and teen boosters
Standardisation and bio-medicines	PHE
Seasonal mortality	LA
Environmental hazards	PHE with support from LA
Screening	NHS Commissioning Board
Accidental injury prevention	LA
Public mental health	LA
Nutrition	PHE and some LA activity
Physical activity	LA
Obesity programmes	LA
Drug, alcohol and tobacco misuse	LA
NHS health check programme	LA
Health at work	LA
Reduction and preventing birth defects	LA and PHE
Prevention and early presentation in relation to cancer	LA
Dental public health	LA with support from PHE
Emergency preparedness	PHE with support from LA
Health intelligence	PHE and LA
Children's public heath for under 5s	NHS Commissioning Board
Children's public health for 5-19	LA
Community safety and violence prevention	LA
Social exclusion	LA
Public health for prisoners	NHS Commissioning Board

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Heatherwood and Wexham Park Hospitals
NHS Foundation Trust

Operational Finance Update

for

Slough Borough Council Overview and Scrutiny Committee

1 February 2012

Philippa Slinger Chief Executive

Monday, 23 January 2012

Financial Background to 2011/12

At the end of the financial year 2010/11 the Trust had delivered the required savings for that year and had reduced the cost base of the organisation. The start of 2011/12 was complicated by the fact that we did not finalise a contract with the PCT until after the start of the year making it difficult for us to know how much income it would receive. We budgeted for similar levels of expenditure as in 2010/11 for the first 2 months of 2011/12.

When the contract was finalised the actual level of income we were to receive was considerably less than 2010/11 because the PCT had plans in place to reduce the amount of patients we would see as they would be offered alternatives in the community or in their own home. In response we reduced the amount of capacity we had so we could reduce the costs to meet the level of income. This included reducing the number of beds available etc. The budget was set to meet the lower level of income.

Unfortunately the services that were in place to help reduce the need for hospital care did not relieve the pressure on the hospital as we had all hoped. For example the Urgent Care Centre at A&E did not prevent as many people as we would have all liked from needing to come into the A&E Department, the Rapid Access Clinic in Maidenhead is very effective but is not yet seeing as many patients as it could.

This meant that we needed to continue to see a similar number of patients to 2010/11 but because it had taken out capacity, it needed to put it back in very quickly and this was at a higher cost as it required high numbers of agency staff to enable the level of need to be met rapidly.

Financial Background to 2011/12 – cont'd

We continued in this manner for 2/3 months as we expected that the numbers of patients would begin to fall as the new services took hold therefore the high level of agency staff was maintained for some time as it did provide the flexibility the Trust needed to increase/decrease staff numbers quickly.

As the summer progressed it became clear that we were overspending our budget. The cost over runs were in part related to the high cost staffing we had to use but also because we had some internal housekeeping issues we needed to address.

Following Board discussion, we submitted a revised financial reforecast for 2011/12 to Monitor on 11 November. The end of year position will be dependent upon the final amount of income we receive but will be a deficit figure somewhere between £13m to £15m. We had planned to end the year with a £4.7m deficit.

The forecast has been developed to enable us to deliver safe, effective care for the remainder of this year to a level equal to the number of patients we see using substantive staff as far as we are able and reducing the number of agency and temporary staff, this means we are actively recruiting Doctors and Nurses.

	Actuals				Reforecast	YTD	
	Sept YTD	October	November	December	December	Actuals	Reforecast
Income	109,492	17,861	18,107	16,783	16,723	162,243	161,850
Pay	78,865	12,962	12,775	12,847	12,809	117,450	117,487
Non Pay	34,765	5,798	5,886	5,753	5,987	52,203	53,169
Operating costs	113,630	18,760	18,661	18,601	18,796	169,652	170,656
EBITDA	(4,138)	(900)	(554)	(1,817)	(2,073)	(7,409)	(8,806)
Financing etc	4,280	719	719	719	717	6,436	6,450
Surplus / (Deficit)	(8,418)	(1,619)	(1,273)	(2,536)	(2,789)	(13,846)	(15,256)

Trust Financial Forecast 2011/12

Whilst managing the hospital to be sure we deliver the quality and quantity of care we need for our patients and to be sure we can cope with winter pressures we must still be sure to drive as much efficiency as we can, so we do have an internal saving plan that is being monitored very closely to be sure it delivers as much as possible to keep the deficit as low as we can. Projects include improving the time it takes to recruit to minimise agency staffing costs, looking harder at our length of stay, and ensuring we discharge people effectively across 7 days a week.

We are confident we can deliver to the revised plan and hopefully improve that position further as we establish robust internal performance management systems and real time cost data to enable faster corrective action.

Finance for 2012/13

We have started contract discussions with the PCT for 2012/13 and it will be important for us all to be sure we plan for the correct number of patients in that year. It will also be important for us to continue to drive out cost through improved efficiency as there are some areas where we spend more than others would, for example our pay to non pay ratio is higher than our neighbour Trusts. This means that we must continue to work to reduce agency and temporary staff spend by ensuring we employ permanent staff, improve our IT systems so we can become less manually driven, and improve the "flow" of patients through the hospital so we can reduce beds through improved length of stay.

Clinical Performance

Our clinical quality and performance has always been and remains our highest priority.

The Trust Board continues to receive monthly Clinical Safety & Quality Reports which has recently demonstrated significant improvement in performance against specific targets:

• In relation to VTE risk assessment compliance, the Trust increased its performance from 61% during Quarter 2 to 90% at the end of Quarter 3.

• There has been a reduction of 28% in the average falls rate for 2011 to date, compared with 2010.

• The Trust's PCT-agreed target with regard to pressure ulcers at Grades 3 and 4 is to have no more than 14 instances for the financial year. The Trust total to date is four.

• At the end of November, the Trust had closed 95% of its complaints received, against a year end target of 90%. (In December 29 formal complaints, 127 informal/PALS complaints and several hundred compliments were received.) Of the complaints, the nature is set out below.

- Treatment and diagnosis 21%
- Communication 20%
- Professional Conduct 11%
- Advice & Information 6%
- Appointment issues 6%
- Care 6%

Clinical Governance & Compliance

The CQC undertook an unannounced inspection of the Wexham Park maternity unit ward on 12 October 2011. The Trust has received confirmation that the CQC assessed the Trust as being compliant with each of the standards reviewed.

Furthermore, on 26 October, the CQC undertook an unannounced inspection as a follow-up to a previous review that had occurred at the end of June 2011. The October follow-up inspection particularly focused upon safeguarding training, the safety of medical equipment and patient care plan documentation. The Trust was again found to be compliant in each of the inspected areas.

On 2 and 8 November, the CQC undertook a joint safeguarding inspection with Ofsted. The inspection examined the Trust's arrangements for safeguarding children. Informal feedback was positive with a good level of awareness of frontline staff and a consistent level of understanding of staff responsibility relating to safeguarding children and domestic violence.

All previous CQC conditions have been removed from the Trust's Registration.

SLOUGH BOROUGH COUNCIL

REPORT TO: Health Scrutiny Panel **DATE:** 1 February 2012

CONTACT OFFICER: Sarah Forsyth, Scrutiny Officer
(For all Enquiries) (01753) 875657

WARD(S): All

PART I

FOR COMMENT & CONSIDERATION

EAST BERKSHIRE MENTAL HEALTH INPATIENT SERVICES

1. **Purpose of Report**

To consider the latest information and request that the Panel provide feedback to the NHS Berkshire Cluster Board on the proposals for the future provision of mental health inpatient services in East Berkshire.

2. **Supporting Information**

Following the discussion of the Health Scrutiny Panel on the 8 December 2011, the Primary Care Trust (PCT) submitted details of the options being considered for the future provision of mental health inpatient services in East Berkshire. These were received by Slough Borough Council on the 3 January 2012, and are attached as Appendix 1.

Following this, confirmation was given that the NHS Berkshire Cluster Board would be making a decision on the provision of services at its meeting on the 24 January 2012. This would mean that the Slough Health Scrutiny Panel would not have the opportunity of fully discussing the options and forming an opinion before the decision would be taken, and the PCT have been made aware of this situation. An update on the situation will be provided at the meeting on the 1 February.

Attached to this report as Appendices 2-5 are the documents produced for the NHS Berkshire Cluster Board meeting on 24th January 2012.

3. **Comments of Other Committees**

Please refer to minutes of Health Scrutiny Panel on the 8 December 2011.

4. **Conclusion**

The NHS Berkshire Cluster Board is due to make a conditional decision on the provision of mental health inpatient services in East Berkshire on the 24 January 2012, however the Panel can still submit follow up comments on the options that have been considered.

5. **Appendices Attached**

1 - Breakdown of options for provision of mental health inpatient services

2 - Summary briefing: Berkshire East mental health inpatient bed provision

3 - Cluster Board report (24 January 2012): Future Provision of East Berkshire Mental Health Inpatient Services

4 - Results of additional engagement work undertaken by NHS Berkshire July-December 2011

5 - Media Release (19 January 2012)

6. **Background Papers**

None.

APPENDIX 1

Option	Description	Clinical Evidence Base	Support of Clinical Commissioners	Promotion of choice for patients and improved patient experience	Engagement of public, patients and local authorities	Estates Issues	Value for money	Accessibility	Resource capacity and capability	Viability
1	All hospital beds to be provided from Prospect Park Hospital (PPH) in Reading resulting in closure of all beds on current three sites in East Berkshire. This option was included in the 2010 consultation.	BHFT Clinicians support consolidation of beds onto one site for optimum clinical outcomes associated with the purpose built environment, the availability of the full range of treatments, flexibility of staffing, and the maximisation of resources available for community investment minimising the need for admission, and promoting early recovery. Inpatient services regarded as specialist provision for approx 2% of patient population with majority of care pathway in local areas. Purpose built environment minimises risks eg from ligature point and absconscion. Mitigates risk of potential for isolated inpatient services linked with possible future reduction in demand. Psychiatric Intensive Care Unit (PICU) is on site so eliminates risks due to transfer from other sites.	Conditional support of Clinical Executive Committee (including Clinical Commissioning Group Leads) confirmed 14.12.11. Conditions are: staged implementation plan with completion of community service planning and deployment, transport support, patient experience and quality improvement prior to closure of existing East Berks facilities, prioritisation of ward 10 closure due to quality and safety concerns.	33% of respondents to 2010 survey confirmed as first choice. Presents only one choice of inpatient unit. Provides individual rooms with ensuite facilities promoting privacy, feeling safe and dignity in care. Access to outside space. Allows continued investment in community services ensuring majority of patients receive treatment locally while living in their own homes.	Access for patients/visitors from East Berkshire a consistent concern for Slough and parts of RBWM. Maintenance and development of community services prioritised by RBWM and Bracknell, majority of whose stakeholders now support this option. Arrangements for transport support have been described in more detail, and commitment to ongoing financial allocation made by BHFT.	Sufficient space available for conversion into estimated inpatient capacity required (64) with a number of potential reconfiguration options. Purpose built facility therefore high quality environment. Allows single bedrooms lockable from inside and ensuite bedrooms, gender separation and separation of older adults with functional and organic illness.	Capital investment of £5-6m available within existing BHFT budget. Individual bed cost higher than existing facilities in East Berks due to being a modern building with higher / latest specification and built under a PFI procurement. Achieves a revenue saving of £1.9m per annum - assumed from 2012/13. Resources available to continue existing community services and allows for investment in new services for people with personality disorder.	Distance of Reading from Slough and parts of Windsor and Maidenhead presents difficulty for some patients and carers. 20 - 25% of Slough inpatients already access Prospect Park Hospital. Proposals for transport support and financial allocation of £100k pa planned to mitigate this. Outpatient services to be maintained in East Berks sites. Community services maintained and additional service developed for people with personality disorder therefore providing local service for majority of patients (98% of people accessing mental health services). Additional distance for police, ambulance and AMHPs to convey patients from East Berks. Balanced by co-location of all beds with intensive care unit which can require police support from East Berks sites. The Approved Place of Safety (APOS) at Prospect Park Hospital currently provides for the large majority of use in Berkshire at 3 - 4 times that experienced at either Wexham Park or Heatherwood. Thames Valley management of mental health protocol confirms use of Police Stations as APOS in exceptional circumstances, which would need to continue in patients' best interests.	Bed requirement can be accommodated at Prospect Park Hospital by reconfiguring current accommodation. Outpatient services would be maintained in East Berkshire locations as part of community service provision. Specific arrangements would need to be agreed with Thames Valley Police and South Central Ambulance Service to ensure effective joint working in terms of APOS and conveyance. Formal response has not indicated lack of support for option 1. Recruitment and retention of staff unlikely to present significant challenge (learning from relocation of Fairmile Hospital from S Oxon). Full range of treatment facilities can be provided. Has potential to provide centre of excellence and employer of choice for specialist inpatient staff.	Option is financially and clinically viable, and includes proposals to mitigate adverse accessibility impact for some of the Slough and Windsor and Maidenhead patients and their families. Enables maintenance of investment in community services therefore ensuring quality and capacity of provision required for patients while living in their own homes, thus reducing the risk of avoidable admission and promoting early recovery. No dependencies on non-mental health service reconfigurations. Time from approval to completion estimated at 21 months, but early relocation of some services could be achieved in 2012 if prioritised. Further work is required to identify optimum configuration and phasing if option formally approved.
2	All hospital beds for adults of working age to be provided from Prospect Park Hospital, but beds for older adults to be retained at St Marks Hospital in Maidenhead. This option was included in the 2010 consultation.	Clinicians for older adults do not support maintenance of a single inpatient service in East Berkshire for older people which would be an isolated unit presenting difficulty in providing full range of treatment facilities. There is strong support for a purpose built facility for older adults providing separate accommodation for people with functional and organic illness, to achieve the best clinical outcomes. Current provision does not achieve this, and it cannot be achieved within existing footprint of Charles Ward.	Not supported.	23% of respondents to 2010 survey confirmed as first choice. Presents a single choice of inpatient unit for adults and maintains 2 units for older adults. Patient experience for older adults compromised by difficulty in providing full range of facilities.	RBWM strongly support continued health provision on St Marks site, and received assurance about improved clinical outcomes from consolidation onto a single site and continued strategic importance of St Marks to health economy.	Space required for required quality of accommodation (see clinical evidence base) would require use of both Charles Ward and Henry Tudor (BUPA), which was not in original consultation.	£7m capital investment to achieve single ensuite rooms (if larger footprint were available, i.e. Charles and Henry Tudor together) inclusive of cost of conversion at PPH for required adult beds. Revenue saving of £1.9m associated with option1 would not be achieved in full (£1.4m saving associated with this option), and therefore would reduce resources available for community services.	Accessibility for inpatient services for older people maintained at current level, but accessibility of community services likely to be compromised as a result of financial impact. APOS could theoretically be maintained in East Berkshire but would present staffing challenges due to lack of presence of dedicated adult staffing. Issues for adult services above apply, but ability to mitigate reduced due to financial impact. Accessibility to community services would be reduced for all East Berkshire patients due to financial impact.	Outpatient services for adults would be retained in East Berks. Service model not supported by clinicians and would present significant problems in terms of staff recruitment and retention if considered viable. Savings would be required from community services which would potentially compromise recruitment and retention of staff in these services.	Option is not supported by clinicians and majority of stakeholders as presenting the optimum solution for patients. Would also require movement of other services to achieve required footprint - consultation on this has not been taken forward because of lack of overall support for this option. Savings would also be required from community services to achieve this option - therefore not considered viable overall.
3	New build on Upton Hospital site in Slough to replace all East Berkshire MH beds. This option is for the full 64 bed Mental Health Unit. This option was included in the 2010 consultation	BHFT Clinicians support consolidation of beds onto one site for improved clinical outcomes, including patient safety, and also maintenance and development of community services for optimum clinical outcomes. Transfer of patients to PICU would remain a challenge in terms of patient and staff safety. Opportunities presented by Shaping the Future - looking at all future hospital provision in East Berks limited due to lack of ability to share clinical staffing across specialist MH inpatient and general services.	Impact on community service provision resulting from financial impact noted as significant concern leading to conditional support for option 1 as stated above.	36% of respondents to survey confirmed as first choice. Would retain 2 inpatient facilities for adults and older people. Would significantly reduce access to community services as a result of additional investment to inpatient services leading to risk of increased need for inpatient services.	Supported by Slough stakeholders, not supported by majority of RBWM, and not supported by Bracknell Forest BC.	Provision of a 64 bed full support services unit. This provides the latest specification of infrastructure but is the most costly of all the options available (Capital and Revenue). Planning consent has not been applied for but it is assumed that it is achievable.	Financial impact of in excess of £20m capital investment with annual commitment of >£2m revenue. Revenue savings associated with option 1 not achieved leading to total savings requirement of approx £2.6m (approx equivalent to more than 50% of total NHS budget for community mental health in any one of the council areas.) Financial impact of a new build on any available site would be very similar to those noted for this option	Good accessibility for inpatients and families from Slough and parts of Windsor and Maidenhead. Poorer accessibility for inpatients from parts of Windsor, Maidenhead and Bracknell. Reduced access to community services for patients from all parts of East Berkshire as a result of financial impact, risking lower rates of recovery and increased demand for more expensive inpatient treatment. Would retain APOS in East Berks in a clinical environment but accessibility to Intensive Care Unit at Prospect Park Hospital would present a challenge, as currently, to be managed in partnership with Police and Ambulance Services.	Option includes full estimated bed requirement. No change to outpatient services. Working in a purpose built environment is more attractive to staff and therefore aids recruitment and retention. A new inpatient service would provide 2 wards of current size for adults - and as such would improve current difficulties associated with the single wards at Wexham Park and Heatherwood, but presents a greater challenge to long term provision of full range of services through effective recruitment and retention of staff than consolidation onto a single site. Linked reduction of community services risks recruitment and retention difficulties in those services thus compromising their viability.	Would require viable plan to enable assumed savings and revenue impact of capital investment to be achieved. The financial impact equates to approximately the level of investment in a community mental health service by BHFT in a single Council area, and there are currently no specific proposals as to how this level of saving could be achieved. Not considered viable overall.
4	Conversion of Wexham Park Hospital Wards in Slough to provide 64 beds. This option was considered as part of the 2011 additional engagement.	BHFT Clinicians support consolidation of beds onto one site for improved clinical outcomes, but not retention of a single isolated ward. Shaping the Future opportunities as for option 3 above. Refurbishment would not provide the quality of accommodation that a purpose built facility would offer, and would therefore present a risk that optimal outcomes would not be achieved. Fewer resources would be available for investment in community services, although this would not be as great a reduction as option 2 due to lower cost of conversion as opposed to new build. Transfer of patients to PICU would remain a challenge.	A modified option has also been considered - retention of existing Ward 10 and accommodation of Heatherwood and Charles Ward beds at Prospect Park Hospital not supported by any of CCGs.	Option not consulted on due to lack of estates viability. Would retain 2 inpatient facilities, but reduce community service provision leading to risk identified for option 3.	Would effectively address concerns from Slough regarding access for local residents but access for patients and visitors from areas south of Wexham would present a challenge. Would not be supported by Bracknell Forest BC because of adverse impact on community services due to additional investment required and poorer access. Additional consultation would be required because of knock on impact on other services on site.	Space required to achieve estimated 64 beds required is not consistent with HWWP Trust plans, which has confirmed no available ground floor space. Refurbishment undertaken to date at Ward 10 has limited benefit because of the nature of the building, and challenges remain in terms of observation, separation of male and female areas, access to outside space and natural light. This option requires the conversion of Wards 10, 11, 12 and the Day Surgery Unit therefore requires significant relocation of current services in some of these areas.	Financial impact of approx £10m capital with corresponding annual commitment. Reduction of resources available for investment in community services as a result of savings requirement of approx £3m.	As above.	As above for purpose built unit. If conversion of existing buildings, accommodation would not be at same level of quality and therefore not achieve the same outcomes for patients and staff.	Would require movement of other non-mental health services to achieve required footprint. Formal consultation of options currently in development for Shaping the Future planned for March 2012, and the time required to achieve approval of preferred option would significantly delay resolution of existing challenges to quality and safety associated with Ward 10. Savings would be required from community services to achieve this option as described above.
5	Conversion of Upton Hospital to provide a 64 bed unit. This option was considered as part of the 2011 additional engagement.	As above	Option not formally considered due to estates limitations noted.	Option not consulted on. Would retain 2 inpatient facilities, but reduce community service provision leading to risk identified for option 3.	As above	This option is to provide the full 64 bed fully supported unit. The option of converting current accommodation is not achievable for patient safety or financial viability. The reason for the above explanation is the age, construction, condition and design suitability of the current building stock at this hospital.	As for option 4 above.	As above.	As above in relation to converted buildings.	Estates analysis concludes existing buildings not suitable for conversion. As above in relation to Shaping the Future and requirement for additional savings from community services. Option assessed as not viable overall.

Option	Description	Clinical Evidence Base	Support of Clinical Commissioners	Promotion of choice for patients and improved patient experience	Engagement of public, patients and local authorities	Estates Issues	Value for money	Accessibility	Resource capacity and capability	Viability
6	Conversion of St Marks Hospital to provide inpatient service possible within site (estimated at 44 beds). This option was considered as part of the 2011 additional engagement.	As above	Option not formally considered due to estates limitations noted	Consideration given to MH Inpatient services possible to provide on St Marks site as part of additional engagement undertaken in 2011, but lack of overall support meant that additional consultation not taken forward	As above. Access for RBWM and Bracknell residents would be better at Maidenhead than Slough, but issues regarding financial impact and consultation apply as above.	Space required to achieve type and amount of accommodation required for older adults would necessitate the move of elderly frail patients to the BUPA facility next door to Charles Ward.	Financial impact in excess of £8m capital with corresponding revenue impact Significant reduction of resources available for investment in community services	As above.	As above in relation to converted buildings.	Estates, financial and clinical analysis concludes this option is not viable overall.
7	Conversion of Heatherwood Hospital, Ascot, to provide inpatient service possible within site (estimated at 36 beds). This option was considered as part of the 2011 additional engagement.	As above	Option not formally considered due to estates limitations noted.	Option not consulted on. Consideration given to MH Inpatients services possible to provide on site, but lack of overall support meant that additional consultation not taken forward.	As above. Access for RBWM and Bracknell residents would be better at Ascot than Slough, but issues regarding financial impact and consultation apply as above.	The conversion of the space occupied for Mental Health at Heatherwood would only provide a facility for 36 patients when converted to the latest required specification.	The cost of conversion for 36 patients is circa £6m partly as a consequence of the current building construction. Bed no's provided means investment also required at Prospect Park Hospital.	As above.	As above in relation to converted buildings.	Estates analysis concludes that existing MH footprint would only provide 36 beds. As for option 4 in relation to Shaping the Future and requirement for additional savings from community services. Not considered viable .
8	Establishment of acute inpatient unit in Slough locality to replace Ward 10. This option was considered as part of the 2011 additional engagement.	Exploration of this option by BSS and CCG in association with BHFT clinicians confirmed not clinically appropriate for the patient group. The facility would represent an isolated unit and therefore pose challenges in terms of provision of the full range of treatment facilities. A larger cohort of staffing would be required to mitigate patient safety issues, and environmental design would be likely to emphasise security features, therefore impacting on patient experience.	Option considered by Slough CCG and not supported due to clinical issues.	Option not consulted on due to lack of overall support.	Engagement work not progressed following identification of this option as clinically non-viable, though access for patients and visitors would be significantly better than option 1.	Potential for use of a converted nursing home has been explored. Conversion of a current nursing home facility is considered difficult and not cost effective but more importantly not a suitable environment for treatment and presenting patient safety concerns.	Costs not analysed in detail as not considered clinically viable. Additional savings would be required as accommodation would be required at Prospect Park Hospital for Bracknell and RBWM patients, so full £1.9m savings would not be secured. Staffing costs would be higher than a consolidated unit.	Service would be more accessible for majority of patients and families from Slough than either existing services or any other options considered.	High level of staffing would be required to ensure safety of patients and staff. The environment would not be purpose built, and this in combination with its isolated nature would present significant risk to recruitment and retention of staff. Would not be supported by clinicians and therefore unlikely that commissioned provider would support the option. Would require savings to be made in community services therefore presenting a risk.	Option would present an isolated unit, not supported by clinicians, and following exploration by GPs and BSS, confirmed as not viable.
9	Commissioning beds from the independent sector in East Berks. This option was considered as part of the 2011 additional engagement as a means of possible mitigation of concerns associated with option 1, and not as a stand alone option.	BHFT Clinicians do not support the clinical need for this sort of provision: patients requiring admission are a very small proportion of total treated in community, and should ideally be treated in a purpose built unit before being discharged home, but BHFT would be willing to work alongside another provider to optimise the care pathway for patients if required.	Option has found limited support.	Option not consulted on - is not a "stand alone" option, but is a potential means of mitigating access concerns associated with option 1.	This option is seen by some stakeholders as having the potential to minimise admission and/or length of stay for patients and therefore mitigate impact of access issues. However, the cost of this model would mean reduction in resource available for other community based services.	Capacity for spot commissioning is currently available in the independent sector. However, this is not purpose built and therefore likely to require high levels of staffing support.	Cost of spot purchase of 2 Nursing Home beds would total approx £125k pa due to high staffing levels needed. Similar cost for Independent Hospital Provision totalling approx £0.5m pa. Would require reduction of resources available for community services.	Minimising admissions and reductions in length of stay for East Berkshire patients could potentially be achieved through the provision of this service, therefore reducing accessibility concerns associated with option 1. However, clinicians advise that the majority of patients will be discharged home with community service support at the earliest opportunity, rather than to a "step down" facility.	Capacity in Nursing Homes and Independent Hospitals is available at the level of 1 - 2 beds in each. Service would be commissioned in accordance with individual need. Appropriately trained staff would be required in sector to support level of individual patient need. Consultants would need to oversee treatment and care provided. Financial impact on community services as described above if use of spot purchased beds remains consistent.	Option has the potential to mitigate concerns about access for Slough patients and patients from some parts of Windsor and Maidenhead in combination with option 1. Careful control of care pathway and expenditure would be required to minimise adverse impact on community service provision.
10	Commissioning beds from neighbouring NHS providers. This option was considered as part of the 2011 additional engagement.	Services would be provided in environments already in use for mental health inpatient services, therefore assumed clinically appropriate. Care pathway would not be provided by a single health organisation.	Option not formally considered.	Option not consulted on.	Engagement work not progressed as long term contract requirement and capital investment identified.	Limited capacity in neighbouring Trusts - could be spot purchased at the level of 1-2 beds. New build and 20 year contract required to provide additional capacity.	Spot purchase of 1- 2 beds at a time would require additional commissioner investment. Purchasing total capacity required would require capital investment for new build and long term contract. This would not realise £1.9m savings currently identified.	Access for some inpatients and their families from Slough and some parts of Windsor and Maidenhead would be improved. Neighbouring providers have confirmed the need to provide a consistent care pathway in partnership with local authorities, and therefore would not recommend this option. Accessibility to community services would be reduced as a result of financial impact.	Neighbouring providers would not form part of existing care pathways and therefore new arrangements would need to be made. This is theoretically possible, though not recommended by neighbouring providers.	Neighbouring providers have not expressed interest in providing a service to patients outside their current catchment other than at the level of 1 - 2 beds at any one time, which would require additional financial commitment. Commissioning higher no's of beds would require capital investment and a long term contract. This would require savings to be made in community services. Overall this option is therefore assessed as not viable.

Summary briefing

Berkshire East mental health inpatient bed provision

January 2012

How and where mental healthcare is provided

- One in four people will experience mental illness (such as depression or anxiety) at some point in their lifetime.
- Most are treated via their GP – increasingly through referral to 'talking' therapies (also known as psychological therapies).
- People who need more specialist treatment receive support from community services provided by the NHS and local authorities, enabling them to maintain a stable life, continue to work and keep up relationships.
- The continued development of effective mental health treatments mean that more and more people can get the help they need without setting foot inside a hospital. Figures for 2011 show that 97-98% of people receiving mental health treatment in east Berkshire fell into this category.
- Only in very few cases is hospital admission needed. In east Berkshire this equates to about 20 people in each local authority area at any one time (approximately one resident in very 7,000), compared to the hundreds under the care of community mental health teams.
- On average each mental health inpatient spends between a few weeks and few months in hospital – depending on individual circumstances and support available.
- Dementia is a growing problem as we live longer. But admission to a hospital ward remains a rare occurrence as community-based options are appropriate for most people.

Current provision in east Berkshire

Berkshire Healthcare NHS Foundation Trust (BHFT) is the local provider of mental healthcare – both community and inpatient services.

Slough: Ward 10, Wexham Park Hospital – 20 general adult beds
Ascot: Ward 12, Heatherwood Hospital – 25 general adult beds
Maidenhead: Charles Ward, St Mark's Hospital – 26 older adult beds (over-75)

These wards do not meet 21st century standards for mental healthcare provision. For example, Charles Ward cannot be adapted to meet the national standards set by the Royal College of Psychiatrists, in particular the need for single rooms and separate living spaces for people suffering from dementia and those with depression and anxiety. Small, isolated units also have less staff flexibility and offer a smaller range of treatments.

Prospect Park Hospital in Reading is a purpose-built facility for mental health inpatient services.

Principles for future provision

- Best outcomes for patients are achieved by providing treatment at home or as close to home as possible as far as possible.
- The best environment for inpatient services is single bedrooms with en-suite facilities – poor environment can harm recovery.
- Services should be evidence-based and provided by well-trained specialist staff.
- Service provision should meet current needs as well as reflecting forecast population changes.
- Travel time for visitors is an important factor.

Change supported by clinicians including GPs

- Mental health professionals employed by BHFT strongly support consolidation of inpatient services on a single site for best patient outcomes
- GP-led clinical commissioning groups (CCGs) (which will take on the commissioning role from PCTs in 2013) support consolidation of inpatient services on a single site for best patient outcomes
- Additional investment in community mental health services with a focus on early intervention and long-term recovery

Transport solutions

The NHS recognises that relocating inpatient services to a single site, while the best solution clinically, would have a significant impact on the ability of relatives and carers to visit. A number of options to address this have been carefully considered. A community transport 'dial-a-ride' type model is seen as offering the most flexible support. This would need to:

- Be easy to use
- Available at short notice seven days a week
- Fit around visiting times
- Geared up for relatively low numbers (reflecting relatively low numbers of inpatients)
- Take account of high turnover (reflecting average length of stay of about a month – so used by the same people for a short period of time).

This work will be developed if the board approves the recommendation.

Timeframe

Discussions around the timeframe for making the transition will be made following the Board decision on 24 January 2012. Given that mental health inpatients rarely stay in hospital for more than six weeks, no current inpatients will be relocated as a result of the proposed changes.

How does this relate to other service reviews?

This decision is purely about mental health services and is unrelated to the ongoing 'Shaping the Future' programme which is looking at how best to provide community and hospital services to meet the needs of local people across east Berkshire.

APPENDIX 3

NHS Berkshire

Name of Meeting	Paper Number
Cluster Board Meeting in Public	***CB/11/68***
Title of Paper	
Future Provision of East Berkshire Mental Health Inpatient Services	
Date of Paper	**Date of Meeting**
16.09.2011	**24.01.2012**
Purpose of Paper	
To provide the Board with the necessary information to enable a decision to be made on the future provision of mental health inpatient services for East Berkshire. This includes information gathered as a result of the additional engagement undertaken by NHS Berkshire during the summer and autumn of 2011, and also from the consultation led by Berkshire Healthcare NHS Foundation Trust (BHFT) during 2010.	
Summary	
Mental Health Inpatient Services in East Berkshire are currently provided in three separate sites, in accommodation that is not now of the standard required for the delivery of the specialist care and treatment required by people with a serious mental illness. Local clinicians estimate that approximately 2-3% of people receiving specialist mental health services required admission to hospital, and therefore it should be regarded as a specialist service, required by a very small minority of patients. The Commissioning Statement for Mental Health Inpatient Services for Berkshire, approved in 2011, includes a vision statement aligned with that published by the Sainsbury Centre for Mental Health: ***To offer time-limited safety, support and therapy to people who are too unwell, and present too high a level of risk to themselves or others to be cared for outside hospital. To achieve this by providing a range of therapeutic and other activities in a good quality environment, with the aim of supporting recovery and return to the community as soon as possible*** In order to identify a way forward which achieves this vision for local people, evidence has been provided about the options which were subject to formal consultation, and also subsequent	

engagement activity which enabled the proposal and exploration of a number of alternative options put forward by stakeholders. None of the alternative proposals proved clinically or financially viable, and therefore no further consultation has been recommended.

The paper includes a summary of the decision making process undertaken to date, an outline of the factors to take into account in the decision making process, the results of the engagement and consultation work undertaken and application of the four tests required for the consideration of NHS Service Reconfiguration Projects.

The criteria for making decisions about future provision of mental health inpatient services are set out under the following headings:

1. Clinical Evidence Base

2. Support of Clinical Commissioners

3. Promotion of choice for patients and improved patient experience

4. Engagement of public, patients and local authorities

5. Value for Money

The East Berkshire Clinical Executive Committee (CEC), comprising the leads of each of the 3 Clinical Commissioning Groups in East Berkshire and the NHS Berkshire Executive, has given careful consideration to the preferred way forward. The meeting of the CEC on 14.12.2011 confirmed recommendation of conditional approval of option1 for consideration by the NHS Berkshire Cluster Board. The conditions of approval were specified as follows:

1. The completion of an implementation plan with clear gateways to mark achievement of key targets prior to progression to the next stage. This will be monitored and reported back to CCGs and informed by “stress markers” to assess the effectiveness of community services as the implementation progresses.
2. The establishment of community services to minimise the need for admission to hospital prior to the closure of East Inpatient beds.
3. The phasing of closure of East Berkshire facilities to prioritise Ward 10.
4. The confirmation of detailed plans for transport support in line with the outlines provided to date, funded by the agreed £100k recurrent budget held by Berkshire Healthcare Trust.
5. Completion of feedback to CCGs on patient experience at Prospect Park Hospital.
6. The inclusion of required quality improvement of inpatient services in contractual arrangements, either through CQUIN or quality schedules.

This approach was discussed with the Slough Clinical Commissioning Locality Group (CCG) on 12.01.2012, and support was confirmed.

Progress in meeting these conditions will be reported to the CEC, by the Director of Joint Commissioning for NHS Berkshire, working closely in partnership with a nominated lead of the East Berkshire CCG Federation.

The consequences of this decision for patients is that inpatient accommodation will be provided in future in a purpose built facility, which will provide single bedrooms and ensuite accommodation, with

easy access to outside space – all factors which have been prioritised by patients. Taking forward option 1 enables continued investment in community services, with the emphasis on minimising the requirement for admission for as many people as possible.

However, taking forward option 1 will mean that patients and visitors will need to travel further to access services in Reading. This has been a major cause fo concern for stakeholders during the consultation and engagement work undertaken to date. Transport support is therefore an explicit part of the conditions of approval of option 1 as set out above, along with other conditions which provide important safeguards which will ensure that the interests of patients and their families are prioritised during implementation.

A report on the progress achieved in meeting the conditions will be provided to the NHS Cluster Board on 27.03.2012.

Recommendations	
The Board is asked to: - Approve the following recommendations.	**1. That conditional approval of option 1 is confirmed, in line with the recommendation of East Berkshire CEC.** **2. That the conditions of approval agreed by the CEC are endorsed by the Board.** **3. That the CEC and East Berkshire CCG Federation receive progress reports on the implementation of conditions in line with agreed timescales** **4. That a summary of progress and any further work required is provided to the NHS Berkshire Cluster Board on 27.03.2012**

Has the content of this paper been discussed with GPC leads and if so what was the outcome?

The East Berkshire Clinical Executive Committee was consulted on 13.07.2011 about its preferred approach to the clinical engagement required to inform the decision making process on the future provision of Mental Health Inpatient Services.
GP Mental Health Leads were involved in the engagement work carried out during summer and autumn of 2011
Progress reports were provided at subsequent meetings of the CEC and a recommendation of conditional approval of option 1 was approved for consideration by the NHS Berkshire Cluster Board 14.12.2011.
This approach was approved by the Slough CCG Locality Group on 12.01.2012

The Berkshire West Transitional Executive Group (TEC) was consulted on 16.09.2010
Financial implications
The estimated capital cost of new build facility for mental health inpatient services for East Berkshire is in excess of £20m: In 2008 BHFT agreed to absorb the costs of the Private Finance Initiative required for the funding of option 3: development of a new, purpose built mental health unit at Upton Hospital, Slough that would replace all the current hospital beds in the east of Berkshire. This was consistent with funding assumptions made at the time regarding growth in NHS financial allocations. However, following the changed economic circumstances and subsequent reduction in NHS growth forecasts, the Trust was required to meet a forecast £12m gap between the cost of running services and the funding available over a 3 year period. This meant that absorbing the PFI costs was no longer possible. The total revenue impact of option 3 is now estimated at between £2.6 and £3m per annum. This sum would need to be found from achievement of savings in existing mental health service budgets. This presents a risk that patients may not be able to access the current amount and range of services in their own communities, and possibly be more vulnerable to hospital admission or requirement for more specialist treatment. Cost of changes required to Prospect Park Hospital for option 1, consolidation of all Berkshire mental health inpatient beds on the Prospect Park Hospital site, would be approx £5-6m. This capital funding is already available within BHFT budget, having been built up over a number of years, as a one-off sum to support anticipated necessary changes to inpatient services. This option includes community service investment of £350k for older people's mental health services already in progress, and £207k for enhanced community services for people with personality disorder, and an allowance of £100k for support with transport for service users and carers. Full financial appraisal of option 2 (All hospital beds at Prospect Park Hospital except for those for older people - aged 75 years and over - at St Mark's Hospital in Maidenhead) was not taken forward fully due to the inability to provide a clinically appropriate service on this site. During the additional engagement undertaken during summer and autumn of 2011, a number of alternative options were proposed and considered, however, none has emerged as clinically or financially viable through initial analysis.
Has an Equality Impact Screening been undertaken? If so please attach
An Equality Impact Assessment (EIA) was undertaken by BHFT in 2010, and is available on the Trust website. The EIA at appendix 8 builds on this assessment, and adds additional information arising from the period of additional engagement conducted in 2011.
Please list any other committees or groups where this paper has been discussed
None

Paper Author	**Lead Director**
Bev Searle, Director of Joint Commissioning Finance section authorised by Nigel Foster, Deputy Director of Finance, NHS Berkshire and Alex Gild, Director of Finance, BHFT.	**Bev Searle, Director of Joint Commissioning**

Estates section completed by Paul Rowley and Brian Feldon, Principal Surveyor and Manager of EDTS	

Future Provision of East Berkshire Mental Health Inpatient Services

Contents

Future of East Berkshire Mental Health Inpatient Services

1.0. Background

The current adult inpatient service provision in East Berkshire is:

Ward 10 at Wexham Park Hospital, Slough:	20 general adult beds
Ward 12 at Heatherwood Hospital, Ascot:	25 general adult beds
Charles Ward at St Marks Hospital, Maidenhead:	26 older adult beds

Berkshire Healthcare NHS Foundation Trust (BHFT) is the main NHS provider of mental health services in Berkshire.

Adult inpatient services for Berkshire West are provided at Prospect Park Hospital in Reading, which also includes the Psychiatric Intensive Care Unit (PICU) and specialist Learning Disability Assessment Unit which serve Berkshire as a whole.

Mental health inpatient services for Children and Young People are provided on a Berkshire wide basis and are sited at Wokingham Hospital. These services are outside the scope of these proposals.

It is estimated by local clinicians that approximately 2 -3% of people requiring mental health services from secondary care providers require inpatient admission. Information provided by BHFT about inpatient admissions and total numbers of people receiving mental health services provided by the Trust in East Berkshire are as follows for the period 01.12.2010 – 30.12.2011:

Adults

Total Caseload	5,472	
Admissions	279	(to East Berkshire Wards)

Older Adults

Total Caseload	2,489	
Admissions	68	(to East Berkshire Wards)

It should be noted that some people will have had more than one admission during this period of time.

3.0 Summary of process to date

The future location of inpatient services for people with mental health problems in East Berkshire has been under review since 2007. The progress of this project has spanned a number of significant changes in the NHS and wider context:

- The introduction of the Health White Paper, and subsequent Health and Social Care Bill, paving the way for the establishment of GP-Led commissioning and closure of Primary Care Trusts in April 2013.
- The establishment of specific requirements associated with NHS Service reconfiguration, introduced by the Secretary of State for Health – often referred to as the four “Lansley Tests”.
- The establishment of PCT clusters as transition organisations prior to formal establishment of Clinical Commissioning Groups subject to the passage of the Health and Social Care Bill.
- Changed economic circumstances leading to a reduction in public spending and review of assumptions informing previous financial planning.

In 2008, the consultation “Right Care, Right Place, Your Say”, was led by Berkshire East Primary Care Trust (PCT) on the future provision of health services in East Berkshire, and a parallel, linked consultation on the future provision of mental health inpatient services was led by BHFT. Following this, the preferred option was to reprovide existing mental health inpatient services in a new build at Upton Hospital, Slough.

“Next Generation Care” was commenced by Berkshire Healthcare NHS Foundation Trust (BHFT) in 2009 – which prompted the review of all services to meet the then current financial constraints, local need and quality requirements.

Public consultation was undertaken between August and November 2010 on 3 options for the future provision of mental health inpatient services:

- Option1. All hospital beds to be provided from Prospect Park Hospital in Reading resulting in BHFT closing all beds on the current three sites in East Berkshire
- Option 2. All hospital beds at Prospect Park Hospital except for those for older people (aged 75 years and over) which would continue to be provided at St Mark’s Hospital in Maidenhead.
- Option 3. Develop a new, purpose built mental health unit at Upton Hospital, Slough that would replace all the current hospital beds in the east of Berkshire

In January 2011 Berkshire East PCT asked BHFT to progress an Outline Business Case (OBC) for option 1 and issued a joint statement with BHFT stating option 3 was unaffordable and option 2 not clinically appropriate. The statement confirmed that the detail of option 1 would be worked up, including exactly what and where additional community investment can be made and how the transport scheme would work. It was also stated that once this information was known, a final decision would be made. This was anticipated by June 2011.

In April 2011, Slough Health Scrutiny Panel advised BHFT that they wished to complete further work in connection with the earlier public consultation. In response to this, BHFT agreed to postpone consideration of the future of inpatient services in East Berkshire to its July meeting.

In line with the requirement for Primary Care Trusts to join together to establish “Clusters”, Berkshire East Primary Care Trust formed a Cluster with Berkshire West Primary Care Trust in June 2011, and a joint Executive Team was appointed.

During June and July, work was undertaken by senior NHS Berkshire representatives to confirm the position of key stakeholders in preparation for the Board decision making process. In particular, emphasis was placed on the need to effectively address the “four tests” for NHS service redesign proposals required by the Secretary of State for Health:

- Clinical evidence base underpinning the proposals
- Support of the GP commissioners involved
- Promotion of choice for patients
- Engagement of the public, patients and local authorities

A stakeholder briefing was issued by NHS Berkshire and BHFT on 11.07.2011, confirming that an additional period of engagement work would be undertaken as a result of the identification of significant concerns that had been expressed by some stakeholders about the options consulted on, and the lack of consensus about a way forward. It was the intention should new options emerge during this period, that formal consultation would follow.

Activity undertaken during the additional period of engagement was initially informed by the East Berkshire Clinical Executive Committee and included discussions with Unitary Authorities (Council Leaders, Lead Members for Health and Social Care, Directors of Adults Social Services and Health Scrutiny Committees) Health and Wellbeing Boards, LINks representatives, BHFT Governors, Clinicians and Managers. Detail of this activity is outlined at appendix 7. A number of potential options were proposed by stakeholders, and were considered during the additional engagement period, however none were identified as clinically or financially viable and therefore no additional consultation has been proposed.

A Gateway Review was undertaken in September 2011. This is an independent peer review which is undertaken by a team of experts through the Department of Health in order support effective delivery of NHS service reconfiguration projects. A further Gateway Review is planned for April 2012, as one of the elements of delivery assurance outlined in section 8 of this paper.

4.0. Decision making process

In making a decision about the future provision of East Berkshire Mental Health Inpatient Services, NHS Berkshire Cluster Board Members will need to consider:

- The case for change – with a particular focus on the needs of patients and their families – summarised in section 5.

- The decision making criteria outlined in the Commissioning Statement on Mental Health Inpatient Services approved by the East Berkshire Mental Health Local Implementation Team. The Commissioning Statement is included in full in appendix 1 and the criteria are outlined in section 8.

- The application of the 4 tests required for service reconfiguration by the Secretary of State for Health. Evidence on the application of the tests is included in summary form in section 5, with further detail on each of the tests in appendices 2, 3, 4 and 5.

- Results of consultation and engagement undertaken by Berkshire East Primary Care Trust, Berkshire Healthcare NHS Foundation Trust and NHS Berkshire. These are summarised in section 7.

- Recommendation of the East Berkshire Clinical Executive Committee (CEC) and Berkshire West Transitional Executive Committee (TEC), which is outlined at section 8. Clearly, the future provision of East Berkshire mental health inpatient services is an issue for which the East Berkshire CEC has the lead role, and therefore the greatest weight is given to this recommendation. However, as a result of the potential Berkshire-wide impact of the decision, the Berkshire West TEC view has also been sought and should also be considered in the decision making process.

- Risks and Delivery Assurance, which are outlined in sections 11 and 12 of this paper.

- Equality Impact Assessment, which is included at appendix 8 – this was undertaken by BHFT in 2010 and additional commentary included following completion of the 2011 engagement work.

5.0. Case for Change

5.1. Quality Drivers

The inpatient accommodation at all 3 East Berkshire sites is below an acceptable standard:

- Patients are required to share bedrooms and bathroom facilities
- Older adults with functional illness (for example depression and anxiety) are cared for alongside those with organic illness (for example, types of dementia), which is not in line with national best practice guidance.
- There is limited access to outside space for some patients.
- The facilities are not purpose – built and therefore present a quality of environment below that available to patients admitted to Prospect Park Hospital in Reading.

5.2. Patient and Carer Views

The patient survey undertaken by BHFT in 2010 identified that patients value their own room and easy access to outside space above other factors. (Information from this survey has been incorporated into the service user views section of the Commissioning Statement at appendix 1.) This was underlined during the period of additional engagement when a number of individuals highlighted the feeling of enhanced safety and dignity they associate with single rooms and ensuite facilities.

5.3. Staffing issues

During the additional engagement period, clinicians highlighted the challenges associated with staffing single, isolated wards, and the advantages of a larger “critical mass” of staff which would be available on a single site. This is important in terms of responding safely and effectively to the most unwell patients requiring additional support, being able to provide effective and sustainable cover for staff sickness and annual leave and being able to provide the full range of therapeutic activities and interventions more reliably.

6.0. Application of the four tests for NHS Service Reconfiguration

In May 2010 The Secretary of State for Health introduced a set of four tests that must be applied to reconfiguration proposals before statutory public consultation can begin. As outlined in section 3 above, the process of this project commenced in 2007 and initial consultation was undertaken by BHFT in 2008, with further consultation on the 3 options for future service provision in 2010. The additional engagement undertaken in 2011 did not, in the event, identify any new options for consultation, but information was assembled during this period to ensure that the tests could be met.

Appendices 2, 3, 4 and 5 outline the information that has been taken into account in addressing the four tests and is summarised below as follows:

6.1. Clinical evidence base underpinning the proposals

Information was gathered from a number of sources to address this test:

- A Public Health Review.
- The views of local clinicians gained during discussions with stakeholders and during service visits.
- The Commissioning Statement developed and approved by the East Berkshire Mental Health Local Implementation Team.
- A brief review of similar activity being undertaken in other parts of the country.

Taken together, the information supports the provision of services in a purpose built environment, with achievement of the best clincial outcomes as a result of consolidation of Berkshire inpatient services onto one site, maintaining effective community based services and ensuring that transport support is provided where required to enable contact between patients and families during admissions to hospital.

6.2. Support of the GP commissioners involved

At the outset of the additional period of engagement in 2011, members of the East Berkshire Clincial Executive Committee were asked to specify what good clinical engagement would look like from their point of view. Subsequent activity was shaped by this advice and progress reports provided to the CEC, culminating in the recommendation of conditional approval of option 1 on 14.12.2011,for consideration by NHS Berkshire Cluster Board. This approach was subsequently supported by members of the Slough Clinical Commissioning Locality Group on 12.01.2012.

6.3. Promotion of choice for patients

Department of Health guidance requires consideration of evidence for this test in relation to the following criteria:

- Services should be locally accessible wherever possible and centralised where necessary
- How proposed service reconfiguration affects choice of provider, setting and intervention.
- The quality of proposed services and health inequalities.
- Improvements in the patient experience.

In order to address this test, information has been gathered from National Policy Guidance and service user, clinician and stakeholder views referenced in appendices 1, 2 and 5.
The Clinical Evidence and Support of GP Commissioners Tests conclude that centralisation of inpatient services results in the best clinical outcomes for patients. The conditions of approval of option 1, location of all inpatient services at Prospect Park Hospital, Reading, ensure that patient experience, transport support, community service provision and quality issues are all addressed as part of the implementation planning for this option. The Equality Impact Assessment recommendations will be taken into consideration in project planning and therefore ensure that health inequality issues are addressed effectively.

6.4. Engagement of the public, patients and local authorities.

NHS Chief Executive Sir David Nicholson‘s reconfiguration guidance to the NHS (Letter from (29 July 2010) requires that evidence is identified in relation to the following:

> *1. Section 242 of the National Health Service Act 2006 which requires local health organisations to make arrangements in respect of health services, to ensure that users of those services, such as the public, patient and staff are involved in the planning, development, consultation and decision making in respect of the proposals.*

BHFT commissioned Dr Foster Intelligence to conduct a Public Consultation in 2010 on the 3 options described in section 7, and also to undertake the analysis of responses. The consultation primarily consisted of a survey and a series of 12 public meetings, which were attended by 150 people, and 777 responses were received to the survey. Two of the meetings were held with staff in affected services. The report of this consultation is available on the BHFT website, along with a patient survey, also conducted in 2010. Discussions were held with patients, staff and other stakeholders as part of the additional engagement undertaken in 2011, which are included in appendix 2.

2. Section 244 of the National Health Service Act 2006 which requires local health organisations (in this case Camden and Islington NHS Foundation Trust – C&I) to request the appropriate Local Authority Health Overview and Scrutiny Committee to review and scrutinise the proposals.

The BHFT Consultation undertaken in 2010 included seeking the views of the Health Scrutiny Panels of the three East Berkshire Councils. The additional period of engagement undertaken by NHS Berkshire also included discussions with all the Health Scrutiny Panel Chairs, followed by meetings with the Royal Borough of Windsor and Maidenhead Health Scrutiny Panel and Slough Borough Council Health Scrutiny Panel. Extracts of the minutes of relevant meetings are included in appendix 6.

3. Relevant equality legislation

BHFT commissioned an Equality Impact Assessment in respect of all 3 options consulted on. The findings in terms of opportunities to promote equality, risks to equality and recommendations for consideration are included at appendix 8, along with further comments derived from the additional engagement undertaken in 2011.

7.0. Results of Consultation and Engagement

7.1. BHFT Consultation

A Public Consultation was commissioned by BHFT and conducted independently by Dr Foster Intelligence in 2010 over a period of 15 weeks and a total of 777 responses were received on the following 3 options:

- Option1. All hospital beds to be provided from Prospect Park Hospital in Reading resulting in BHFT closing all beds on the current three sites in East Berkshire
- Option 2. All hospital beds at Prospect Park Hospital except for those for older people (aged 75 years and over) which would continue to be provided at St Mark's Hospital in Maidenhead.
- Option 3. Develop a new, purpose built mental health unit at Upton Hospital, Slough that would replace all the current hospital beds in the east of Berkshire

The Trust also engaged with the Overview and Scrutiny Committees, Members of Parliament, local Councillors and other key stakeholders.
There was no overall consensus on the 3 options, with respondents mainly supporting the option that maintained a facility closest to where they lived. This was also the case with the response from the Councils Health Scrutiny Panels, which each confirmed they would support the option that placed the facility closest to their populations:
Slough Borough Council preferred Option 3
Royal Borough of Windsor and Maidenhead preferred Option 2
Bracknell Forest Council preferred Option 1.

BHFT senior clinicians preferred Option 1 on the basis that it represented the best means of achieving quality improvements and the potential to develop a "centre of excellence", while reducing the risk of reductions to community services.

BHFT also commissioned a travel survey of visitors, which was repeated the survey during the consultation period. The Transport survey was also conducted by an external company who interviewed visitors to all wards in East Berkshire on different days and at different times. The findings of the survey were:

- 97% of visitors travel by car to visit patients
- On average, people visit several times a week, with the majority of visits made by people in groups of one or two people who travel an average of 23 minutes to the hospital.
- Patients may not receive visitors for reasons other than transport problems.

The consultation showed that people were very concerned about the transport issues that would be associated with a move of inpatient services to Prospect Park Hospital in Reading. This informed the decision of BHFT to allocate a recurrent sum of £100k to provide support for transport. A transport group was also established to look at ways of providing effective support for patients and their families, which identified a number of options – with the preferred one being the commissioning of community transport providers to provide a flexible service , with the addition of options for petrol cost reimbursement and public transport vouchers if appropriate to individual situations. It should be noted that the conditions of approval of option 1 include the requirement for completion of work on transport support prior to any relocation of East Berkshire inpatient services.

The response of Thames Valley Police to the BHFT Consultation highlighted that ideally, the preference would be for option 3, a new build at Upton Hospital, but if funding could not be guaranteed, then the preference would be for option 1. It should be noted that, in taking forward option 1, work will be required in partnership with Thames Valley Police to ensure effective operation of the Approved Place of Safety. This would not be maintained in East Berkshire with option 1, and therefore patients and police will need to travel further to access this facility at Prospect Park Hospital.

South Central Ambulance Service expressed no fundamental objections to the options, but the service has indicated the need for further discussion to ensure the patient transport service arrangements most appropriate to local need.

The reports of the BHFT commissioned Public Consultation are available on the BHFT website for reference.

7.2. Additional Engagement

Details of the engagement undertaken are included in appendices to this report, and a summary of activity completed at appendix 7.

During the period of additional engagement in summer and autumn of 2011, a number of alternative options were put forward by stakeholders for the provision of mental health inpatient services:

1. Conversion of Wexham Park Hospital
2. Conversion of Upton Hospital
3. Conversion of St Marks Hospital
4. Conversion of Heatherwood Hospital
5. Establishment of an acute inpatient unit in Slough locality to replace Ward 10 at Wexham Park Hospital
6. Commissioning beds from the independent sector in East Berkshire. This option was proposed as a means of possible mitigation of concerns associated with option 1 and not as a stand-alone option.
7. Commissioning beds from neighbouring NHS Providers.

These were discussed by BHFT Clinicians, GP Mental Health Leads, CCG representatives, and other stakeholders, and were also subject to estates and value for money analysis (see section 9). None emerged as clinically or financially viable and therefore no additional consultation has been proposed.

Slough Borough Council Health Scrutiny Panel requested that all the options (both those formally consulted on and those proposed during the additional engagement) be presented to them alongside the following criteria:

Clinical evidence base
Support of clinical commissioners
Promotion of choice for patients and improved patient experience
Engagement of public, patients and local authorities
Estates issues
Value for money
Accessibility
Resource capacity and capability
Viability

This was completed in partnership with BHFT and Berkshire Shared Services and forwarded to the Council on 27.12.11.

8.0. Finance

Information contained within this section has been provided by Berkshire Healthcare NHS Foundation Trust (BHFT) and reviewed by NHS Berkshire Deputy Director of Finance.

8.1. Background

In 2008 BHFT agreed to absorb the cost pressure of the costs of the PFI required for the funding of option 3: development of a new, purpose built mental health unit at Upton Hospital, Slough that would replace all the current hospital beds in the east of Berkshire. This was consistent with funding assumptions made at the time - in 2008 BHFT had forecast +2.3% income growth for 2010/11. However, the actual 2010/11 allocation was 0% growth and in 2011/12 is -1.5% growth.
To meet the NHS funding challenge the Trust was required to forecast a compound efficiency requirement of 4% per annum. This led to a forecast £12m gap between the cost of running services and the funding available over a 3 year period. In light of this the Trust recognised that its ability to absorb the cost pressure of the Upton new build was severely compromised and that choices would need to be made about how funding was deployed to achieve best outcomes for patients.
In 2010 the Trust developed The Next Generation Care programme to respond to the NHS funding constraints identified in 2009. This identifies £12m efficiencies resulting from service redesign and increased productivity, and includes a sum of almost £1.9m which would be achieved through the implementation of option 1,(all hospital beds to be provided from Prospect Park Hospital in Reading resulting in BHFT closing all beds on the current three sites in East Berkshire) should this be approved by commissioners.

8.2. Option 1 – estimated costs of implementation

Cost of changes required to Prospect Park Hospital would be approx £5-6m. This capital funding is already available within BHFT budget, having been built up over a number of years, as a one-off sum to support anticipated necessary changes to inpatient services.
The PFI cost of Prospect Park Hospital is approximately £4m per annum and the contract is for 33 years. There would be a slight increased annual cost of £7 – 800k per annum in this option, depending on the ward configuration. However, as stated above, consolidation on this site would realise a net saving of approx £1.9m per annum.
This option includes community service investment of £350k for older people's mental health services and £207k for enhanced community services for people with personality disorder, and an allowance of £100k for support with transport for service users and carers.

8.3. Option 2 – costs of implementation

Full financial appraisal of this option (All hospital beds at Prospect Park Hospital except for those for older people (aged 75 years and over) at St Mark's Hospital in Maidenhead) was not taken forward fully due to the inability to provide a clinically appropriate service on this site:

- The footprint of existing accommodation in Charles Ward is insufficient to provide the single rooms with en suite facilities that would be the required standard, and expansion of this footprint would have significant knock on impact on other service areas.

- BHFT Clinicians have advised that they would not be in favour of a single small unit in East Berkshire on the St Marks site, if all other inpatient services had been transferred to Prospect Park Hospital.

8.4. Option 3 – costs of implementation

The estimated cost of new build facility is in excess of £20m. This comprises £16.7m capital build cost plus £4.5m land cost required from Berkshire Healthcare Trust cash. The revenue cost impact of the required borrowing would be £2m per annum, with an additional £0.6 – 1m as a result of the need to provide separate accommodation for older people with organic and functional mental health problems, rather than a single ward as is the case currently. The total revenue impact of this option is therefore between £2.6 and £3m per annum.

8.5. Additional Information

Wexham Park Options considered all have approximately the same cost as a new build on the Upton site (option 3) – which has a total revenue impact of £2.6 and £3m per annum as specified above. The current rental cost for space occupied is approximately £820k per annum for the 20 beds which does not include staffing.

9.0. Estates

In response to work undertaken in partnership with stakeholders as part of the additional engagement carried out in the summer and autumn of 2011, NHS Berkshire completed a summary of 10 options for the provision of mental health inpatient services for the residents of Slough, Windsor, Maidenhead, Ascot and Bracknell. This included the original 3 options formally consulted on in 2010, along with a further 7 options proposed by stakeholders (listed above in section 7). Within each option there are sections on "Estates" and "Value for Money" which were completed in association with Berkshire Shared Services working at the direction of NHS Berkshire.
This section sets out the thinking and methodology for the estates section of the options summary, and includes the cost of financing the estates changes in the value for money section.

9.1. New Build – Option 3 in 2010 consultation

Estimates were based on the "Finnamore" report prepared for BHFT in May 2009, which provided an estimate of the numbers of beds required for the East Berkshire population. The estimate was established in some detail following the development of a specification which then enabled the use of Department of Health Building Notes and subsequently Department of Health cost allowances.

9.2. Conversion of Facilities at Prospect Park Hospital – Option 1 in 2010 consultation

This option has been developed with the BSS internal design team (EDTS) and followed the development of the specification and identification of changes needed at the hospital. An average cost per square metre was used to calculate the capital cost requirement.

9.3. Option 2 in 2010 consultation and options 1, 2, 3, 4 and 5 as listed in section 7.

These used the specification developed for the New Build option i.e. single bedrooms, en-suite, modern environment, place of safety (where specified), anti ligature, open spaces for recreation and smoking, full supporting space including interview rooms, dining rooms, lounge areas etc.

Using the specification, each location was considered for suitability and an estimate of space required versus the space available was used to establish the overall square meterage required. An average cost of conversion per square metre was used to calculate the capital required. Option 5, establishment of a stand-alone facility to replace Ward 10 was considered, but discounted as an opportunity as a result of patient safety and financial viability issues.

10.0. Recommendations

In deciding an appropriate means of providing mental health inpatient services for East Berkshire residents, the vision and decision making criteria outlined in the Commissioning Statement at appendix 1, need to be taken into account, alongside the evidence included in the main body of this paper and appendices:

The vision for inpatient services in Berkshire aligns with that proposed by the Sainsbury Centre for Mental Health as follows:

> ***To offer time-limited safety, support and therapy to people who are too unwell, and present too high a level of risk to themselves or others to be cared for outside hospital. To achieve this by providing a range of therapeutic and other activities in a good quality environment, with the aim of supporting recovery and return to the community as soon as possible***

10.1. Decision Making Criteria:

1. Clinical Evidence Base
This should be clearly demonstrated, and be supported by the majority of clinicians involved.
Service change proposals should represent provision of safe, effective services, where the physical environment promotes good outcomes for patients.
Proposals for change should effectively balance an understanding of current need with demographic change and analysis of the impact of continued development of community based services.
Proposals for change should enable the care pathway to be enhanced, fostering close and collaborative working between inpatient and community services.
Proposals should facilitate compliance with statutory requirements of the Mental Health Act (including arrangements for APOS and Intensive Care provision)
National guidance should be used to inform local proposals, which should describe the extent to which specified standards and criteria will be met.
Proposals should support the achievement of performance and quality targets

2. Support of Clinical Commissioners
Developments should be supported by the majority of the 7 Clinical Commissioning Groups in Berkshire, including their non-GP Members, at the relevant level of federation.

3. Promotion of choice for patients and improved patient experience.
Services should be locally accessible wherever possible and centralised where necessary.
Choice of provider for mental health inpatient care is not at present a NHS policy aim due to the benefits of integration with social care and the operation of the Mental Health Act.

However, proposals for service change should outline the interaction between the proposed service environment and treatment and care provided.
Proposals should also demonstrate how service user and carer experience will be enhanced, as well as mitigation of any adverse impacts. This should include understanding diversity and mitigation of inequalities as well a patient centred approach to care planning, which is informed by individual priorities and service user and carer involvement in service development.

4. Engagement of public, patients and local authorities
Proposals for major change should include required engagement and consultation, the findings of which should inform their development and plans for implementation.
For major service change proposals, review by appropriately qualified external advisors should be undertaken, and recommendations used to refine proposals as required.

5. Value for Money
Financial impacts of proposals should be clearly demonstrated in project documentation or an Outline Business Case as appropriate.
Financial analyses should take into account any differential impacts between Clinical Commissioning Groups and/or be agreed at the appropriate level of "federation" with the Director of Finance for NHS Berkshire, before Board approval.
Proposals should demonstrate effective use of financial and non-financial resources across the range of mental health services provided, and reflect an appropriate balance between community and inpatient services.
Proposals should be affordable across the local health and social care system, taking into account future financial and demand projections.

The East Berkshire Clinical Executive Committee has given careful consideration to the preferred option for the provision of mental health inpatient services and concluded at its meeting on 14.12.2011 that it would recommend conditional approval of option 1 for consideration by the NHS Berkshire Cluster Board.

The conditions that were agreed are as follows:

1. The completion of an implementation plan with clear gateways to mark achievement of key targets prior to progression to the next stage. This will be monitored and reported back to CCGs and informed by "stress markers" to assess the effectiveness of community services as the implementation progresses.
2. The establishment of community services to minimise the need for admission to hospital prior to the closure of East Inpatient beds.
3. The phasing of closure of East Berkshire facilities to prioritise Ward 10.
4. The confirmation of detailed plans for transport support in line with the outlines provided to date, funded by the agreed £100k recurrent budget held by Berkshire Healthcare Trust.
5. Completion of feedback to CCGs on patient experience at Prospect Park Hospital.
6. The inclusion of required quality improvement of inpatient services in contractual arrangements, either through CQUIN or quality schedules.

It is therefore recommended that the NHS Berkshire Board confirm conditional approval of option 1 in line with the preferred approach of the CEC.

11.0. Risks

Project risks have been identified and mitigation confirmed – these are risks common to all projects such as lack of capacity and capability.

There is a risk that, due to concerns from stakeholders on the Board, a decision may be taken to refer the project to the Secretary of State for Review:

It is perceived that concerns from Royal Borough of Windsor and Maidenhead Council (including the Health Scrutiny Panel) have been addressed through the provision of additional information and an opportunity to discuss the strong recommendation of clinicians that the best clinical outcomes for patients will be achieved by proceeding with option 1. The Windsor and Maidenhead Clinical Commissioning Groups confirmed their support for option 1 as the most clinically appropriate and financially viable.

Slough Borough Council has continued to express significant concern about the impact of option 1 on Slough residents during the BHFT Consultation and the additional engagement led by NHS Berkshire. The Task and Finish Group established by the Health Scrutiny panel in 2010 clearly recommended referral to the Secretary of State, should option 1 be approved, which was formally approved by the Health Scrutiny Panel (see appendix 6). However, significant efforts have been made to assure the Committee that their concerns have been understood, and they have been taken into account in the conditions for approval of option 1. Additionally, the Slough CCG was part of the CEC decision to recommend conditional approval of option 1 by the BHS Berkshire Cluster Board, and the Slough CCG Locality Group subsequently approved this approach. Further work will be required in partnership with Slough Borough Council and the CCG to ensure mitigation of any adverse impacts associated with taking forward option 1, which will be taken forward through the Health and Wellbeing Board at which a presentation will be made to this effect on 23.01.2012.

Secretary of State referral may result in the Independent Reconfiguration Panel (IRP) undertaking an initial assessment, which takes approximately 3 – 4 weeks to complete, or a full review which appears to take approximately 5 months (from review of examples published on the IRP website).

Decisions can also be subject to Judicial Review, which needs to be initiated by a “letter of claim”. A judge will make the decision whether permission can be granted to judicially review a decision, considering whether the process of decision making was flawed or the decision itself was irrational.

12.0. Delivery Assurance

12.1. Gateway Review

The Gateway Review undertaken in September 2011 assessed the project overall as amber in terms of delivery confidence. Recommendations of the Gateway Review were previously reported to the Board, and action has been taken to implement them. A further Gateway Review has been planned with the regional Department of Health representative of the Gateway Team to take place in April 2012, to provide assurance of the conditions for approval being met and implementation of project delivery.

12.2. BHFT Outline Business Case (OBC)

The draft OBC on option 1 was completed following the request made by from Berkshire East PCT in January 2011. The draft OBC was not formally considered by either BHFT or PCT Boards as a result of the changes to the original planned process outlined in section 3 above. However, the draft OBC was considered by the Gateway Review Team in September 2011, and amended in light of the recommendations made by the team.

Authorisation for the use of the revised draft OBC as part of the Delivery Assurance of this project was provided by the Chief Executive of BHFT.

12.3. Project Arrangements

Subject to NHS Berkshire Cluster Board agreement to conditional approval of option 1 as described above, a Full Business Case (FBC) will be completed and presented to the BHFT Board. The FBC will include design and associated costs of a recommended configuration of space at Prospect Park Hospital to provide the required inpatient facilities. On approval of the FBC a deed of variation will be signed, if required, with the PFI provider.

Subject to agreement of the recommended conditional approval, the leadership of the project will pass to BHFT from NHS Berkshire – who will be represented on the Project Team by the Director of Joint Commissioning, working closely in partnership with the nominated representative of the East Berkshire CCG Federation.

12.4. Implementation Plan for Conditions of Approval

An Implementation Plan detailing work required to meet the conditions for approval of option 1, all hospital beds to be provided at Prospect Park Hospital, Reading, will be completed in partnership between NHS Berkshire and BHFT. This will be presented on completion to the East Berkshire Clinical Executive Committee and the East Berkshire CCG Federation will receive regular progress reports on the completion of work required to meet the required conditions. The CCG Federation will nominate a representative to work alongside the Director of Joint Commissioning ensuring that conditions are met according to agreed timescales.

It is proposed that a progress report is provided to the NHS Berkshire Cluster Board on 27.03.2012, enabling formal confirmation that the conditions of approval have been met, and any further work required. This report will include the views of the CCG Federation following their assessment of progress against their recommended conditions of approval.

12.5. Clinical Interface Group

In 2011, the East Berkshire Clinical Executive and Berkshire West Transitional Executive Committees both approved the establishment of a Clinical Interface Group along the lines of the established group with the Royal Berkshire Hospital and Berkshire West PCT. This group will provide an ongoing opportunity for joint work on mental health service redesign between GPs and BHFT Clinicians, thus providing a further assurance opportunity for satisfactory progress in terms of both inpatient and community mental health services. Draft terms of reference have been completed and are now subject to final review by the CEC and TEC prior to forwarding to BHFT for review.

Appendix 1.

NHS Berkshire: Mental Health Inpatient Services for Adults: Commissioning Statement. Approved by East Berkshire Mental Health Local Implementation Team, October 2011.

1.0. Introduction

The purpose of this document is to provide a local framework for the future development of mental health inpatient services for adults of working age and older adults in Berkshire. The scope of the statement includes 2 parallel, but linked elements:

- The physical environment in which services are provided

- The model of care provided

Tier 4 medium secure, regional and national specialist services are not included in the scope of the document.
The document also includes criteria for decision making against which options for future development of services will be judged.
National guidance and local planning and consultation documents have been used in the drafting of this document, which has been approved by Local Implementation Teams, Mental Health Leads of Clinical Commissioning Groups and the Clinical Executive Committees in Berkshire.

2.0. Current Provision

Berkshire Healthcare NHS Foundation Trust (BHFT) is the local provider of mental health services – both community and inpatient services. The current adult and older adult acute inpatient service provision is:

Ward 10 at Wexham Park Hospital, Slough:	20 general adult beds
Ward 12 at Heatherwood Hospital, Ascot:	25 general adult beds
Charles Ward at St Marks Hospital, Maidenhead:	26 older adult beds
Prospect Park Hospital, Reading:	
Bluebell Ward	27 general adult beds
Daisy Ward	23 general adult beds
Jasmine Ward	12 older adult (organic) beds
Rowan Ward	20 older adult (functional) beds
Sorrell Ward	12 intensive care beds

It should be noted that the above bed numbers reflect historical arrangements rather than identified allocations based on current estimates of locality need. Although the inpatient wards are linked to geographical areas, flexibility is required in order to effectively meet the needs of the population as a whole.
While Prospect Park Hospital is a purpose built facility for mental health inpatient services, the accommodation provided by the East Berkshire wards is not of the required standard. Work is currently underway to identify a clinically appropriate and cost effective alternative to current provision.

3.0. National Policy Background

3.1. Acute Care Declaration. Published by the Mental Health Network and the Mental Health Development Unit, to be launched November 2011

This widely endorsed publication addresses both hospital and community based approaches, and includes the elements specifically relevant to inpatient care:
• Services which are safe for everyone in a context of positive, considered risk management in the least restrictive settings
• A culture of therapeutic optimism which supports recovery and personal responsibility
• A comprehensive range of well integrated and co-ordinated acute care services and choice of effective treatment and care based on the best available evidence
• A safe, clean, comfortable and welcoming physical inpatient environment
• Appropriate needs led provision for all age groups
• Simple and timely access into and discharge out of inpatient services if care cannot be best delivered at home
• Better mental and physical health and quality of life outcomes; and
• a service which shows respect for people who use acute mental health services and their families and carers; includes them as partners in care and provides support to families, friends and other informal care givers when needed.

3.2. Do the right thing: how to judge a good ward. Ten standards for adult in-patient mental healthcare. Royal College of Psychiatrists. June 2011

This recently published document provides a helpful link between the physical environment in which inpatient services are provided, and the model of care. The ten standards proposed are as follows:

1. Bed occupancy of 85% or less
2. Ward size: 18 maximum
3. Environment offers gender specific bedrooms and toilet facilities, and direct access to external space and a quiet room
4. Daily therapeutic activities
5. Positive risk management policy
6. Information sharing on diagnosis and treatment to inform the care pathway
7. Linking with external community for housing, faith communities, employment, voluntary services, etc.
8. Access to at least one psychological intervention a week
9. Daily one-on-one contact
10. Cultural sensitivity: staff trained in cultural awareness with access to interpreters

3.3. Inpatient Care for Older People within Mental Health Services. Faculty Report. FR/OA/1. Faculty of the Psychiatry of Old Age of the Royal College of Psychiatrists. April 2011

The Faculty recommends that in-patient areas should be separate and dedicated where possible. Current accommodation at Charles Ward does not provide this, and cannot be adapted to provide the separate living spaces recommended by the Faculty for people suffering from dementia and those with functional mental illnesses (primarily depression and anxiety) which was also recommended in previous reports Audit Commission, 2000).

3.4. Mental Health Policy Implementation Guide – Adult Acute Inpatient Services. DH 2002

Although published 9 years ago, as part of the National Service Framework for Mental Health, this document includes some important guidance for the provision of inpatient services. Specific recommendations and priorities described are:
Bed occupancy levels of 85%; safety, dignity and privacy of patients is facilitated; personalised care is provided; diversity is respected and valued; clinical treatment provided is evidence based; there is gender separation – both for sleeping and day time; observation is facilitated; there is good space light and ventilation and access to outside space; activity space on and off ward is provided; safe and accessible storage of personal items is facilitated; there is access to drinks and refreshments; carer involvement and visiting is promoted; there is an effective Care Pathway.

3.5. An Executive Briefing on adult acute inpatient care for people with mental health problems. Sainsbury Centre for Mental Health. 2002

Dating from the same year as the document referenced above, this briefing includes a vision for inpatient care:
To offer time-limited safety, support and therapy to people who are too distressed to be cared for outside hospital in order to improve their mental and physical health and functioning. To achieve this by providing a range of therapeutic and other activities in a good quality environment, with the aim of supporting recovery and return to the community as soon as possible

3.6. Healthcare Commission. Acute inpatient mental health service review. Final Assessment Framework 2008

This document highlights a number of criteria for acute inpatient services as follows:
• Inpatient services are part of a well functioning care pathway for service users in crisis, which ensures appropriate admissions and timely discharge. There are governance mechanisms in place to ensure the effectiveness of the acute care pathway and to promote improvement in acute inpatient care
• Where admission is required, inpatients can access appropriate interventions, which promote social inclusion, address physical health as well as mental health problems, and account for individual needs
• Service users and carers are provided with information about the ward, their care and treatment and are actively involved in planning individual care and in operational and strategic development
• The ward is a safe environment for service users, staff and visitors, there are systems in place to avoid adverse outcomes, and the environment promotes a therapeutic and safe experience.

4.0. Needs Assessment

The National Service Framework for Mental Health provided a framework for development of mental health services over the ten years from 1999. A significant focus of the NSF was on the development of community services – with a major shift away from inpatient treatment for the vast majority of people with mental health problems. The inevitable result of this shift has been a continued national decrease in the proportion of people requiring inpatient care as a % of the total service user population. In addition, the proportion of people admitted compulsorily admitted to hospital as a % of the total inpatient population is continuing to increase.

The impact of demographic changes needs to be taken into account in assessing the need for inpatient services for people with dementia – balancing the increased numbers of people at risk of dementia with the impact of earlier diagnosis and treatment. In addition, there is anecdotal evidence of the economic downturn resulting in some people no longer accessing private health services, and turning to NHS provision, which may increase demand to some extent in some areas.

In 2008, BHFT commissioned an assessment of local mental health need in East Berkshire, and the inpatient facilities that would be needed to meet them. The Finnamore Report (May 2009) identified a range of future mental health bed requirements from 56 – 78 beds. The number required varying as a consequence of consideration of provision and the performance of other local services available to support people with mental health needs and also improvements in performance arising from recommended service model and delivery changes. The requirements also made an allowance for the unknown, unmet need arising from Slough's "hidden" population. Subsequently, the report was reviewed by the BHFT Project Board and, guided by its recommendations, the future inpatient provision for East Berkshire was identified as 64 beds (44 general adult and 20 for older people)

The Joint Strategic Needs Assessment (JSNA) provides the local framework for identification of health needs of the local population, and is used to inform annual Operating Plans of Primary Care Trusts, along with national guidance. The current Operating Plans of Berkshire East and Berkshire West PCT (now combined as the NHS Berkshire Cluster) highlight the substantial increase in long term conditions to 2019 and their associated mild to moderate mental health problems. In addition, an aging population will result in an increased prevalence of dementia. In both PCT areas, investment in dementia services is prioritised in order to reduce length of stay and unnecessary hospital admission.

In common with other parts of the country, the vast majority of mental health service provision in Berkshire is community based, and delivered in partnership with Local Authorities, who share responsibility for commissioning and providing mental health services with the NHS. Based on analysis of local need, the Commissioning Strategies of our partner Councils emphasise the importance of:

- Reduced reliance on acute hospital provision, and continued development of home treatment, including extra care sheltered housing for people with dementia.
- Commissioning personalised services and the use of Direct Payments.
- Access to timely advice and information and support for carers.
- Promotion of Social Inclusion independence and enablement.
- Mental health promotion and prevention of ill health.

Although rates of mental illness across Berkshire as a whole are comparatively low, there are some important local variations:

Slough and Reading Borough Council areas have a relatively young population in comparison to the other Unitary Authority areas in Berkshire, but there are higher rates of deprivation, health inequality and diversity. One third of the Slough population was born outside the UK and there are over 50 different languages spoken as a first language.

Bracknell Forest and Wokingham Borough Councils, the Royal Borough of Windsor and Maidenhead and West Berkshire Council areas have relatively low levels of deprivation, but still experience health inequalities. The populations of these council areas tend to be older – with West Berkshire experiencing the highest rate of projected growth in the population aged over 85. This has a significant impact in terms of the need for dementia services

5.0. Clinical Evidence

A review of the clinical evidence relating to Mental Health Inpatient Services was undertaken in July 2011 by the East Berkshire Public Health team at NHS Berkshire. The key points identified are as follows:

- Emphasis is on the provision of treatment in patient's own homes as far as possible, to achieve the best outcomes. This includes patients of all ages.

- Provision of single bedrooms with en-suite facilities is the optimum environment for inpatient services, ensuring patients are treated with respect and dignity.

- Consideration of travelling distance should be included in decision making about service provision.

- The physical environment is an important component of treatment and a poor environment can have a detrimental impact on patients.

- Access to evidence based interventions, provided by a well trained workforce - helping people to move into a more socially included way of life on discharge from hospital.

Also, a brief review of development plans currently in progress in other parts of the country was undertaken, to identify issues in common and potential learning points:

- Future plans in Lancashire have identified the need for more personalised support, and a network of community and hospital based services. The "specialist" nature of inpatient care is highlighted and a reduced number of inpatient sites is planned to correspond with reduced demand, and increased provision of community services. Evidence and independent review supports improved outcomes for people receiving treatment in community settings. The impact of increased community service investment has resulted in reduction in the original estimate of inpatient service need.

- Manchester services have planned to consolidate onto 2 sites, following consultation in 2010. The objectives were to provide same sex accommodation, improved staff response as a result of the physical environment and improved user and carer experience.
- Central and North West London Foundation Trust has experienced reduced demand in need for inpatient services for older adults, with the development of community services. This has identified an inpatient service requirement 60% less than existing provision. The aim is to provide a single centre of excellence for older people on one site rather than the existing 2 sites.

In addition, a meeting was held in August 2011 with senior clinicians from BHFT (Consultants for both older adult and adults of working age services) and the three GP Mental Health Leads for Berkshire, along with senior managers of BHFT and PCT Commissioners. The BHFT Clinicians strongly supported consolidation of inpatient services on a single site in order to achieve the best clinical outcomes for patients. Their experience of the increased provision of community services is that requirement for inpatient services is reducing, in line with other areas of the country (see above). Clinicians recognise the need for locally accessible services – but see inpatient provision as a specialist function, for a small minority of patients (approximately 2% of adults of working age receiving support from Community Mental Health Teams, and the total number of patients of all ages requiring inpatient treatment at any one time equates to approximately 20 from each of the East Berkshire Council areas).
BHFT clinicians confirmed their view that better outcomes would be achieved for patients if they were treated in an environment which enabled access to outside space, provided single bedrooms, enabled flexible and sustainable staffing and provided access to therapeutic activity throughout the week.
There is some variation between localities in terms of both rates of admission and average length of stay and numbers of delays to discharge which merits further work, to ensure that all areas are providing the same quality of provision and effectiveness of their use of resources.
It is recognised that there will be an ongoing requirement for services which meet the needs of people with a dual diagnosis – which may be co-existing mental health and substance misuse problems or people with mental health problems alongside a learning disability. Further work is needed to ensure that there is an appropriate range of options for people with mental health and substance misuse problems requiring detoxification according to their individual need, including community based alternatives.

6.0 Service user views

5.1. BHFT Patient Survey 2010

This highlights some of the factors which are prioritised by people using inpatient services. Responses were received from 80 patients who had been an inpatient during the 2 years prior to the survey. Of those people who provided a response to the specified questions:

- 93% consider that private facilities are either a good / very good idea
- 86% consider that having outside space is either a good / very good idea
- East Berkshire service users rate private facilities and outside space higher still
- There is significant support for all of the possible patient grouping methods
- The most popular grouping of patients is by age
- Same sex separation is almost twice as popular with females as males
- Only four responses were received from BME service users and this is considered to be too small a sample from which to draw conclusions

5.2. Berkshire Healthcare Trust Public Consultation 2010

This consultation was undertaken by Dr Foster Intelligence for 3 months from August 2010 on three possible options for the future provision of inpatient services for people from East Berkshire. The consultation report is available on the BHFT website. 12 public meetings were held, which included over 150 participants and 777 responses to a survey were received. A significant number of respondents to the survey were service users or carers: 41% of the respondents stated that they were either service users or carers or have a disability. 12% represented a community or interest group and 31% worked for the NHS.

However, the consultation participants' responses did not result in a strong preference for any one option, and were strongly related to the area in which people lived. In addition, it was not possible to determine a preference for investment in community or inpatient services from the survey, as respondents supported investment in both areas, with neither emerging as a priority over the other, based on the questions asked. 93% of respondents stated that they "agree or strongly agree" with the Trust investing NHS funds to maintain and improve community services for people with mental health needs. 87% of respondents stated that they "agree or strongly agree" with investing to improve inpatient facilities.

The consultation also included a section on respondents views about the criteria on which a decision about inpatient service options should be based. The results are summarised in the table below:

	1st choice	2nd choice	3rd choice	Not ranked
Maximise benefits to majority of service users	43%	24%	14%	19%
Clinical/quality evidence base	32%	28%	15%	25%
Support of GPs	11%	11%	20%	58%
Meet quality and financial regulators requirements	5%	11%	19%	65%
Value for money for taxpayer	4%	10%	19%	67%

Although 2 of the criteria included a significant number of "not ranked" responses, a large number of respondents ranked the benefits to the majority of service users, and the clinical/quality evidence base as their first choice. This has been reflected in the criteria for inpatient service development below.

5.3. Patient Choice

Significant developments have taken place in the promotion of choice in health and social care services in recent years, primarily in terms of planned or elective inpatient services. The vast majority of mental health acute admissions are not planned, and tend to be associated with management of risk presented to an individual as a result of their mental ill health. Therefore, the focus needs to be on the continued development of individualised care planning, a patient-centred approach to treatment, reflecting the priorities of the individual and patient and carer involvement in acute inpatient service development.

6.0. Psychiatric Intensive Care

Psychiatric Intensive Care is for patients compulsorily detained under the Mental Health Act, usually in secure conditions, who are in an acutely disturbed phase of a serious mental disorder. This is required for a small minority of people suffering from mental health problems. There is one Psychiatric Intensive Care Unit (PICU) serving Berkshire, located at Prospect Park Hospital. Patients requiring transfer from acute inpatient wards in East Berkshire therefore have to travel to Reading from either

Wexham Park or Heatherwood Hospital, with appropriate support, which can resent a significant challenge to the patient and their families, as well as to staff supporting the transfer.

7.0. Approved Place of Safety (APOS)

Part of the Mental Health Act (section 136) details the arrangements for removing a mentally ill person from a public place to a place of safety. A place of safety could be a hospital or a police station, but the latter should only be used in exceptional circumstances. Taking someone to an APOS enables that person to be assessed by a doctor and interviewed by an approved mental health professional, which may then result in a compulsory admission to an acute inpatient ward. There is an APOS at Prospect Park Hospital and Wexham Park Hospital.

8.0. Financial Considerations

Reflecting the relatively low levels of deprivation in Berkshire, funding available to the PCTs is amongst the lowest in the country. All organisations commissioning and/or providing mental health services are facing significant funding constraints which mean that work is required to ensure that resources are used to achieve the maximum impact in terms of positive outcomes for service users. Any proposals for changes to inpatient services need to take into account the balance of investment required for community service provision which provides the major means for reduction of avoidable admission to hospital.
Next Generation Care is the BHFT plan to achieve the continued provision of quality services in response to need within available resources – and it includes the achievement of a saving of £12m over the three years 2011/12 – 2013/14.

9.0. Conclusions: Vision and Criteria for Development of Mental Health Inpatient Services

The vision for inpatient services in Berkshire aligns with that proposed by the Sainsbury Centre for Mental Health as follows:

To offer time-limited safety, support and therapy to people who are too unwell, and present too high a level of risk to themselves or others to be cared for outside hospital. To achieve this by providing a range of therapeutic and other activities in a good quality environment, with the aim of supporting recovery and return to the community as soon as possible

The following criteria have been informed by the information contained in sections 3 – 7 above, and organised under headings which describe the Lansley criteria for major NHS Service change as follows:

1. Clinical Evidence Base
This should be clearly demonstrated, and be supported by the majority of clinicians involved.
Service change proposals should represent provision of safe, effective services, where the physical environment promotes good outcomes for patients.
Proposals for change should effectively balance an understanding of current need with demographic change and analysis of the impact of continued development of community based services.
Proposals for change should enable the care pathway to be enhanced, fostering close and collaborative working between inpatient and community services.
Proposals should facilitate compliance with statutory requirements of the Mental Health Act (including arrangements for APOS and Intensive Care provision)
National guidance should be used to inform local proposals, which should describe the extent to which specified standards and criteria will be met.
Proposals should support the achievement of performance and quality targets

2. Support of Clinical Commissioners
Developments should be supported by the majority of the 7 Clinical Commissioning Groups in Berkshire, including their non-GP Members, at the relevant level of federation.

3. Promotion of choice for patients and improved patient experience.
Services should be locally accessible wherever possible and centralised where necessary.
Choice of provider for mental health inpatient care is not at present a NHS policy aim due to the benefits of integration with social care and the operation of the Mental Health Act. However, proposals for service change should outline the interaction between the proposed service environment and treatment and care provided.
Proposals should also demonstrate how service user and carer experience will be enhanced, as well as mitigation of any adverse impacts. This should include understanding diversity and mitigation of inequalities as well a patient centred approach to care planning, which is informed by individual priorities and service user and carer involvement in service development.

4. Engagement of public, patients and local authorities
Proposals for major change should include required engagement and consultation, the findings of which should inform their development and plans for implementation.
For major service change proposals, review by appropriately qualified external advisors should be undertaken, and recommendations used to refine proposals as required.

5. Value for Money
Financial impacts of proposals should be clearly demonstrated in project documentation or an Outline Business Case as appropriate.
Financial analyses should take into account any differential impacts between Clinical Commissioning Groups and/or be agreed at the appropriate level of “federation” with the Director of Finance for NHS Berkshire, before Board approval.
Proposals should demonstrate effective use of financial and non-financial resources across the range of mental health services provided, and reflect an appropriate balance between community and inpatient services.
Proposals should be affordable across the local health and social care system, taking into account future financial and demand projections.

Bev Searle, Director of Joint Commissioning, NHS Berkshire

Appendix 2

Test No. 1: The Clinical Evidence Base

Application of the clinical evidence base test should be informed by the Department of Health guidance on the application of the Secretary of State's four tests. (Gateway reference: 14543. 29.07.2010)

"In meeting the clinical evidence test, local commissioners will need to consider both the strength of the clinical evidence and the support from senior clinicians whose services will be affected by the reconfiguration. It will be for commissioners and their provider partners to determine the specific composition of the clinical body to engage, though this should include representatives from across the patient pathway and from different relevant clinical specialties. It is recommended that clinicians should lead in gathering this evidence, considering current services and how they fit with the latest developments in clinical practice, and current and future needs of patients."

1.0. Method

A number of information sources have been used in the application of this test:

- A Public Health Review.
- The views of local clinicians gained during discussions with stakeholders and during service visits.
- The Commissioning Statement developed and approved by the East Berkshire Mental Health Local Implementation Team.
- A brief review of similar activity being undertaken in other parts of the country.

2.0. NHS Berkshire Public Health Review

A review of the clinical evidence relating to Mental Health Inpatient Services was undertaken by the Public Health team at NHS Berkshire in June 2011, and a report provided to the Director of Joint Commissioning. The key points identified are as follows:

- Emphasis is on the provision of treatment in patient's own homes as far as possible, to achieve the best outcomes. This includes patients of all ages.
- Provision of single bedrooms with en-suite facilities is the optimum environment for inpatient services, ensuring patients are treated with respect and dignity.
- Consideration of travelling distance should be included in decision making about service provision.
- The physical environment is an important component of treatment and a poor environment can have a detrimental impact on patients.

3.0. Commissioning Statement

In order to inform effective decision making, and enhance stakeholder involvement in determination of future provision of inpatient services for East Berkshire, a commissioning statement was developed by members of the East Berkshire Mental Health Local Implementation Team (LIT) and formally approved by the group as a whole. This work included the GP MH Leads for Berkshire, BHFT Clinical Director, BHFT Learning Disability Lead, NHS Berkshire Commissioners and representatives of all three Unitary Authorities in East Berkshire.

The Commissioning Statement (appendix 1) draws on relevant clinical guidance to inform decision making criteria regarding mental health inpatient services.

4.0. Views of Local Clinicians

A number of meetings were held during the additional engagement period, to provide stakeholders with an opportunity to discuss the evidence for and against the various options under consideration in terms of clinical outcomes:
A meeting was held on 10.08.2011 with senior clinicians from BHFT (Consultants for both older adult and adults of working age services, and Clinical Director) and the three GP Mental Health Leads for Berkshire, along with senior managers of BHFT and PCT Commissioners. The BHFT Clinicians strongly supported consolidation of inpatient services on a single site in order to achieve the best clinical outcomes for patients. Their experience of the increased provision of community services is that requirement for inpatient services is reducing, in line with other areas of the country. BHFT clinicians confirmed their view that better outcomes would be achieved for patients if they were treated in an environment which enabled access to outside space, provided single bedrooms, enabled flexible and sustainable staffing and provided access to therapeutic activity throughout the week.
BHFT Clinicians recognise the need for locally accessible services – but see inpatient provision as a specialist function, for a small minority of patients:

Approximately 2% of adults of working age receiving support from Community Mental Health Teams, and the total number of patients of all ages requiring inpatient treatment at any one time equates to approximately 20 - 25 from each of the East Berkshire Council areas.

Representatives of the Slough Clinical Commissioning Group (CCG), Berkshire Shared Services (BSS), NHS Berkshire met with BHFT Clinicians on 17.10.2011 to consider the potential viability of a "stand alone" unit in Slough. BSS and BHFT had been asked by the CCG to look at the potential for an adult inpatient service for to be established in Slough, given the concerns expressed about access to Reading for local patients and their families. Clinicians were clear that this would not meet the needs of people requiring inpatient services, because of the adverse impact of the security necessary for patients at risk of harming themselves in a small unit, the need for the full range of therapeutic activity to be offered – which would be a challenge for the necessarily small staff group working with a unit equivalent to a single ward, and the relative cost of service provision which would impact on availability of community services. BHFT clinicians agreed to give further consideration to the potential provision of a "hub and spoke" style service, which could facilitate local access, while establishing Prospect Park Hospital as the central hub for people with the most acute illness. A report was subsequently provided by the BHFT Medical Director, which concluded that this was not a clinically appropriate option.

Slough LINk representatives, Consultant Psychiatrists for Adults and Older Adults for Slough, BHFT Clinical Director and Director of Joint Commissioning met on 14.11.2011 to consider the clinical implications of proposals for MH Inpatient Services developed from a meeting of local stakeholders hosted by the Slough LINk. Clinicians confirmed the requirement for a purpose built unit in order to achieve optimum clinical outcomes.

5.0. Service Visits

A number of visits to adult inpatient services were carried out during the additional engagement period. These provided an opportunity to seek views from patients and carers (reported in appendices 3 and 4), as well as nursing staff.

Visits to older adults wards in East and West Berkshire were not carried out due to the consensus achieved relatively early in the additional engagement process that transfer to Prospect Park Hospital was the most clinically appropriate option.

Visits to Ward 10 at Wexham Park Hospital were carried out by the MH Lead GP for Slough, the Director of Joint Commissioning and members of the PCT Commissioning, Contracting and Quality Teams. The key points from the discussions with nursing staff during these visits were:

- The importance of the physical environment in terms of quality, dignity and safety issues, which present a significant challenge at Ward 10. This includes the requirement for staff escorts for patients when they wish to access outside space, the shared bedroom accommodation (both male and female areas include areas where up to 4 people share a room)
- The link between quality of environment and care provided. One visit in particular highlighted concerns about quality of nursing care, which have been actively followed up by the PCT and BHFT. This clearly illustrated the importance of a good quality environment for recruitment and retention of high quality staff, and the maintenance of motivation to provide optimum quality service.
- The number of staff able to respond to calls for urgent assistance as a result of the ward being an isolated unit.
- The difficulties presented as a result of the distance to the Intensive Care Ward at Prospect Park Hospital when the most unwell patients require transfer.

The staff confirmed that they believed that nursing patients in purpose built environments with single rooms and ensuite facilities was the required quality standard for patients.

A visit to Bluebell and Daisy Wards at Prospect Park Hospital, Reading was also carried out by the Director of Joint Commissioning, NHS Berkshire. Nursing staff and managers highlighted the following clinical issues:

- Consolidation of services at Prospect Park Hospital would present difficulties for community staff from East Berkshire – for example attendance of CPA meetings, which could result in delays to discharge of patients if not addressed effectively. This would be a particular issue for Slough staff.
- Patients need to be supported for day visits home as part of their recovery, and transport solutions would be needed to facilitate this.
- Some staff had worked at Fairmile Hospital in South Oxfordshire, which was the local inpatient provision prior to the building of Prospect Park Hospital, and remembered travel difficulties for visitors from Wokingham and Newbury – they felt these had been largely overcome by efforts of staff, but felt support with transport would be an important consideration for future arrangements.
- The purpose built environment allows significant flexibility, enabling the establishment of “mini wards” for assessment or other functions – enabling a more individualised approach for patients. This was seen as a significant benefit by staff.
- Arrangements for Approved Place of Safety would need to be effectively managed in partnership with Thames Valley Police. Current arrangements are not wholly satisfactory as they present a staffing challenge in East Berkshire Units (2 members of staff need to be deployed when APOS is required) however, the loss of this facility in East Berkshire would need careful consideration.
- Staff were not aware of complaints having been made by East Berkshire patients admitted to wards at Prospect Park Hospital, although they did relate experience of patients not wanting to be transferred back to East Berkshire Wards.

6.0. An evaluation of a 'Hub and Spoke' option for providing inpatient services for Slough and East Berkshire from a clinical perspective

This report was provided by the Medical Director of BHFT at the request of the Slough Clinical Commissioning Group. The report takes into account the strengths, weaknesses, opportunities and threats associated with building a smaller unit in the East of Berkshire through a 'hub and spoke' model, and concludes that this would not be the best clinical choice for patients in Slough or the rest of Berkshire. "This is principally a clinical view but also incorporates political, economic, social, technological and environmental aspects. There would be some advantages to the proposal, but these are outweighed by the disadvantages."

7.0. Evidence from Reconfiguration Projects in Progress in Other Areas

A brief review of development plans currently in progress in other parts of the country was undertaken in July 2011, to identify issues in common with East Berkshire and potential learning points:

- Plans for future provision in Lancashire identified the need for more personalised support, and a network of community and hospital based services. The "specialist" nature of inpatient care is highlighted and a reduced number of inpatient sites is planned to correspond with reduced demand, and increased provision of community services. Evidence and independent review supports improved outcomes for people receiving treatment in community settings. The impact of increased community service investment has resulted in reduction in the original estimate of inpatient service need.
- Manchester services planned to consolidate services onto 2 sites, following consultation in 2010. The objectives were to provide same sex accommodation, improved staff response as a result of the physical environment and improved user and carer experience.
- Central and North West London Foundation Trust has experienced reduced demand in need for inpatient services for older adults, with the development of community services. This has identified an inpatient service requirement 60% less than existing provision. The aim is to provide a single centre of excellence for older people on one site rather than the existing 2 sites.

Appendix 3

Test No. 2: Support of the GP Commissioners Involved

Department of Health guidance states that commissioners should review the level of support and consensus for proposed service changes amongst local GPs. Since the publication of this guidance, development of NHS Reforms has progressed considerably, with some amendments to the Health and Social Care Bill being made in response to the national listening exercise, and considerable progress being made in local implementation plans:

This has resulted in the requirement for clinical commissioning groups which include the involvement of secondary care clinicians. This is an important factor in the decision making process in relation to this project, which requires the consideration of views of both GP Commissioners and BHFT Clinicians.

The East Berkshire Clinical Executive Committee (CEC) has replaced the previous Professional Executive Committee, and three Clinical Commissioning Groups have been established as formal sub committees of the NHS Berkshire Cluster Board. The CEC comprises Clinical Commissioning Group (CCG) Leads from the 3 CCGs in East Berkshire; Bracknell, Windsor and Maidenhead and Slough along with the NHS Berkshire Executive Team. Each of the CCGs is in the process of developing formal governance arrangements required for authorisation, but all have established a means of consulting with their member practices on key decisions.

All local strategic commissioning and other significant financial decisions are now taken by the CEC, and therefore it has been the key point of contact for progress reporting and seeking approval of future actions for this project.

1.0. Method

At the start of the period of additional engagement – the views of the East Berkshire Clinical Executive Committee (CEC) were sought on the most appropriate approach to take. In response to the views of the CEC, a meeting was set up between Mental Health Lead GPs for Berkshire, BHFT Clinicians and NHS Berkshire Commissioners, and also a meeting between Slough CCG Management Group, BHFT and NHS Berkshire representatives.
Subsequent meetings were held, specifically with Slough CCG Management Group and Locality Meetings (which include representatives of all Slough GP Practices)
Progress reports were provided to the CEC, and a paper requesting approval of recommendations to the NHS Berkshire Cluster Board was considered by the CEC on 14.12.2011
The recommendation approved by the CEC was also specifically considered by the Slough Locality Group on 12.01.12.

2.0. The key outcomes from discussions with GP Commissioners:

- GPs understand the clinical case for change, but are concerned to ensure that the service user and carer experience is a positive one, and requested that some work is undertaken to ensure that the voice of users and carers informs their decision making. This will build on the work undertaken by BHFT to date. GP leads also worked with BHFT to ensure that all possible options have been considered to enable provision of inpatient services in East Berkshire, which are clinically appropriate and affordable.

- GPs have highlighted the importance of their clinical leadership in service development, and the establishment of a “clinical interface group” with BHFT, which is now being formally established. This group would provide the required leadership of service change across primary and secondary care, and would include ensuring that the required community service provision were in place to enable inpatient changes.

- Significant efforts were made to identify and explore potential ways of continuing to provide mental health inpatient services in East Berkshire, in partnership with GPs, BHFT Clinicians and Berkshire Shared Services. Options explored are listed in section 7 of the main paper, but all were assessed as not clinically or financially viable, and therefore no recommendation was made for further consultation.

- The recommendation of the East Berkshire CEC for conditional approval of option 1 provides for a number of safeguards to address the concerns of GPs about patient experience, community services, transport support and quality issues. Progress on the completion of these conditions will be monitored by the CEC and the Director of Joint Commissioning will work in partnership with a nominated GP representative to ensure effective progress.

3.0. Transitional Executive Committee

Information about the additional engagement and options for future mental health inpatient service provision was also provided to members of the Berkshire West Transitional Executive Committee and GP Mental Health Lead for Berkshire West for comment. Although this is primarily an East Berkshire issue, there were implications for services across the whole of Berkshire, should the decision be taken not to implement option1. The TEC were concerned about the potential adverse impact on community services across Berkshire, but understood the requirement for the CEC to take the lead role in determining a recommendation to the NHS Berkshire Cluster Board.

Appendix 4

Test No. 3: Promotion of Choice for Patients

Application of the patient choice test should be informed by the Department of Health guidance on the application of the Secretary of State's four tests. (Gateway reference: 14543. 29.07.2010). This emphasises that quality is an aspect of choice, and also that it is important to look at choice in the future compared with choice under the current model of provision. This requires consideration of evidence in relation to the following criteria:

- Services should be locally accessible wherever possible and centralised where necessary
- How proposed service reconfiguration affects choice of provider, setting and intervention.
- The quality of proposed services and health inequalities.
- Improvements in the patient experience.

1.0. Method

Information has been gathered from two main sources in the application of this test:

National Policy Guidance (some of which is referenced in Mental Health Inpatient Services for Adults: Commissioning Statement. October 2011.)
Service User, clinician and stakeholder views referenced in appendices 1 and 2.

2.0. Local Accessibility and Centralisation

Developments in treatment of mental health problems, alongside changes in health policy have resulted in a significant reduction in the numbers of people admitted to hospital for treatment over many years. In particular, the National Service Framework for Mental Health published by the Department of Health in 1999 outlined a 10 year programme, requiring the development of specified community services, which has culminated in the treatment of approximately 97% of Berkshire patients being treated in community settings.

Historically, East Berkshire Mental Health Inpatient Services have been provided on three sites: Wexham Park Hospital in Slough, Heatherwood Hospital in Ascot and St Marks Hospital in Maidenhead. Inpatient services from patients from the West of Berkshire were provided at a single site; Fairmile Hospital in South Oxfordshire along with patients from that area prior to the building of Prospect Park Hospital.

Currently, inpatient service provision in East Berkshire is limited to a single ward at each of the sites as follows:

Ward 10 at Wexham Park Hospital: 20 general adult beds
Ward 12 at Heatherwood Hospital: 25 general adult beds
Charles Ward at St Marks Hospital: 26 older adult beds

In addition, a number of patients access Prospect Park Hospital in Reading as a result of either insufficient beds available in East Berkshire, patient choice or requirement for intensive care.

The geography and demography of Berkshire East raise a number of important issues:

- Slough has the densest population, with the highest relative deprivation and diversity of population, and is located at the most northerly part of Berkshire, close to the Buckinghamshire border.
- The Royal Borough of Windsor and Maidenhead also includes the town of Ascot, and has relatively lower overall deprivation, but the highest proportion of older people in its population of the three East Berkshire Unitary Authorities.
- Bracknell is more accessible from Reading and local stakeholders have expressed a preference for option 1, location of all inpatient services at Prospect Park Hospital.

3.0. Choice of provider, setting and intervention

Choice of provider for mental health inpatient care presents a specific challenge due to the benefits of integration with social care and the operation of the Mental Health Act. However, proposals for service change should outline the interaction between the proposed service environment and treatment and care provided. Developments have taken place in the promotion of choice in health and social care services in recent years, primarily in terms of planned or elective inpatient services. The vast majority of mental health acute admissions are not planned, and tend to be associated with management of risk presented to an individual as a result of their mental ill health. Therefore, the focus needs to be on the continued development of individualised care planning, a patient-centred approach to treatment, reflecting the priorities of the individual and patient and carer involvement in acute inpatient service development.

It should be noted that Payment by Results is currently being developed in Mental Health Service which is likely to drive the availability of choice of provider in future – though this may take a number of years to achieve in terms of inpatient services, it may present new opportunities for individuals and communities to access services of their choice more easily than at present.

4.0. Quality of proposed services and health inequalities

The service proposed in option 1 enables the provision of services in a purpose built environment, which will enhance the quality of provision. The accommodation at Prospect Park Hospital enables a flexible approach to be taken to patient need, with the ability to achieve “mini wards” within existing configurations, for specific purposes.
As identified in the Equality Impact Assessment, work will be needed to ensure that equalities issues are embedded in the project planning and implementation process – to ensure that the opportunities to reduce inequalities are fully capitalised on. This is particularly important in terms of service provision for people from Slough and parts of the Royal Borough of Windsor and Maidenhead, who are likely to have the most significant impact in terms of travel to Prospect Park Hospital, and in terms of the highly diverse population of Slough.

5.0. Improvements in patient experience

Proposals should also demonstrate how service user and carer experience will be enhanced, as well as mitigation of any adverse impacts. This should include understanding diversity and mitigation of inequalities as well a patient centred approach to care planning, which is informed by individual priorities and service user and carer involvement in service development.

5.1. BHFT Patient Survey 2010

This highlights some of the factors which were prioritised by local people using inpatient services. Responses were received from 80 patients who had been an inpatient during the 2 years prior to the survey. Of those people who provided a response to the specified questions:

- 93% consider that private facilities are either a good / very good idea
- 86% consider that having outside space is either a good / very good idea
- East Berkshire service users rate private facilities and outside space higher still
- There is significant support for all of the possible patient grouping methods
- The most popular grouping of patients is by age
- Same sex separation is almost twice as popular with females as males
- Only four responses were received from black and minority ethnic service users and this is considered to be too small a sample from which to draw conclusions

Appendix 5

Test No. 4: Engagement of the Public, Patients and Local Authorities

1.0. Berkshire Healthcare Trust Public Consultation 2010

This consultation was undertaken by Dr Foster Intelligence for 3 months from August 2010 on three possible options for the future provision of inpatient services for people from East Berkshire. The consultation report is available on the BHFT website. 12 public meetings were held, which included over 150 participants and 777 responses to a survey were received. A significant number of respondents to the survey were service users or carers: 41% of the respondents stated that they were either service users or carers or have a disability. 12% represented a community or interest group and 31% worked for the NHS.
The consultation also included a section on respondents views about the criteria on which a decision about inpatient service options should be based. The results are summarised in the table below:

	1st choice	2nd choice	3rd choice	Not ranked
Maximise benefits to majority of service users	43%	24%	14%	19%
Clinical/quality evidence base	32%	28%	15%	25%
Support of GPs	11%	11%	20%	58%
Meet quality and financial regulators requirements	5%	11%	19%	65%
Value for money	4%	10%	19%	67%

for taxpayer				

Although 2 of the criteria included a significant number of “not ranked” responses, a large number of respondents ranked the benefits to the majority of service users, and the clinical/quality evidence base as their first choice. This has been reflected in the criteria for inpatient service development included in the Commissioning Statement approved by Berkshire East Mental Health Local Implementation Team (appendix 1.)

2.0. BHFT Patient Survey 2010

This survey included people who had received inpatient services during the 2 years prior to the survey. 80 responses were received, and a very brief outline of the results reported in appendix 4. The survey is available on the BHFT website for reference.

3.0. Outcomes from additional engagement, summer and autumn 2011

Meetings have taken place with East Berkshire Lead Councillors for Health and Social Care, senior Council Officers and Chairs of Health Scrutiny Committees. In addition, a progress update on the additional work undertaken has been provided to all 3 Berkshire East Health Scrutiny Committees, and discussions held with the Royal Borough of Windsor and Maidenhead (RBWM) Health Scrutiny Committee and the Slough Borough Council Health Scrutiny Committee. An agreement has been made with the Bracknell Forest Council Scrutiny Chair for their comments to be provided in response to the update paper in writing.

Views expressed by the RBWM Health Scrutiny Committee and Lead Councillor for Health and Social Care were as follows:

- Concern remains about transport and access issues with regard to option 1. More detail of support with transport is required, as well as a clear explanation of the community service development planned, which would be accessible within the area.
- The views of clinicians about the model of treatment most likely to benefit patients were important and should influence decision making.
- The previous consultation had not enabled local people to understand the key issues – including the nature of inpatient treatment as a specialist activity and needed by a very small proportion of the population. There is a need for effective communication going forward.

The presentation of additional information about clinical outcomes to the RBWM Health Scrutiny Committee and Health and Wellbeing Board (which included the Lead Councillor for Health and Social Care) resulted in a greater understanding of the benefits of locating all inpatient services on the Prospect Park Hospital site, including the benefits of retaining community services for local people. However, it should be noted that Councillors expressed concern about transport for visitors and potential difficulties for local people in accessing services in Reading.

A number of meetings have taken place with Slough Borough Council Health Scrutiny Panel, which has consistently expressed concern about the adverse impact of relocating inpatient services to Reading on residents of Slough. Detailed information has been provided to the Scrutiny Panel on the options proposed during the period of additional engagement, against a range of criteria as requested by the Panel. This includes confirmation of the recommendation of conditional approval of option 1 for consideration by NHS Berkshire Cluster Board on 24.01.2012.

Extracts from the minutes of relevant meetings are included at appendix 6.

Discussions with Council Officers have highlighted concerns already described about transport and community services, and the requirement for clear communication about both of these factors.

A meeting was held with the BHFT Governors, which includes patient and carer representatives, to discuss the additional engagement work taking place. Patient feedback included a strong preference for inpatient treatment at Prospect Park Hospital from one person who had direct experience of both that hospital and Ward 10 at Wexham Park. Carer feedback included concern about the quality of experience of patients in Charles Ward in shared bedroom accommodation, and the anxiety experienced by people accessing toilet facilities during the night. There was also a general concern about the need to achieve a speedy improvement to the inpatient services for East Berkshire patients

Appendix 6

1.Engagement with Local Authorities: Royal Borough of Windsor and Maidenhead Health Scrutiny Panel

13.09.2011

Meeting attended by Dr Katie Simpson, Mental Health Lead GP, East Berkshire, Bev Searle, Director of Joint Commissioning, NHS Berkshire and Julian Emms, Deputy Chief Executive, Berkshire Healthcare NHS Foundation Trust.

Extract from Meeting Minutes:

23/11 Future of Mental Health Inpatient Services – Progress Update on Additional Engagement and Consultation Activity – September 2011

The Panel received a report that provided an update on the additional work agreed by NHS Berkshire and Berkshire Health NHS Foundation Trust (BHFT) in July to inform decision- making on the future of Mental Health Inpatient Services for East Berkshire.

Members were advised that he decision had been taken to undertake a further period of engagement as no clear consensus had emerged on the way forward and there had been significant concerns raised by key stakeholders about some of the options.
Bev Searle, Director of Joint Commissioning – NHS Berkshire, commented upon the additional work that had been undertaken to date and the further work that was planned regarding clinical engagement and review, engagement with stakeholders and the review of inpatient service development proposals in other areas.

In response to a number of comments/questions, further information was provided on the nature of the support that patients received from community based services. Members were advised that, although clinicians would prefer an inpatient facility to be provided locally, it was recognised that the current facilities were inadequate and that alternative provision was not financially viable. However, GPs were reviewing the options to satisfy themselves that nothing had been missed that would enable a local option to be achieved. With regard to the Upton Hospital option, it was noted that, whilst that option could be pursued, the repayment costs associated with the borrowing of funds to provide the facility would have a detrimental effect on the funding of community based services. With regard to the further review of clinical evidence that was being undertaken it was stressed that the cost and accessibility of public transport should also be considered along with travelling distance in the decision ,making about service provision.

With regard the services being provided at Charles Ward, Bev Searle advised that Charles Ward did not provide end of life care, but was an inpatient facility for people to be admitted for a short period of time to receive treatment and stabilisation. She also stated that the potential of commissioning services from neighbouring Trusts had been looked at but, due to the nature of the services being provided, that was not considered practical due to the disruption that would occur in the patient's pathway.

08.11.2011

Meeting attended by Bev Searle, Director of Joint Commissioning, NHS Berkshire and Julian Emms, Deputy Chief Executive, Berkshire Healthcare NHS Foundation Trust.

Extract from Meeting Minutes:

34/11 UPDATE ON THE FUTURE OF MENTAL HEALTH INPATIENT SERVICES

Bev Searle, Director of Joint Commissioning – NHS Berkshire, provided Members of the Panel with an update on the additional engagement work that had been undertaken on the future provision of mental health inpatient services for East Berkshire. She commented upon the results of the additional engagement work, which would be published shortly, and advised that the Clinical Executive Committee were due to meet and would be making recommendations to the PCT Board.

She commented upon the facilities and service provided at Prospect Park in Reading and the community services that were currently provided to support patients locally. She advised that the local Commissioning Group had expressed support for the relocation of inpatient services, subject to enhancement to the current community services and the satisfactory resolution of the transport provision.

In response to a number of questions, Julian Emms, Deputy Chief Executive – Berkshire Healthcare Foundation Trust, commented upon the types of treatment available to treat people with personality disorders and advised that with the correct treatment the recovery rates were very high. He stated that, dependant on a person's social environment, with ongoing treatment and monitoring their disorders could be contained and the person should be able to lead a full and active life. He also commented upon the treatment and medication that was now available to slow down the onset of dementia and Alzheimer's. He also reiterated the potential problems that could occur from the commissioning of services from neighbouring Trusts due to the disruption that would occur in the patient's pathway.

Members were advised of the services that were also currently provided by the Royal Borough to support people with mental health needs and it was stressed that it was expected that the development and enhancement of community services would result in a reduction in the number of people receiving inpatient care.

2. Engagement with Local Authorities: Royal Borough of Windsor and Maidenhead Health and Wellbeing Board

Meeting attended by Adrian Hayter, Windsor and Maidenhead Clinical Commissioning Group Lead, Charles Waddicor, Chief Executive, NHS Berkshire, Bev Searle, Director of Joint Commissioning, NHS Berkshire

Extract from Meeting Minutes:
19/11 NHS BERKSHIRE COMMISSIONING OF MENTAL HEALTH SERVICES AT ST MARKS HOSPITAL

The Board received the report which dealt with the future provision of mental health inpatient services for East Berkshire. It summarised the current service provision, key findings of the additional engagement and consultation work undertaken during the Summer, and described the current status of work in progress.

The additional work had been carried out as a result of concerns expressed. Attention was drawn to the data in Section 3 of the report, Key Implications. This estimated that at any one time 6-8 inpatients were older adults from the Royal Borough. The report also stated that the accommodation in East Berkshire in which some services were provided were not at the standard required in order to achieve the best outcomes.
In the ensuing discussion, the following comments were made:

- Efficient use of resources would allow more funding to be invested in services for patients with personality disorders. Good treatments at an early stage benefited the patients and their families.
- Around £100k could be allocated to transport funding to support visits by families and friends but these proposals did require further work. Transport services could include community transport providers, public transport vouchers and contributions towards petrol costs.
- The experience of service users was a crucial part of the consultation. Lead GPs were surveyed, wards were visited and patients and carers were all spoken to. Key outcomes of this work were the need for quality accommodation. Patients required dignity and respect and this was not always achieved if they had to share bedrooms and/or toilets.
- There had been an established clinical need for more investment in community based treatments. This had been shown to reduce the demand for inpatient care.
- The Clinical Executive Committee would consider the options week commencing 7th November 2011 and the matter would be discussed a the NHS Berkshire Board level on 22nd November.
- The Panel requested that NHS Berkshire continued to engage fully with the press to ensure that patients and their families were kept fully informed of progress.

RESOLVED: Unanimously that content of the report be noted and that the planned additional work be supported.

3.Engagement with Local Authorities: Slough Borough Council Health Scrutiny Panel Recommendations of Task and Finish Group – reported to Health Scrutiny Panel on 22.06.2011

Meeting attended by Julian Emms, Deputy Chief Executive, Berkshire Healthcare NHS Foundation Trust

1. The Slough Borough Council Health Scrutiny Panel and the overarching Overview and Scrutiny Committee **rejects** the findings and outcome of the Public Consultation and **suggests** that, at the very least, requests a new independent impartial Public Consultation be undertaken that contains a full and open range of options particularly as:

a) The choices for the public to consider were not the full extent of options really available to BHFT
b) Local and a wider sphere of impartial clinicians have not been consulted during the process of the Public Consultation particularly as it would appear that neither Berkshire East PCT not BHFT have considered such GP feedback
c) The arguments put forward in the consultation are potentially misleading and outdated

2. That Slough Borough Council's Health Scrutiny panel **recommends in the strongest terms that the the Council's Overview and Scrutiny Committee refers this matter to the Secretary of State for Health, Andrew Lansley, MP**, advises him of the severe misgivings the Group has and requests a thorough investigation is launched as to whether those wo conducted the Public Consultation did so in the best interests of the public, in the best interests of clinical excellence, in the best interests of spending public money most effectively and in the spirit of and guidance subsequently received from HM Treasury.
3. That BHFT is **requested formally** to seek independent advice regarding the exact costs of a new purpose-built facility at Upton Hospital
4. That is cost of a new purpose-built facility at Upton Hospital is independently assessed as unaffordable, that it is **formally placed on record** that an improved and enhanced service provided in conjunction with Heatherwood and Wexham Park Foundation trust be considered.
5. That an independent body **investigates further** the transport impact of any moves and/or relocations including the extra financial, practical and environmental (e.g. carbon emissions) and the difficulties these pose for patients.

4.6. Finally, as **serious questions remain** surrounding the whole of the conduct from beginning to end of the public consultation, the Group stresses the outcome remains **fundamentally flawed**.

4.7. Throughout this whole process, the key consideration for the group has been on protecting the interests of Slough patients. It remains the case that given the diversity and demographic profile of Slough, the mental health needs of Slough residents remain considerably greater, both in absolute terms and relative to its Berkshire peers. Whilst considerations on finance are always important, particularly in the current climate, it is the needs of patients that should be the foremost concern. It is the view of the group that these considerations have not been foremost in the consultation. Indeed, many of the arguments for moving services from East Berkshire cut against the grain of the NHS Constitution and the government's policy on patient choice.

4.8. Finally, with question marks surrounding the conduct of the consultation, whether this relates ot the choice of options being pursued, the advice used to inform the public and decision making process or the extent to which views garnered in the consultation were factored into any final considerations, the whole premise of the consultation remains flawed.

The Health Scrutiny Committee resolved that:

a) The Health Scrutiny Panel does not accept the findings of the public consultation on reprovision of Mental Health Inpatient provision in East Berkshire
b) That in the event that the Trust decides to relocate Mental Health provision to Prospect Park Hospital, Reading, that the panel recommend that the Overview and Scrutiny Panel refer the matter to the Secretary of State for Health
c) That the Panel request that BHFT seek independent advice on the cost of a new purpose built facility and that the resulting detail be submitted to the Panel at the earliest opportunity.
d) That in the event the independent advice determines that a new facility is unaffordable, that the Panel recommend that an improved and enhanced service in conjunction with Heatherwood and Wexham Park Hospital is the preferred option.
e) That the Panel recommend that once concluded, the outcome of the transport business case be presented at its next meeting in September 2011.

Health Scrutiny Committee Meeting 20.09.2011

Meeting attended by Bev Searle, Director of Joint Commissioning, NHS Berkshire and Philippa Slinger, Chief Executive, Berkshire Healthcare NHS Foundation Trust

Extract from the Minutes of the Meeting

16. Future of Mental Health Inpatient Services – Progress Update on Additional Engagement and Consultation Activity: Bev Searle, Director of Joint Commissioning, NHS Berkshire.

Bev Searle, Director of Joint Commissioning, NHS Berkshire outlined a report to provide an update on the additional work agreed by NHS Berkshire and Berkshire Health NHS Foundation Trust (BHFT) in July, to inform decision making on the future of Mental Health Inpatient Services for East Berkshire.
The Panel was advised that a decision had been taken to undertake a further period of engagement due to the fact that no clear consensus had emerged on the way forward and significant concerns had been raised by key stakeholders about some of the options. Ms Searle discussed the background to the options for the future provision of Mental Health Inpatient Services for East Berkshire and the options considered with the consultation process undertaken between August and November 2010. The Panel noted the additional work undertaken regarding clinical engagement and review, engagement with stakeholders and the review of inpatients service development proposals in other areas. Ms Searle summarised further work planned which included the conclusion of clinical engagement work and consideration of progress to date by the East Berkshire Clinical Executive Group in September, completion of Gateway review and engagement with LINks and Carer Groups.

The Panel noted a letter which had been tabled by John Kelly, LINks who felt that there had to be an East Berkshire option and that Upton Hospital or St Marks could provide that. In the ensuing discussion a number of comments and questions were raised including a request for more clarification on how this consultation was different to the first one. Ms Searle advised that is was realised that there was no consensus ad more engagement work was needed. It was a requirement that any change would require the approval of clinician groups and satisfactory engagement with stakeholders. There had been significant concerns in this areas and these were being incorporated in feedback provided. It was clear that this was a challenging decision to make and the outcome would be unlikely to have the full agreement of all parties. It was confirmed that the Berkshire Health Care Trust had conducted the original consultation, and the Berkshire Cluster would now conduct the exercise which was one of engagement rather than consultation. Ms Searle confirmed that it was not the case that the original consultation was carried out incorrectly, but rather a reflection of what a difficult task this was. A Member asked whether it was correct that offices within Prospect Park Hospital would require conversion to Wards. Philippa Slinger, Chief Executive, Berkshire Healthcare NHS Trust, confirmed that it was likely that some areas would be converted and that Reading Mental Health Team could be re-vacated as they did not need to be in the building. A Member questioned what would happen if Prospect Park Hospital did not receive the £4.9m necessary and Ms Slinger advised that Prospect Park did not need this money as this was capital money the Trust had been collecting to spend on improving in-patients services in the East of Berkshire. In response to a further question regarding the position of GPs in Slough, Ms Searle advised that work was being undertaken with GPs to make sure that they had explored the outcomes themselves.

Resolved – That the report be noted and that an update report be submitted to the Panel on 8th December 2011.

17. Future of East Berkshire Mental Health Inpatient Services – Transport Solutions to support relatives and carers proposed by Berkshire Healthcare Trust: Julian Emms, Deputy Chief Executive, Berkshire Healthcare NHS Foundation Trust

Philippa Slinger, Chief Executive, Berkshire Healthcare NHS Trust, outlined a report on the current position regarding Transport Solutions to support relatives and carers proposed by Berkshire Health Care Trust. The Panel was reminded that the results of Transport surveys undertaken as part of the public consultation exercise had found that visitors overwhelmingly travelled by car (97%), to visit patients in hospital and there was no evidence that problems with travel had been identified as a reason for patients not receiving visitors. It was accepted that despite the survey results concerns

were expressed regarding the impact on relatives and carers should inpatient services be relocated to the Prospect Park Hospital site. A transport group had been created comprising representatives from Overview and Scrutiny Committees, LINks and Service User and Carer representatives. A number of key expectations and solutions were identified and a transport consultations company was engaged to consider possible solutions. The Panel noted five identified options for the provision of transport for relatives and the merits of these were discussed. The most favoured option was the provision of community transport whereby a number of existing operators would provide a service. Further discussion was required around this option including the need to possibly charge a small amount in some cases, should the decision be made to relocate inpatient services to Prospect Park Hospital. It had also been suggested that an Internet based communications option such as Skype could be useful in helping patients and their carers/relatives to make contact between visits.

In the ensuing discussion a Member commented that he had undertaken a mock journey from Langley to Prospect Park Hospital and the journey time was in excess of 1.5 hours each way. It was important to measure not only the cost but also the journey time. Ms Slinger commented that you could not mitigate for someone's time or inconvenience and noted that the majority of visitors would drive to the hospital and the challenge could be the cost of petrol. It was suggested that there could possibly be a petrol reimbursement scheme based on statutory mileage rates in force.

Resolved – That the report be noted.

Health Scrutiny Meeting of 8.12.11

NHS Berkshire Progress Update on Additional Engagement Work Undertaken Regarding the Future of East Berkshire Mental health Inpatient Services

Meeting attended by Bev Searle, Director of Joint Commissioning, NHS Berkshire

Minutes of the meeting are not yet available, but in response to this discussion, a summary table of options considered as part of the 2010 public consultation and options which were proposed during the additional engagement was prepared and forwarded to Slough Borough Council on 27.12.2011.

The table included 10 options in total, presented against 9 criteria listed in section 7 of the main paper.

Appendix 7

Future of East Berkshire Mental Health Inpatients. Additional Engagement Chronology and Summary of Activity. July 2011 – January 2012

Date	Activity
26.07.11	NHS Cluster Board
	Clinical Executive Committee
10.08.11	East Berkshire MH Leads meeting
19.08.11	1:1 Meeting with Slough Locality MH Lead GP
31.08.11	Slough GP Meeting
16.08.11	Slough HOSC Chair and Policy Officer
17.08.11	BHFT Governors
24.08.11	Bracknell HOSC Chair and Policy Officer
31.08.11	RBWM HOSC Chair and Policy Officer
01.09.11	Specialist Review of consultation and engagement undertaken
02.09.11	Visit Ward 10
02.09.11	RBWM Council Leader, Lead Member and DASS

05.09.11	Bracknell Council Leader, Lead Member and DASS
05.09.11	Slough Council Leader, Leader Member and DASS
08.09.11	1:1 Meeting with GP MH Lead
13.09.11	RBWM HOSC and MH Lead GP, BHFT Deputy Chief Executive and Director of Joint Commissioning
14.09.11	Clinical Executive Committee
16.09.11	Transitional Executive Committee (paper forward)
20.09.11	Slough HOSC
21,22,23.09.11	Gateway Review
27.09.11	NHS Berkshire Cluster Board
11.10.2011	Visit to Ward 10 with MH Lead GP
17.10.2011	Slough Locality Meeting with BSS
	LINk – meeting with John Kelly
27.10.2011	East Berkshire Mental Health Local Implementation Team
25.11.2011	TEC
4.11.2011	RBWM Health and Wellbeing Board
14.11.2011	LINk – meeting with John Kelly, Colin Pill and BHFT Clinicians at Upton Hospital
04.11.11	RBWM Health and Wellbeing Board
09.11.11	Clinical Executive Committee
14.12.11	Clinical Executive Committee
29.12.11	Meeting with DH Gateway Lead
30.12.11	Visit to Prospect Park Hospital
12.01.12	Slough CCG Locality Meeting
23.01.12	Slough Health and Wellbeing Board

Appendix 8

Equality Impact Assessment

The Berkshire Healthcare NHS Foundation Trust document "Next Generation Care Programme – Equality Impact Assessment (EqIA) Proposed Changes to the location of In-patient Facilities currently provided in East Berkshire", October 2010, is available in full on its website.

The BHFT EQIA identified a number of opportunities and risks associated with the 3 options for future provision of Inpatient Services which were consulted on in 2010. This document draws on the BHFT EqIAt, with additions (in italics) below informed by the engagement led by NHS Berkshire during the summer and autumn of 201. Particular emphasis is placed on option 1, location of inpatient beds at Prospect Park Hospital, as this has now been recommended for conditional approval by the NHS Berkshire Cluster Board in line with the view of the Berkshire East Clinical Executive Committee in December 2011.

1. **Opportunities to promote equality**

- Providing access to high quality inpatient mental health care, positive patient experience and improved health outcomes for all groups leading to a reduction in health inequalities.
  During the additional engagement process, BHFT Clinicians confirmed their view that optimal clinical outcomes would be achieved by providing inpatient services in a purpose built environment, and the maintenance of community based services. The conditions attached to the recommended approval of option 1 contain important safeguards about patient experience, community services and quality improvement which will be monitored by the East Berkshire Clinical Executive Committee and a progress report provided to NHS Berkshire Board on

- Designing and developing a new site which affords the very best practice in terms of clinical care and inclusive modern facilities for all users.
  Although Prospect Park Hospital is not a new site, it is purpose built and relatively new. During the additional engagement period, nursing staff highlighted the flexible nature of the building design in terms of the ability to create "mini wards" within existing wards, and therefore increasing the potential for provision of specific types of service – for example, for assessment.

- A range of coordinated mental health services provided in one location resulting in effective care coordination and better access to a wide range of services for all users.
  Clinicians have identified the advantages of a larger group of staff available on a single site, in order to respond effectively and reliably to patient need.

- Developing new models of service provision and the opportunity to build in systems and protocols from the outset which best support equitable and accessible patient care with robust systems for outcome monitoring
  The conditions of approval of option 1 include quality monitoring and an implementation plan which includes effectiveness of community services and quality of inpatient services.

2. Risks to equality

The location of the future sites and the risks that some groups will be disadvantaged in terms of journey times (and the impact this may have on health outcomes and experiences) and/or access to the site by friends and family.
This risk has been confirmed by the views of a number of stakeholders during the additional engagement undertaken. One of the conditions of approval of option 1 is that transport support plans will be completed as part of the implementation plan and that transport support will be in place prior to the relocation of services.

A lack of continuity in the care pathways for some patients and the risk that patient choice will be reduced as a result of patients having restricted access to their preferred community facilities; and that some groups will be disadvantaged by this in terms of continuity of care, access arrangements, communication, experiences of the relocation, or impact on friends and family;
The recommendation of conditional approval of option 1, means that additional funding will not be required which would be the case for option 3 (new build on Upton Hospital site) which could have an adverse impact on the availability of community services.

Opportunities to promote equality arising from the development of a new site, including new and innovative models of working, will be missed and the benefits for different equality groups will not occur and/or will not outweigh the costs.
Involvement of the Clinical Interface Group, the East Berkshire Health and Wellbeing Board, LINks and CCGs in the development and implementation of mental health service plans will provide important opportunities to capitalise on opportunities to promote innovation.

3. Recommendations for consideration

Continue to work with public transport agencies and key stakeholders, exploring options for shuttle/transport services (for Options 1 and 2) to enable access to the new facility,

e.g. for elderly carers and those with mobility problems

Monitor visitor levels and continue to collect carer feedback on accessibility to the new site.

Include equalities considerations within further planning on policies and protocols for patient pathways including the involvement of third sector agencies representing minority groups; For example, the involvement of third sector agencies and the support they provide to individual patients should be routinely monitored in care planning and discharge plans.

Embed equalities within the planning and procurement process for all new facilities including physical environment and the provision of faith based space.

Continue to demonstrate best practice in involving the public, including equality groups, in the development of the site.

Conduct a further EqIA on patient experience once the new site is established.

These recommendations are endorsed following the additional engagement undertaken by NHS Berkshire, and will be reviewed by the Project Team for inclusion in the Project Planning process.

The future of mental health inpatient services for east Berkshire

Results of additional engagement work undertaken by NHS Berkshire July-December 2011

The key outcomes are as follows:

1. **It was clear that not all stakeholders had a clear idea of the nature of inpatient treatment for mental health problems or how many people might need it, in relation to the numbers of people who receive their treatment and support in the community.**

In response to this, there were detailed discussions between clinicians (consultant psychiatrists, specialist nurses and GPs) and a number of stakeholders (clinical commissioners, council representatives and Local Involvement Network – LINk – representatives).

Approximately 2-3% of people receiving mental health services need to be admitted to hospital, with the vast majority receiving support and treatment while living in their own home. When people need inpatient admission, it is for specialist treatment and care, best provided in a purpose-built environment.

As a result of these discussions there was increased support for providing all inpatient services on one site, in a good quality environment, to achieve the best outcomes for patients, while also investing in community services.

2. **Concerns were expressed about access to inpatient services for people from east Berkshire if these were to be located in Reading at Prospect Park Hospital – as described in option 1 in the 2010 consultation by Berkshire Healthcare NHS Foundation Trust (BHFT).**

In response, further detail about transport support was provided. BHFT is committed to providing £100,000 annually to support this.

As a result some stakeholders have been reassured around transport issues. However, it is recognised that some people remain extremely concerned about this. Access to visitors is a very important part of recovery for patients. That is why the GP-led Clinical Commissioning Groups (CCGs) in east Berkshire have cited establishing support arrangements as a condition of approval of any move of inpatient services from east Berkshire. This is one of the recommendations to the Board of NHS Berkshire.

3. **It was not clear to some stakeholders that all options for future provision of services had been considered.**

NHS Berkshire asked Berkshire Shared Services (BSS) to look at the use of existing NHS sites in east Berkshire, to ensure that all options had been considered. BSS has worked with Slough CCG to look at the feasibility of providing a specialist unit in Slough for people requiring mental health inpatient services. The CCG also asked BHFT to consider whether a “hub and spoke” style of service could be provided. Slough LINk also brought together a group of stakeholders which produced some proposals for consideration.

Despite a great deal of additional work to look at potential alternatives to the three options on which consultation was carried out in 2010, no new clinically or financially viable options were identified. However, these discussions have been useful in deepening understanding of stakeholder concerns, financial and estates issues and the rationale for clinicians' views about service models.

4. **Some stakeholders felt that a decision to move all inpatient services to Prospect Park Hospital in Reading had already been made on financial grounds.**

Presenting information about the financial position to stakeholders was an important part of the engagement work. People appreciated the opportunity to have further discussions about the financial issues, and the difficulty of making decisions about priorities for funding. They understood that investing in new buildings would significantly reduce the amount available for community services. BHFT is already making savings to achieve a balanced budget and would need to make even more to fund a new building. A new building would take up more than half of the BHFT community mental health budget in any one of the east Berkshire council areas.

5. **People were concerned about the experience of patients and their families, and wanted to be sure that planning was taking this into account.**

This was a particularly important point for some east Berkshire GPs. Work will continue to ensure that patient experience is considered and used to inform future work. In addition, NHS Berkshire will ensure that patients' views are independently surveyed. The PCT will also work with BHFT to continue to improve service quality.

6. **Some people were concerned that plans were not in the best interests of patients, and their health might be adversely affected by moving inpatient services further away.**

It was helpful for people to have the opportunity to talk directly to specialist doctors and nurses who are responsible for providing mental health inpatient care – and to hear from them that they are unanimous in their belief that moving all inpatient services to Prospect Park Hospital will produce the best clinical outcomes for patients. In other specialist areas as well as mental health, improvements in the way healthcare is provided in the community is resulting in regional specialist units being established alongside more treatment at home.

20 January 2012

NHS Berkshire

19.1.12

Media Release

The Board of NHS Berkshire is being recommended to approve the centralisation of inpatient services for mental health patients onto a single site.

A report to the Board concludes that bringing all Berkshire's inpatient mental health services together will lead to better outcomes and better recovery for patients. However, it also says that this should go hand-in-hand with increased investment in community mental health services and transport for relatives and carers of inpatients who face longer journeys.

Mental health professionals and local GPs support the move which would see existing mental health facilities transfer to Prospect Park Hospital, Reading, from three locations in east Berkshire: Wexham Park Hospital, Slough, Heatherwood Hospital, Ascot and St Mark's Hospital, Maidenhead.

The recommendation follows public consultation and months of research and discussions to explore all options.

The decision will be taken by the NHS Berkshire Primary Care Trust (PCT) cluster board meeting in public on Tuesday 24 January at The Centre, Farnham Road, Slough, from 10am.

Dr Katie Simpson, the GP lead for mental health in east Berkshire, said: "Having weighed up all the evidence it is clear that there is a convincing clinical case for change. Local GPs and mental health professionals strongly believe that inpatients get the best possible care and best outcomes when

they are treated in modern, purpose-built single site hospitals instead of in smaller, isolated, substandard facilities. We understand the concerns about transport and access and we are working to address these.

“It is important to remember that the vast majority of people coming into contact with mental health services get the support they need in or close to their homes and we are investing more in these areas.”

In 2011 there were approximately 280 admissions to east Berkshire wards out of a total of 5,472 working age people receiving support from mental health services (about 1 in 20 or 5%). For people over the age of 65 there were 70 admissions out of 2,489 patients (3% receiving inpatient care). These figures relate to the number of admissions not the number of individual patients.

Bev Searle, Director of Joint Commissioning at NHS Berkshire, said: “We have listened carefully over many months to the views of clinicians, patients and their families, our local authority colleagues and other stakeholders.

“Despite a great deal of additional work to look at potential alternatives to the three options on which consultation was carried out in 2010, no new clinically or financially viable options were identified.

“The clear consensus is that bringing inpatient services together in one place is the best way of ensuring good quality services both for the small number of people needing inpatient care and for those receiving treatment and support in their own homes.”

ENDS

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Notes to editors:

1. A media briefing takes place on Friday 20 January, 2-3pm at King Edward VII Hospital, Windsor. Please confirm attendance with Martin Leaver

2. From August-November 2010 Berkshire Healthcare NHS Foundation Trust, which provides mental health services in the county, held a public consultation over future options for inpatient mental health services for east Berkshire. There were three options:

Option 1 All beds to be relocated to Prospect Park Hospital in Reading
Option 2 Beds for older people to be at St Mark's Hospital in Maidenhead and for working age adults in Prospect Park
Option 3 A new £20m unit at Upton Hospital, Slough.

3. A summary of current and potential future mental health inpatient services in east Berkshire is attached, along with a summary of the work that has taken place since the conclusion of public consultation.

4. The paper on future mental health inpatient services in east Berkshire is due to be posted online at www.berkshireeast.nhs.uk/aboutus on Thursday 19 January along with all papers for the NHS Berkshire PCT cluster board meeting in public on Tuesday 24 January at The Centre, Farnham Road, Slough, starting at 10am.

5. NHS Berkshire East and NHS Berkshire West primary care trusts are now working together as the NHS Berkshire cluster. We are working with GPs and other clinicians who have formed clinical commissioning groups (CCGs) to support them to prepare to take over the commissioning role in 2013. The cluster role is to help you stay healthy or to get the care you need when you need it. We are responsible for buying (commissioning) your care from hospitals and other service providers including health services in the community and at home. The area we cover extends from Hungerford in the west to Slough in the east, and includes Bracknell, Reading, Wokingham, Newbury, Ascot, Maidenhead and Sandhurst. Together we have 107 GP practices, 120 NHS dental practices, 147 pharmacies and 84 optometry contracts. Our combined budgets total £1,227m and we serve a population of nearly a million.

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HEALTH SCRUTINY PANEL
WORK PROGRAMME 2011/2012

Agenda Items	Final deadline for Reports	Agenda Despatch	Date of Panel Meeting
Scrutiny Items • Shaping the Future (Charles Waddicor) • Child Health in Slough (Clair Pyper/Asmat Nisa) – particular focus on obesity • Public Local Account – Social Care • Maternity Services • Heatherwood and Wexham Park Hospitals NHS Trust- Quality Account 2010/11- Update report by Deirdre Thompson, Acting Director of Nursing (ref from mtg 21/3/11) • Drug and Alcohol misuse in the Borough (the effect on health services and how this is being tackled) (James Priestman/Julia Wales) – deferred from 1 February **Information Items**	**Wednesday 7 March 2012**	**Friday 9 March 2012**	**Tuesday 20 March 2012**
Unprogrammed • East Berkshire NHS Car parking review			

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AGENDA ITEM 11

MEMBERS' ATTENDANCE RECORD 2011/12

HEALTH SCRUTINY PANEL

COUNCILLOR	22/06	20/09	13/10	18/10	08/12	01/02	20/03
Chohan	P	P	P	P	Ab		
Davis	P	P	P	P	P		
Long	P	P	P	P	P		
P K Mann	P	P	P	P	P		
Munawar	P	P	P	P	Ap		
Rasib	P	Ap	P	P	Ap		
Plimmer	P	P	P	P	P		
Sharif	P	P	P	P	P		
Strutton	P	P	P	P	P		

P = Present for whole meeting
P* = Present for part of meeting
Ap = Apologies given
Ab = Absent, no apologies given

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