Warwickshire Health and Wellbeing Board

Agenda

26th March 2014

Please Note Change of Venue.

A meeting of the Warwickshire Health and Wellbeing Board will take place in **Conference Room, Northgate House, Warwick** on **Wednesday 26th March 2014 at 13.30.**

The agenda will be:-

1. (13.30 – 13.35) 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 if s/he has not already registered it;
- Not participate in any discussion or vote;
- Must leave the meeting room until the matter has been dealt with (Standing Order 42); and
- 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 Meetings of the Warwickshire Health and Wellbeing Board on 20th January 2014 and the Extraordinary Board Meeting held on 11th February 2014 and Matters Arising

Draft minutes of both meetings are attached for approval.

Mobilising Communities to Develop and Maintain Independence

2. (13.35 – 14:05) Implications of the Care and Support Bill

Jenny Wood

Access to Services

3. (14. 05 – 14.25) Coventry and Warwickshire Partnership Trust – Update

Rachel Newson / Josie Spencer

Working Together

4. (14.45 – 15.15) Planning for Healthy Communities – Discussion

A discussion item with contributions from district and borough councils, NHS England and NHS Property Services

5. (14.25 – 14.45) "Better Care" (formerly Integration Transformation) Fund – Detailed Plan Sign-off

Report to follow from Chris Lewington

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

Health and Wellbeing Board Newsletter Link to Newsletter

Date of Future Meetings and Events:

28 April	Joint Seminar on Better Care with Coventry's Health and Wellbeing Board
29 April	JSNA and HWB Strategy Review Launch - Stakeholder Event
21 May	Health and Wellbeing Board Meeting and Annual Review Conference
23 June	JSNA and HWB Strategy Prioritisation Workshop
15 July	Health and Wellbeing Board Meeting
1 Sept.	HWB workshop to discuss draft HWB Strategy

Health and Wellbeing Board Membership

Chair: Councillor Izzi Seccombe (Warwickshire County Council)

Warwickshire County Councillors: Councillor Maggie O'Rourke, Councillor Bob Stevens, Councillor Heather Timms

Clinical Commissioning Groups: Heather Gorringe (Warwickshire North), David Spraggett (South Warwickshire), Adrian Canale-Parola (Coventry and Rugby)

Warwickshire County Council Officers: Wendy Fabbro - Strategic Director, People Group, Monica Fogarty - Strategic Director, Communities, John Linnane - Director of Public Health

NHS England: Martin Lee – Medical Director

Healthwatch Warwickshire: Deb Saunders

Borough/District Councillors: Councillor Roma Taylor (NBBC), Councillor Claire Watson (RBC), Councillor Michael Coker (WDC) , Councillor Derek Pickard (NWBC), Councillor Gillian Roache (SDC)

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Minutes of the Meeting of the Warwickshire Health and Wellbeing Board held on 20 January 2014.

Present:-

Chair

Councillor Izzi Seccombe

Warwickshire County Councillors (In addition to the Chair)

Councillor Maggie O'Rourke
Councillor Bob Stevens

Clinical Commissioning Groups

Juliet Hancox (Coventry and Rugby CCG)
Andrea Green (Warwickshire North CCG)

Warwickshire County Council Officers

Monica Fogarty – Strategic Director, Communities
Dr. John Linnane – Director of Public Health

Healthwatch Warwickshire

Phil Robson – Chair

NHS England

Richard Hancox – Assistant Director, Clinical Strategy

Borough/District Councillors

Councillor Derek Pickard (North Warwickshire Borough Council)
Councillor Gillian Roache (Stratford District Council)
Councillor Claire Watson (Rugby Borough Council)
Councillor Michael Coker (Warwick District Council)

1. (1) Apologies for Absence

Councillor Heather Timms (Warwickshire County Council)
Adrian Canale-Parola (Coventry and Rugby CCG)
David Spraggett (South Warwickshire CCG)
Heather Gorringe (Warwickshire North CCG)
Wendy Fabbro (Strategic Director, People Group)
Martin Lee (NHS England)
Deb Saunders (Healthwatch Warwickshire)
Councillor Roma Taylor (Nuneaton and Bedworth Borough Council)

(2) Members' Declarations of Pecuniary and Non-Pecuniary Interests

Councillor Bob Stevens declared a non-pecuniary interest as a member of the Royal British Legion.
Councillor Maggie O'Rourke declared a non-pecuniary interest as an employee of South Warwickshire NHS Foundation Trust.
Councillors Derek Pickard and Claire Watson declared a non-pecuniary interest as members of the County Council's Adult Social Care and Health Overview and Scrutiny Committee and The George Eliot Hospital Stakeholder Group.

(3) Minutes of the meeting held on 20 November 2013 and matters arising

The minutes were agreed as a true record of the meeting.

The Chair reported on the Francis/Memorandum of Understanding workshop held on 26th November and further details could be found in the latest Health and Wellbeing Board newsletter.

Chris Lewington, Head of Strategic Commissioning was asked to provide an update to the Board about Children's Safeguarding.

Dr. John Linnane, Director of Public Health referred to the information circulated with the Board documents on winter pressures and take-up of flu vaccinations. Up-dated information on the flu vaccinations was available for collection after the meeting. He commented on the current levels of take up, differences in this rate across the County and when GPs and pharmacists would provide the vaccinations until.

2. Veterans' Health and Wellbeing

Dr Dan Barnard (Coventry and Warwickshire Foundation Trust) and Jane Britton (Royal British Legion) made a presentation and played a short video, to accompany the circulated report.

The report reminded of the Armed Forces Community Covenant, which the County Council and partners had signed in June 2012. It confirmed the main aims of this covenant and actions taken since that time. There were a number of issues for consideration, under the headings of understanding need, culture, improving access and raising awareness. The observations of professional working with veterans, in terms of mental health/emotional wellbeing were reported, together with details of current service provision through the Royal British Legion.

The presentation included statistics for the Coventry and Warwickshire area, showing the proportions of veterans suffering post-traumatic stress

disorder, mental health issues and alcohol related problems. The support provided by the Royal British Legion and initiatives across the country were other areas reported. The video highlighted the issues faced by one individual.

The Chair wanted to raise awareness of the issues faced by veterans, referring to the statistics in the presentation. Councillor Bob Stevens spoke of the role of the Health and Wellbeing Board to support veterans and the need for Warwickshire to give continuing support. Representatives of Combat Stress, a support group were also present and contributed to the discussion on this item.

The Chair referred to the report's recommendations and asked how the Board could achieve these, particularly speaking about the difficulties in identifying the numbers of veterans and their individual needs. A booklet had been produced to raise awareness and Dr. Linnane explained distribution arrangements. Councillor Gillian Roache referred to a later item on the Board's Agenda, concerning the Mental Health Strategy and suggested the recognition of veterans' needs within that strategy.

Resolved

1) That the report is noted.

2) That the needs of veterans be incorporated in future Joint Strategic Needs Assessments.

3) That clinical commissioning groups be invited to forge closer links with veteran's organisations and those involved in veteran's health via a programme of engagement sessions in 2014; and

4) That the Health and Wellbeing Board requests a process for encouraging those engaged in frontline delivery (including GP's) to identify the numbers and needs of veterans within their population.

3. 'Living in Warwickshire' Survey – Headline Analysis

Dr. John Linnane gave a presentation to the Board. This included slides showing the purpose of the survey and methodology, details of the question topics and the key headlines for Warwickshire, including the fear of crime, economic concerns and those related to health and wellbeing. Further areas concerned lifestyle aspects on healthy eating, physical activity, smoking and alcohol consumption. The presentation concluded with respondents' likes and dislikes of living in Warwickshire and planned future analyses.

Comments were made on the survey results relating to lifestyle choices. In particular, the figures for amounts of alcohol consumption and frequency of exercise were considered to be questionable. The

difficulties in securing feedback from younger people was also discussed, with use of social media being mentioned as a means of engaging this group. The disproportionate perception of 'fear of crime' was also raised.

Resolved

1. That geographic targeted analysis be undertaken to identify areas for focus.

2. That the results be triangulated against other data sets.

3. That the Warwickshire Health & Wellbeing Board notes the headline findings from the 'Living in Warwickshire' survey, as a key part of the emerging evidence base for the review of Warwickshire's Joint Strategic Needs Assessment during the early part of 2014.

4. That the results feed into other key strategies such as the emerging Strategic Economic Plan and Alcohol Harm Reduction Strategy.

4. "Better Care" (formerly Integration Transformation) Fund

Chris Lewington, Head of Strategic Commissioning gave a verbal report to the Board. Nationally, the Better Care Fund provided some £3.8 billion and for Warwickshire it was anticipated to be £33 million. However, it was noted that this was a reallocation of current resources, not additional money, from the Government. There were a series of specific requirements that had to be met to receive the funding, which could be reduced for future years, if some of the criteria were not met. An extraordinary meeting would be held on 11th February 2014, to seek the Board's final approval to the submission. An outline was given of the requirements for 2014/15, including care out of hospitals, earlier intervention and seven day working at hospitals. The process would be performance managed. It was planned to pool the resources received, to achieve savings and efficiencies.

There was discussion about the development of strategies, building on the work completed to date and plans for wider engagement, through patient forums and the transformation assembly. The key was a commitment to patients being at the centre. Dr Linnane spoke about the need for a Public Health approach, not a shift of funding/responsibility. He referred to transformation, using an example of reducing emergency hospital statistics.

Resolved

That the Warwickshire Health and Wellbeing Board notes the report and considers this matter further at its Extraordinary meeting on 11th February 2014.

5. Warwickshire Public Mental Health Strategy 2014-16

Dr Charlotte Gath, Consultant in Public Health, introduced this item. The report set out a work programme for Public Health, in conjunction with partners, to improve mental health and wellbeing for Warwickshire residents. It explained what the strategy covered and its key aims, together with proposed next steps for wider consultation on the strategy and development of an action plan. Dr. Gath commented that the report was timely, given recent national media coverage about the apparent disparity between physical and mental health strategies.

Comment was made on the links between this strategy and the Health and Wellbeing Strategy. It was suggested that a more definitive document be submitted to the next Board meeting. The roles for district and borough councils were considered. Other aspects raised were improving the mental wellbeing of individuals through addressing their economic and housing issues. The specific recognition of veterans within the strategy was also requested.

Resolved

That, subject to the addition of veterans as a specific category of those requiring support, the Board approves the Mental Health Strategy 2014-16, for consultation with partners and the public.

6. Reports from NHS Trusts

(a) Response to the Keogh Report on Accident and Emergency (A&E) Services

The Board received reports from Kevin McGee, Chief Executive of the George Eliot Hospital, David Eltringham, Chief Operating Officer at University Hospital Coventry and Warwickshire (UHCW) and Glen Burley, Chief Executive, South Warwickshire NHS Foundation Trust (SWFT). Each report gave an update on how the trusts had responded to the Keogh report and the officers responded to questions.

Mr. McGee spoke about discharge processes, the move to seven day working and transformation, to build capacity. He then referred to the acute medical unit and explained the improvements made through

increasing senior staffing, to give an improved service to patients and speeding patient flow through to the correct ward. Whilst the Hospital was busy, there was a sense of control and calmness. Significant investment had been made with no additional funding provided and so a key issue was sustaining the improvements within existing resources.

David Eltringham spoke about the UHCW campaign “getting emergency services right”. He referred to the difficulties of the previous winter period and the current focus to give patients the care they needed, as speedily as possible. He highlighted the improvements in performance statistics which were shown in the report.

Glen Burley took the Board through his report, which focussed on the national policy and the local implications for SWFT. The Trust had made significant progress, through work on patient pathways and consistently achieved its targets over each of the last seven months. He referred to the Health Foundation publication on improving patient flow and explained how SWFT had been involved in this development work.

The Chair noted the positive reports and invited questions. Councillor Derek Pickard asked about the use of locum staff and the costs involved. This was acknowledged by Kevin McGee as a national issue, who advised of the appointments made at the George Eliot Hospital. He also responded to a related question from the Chair about the operation of the acute medical unit. Councillor O’Rourke asked about stress-related illnesses amongst hospital staff and it was confirmed that this national issue was monitored closely. Adopting a hospital wide ‘team’ approach rather than focussing just on A&E was another strategy used.

Councillor Claire Watson noted the progress made on A&E services and questioned whether there were improvements required in other parts of the hospitals. Points were raised about the move to seven day working, the positive perceptions of the new facilities at George Eliot Hospital and preventable death statistics. The referral of domestic violence cases and cases involving frail elderly people to other agencies were also raised.

Resolved

That the reports are noted

(b) Coventry and Warwickshire Partnership Trust – Preparations for Inspection and Foundation Trust Status

Justine Richards, Programme Director and Business Development Lead, Coventry and Warwickshire Partnership Trust (CWPT) provided an update. The Board was reminded of the Trust’s assessment in 2013 by Monitor, the deferral of its authorisation for Foundation Trust status and recommendations made at that time. The report also set out the subsequent improvements made and the actions completed.

The CWPT had been selected as a pilot site for the Care and Quality Commission's (CQC's) national programme of inspection of care. She gave an outline of the key areas of the inspection, which had commenced today. It was anticipated that the CQC's report of its findings would be received in approximately one month. Once this inspection had been concluded satisfactorily, a further assessment by Monitor could be sought. It was anticipated that the Foundation Trust status would be achieved in the Autumn of 2014.

Resolved

That the report is noted.

7. Impact of the 2014 Operating Framework – Clinical Commissioning Groups

A presentation was made by Gillian Entwistle, Chief Officer, NHS South Warwickshire CCG, entitled 'Everyone Counts: Planning for Patients 2014/15 to 2018/19'. An overview was provided, together with slides on the domains for better outcomes, measures of outcome ambitions, and delivering transformational change. Slides on the CCG resources available, including savings requirements and the planning timetable were also included.

Councillor O'Rourke spoke about the funding arrangements and was concerned about the ambitious targets. Dr. Linnane commented on the ambitions, the trajectories, timescales and how these linked to other strategies.

Resolved

That the Warwickshire Health and Wellbeing Board notes the presentation.

8. Health and Wellbeing Strategy – Progress on Outcomes

Nicola Wright, Speciality Registrar in Public Health presented this item. The Interim Health and Wellbeing Strategy was approved by the Shadow Board in March 2013. The Board was reminded of the three priorities in the Interim Strategy and these were underpinned by detailed areas of focus. Appended to the report were the annual work programme and draft performance framework. A section on progress to date was included, which highlighted specific areas of the Board's activity. Further

sections reported on key issues and areas of future focus. Technical supporting information had been circulated for the Board's consideration.

The Chair suggested that a workshop be held to engage all partners in the review of the Strategy. A further report would be brought to the Board in March and this could be followed by such a workshop, as part of the planned stakeholder engagement and public consultation process.

Councillor Pickard asked about the Board's role in relation to planning for large residential developments, and the associated health service provision. This was discussed and it was suggested could form the subject of an agenda item to a future Board meeting, involving the planning authorities. Bryan Stoten added that this was about service design for health, transport and education functions. It was a public health, rather than a purely health concern.

Resolved

That the Warwickshire Health and Wellbeing Board:

1) Notes the progress made to date in relation to the Board's priorities.

2) Approves the approach to the review of the Health and Wellbeing Strategy and future activity for the Board and its partners.

9. Any Other Business

None.

The meeting rose at 15.55

……..Chair

Minutes of the Meeting of the Warwickshire Health and Wellbeing Board held on 11 February 2014.

Present:-

Chair

Councillor Izzi Seccombe

Warwickshire County Councillors (In addition to the Chair)

Councillor Maggie O'Rourke
Councillor Bob Stevens
Councillor Heather Timms

Clinical Commissioning Groups

Gillian Entwhistle (South Warwickshire CCG)
Andrea Green (Warwickshire North CCG)
Juliet Hancox (Coventry and Rugby CCG)

Warwickshire County Council Officers

Wendy Fabbro – Strategic Director, People Group
Dr. John Linnane – Director of Public Health

Healthwatch Warwickshire

Deb Saunders - Chief Executive

NHS England

Francis Campbell – Associate Medical Director

Borough/District Councillors

Councillor Michael Coker (Warwick District Council)
Councillor Derek Pickard (North Warwickshire Borough Council)
Councillor Gillian Roache (Stratford District Council)

1. (1) Apologies for Absence

Adrian Canale-Parola (Coventry and Rugby CCG)
Heather Gorringe (Warwickshire North CCG)
David Spraggett (South Warwickshire CCG)
Martin Lee (NHS England)
Councillor Roma Taylor (Nuneaton and Bedworth Borough Council)
Councillor Claire Watson (Rugby Borough Council)

(2) Members' Declarations of Pecuniary and Non-Pecuniary Interests

Councillor Maggie O'Rourke declared a non-pecuniary interest as an employee of South Warwickshire NHS Foundation Trust. Councillor Derek Pickard declared a non-pecuniary interest as a member of the County Council's Adult Social Care and Health Overview and Scrutiny Committee and The George Eliot Hospital Stakeholder Group.

2. Better Care Fund

Wendy Fabbro, Strategic Director for the People Group introduced this item, with Chris Lewington, the County Council's Head of Strategic Commissioning and Anna Burns, Director of Strategy and Engagement at South Warwickshire CCG presenting the circulated report.

Background and context was provided about the Better Care Fund (BFC) which is a central government initiative to integrate health and social care. Nationally, funding of £3.8bn would be used to support the redesign and remodelling of community services as a tangible alternative to acute care. The report explained the complex partnership arrangements for commissioning health and social care services, the good models of joint and aligned commissioning already in place and the opportunities available to enhance aligned working.

The key issues were reported with a focus on the funding aspects from the June 2013 spending round and the funding sources for 2015/16. It was stated that none of the £3.8bn of national funding was additional resources, but a reallocation of current budgets. A section was included on the existing social care transfer budget from health to local government. In Warwickshire this equated to £8m per annum and would increase by £2.2m for 2014/15 in preparation for the implementation of the BCF. There were conditions attached to the BCF that clinical commissioning groups and the County Council would need to agree joint spending plans and from 2015/16 there would be pooled budgets.

For 2015/16 there would be an additional integration fund of £1.9bn and the report set out the headline conditions attached to this funding. It was explicit that the funding, to be paid in two instalments, would be based on performance. A table in the report showed the performance schedule for release of the BCF.

The timescales for submission of the better care template and plan were reported. The high level plan had been circulated, together with the proposed governance structure and draft partnership agreement, for the Board's consideration.

The Chair referred to the key documents and sought the Board's views on them. A draft letter on the high level plan was also circulated, which the Board was asked to approve for signature by the Chair.

Information was sought on how service providers, partners and others could engage with this process. There would be a further stage in formulating the detailed plans when feedback would be sought. Other contributors spoke about the tailored approach that each CCG would take to engage people in their area and the approach that would be required from an adult social care perspective. Discussion took place about the governance and funding arrangements.

With regard to the covering letter from the Chair, Dr John Linnane, Director of Public Health suggested the inclusion of additional text, about the focus on preventative measures and self-help as ways of managing the demand for services.

Francis Campbell of NHS England referred to health outcome indicators, the work on transforming primary care and ensuring consistent delivery of services. A point was made about workforce issues. It was clarified that this was a functional not structural integration, with a focus on care pathways and achieving desired outcomes. Further points were made about the difficulties in completing the templates for this submission, the targets around 7-day working and involvement of the district and borough councils. The timescales for subsequent stages were reported.

The Chair reminded the Board of the recommendations and proposed alterations to the covering letter.

Resolved

1) That the Warwickshire Health and Wellbeing Board approves the Better Care Fund Template and its submission to NHS England by 14th February 2014.

2) That the covering letter be amended to incorporate the comments made by the Director of Public Health and then signed by the Chair, on behalf of the Board.

3. Any Other Business

The Chair sought the Board's views about participation in the health and wellbeing system improvement peer challenge for 2014/15. After discussion, there was a consensus that this should not be progressed at present. The Chair also referred to the Department of Health Children, Families and Maternity e-bulletin for January 2014, on which further information would be circulated via the Board's newsletter.

The meeting rose at 14.15

……..Chair

Item No 2

Warwickshire Health and Wellbeing Board

Meeting Date: 26 March 2014

Report Title: A Summary of the Care Bill and its Implications

Summary

This report provides an update on the current progress of the Care Bill and a summary of the potential implications for Warwickshire, based on current available information.

Recommendation(s)

The Board is invited to comment on the potential implications of the Care Bill for Warwickshire.

1.0 Purpose of Report

1.1 To update the Board on the current progress of the Care Bill, and summarise the potential implications for Warwickshire, on the basis of current available information.

2.0 Background and Context

2.1 In 2011, the Law Commission reviewed the current legislation associated with community care provision for adults and published a series of recommendations in their report 'Adult Social Care'. The intention of the recommendations was towards the establishment of a single, clear, modern statute and code of practice that would pave the way for a coherent social care system, with local councils having clear and concise rules to govern when they must provide services. Included in the Law Commission's recommendations were:

- putting the individual's wellbeing at the heart of decision-making, using new statutory principles
- giving carers new legal rights to services
- placing duties on councils and the NHS to work together
- building a single, streamlined assessment and eligibility framework

- protecting service users from abuse and neglect with a new legal framework, and
- for the first time, giving adult safeguarding boards a statutory footing.

2.2 Additionally, the Dilnot Commission was established by the Government to report on how to deliver a fair, affordable and sustainable funding system for adult social care in England. Local government and NHS finances were recognised as under significant pressure and the demand for services is increasing as the population ages. The Dilnot report suggested a costed model for the future, in terms of the future costs of social care services and how charges should potentially be applied in future. This information was considered by the Government and many of the recommendations were incorporated into the White Paper, 'Caring for Our Future: Reforming Care and Support' (July, 2012), and the Care and Support Bill (July, 2012).

2.3 As due process continued, the name was amended and it simply became 'the Care Bill'.

2.4 There was a wide range of consultation following the publication of the Care and Support Bill from July to October, 2012. A Joint Committee of Parliament was also established to conduct pre-legislatory scrutiny.

2.5 Over three months, the Joint Committee received further written evidence and held 10 oral sessions with a range of stakeholders. The Joint Committee's work concluded on 7 March, 2013, and their final report was published on 19 March, setting out 107 recommendations. The Government has responded to these recommendations. Parts 1-3 of the Care Bill reflect changes made, taking into account what was heard.

2.6 Progress of the Care Bill through Parliament continues. The current position at any time can be viewed at: http://services.parliament.uk/bills/2013-14/care.html

2.7 The current status is that the Bill has been through the House of Lords and there were some significant amendments. It is now at Committee stage in the House of Commons and the above website made provision for those with expertise, experience or special interest in the area to submit views or evidence by 4th February, 2014.

3.0 Overview of the Care Bill as brought from the House of Lords

3.1 The Care Bill spans a great range of duties and powers and the associated regulations are not yet finalised. To enable the presentation of a broad picture, this section of the report provides a general overview of the intentions of each of the three parts of the Care Bill. A further table then provides some examples of the more detailed implications which will need to be addressed locally. It is possible that there may be further significant change before the legislation is enacted. This means that in terms of preparation, careful thought is needed with

respect to which aspects seem very likely to be enacted as they currently stand, and which may be subject to further change or addition.

3.2 Part 1 (Care and Support):

- Modernises over 60 years of care and support law into a single, clear statute, which is built around people's needs and what they want to achieve in their lives;
- Clarifies entitlements to care and support to give people a better understanding of what is on offer, help them plan for the future and ensure they know where to go for help when they need it;
- Provides for the development of a national eligibility criteria, bringing people greater transparency and consistency across the country;
- Treats carers as equal to the person they care for and on the same legal footing;
- Reforms how care and support is funded, to create a cap on care costs which people will pay, and intends to give everyone peace of mind in protecting them from catastrophic costs;
- Supports the aim of rebalancing the focus of care and support on promoting wellbeing and preventing or delaying needs in order to reduce dependency, rather than only intervening at crisis point;
- Provides new guarantees and reassurance to people needing care to support them to move between local authority areas or to manage if their provider fails, without the fear that they will go without the care they need; and
- Intends to simplify the care and support system and processes to provide the freedom and flexibility needed by local authorities and care professionals to integrate with other local services, innovate and achieve better results for people.

3.3 Part 2 (Care Standards):

3.3.1 The report of the Mid Staffordshire NHS Foundation Trust Public Inquiry, led by Robert Francis QC and published on 6 February 2013, called for a system-wide response, across health and care, to ensure that the failures of Mid Staffordshire NHS Foundation Trust are not repeated. The report made 290 recommendations with the aim of ensuring that the commissioning, delivery, monitoring and regulation of healthcare brings about a transformational change that focuses on achieving reliably safe and high quality care, that puts patients at its heart and where compassionate care and patient experience is as important as clinical outcomes. The Government is progressing a range of further plans in response to the report and has also determined that some changes to primary legislation are needed to deliver the plans. Part 2 of the Care Bill takes forward a package of measures, the most significant of which focus on:

- Requirements for the CQC to develop a system of performance reviews and assessments – an intention for a single version of performance that will allow organisations and the services they provide to be compared like for like in a fair and balanced way, that is meaningful to patients and the wider public.

- Powers to allow the new Chief Inspector of Hospitals, appointed by the CQC, to instigate a new failure regime. This aim of this is that in cases where urgent changes are needed to address poor care or quality failings in NHS hospitals, this will be detected quickly, and there will be a clear and time limited process for intervening and tackling unresolved problems urgently.
- Greater transparency and stronger accountability about the information providers produce on their own performance and outcomes, making it an offence for care providers to supply or publish certain types of false or misleading information and introducing additional legal sanctions.

3.3.2 The measures within Part 2 of the Care Bill were not included in the Draft Care and Support Bill, and therefore were not subject to the same public consultation and pre-legislative scrutiny as the other areas of the Bill. There have been some concerns raised as to the potential for the proposed legislation to be used in other ways than that which is seemingly intended. For example, the Nuffield Trust Parliamentary Briefing 'Care Bill: Second Reading, House of Commons' (December, 2013), notes that the new powers to change the operations of trusts neighbouring a failing trust could radically shorten and centralise the process of reconfiguring hospital services.

3.4 Part 3 (Health Education England (HEE) and the Health Research Authority (HRA))

- Establishes Health Education England (HEE) as a non-departmental public body (NDPB), intended to provide the necessary independence and stability to empower local healthcare providers and professionals to take responsibility for planning and commissioning education and training.
- Establishes the Health Research Authority (HRA) as an NDPB to strengthen its ability to protect and promote the interests of patients and the public in health and social care research, as well as providing assurance that the HRA will continue streamlining the research approvals process and encouraging investment in research.

3.5 Examples of Implications that will need careful local consideration.

3.5.1 The following table provides some key examples of areas of the Care Bill, primarily those relating to local authority duties and powers, and provides some early indicators of possible implications.

Table 1: Examples of Implications of the Care Bill

	Subject	LA duties	Comments/ implications
1.	Well-being; and preventing, reducing and delaying needs for care and support (Clauses 1 and 2)	A new statutory principle to promote individual wellbeing when taking any step under Part 1 of the Bill. A duty to take steps (including providing or arranging services) intended to prevent, reduce or	Integration of services, prevention and re enablement elements to be delivered and supported through the Better Care Fund plans. The Making Every Contact Counts (MECC) agenda and health and wellbeing services will support and

		delay needs for care and support.	provide preventative care. Failure to follow the principle could be used in judicial review and complaints cases to challenge LA decision-making. Thought must be given to the balance of how to apply the 'national eligibility criteria' fairly, alongside a statutory function to provide lower level preventative / wellbeing services.
2.	Information and advice on care and support (Clause 4)	A duty to provide an information and advice service in relation to care and support.	Expands existing duty. Includes carers. Includes the need to provide advice on how to access independent financial advice for adults with care and support needs, or making plans for such needs; and support to identify matters relevant to their personal financial position. Services for 'self-funders' will need further development.
3.	Support providers (Clause 5)	A duty to promote a market of diverse and high-quality range of care and support services in the local area, including a focus on sustainability of the market.	There is a financial challenge associated with developing and maintaining a diverse and sustainable market.
4.	Care and support planning, including personal budgets and direct payments (Clauses 9, 11-13, 18, 24-26)	A duty to carry out 'needs assessments' [brings together a number of existing powers and duties to create a single legal basis for assessment] Even if an adult refuses, assessment must be carried out - a) if adult lacks capacity to agree but LA is satisfied that assessment would be in their best interests; or b) if adult is at risk of harm or financial abuse. Ongoing duty to offer assessment to someone who has refused but	Expansion of LA duties. Applies whether or not LA thinks the adult has eligible needs, and regardless of adult's financial resources. **There is likely to be a requirement for more assessments.** Those funding their own care (and intending to continue to do so) have right to assessment. There will be more interest in timely assessments, in order to 'register' expenditure against the new 'care cap'. **This may also mean more assessments,** and the need for skilled assessments, because of the difficulties of the situation. This indicates a need for a process for keeping track of people who have

		whose circumstances have changed. Duty to meet eligible needs of adults ordinarily resident in LA area who have not reached the care 'cap' – If services are not chargeable OR • If adult's financial resources are at or below the financial limit (so adult does not have sufficient financial resources to be able to pay the assessed charge); • If adult requests LA to meet their needs, even if their resources are assessed as above the financial limit, so that they have to pay for their care in full. • If adult lacks mental capacity to arrange care and support, and there is no other person willing/able to do it. Duty to meet adult's needs for care and support which meet the eligibility criteria where the adult's accrued costs exceed the cap on care costs, if adult is ordinarily resident in LA area. Duty to prepare a care and support plan for an adult with eligible needs; inform adult which of their needs LA will meet and where direct payments may be used to meet needs; help the adult in deciding how to have the needs met. Duty to provide a written explanation for any non-eligible needs and information about services to meet or reduce needs. Duty to provide personal budget for those entitled to care and support (regulations to exclude certain people)	refused but may need services, to determine when their circumstances have changed. LA has to meet needs of self-funders if they ask for this. But the LA can charge for making the care arrangements (the care itself is still paid for by the self funder). This will need practitioners to further develop skills in support planning, personal budget / indicative budget planning and 'talking about money'. A personal budget is already an available option in Warwickshire, but further work will be needed to meet the requirements of any national regulations on how a 'personal budget' is calculated.

		Duty to provide 'independent personal budgets' for adults who have eligible needs, but who choose not to have their needs met by LA, and to keep these under review	Must be broken down so adult can see how much of the costs are attributable to daily living costs, not direct care. Need new process to provide mechanism for recording care costs for the purposes of measuring progress towards the costs cap.
5.	Carers (Clause 10)	A new **duty** to assess carers and meet their eligible needs for support. A power to charge for support to carers.	This duty applies whatever the LA thinks about the level of carer's needs for support or financial resources of either the person needing care or the carer. **This is likely to increase the number of assessments needed.** The new system appears to introduce a significant financial disincentive for the family of vulnerable adults to provide informal care. As family care is not covered as an expense and would therefore not count towards the cap, this care provision would lengthen the time that an individual would need to fund their own care. Unless the service user was paying the full cost of their support, it would ultimately result in a worse financial situation. This anomaly has been identified to the Department of Health both as a significant risk both in financial terms to individuals but also in terms of the potential need for an increased social care workforce in the medium-term.
6.	Charging, the cap on care costs and the care account (Clause 14-16, 29)	LA to have general power to charge for services. May only charge what it costs to provide. LA can charge a fee for arranging support for person who has care and support needs but does not qualify for financial support from LA. There will be a limit ('cap') on the amount that adults can be required to pay towards eligible care costs over their lifetime. Level of cap to be set in regulations. May be set at	Some exclusions, as currently. Replaces **duty** to charge for residential care. DH formal consultation -17.7.13 to 25.10.13 https://www.gov.uk/government/consultations/caring-for-our-future-implementing-funding-reform Implementation from April 2016 likely: £72,000 cap for older people (2016/17 prices); £118,000 upper capital limit in

		different amounts for people of different ages. For care and support in a care home, daily living costs do not count towards accrued costs. LA can continue to charge for these even when cap is reached. Duty to keep a care account for adults whose care costs are counted towards the costs cap, provide regular statements, and inform adult if level of accrued costs in their care account reaches the cap.	residential care; £17,000 lower capital limit in residential care; and Around £12,000 annual contribution to general living costs. Given that any spending on care does not count towards the £72,000 cap until a formal community care assessment has been carried out by social services, there are likely to be a large number of people who are currently funding the cost of their own care who will approach the council for an assessment when the new rules come into effect. This is likely to be a significant number of people (in the thousands).This will present temporary recruitment difficulties as additional staff will be required for the year 2016 to undertake these one-off assessments. The new rules will also lead to a significant permanent increase in the total number of community care assessments requested by self-funders who wish to start recording eligible care costs counting towards their £72,000 cap after 2016. Similarly more people who have assets of less than the new upper capital limit of £118,000 will present for assessment and care services. The extra staffing needed to respond to this permanent increase is currently being calculated. In the new system, therefore, self-funders will require needs assessments, financial assessments, care management and care reviews to determine their level of need, how much the LA would pay to meet that need, what the individual is actually paying, and a recording process to track how much the person has spent on care, in progress towards the 'care cap'. This will require additional staffing of various types. There will be set-up costs for new recording systems/processes and costs associated with maintaining

			these. There may be loss of income to the council, for those who reach the 'care cap' where previously, the customer would continue to have contributed to their own care costs.
7.	Eligibility and continuity of care (Clauses 36-40)	A national threshold for eligibility for care and support; A duty to meet the needs of care and support for users and their carers who move into their areas, from the day of arrival until they undertake a new assessment.	DH launched a policy discussion document and draft regulations on 26.6.13. https://www.gov.uk/government/publications/draft-national-eligibility-criteria-for-adult-care-and-support. Formal consultation will take place in 2014. Detailed provisions for notification between LAs when adults move are likely, e.g., new processes/standard letters needed.
8.	Transition for children to adult care and support (Clauses 55-63)	A power to assess children, children's carers and young carers on request, in order to consider their future needs and support transitional planning. A duty to continue to provide children's services after the child's18th birthday, where adult care and support is not in place.	Care and Support through transitions and to young carers is likely to be an area where further changes to the bill can be expected.
9.	Prisoners (Clause 69)	A duty to assess prisoners and provide care and support (in conjunction with prisons/approved premises) This will be the responsibility of the local authority of the area in which the prison/approved premises is situated. The threshold will be the same as for people who live in the community and require care and support.	
10.	Adult safeguarding (clause 41-44)	Duty to make enquiries (or ask others to) where they reasonably suspect that an adult in LA area is at risk of neglect or abuse, including financial abuse.	Applies to adults who have care and support needs (regardless of whether they are currently receiving support, from LA or indeed anyone); and who are either at risk of or experiencing neglect or abuse, including financial abuse; but are unable to protect themselves. Applies whether or not

		Duty to establish a Safeguarding Adults Board (SAB), to help and protect individuals who LA believes to have care and support needs and who are at risk of neglect and abuse and unable to protect themselves, and to promote their wellbeing.	adult is actually OR in area. SAB must conduct a Safeguarding Adults Review into cases where there is reasonable cause for concern about how the SAB, its members or some other person involved in the case worked together and either adult has died and SAB knows/ suspects that death resulted from abuse or neglect or adult is still alive and SAB knows/ suspects that adult has experienced serious abuse or neglect.
11.	Provider failure (Clauses 47-49)	A duty to ensure that adults' needs for care and support continue to be met when service providers fail.	LA's duty applies to adults and carers whose needs are being met by residential and non-residential services in the LA area (even if ordinarily resident in another LA area). Importantly, this duty also applies to self-funders, not just those supported by the Local Authority.
12.	Universal deferred payments (Clause 34-35)	A duty to offer deferred payments for residential care, with consistent rules on who is eligible, what fees may be deferred and for how long. LA will be able to charge interest throughout.	Details of scheme to be subject to consultation. Government will also be consulting on DPs for non-residential care and for younger adults Warwickshire County Council already runs a deferred payments scheme, although the national rules are likely to be changed, for example, to allow councils to charge interest for the whole duration of the loan rather than only after the person's death, as now. The current scheme will be evaluated against the new regulations as soon as these are published.
13.	Training of social work and contact centre staff on the Bill/Act		It will be necessary to train existing social workers in the new law. The Law Commission suggested a requirement of four days of training per adult social worker in the first year and a further two days in the second year.
14.	Complaints		Due to the new financial implications of determining 'eligible' care needs by social services, it is expected that there will be an increase in the number of appeals and complaints

			about the outcome of these assessments, particularly from people who have been funding their own care but whose needs are not deemed as being 'eligible' using national eligibility criteria.

4.0 Timescales and next steps

4.1 The current national plans indicate that the Care Bill will be enacted by 2016.

4.2 Scoping work continues locally and the next step is an estimate of the local financial impact of the Care Bill and the creation of an implementation plan. This work will need to be integrated with the ongoing work associated with the One Organisational Plan in due course.

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working together

Coventry and Warwickshire Partnership NHS
NHS Trust

Agenda Item 3

Securing Sustainability
2 Year Plan

2014/15 & 2015/16

Update to Warwickshire Health & Well Being Board

Purpose

- Background
- High level plan outline
- Finance and Workforce Assumptions
- Next steps

Background

- Journey since 2011…..
- Key components

STRATEGY ON A PAGE

our vision

*"To improve the **wellbeing** of the **people** we serve and to be recognised for **always** doing the **best** we can"*

Our Values:

- compassion in action
- working together
- respect for everyone
- seeking excellence

Strategic Objectives:

- To deliver an exceptional patient experience first time, every time
- To provide excellent care, ensuring effective, person-centred clinical outcomes
- To be an employer for whom people choose to work
- To be an active partner, always ready to improve by working with others
- To be an efficient organisation providing excellent services

Quality Goals:

- **C** – Customer Care
- **A** – Achieving shared and agreed outcomes
- **R** – Respectful environments
- **E** – Efficiency through effectiveness

Transformational Change Programme

Central Booking Service
- Single route into services
- Trusted Triage booked into Assessment
- E-referral
- Improving access to services

Community Resource Centres
- Records management
- Admin & Support Hubs
- Central Procurement
- Locality Focused

Integrated Practice Units
- Outcome focused
- Quality
- VALUE based approach
- Personalised and efficient

Centres of Excellence
- Secondary Care Mental Heatlh
- Specialist Services
- Aligned to support Community IPUs
- Integrated Pathways

Clinical Systems
- Web based mobile technology
- Tele-health
- Integrated & shared record across system
- Improving efficiency and effectiveness

New Ways of Working
- Agile working
- Integrated teams
- 7 day working
- Productive and efficient

Supporting Strategies

Market Strategy
- Protecting our core business
- Ensuring we are the provider of choice

Enabling Strategy
- Information
- Estate
- Workforce
- IT

Clinical Strategy
- VALUE Based Health
- Focus on Patient Outcomes
- Integrating care

Better Care Fund
- Supporting people to stay well in the community
- Meeting the needs of people with Dementia

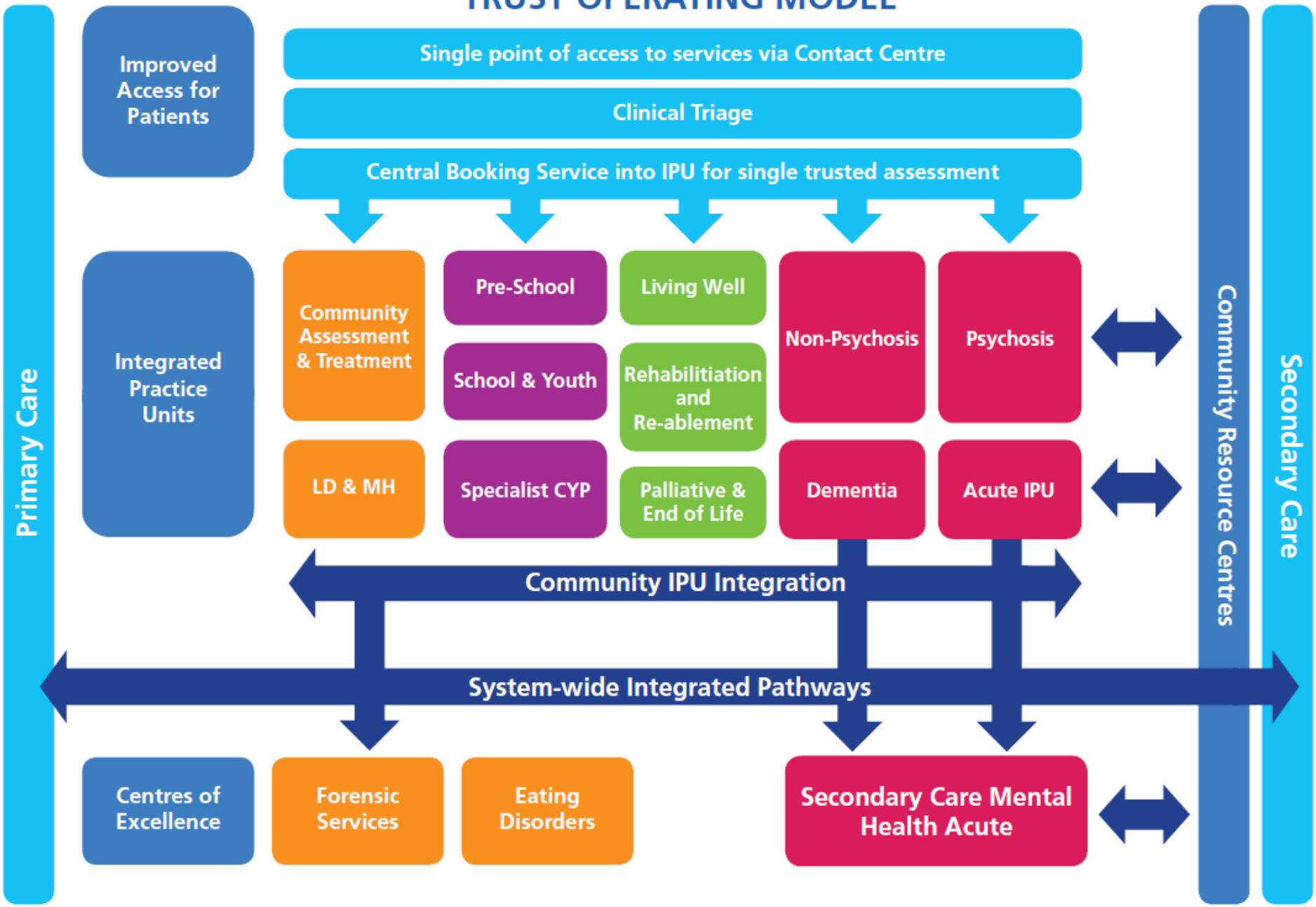
System Wide Integrated Pathways

- Integrated Children's
- Dementia
- End of Life
- Stroke
- Community LD

Programme Challenge

- Aligning our enabling programmes to support the delivery of the Clinical Strategy and in turn benefits – qualitative and quantitative.

TRUST OPERATING MODEL



Financial Planning Assumptions

Income

- Inflation uplift of 2.2%
- Cash Releasing Efficiency Savings of 4% (£7.4m)
- CQUIN uplift of 2.5%.

Expenditure

- Pay Awards 1% - £1.5m
- Incremental Drift - £2.9m
- Cost Pressures 14/15 - £8.6m. £(1.9m safer staffing, £0.8m NHS Professionals & e-rostering, £1.7m IT Strategy, £1m depreciation / PDC)
- Cost Improvement Programme 4.46% - £9.3m. (+0.46% fund cost pressures)
- 0.5% contingency (£1m to manage in year risk)

Surplus

- Plan surplus £2.844m – 1.4%.
- Continuity of Service FRR 4

Workforce

- Leadership challenge
- Staff engagement
- 7 day working
- Safer Staffing

System Alignment

- Section 75 arrangements
- System Board
- Better Care Fund Coventry and Warwickshire
- Responding to the JSNA's

- **Information from the JSNAs:**

  - ✓ There is a large elderly population in Coventry and Warwickshire;
  - ✓ There is a significant elderly population with a one or more long term conditions;
  - ✓ The healthy adult population is able to access services that build resilience and prevent a decline in ill health;
  - ✓ There is a significant children' population with diverse needs;
  - ✓ Deprivation indicators vary across urban and rural populations leading to variation in outcomes;
  - ✓ Mental ill health has a disproportional impact on lives and outcomes;
  - ✓ Mental health does not have a parity of focus or investment;
  - ✓ Learning disabilities disproportionally impact on health outcomes;

Next Steps

- Building 5 year strategy NTDA June 14
- Tranche III *Transformational Change Programme*
- IBP and LTFM end April 14
- BCF Programme development

Item No 5

Health & Wellbeing Board
26th March 2014

Better Care Fund Update.

Recommendations

(1) That the Health & Wellbeing Board notes the progress being made and receives regular updates of progress from the Adult Joint Commissioning Board.

1.0 Key Issues

14th February initial submission

1.1. The Warwickshire Better Care Fund initial draft was submitted on the 14th February 2014. Feedback from the West Midlands Local Area Team indicates that Warwickshire is mostly amber and the following comments will assist in reaching green overall:

- Schemes need to demonstrate more clearly how social care will be protected
- Needs more detail around the governance arrangements eg; risk sharing and better description of project management approach.
- Provider engagement needs strengthening
- Need to develop a communication strategy
- Confirmation of the local metric
- Need to be more visible about the work with; carers, dementia and LD and MH.
- Care Bill implementation needs to be further scoped
- Contingency plans need further explanation
- Joint planning and accountable lead needs further clarification and links to GP leads.
- 7 day working will need to demonstrate what the BCF will support within the system.
- How will we join up the health and social care workforce in key areas
- Within the information sharing process also need to cover business processes not just data sharing.

2.0 National changes to guidance and funding allocation

On the basis of the first draft submissions the national guidance and planning tools have been revised and updated. In addition the funding allocation has also been revised. National Government reports that; …the spreadsheet has been updated to correct a minor calculation error in the original BCF allocations. This

did not affect overall CCG contributions, but did affect the division of CCG totals between multiple HWBs. The original funding allocation is in Table 1. The impact of the changes for Warwickshire is shown in Table 2.

Table 1 Original funding allocation:

NHS Warwickshire North CCG	11,036	
NHS South Warwickshire CCG	15,500	
NHS Coventry and Rugby CCG	6,432	
Total Allocation		**36,137**

Table 2 Revised funding allocation

NHS Warwickshire North	11,036	**36,427**			0
NHS South Warwickshire	15,500				0
NHS Coventry & Rugby	6,722		-290	-0.8%	**290**

The impact of the revised funding allocation is for Rugby only. NHS England report that any CCG that has been affected by these changes has been informed.

3.0 Progress towards 4th April 2014

3.1. The Adult Joint Commissioning Board, as the lead for the Better Care Fund, has held a collaborative workshop to approve the suite of metrics. The revised guidance stipulates that each target must be statistically significant. A calculator has been provided on the NHS England BCF website. This has been used to determine the statistical relevance of each indicator at a minimum level. The approved metrics recognising that some of these targets are stretching given previous trends. The baseline and targets for each metric are attached as appendix 1.

3.2 Further work is progressing to align and agree the final financial plan to be submitted to NHS England. Initial figures have been submitted from health, public health and social care. Further ongoing discussions will need to be finalised over the coming week with each of the clinical commissioning groups. The Adult Joint Commissioning Board agreed that further detail was required to ensure that the BCF demonstrated compliance with the national condition to protect social care.

3.3 Further work is required given the significant work to achieve consensus and to align the final financial framework, with the metrics and the schemes to be progressed. As an example the following actions are still to be progressed:

- CCG's and LA to confirm the figures proposed to go in the pool are correct and complete (**to be co-ordinated by finance leads in each organisation and send to CN by 26/3**).

- CCG's and LA to confirm the values of relevant unit costs and add any others that would be useful (**CCG and LA finance leads to confirm or provide updates to CN by 28/3**).

- Meeting of relevant colleagues to discuss metrics and link them to finance (**CN to look for a relevant meeting already diarised to do this at, or arrange a specific meeting**).

- CCG's and LA to progress discussions about what is funding what in 2015/16. (**CCG and LA finance leads to co-ordinate proposals and return to CN by 1/4, CN to identify appropriate meeting to then discuss**).

3.3 The financial framework is continually being revised and added too as discussions with partners clarify which funds could be aligned into a pooled budget arrangement across health, public health and social care.

3.4 There have been different approaches to provider engagement within each of the clinical commissioning groups. But it is acknowledged that further work is required. For this reason a meeting has been scheduled for the 26th March 2014 as an opportunity to highlight the direction of travel and to determine how to improve provider engagement as the BCF moves forward. Warwickshire North has confirmed that providers will be engaged through their Urgent Care Board.

4.0 Timescales associated with the decision/Next steps

4.1 More detailed work to address the issues received from the Local Area Team and to produce the detailed plan is being progressed on a daily basis. The draft plan will be further updated to reflect the feedback from the Local Area Team and in addition scoping documents outlining the five schemes to be progressed for Warwickshire will be included.

4.2 The governance structure will be amended to reflect the decision to produce a delivery plan for each of the respective clinical commissioning groups which will be underpinned by Section 75s.

The revised version of the Better Care Plan will be submitted to NHS England, as an integral part of the constituent CCGs' Strategic and Operational Plans by **4 April 2014**.

Background Papers

1. http://www.england.nhs.uk/ourwork/part-rel/transformation-fund/bcf-plan/

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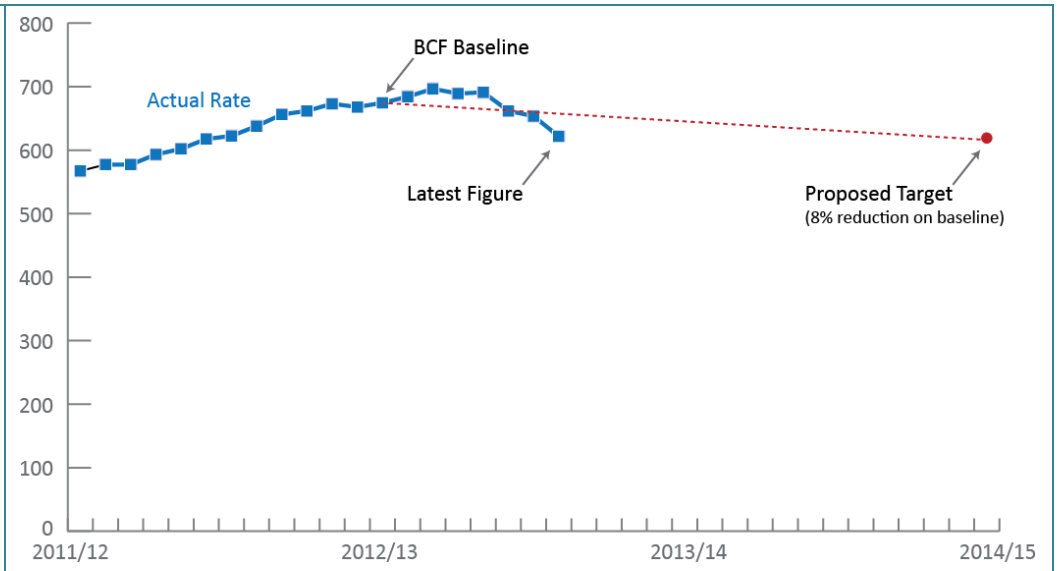
social care Portfolio Holder for Health	Cllr Bob Stephens	

1 Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population

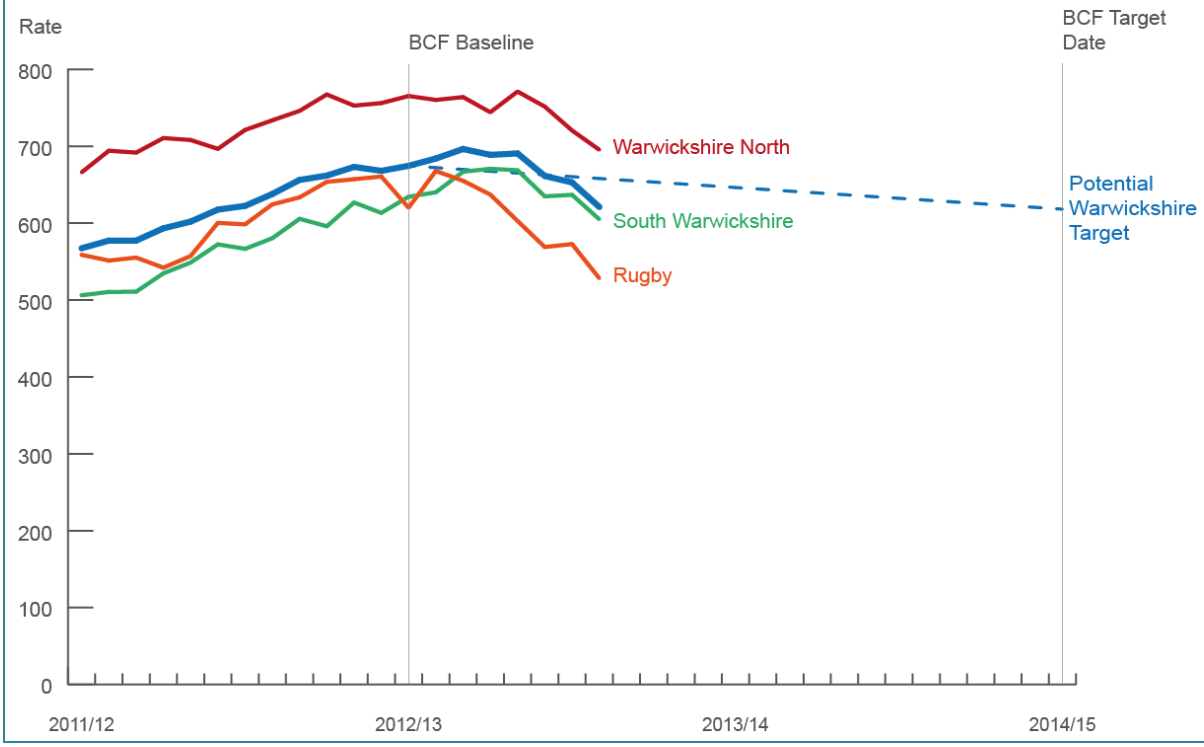
Outcome Sought	Reducing inappropriate admissions of older people (65+) in to residential care.
Data Source / Notes	Description: Annual rate of council-supported permanent admissions of older people to residential and nursing care. Numerator: Number of council-supported permanent admissions of older people to residential and nursing care, excluding transfers between residential and nursing care (aged 65 and over). This is from the ASC-CAR survey. Denominator: Size of the older people population in area (aged 65 and over). This should be the appropriate ONS mid-year population estimate or projection. This information is captured by adult social care finance systems. The indicator counts supported admissions (i.e. where the council is making a contribution towards the cost of the placement) where there is no immediately preceding residential or nursing care package. The data is available monthly but there is a 2-3 month lag before all data is available. Historical and baseline figures validated against the data supplied on the BCF website, which is taken from the HSCIC.
Baseline & Trend	The underlying trend from April 2011 through to the BCF baseline period saw an increase in the number of monthly admissions. In the twelve month period Apr-11 to Mar-12 the admission rate per 100,000 population was 567. During the following twelve months, the rate rose to 674. This figure provides the baseline for the BCF measurement period (Apr-12 to Mar-13). There have been some reductions since April 2013, with the average monthly number of admissions falling from 59 in 2012/13 to 53 so far in 2013/14.
Proposed Target	Our targets will be assessed to ensure that they are striving to achieve a *statistically significant* improvement. The BCF provides a tool to identify what scale of reduction would be required to achieve such an improvement. Based on the projected population size by 2015, we would need to achieve a reduction in our admissions rate of 8% by the end of 2014/15. This translates as a rate of 618 per 100,000 population or 686 admissions during 2014/15. To put this in context, the total number of admissions during the most recently available twelve months (Nov-12 to Oct-13) has been 661. Although it appears we could actually reach an acceptable target with a small increase in admissions, this needs to be placed in the context of an increasing population.



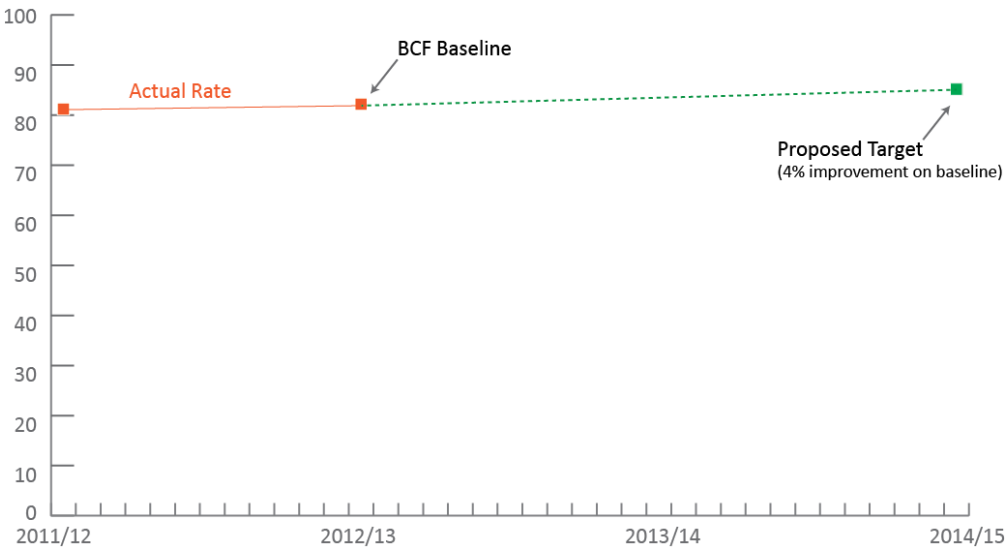
CCG Analysis

As requested as the February meeting of the Joint Adults Commissioning Board, we have disaggregated the county-level total into figures for the three CCGs. This is to help determine whether there are local variations in admissions rates across the county. In the case of Coventry & Rugby, we have just examined the Rugby aspect so that the figures re-aggregate to the Warwickshire total.

	April-12 to March-13 Baseline	
	Number	Rate
Warwickshire North	260	765.3
Rugby	113	620.1
South Warwickshire	331	634.3
Warwickshire	**704**	**674.5**



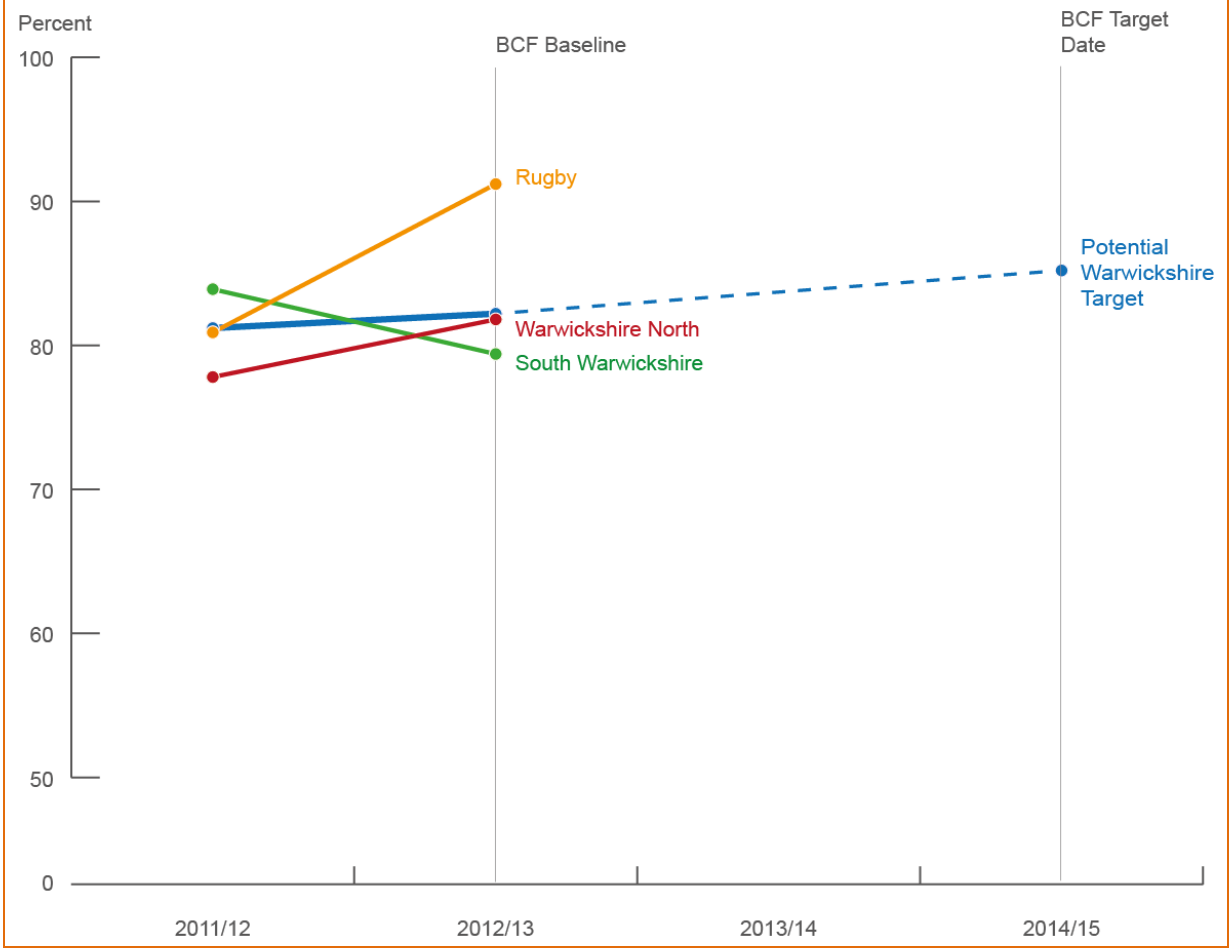
2 Proportion of Older People (65+) who were still at home 91 days after discharge from hospital into Reablement/rehabilitation services

Outcome Sought	Increase in effectiveness of these services whilst ensuring that those offered service does not decrease
Data Source / Notes	Information for this measure comes from two sources: 1. People identified as receiving reablement following a stay in hospital, either referred by a hospital social care team or CERT. This is captured by council systems 2. People identified as receiving intermediate care following a stay in hospital. This information is captured by health systems and fed back to WCC for submission in statutory returns In each case the responsible organisation checks if the person was living at home 91 days after their discharge from hospital; local arrangements are in place to do this. Historical and baseline figures validated against the data published on the BCF website, which is taken from the HSCIC. Sub-County figures may not sum to the Warwickshire total due to the published county level being rounded to the nearest five people.
Baseline & Trend	This measure has remained consistent in recent times, at 81.2% in 2011/12 and 82.2% in 2012/13. This second figure will be used as the baseline for the BCF measurement.
Proposed Target	It is more difficult to forecast this measure as we have to predict both the denominator (the number of older people discharged from hospital into reablement/rehabilitation services) and the numerator (the number of these people still at home after 91 days). To achieve a *statistically significant target*, we would need to improve the rate by about 4%. This, based on the projected population, would mean an increase in the metric of about three percentage points or a rate of 85.2%. 

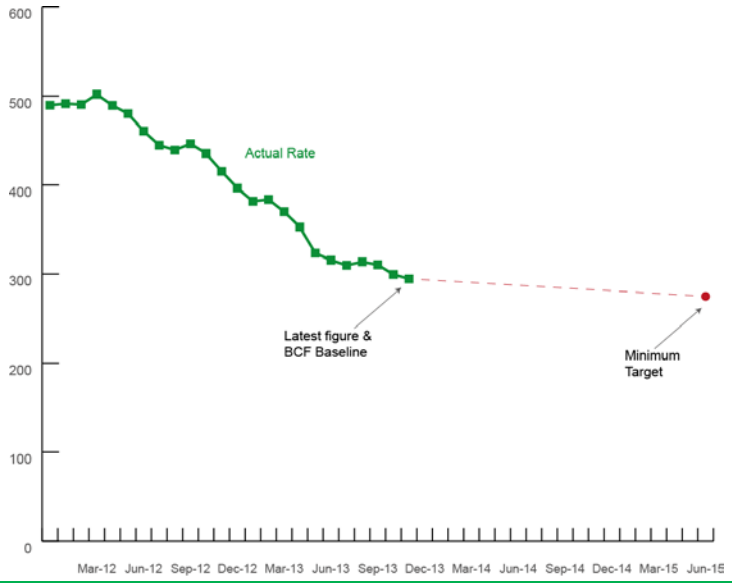
CCG Analysis

The table below presents a disaggregation of the county-level total into figures for the three CCGs. In the case of Coventry & Rugby, we have just examined the Rugby aspect so that the figures re-aggregate to the Warwickshire total. Please note that the CCG figures do not sum precisely to the county total due to rounding of the published county figure.

	April-12 to March-13 Baseline		
	Number	Denominator	Percentage
Warwickshire North	135	165	81.8%
Rugby	125	137	91.2%
South Warwickshire	432	544	79.4%
Warwickshire	**695**	**845**	**82.2%**



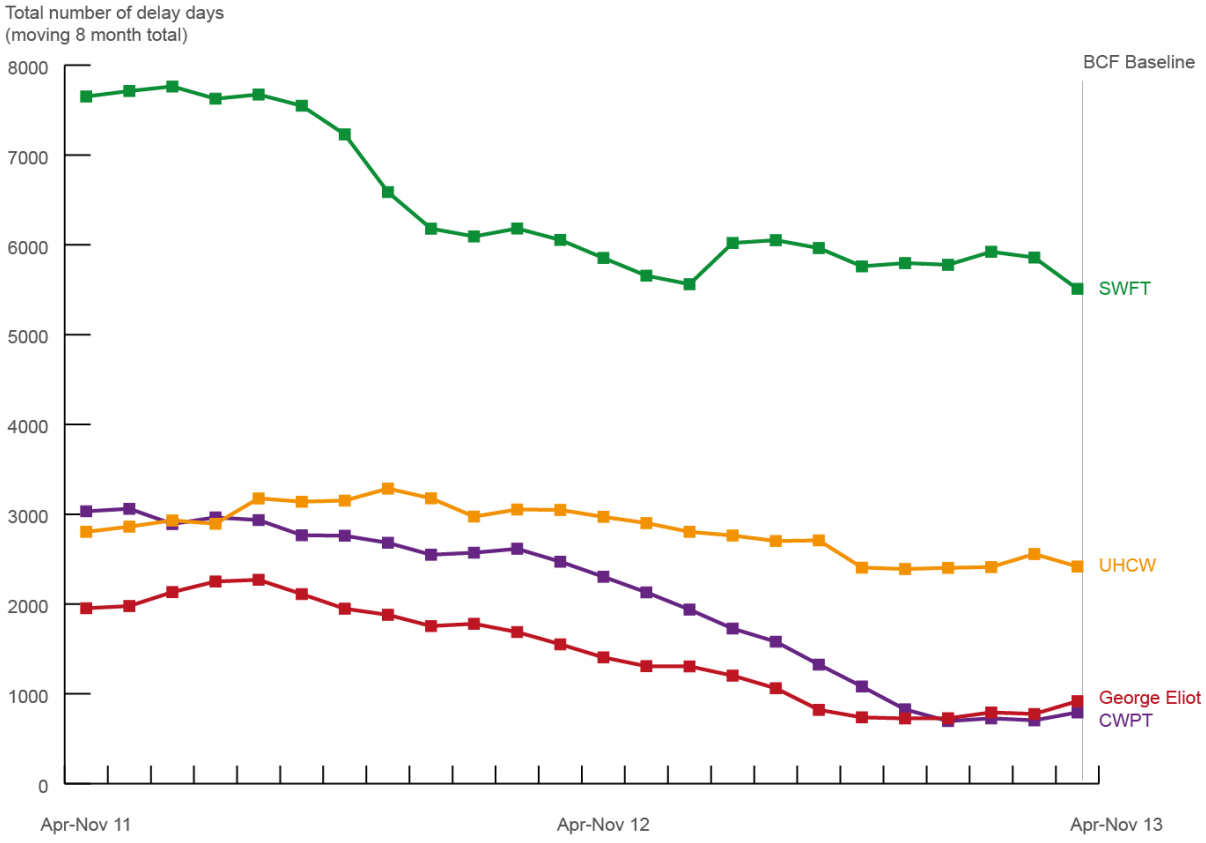
3 Delayed Transfers of Care from Hospital per 100,000 population

Outcome Sought	Effective joint working of hospital services (acute, mental health and non-acute) and community-based care in facilitating timely and appropriate transfer from all hospitals for all adults.
Data Source / Notes	This indicator uses a snapshot of the last Thursday of each month for people whose discharge from hospital has been delayed. The delays are signed off by ward managers and social care managers each week along with the reason for delay and responsible organisation. This is submitted by the hospital to the national delayed discharge system, Unify. Up to date information is available on the NHS Statistics website. Although locally and within ASCOF this metric has traditionally been presented in terms of patient numbers, the BCF website, using data from NHS England, has presented the historical volumes in terms of overall days delayed. This dataset cannot be presented on a CCG-level. Instead, our sub-county analysis considers provider-based statistics as a proxy for exploring local variations.
Baseline & Trend	Our baseline covers the period April to November 2103. During this time, we had an average of 294 days delay per month, per 100,000 population. This indicator has been improving considerably in recent times, from an average of 2,127 delays per month in April-November 2011 to the current level of 1,193 in November 2013.
Proposed Target	In order to achieve a statistically significant improvement on this measure, we would need to reduce the number of delayed transfer days from 1,295 to 1,233 per month. The guidance does not clarify whether a statistically significant improvement is required by the time of the first payment (December 2014) or the second date (June 2015). If we work to the second date, we would need to reduce the metric from 294 to 275 per 100,000 population. 

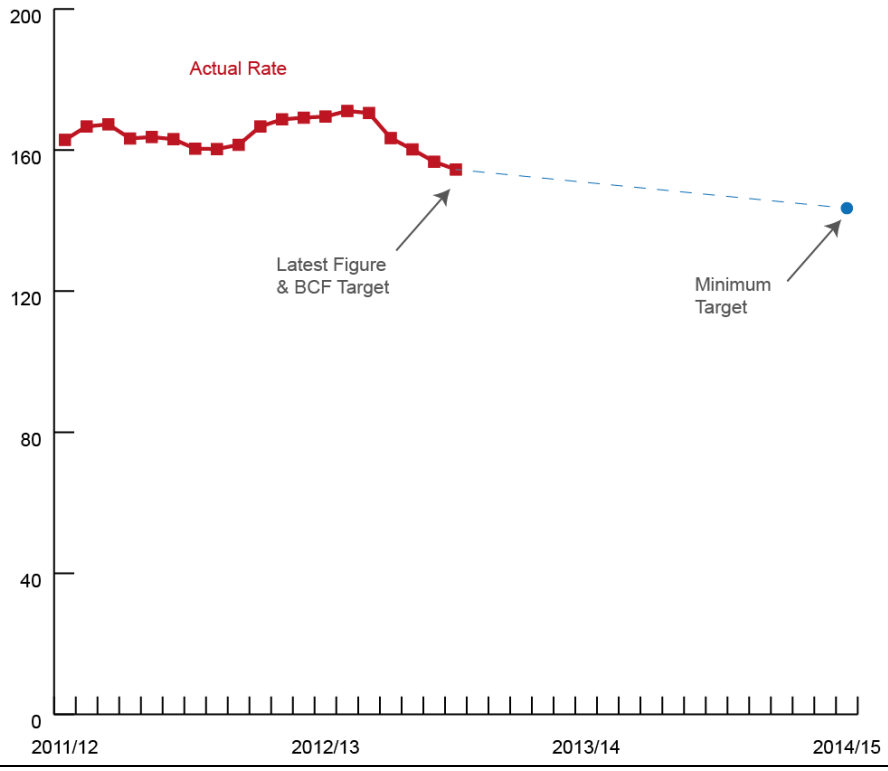
Provider Analysis

As described earlier, it is not possible to present this dataset on a CCG basis, as the information relates to providers. As such, the numbers do not necessarily sum to the county total. Calculating rates on a provider basis is problematic, so the sub-county analysis presented below provides raw counts (total number of delay days). This still enables us to understand the relative volumes across each provider as well as the direction of travel.

	April-13 to November-13 Baseline		
	Average day delays per month	Denominator (proxy using Districts)	Metric
George Eliot	124	-	-
UHCW	297	-	-
SWFT	690	-	-
Coventry & Warwickshire Partnership NHS Trust	101	-	-
Warwickshire	**1,294**	**439,845**	**294**



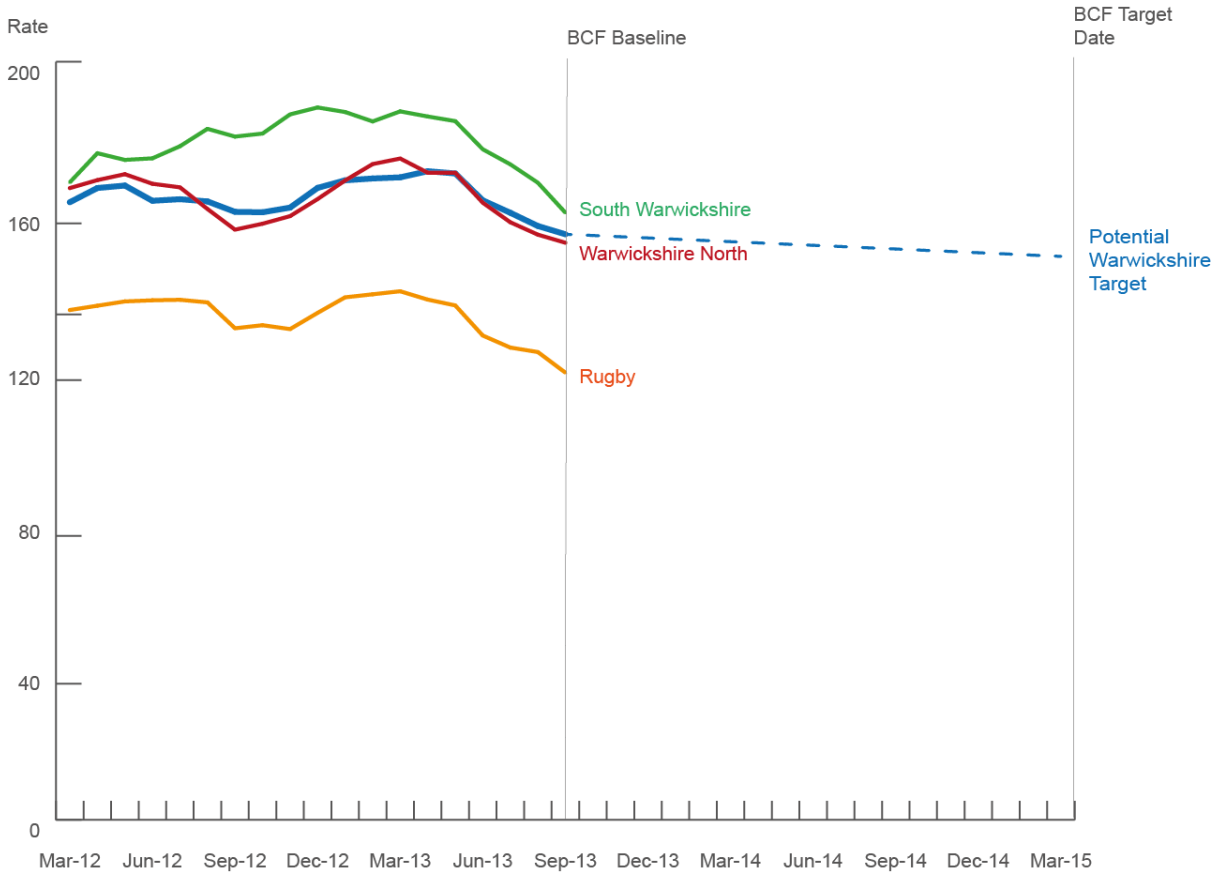
4 Avoidable emergency admissions per month per 100,000 population

Outcome Sought	Reduce emergency admissions which can be influenced by effective collaboration across the health and care system.
Data Source / Notes	Historical and baseline figures validated against the data published on the BCF website, which is taken from Hospital Episode Statistics (HES). Sub-County figures provided by Arden CSU. Apr 11-Mar 12 & Apr 13 - Dec 13 CMCSU data; Apr 12-Mar 13 NHS England Operational Atlas (please note: until 1 April 2013, PCTs (CCGs) were responsible for Specialised Services - this is now provided by NHS England.
Baseline & Trend	During the BCF baseline period April – September 2013 there was an average of 852 avoidable emergency admissions in Warwickshire per month, generating a metric of 155.5 avoidable emergency admissions per 100,000 population per month. The underlying trend during the past three years has been relatively static, with peaks typically occurring in December of each year.
Proposed Target	Based on the tool provided with the BCF guidance, we would need to achieve a reduction of around 3% to achieve a statistically significant improvement on this measure. Therefore, our proposed target for the second payment period (October – March 2015) is a metric of 143.5 per 100,000 population per month. Given the expected population rise during this period, this translates to a numerator (actual admissions) of 809 per month. We understand the CCGs have submitted a draft operational plan to the area team which proposes a 10% decrease between 2012/13 and 2018/19 for this indicator. Our proposed BCF target would not be contrary to this CCG target. 

CCG Analysis

The table below presents estimated data for the sub-county areas. Note that the sum of these does not necessarily match the county total as there are some small discrepancies between locally produced figures and the Warwickshire totals published on the BCF website.

	April-13 to September-13 Baseline		
	Numerator	Denominator	Metric
Warwickshire North	287	189,456	151
Rugby	120	102,677	117
South Warwickshire	418	262,487	159
Warwickshire	**852**	**554,620**	**154**



5 Patient/service user experience

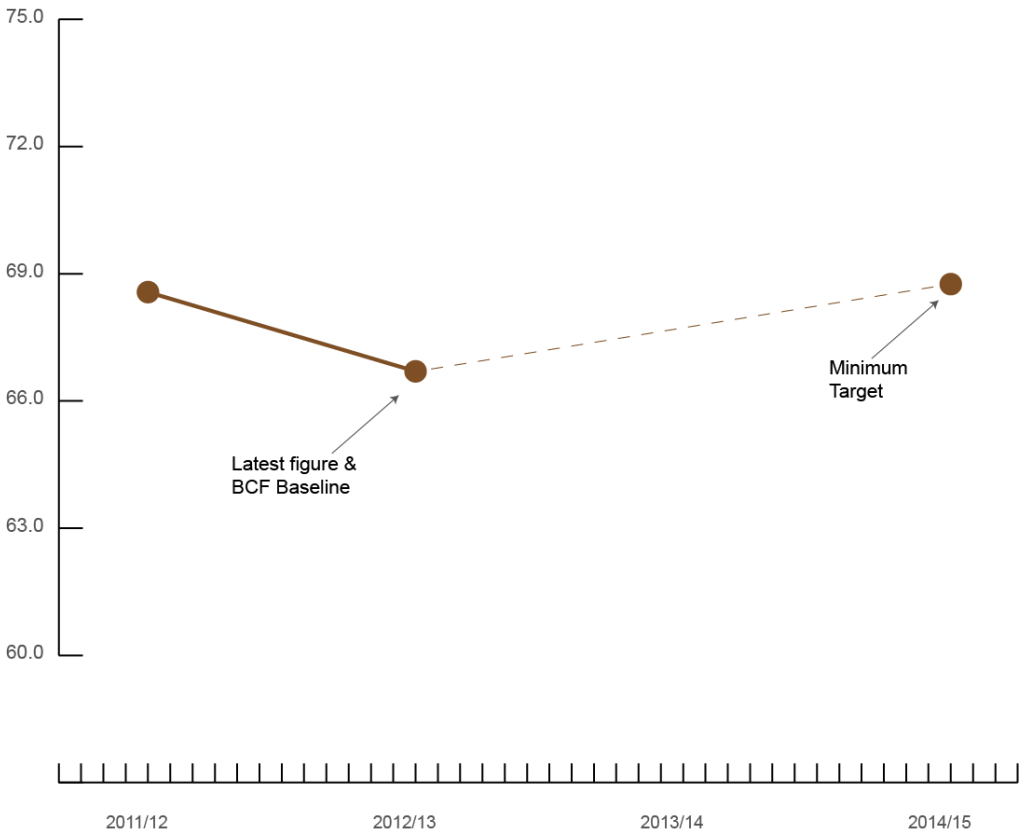
Outcome Sought	To demonstrate local population/health data, patient/service user and carer feedback has been collated and used to improve patient experience. To provide assurance that there is a co-design approach to service design, delivery and monitoring, putting patients in control and ensuring parity of esteem.
Baseline & Trend	Payment can be based on either an existing or a newly developed local metric or on a national metric. The BCF guidance has not released details of a national metric at this stage. Analysis of potential existing measures has identified a number of shortcomings in these measures, particularly in their ability to reflect experience across entire journeys of care and sectors. Therefore, a new national metric is currently being developed. We have two options; wait for the details of the national metric to emerge or define our own local measure on the theme of patient/user experience. For those choosing to use the national metric details of payment will be confirmed once the national metric has been agreed. If we go for the latter, then one option is to use the measure 'Social Care-related Quality of Life'. This is derived from the annual National Social Care Survey. The measure is comprised of the responses to eight specific questions within the survey. Each question provides a score based on how positively it was answered (according to the multiple choice options) and those scores are summed to provide the numerator. The denominator is based on the total number of respondents to the survey to answer all eight of those questions. The measure is presented as a score out of 24. The current baseline ASCOF score for the 2012/13 survey was 18.5. The ASCOF measures have only recently been implemented in this format so comparative data for previous years is not available.
Proposed Target	It is very difficult to predict a trend for these survey results as there are so many variables involved including: - Overall response rate - Make up of respondents - Proportion of those respondents completing all 8 questions - Respondents understanding of the questions - Respondents understanding of the services they receive - Respondents opinions of the services received However, if the proportion of people responding to each question with the most positive possible score increase by 1% (i.e. moving 1% from the least positive possible score to the most positive possible score) the overall ASCOF measure would increase to 18.7.
CCG Analysis	This indicator is derived from fairly complicated calculations; we can explore the feasibility of producing sub-county figures if this measure is ultimately selected for inclusion in our BCF indicators.

6 Local Metric: Proportion of people feeling supported to manage their (long term) condition

Outcome Sought	As well as the pre-determined national metrics, we must choose one additional indicator. The BCF guidance makes recommendations on suitable measures and Warwickshire has opted to use one of these; "Proportion of people feeling supported to manage their (long term) condition". This is taken from the NHS Outcomes Framework.
Data Source / Notes	Data is made available via the HSCIC and is based on responses to a question from the GP Patient Survey (GPPS). The numerator is the total number of 'Yes, definitely' or 'Yes, to some extent' answers to GPPS Question 32: In the last 6 months, have you had enough support from local services or organisations to help you manage your long-term condition(s)? *Please think about all services and organisations, not just health services* Yes, definitely / Yes, to some extent / No / I have not needed such support / Don't know/can't say The denominator is the total number of 'Yes, definitely', 'Yes, to some extent' and 'No' answers to question 32 above. The survey results are published annually and are available approximately three months after the end of each data collection period, e.g. 2013/14 data released in summer 2014.
Baseline & Trend	The latest figure for Warwickshire, covering the period July 2012 – March 2013, was 66.5%. This is based on the responses of around 3,500 patients with long term conditions. The comparative figure in 2011/12 was 68.3%. Nationally, the figures for upper-tier local authorities range between 54% and 74%, and Warwickshire falls in the second quartile.

Proposed Target

A statistically significant improvement on our baseline would require us to raise the figure to 68.7%.



CCG Analysis

Figures on this measure are available for both CCGs and Districts, although the CCG results for 2012/13 have not been formally published by the HSCIC.

		July-11 to March-12	July-12 to March-13 Baseline
CCGs	Warwickshire North	67.8%	n/a
	Coventry & Rugby	67.2%	n/a
	South Warwickshire	74.4%	n/a
Districts	North Warwickshire	60.1%	59.5%
	Nuneaton & Bedworth	65.8%	63.9%
	Rugby	66.9%	66.8%
	Stratford-on-Avon	69.1%	72.6%
	Warwick	73.0%	66.9%
	Warwickshire	**68.3%**	**66.5%**