Warwickshire Shadow Health and Wellbeing Board

Agenda

17th July 2012

Please note that a buffet lunch will be available from 13.00.

A meeting of the Warwickshire Shadow Health and Wellbeing Board will take place at **Committee Room 2, Shire Hall, Warwick** on **TUESDAY 17th JULY 2012 at 13.30.**

The agenda will be:-

1. (13.30 – 13.40) General

1) Apologies for Absence

2) Members' Disclosures of Pecuniary and Non-Pecuniary Interests.

Members are required to register their disclosable pecuniary interests within 28 days of their election of appointment to the Council. A member attending a meeting where a matter arises in which s/he has a disclosable pecuniary interest must (unless s/he has a dispensation):

- Declare the interest <u>if s/he has not already registered it</u>
- Not participate in any discussion or vote
- Must leave the meeting room until the matter has been dealt with (Standing Order 42).
- Give written notice of any unregistered interest to the Monitoring Officer within 28 days of the meeting

Non-pecuniary interests must still be declared in accordance with the new Code of Conduct. These should be declared at the commencement of the meeting.

3) Minutes of the Meeting on 22nd May 2012 and Matters Arising

Draft minutes are attached for approval.

2. (13.40 – 13.50) George Eliot Hospital –

i) Summary Hospital Mortality Indicator (SHMI)
ii) Progress to Foundation Status

Reports introduced by Kevin McGee (Chief Executive – George Eliot Hospital)

3. (13.50 – 14.00) Dementia – Proposal for Workshop

Verbal introduction by Wendy Fabbro (Strategic Director, People's Group – Warwickshire County Council)

4. (14.00 – 14.25) Integrating Care Pathways and Discharge to Access – Update on Work by WCC, SWFT and the CCGs

Introduced by Wendy Fabbro (Strategic Director, People Group – Warwickshire County Council)

5. (14.25 – 14.45) NHS Transfer of Capital

Introduced by Stephen Jones (Chief Executive – Arden Cluster)

6. (14.45 – 15.05) Clinical Commissioning Groups (CCGs) – Update on Progress Towards Authorisation and Development of Commissioning Plans.

Report Introduced by Alison Walshe (Director of Commissioning Development Arden Cluster) and Lead GPs from the three Clinical Commissioning Groups

7. (15.05 –15.15) Children and Adolescent Mental Health Services Update on Strategic Review.

Two reports (i&ii) introduced by Josie Spencer (Coventry and Warwickshire Partnership Trust) and Jo Dillon - (Associate Director of Strategic Joint Commissioning - Children and Maternity, Warwickshire County Council)

8. (15.15 – 15.20) Health and Wellbeing Board Strategy – Update on Consultation

Introduced by Monica Fogarty (Strategic Director – Communities Group, Warwickshire County Council)

9. (15.20 – 15.30) "Board Futures"

Introduced by Monica Fogarty (Strategic Director – Communities Group, Warwickshire County Council)

10. (15.25 – 15.30) Six Lives Survey

Introduced by Wendy Fabbro (Strategic Director, People Group – Warwickshire County Council)

11. Any other Business (considered urgent by the Chair)

Bryan Stoten
July 2012

Future meetings – Please note Changes in July, September and November and venues

24th September 2012	13.30 – 15.30	Committee Room 2, Shire Hall
13th November 2012	13.30 – 15.30	Committee Room 2, Shire Hall

Shadow Health and Wellbeing Board Membership

Chair: Bryan Stoten

Warwickshire County Councillors: Councillor Alan Farnell, Councillor Heather Timms; Councillor Isobel Seccombe; Councillor Bob Stevens

GP Consortia: Dr Inayat Ullah/Dr Ram Paul Batra-Nuneaton and Bedworth; Dr Charlotte Gath-Rugby; Dr Kiran Singh/Dr Heather Gorringe-North Warwickshire; Dr David Spraggett/Dr Richard Lambert -South Warwickshire

Warwickshire County Council Officer: Wendy Fabbro Strategic Director for People

Warwickshire NHS:; John Linnane-Director of Public Health; Stephen Jones - Chief Executive (Arden Cluster)

Warwickshire LINKS: Councillor Jerry Roodhouse

Borough/District Councillors: Councillor Neil Phillips, Councillor Claire Watson, Councillor Michael Coker

Warwickshire County Council Advisor to the Board: Monica Fogarty – Strategic Director for Communities

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Minutes of the Meeting of the Shadow Warwickshire Health and Wellbeing Board held on 22nd May 2012

Present:-

Chair

Bryan Stoten

Warwickshire County Councillors

Councillor Alan Farnell
Councillor Bob Stevens
Councillor Heather Timms

Clinical Commissioning Groups

Dr David Spraggett – South Warwickshire CCG
Dr Charlotte Gath – Rugby CCG

Warwickshire County Council Officers

Monica Fogarty – Strategic Director, Communities Group
Wendy Fabbro – Strategic Director, People Group

NHS

Stephen Jones – Chief Executive Arden Cluster
John Linnane - Director of Public Health (WCC/NHS Warwickshire)

Borough/District Councillors

Councillor Derek Pickard – North Warwickshire Borough Council
Councillor Claire Watson – Rugby Borough Council

Warwickshire LINk

Councillor Jerry Roodhouse

1. (1) Apologies for Absence

Councillor Michael Coker
Councillor Neil Phillips
Councillor Izzi Seccombe
Dr Kiran Singh

(2) Members' Declarations of Personal and Prejudicial Interests

None

(3) Minutes of the meeting held on 19th January 2012 and matters arising

The minutes were agreed as an accurate record. The meeting was informed that, as agreed, details of the £6m Section 256 funding spend had been circulated.

The importance of dementia was discussed and it was agreed that a workshop should be organised for the board on this topic. The Chair suggested that Professor Ian Philp should be invited to be involved in this.

The Chair welcomed Paul Tolley (Warwickshire CAVA), Philip Bushell-Matthews (CWPT) and other guests to the meeting.

2. Update from Clinical Commissioning Groups on Progress towards Authorisation

Stephen Jones provided a general overview of the move by the CCGs towards authorisation, explaining that significant progress had been made over the last two months. Debate had focused on the viability of a separate Nuneaton and Bedworth CCG and on the possibility of a combined Rugby/Coventry CCG. It is anticipated that South Warwickshire CCG will fall under wave 2 whilst the others will be in wave 4. There has also been some debate around the size and shape of the areas covered by the NHS Commissioning Board Local offices. It is likely that the model agreed will cover an area significantly larger than Coventry/Solihull/Warwickshire. Monica Fogarty informed the meeting that Warwickshire County Council would favour a local office that covered the Arden Cluster footprint, preferably including Solihull to mirror the sub-region. However, acknowledging that this was unlikely she called for a local area that was as compact as possible. Stephen Jones agreed to email a set of wording to Monica to ensure an audit trail and confirm Warwickshire County Council's response. Wendy Fabbro expressed concern that an office that covers a large area may not give integration the emphasis it deserves. In response to a question from Councillor Roodhouse the meeting was informed that the consultation letter concerning the local offices had not been sent specifically to LINk.

Regarding the development of a combined Rugby/Coventry CCG, Charlotte Gath apologised for not bringing the matter to the March 2012 Board meeting. She explained that consideration had been given to having a stand-alone Rugby CCG but the 100k population of the area would have been too small. She informed the meeting that the CCG had sought to be as transparent in its dealings as possible and had requested the views of many stakeholders. The

Rugby/Coventry configuration had been agreed on 2nd May 2012. Charlotte observed that Rugby CCG was not obliged to formally consult the County Council on its future form. The CCG had, however, involved the council in its Partnership Group and discussions relating to the potential structure and options appraisal from the outset and sent copies of the options appraisal paper to key members of the Health and Wellbeing Board back in February. The Chair reminded the Board that a concern with the integration of health and social care and the mechanisms to achieve it lay at the heart of its role. Acknowledging the current position, Councillor Roodhouse suggested that moving forward, the key will be to look at how patient engagement will work. He explained that following a visit to UHCW he had come away concerned over the future plans for Rugby St Cross Hospital. He felt that not enough consideration had been given to the plans for the future development of Rugby and the pressure this will apply on health services. Councillor Timms' concern was that almost regardless of the structure agreed, the key is to ensure good service delivery. She reiterated the concerns about the future of Rugby St Cross.

There followed a discussion around the level of engagement of stakeholders in this matter. It was acknowledged that with the new relationships between local authorities and the health economy lessons are to be learned. It was also recognised that should it be found in the future that the Coventry/Rugby model does not work effectively the matter will be reviewed.

Stephen Jones noted that local authority boundaries do not always reflect patient flows and emphasised the need for agreement on the Coventry/Rugby model. Councillor Roodhouse called for a degree of consistency of approach by CCGs to communication with LINk/Heathwatch.

The Board resolved that the Shadow Health and Wellbeing Board:

1. Accepts the principle of closer working between Rugby and Coventry CCGs in order to pool knowledge and good practice, clinical capacity and leadership, achieve economies of scale, and commission effectively in line with patient flows.

2. Accepts, as a fait accompli, the progress made by Rugby CCG in working towards a single Coventry and Rugby CCG structure which will greatly strengthen the CCG's commissioning role with its main provider UHCW (University Hospitals Coventry and Warwickshire) and thereby help to strengthen, develop and protect services for residents at St Cross Hospital, Rugby and in the community.

The Chair invited Dr David Spraggett to update the board on the position regarding the South Warwickshire CCG. Having explained how the CCG might be put into wave 3 he offered to produce a briefing note for the board and provide a copy of the CCG's vision document and strategy. This was welcomed. Finally David Spraggett assured the board that any 360 degree assessment undertaken would go to many stakeholders.

3. The Arden Cluster Systems Plan

The Chair welcomed Sue Roberts from the Arden Cluster to the meeting. Using Powerpoint, Sue summarised the key points of the plan. She outlined the savings to be made and explained that there remains a gap between the target savings and those already identified.

Councillor Roodhouse, recognising the impending demise of the Arden Cluster asked what the future would be of the plan. It was explained that the CCGs have signed up to the plan and will pick it up when the cluster ceases to exist.

Wendy Fabbro expressed he disappointment that the Social Care White Paper has been shelved. She called for a clear process to be put in place to monitor progress of the plan's implementation.

John Linnane acknowledged the synergy between the plan and the JSNA.

The Chair thanked Sue for her presentation and wished her well in her new role.

4. George Eliot Hospital NHS Trust – a) Securing a Sustainable Future & b) Mortality Update

The Chair welcomed Kevin McGee back to the board. Kevin explained that he did not intend to read his reports out but sought to summarise them before taking questions.

Kevin highlighted that a decision will be taken on 30th May regarding the procurement route to be followed. He emphasised that no decision regarding the partner selected will be made on that date. The hospital is keen that as many stakeholders as possible have the opportunity to feed into the process and he was confident that robust governance arrangements had been put in place.

The Chair and Councillor Farnell expressed the preference for a Warwickshire solution. Kevin agreed to feed this view into his board meeting.

Turning to mortality rates, Kevin reminded the board of the complexity of this area. He informed the meeting that the Doctor Foster figures for January/February 2012 were less than 100%. He added that fluctuations in performance are expected but the general trend is downwards. Kevin emphasised that improved mortality rates is now top priority for the Trust Board.

In response to a question from Councillor Roodhouse, Kevin stated that considerable work is being done regarding end of life care. He did, however, acknowledge that more work is needed.

Regarding changes in working practices at the George Eliot, Kevin stated that the workforce is being very flexible and that 7 day working was becoming more the norm rather than the exception.

It was agreed that the next SHMI performance data be brought to the next board meeting.

5. The Draft Health and Wellbeing Board Strategy

Mike Caley introduced this item. He informed the meeting that there had been a good response to the pre-consultation draft. Responses had been received regarding the need to ensure service integration, there was acknowledgement that the strategy and the JSNA are closely aligned and the input from housing and community safety teams had resulted in major re-writes of sections of the document.

It had been suggested that the document should include specific sections for the CCGs and district and borough councils but a desire to retain the strategy's high-level approach meant that this had been rejected.

It is expected that the strategy will be subject to a 12 week consultation between June and August.

John Linnane stated that it is expected that in time localised JSNAs will be produced. These will reflect local issues.

In response to a question from the Chair it was noted that mental health matters are woven throughout the whole document.

It was resolved:

> That the Warwickshire Shadow Health and Wellbeing Board approves the draft Warwickshire Joint Health and Wellbeing Strategy 2012-15 for consultation.

6. Performance Monitoring by the Health and Wellbeing Board

This item was opened by Mike Caley. He emphasised that the board does not exist to performance manage constituent organisations, but acknowledged that it has a strategic performance role. It was suggested that a twice yearly conference be held to review performance.

The board acknowledged that it would not be appropriate to occupy the regular, scheduled meetings with performance matters. However, an annual event might be more appropriate.

Councillor Roodhouse stated that LINK/Healthwatch will focus more on the "softer" experience-based side of performance.

It was resolved;

> That the Warwickshire Shadow Health and Wellbeing Board agrees the option set out in the report to monitor delivery of strategic objectives in the Health and Wellbeing Strategy.

7. Section 106 Funding – Verbal Update

Monica Fogarty gave a verbal update to the board on S106 and its successor the Community Infrastructure Levy. She stated that the responsibility for responding to planning consultations will rest with the CCGs in the future. In addition, CCGs will be required to provide input into local plans. Monica undertook to write to the CCGs to set out this responsibility.

8. Any other Business

Stephen Jones noted that 12th September would be a problem for some board members as this clashes with the Cluster Board meeting. It was agreed that the HWB meeting should be moved.

David Spraggett suggested that the CCG commissioning intentions should be brought to the next meeting of the board.

The Chair expressed his concern that resources for support for the work of the board had not been identified and called on the Arden Cluster and CCGs to sort this out. It was agreed that this should be discussed at the next meeting.

The Chair called for the transfer of health service capital to be brought to the next meeting. This was agreed.

Wendy Fabbro agreed to share the response to the “Six Lives” document with the board.

Finally the Chair informed the meeting that Mike Caley will be moving on in the summer. He thanked Mike for his help over the last year and the board wished him well.

The meeting rose at 14.10

……..Chair

Item No 2(i)

Warwickshire Shadow Health and Wellbeing Board

17 July 2012

Mortality Review – George Eliot Hospital

Recommendation

That the Health and Wellbeing Board notes the current mortality rates.

1.0 Context

1.1 The George Eliot Hospital has been repeatedly identified as an 'outlier' against mortality ratings over the years, with a higher than expected HSMR. We have also been identified as having a higher than expected SHMI, the highest in England.

2.0 Current Mortality Rate

2.1 The current HSMR for the time period analysed was 109.1; April 2012's HSMR was 95.3. It is important to note that the current benchmark year is 2010/11 and is due to be rebased at the end of August 2012.

2.2 The most recent SHMI (Oct-10 to Sep-11) is 123.18.

3.0 Actions

3.1 As a direct and immediate response to the increase in HSMR last September and prior to the October SHMI being released, the Trust put an action plan in place to undertake a wholesale review of systems and processes in place. Details of actions within the plan have been previously reported. Further work has since been implemented or completed which includes;

- As a result of an increase in HSMR mortality rates for the months of February and March further work is being undertaken. The Trust is extending attention to the coding of all patient discharges in people over 65 years of age with a length of stay greater than two days with no recorded co-morbidities. Work has commenced and data will be resubmitted for completion in July.

- An internal systematic review of all deaths to identify any underlying problems in the quality of care which may underlie the high mortality rate has been undertaken. This review was undertaken by the Associate Medical Director with support from three matrons and the Senior Clinical Audit Officer. The review highlighted some areas for additional work around adverse events that may have contributed to or resulted in harm to the patient e.g. infections and or electrolyte disturbances.

- Investigation of a number of Dr Foster alerts over a period of time have also been investigated and have demonstrated inaccuracies of coding and recording of comorbidities and have not demonstrated sub standard care.

- The Trust Board continues to be assured through receipt of detailed information regarding HSMR and SHMI and are fully appraised of the actions and progress on a regular basis, including monthly reports utilising the Dr Foster data.

- Medical and Nursing Directors of both the Trust and Arden Cluster continue to meet monthly to review the action plan.

Kevin McGee
Chief Executive
George Eliot Hospital

Item No 2(ii)

Warwickshire Shadow Health and Wellbeing Board

17 July 2012

George Eliot Hospital NHS Trust
Securing a Sustainable Future

Recommendation

The Shadow Health and Wellbeing Board is asked to note the progress report

1.0 Key Issues

1.1 The Outline Business Case was approved by the Trust and NHS Midlands & East SHA Cluster in May. Department of Health approval is now awaited. Evaluation and selection criteria and procurement documentation are being developed in anticipation of approval.

2.0 Proposal

2.1 George Eliot's Board has agreed that it is in the best interests of the hospital, its patients and staff to undertake a procurement process that enables both NHS and independent sector healthcare providers to make proposals for working in partnership with the Trust.

2.2 Once Department of Health approval for the proposed procurement has been secured, organisations will be invited to formally express their interest in becoming the Trust's partner through an operating franchise, or variations on this model, should they wish to do so, after which the procurement process is expected to take approximately ten months.

3.0 Timescales associated with the decision/Next steps

3.1 Subject to DH approval, procurement will commence in July and the project can be completed with the Full Business Case approval by February. Commencement of the project would be dependent on DH final approval and the agreed timetable for implementation.

Background Papers

1. Report to Trust Board on 27th June 2012 is attached
2. The Outline Business Case and other project documents are available from the Trust website at: http://www.geh.nhs.uk/

	Name	Contact Information
Report Author	Chris Bradshaw Director of Finance George Eliot Hospital NHS Trust	02476351351 Chris.bradshaw@geh.nhs.uk

Securing a Sustainable Future

Progress Report to Trust Board 27th June 2012

Board approval of the OBC was completed on 30th May in line with the Tri-partite Formal Agreement. SHA approval was given on 31st May and the SHA has submitted the case to DH for approval.

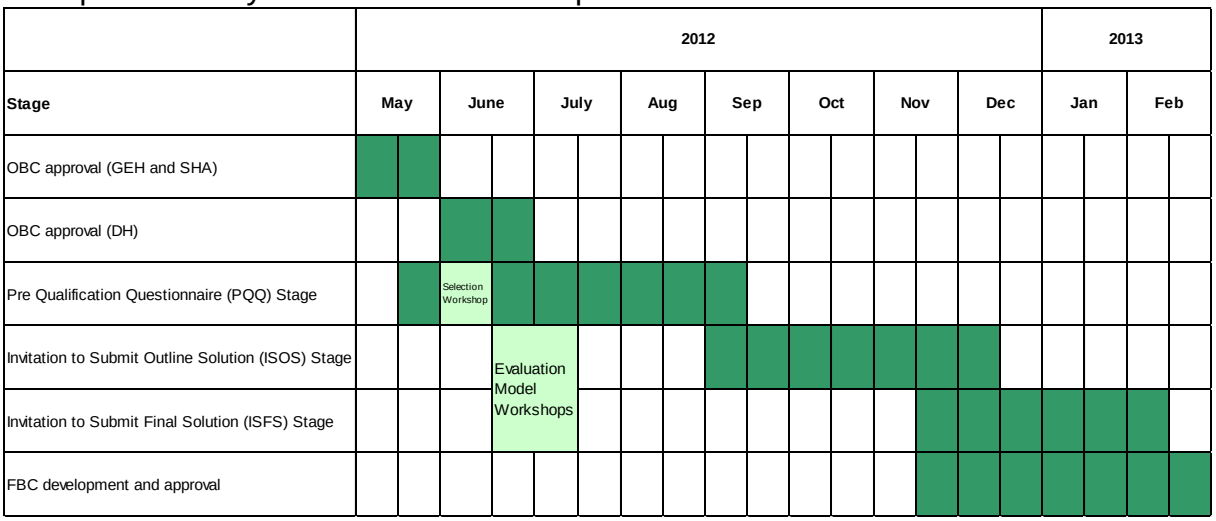
The reasons for the board's decision have been actively communicated to staff and directors continue to take opportunities to ensure that staff groups are fully aware of the next steps in the project.

The project is continuing on schedule with the aim of completing the selection of preferred bidder and full business case in this financial year.

The project team is actively working on preparation of the following in readiness for commencing procurement:

- OJEU Contract Notice
- Pre-Qualification Questionnaire
- Evaluation criteria and process for evaluation itself
- Memorandum of Information
- Communications & Engagement Strategy (update)
- LTFM update

A simple summary of the timeline to completion is shown below:



Pre-Qualification Questionnaire

The purpose of the PQQ stage is to ensure that bidders are eligible and to assess their technical experience and capacity and their financial ability to perform the contract. It does not consider any proposal at this stage. As stated in the OBC, up to 9 candidates may then be invited to submit outline proposals (ISOS stage). The project team has been involved in developing the technical content of the PQQ (the selection criteria). A workshop has taken place for those involved in the selection at this stage, and involving some stakeholders, to finalise these criteria and be briefed on their role in the selection process.

Evaluation criteria and process for evaluation

The evaluation criteria and process for evaluation must be agreed and shared with candidates when invited to submit outline solutions. These criteria will be used throughout the project from this point on. Initially, they will be used to down-select the short-list of 2-3 candidates that go through to the final dialogue and bidding stage. It is intended to involve a wide range of stakeholders in the development of these criteria and subsequently in the evaluation. Workshops have been scheduled for 18th June and 2nd July.

Memorandum of Information (MOI)

The MOI sets out again the objectives of the project and describes the procurement process in more detail. The MOI ha s largely been drafted and the project team is working on certain technical and legal aspects prior to its sign off by the Project Board and subsequently the Trust Board.

Communications & Engagement Strategy

The Project Board sees this as a real priority. It should be recognised that everyone who may wish to be directly involved can attend the workshops and other events that will be held. Other opportunities will therefore be taken to speak to key groups of staff and members of the community to inform them about the project and listen to their opinions. The project team welcomes the opportunity to talk to any interested group.

Long term financial model

A more detailed LTFM is being developed in readiness for use in the ISOS stage of the project and beyond. This starts from the existing business plan. The Trust will develop a base case against which proposals are evaluated. This will enable the evaluation process to measure the value for money offered by each proposal.

Item No 3

Warwickshire Shadow Health and Wellbeing Board

17 July 2012

Dementia Workshop

Recommendation

That the Health and Wellbeing Board supports the running of a dementia workshop.

1.0 Introduction

1.1 "Dementia results in a progressive decline in multiple areas of function, including memory, reasoning, communication skills, and those skills needed to carry out daily activities. Alongside this decline, individuals may develop behavioural and psychological symptoms such as depression psychosis, aggression and wandering, which complicate care." (National Dementia Strategy 2010).

1.2 The projected increase in the number of people with dementia in Warwickshire is currently estimated to rise by 39% between 2011 – 2021 (pop: 7166 – 9940).

2.0 What are the big issues?

- The prevalence of dementia increases with age, at present, 1 in 14 people aged over 65, and 1 in 6 people aged over 85 have some form of dementia.
- Combined with the projected increase in older people in Warwickshire, as a result of people living longer, there is likely to be an increase in demand for services to support people with dementia as well as their carers and families.
- Between 2010 and 2030, it is estimated that the number of older people with dementia in Warwickshire will double, to more than 13,000. The majority of these will be aged 75 and over.
- Dementia diagnosis is low; according to the Alzheimer's Society only 38% of dementia cases in the West Midlands are diagnosed. In 2008 less than 50% of the predicted number of people with dementia were recorded by their GP as having dementia.
- Currently, in the UK, around two thirds of people with dementia live in private households.
- It is not currently known how many people with dementia are funding their own care both in residential care and in their own home.

2.1 In 2010 – 2011, Adult Social Care supported 863 people with dementia in Warwickshire. Of those 500 (58%) were in residential or nursing care. 863 customers represent 10% of the Adult Social Care customers aged over 65. It is likely that more people with dementia received adult social care support in 2010-

2011 but customers are not recorded as dementia unless they have a diagnosis from a health professional.

2.2 The provision of carer replacement services for people with Dementia in Warwickshire is small. Community based carer support is provided by Carers Short Break services, however, these contracts are not dementia specific.[i]

3.0 What do we need to do?

3.1 Awareness and Understanding: A lack of understanding of dementia can lead to a number of problems including symptoms not being recognised early enough leading to poor access to services and poor outcomes.

3.2 Early Diagnosis and Support: Early diagnosis is key to providing the right support to both service users and carers in a timely manner.

3.3 Living Well with Dementia: Users and carers highlight that once diagnosed with dementia they require a range of services that fully meet changing needs. Whilst there are already a number of services in Warwickshire that offer both support and services to people living with dementia, it is recognised that there is more to be done to make sure the highest quality support and services are available to people with dementia and their carers.

3.4 Making the Change: Service users and carers in Warwickshire have told us that the National Dementia Strategy recommendations for an informed and effective workforce are key to improving services.

4.0 Aim of the Workshop

1) Clarify the demographic, economic and cost pressures of dementia over the next 10 years for; individuals and their families, statutory services and wider socio economic implications.
2) Explore Investing in models of person centred care across the health and social care economy
3) Debate the Prime Ministers challenge and consider becoming a Dementia Friendly County.
4) Agree performance outcomes for statutory services and key partners moving forward.

5.0 Outcomes

5.1 Members of the Health & Wellbeing Board are:

1) Informed and knowledgeable about the impact on the, demographic, socioeconomic and cost pressures across health and social care.
2) Fully aware of the good practice that currently exists within the County
3) Signed up to Warwickshire becoming a Dementia Friendly County
4) Support and invest in a person centred care model and programme;

CareforVIPS[ii] across the health and social care economy

5) Confident and agree the priorities for 12/13
6) Provide leadership for Dementia across the Health and Social Care economy.

6.0 Expert Advisors

Dr Graham Stokes. BUPA.

Professor Dawn Brook, Centre for Dementia Studies, Worcester University.

7.0 Workshop Delegates

7.1 Clinical Commissioning Groups, Commissioning Support Services, Senior Clinicians within Acute Trusts, Senior Officers within Adult Social Care (commissioning and operational), Heads of Housing, Representation from voluntary and independent sector providers, people with dementia and their carers.

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[i] JSNA. 2012

[ii] 1. VIPS model of person centred care is based on evidence-based practice that Values people, provides Individualised care, looks at services from the Perspective of the person living with dementia and that provides the supportive Social-psychological support to compensate for the disability of cognitive loss.

Agenda Item No 4

Warwickshire Shadow Health & Wellbeing Board

17 July 2012

'Discharge to Assess' Pathways

Integration / Alignment Status

1. Background

1.1 Against a background of a series of early service integration pilots in Warwickshire, senior leaders from Warwickshire County Council, South Warwickshire Foundation Trust, NHS Warwickshire PCT and South Warwickshire Clinical Commissioning group met to discuss the way forward towards integrated / aligned services for older people. This paper is a summary of a longer document, and outlines the approach that has been agreed. Project initiation is now underway.

2. Executive Summary - Our Shared Purpose

- We agreed that our shared purpose was to focus on developing and implementing a complete discharge to assess pathway as part of a vision to develop and deliver aligned care.
- We agreed that this process should be 'bottom-up' including patients and staff.
- We agreed that we must record what we are doing.
- We agreed that it would be South Warwickshire based at first with others kept in the loop as Phase One and then would be shared.

3. What we are aiming for and for whom:

4. System Drivers

4.1 The Dilnot Report (DoH, 2011a) highlighted the challenges health and social care face and made it clear that we as a nation face huge challenges in determining how we will fund the care and support that the most vulnerable and older and disabled people of our communities will need. It highlighted the challenges of determining what kind of assistance people should be entitled to expect and how we should all contribute to building a society which values all citizens and does not see supporting the most vulnerable as a burden. There are currently three million people over 80 in the UK, and this number is expected to almost double by 2030.

4.2 The National Health Service (NHS) reorganisation, catalysed by a change in Government in 2010 saw Andrew Lansley, Secretary of State for Health, designing a system to 'liberate the NHS' by broadly, developing clinically-led commissioning, reducing bureaucracy, strengthening regulation and reinforcing the use of marketisation (Dixon, 2012). As the architect of the redesign, Andrew Lansley presided over the development of the Health and Social Care Bill (DoH, 2011b). The Bill outlines what has been described as 'The Biggest Reorganisation in the History of the NHS', (Jowett, 2012). The Bill was finally given Royal Assent in early 2012, with huge opposition from many areas, most notably from the medical and nursing professionals from within the NHS (Buckman, 2012; Middleton, 2012). In addition to this political backdrop, the financial environment of health and social care had changed dramatically, with huge reductions in Social Care budgets (NSPCC and CIPFA, 2011) and also NHS budgets, (Appleby et al, 2009). The project described below is also delivered in the environment of the Quality, Innovation, Productivity and Prevention (QIPP) challenge which required all parts of the health service to rise to what has been described as the 'Nicholson Challenge' set by the Chief Executive of the NHS to deliver £20 billion of efficiency savings in the NHS, (Smith and Charlesworth, 2011).

4.3 At a recent Kings Fund summit on the care of frail older people (Cornwall, 2012) the key messages were:

- People in the UK are living longer, but many are living with one or more long-term medical conditions, and for a significant number, advancing age brings frailty. Although we have seen staggering improvements in medicine in the past 25 years, many of our health professionals were educated and trained for a different era.

- Successive governments have recognised the complexity of this problem and introduced policies and guidance for the care of older people. However, the great urgency is to turn the rhetoric of personalised care into the reality of everyday care and practice in relation to frail older people.

- Older people's services do not have high societal status and are not generally considered attractive options for professionals. The majority of staff providing the physical and emotional care for older people in hospital and at home have few qualifications, are on low pay and have poor working conditions.

- The quality of interactions and relationships between frail older people and professional caregivers is shaped by the team and the organisational 'climate' of care. Effective managers and staff working in a supportive organisational context could remedy many of the problems encountered by patients and carers in both their own homes and hospital.

- Actions can be taken at different levels of the system to deal with this issue, but we believe that the responsibility for quality of care and outcomes for patients is firmly located at the level of the team. The main purpose of decisions and actions taken at other levels of the system should be to enable frontline staff to do their work.

5.0 The 'initial' proposal

5.1 Each party has agreed to explore a series of shared Key Performance Indicators applied to shared simplified discharge pathways, subject to explicit entry and exit points and explicit accountability for the patient's journey and funding responsibility.

5.2 Pathway 1 (5 a day project) is in place. Our objective is to achieve a flow of 30 patients a week to CERT/IMC for South Warwickshire and a flow target will also be set for Reablement Services.

5.3 Pathway 2 is for patients who are likely to be not able to return home. This pathway is either funded by social care in the moving on beds (work is ongoing on the future model) or is funded by SWFT if the 'moving on' beds are unsuitable. At the end of 2-4 weeks the patient will either move into home based reablement or intermediate care services or will receive social care funding for their care or start self-funding their care. This is approximately 4 patients a week.

5.4 Pathway 3 is for patients who trigger in for full CHC assessment. It is proposed that health commissioners fund up to 4 weeks of nursing home care for CHC assessment to be completed. At the end of this time the patient will either be CHC funded, social care funded or self-funding and the transfer of responsibility will take place. This is approximately 6 patients a week.

5.5 The following principles will be applied:

- Clear and understandable pathways for all stakeholders, patients, carers and referrers
- A culture that takes responsibility for people that are referred
- A service that is timely –leading to best outcomes
- A service that is operationally and financially sustainable with risk and remuneration clearly identified/linked for organisations
- A system that is transparent
- A system that deliberately helps its constituent members with their challenges.

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Item No 5

Warwickshire Shadow Health and Wellbeing Board

17 July 2012

Future Ownership & Management of Estate in the Ownership of Primary Care Trusts in England

Recommendation

That the Health and Wellbeing Board notes the current position regarding capital transfer

1. Introduction

1.1 The guidance 'PCT Estate – Future Ownership of the PCT Estate' was published on 4th August and required PCTs to consider and recommend properties that could be transferred to a Community Foundation Trust, Foundation Trust or NHS Trust upon their abolition in 2013.

1.2 NHS West Midlands issued supplementary guidance which set out the 10 tests that needed to be satisfied in order that a recommendation for transfer can be made.

1.3 A report was submitted to the Cluster Trust Board at its meeting on the 14th September, 2011, making a number of recommendations for further discussion with providers and the 6 CCGs within the Cluster. During September and early October we have held a series of discussions with both SWFT and the CWPT regarding property transfer and applied the ten tests to the property portfolio to identify those properties that could transfer.

1.4 We have also received letters from SWFT and CWPT requesting the transfer of a number of properties.

1.5 A report has been submitted to the six CGCs in the Arden Cluster and their views have been recorded.

2.0 Request for Transfer from NHS Warwickshire to SWFT

2.1 SWFT have requested that the following properties are transferred to them:

- Royal Leamington Spa Rehabilitation Hospital(RLSH)
- The Ellen Badger Hospital in Shipston
- The following clinics:- Coleshill Clinic, Crown Way Clinic, Orchard Centre, Kenilworth Clinic, Southam Clinic

2.2 Analysis of the RLSH has demonstrated that it meets the tests as more than 50% of the space if used to deliver clinical services and 93% of the building is occupied by the Trust.

2.3 Analysis of the Ellen Badger Hospital also demonstrates that the tests are met. However the CCG have made the following points in respect of Ellen Badger:-

- Could there be a pause in the transfer process pending the Strategic Outline Case for the redevelopment of services in Shipston; - *the strategic outline case has not yet been formally approved therefore there is no reason to retain the property on this basis*

- Should consideration be given to the fact that there had been a feasibility study undertaken prior to the guidance being issued? Any transfer would blur the issues with the possible Shipston development. – *the Trust are a key stakeholder in the Shipston development and transferring the property to them would strengthen this position*

2.4 In respect of the transfer of clinics, it is quite clear that the majority use of the building is team base/admin for teams that do not operate in the building. It is therefore not patient facing and is not critical clinical infrastructure.

3. Requests for Transfer from NHS Warwickshire to CWPT

3.1 The CWPT have requested that the following property transfers to them:

- Ashby House (freehold)

3.2 The freehold of Ashby House, the land on which Ashby House sits, should be transferred with adequate protection for the remainder of the Bramcote Hospital site being included.

4. NHS Property Services

NHS Property Services Ltd has been established as a limited company, 100% owned by the Department of Health. It will have transferred to it all property that has not been transferred to Providers on the abolition of PCTs in 2013. It is expected that nationally 30% of the PCT-owned Estate will transfer to Providers.

The main purpose of NHS Property Services Ltd will be to:-

- Ensure Fitness for Purpose of properties for delivery of Clinical Services;

- Hold property for use by Community and Primary Care Providers;
- Deliver Value for Money Property Services;
- Cut costs of administering the Estate by consolidating the management nationally of over 150 Estates;
- Deliver and develop cost effective property solutions for Community Health Services and dispose of property surplus to NHS requirements.

5. Recommendations

5.1 The following recommendations for the transfer of property have been made to NHS West Midlands and have Chairs and Chief Executive approval under delegated powers from the Cluster Board:

5.2 Property to transfer to SWFT from NHS Warwickshire:-

- Royal Leamington Spa Rehabilitation Hospital
- Ellen Badger Hospital, Shipston on Stour

5.3 Property to transfer to CWPT from NHS Warwickshire:-

- The freehold interest of the land at Ashby Lodge

Graham Nuttall, Associate Director of Estates and Facilities

Item No 6

Warwickshire Shadow Health and Wellbeing Board

17 July 2012

The Development of Clinical Commissioning Groups and their Relationship with the Health and Wellbeing Board in Warwickshire.

Recommendations

That the Health and Wellbeing Board:

1) Receives this report for information.
2) Notes and puts in place a process to respond to the opportunity to contribute to the Authorisation process for Clinical Commissioning Groups (CCGs) through the "360 degree survey".
3) Invites CCG's to update the Health and Wellbeing Board on their progress towards Authorisation.

1.0 Introduction

1.1 This paper outlines

1) The Role and Purpose of Clinical Commissioning Groups
2) Their journey to Authorisation
3) Their links to Health and Wellbeing Boards
4) The links between the HWB and other elements of the NHS Commissioning System

2.0 Clinical Commissioning Groups. (CCGs) Role and Purpose

2.1 The development of Clinical Commissioning Groups (CCGs) will form the centre piece of the changes in the way in which NHS services will be commissioned in future. Whilst the creation of CCGs continues to emphasise the split between the commissioning of services from their provision, CCGs will be expected to be different from predecessor NHS organisations.

"Whilst statutory NHS bodies, they will be built on the GP practices that together make up the membership of a CCG. These member practices must decide, through developing their constitution, and within the framework of legislation, how the CCG will operate. They must ensure

that they are led and governed in an open and transparent way which allows them to serve their patients and population effectively"

Towards Establishment

2.2 In this context "Commissioning" means

2.3 The process of arranging and continuously improving services which deliver the best possible quality and outcomes for patients, meet the population's health needs and reduce inequalities within the resources available. The process includes

- Planning the optimum services which meet national standards and local ambitions, ensuring that patients and the public are involved in the process alongside other key stakeholders and the range of health professionals who contribute to patient care;

- Securing services, using the contracting route that will deliver the best quality and outcomes and promote shared decision-making, patient choice and integration;

- Monitoring, assessing and, where necessary, challenging the quality of services; and using this intelligence to design and plan continuously improving services for the future.

2.0 Establishing and Authorising CCGs

2.1 The Arden Cluster is in the process of "Establishing" three Clinical Commissioning Groups (CCGs) to Commission Health Services on behalf of the populations of Coventry and Warwickshire

2.2 Each of the prospective CCGs is now working through a process of development which is intended to allow them to become an "Authorised" CCG on the 31st of March 2013.

2.3 CCGs will apply to the NHS Commissioning Board (NHSCB), the national body with overall responsibility for the commissioning of all NHS services to become "Established" and "Authorised" to take on the responsibilities of commissioning services for their populations. Each CCGs application will be appraised by the NHSCB which will be categorised as "Authorised", "Authorised with conditions" or "Established". For those organisations who are only Established, the NHSCB will determine who will take on commissioning responsibilities for their populations. Those organisations that are Authorised with conditions will have clear criteria which they will be expected to meet within a set time.

3.0 Configuration

1.1 Following consultation with the prospective “members” of CCGs, (the GP Practices who will comprise them), three CCGs will cover the following populations

- Warwickshire North
- South Warwickshire
- Coventry and Rugby

3.3 The configuration of CCGs has been subject to approval by the NHS CB and scrutiny by the Local Authorities. Particular assurances have been requested from CCGs who plan to work across Local Authority boundaries, as is the case in relation to Coventry and Rugby.

3.4 Coventry and Rugby have chosen to emphasise the significance of the three localities within their organisation which represent the historic configuration of Practice Based Commissioning. All three predecessor organisations are committed to the development of a single organisation which remains capable of maintaining the benefits of the local focus of its predecessors.

3.5 Warwickshire North is likely to operate with two sub groups, which will reflect former Practice Based Commissioning groupings

4.0 Development

4.1 All CCGs will be expected to provide evidence of and a growing track record of meeting 6 broad criteria

1) A strong clinical and multi-professional focus which brings real added value;
2) Meaningful engagement with patients, carers and their communities;
3) Clear and credible plans which continue to deliver the QIPP (quality, innovation, productivity and prevention) challenge within financial resources, in line with national requirements (including excellent outcomes), and local joint health and wellbeing strategies;
4) Proper constitutional and governance arrangements, with the capacity and capability to deliver all their duties and responsibilities including financial control, as well as effectively commission all the services for which they are responsible;
5) Collaborative arrangements for commissioning with other CCGs, local authorities and the NHS Commissioning Board as well as the appropriate external commissioning support; and

6) Great leaders who individually and collectively can make a real difference.

4.2 For CCGs to become Authorised, they will need to be able to demonstrate an adequate level of competence across all these areas and the potential to achieve excellence in future.

4.3 Each applicant will be expected to present a portfolio of evidence that shows their capacity and capability to operate effectively from the outset and to develop into fully fledged organisations capable of leading the commissioning of health care for their population.

4.4 Each CCG faces its own unique set of challenges and is at a different point in their development. Interim Governing Bodies have been established in South Warwickshire and Coventry and Rugby and leadership teams are now established.

4.5 Accountable Officers (designate) have been confirmed for:

- Coventry and Rugby CCG (Dr Steve Allen)
- South Warwickshire CCG (Gillian Entwistle)

4.6 Warwickshire North CCG has appointed an Interim Senior Officer (Andrea Green) to support the CCG over the next 6 months and will recruit an Accountable Officer (designate) in due course.

4.7 The emerging Warwickshire North CCG has had further SHA facilitation to help support the creation of a Governing Body and constitution. Formal elections will be held in due course for the substantive Governing Body.

5.0 Application

5.1 CCGs have opted to make their applications for authorisation in the following waves

- Coventry and Rugby CCG - Application in November - Wave 4
- Warwickshire North CCG - Application in November - Wave 4
- South Warwickshire CCG - Application in October - Wave 3

6.0 CCG links to Health and Wellbeing Boards.

6.1 As part of the process of developing clear and credible plans, developing good governance and meaningfully engaging with patients, carers and their communities CCGs .

“will require a comprehensive and effective patient and public engagement strategy with systems and processes to assure the governing body that this is taking place throughout the organisation. They will need to play a full role on their local Health and Wellbeing

Boards including co-operating, in preparing joint strategic needs assessments, and agreeing a joint Health and Wellbeing Strategy. They will also work in partnership with Local Authorities and (as members of the Health and Wellbeing Boards) have a role in encouraging health and social care commissioners with the aim of securing better integrated health and social care for their patients. They will have a responsibility to ensure that relevant health and care professionals are involved in the design of services and that patients and the public are actively involved in the commissioning arrangements."

Towards Establishment

7.0 Stakeholder Survey

7.1 As part of the Authorisation process CCGs will be subject to a 360 degree assessment. 360° stakeholder surveys will be undertaken shortly before each application.

- Coventry and Rugby CCG -Survey in October
- Warwickshire North CCG - Survey in October
- South Warwickshire CCG - Survey in September

7.2 A range of stakeholders including Health and Wellbeing Boards (see Annex C for list of stakeholders) will be invited to complete a short web-based survey.

7.3 Stakeholders will be asked to respond to a series of standard questions addressing how they perceive the aspiring CCG has fulfilled and will continue to fulfil the six domains of authorisation. In addition, as representatives from a specific stakeholder group, participants will be asked a number of bespoke questions linked to their specific relationship with the CCG in question.

7.4 A report analysing responses will be sent to the applicant CCG for them to submit to the NHSCB. The applicant CCG will be able to comment on and provide a response to any issues raised by the survey. Survey findings will inform the wider Authorisation process.

8.0 The Wider Commissioning Architecture

8.1 The development of CCGs forms part a radical restructuring of commissioning within the NHS. Other components of the commissioning system for the NHS which will influence or interact with the HWB include

8.2 The National Health Service Commissioning Board.

8.3 The NHS CB came into being in October 2012. The Board plays a vital role in providing national leadership for improving health outcomes and

driving up the quality of care. At its simplest, the purpose of the Board will be to work with clinical commissioning groups (CCGs) and the wider system to use the commissioning budget of around £80 billion a year to secure the provision of high-quality health services for patients and communities. The Board has a direct responsibility for Primary Care Commissioning, which includes General Practitioner, Dentists, Pharmacists and Optometrists.

8.4 Local Area Teams

8.5 There are 27 Local Area Teams (LATs) to provide a local presence for the NHS CB. The LAT covering Warwickshire will also be responsible for Coventry, Worcestershire and Herefordshire and will work through a number of more local offices.

8.6 All LATs will have the same core functions around:

- CCG development and assurance
- emergency planning, resilience and response
- quality and safety
- partnerships
- configuration
- system oversight

8.7 Senates

8.8 There will be 12 Senates nationally. Clinical senates will help Clinical Commissioning Groups, Health and Wellbeing Boards and the NHS CB to make the best decisions about healthcare for the populations they represent by providing advice and leadership at a strategic level.

8.9 They will be made up of a range of clinicians and professionals from health, including public health and social care alongside patients, public and others, as appropriate.

9.0 Proposals

9.1 Issues from the Health and Wellbeing Partnership Board

- CCGs are expected to foster and develop a wide range of relationships in order to fulfil their role and responsibilities

- The requirement to work with Health and Wellbeing Boards will make a significant contribution to their planning and prioritisation processes as well as the development of partnership working to address the wider health and well being issues that affect the communities that each body serves.

- Health and Wellbeing Boards will make a formal contribution to the Authorisation process for each CCG within the Arden Cluster through the 360 degree Survey process.

9.2 The Health and Wellbeing Board are invited to accept the following proposals

1) Receive this report for information.
2) Note and accepts the opportunity to contribute to the Authorisation process for Clinical Commissioning Groups (CCGs) through the “360 degree survey”.
3) Invite CCGs to update the Health and Wellbeing Board on their progress towards Authorisation.

10.0 **Timescales associated with the decision/Next steps**.

10.1 The 360 degree Surveys will be conducted in September and October. The Health and Wellbeing Board should ensure that appropriate links are made with each CCG to ensure that Board members can appropriately contribute to the process.

10.2 The Board may wish to invite CCGs to update them on their progress towards Authorisation at their September meeting.

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Item No 7(i)

Warwickshire Shadow Health and Wellbeing Board

17 July 2012

Children and Adolescent Mental Health Services Update on Strategic Review

Recommendation

That the Shadow Health and Wellbeing Board notes and endorses the collaborative working being undertaken to redesign the Warwickshire Specialist Child and Adolescent Mental Health Service (CAMHS).

1.0 Key Issues

1.1 Waiting times for CAMHS have been a matter of concern for a number of years. These concerns have been raised at Warwickshire County Council's Adult Social Care and Health Overview and Scrutiny Committee (ASC&HOSC) a number of times. Coventry and Warwickshire Partnership Trust (CWPT) constructed a robust action plan to improve specific aspects of their services as a result of the ASC&HOSC Select Committee investigation (September 2010) and subsequent recommendations for improvement.

1.2 In 2010/11 NHS Warwickshire applied a Commissioning for Quality and Innovation (CQUIN) incentive to reduce the referral to treatment waiting time to a maximum of 14 weeks. Waiting times were reducing and when aggregated over the twelve month period just over 50% of patients were seen within the 14 week maximum waiting time target for treatment.

1.3 In February 2012 the CAMHS commissioner reported a number of CAMHS related concerns to ASC&HOSC including a notable rise again in waiting times. In consequence CWPT were asked to report to the April 2012 ASC&HOSC meeting with accurate CAMHS waiting times data and a revised action plan for addressing them. CWPT was also asked to attend ASC&HOSC again in September 2012 to report upon the completion of these actions and their impact upon waiting times.

1.4 The Committee also agreed to the recommendation that the CAMHS Commissioning Manager should report back in September with the results of a benchmarking exercise, comparing CWPT's performance against statistical neighbours. In addition the Commissioning Manager should report back with the results of the exercise to explore alternatives means of addressing waiting times by testing the market, and through this possible renegotiation of the contract with CWPT, will also be reported.

2.0 Progress to date

2.1 Commissioners are supportive of the approach CWPT has taken to drive improvements in Warwickshire's specialist child and adolescent mental health services. CWPT has to date shown unprecedented efforts in not only reducing the number of children on the waiting list by enhancing capacity but by simultaneously undertaking service redesign to sustain performance, maximise efficiency and ensure appropriate and timely care.

2.2 A key element of the service redesign is that of data quality and validation; this is critical so that CWPT is able to provide and sustain real time information about activity and performance and flex capacity to meet need.

2.3 Autistic Spectrum diagnostic work involves a number of different providers and initial pathway redesign work suggests that a proportion of the assessment work be undertaken by community paediatricians to allow CWPT's clinical psychologists to work with the more complex cases. Further work to understand the impact upon resources of alternative pathways is still to be scoped.

3.0 Timescales associated with the decision/Next steps

3.1 The intervention of the ASC&HOSC has provided the necessary leverage to precipitate concerted efforts from CWPT to begin to resolve the recurring waiting times issue in a way which includes redesigning and planning for sustained and longer term changes.

3.2 CWPT has been asked to report back to ASC & HOSC in September regarding the implementation and outcomes of its transformation plan to improve services and drive down waiting times.

3.3 The CAMHS Commissioning Manager will report to the September ASC&HOSC with baseline data from statistical neighbours CAMHS services to allow the Committee to draw comparisons with the performance of Warwickshire CAMHS. In addition the Commissioning Manager shall report back with the results of an exercise to explore alternatives means of addressing waiting times by testing the market, and through this possible renegotiation of the contract with CWPT.

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Item No 7(ii)

Warwickshire Shadow Health and Wellbeing Board

17 July 2012

Child and Adolescent Mental Health Services (CAMHS) Current Position and Action Plan

Recommendation

That the Shadow Health and Wellbeing Board notes the current position regarding waiting times and comments on the work being done to reduce them.

1. Introduction

1.1 The significant waiting times for CAMHS have been a matter of both internal and external concern.

1.2 This paper sets out the following:

1) The current picture of waiting lists and waiting times;
2) The capacity plans to reduce the waiting lists;
3) Service outcomes and service user satisfaction;
4) An update on service improvement activity.

2. Current Waiting Lists/Times

2.1 Work continues to develop a definitive picture of the number of children and young people waiting for CAMHS in Warwickshire and to understand the workforce capacity and process improvements required to alleviate their waiting times. To ensure accuracy in reporting our current position we have been working to improve data systems and data capture within the service

2.2 The key points of the current picture are:

1) Waits and waiting times in Warwickshire reflect the historical lack of a 'single service' approach, which has resulted in inconsistencies in relation to systems, processes and clinical capacity across localities - these issues are being addressed.
2) As at the end of June 2012, there were a total of 245 children and young people on CAMHS waiting lists across Warwickshire.
3) In Warwickshire there are no outstanding waits for an initial assessment – current referral to assessment times meet our 7-week target.
4) Of the children and young people who are waiting to access a treatment pathway, circa 50% are waiting to access neurodevelopmental pathways (including ASD).
5) Since the CAMHS report was tabled at the April 2012 Adult Social Care and Health Overview and Scrutiny Committee meeting, there has been a 40 %

reduction in the total number of children and young people waiting to be seen in CAMHS, from 473 to 245 . 12% of this reduction can be attributed to continued validation of the waits and 88% to the increased workforce capacity.

6) South Warwickshire current waiting times for routine patients are an average of 14 weeks. However in Nuneaton and Rugby there is still unacceptable long waits for children and the demand for the service continues to be an issue.

2.3 The current waiting time targets for CAMHS have been included within the 2012/13 contract which will require achievement of the following:

By 30.09.12 (Q2):	<9 weeks for referral to assessment <9 weeks for assessment to treatment
By 31.12.12 (Q3)	<8 weeks for referral to assessment <8 weeks for assessment to treatment
By 31.03.13 (Q4)	<7 weeks for referral to assessment <7 weeks for assessment to treatment

2.4 The non-achievement of these targets will attract financial penalties.

2.5 This target is more demanding than the National RTT target for non admitted patients which are 95% of patients are to receive their first definitive treatment in 18 weeks. There will need to be further debate with the commissioners of the service regarding the achievability and affordability of the current stretch 14 week target. . .

3. Capacity Plans

3.1 It is clear that additional capacity is required to reduce the waiting lists and waiting times to acceptable levels within reasonable timescales.

3.2 A great deal of work is being undertaken to secure additional clinical capacity (psychological therapists, psychiatrists & nursing) and administrative capacity. Some existing CAMHS staff have agreed to increase their hours and additional locum capacity is being sourced for an initial 3 month period.

We currently have 6.6 wte additional staff in place. However, identifying a sufficient number of individuals who are highly competent in the delivery of evidence-based child and adolescent mental health interventions is proving challenging. This deficit is a national problem and has been referred to in a number of policy documents. .

Since April 2012 CWPT has invested in excess of £130,000 in temporary staffing.

In addition CWPT has recruited 2.0 wte Consultant Psychiatrists to cover Nuneaton and Rugby. They will take up post during September.

We do not expect to see a significant drop in the waiting list for children during the school summer holidays as there is no access to school information during this

period. Once the waiting list has been stabilised we will need to account for this known variation in our planning for future years.

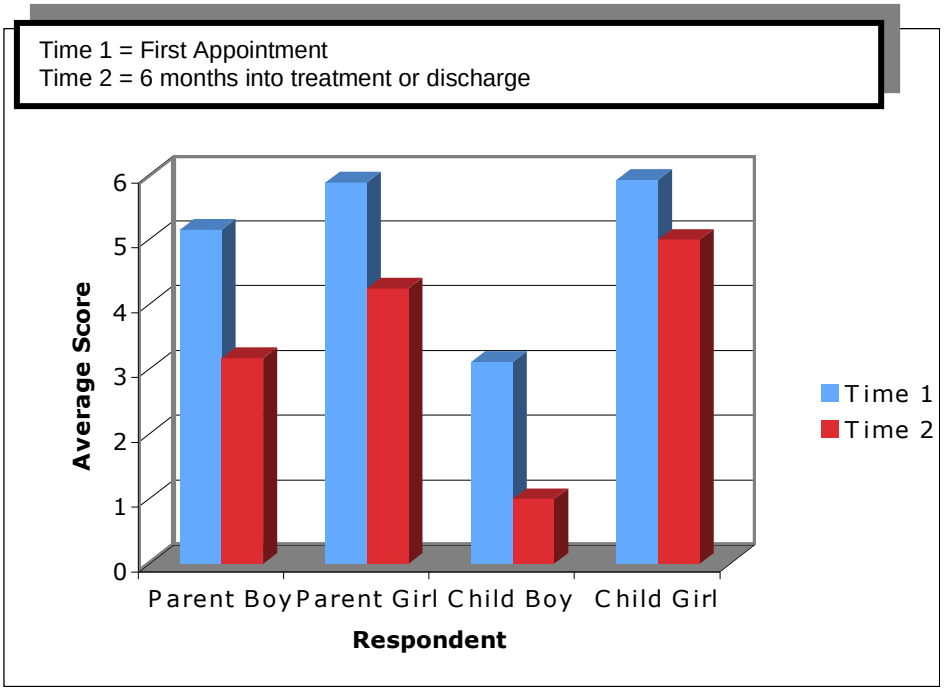
3.3 It is important to note that the work to reduce the waiting list for ASD patients in Warwickshire requires support / collaboration from commissioners and partner organisations. The CAMHS waiting list initiative is likely to result in an increased number of children receiving an ASD diagnosis and requiring services from partner agencies, such as Integrated Disability Services (IDS), SWFT and Education. Commissioners are aware of the additional demand the CAMHS waiting list blitz is likely to create for our partners and they have agreed to communicate this with partners. .

4. Outcomes delivered by the service

4.1 Work is on-going to track clinical outcomes within CAMHS which is helping to provide a better understanding of the overall impact of the service and to gauge service user satisfaction. The quality and effectiveness of our healthcare interventions are routinely measured by asking young people, parents/carers, and clinicians to rate the nature and severity of symptoms at specific intervals within each episode of care.

4.2 The graph below highlights the improvements in wellbeing experienced by children and young people accessing Warwickshire CAMHS between January and March 2012. According to parents and the youngsters themselves, there is a significant reduction in the impact of mental health problems on daily activities and relationships over the course of treatment. Six months into an episode of care or at discharge the degree to which emotional and behavioural problems interfere with daily life has reduced significantly.

Impact of Emotional and Behavioural Difficulties for Children



4.3 Between 21st and 25th May 2012 we invited all families attending Warwickshire CAMHS to participate in a service user satisfaction survey. 130 parents and 83 children/young people completed the Experience of Service Questionnaire and results showed an overall satisfaction with the services received. Results show that 94% of parents and 88% of children/young people were either completely or partly satisfied with the services they received. However, in terms of future improvements, families told us that they would appreciate more information about the range of help on offer within the service and greater flexibility of appointment scheduling. We are intending to incorporate this feedback into the CAMHS service improvement project.

5. Action Underway

5.1 Initiation of a formal service improvement project

5.2 A formal service improvement project has been established to deliver a focused and systematic approach to improving waiting times and to drive associated service improvements.

5.3 There are 4 main work streams:

- Capacity & demand work, including waiting list management and triaging;
- Data quality and validation work;
- Development of integrated care pathways, with a specific initial focus on the ASD pathway;
- Stakeholder engagement and communications.

5.4 Governance arrangements are in place with a requirement to report to theCWPT Trust Board In addition partnership arrangements with appropriate external agencies – including Commissioners, Warwickshire County Council and South Warwick Foundation Trust have been agreed for involvement in the project.

6. Replacement of CAPA & waiting list management arrangements

6.1 Processes are being put in place to replace CAPA to enable CAMHS to better manage the patient journey from referral to assessment and from assessment to treatment – please note that the targets within this year's contract are constructed in this way. These will take the best elements of the current CAPA processes, as well as good practice from elsewhere. The objective is to introduce a streamlined, sustainable and efficient process which provides a simpler path to treatment, makes best use of clinicians' time, and is easier for families to understand.

7. Sustainability

7.1 Despite the hard work undertaken by the team in partnership with our stakeholders there has been feedback that "***we have been here before***". To a degree this is valid. However, it is worth noting that the historical improvements were achieved by using non-recurrent CQUIN funding with no thought to sustainability. It is important that we learn from previous experience and ensure that we embed improvements

and allocate adequate resources so that the service is able to deliver the required access times and quality of care to this vulnerable group.

8. Future contract currency – PBR

8.1 CWPT have applied to be part of the DOH pilot for CAMHS PBR. The DOH team Plan to let providers know if they have been selected as pilot sites on Monday 30th July. If successful there will be initial induction events for those sites selected on 12th and 18th September.

Contacts:
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Jed Francique, General Manager for Integrated Children's Services

Item No 8

Warwickshire Shadow Health and Wellbeing Board

17 July 2012

Health and Wellbeing Strategy Consultation Update

1. The public consultation on the Health and Wellbeing Strategy was launched on the 11th June. It will run for twelve weeks ending on the 3rd September.

2. Hard copies have been printed and sent to:

    - All county councillors
    - All GP practices
    - All CCGs
    - Chief execs of NHS providers
    - Chief execs of district and borough councils
    - LiNKs
    - Chief execs of Warwickshire Probation Trust, Police, WREP, University of Warwick
    - Local Medical, Dental, Pharmacy and Optometry Committees

3. A second round of hard copy distribution will include sending copies to heads of schools and colleges.

4. The consultation will also be cascaded to community forums via area managers.

5. The consultation is available on the Warwickshire County Council consultation hub. It has been advertised on the Warwickshire County Council and NHS Warwickshire websites.

6. A press release regarding the launch of the strategy has gone out. An interview has been given to the Coventry Telegraph.

7. The consultation document was considered at the Health and Social Care OSC on 19th June.

8. Responses to the consultation will be collated and the final strategy document brought to the board in September.