Appendix 2

Adult Social Care

Tri-Borough Service Plans and Proposals

Cabinet Meeting

20 June 2011

Senior Responsible Owner: Geoff Alltimes

Content

ASC Programme – report to June Cabinets

1. Executive summary

Adult Social Care Programme - Full Year Savings Summary

	Full Year Savings £000s	Costs of Transition (i.e. one-off) £000s
Commissioning, Finance and Inhouse Services	2906	-1033
Overheads (Training, Project management)	656	
IT	428	
CLCH Integration - Management	241	-38
CLCH Integration - Impact on Demand	3784	
Joint Commissioning and support services with GP consortia	1000	
Procurement savings	1935	
Total	**10950**	**-1070**

Phasing and Breakdown by Borough

	Savings £000s				Costs of Transition £000s
	2011/12	2012/13	2013/14	2014/15	
LBHF	63	1026	4031	5303	-461
RBKC	31	601	1230	2094	-225
Westminster	52	1321	2325	3554	-383
Total	**146**	**2949**	**7586**	**10950**	**-1070**

Boroughs expect to deliver savings of £10.95m by 2014/15, while meeting residents aspirations for quality seamless services.

Savings will be delivered by combining services. If proposals are agreed, boroughs will have in place:

- A joint commissioning team led by a single Director of Adult Social Care, reducing back office costs and overheads by 38% and facilitating savings from joint procurement.

- A single integrated provider organisation combining adult social care and community health services, reducing service duplication and reducing demand as well as the intensity and length of expensive care.

- Joint Commissioning: GP consortia will need to establish their own commissioning support organisations from 2013/14. They will need to develop shared arrangements with other consortia in order to be able to commission at scale (e.g. acute hospital commissioning). Our aspiration for a shared single commissioning support organisation allows for expertise and associated costs to be shared. This would realise efficiency savings for both the NHS and social care. Our estimate is that this would generate for boroughs a further £1m of savings.

2. Recommendations

- To agree to appoint across the three boroughs a joint Director of Adult Social Care.

- To set up a joint steering group of two Members of each participating Borough to supervise further refinement and implementation of the proposals.

- To agree to continue Local Authority control of budget management ensuring budgetary control remains with the Councils.

- To agree proposals for the establishment of a joint Adult Social Care Commissioning Department including support functions.

- To agree to negotiations with Central London Community Healthcare to establish integrated health and social care services both for assessment and long term support. These services are to be borough specific where appropriate and tailored to local needs and include gate keeping mechanisms to ensure effective financial and quality control.

- To agree the development of a legal agreement with Central London Community Healthcare ensuring service standards and accountability are clear.

- To agree to the establishment of a single Operational Assistant Director across three boroughs reporting to the Chief Executive of Central London Community Healthcare and the Director of Adults Social Services.

- To refer the proposals for further comment by scrutiny committees and for further formal consultation with the trade unions.

3. Introduction and context

Boroughs' Adult Social Care (ASC) Departments are responsible for arranging services to eligible residents over 18 who need support due to old age, long-term illness or disability.

Boroughs current spend £306m[1] on Adult Social Care services each year. After assessing need and eligibility, services are procured from private, independent and third sector providers, or delivered in-house.

Total Gross Expenditure Budgets 2011/12

Sum of Expenditure Budget Forecast 2011/12 £000s	
Borough	Total
LBHF	104953
RBKC	71618
Westminster	129958
Grand Total	306528

A combination of budgetary and demographic pressures means boroughs face an unprecedented challenge to sustain the quantum and quality of services.

As the table below highlights, boroughs face significant financial pressures during a period of rising inflation.

ASC – Budget reductions to be found	
Borough	**Budget reductions by 2014/15**
H&F	16%
RBKC	13% overall borough reduction
WCC	13.4% to 2013/14

At the same time as budgets are reducing, demand is rising. Boroughs' changing demography means that an increasing number of residents will require support in the future. The Kings Fund highlight that Adult Social Care has enjoyed an average annual rise of 5.1% since 1994, but much of this has been absorbed by demographic pressures[2]. An increasing proportion of support required will be more complex in nature, and therefore more costly to provide.

Boroughs wish as a priority to protect services provided to residents. This is possible through lowering overheads, reducing demand for expensive care, lowering the cost of providing necessary care through economies of scale on procuring services and reducing duplication and costs in the delivery of services. This report outlines how, by combining departments, boroughs can deliver these aims while retaining sovereignty over services.

[1] Gross of income
[2] Social care funding and the NHS: An impending crisis? Richard Humphries, March 2011

3.1. Savings overview

Boroughs expect to deliver savings of £10.95m by 2014/15, while meeting residents aspirations for quality seamless services.

Savings will be delivered by combining services. If proposals are agreed, boroughs will have in place:

- A joint commissioning team led by a single Director of Adult Social Care, reducing back office costs and overheads by 38% and allowing for savings from joint procurement.

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- Joint Commissioning: GP consortia will need to establish their own commissioning support organisation from 2013/14. They will need to develop shared arrangements with other consortia in order to be able to commission at scale (e.g. acute hospital commissioning). Our aspiration for a shared single commissioning support organisation allows for expertise and associated costs to be shared. This would realise efficiency savings for both the NHS and social care. Our estimate is that this would generate for boroughs a further £1m of savings.

Adult Social Care Programme - Full Year Savings Summary

	Full Year Savings £000s	Costs of Transition (i.e. one-off) £000s
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Total	**10950**	**-1070**

Savings Risk Profile

	£000s
Assured	4231
Projected	1935
Possible	4784
Total	**10950**

The savings set out above have been further analysed to give a “confidence level”.

Assured: where agreement to tri-borough working will confidently yield the savings upon implementation. Savings from combining commissioning departments, CLCH management integration, overheads and ASC IT procurement are highlighted here.

Projected: Where savings are likely, but where figures can only be estimated at this stage. Savings from joint procurement are expressed here.

Possible: Where professional opinion suggests that savings are possible from reducing duplication, optimising practice and avoiding costs – savings from integrating assessment and care management teams is highlighted here.

Phasing and Breakdown by Borough

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Source of Saving By Borough and Year

	2011/12	2012/13	2013/14	2014/15	Costs of Transition £000s
LBHF					
Commissioning, Finance and Inhouse Services	63	778	778	1258	-447
Overheads (Training, Project management)	0	0	0	252	0
IT	0	0	0	0	0
CLCH Integration - Management	0	93	93	93	-14
CLCH Integration - Impact on Demand	0	0	2900	2900	0
Joint Commissioning and support services with GP consortia	0	0	0	433	0
Procurement savings	0	155	260	367	0
Total	**63**	**1026**	**4031**	**5303**	**-461**
RBKC					
Commissioning, Finance and Inhouse Services	31	379	379	612	-217
Overheads (Training, Project management)	0	0	0	196	0
IT	0	0	0	0	0
CLCH Integration - Management	0	51	51	51	-8
CLCH Integration - Impact on Demand	0	0	250	250	0
Joint Commissioning and support services with GP consortia	0	0	0	211	0
Procurement savings	0	171	550	773	0
Total	**31**	**601**	**1230**	**2094**	**-225**
Westminster					
Commissioning, Finance and Inhouse Services	52	641	641	1036	-368
Overheads (Training, Project management)	0	0	0	207	0
IT	0	321	428	428	0
CLCH Integration - Management	0	97	97	97	-15
CLCH Integration - Impact on Demand	0	0	634	634	0
Joint Commissioning and support services with GP consortia	0	0	0	357	0
Procurement savings	0	262	525	795	0
Total	**52**	**1321**	**2325**	**3554**	**-383**

ASC Tri borough Return on Investment

£000s	Year 0	Year 1	Year 2	Year 3	Year 4
Cash In-Flows	0	146	2949	7586	10950
Cash Out-Flows	0	517	150	403	0
Net Cash-Flow	**0**	**(371)**	**2,799**	**7,182**	**10,950**
Cumulative Cash-Flow	0	(371)	2,428	9,611	20,561

Payback (non discounted) 1.1 Years

4 Yr NPV (DR 4.0%) £ 17,977

3.2. Savings attribution methodology

Savings are realised as lower operating costs. Savings and costs are attributed to boroughs in proportion to what they spend currently in 2011/12. This is a fair method and is likely to satisfy audit testing.

Other services are commissioned or procured, or relate to staff that work within a particular locality. Costs here are easily charged back to particular boroughs.

3.3. Summary of investment requirements

There are four sorts of costs in implementing a tri-borough service:

Staff exits costs – Actual costs depend on who exactly is made redundant, but current estimates based on detailed work around the commissioning structure are £695k. This is calculated by taking the number of posts deleted x 50% (assuming half are redeployed) x £25,000 (an average redundancy payment).

IT – WCC and RBKC have already agreed to procure a new ASC IT system. Costs will become clear in late June/July once the tender analysis is underway. Both boroughs have set aside capital for this investment, £1.3m in WCC and £0.75m in RBKC, based on the expectation of a payback from savings (see IT Savings section).

Redesigning assessment and care management services – these changes to reduce care costs will be highly complex. External support will be required to deliver within desired timescales. A clear picture of these costs is being considered. As with IT, an advantage of combined working is that these costs can be shared, in this case between the boroughs and the NHS.

Project management costs: Combining departments will require support and some staff will need to be freed up to manage the change ahead. This can partly be achieved through controlling the phasing of departures. Nevertheless, some costs will be incurred, which are estimated at £375k over 3 years.

4. Integrated commissioning

4.1. Case for change

Boroughs' currently employ 130 FTE staff at a cost of £7.1m to procure and manage services and in roles that support that core activity, for example around finance, analysis and IT. [3]

A further group of staff is employed to assess and manage care. These are considered separately.

Reflecting boroughs' legal duties, many of the services provided by boroughs are similar or identical and procured from the same organisations (see procurement section).

Consequently, the roles and skill sets within boroughs' commissioning teams are broadly replicated. By combining functions and teams, efficiencies can be made as, for example, managing three boroughs' contracts with the same organisation does not triple the workload.

Larger overall staff reductions can also be made more safely; the combined workforce remains larger than any individual borough's, thus ensuring a critical mass of staff are available to oversee the very complex care-redesign work ahead, as well as ensuring there is sufficient resilience to addresses pinch points.

Providing services to a larger combined population will also allow for specialist expertise to be retained to commission support to smaller groups with complex needs such as people with autism, services for people with dual diagnosis, services for people with brain injuries and services for people with high level mental health needs.

4.2. Analysis of savings

Savings and service improvements would be realised in two phases.

In phase one boroughs propose to create a joint commissioning team or department led by a single Director of Adult Social Care responsible for commissioning relationships for health and social care across the three boroughs. This will include finance, business intelligence and other services necessary to support the commissioning structure and front line services. This will reduce the workforce from 130 to 81 FTEs or 38%, leading to a saving of £2,756k[4], while retaining service

[3] Service configurations differ to an extent. For example certain commissioning staff in WCC are employed through a corporate commissioning team. Analysis has identified those who, directly or indirectly, are employed to deliver for borough ASC Departments.

[4] The salaries for posts costed in the new structures are assumed to be similar to current equivalent posts, with the addition of LBHF's employer oncosts.

quality and ensuring capacity is retained to better and more rapidly achieve considerable reductions in unit cost.

In phase two boroughs aspire, in consultation and agreement with GP consortia to create a single commissioning support organisation for both adult social care and NHS GP Commissioning. Through sharing with consortia the cost of a combined commissioning organisation, boroughs believe there are further savings of up to a further £1m, as well as benefits from better joining up of services.

The section below outlines a detailed operating model for phase one i.e. a combined borough commissioning team. Work around a single commissioning support organisation will depend on further discussion with GP consortia.

4.3. Operating Model

The chart below outlines a combined structure for ASC commissioning. It will deliver a year 1 saving in staff costs.

Design of the structure has been informed by key principles:

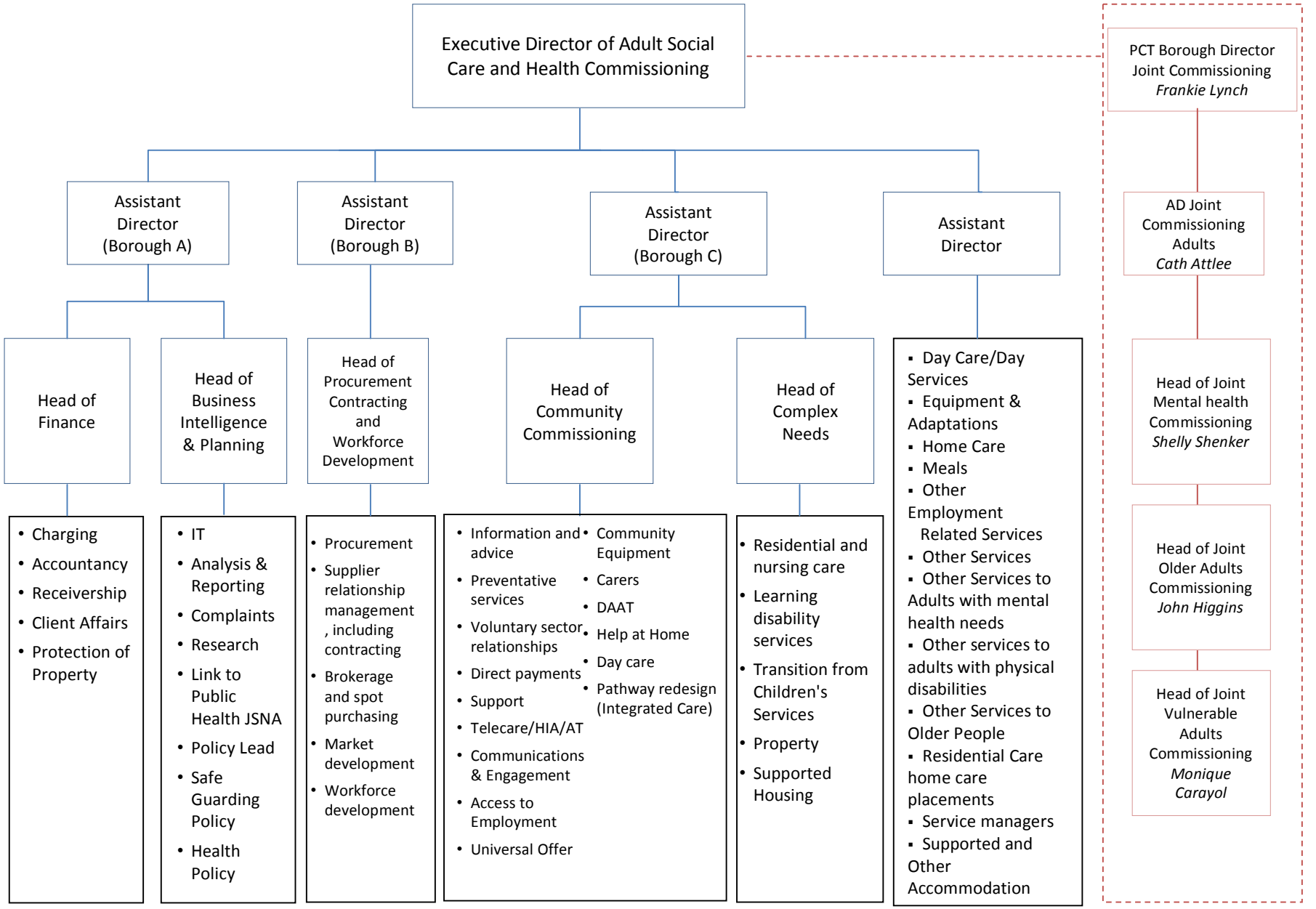
- The Service represents the leanest management and overhead budget immediately possible (further savings can be later realised via combining commissioning with GP consortia).
- The Service has the capacity to commission services in the most cost effective manner to deliver upon the required outcomes;
- The Service is able to respond to the Government's agenda, and the policy agenda of the 3 councils;
- The Service is resilient, particularly in regard to ensuring the most vulnerable adults are properly protected;
- The Service is organised in a manner that ensures that costs are controlled.

The new proposed structure is detailed in table 1 below; it is configured around six broad service groups. Alongside their functional responsibilities each Assistant Director will act as the key link for one of the three Boroughs (nominally represented here as Borough A, B or C). Further details around the roles of each of the groups can be found at appendix A1 – 4, alongside organograms and detailed staff costings for each group:

Procurement contracting and workforce development: will manage all procurement exercises. They will be responsible along with the commissioners for developing the social care market and maintaining ongoing relationships with contractors. They will work with commissioners to develop specifications for services and ensure contracts are appropriately monitored. They will also ensure that there is a suitable adequately trained workforce across all providers **Overall saving:** 15.5 FTEs or £697k (35%)

Table 1: Structure for Tri-Borough and NHS Integrated Commissioning

Version: 8 June 2011



Commissioning: This team will commission all services which support people who are living in the community with social care needs. There is potential that DAATs could be managed though this team, however, it seems to be government policy that they will eventually be managed within Public Health in local government

Preventative Services Commissioning will ensure that all 3 boroughs have a robust preventive offer for all adult social care user groups and build on the strong relationships which exist between the voluntary sector, community groups and the 3 Councils. **Overall saving for complex needs and wider commissioning:** 10.1 FTEs or £503k (35%)

Complex Needs: This directorate would commission services for a range of people including those with autism, dual diagnosis, brain injuries and high level mental health needs. The responsibility for property issues will be with these teams as most of the buildings based services will be commissioned by this team. **Overall saving for complex needs and wider commissioning:** 10.1 FTEs or £503k (35%)

Business intelligence and planning are some of the key functions necessary both to inform commissioners and also to ensure the performance of the service is appropriately managed and reported both internally to Councils and elected members and externally to regulators. **Overall saving:** 7 FTEs or £401k (36%).

. **Finance** will support the commissioning and statutory adult social care functions of the 3 Councils. In Westminster this will mean some disentangling of current centralised arrangements. With the synergies across the 3 boroughs of such support services it is more likely that efficiencies will be delivered this way[5]. **Overall saving:** 15 FTEs or £543k (38%).

The savings in finance depend upon three things:

- Adopting common computer systems (e.g. general ledger, where there is a dependency on Project Athena)
- Having common policies, as far as possible (e.g. charging policies)
- Standardising business processes (e.g. budget setting, budget reporting)

Costs of computer systems may include redesigning systems, new user licences, and re-writing interfaces, amongst other things. No allowance has been made for these costs yet.

Directly managed services: Each of the three councils still directly manages some social care services. These services have a combined value of just under £22m and include day care, day services and residential care home placements in each of the three boroughs. The strategic direction continues to be to outsource services and there are plans to do this as at different stages of implementation.

[5] Frontline client finance services (such as staff who look after client's money on their behalf) will remain within the Department. These are non-management function funded by user contributions. They have therefore not been considered as part of this management reduction exercise. Services will instead be re-designed as part of the review of frontline assessment and care management services.

Whilst the services remain within the councils they will need sound management. It is proposed that one senior manager will be designated to manage these services together as a specific management role reporting to the DASC. Once suitable arrangements are made for the remaining services, this role would cease, potentially saving £125k by 2014/15.

Other key service relationships:

Public health: A single service led by a Joint Director of Public Health has been established across the boroughs. In the short term, the combined commissioning department will ensure priorities and funding are aligned. Once full details of the transfer of public health functions to Local Government are known, boroughs will make detailed plans for integration.

Joint Commissioning: The 3 boroughs and the PCT sub-cluster already have agreed joint commissioning arrangements (mental health, older people, other vulnerable adults), these have responsibility for all areas where there is a clear advantage from doing so. They ensure services are commissioned across organisational boundaries and that best use is made of pooled budget arrangements.

4.4. Protecting sovereignty

One commissioning team is more than capable of procuring services to multiple specifications, as highlighted in the box below. Because of increased scale, services can be procured at lower cost.

Box 1: Joint commissioning to different specifications

Kensington and Chelsea tendered for a community equipment loan service on behalf of a consortium of 8 boroughs to achieve greater volumes and lower unit costs. As well as a saving on procurement costs, each borough was able to use this contract to make savings – 15% in LBHF, and can still tailor it to suit local factors. It is now being used by 13 boroughs with 4 others planning to join.

Each borough will have a senior manager at Assistant Director Level nominated to work with them to ensure availability to elected members and representation of Adult Social Care within the core functions of the Councils. Members will continue to meet regularly with the Executive Director. See appendix B for an outline of the proposed annual cycle for agreeing with Members priorities and oversight of their delivery

Members already find it valuable to meet together to discuss opportunities for collaboration and to compare and contrast current service delivery methods. This new way of working, in combined services, offers advantages to strengthen political leadership and accountability because a team approach by Cabinet Members will provide them with more opportunity to compare and contrast performance on behalf of their boroughs and to challenge officers on asserted best practice.

4.5. Health and wellbeing boards

Boroughs will wish to consider once the Government's Health proposals are settled the right configuration to ensure cooperation where it would be advantageous to do so.

5. Combined procurement of services

5.1. The case for change

Tri-borough ASC contractual spend is approximately £200m and the three boroughs contract many of the same providers to deliver similar services.

Combined procurement offers opportunities to reduce costs in several ways, including through reduced transaction costs from doing things once instead of three times, and by adopting the most efficient of each borough's contracting practices in the tri-borough arrangements.

The most significant cost reduction comes from lower contract prices driven by the greater purchasing power of three boroughs. For example, the six Boroughs of the West London Alliance (which includes H&F) have made a £4.2m saving in Home Care contracts through joint procurement arrangements. However, the care market is fragile and this brings risks to achieving the savings targets, even with a tri borough approach.

In those cases where joint procurement does not prove advantageous, boroughs can procure separately; there are no downsides to having additional procurement options.

Boroughs would look for additional procurement savings through joint commissioning with GP consortia, though it is too early to estimate possible savings.

As highlighted above in box one, savings can be made even if services are procured to different specifications.

5.2. Savings analysis

Analysis of the prices paid to common providers of similar services across the three boroughs suggests that savings can be realised by bringing prices closer to the tri-borough average price. The tables below shows the projected savings for older people's and mental health residential and nursing spot purchased placements if each borough paid no more than the current average price paid to that care home across the three boroughs:

Older People

		Number of OP spot purchased placements	Annual savings from adoption of average price
Annual	H&F	301	£102,436
Annual	K&C	177	£147,566
Annual	Westminster	290	£543,029.
	Total	**768**	**£793,031**

Mental Health

		Number of MH spot purchased placements	Annual savings from adoption of average price
			50% of actual savings *
Annual	H&F	128	£64,119.
Annual	K&C	72	£68,552.
Annual	Westminster	151	£252,112
	Total	**351**	**£ 384,783**
Total OP and MH		**1119**	**£1,177,814**

50% of savings have been used as the nature of mental health placements for H&F and RBKC. WCC have asked for a lower figure. It should be noted that mental health prices are more variable than older people and the number of homes is far less. The 50% allows placements at varying needs to be considered.

The tables above and below are based on the premise that, if a borough pays less than the average price, their price paid would not increase to the average price level.

A similar analysis of homecare prices also suggests savings can be realised by bringing prices closer to the tri-borough average:

Home Care

		Number of homecare Hours	Annual savings from adoption of average price
Annual	H&F	583,652	£0
Annual	K&C	420,082	£357,070
Annual	Westminster	898,838	£0
	Total		**£357,000**

Homecare prices should be compared with caution as service specifications and monitoring arrangements differ, for example, RBKC contracts include service development and e-monitoring and billing considerations and requirement to pay workers the London Living Wage – approx £1 above West London Alliance (WLA) rate. The e- monitoring has saved RBKC over £1 million over three years.

Whilst homecare and residential care represent the largest ASC spend areas, there will be opportunities to realise savings across all contracts as they come up for renewal. Complete alignment of the three boroughs procurement programmes will take several years, however, there are 217 adult social care contracts across the three boroughs with a value of £80 million which come up for renewal between now and 2014.

It is already common practice to jointly procure services across the three boroughs where possible. Current joint tenders include the Drug Intervention Programme, Direct Payment Support Services, Meals on Wheels, and Supporting People (which is being procured under a framework agreement across the tri-borough and west

London). LBHF expects a £200k annual saving on Supporting People prices through this framework agreement, and RBKC expects a similar saving.

5.3. Timeline

The rate of annual turnover in residential and nursing care (approximately 30%) and homecare (approximately 36%), and the expected timeframe for completion of planned tenders over the next few years provide some indication of likely phasing of savings. These indications are shown in the tables below:

Phasing by Service

	2012/13	2013/14	2014/15
Residential Care(OP and MH)	£388,678	£777,357	£1,177,814
Homecare	£0	£257,070	£357,070
SP & other contracts	£200,000	£300,000	£400,000
Total	**£588,678**	**£1,334,357**	**£1,934,884**

Phasing by Borough

	2012/13	2013/14	2014/15
LBHF	£154,963	£259,926	£366,555
RBKC	£171,318	£549,637	£773,188
WCC	£262,396	£524,793	£795,141
Total	**£588,678**	**£1,334,357**	**£1,934,884**

5.4. IT savings

Westminster and Kensington and Chelsea are jointly procuring an adult social care IT system. Existing systems had become costly and difficult to maintain, and the technology used has limitations in being able to meet the demands from personalising services.

Systems are being purchased via a Framework Agreement available to all London Boroughs. This means that Hammersmith & Fulham are able to buy into the framework when their current system needs replacement.

The procurement exercise is likely to reach contract award in July/August 2011 and the expected implementation timetable for the new service is estimated to fall in the first quarter of 2012.

Westminster is expecting to release savings of £428k per year through a reduction in IT costs from this process. RBKC is looking to enable more direct user based

transactions, reducing back office support and through streamlining processes and mobile working. RBKC is anticipating that up to £250k per year can be saved in the two years following implementation through reducing staffing costs. A clearer estimate on IT savings will be available once tenders have been considered.

Further savings of up to £1.4m around ASC IT and associated support are being delivered through the Corporate Services programme. The June Corporate Services Cabinet report will outline the business case in more detail

Boroughs are commencing work with CLCH and other providers to ensure systems are aligned and compatible.

6. Delivery of services

6.1. Assessment and care management

The case for change

In general, councils only provide services to people in need of care and attention which is not otherwise available to them. There is a statutory requirement to assess people's needs for services against transparent eligibility criteria before determining which service or services to provide and in what amounts. The need for services provided by boroughs is usually reviewed at least yearly. Services include reablement, occupational therapy and support for older and disabled people and people with learning disabilities.

This process is known as assessment and care management. Boroughs currently employ 409 staff at a cost of £17.4m to provide these services.

CLCH Integration Workstream Staffing Budgets

		Borough Data							
		LBHF		RBKC		Westminster		Total Sum of Budgeted FTE 2011/12	Total Sum of Pay Budget Forecast 2011/12 £000s
Status with Potential Provider	Service	Sum of Budgeted FTE 2011/12	Sum of Pay Budget Forecast 2011/12 £000s	Sum of Budgeted FTE 2011/12	Sum of Pay Budget Forecast 2011/12 £000s	Sum of Budgeted FTE 2011/12	Sum of Pay Budget Forecast 2011/12 £000s		
CLCH	Assessment & Care Management	74	3826	122	4291	121	6285	317	14402
	HIV/AIDS	0	0	3	58			3	58
	Home Care	2	63					2	63
	Lone Adults					2	84	2	84
	Occupational Therapy	20	0	25	868			45	868
	Other Employment Related Services	0	0					0	0
	Other Services	3	142					3	142
	Other Services to Adults with Learning disabilities	0	0		0			0	0
	Other Services to Older People				0				0
	Reablement	26	1095					26	1095
	Service Managers	6	232	1	85			7	317
	Strategic Management					2	192	2	192
	Supported and Other Accomodation.	0	0					0	0
	Senior Managers	1	95	2	108			3	203
CLCH Total		130	5452	153	5410	125	6561	409	17423
Grand Total		130	5452	153	5410	125	6561	409	17423

The NHS separately has a duty to assess health needs, such as for community nursing care, and employs staff across the boroughs through the local community healthcare provider, Central London Community Health (CLCH).

Boroughs and NHS assessments and care arrangements are currently made in isolation. Yet people in need of support tend to be frail because of their health deteriorating in older age or because of disabilities or illnesses. They are, therefore, often in need of health care services as well as social care services.

Feedback from people who use both services tell of duplication, multiple visits by different workers, all asking very similar questions and lack of co-ordination of their care. This is wasteful of resources and frustrating to the service user.

Equally significantly, a service commissioned by one organisation can often have a positive or negative impact on the budget of the other. An example of this would be

how a change in investment in community nursing by the NHS will impact on the level of care provision which the local authority needs to commission to support individuals in the community. Currently, no party is incentivised to make savings to the healthcare system as a whole, as the benefit of increased investment is often not realised by that organisation. This means that investment in interventions to reduce overall the demand for care and in particular the most expensive care (such as hospital in-patient care) is not optimised.

By working together and sharing the costs and savings from reducing demand for services, especially more expensive intensive forms of support, residents can be better supported and costs can be reduced significantly.

Boroughs propose to achieve these savings and service benefits by combining NHS and borough assessment teams. Joint teams would provide holistic assessments of support to individuals in need. Redesigned assessment and care processes would ensure care staff can i.) put in place preventative programmes to avoid the need for expensive acute support and ii.) reduce the length and intensity of support where it is required. A combined service also means savings from fewer managers.

Attempts over many years to achieve similar results through agreements around working practices have not proved to be successful, although savings have been made in some areas.

Even within the NHS, assessments are currently undertaken in different ways by different professional groups. In community health services nursing teams are not integrated with therapy services so there can be multiple assessments carried out on one individual. Community health services in CLCH are moving to a single point of access for all services which means that assessments will be carried out by the most appropriate professional and duplication will be reduced.

It makes sense, including because of the scale and the speed of the savings required, to take the opportunity to combine teams more widely across health and social care. There is a significant body of evidence around the success of this approach, as outlined in the box below. This approach has wider support, such as from the Independent Westminster Social Care Commission[6].

[6] A Vision for the Future Health & Social Wellbeing of a City – Final Report of the Independent Westminster Social Care Commission, April 2011.

Box 2: Achieving the savings - the evidence base for integrated provision

- In Torbay, the local council and the PCT established a care trust which brought responsibilities for health and adult social care into one organisation. It has a single budget for health and social care, and teams are able to use this budget flexibly to meet patients' needs. A priority has been to **increase spending on intermediate care services that enable patients to be supported at home and help to avoid inappropriate hospital admissions**. The results can be seen in:
    - Reduced use of hospital beds (daily average number of occupied beds fell from 750 in 1998-9 to 502 in 2009-10)
    - Low use of emergency bed days among people aged ≥65 (1920/100000 population compared with regional average of 2698/100000 population in 2009-10)
    - Minimal delayed transfers of care.

- The Care Quality Commission report that a focus on better coordination of services has led to a **reduction in delayed transfers of care from acute hospitals** from 3,600 a week in 2003/4 to 2,200 a week in 2008/9. A total of 148,000 people had access to services that helped them to avoid being admitted to hospital as an emergency, compared to 80,000 in 2004. A further 157,000 had access to services that helped them to return home quickly from hospital, compared to 112,000 five years ago (Care Quality Commission 2010).

- The Milton Keynes Rapid Assessment and Intervention Team, jointly funded by the Council and PCT, has shown that, over a 12-month period, 722 hospital admissions and 100 **admissions to residential or nursing home care were avoided**. Total savings to health and social care were £3m.

- The Rapid Response Service in Salford offers **intermediate care** through a pooled budget. In 2007/8 at least £1 million was saved (£689,000 to health and £378,000 to social care) as a result of **diversion from hospital and residential placements**.

- A systematic review and critical appraisal of a range of **prevention / early intervention** programmes – the Supporting People, POPP and LinkAge Plus programmes – suggested that these integrated approaches could generate resource savings of between £1.20 and £2.65 for every £1 spent (Turning Point 2010) along with improvement in older people's quality of life.

6.2. Proposed operating model

CLCH will be commissioned to work with Councils to combine teams and redesign care processes. It is proposed that there is some integration between health and social care staff into joint teams. The services will be divided into two complementary parts which will include gate keeping mechanisms to ensure effective financial and quality control.

6.3. Assessment

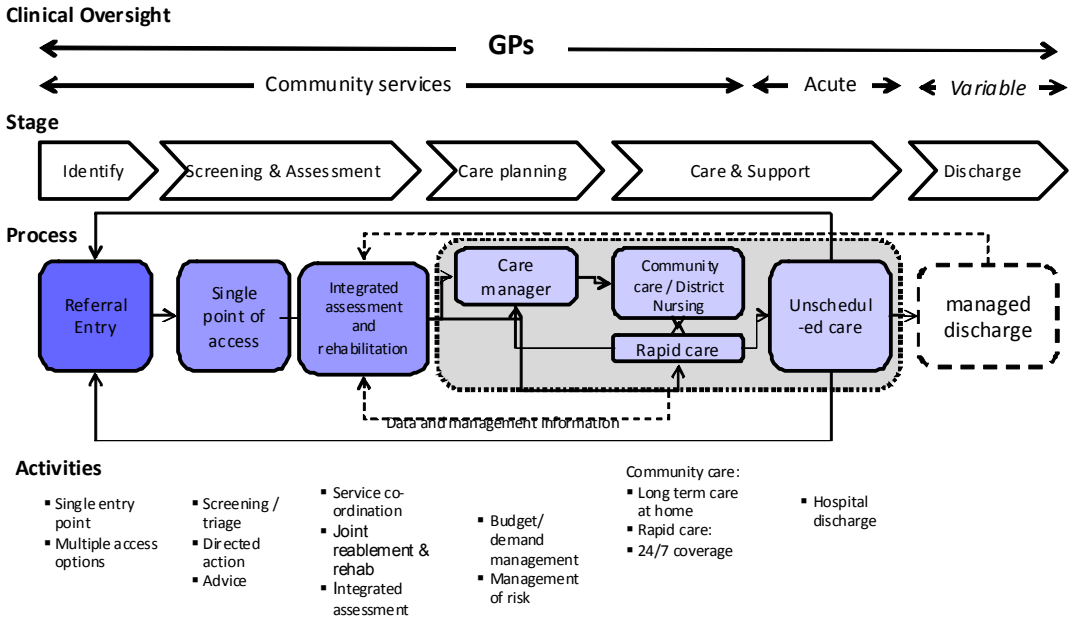
It is proposed to have a new joint assessment and reablement service accountable to boroughs as well as the NHS. Boroughs would control charging policies and assessment criteria and therefore retain control over demand. GP consortia would want to put in place similar arrangements once handed budgetary responsibility.
The staff in these front line integrated teams would consist of qualified and unqualified social care staff, occupational therapists and physiotherapists. These teams would be able to assess an individual's requirements and provide necessary short term therapy input to ensure people are able to be as independent as possible. Disability equipment would be provided to maintain independence. A continuing push towards individual budgets will mean over time that less services are arranged directly by assessment staff, creating a clear distinction between the assessor gatekeeper role and ongoing care management.
Personal budgets or care packages would be organised for people who require ongoing care after the period of assessment. Research shows that teams operating in this way only have to fund ongoing care for approximately 50% referred for assessment.

6.4. Teams for people with long term conditions

For people with long term conditions or who are considered to be vulnerable and at risk; joint teams of social workers, district nurses and community matrons would provide ongoing support, advice and nursing care. These teams would ensure people are kept safe, out of residential and nursing care and only admitted to hospital when absolutely necessary. These teams would work closely with GPs to identify those most at risk and target services at them. 3 out of the 4 local GP Practice Based Commissioning clusters have expressed an interest in this type of service through the Integrated Care Pilot which is just starting in North West London. This pilot also involves hospital clinicians providing support to people in the community and primary care teams.

The diagram below outlines how a redesigned integrated structure would operate.

Integrated Assessment – a new model of care delivery model for adults



Box 3: Building on existing models

The model being developed for integrated health and social care provider services is based on the models which have started to be developed across the 3 Councils.

In Hammersmith Continuity of Care model being developed with partners is predicated on the assumption that many hospital and nursing home admissions could be prevented – and better patient outcomes achieved - through more timely and targeted intervention with at-risk individuals.

In Westminster the joint reablement service ensures that all people who are referred to health and social care receive an assessment designed to maximise their independence. Over 50% do not require ongoing services after a period of work with the therapists in the reablement team and the provision of some disability equipment .

In RBKC, the Council in partnership with Kensington and Chelsea PCT and the Community Health Services have developed a range of preventative services which include a joint Intermediate Care Team and a specialist re-ablement team, both of which are focused on enabling people to regain their full potential for independence particularly after a hospital admission. This involves all professionals working in a joined up way to support people back to their maximum independence in order to improve an individual's quality of life and reduce the demand for long term on-going services

Integration with community health services will enable all assessments to be carried out efficiently with a focus on maintaining independence. Integration of social care and community health services will re-shape the health and care system so that it is designed to maintain peoples independence and effectively manage long term conditions in less expensive community settings.

This means in the first instance entering into a contractual partnership agreement with CLCH[7] around line management (but not employment) of borough assessment and care management staff[8]. As for all service delivery contracts, the partnership agreement would set out borough expectations around quantum, type and quality of services. This will be tailored to each boroughs priorities and care budget envelope.

The Chief Executive of CLCH would be held jointly accountable for service delivery with the Director of Adult Social Care. One Assistant Director would manage social care across the three boroughs with three heads of service reporting to them responsible for individual borough services.

In addition to regular performance monitoring reports to the Director of Adult Social Care, there would be a Governance Board to oversee the performance of the partnership. This would consist of the three Cabinet Members together with non-executive directors of the health partner; the Director of Adult Social Care and the Chief Executive of the health partner. Boroughs hope to have this arrangement in place by October 2011. Members would sign off the draft partnership agreement to ensure it is sufficiently robust.

This model replicates the successful mental health trust arrangements boroughs have in place – see box 4 below.

6.5. Budgetary Control

The commissioning and purchasing budgets would be retained by the commissioners. Councils would retain responsibility for gatekeeping access to services. All significant expenditure such as residential and nursing home placements and large care packages would be sanctioned by the commissioners through the funding panels which currently exist in each borough, who would also ensure that funding from NHS Continuing Care budgets are accessed where possible. This model takes account of the proposals for GPs to be allocated budgets for commissioning services. Wherever possible it would be appropriate for these budgets to be managed jointly.

Boroughs will set reduced budgets around which services will be redesigned. The NHS has set CLCH a target of 6% p/a savings reductions and boroughs would look to CLCH to achieve the same for social care. Intensive work over the following months will see assessment and care processes redesigned and equivalent work around frontline finance i.e. client affairs and charging, although this service would remain with boroughs. This work will be informed and developed in conjunction with GP consortia who will eventually take on health commissioning responsibilities, and by wider partners such as Hospital Trusts. In the first year of operation we would look to these teams, with new GP referral procedures, to keep more people at home in the community, making bigger savings in the placement and packages budgets.

[7] Under s75 of the National Health Services Act 2006, as successfully used to deliver combined Mental Health services

[8] Learning disabilities services are already jointly delivered with CLCH. The plan here is to bring together the three community teams across the three boroughs into a single management arrangement in CLCH

Once redesign work is complete, and subject to Member agreement, boroughs will modify the partnership agreement to take account of its findings e.g. agreed cost and savings sharing methodologies and common eligibility and assessment protocols across the healthcare system. It will also consider whether staff reductions can be made by reducing duplication. The revised agreement will commit and hold CLCH to account for implementing the redesign work and making the associated savings.

Like any other contractual agreement, should standards fall short, Members can take action, including if necessary terminating the agreement.

It is foreseen that combined teams will be borough based, with specialists working across boroughs. Members will, as now, control priorities and spend within their own budget envelopes.

At this point boroughs would also be able to make management savings. There are currently 9.8 FTE managers across the boroughs – it is estimated that this can be reduced to 6.8, delivering savings of £241k.

Box 4 – Mental Health Trust Partnership Arrangements

Mental health services have been delivered in partnership with health providers for many years. Boroughs spend £51m (gross) on services. In all three boroughs, mental health social workers are managed by mental health trust managers as part of multi disciplinary teams.

Agreements are in place using the powers of s75 of the National Health Services Act 2006 to ensure clarity about roles and responsibilities between the local authority and the mental health trusts. Like in all commissioning relationships, objectives and budget envelope are clearly outlined and costs are monitored and controlled through regular reports and meetings between commissioners and counterparts within trusts.

6.6. Impact of service demand: savings analysis

Hammersmith and Fulham have estimated savings of £1.7m per annum to the council from changing the way in which nursing home placements are utilised and £2m to the NHS from reducing hospital admissions. RBKC estimate a 250k saving around duplicate staffing and £250k saving from adopting a variety of measures including a preventative approach to long term social care provision. WCC analysis suggests a £200k saving from increasing reablement / rehabilitation support to avoid the need for more costly care and £434k savings from reducing admissions to residential care to levels in neighbouring boroughs.

6.7. Market testing

At present CLCH exclusively provides health assessment and care management services for the NHS across the three boroughs. The Government plans as part of its health reforms to open this service to wider competition, although at present no

timescales have been set. Consistent with wider commissioning principles, boroughs will wish to consider in consultation with partners e.g. GP Consortia the right point to test the market in terms of price and quality, which will be reflected in agreements with CLCH.

6.8. Timeline

October 2011: Line management of assessment and care management staff transferred to joint management with CLCH

April 2012: Redesign work complete. Boroughs enter into agreement with CLCH over the provision of future services and delivery of the savings. Any agreed management savings / staff transfer arrangement implemented.

Date tbc: Testing the market for integrated assessment and care management services can only take place once the Foundation Trust a
pplication process ends. The latest date CLCH can achieve trust status is 2014; they are aiming for 2013.

7. Operating model – Member and resident perspectives

The transformation of commissioning and care provision as outlined above is ambitious and will keep boroughs at the cutting edge of health and social care work. Below we consider what the sum of changes means for Members and residents. This outline is indicative and will be informed by Members views and the results of the assessment and care redesign work.

7.1. Member perspective (also see appendix B)

As well as meeting weekly with the Assistant Director responsible for oversight of borough affairs and bi-weekly with the joint DASC, Members would engage with other Assistant Directors as appropriate to discuss day-to-day issues and priorities.

Monthly performance and budget reports across the three boroughs for commissioned and directly provided services allows Members to ensure borough service provision remains sound and provides the opportunity to compare and contrast relative performance and challenge officials on service standards and price.

Bi-monthly meetings with the Chief Executive of CLCH provides assurance on service delivery, and an opportunity to consider future challenges and solutions.

Periodic meetings with Members across boroughs allows portfolio holders to consider opportunities for future collaboration, both to look for ways to lower investment and service costs and to share ideas around priorities and best practice. Comparison across boroughs of performance and delivery models means Members are now better able to challenge officers around strategies.

Around Budget setting, Members will agree with the DASC their strategies, priorities and budget envelopes in Borough Business Plans. Directors will aggregate these documents into a Departmental Delivery Plan, looking to take full advantage of opportunities to jointly provide and procure services to reduce costs and improve quality. In approving the Delivery Plan, Members would always be able to stipulate a desire to commission services on a single borough basis.

7.2. Resident perspective

Regardless of whether a resident approaches their borough, GP or are referred via another route such as the hospital, they will be contacted by a care assessor who will remain their key worker throughout.

The key workers will assess need and eligibility. The resident will only need ‘tell their story once’, rather than to multiple organisations.

The key worker will coordinate the right mix of health and social care related support. This may include preventative support – such as occupational therapy to prevent problems becoming acute – better for the resident and cheaper for the health system.

Alternatively, where appropriate residents may elect to select the right mix of care support themselves, advised as necessary by the key worker.

Care wherever possible will be provided in residents’ own homes, providing additional comfort for the individual and helping to reduce costs to the health system.

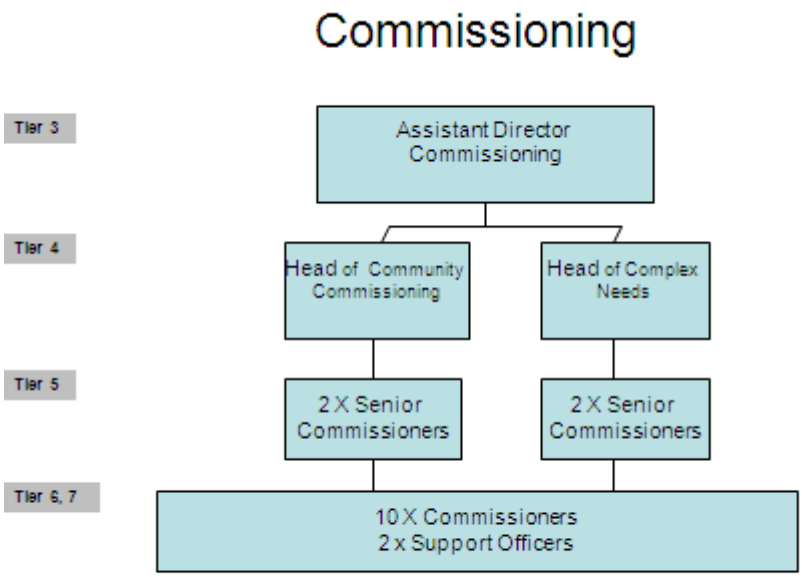
Should problems re-occur, a single comprehensive set of records will ensure further support properly takes account of all factors in considering care needs.

8. Timetable for ASC Integration Process

This timetable set s out the process for integration between the three boroughs adult social care provision and CLCH, up until April 2012.

• End of May 2011	Business Plan completed
• 2nd June	CLCH Board Meeting – Heads of Terms & Option Appraisal
• June	OSC – K&C and Westminster
• Mid June	Boro Exec discussions Due Diligence paper completed
• End of June	Cabinet Meetings
• Early July	Staff consultation Appointment process for joint DASS commences Operations Service – senior appointments
• Early July	Member process agreed for AD appointment. Permanent AD in CLCH Provider AD Commissioning ADs Head of LD Services
• Late July	Appointments process started
• 4th August	CLCH Board Meeting: Sec 75 agreed
• September	Cabinet Approval of S75 agreement with CLCH Senior appointments made Service Redesign starts (CLCH) Commissioning Implementation starts
• October	Operations Service transfers to CLCH
• December	DASS starts
• Feb 2012	Review of service redesign Cabinet reports CLCH Board reports
• April 2012	Implementation of new CLCH structure

Appendix A1



Name of Directorate: Commissioning

Name of Business Group: Complex Need and Community Services

Aims of the Business Group:

- Managing relationships with other departments and partners
- Leading user engagement
- Leading consultations especially around
    - Policy
    - Eligibility criteria
    - Closure of services / facilities
- Working to / with politicians

Roles required at tier 6 and 7 to deliver the different function for this group.

Senior Commissioners × 4

Key functions to be performed:

- Deputise for Head
- Provide knowledge and leadership on all elements of commissioning cycle
- Lead on complex, major projects
- Developing strategy
- Understanding national picture and best practice on all key areas
- Project Lead
- Cross Council work

Commissioners × 10
Key functions to be performed:
- Knowledge of all elements of commissioning cycle
- Project Management skills
- Analysis skills
- Strategic thinkers
- Relationship Managers
- Specialist in one or more areas

Commissioning Support Officers × 2
Key functions to be performed:
- Managing small projects
- Financial understanding
- Engagement with service users
- Organisational skills
- Strong administrative skills

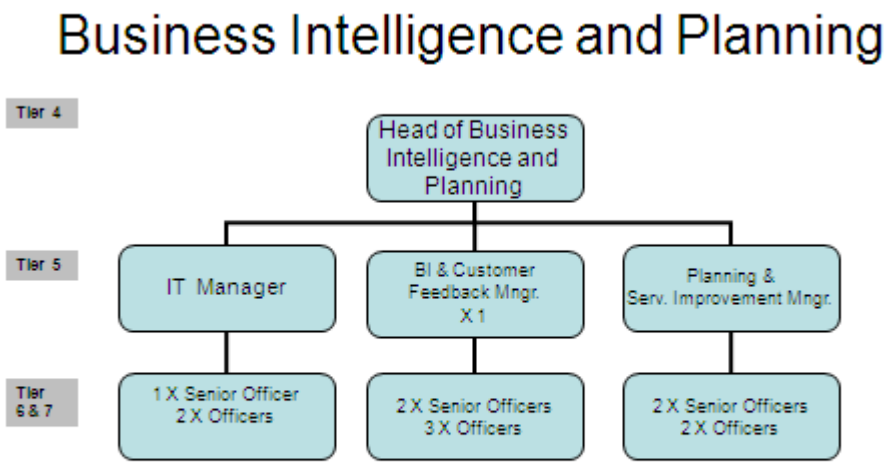
Principles and Fundamentals of Function
- Ability to work quickly on priorities of the time
- Bring together different specialists
- The "Heads of" will need an understanding of both history and strategy
- People underneath will work on projects
- Importance of user engagement - critical in developing and maintaining goodwill

Assumptions
- Single Procurement Process
- Rational Decision Making Process
- Commissioning Framework Across 3 Boroughs (massive undertaking)

Financial breakdown for Commissioning

	Current FTE	Commissioning Roles	Range	Mid Point	With On Costs	*Total Costs plus on-*	Phasing: Savings	2011/12	2012/13	2013/14	2014/15	
WCC	WCC											
	0	Assistant Director										
	2	Head of LD, Generic)	£55-£68k	61.5	76.875	154						
	7	Comissioners	£33-£41k	37	46.25	324						
	2	SP Commisioner	£33-£41k	37	46.25	93						
Sub-Total	11					570						
	LBHF											
	0	Assisrant Director										
	1	Head of Commissioning	£55-£68k	61.5	78.72	79						
	3	Senior Commissuioners	£42-51k	46.5	59.52	179						
	3	Commissioners	£33-£41k	37	47.36	142						
	1	Project Manager	£33-£41k	37	47.36	47						
	1	Project Support	£22k -£30k	26	33.28	33						
	0.5	Admin	£22k -£30k	26	33.28	17						
Sub-Total	9.5					497						
	RBKC											
	2	Senior Commissioner	£42-51k	46.5	57.66	115						
	4	Commissioners	£33-£41k	37	45.88	184						
	1.6	SP Commissioners	£33-£41k	37	45.88	73						
Sub-Total	7.6					372						
Total Current	**28.1**					**1439**						
	New Merged Commissioning New FTE											
	2	Heads of	£55-£68k	61.5	78.72	157						
	4	Seniors	£42-51k	46.5	59.52	238						
	10	Commissioners	£33-£41k	37	47.36	474						
	2	Commissioning Support	£22k -£30k	26	33.28	67						
Total New	**18**					**936**	**503**	**-503**	**503**	**-503**	**503**	
% Reduction						**35%**						

Appendix A2



Name of Directorate: Finance and Business Intelligence

Name of Business Group: Business Intelligence and Planning

Units in the Business Group is listed below.

1. Business Intelligence and Customer Feedback

Aim of the unit: Driving and supporting the Commissioning Cycle.

Key functions to be performed under this unit:
• Analysis and provision of data as evidence all commissioning contract.
• Contract Monitoring – against performance indicators so data available for negotiation and reviewing relationship management.
• Voluntary Sector Contract Monitoring
• Needs Assessment
• Value for Money reviews
• Demand Modelling
• Monitoring quality outcome and service improvement.
• Providing data for Health & Safety Care.
• Reporting to individual Boroughs/Members.
• Safeguarding – performing quality assurance.

1.1 Customer Feedback

Aim of unit: To monitor customer feedback and manage resolution of complaints from all areas of ASC services including Provider organisations.

Key functions to be performed under this unit:
• Collate customer feedback.
• User Surveys (from carer)
• Supporting consultation.
• Manage statutory complaints – Local Government Ombudsman
• Service improvement.

2. Planning and Service Improvement
Aim of the unit: Ensure national policies are practically reflected in commissioning and front line services. Furthermore undertake strategic business planning for the ASC as a whole and supporting feedback to scrutiny committees in the three boroughs.

Key functions to be performed under this unit:
• Providing position on national government policy /legislation.
• Research / Information partnership "Health well being" strategy.
• Policy implementation – overview across ASC.
• Facilitating integration and corporate partnership work (Health & Well Being Board).
• Strategic Business Planning – aligned with Business Intelligence.
• Supporting Scrutiny Teams to provide reports and feedback.

3. ASC IT Development and Support
Aim of area: Identify business needs, develop IT strategy, create implementation options, and provide support

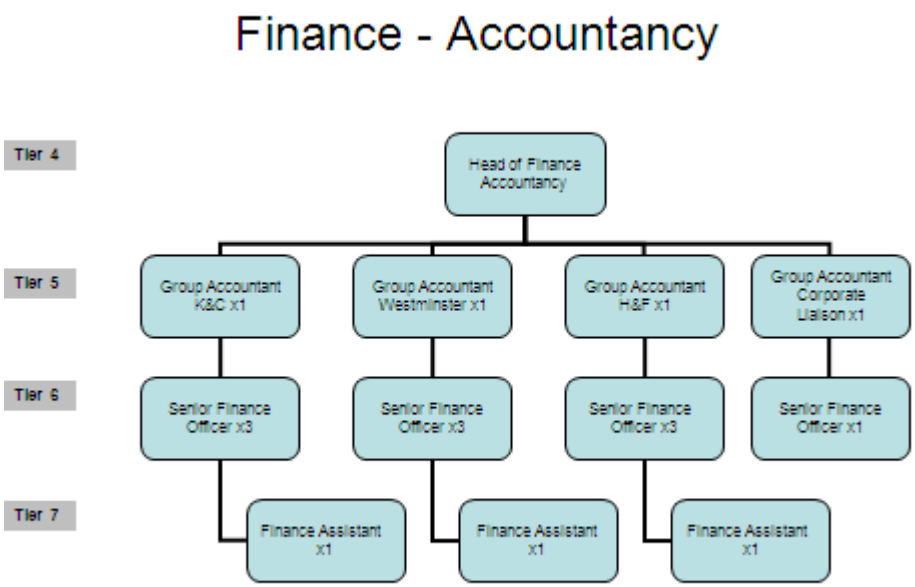
Key functions to be performed under this unit:
• Co-ordinate IT commissioning for ASC
• Undertaking needs analysis and identify business system problems
• Co-ordinating data sharing with new emerging local NHS structures and IT relationship management.
• User acceptance of upgrades
• Partnership arrangement with corporate IT and external suppliers.
• Reporting - business object report.

4. Breakdown of financial savings – Business Intelligence and Planning.

							Phasing				
	Current FTE	**Business Intelligence and Planning**	Range	Mid Point	With On Costs	*Total Costs plus on-cost £'000*	Saving	2011/12	2012/13	2013/14	2014/15
	16	Analysis Performance and Policy				837					
	3	Complaints				103					
	4	IT Support				178					
Total Current	**23**					**1118**					
	New FTE										
Tier 4	1	Head Of	£55-£68k	61.5	78.72	79					
Tier 5	1	IT Manager	£42-£51k	46.5	59.52	60					
Tier 5	1	Business Intelligence and customer feedback manager	£42-£51k	46.5	59.52	60					
Tier 5	1	Planning and service improvement manager	£42-£51k	46.5	59.52	60					
Sub-total of FTE	4					257					
Tier 6	1	IT Officer	£33-£38k	35.5	45.44	45					
Tier 6	2	Business Intelligence Senior	£33-£38k	35.5	45.44	91					
Tier 6	2	Planning and Service Improvement Senior	£33-£38k	35.5	45.44	91					
Sub-total of FTE	5					227					
Tier 7	2	IT Officers	£22k-£30k	26	33.28	67					
Tier 7	3	Business Intelligence Customer Feedback Officer	£22k-£30k	26	33.28	100					
Tier 7	2	Planning and Service Improvement Officer	£22k-£30k	26	33.28	67					
Sub-total of FTE	7					233					
Total New	**16**					**717**	**401**				**401**
% Reduction						**36%**					

Appendix A3

This diagram excludes Client Affairs and Charging as both of these areas are connected to frontline service delivery.



Name of Directorate: Finance and Business Intelligence

Name of Business Group: Finance

Business Unit: Accountancy

1. Accountancy

Aim of unit: Financial management support for the ASC business and fulfilling requirements delegated from the Director of Finance to the Assistant Director.

Main Functions:

- Closing Accounts
- Budget Process
- Liaise with Auditors
- Financial support to budget holders
- Budget Monitoring
- Financial Planning
- ASC unit costing
- Stats

- Information to Corporate
- Financial Appraisals
- FOI Requests
- Home Care payments (providers)
- SP payments
- Code maintenance of GL system
- Raising debt invoices
- Invoicing PCT for nursing
- Monitoring section 75 agreements
- Capital Budgets
- Open book accounting

Note:

To ensure borough finances are properly managed, it is envisaged that the (Assistant) Director of Finance (indicative 'Borough A' in table 1) would be a qualified accountant".

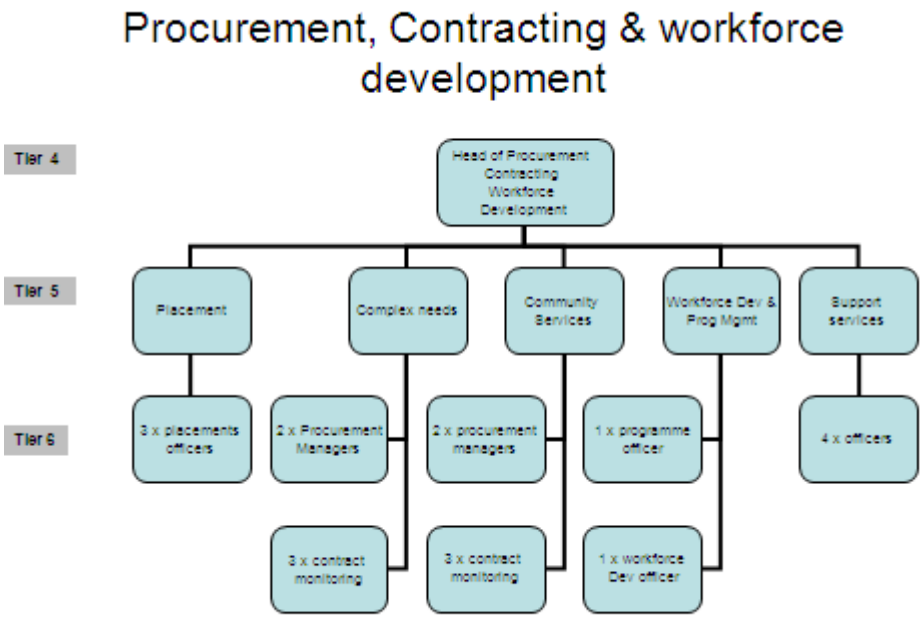
The savings in finance depend upon three things:

- Adopting common computer systems (e.g. general ledger, where there is a dependency on Project Athena)
- Having common policies, as far as possible (e.g. charging policies)
- Standardising business processes (e.g. budget setting, budget reporting)

2. Breakdown of financial savings – Accountancy

		Finance	Range	Mid Point	With On Costs	*Total Costs plus on-cost £'000*	Savings	Phasing 2011/12	2012/13	2013/14	2014/15
	Accountancy - Current Structure FTE										
WCC	1	Finance Manager	£61-£85k	68	85	85					
	3	Group Accoutant	£42-59k	47	58.75	176					
	2	Principal Accountancy Ass	£23-46	31	38.75	78					
	4	Senior Finance Officer	£23-46	31	38.75	155					
	2	Finance Assistant	£23-46	31	38.75	78					
Sub-total	12					571					
LBHF											
	1.75	Finance Manager	£47-72k	59	75.52	132					
	3	Group Accoutant	£41-48k	45	57.6	173					
	3	Principal Accountancy Ass	£31-£41	36	46.08	138					
	2	Senior Finance Officer	£23-£32k	27	34.56	69					
	0	Finance Assistant									
Sub-total	9.75					512					
RBKC											
	0.5	Finance Manager	£50-70	60	74.4	37					
	1	Group Accoutant	£40-£50	45	55.8	56					
	3	Principal Accountancy Ass	£35-40K	37	45.88	138					
	1	Senior Finance Officer	£28-£32	30	37.2	37					
	2	Finance Assistant	£23-£27	25	31	62					
Sub-total	7.5					330					
Total Current	**29.25**					**1413**					
	Accountancy New Structure FTE										
	1	Head of Finance (Accounta	£47-72k	59	75.52	76					
	4	Group Accountant	£41-48k	45	57.6	230					
	10	Senior Finance Officer	£31-£41	36	46.08	461					
	3	Finance Officer	£23-£32k	27	34.56	104					
Total New	18					**870**					
Current StrutureTotal	29.25					1413					
New Structure Total	18					870	543	0	0	0	543
Reduction	38%					38%					

Appendix A4



Name of Business Group: Procurement and Workforce Development

Functions for different units in the Business Group is listed below.

1. **Main functions for Placements, Complex Needs, Community Services, Workforce Development, and Support Services.**

- Spot purchasing (likely to increase with three borough working) – embedded in the team (Homecare and Residential).
- Contract and care management performance monitoring
  - In partnership with the Commissioners
  - Procurement to lead with input from other functions (e.g. client side, commissioners, others)
  - Proportionate and risk-based
- Market Development
  - social enterprise creation
  - provider forums
- Workforce Development
  - provider workforce e.g. DOLs and safeguarding – requires cross-development
  - staff development
  - supports commissioning hub development
- Strategy Development
- Procurement to contract management

2. Breakdown of financial savings – Procurement and Workforce Development.

		Procurement	Range	Mid Point	With On Costs	*Total Costs plus on-cost £'000*	Savings	Phasing 2011/12	2012/13	2013/14	2014/15
	Current Structure										
	FTE										
WCC											
	1	Tier 4		64	80	80					
	6	Tier 5	£40-£43k	42.5	53.125	319					
	5	Tier 6	£33-£36	34	42.5	213					
Sub total	12					611					
LBHF	1	Tier 4		64	81.92	82					
	3	Tier 5	£40-£43k	42.5	54.4	163					
	7	Tier 6	£33-£36	34	43.52	305					
Sub total	11					550					
RBKC	1.5	Tier 4		64	79.36	119					
	3	Tier 5	£40-£43k	42.5	52.7	158					
	13	Tier 6	£33-£36	34	42.16	548					
Sub total	17.5					825					
Total Current	40.5					1986					
	New Structure										
	FTE										
	1	Head of Proc. and Workforce Devp.		68	87.04	87					
	5	PO 5		50	64	320					
	4	PO 4		42	53.76	215					
	11	PO 2 & PO 3		35	44.8	493					
	4	PO 1		34	43.52	174					
Total New	25					1289	**697**	697	697	697	
Procurement % Savings						35%					

Appendix B: Adult Social Care Annual Cycle