South Bucks
District Council

Agenda

OVERVIEW & SCRUTINY COMMITTEE FOR PUBLIC HEALTH SERVICES

Date	Friday 2 November 2007
Time	10.00 am
Venue	Room 6 South Bucks District Council, Capswood, Oxford Road, Denham, Bucks UB9 4LH

PLEASE NOTE CHANGE OF VENUE

9.45 am Pre-meeting Discussion

This session is for members of the Committee only. It is to allow discussion of matters such as; what line of questioning should be pursued and by whom, which areas of discussion should be covered, what members wish to achieve from the meeting etc.

Please note the following visits have been arranged:-

Oxfordshire and Buckinghamshire Mental Health Trust on Thursday 8 November 09.30am until 12 noon to visit the Manor House site in Aylesbury.

10.00 am Formal Meeting Begins

Agenda Item		Time	Page No
1	**APOLOGIES FOR ABSENCE / CHANGES IN MEMBERSHIP**	**10.00am**	
2	**DECLARATIONS OF INTEREST** To declare any personal and prejudicial interests	**10.02am**	
3	**MINUTES** of the meeting held on 5 October 2007 to be confirmed as a correct record	**10.03am**	**1 - 4**
4	**PUBLIC QUESTIONS** The Chairman of the Committee will receive questions from members of the public relating to health issues in the south of Buckinghamshire.	**10.05am**	
5	**REPORT FROM SOUTH BUCKS GP PRACTICE** The Committee Member representing South Buckinghamshire District Council will present a report from local GPs outlining the	**10.20am**	**5 - 6**

challenges facing primary care in the south of the county.

Councillor Maureen Royston

6	**SHAPING HEALTH SERVICES REVIEW** The Chief Executive of Buckinghamshire Hospitals Trust will provide Members with a report on the review of the Shaping Health Services (SHS) proposals. In 2004 the Public Health Overview and Scrutiny committee were statutory consultees on proposals for changes to key areas of health delivery in the County. Members will learn of the impact of the SHS recommendations, those that have achieved the anticipated outcomes and those where there is still work to be done. Specifically the Chief Executive will focus on the areas of Emergency Care and Women and Children Services. **Anne Eden – Chief Executive Buckinghamshire Hospitals Trust** **Dr Graz Luzzi – Medical Director** **Damian Eustace – Divisional Chair of Womens and Childrens**	**10.30am**	**7 - 22**
7	**HOSPITAL ACQUIRED INFECTION** The Committee will be updated on the current situation on the incidences of MRSA and Clostridium difficile in the Buckinghamshire Hospitals Trust. **Dr Jean O' Driscoll Director of Infection Prevention and Control**	**11.20am**	
8	**CHILDREN'S AND ADOLESCENT MENTAL HEALTH SERVICES (CAMHS)** The Director for CAMHS, a Division of the Oxfordshire and Buckinghamshire Mental Health Trust, will present proposals to the Committee outlining a realignment of services in Buckinghamshire. **Yvonne Taylor Director CAMHS**	**11.45am**	**23 - 52**
9	**WEXHAM PARK AND HEATHERWOOD HOSPITALS CONSULTATION** Members will be asked to agree to the formation and member representation on a Joint Overview and Scrutiny Committee with the East Berkshire Overview and Scrutiny committee to address the forthcoming consultation on Wexham Park and Heatherwood Hospitals. The terms of reference for the current Joint Committee are attached for information.	**12.05pm**	**53 - 54**
10	**COMMITTEE UPDATE** An opportunity to update the Committee on relevant information and report on any meetings of external organisations attended since the last meeting of the Committee. This is particularly pertinent to members who act in a liaison capacity with NHS Boards and for District Representatives.	**12.15pm**	

11 DATE AND TIME OF NEXT MEETING **12.30pm**

Friday 7 December 2007 at 10am.

For further information please contact: Clare Gray on 01296 383610
Fax No 01296 382538, email: cgray@buckscc.gov.uk

Members

Mr M Appleyard (C)
Mrs P Wilkinson MBE (VC)
Mrs M Aston
Mrs P Bacon
Mr H Cadd
Mrs A Davies
Mr R Woollard

District Council Members

Sir J Horsbrugh-Porter, Chiltern District Council
Mrs W Mallen, Wycombe District Council
Mr D Rowlands, Aylesbury Vale District Council
Mrs M Royston, South Bucks District Council

South Bucks
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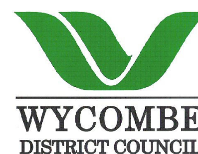

Minutes

OVERVIEW & SCRUTINY COMMITTEE FOR PUBLIC HEALTH SERVICES

MINUTES OF THE OVERVIEW & SCRUTINY COMMITTEE FOR PUBLIC HEALTH SERVICES HELD ON FRIDAY 5 OCTOBER 2007, IN MEZZANINE ROOM 2, COUNTY HALL, AYLESBURY, COMMENCING AT 10.00 AM AND CONCLUDING AT 12.00 PM.

MEMBERS PRESENT

Buckinghamshire County Council

Mr M Appleyard (In the Chair)
Mrs P Wilkinson MBE, Mrs M Aston and Mrs A Davies

District Councils

Mrs W Mallen	Wycombe District Council
Ms J Puddefoot	Aylesbury Vale District Council
Mrs J Woolveridge	South Bucks District Council

Officers

Mrs C Gray, Senior Democratic Services Officer
Mrs A Macpherson, Policy Officer (Public Health)

Others in Attendance

Mr M Colston, Cabinet Member for Adult Social Care
Dr J O'Grady, Director of Public Health, BCC & Buckinghamshire PCT

1 APOLOGIES FOR ABSENCE / CHANGES IN MEMBERSHIP

Apologies were received from Mrs P Bacon, Mr H Cadd, Mr R Woollard and Sir J Horsbrugh-Porter (Chiltern District Council). Mrs J Puddefoot replaced Mr D Rowlands (Aylesbury Vale District Council) and Mrs J Woolveridge replaced Mrs M Royston (South Bucks District Council).

2 DECLARATIONS OF INTEREST

Mrs W Mallen and Mrs J Woolveridge both declared a personal interest as Members of the Countywide Public Health Strategy Group.

3 MINUTES

The Minutes of the Meeting held on 7 September 2007 were agreed as a correct record.

4 THE PUBLIC HEALTH AGENDA FOR BUCKINGHAMSHIRE

This item focused around the key public health issues for the population of Buckinghamshire. An overview was given of the priority areas and their related issues and how agencies are working in partnership to meet agreed targets and deliver outcomes.

(i) REMIT OF THE COUNTYWIDE PUBLIC HEALTH STRATEGY GROUP

The Cabinet Member for Adult Social Care attended this Meeting to provide information about the remit of the Countywide Public Health Strategy Group, as he chaired this Group.

He particularly highlighted the following points:-

- Despite a long history of partnership working around promoting health and wellbeing, there was a gap in countywide multi-agency strategic planning which became even more apparent with the development of the Local Area Agreement. In response to this, officers agreed to set up the Group. The Group was set up a year ago.
- The Group has agreed the following priorities – Improving health where needed most, Childhood poverty, Obesity and Physical activity, Alcohol, Smoking and Improving the Health of Vulnerable Groups.
- There was some discussion about how this Group should communicate to this Committee. It was agreed that it would be inappropriate to have a Member of this Committee on the Group, as it was important for the OSC to preserve independence, but it would be possible for an OSC Member to sit as an observer.
- It was important to liaise over Work Programmes between the OSC and the Group to ensure work was not undertaken on the same area at the same time.
- The Group previously did not have any dedicated officer support but they were in the process of recruiting an officer.
- District Council representatives provide regular reports back to their District Council.
- The Group reports to Cabinet and a Partnership Group for governance arrangements and through the new governance arrangements of the Local Area Agreement.
- The Group monitors the healthier communities block of the Local Area Agreement.
- Interviews were currently taking place as part of the Healthier Communities Peer Review.

Mike Colston was thanked for his report. The Committee agreed that the Group should give regular reports to OSC on the work they were undertaking and submit any Action Plans so that they could be monitored by the OSC.

(ii) OVERVIEW OF THE PRIORITY AREAS FOR PUBLIC HEALTH

Jane O'Grady gave a presentation on priority areas for public health (which is available on http://www.buckscc.gov.uk/moderngov/mgConvert2PDF.asp?ID=2357&J=5). The Director of Public Health's Annual Report is due to be published at the year end. Following discussion the following points were made:-

- There were a number of surprising statistics, particularly relating to smoking.
- High flyers/workaholics were discussed with an example of a young person having a stroke at the age of 32. This group often did not access health care or had no time to exercise. Jane O Grady reported that those people who worked at the top

of an organisation were usually much healthier than those at the bottom; people were healthier if they were at the top of the social hierarchy.
- There were concerns about child obesity. Some of these children were difficult to monitor as their parents did not want them to be singled out or stigmatised.
- A question was asked about nicotine substitutes and whether they could be made stronger to help people who had just given up smoking. In addition whether they could be sold at garages and shops. Jane O Grady reported that she would need to obtain advice on safe levels of nicotine substitutes. A Member suggested advertising the harms of smoking in all smoking shelters.
- Practice based commissioning was recommended as a possible approach to evaluate, how care was commissioned, what initiatives are given to GPs to engage patients in leading a healthy lifestyle, and how public health issues were dealt with such as smoking and obesity.
- Different messages needed to be sent to different people. Changing attitudes was important and could be undertaken in different ways e.g advertising. It was difficult to target all areas at once and had to be prioritised.
- Some Parishes delivered Medical News with the Parish newsletter which helped to deliver public health messages.
- A question was asked about what impact Children's Centres had on the health of the local community. This would be discussed with the Director of Children's Services and reported back to the Committee. There was more likely to be qualitative rather than quantative information.
- There should be a response to the consultation on housing numbers in Aylesbury Vale from a public health perspective, particularly in relation to footpaths and cycle routes, leisure and green spaces.
- In terms of targeting older people it was important to do this from the age of 50 onwards as changing behaviours could have a dramatic impact on health and life expectancy.

The Committee agreed that the two areas that should be looked at for their future Work Programme was:-

- The impact of primary care and practice based commissioners on the delivery of key public health targets
- Children and Obesity

It was suggested that before a scoping paper was drawn up by the Policy Officer on Children and Obesity that a discussion should be held with the Director of Children's Services regarding areas for research and how the research was conducted. In relation to practice based commissioning it was important to include other parts of the NHS such as the Mental Health and Acute Trusts and what they were doing to contribute to public health targets.

Jane O Grady was thanked for her informative presentation.

5 PATIENT AND PUBLIC INVOLVEMENT FORUMS (PPIF)

The Forum Support Officer gave an update on key patient issues arsing from the Forum's current Work Programmes. In addition the following points were made:-

- 90 responses had been received from people in Buckinghamshire out of 6,000 responses nationally on the National Dental Survey. A full report would be available on 15 October 2007.
- The Milton Keynes Forum were hosting a health event on 9 October at the Shopping Centre where there would be 60 exhibitors.
- The hospital discharge policy was welcomed as a work priority issue. There were concerns about the huge variation between services on discharge packages.

The Committee thanked the Forum for their report.

6 COMMITTEE UPDATE

The Chairman updated the Committee with the following information:-

- The future vision of Buckinghamshire PCT had been presented to the Committee on their Strategy 'Getting healthcare right for the future'.
- An announcement was expected soon on the number and location of control rooms/HQ sites in the area from the Ambulance Trust. The Committee had responded to the consultation previously and would wait to see what decision was made at the next Board Meeting.
- The next meeting of this Committee was being held at South Bucks District Council and members of the public would be invited to speak, particularly to raise issues affecting their area.

7 DATE AND TIME OF NEXT MEETING

The next meeting would be held on Friday 2 November 2007 at 10am at South Bucks District Council.

CHAIRMAN

Health Issues in the South of the County

It is felt that the Wycombe Accident and Emergency Department will be downgraded if an ‘urgent case centre’ is introduced.

If so, what kind of patients will the hospital staff be able to see? (excluding any GP service)

What cases does Wycombe A&E currently see that they will no longer be able to fully care for and admit to the hospital?

It is wondered what services the hospital will provide in 10 years time. There is a possibility that if the hospital is downgraded to an urgent case centre, recruiting doctors will become a major difficulty, as the status will be more of a cottage hospital.

The doctors are the voice of the PCT, but the PCT does not involve the doctors. There is a Professional Executive Committee (PEC) in existence. Are the public aware of this body, and could it be explained or described? A complaint from the GPs is they discover what is happening in the PCT ‘by accident’. Is this so?

There are concerns that the people who do the talking in the PCT are not going to be around in the future. Papers and documents are produced, with little continuity of staff.

Questions are raised, for example, ‘what did they say’? and ‘who said that’?

Are names put at the bottom as signatories, without having read the document? There is insufficient consultation with the health care clinicians.

Buckinghamshire Hospitals NHS Trust

OSC, 2nd November

Anne Eden, Chief Executive
Graz Luzzi, Medical Director
Jean O'Driscoll, DIPC
Damian Eustace, Divisional Chair of W&C

Buckinghamshire Hospitals NHS Trust

Shaping Health Services

Graz Luzzi, Medical Director

Buckinghamshire Hospitals NHS
NHS Trust

The original SHS case for change

- Service sustainability
  - Nationally recommended that many services require population base of 500,000
  - Increasing need to provide safe 24/7 emergency cover
  - Surgery: need to strengthen through developing single unit with larger population base
  - Paediatric inpatients
  - Special Care Baby Unit - particularly NICU cots
- Workforce pressures
  - European Working Time Directive
  - Training accreditation and capacity
  - Shortage of specialist nursing staff
- Increasing sub-specialisation
  - Surgery, cardiac, respiratory medicine, stroke
- Access to services
  - Need to reduce waiting time in A&E
  - Improve access to elective surgery and reduce cancellations
- Keeping the NHS local
  - Trend towards increasing care in the community
  - Patient Choice

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NHS Trust

The benefits of Shaping Health Services

The Shaping Health Services reconfiguration was designed to develop services for Buckinghamshire that:

- **Were provided locally for most healthcare needs**
- **Provided a safe emergency assessment and treatment service**
- **Were based on the best available evidence and of high clinical quality**
- **Offered rapid access to specialist care when it will be of benefit to the individual patient**
- **Reduced the need for numerous hospital visits or lengthy hospital stays by providing more comprehensive primary care-based services**

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NHS Trust

The benefits of Shaping Health Services

The Shaping Health Services reconfiguration was designed to develop services for Buckinghamshire that:

- **Provided equity of access for all**
- **Incorporated strong links between different parts of the health care system**
- **Were sustainable and affordable**
- **Were provided in a high quality environment**

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NHS Trust

Shaping Health Services – where are we now?

Surgical Services

Reorganised in September 2005

- **Outpatients and diagnostics continue on all 3 hospital sites**
- **Day surgery provided at Wycombe and Stoke Mandeville**
- **Treatment centre opened at Wycombe Hospital for all inpatient planned surgery**
- **Emergency surgery and trauma care provided at Stoke Mandeville**
- **Emergency patients can attend Wycombe A&E and will be transferred to Stoke Mandeville if they need to see a specialist**

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Buckinghamshire Hospitals NHS
NHS Trust

Shaping Health Services – where are we now?

Medical Services

Reorganised in April 2006

- **Specialist cardiac, respiratory and haematology units developed at Wycombe Hospital**
- **Emergency medical patients can attend Stoke Mandeville A&E and will be transferred to Wycombe if they need to see a specialist in the above areas**
- **Gastroenterology, stroke and rehabilitation services continue to be provided at both Wycombe and Stoke Mandeville**
- **Summer 2007 – specialist cardiac angioplasty service developed at Wycombe Hospital, previously patients has to be transferred to the Hammersmith Hospital**

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Shaping Health Services – where are we now?

Women and Children's Services

Service changes to be implemented by 2008

- **Outpatient and diagnostic antenatal and children's services to continue at all 3 hospital sites**
- **Women and children's centre to be opened at Stoke Mandeville to include:**
  - **Specialist consultant maternity unit**
  - **Neonatal intensive care unit**
  - **Consultant-led emergency inpatient children's service**
  - **Children's planned surgery unit**
- **Emergency care children's day unit to be developed at Wycombe Hospital**
- **Midwife-led birthing centre to be opened at Wycombe**

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NHS Trust

Strategic review of emergency care

- Undertaken by Finnamore Management Consultants
- Brief to review the changes to acute services implemented as a result of the Shaping Health Services Consultation
- Reported in May 2007
- Reviewed clinical data and interviewed over 30 clinical and managerial staff

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Review conclusions

- *General Surgery* – elective surgery working well
- *Elective orthopaedics* – working relatively well
- *Cardiac* – working well but capacity issues and further service redesign required
- *Acute stroke* – further service redesign needed
- *Stroke rehabilitation* – whole systems approach to be taken forward
- *Respiratory Medicine* – working well but capacity issues
- *Haematology* – working well

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NHS Trust

Review conclusions

- *Acute Medicine* – further service redesign needed
- *Rehabilitation* – review of this service model
- *Gastroenterology* – review of models of care across the two sites
- *Women and Children's* – planned SHS changes to be taken forward
- *Critical care* – capacity imbalance across the sites – needs to be addressed
- *A&E* – absence of trauma and emergency surgery support on Wycombe site - review of urgent care needed in context of Trust wide strategic planning for both sites and to provide clarification to the public

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NHS Trust

Key message

- Elective care – generally working well
- Emergency care – concern amongst clinical and managerial staff interviewed
  - Need to prevent major trauma attending Wycombe
  - Need to more clearly define Wycombe A&E; patients are going elsewhere as they don't know what services are offered
  - Need to enhance Wycombe's reputation as a specialist medical centre

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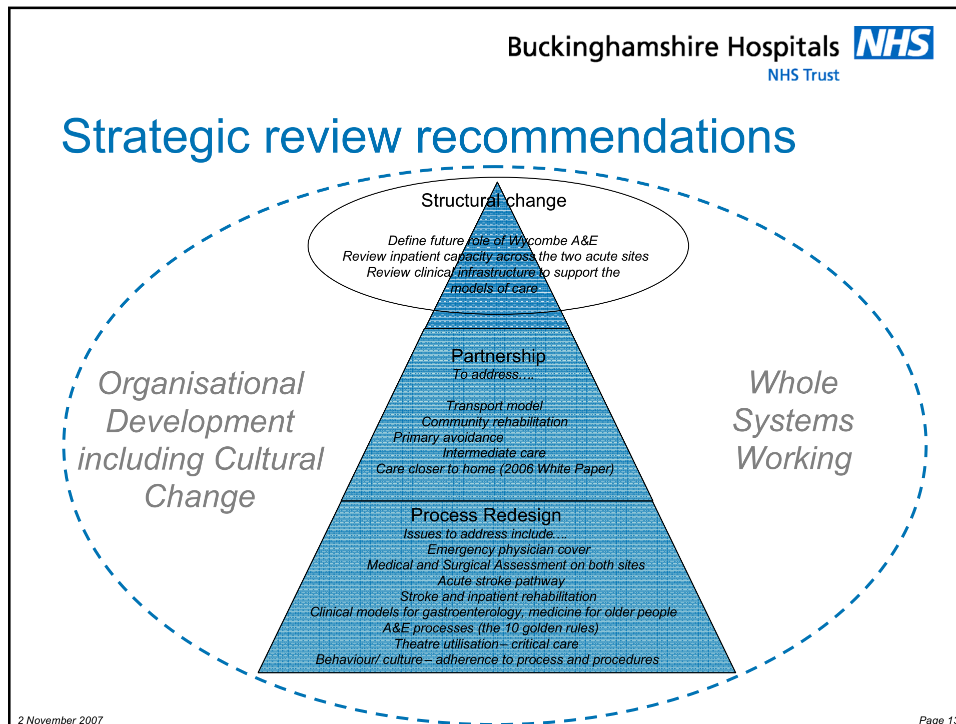

Buckinghamshire Hospitals NHS

NHS Trust

Emergency Medical Centre for Wycombe Hospital

- **Proposal developed in partnership with Buckinghamshire PCT and GP collaboratives**
- **Aim to enhance emergency services available in Wycombe and to provide greater clarity to the public on service availability**

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NHS Trust

National Context

- **"Direction of Travel for Urgent Care" published in October 2006 by Department of Health**
- **Paper highlights need to move away from generic accident and emergency departments and develop emergency care services that are:**
  - **more responsive to people's needs**
  - **more efficient in the way they deploy resources**
  - **take account of changing public expectations and technological and medical advances.**

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NHS Trust

Principles of Urgent Care

- **6 principles described in national paper, used to underpin the development of emergency services at Wycombe**

One	My **voice** as a service user or carer is clearly heard and acted on.
Two	I **know** how to access services if I have an urgent need.
Three	If I have an urgent need I can access care **quickly and simply**.
Four	My **safety** is paramount to everyone who cares for me.
Five	I can **rely** on getting the right care (including support for self-care), **whenever** I need it and **whoever** I am.
Six	The care I receive meets my needs **appropriately, taking account of the urgency and value for money.**

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What is an Emergency Medical Centre?

- **Provides access to doctor-led, emergency medical services and minor injuries service 24 hours a day, 7 days a week**
- **Surgical patients able to access care at Wycombe hospital but will be transferred to Stoke Mandeville as currently happens**
- **Patients with severe trauma will be taken directly to Stoke Mandeville by the ambulance service**

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Buckinghamshire Hospitals NHS
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The benefits of the Emergency Medical Centre

- **Integration of primary care with acute care services**
  - **40% of patients who attend the A&E have primary care needs**
  - **A GP will be available in A&E**
  - **Improved access to services that facilitate discharge home**
- **Fast track referral to specialist medical care**
  - **If a patient needs specialist medical care e.g. cardiac, respiratory or stroke care, they will be seen directly by the specialist and not via a generalist A&E doctor**

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Buckinghamshire Hospitals NHS Trust

The benefits of the Emergency Medical Centre

- **Rapid access to diagnostic tests as needed - diagnostics will be reorganised to ensure patients receive appropriate tests without waiting**
- **Direct access to specialist trauma services at Stoke Mandeville**
  - **Affects approx 10 patients per year**
  - **Taken directly to specialist centre**
  - **Evidence demonstrates this gives better outcomes**
- **Clearer public understanding**
  - **Evidence that many residents believe Wycombe A&E has closed**
  - **Wycombe is a specialist medical centre - public need to be aware**
  - **By describing the services more accurately - those needing surgical services will be encouraged to attend Stoke Mandeville directly**

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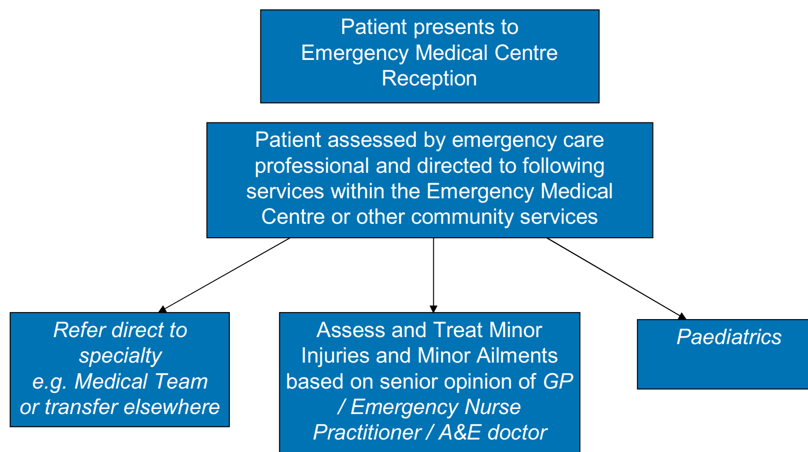
Buckinghamshire Hospitals NHS Trust

Accessing services in the Emergency Medical Care Centre



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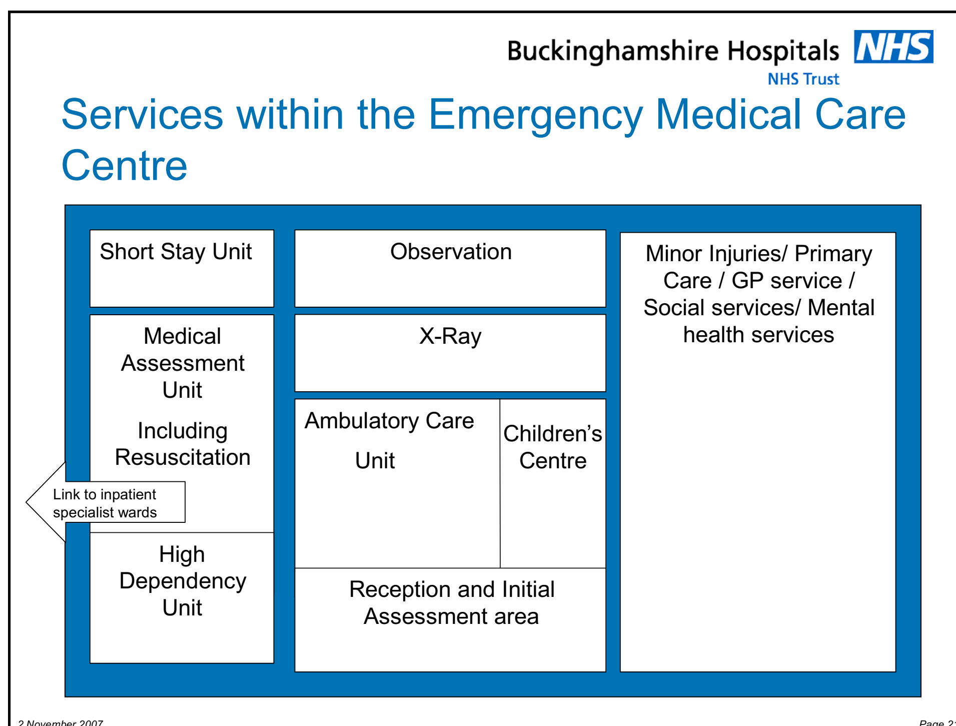

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The Future is Bright for Wycombe Hospital

- **Emergency Medical Care Centre**
- **Treatment centre for planned operations**
- **Birthing centre**
- **Specialist cardiac, haematology, stroke, and other medical services**
- **Specialist cancer services**
- **General outpatients**
- **Early access diagnostics e.g. radiology, pathology and pharmacy**

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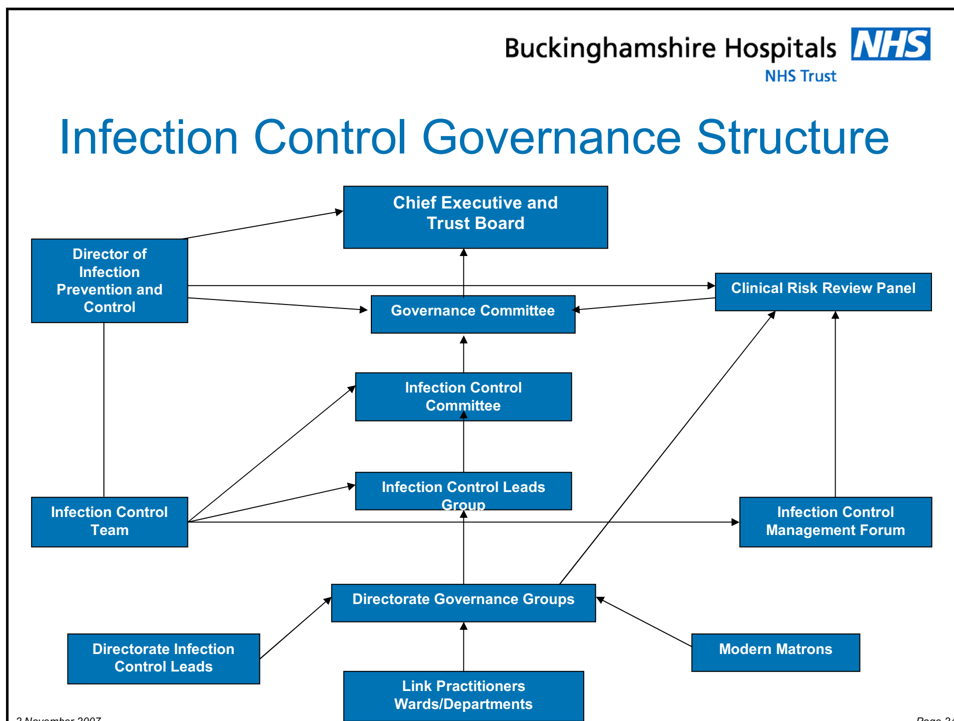
NHS Trust

Management of Hospital-Acquired Infections

Jean O'Driscoll, Director of Infection Prevention & Control (DIPC)



Buckinghamshire Hospitals NHS Trust

Relevant National Standards

- **The Health Act 2006 Hygiene Code**
- **Standards for Better Health**
- **HCC found Trust compliant for 2006-2007**

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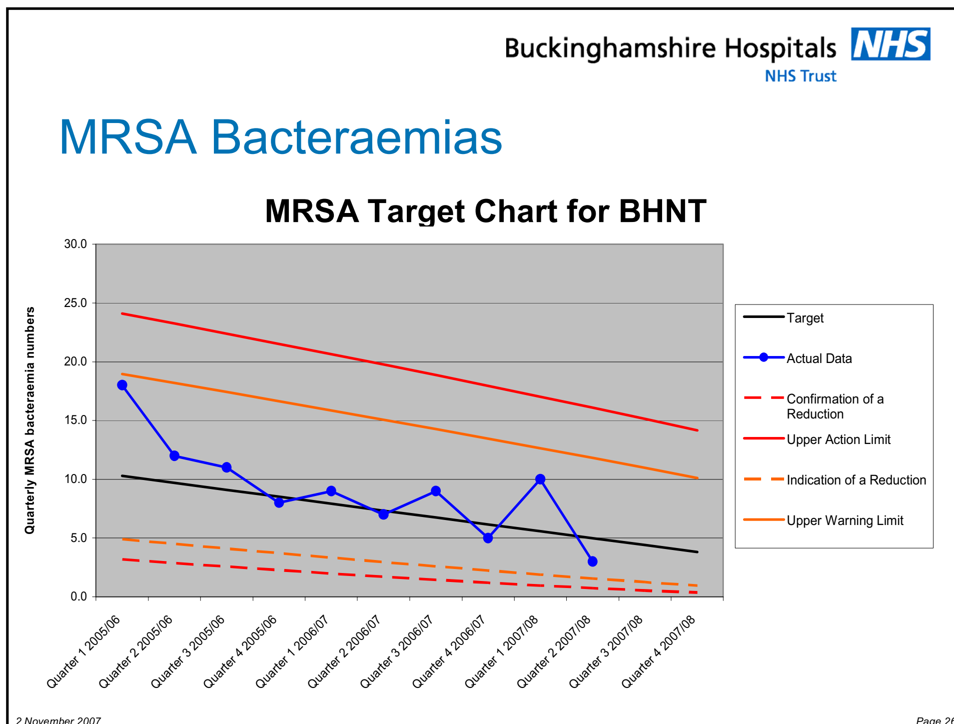
Buckinghamshire Hospitals NHS Trust

MRSA Bacteraemias



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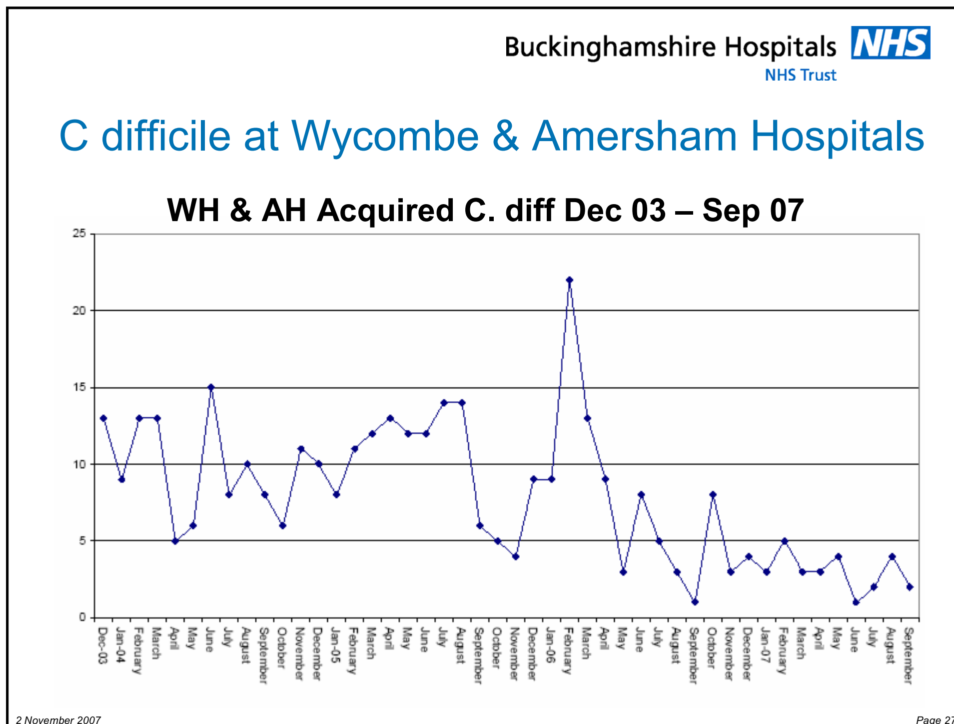
Buckinghamshire Hospitals NHS
NHS Trust
C difficile at Wycombe & Amersham Hospitals
WH & AH Acquired C. diff Dec 03 – Sep 07
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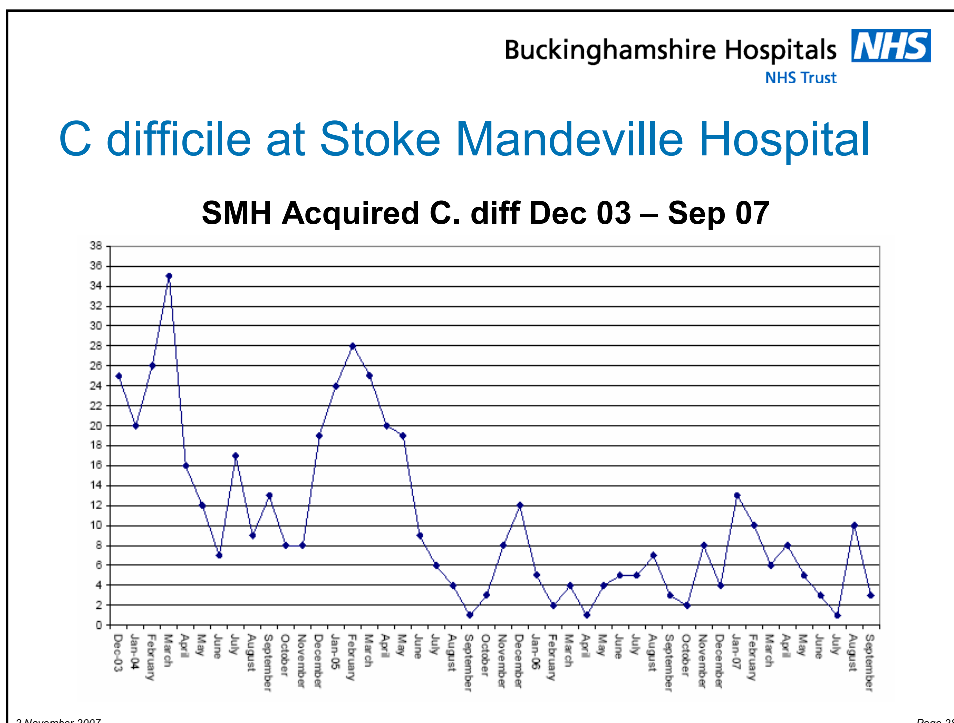
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C difficile at Stoke Mandeville Hospital
SMH Acquired C. diff Dec 03 – Sep 07
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Buckinghamshire Hospitals NHS Trust

Maidstone C diff Report - Findings

- **No effective surveillance system for C diff**
  (An effective system is in place at BHT)
- **Clinical management of cases suboptimal**
  (Regular reviews take place at BHT)
- **Overuse of broad-spectrum antibiotics**
  (Very restricted use of these antibiotics at BHT)
- **Poor management of IC Team**
  (Cons Microbiologist is DIPC at BHT since Dec 06)
- **Poor standards of cleanliness**
  (Good standards of cleanliness at BHT – PEAT scores)
- **Poor outbreak management**
  (Good C diff Policies at BHT)
- **Under-reporting of deaths due to C diff**
  (Ongoing analysis at BHT)
- **Too much focus on other Targets**
  (Patient safety a key objective at BHT)

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Oxfordshire & Buckinghamshire NHS
Mental Health Partnership NHS Trust

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Service Model for the Organisation and Management of Child and Adolescent Mental Health Services

June 2007

1. Introduction

The Children's NSF and Every Child Matters provide clear frameworks for the strategic direction and modernisation for Child and Adolescent Mental Health Services. The key deliverable is comprehensive CAMHS through integrated commissioning and service delivery across Social Services, Education and Health.

2. Local Structures

In Oxfordshire and Buckinghamshire the virtual Children's Trusts provide the mechanism for monitoring the delivery of the five key outcomes of ECM (Being healthy; staying safe, enjoying and achieving, making a positive contribution and achieving economic well being).

With respect to CAMHS (which essentially sits under the being healthy outcome but of course impacts on the others) as multi-agency CAMHS Strategy Group which reports to the Children's Trust Boards. OBMH is represented on the Strategy Groups in both counties and the Trust Board in Buckinghamshire. In Oxfordshire, the Trust Board has commissioning representation only and there is another Partnership Group at which this Trust is represented.

3. CAMHS Strategy in Oxfordshire and Buckinghamshire

The strategies are been developed using the CAMHS self assessment framework. As one would expect, given the national policy drivers and the similarities of the two counties, the strategic intent in Oxfordshire and Buckinghamshire are very similar.

- A single point of access to all CAMHS services
- Implementation of the Common Assessment Framework (CAF) across all agencies
- A locality focus with the development of a number of children's centres
- The use of a lead professional
- The development of prevention and early intervention services at Tier 2
- To change Tier 3 specialist CAMHS from a medical, clinic based model into a community based model providing a flexible range of services in non-psychiatric settings
- Reduce waiting times for treatment
- Access improved for Black and Minority ethnic groups, Looked After Children and other traditionally hard to reach groups.
- 24/7 access

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- Ensure that children and young people with a Learning Disability have access to the full range of CAMHS services
- Ensure participation of Children, Young People and Families in the development and modernisation of services
- Develop local multi-disciplinary teams working in extended schools and children's centres
- Work more effectively with voluntary, community and private sectors

These are reflected within the Children and Young People's Plan for each county.

4. Proposed Service Model for Oxfordshire and Buckinghamshire CAMHS

Based on the agreed CAMHS Strategies in Oxfordshire and Buckinghamshire, we propose the following Service Model:

- A single inpatient unit in Oxfordshire (18-20 beds)
- Day care in Oxford and Buckinghamshire (currently at Wycombe)
- Two CAMHS county-wide Assertive Outreach Services
- Three Community Teams in each county shadowing the two County Councils' Children, Young People and Families Directorates (North and West, Central and South Oxfordshire) (Wycombe, Aylesbury and Amersham in Buckinghamshire)
- Three locality based Tier 2 teams in each county (co-located with Tier 3)

(Note: The Tier 4 Infant Parent Service and the Neuro-Psychiatry service are currently commissioned by Oxfordshire with specialist assessment purchased by other commissioners on a spot purchase basis).

5. Tier 4 Oxfordshire and Buckinghamshire

The Local Specialist Commissioning Group (LSCG) for Thames Valley undertook a review of Tier 4 services in 2005. Key recommendations were:

- Ceasing the provision of in-patient services for children under 11
- The specialist adolescent inpatient unit in Oxford should provide services for 11 – 18 age group (previously 13-18).
- The Down's Service should be transferred to the Oxford Radcliffe NHS Hospitals Trust (ORH) from OBMH
- The Paediatric EEG Service should be transferred from OBMH to ORH.
- An inpatient service for young people 11-18 will be commissioned as a managed, networked or single provision.

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Current Position

- The Park Hospital ceased providing inpatient services in September 2006 and is currently being refurbished to provide a Children and Young People's mental health resource centre. Phase 1 was completed in March 2007 and Phase 2 is due to be completed early in 2008.
- Highfield is now providing specialist inpatient service for Oxfordshire, Buckinghamshire and beyond for 11 – 18 age group. An additional bed with a separate area to allow younger children to be nursed safely opened in May 2007.
- The Down's Service transferred to ORH in April 2007.
- The service transfer of EEG is almost complete and is anticipated to take place by October 2007. (It is anticipated that a transfer of managerial responsibility will happen in May/June 2007).
- Oxfordshire commissioning investment in children's inpatient services has been transferred to support further development of community based services – Infant Parent Service, Neuro-psychiatry service and CAMHS Assertive Outreach Service.
- Buckinghamshire commissioners' investment in children's inpatient services will be used to develop a new CAMHS Assertive Outreach Service for Buckinghamshire.
- There have been problems with the service model agreed for the Infant Parent Programme to move from a bed based model to a community service and so we are currently reviewing the service model with commissioners and other stakeholders and it appears there will be a need for some further changes.
- LSCG have not yet made decisions about future adolescent inpatient provision across the Thames Valley. OBMH has therefore made the decision to reprovide and expand the current unit to a maximum of 20 beds on the Warneford site. This will ensure a building which is fit for purpose, enable us to retain our current business within Oxfordshire, Buckinghamshire and a range of other commissioners within the South East as well as develop our inpatient business further over the next five years.
- Forensic CAMHS Service has both a local and regional role. The local role is providing in-reach to Huntercombe Young Offenders Institute through an SLA with Oxfordshire PCT and its regional service which is commissioned through LSCG. The Service also supports Tier 3 teams within both Oxfordshire and Buckinghamshire to provide services to forensic clients in order to prevent inappropriate hospital detention orders.

6. Tier 3 Oxfordshire and Buckinghamshire

The proposed model for Tier 3 has been developed through a participative process with representatives from staff, commissioners, partner agencies and other stakeholders. Although this began as a process within Oxfordshire,

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following the merger of Oxfordshire and Buckinghamshire Trusts in 2006, representatives from Buckinghamshire services joined the project groups. An extensive amount of staff engagement in the process also took place within the Oxfordshire Service. Whilst strategic intent suggests we apply the same principles, it is important to have a similar engagement and development process in Buckinghamshire. Although we operate the service within the same framework across the two counties, the will inevitably need to be operational differences as the Oxfordshire and Buckinghamshire contexts are different.

Historically, Tier 3 services have developed as outpatient based clinics. In order to meet NSF and ECM requirements, we need to move to a community based model providing services in a flexible needs led way to provide engagement, timely support and practical help to enable access to CAMHS services for client groups previously excluded. The service model for Tier 3 will be based on:

- Early engagement
- Strong emphasis on developing a therapeutic relationship
- Practical needs led support
- Improved access to psychological therapies
- Case management based
- Team approach to risk management
- Multi-agency input that is well co-ordinated using CPA.

7. Core Elements of Tier 3 Service

a. Assessment - Common Assessment Framework (CAF)

Within Oxfordshire a single point of access is now in place through PCAMHS and so all referrals now come with a completed Common Assessment Framework. This will enable Tier 3 services to have access to a wide range of information from all the agencies involved, as quickly as possible, supporting Tier 3 to offer the appropriate intervention quickly, reducing the number of assessments the clients receive and freeing clinical time to increase capacity for direct clinical intervention.

The CAF is a national, more standardised approach to a holistic assessment of children's needs for services and how they should be met and is intended to reduce the number and scale of assessments. It is also a means to support early identification and intervention by enabling practitioners in universal as well as targeted or specialist services to assess needs at an early stage.

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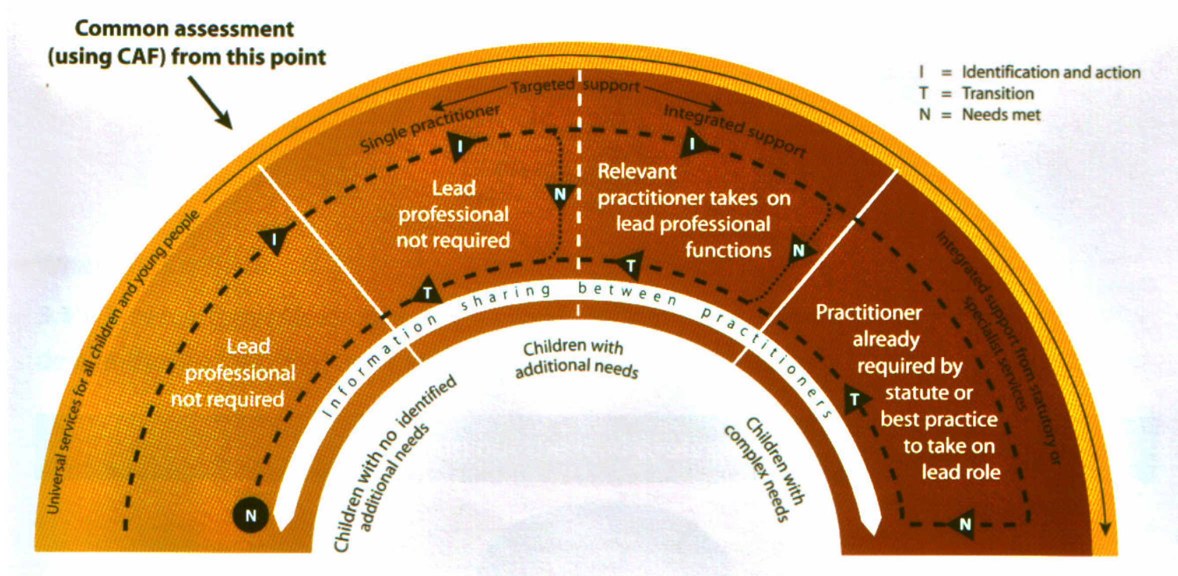

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In Oxfordshire the CAF is now well embedded in all agencies. Minimum requirements have been agreed for referrers including GPs. PCAMHS is in place across the whole county as a single point of referral for all CAMHS services.

In Buckinghamshire the CAF is not yet in use. This is because a single point of access has not yet been achieved. See the section on Tier 2 below.

Some examples of care pathways are attached at Appendix A

b. Care Programme Approach (CPA)

CPA has been implemented across all tier 3 teams within Oxfordshire and Buckinghamshire. All children and young people receiving Tier 3 services will be case managed and have a care co-ordinator who managed the case process through CPA. This will include:

- A comprehensive assessment
- A risk assessment
- Allocation of a care co-ordinator
- A care plan
- Regular reviews
- Discharge planning

Standard CPA applies to people who may have a less severe illness with a relatively stable social situation. Their mental health care is likely to be offered by a single mental health worker. The person subject to standard CPA may:

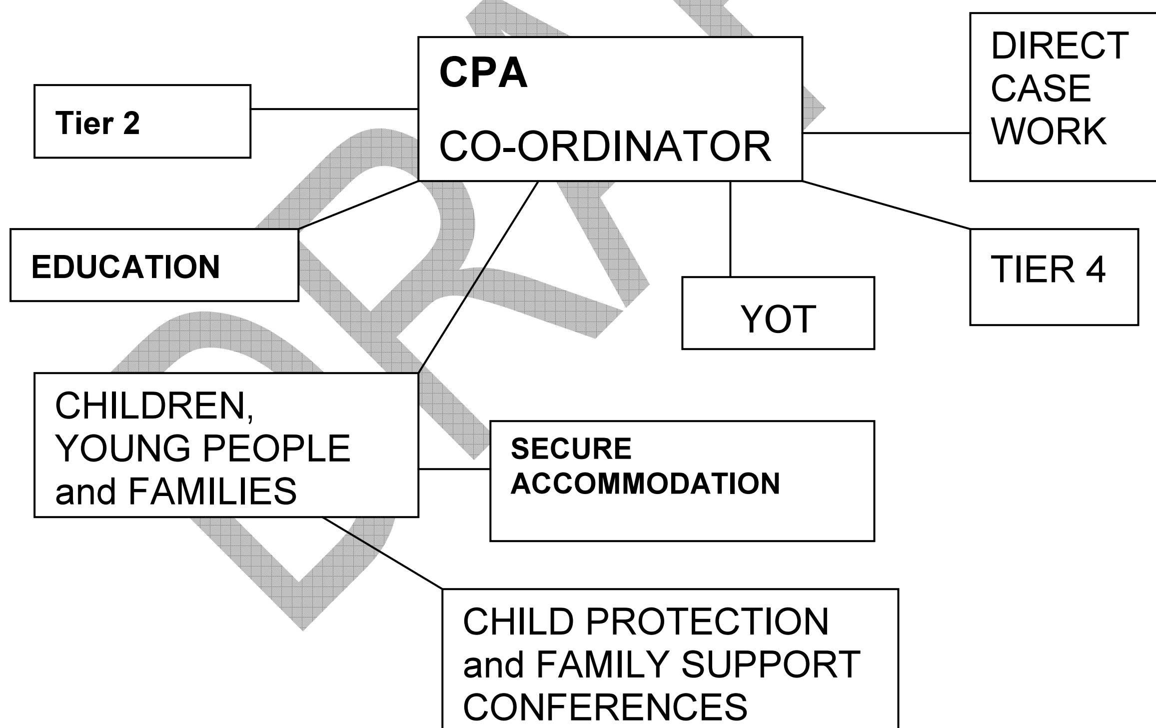
- Need a single specialist practitioner's intervention
- Only require low key support
- Be more able to self manage their mental health problems
- Have an active informal support network

- Pose no danger to themselves or others
- Be more likely to maintain appropriate contact with services

Enhanced CPA applies to people who may have a more serious mental illness and a less stable social situation. They may need care or services from more than one worker or agency. The young person subject to enhanced CPA may:

- Have multiple care needs requiring inter-agency co-ordination
- Be only willing to work with one professional or agency even though they have multiple case needs
- Be in contact with a number of agencies (including the criminal justice system)
- Is likely to require more frequent and intensive interventions, perhaps with medication management

The Care Co-ordinator will follow the young person through all care options



whilst Specialist CAMHS input is required.

Risk Assessment Risk management

Risk assessment is key. All clients will have a full risk assessment

A comprehensive multi agency assessment should be made and reviewed on a regular bases line with CPA
Trust staff safety policies for community and lo9ne working will be followed.

Thresholds

As referral criteria move away from a diagnosis based model, as young people will not have a diagnosis when referred, thresholds will become more important (current referral criteria/thresholds for Tier 3 CAMHS Ox and Bucks are attached at Appendix C. These include severity, complexity, enduring difficulties over time, difficulties in one or more domain, impairment of function at home, school or socially. There will be an emphasis on assessment to ascertain presence or not of severe mental ill health and Specialist CAMHS contribution to the management of complex cases. Children's Global Assessment Scales (CGAS) may be helpful in looking at thresholds (clinician assessment of clinical impairment). Specialist CAMHS may expect to see those young people scoring 50 or less.

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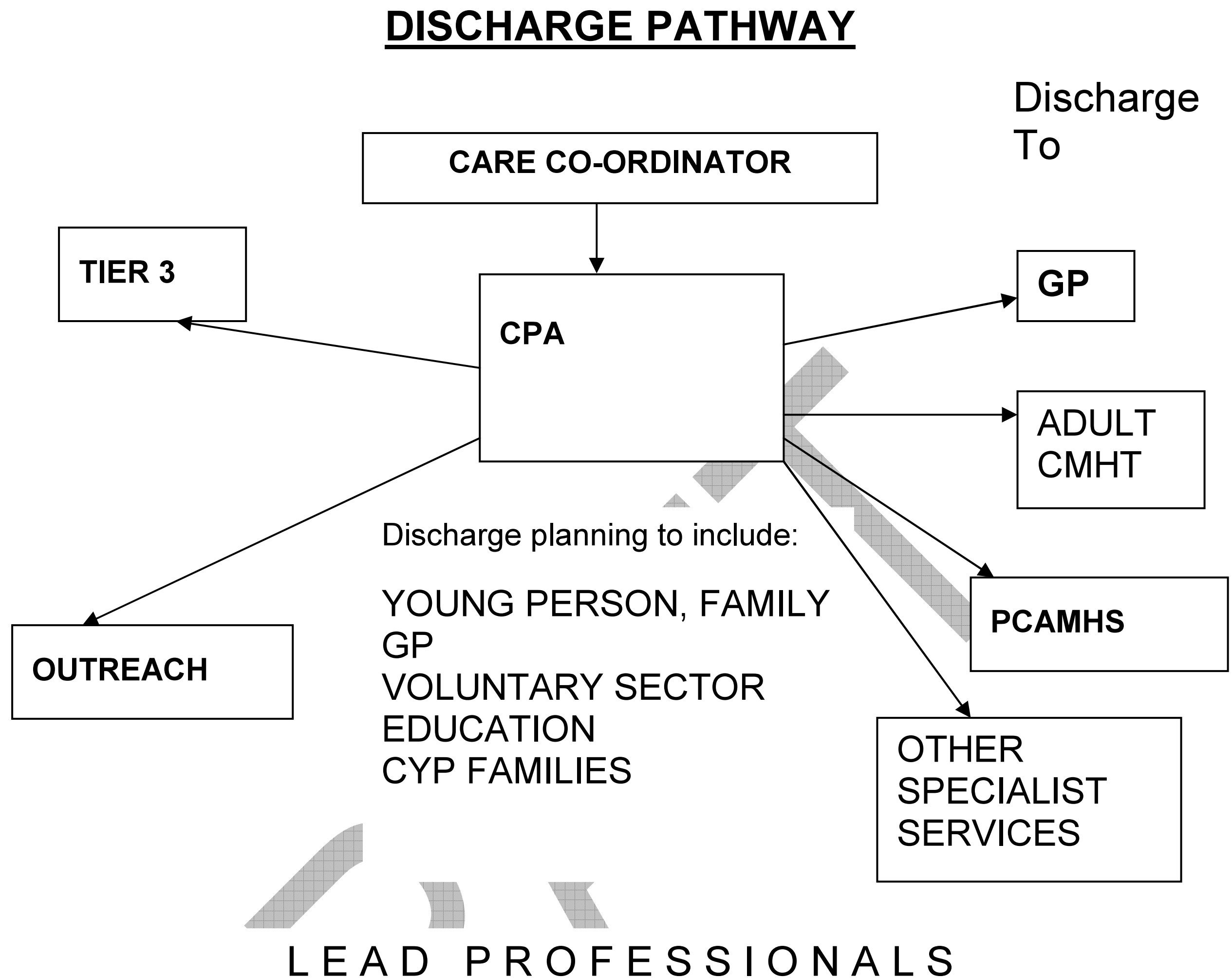
d. Discharge



e. Monitoring Performance

It is essential that we agree with commissioners a range of outcome measures for the service rather than simply focusing on numbers of contacts. We are working with the Performance Directorate to update our Service Level Agreements to reflect the service the Trust is now being commissioned to provide. The Health Care Commission has indicated that all Trust's need to undertake HoNOSCA, the Directorate's CAMHS Management Group has agreed to look at an implementation plan to ensure we are able to routinely collect this, CGAS and user and carer satisfaction questionnaires.

e. User and Carer Input

We have been working with the County Council Children's Participation Team in both counties to develop mechanisms for meaningful service user input into service developments. In Oxfordshire, the service has been a Big Ideas Project National Pilot and through that pilot has developed a Young People's Forum which, as well as service users, includes young people who have

traditionally found it difficult to access our CAMH services and so have been poorly serviced. The Forum was involved in the design of Phase 1 of the Park refurbishment and will be beginning work soon on Phase 2 and the Highfield reprovision. Users and carers have also been involved in the interview process for recent consultant psychiatrist appointments in both counties. In Buckinghamshire, we are developing links with the Youth Cabinet.

8. Skill Mix within Tier 3 Teams

New Ways of Working for Consultants in effect means new ways of working for the whole multi-disciplinary team. In order to be able to deliver the full range of interventions in a community based service model, the skill mix within the teams needs to be broadened.

Oxfordshire

A reconfiguration within Oxfordshire has already taken place in line with agreed CAMHS Strategy and a review of Consultant Psychiatrist allocation in line with Oxfordshire sector populations. The three teams are now:

North (bases in Banbury and Witney)
- Banbury
- Bicester/Kidlington
- Witney/Eynsham/Woodstock
- Carterton/Burford/Chipping Norton

Central (base Park Hospital)
- Headington/Wheatley
- Isis
- North Oxford/Cumnor/Botley
- Oxford South East

South (base Abingdon with satellite clinics in Henley, Didcot and Thame
- Didcot
- Thame/Watlington
- Abingdon/Berinsfield
- Henley/Sonning Common/Woodcote/Wallingford
- Wantage/Faringdon/Grove

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Buckinghamshire

We have given an undertaking to shadow Children, Young People's and Families Directorate once their plans are clear. Our current teams are:

Wycombe
Aylesbury
Amersham

Clinical Team Manager

Each locality will have a Clinical Team Manager (job description attached at Appendix B) from any clinical background who will hold responsibility for the day to day operational and clinical performance of the Team. Clinical Team Managers will also have a service wide responsibility eg CPA, safety, training, to develop and ensure consistency of clinical governance and quality across the whole service. Clinical Team Managers will report to their county Service Manager. They will also participate in the Directorate CAMHS Management Group and their county Operational and Clinical Governance Groups.

Consultant Psychiatrist

The role of the Consultant has been reviewed in line with 'New Ways of Working' which has implications for the traditional clinical team leader role, and has implications for all other professionals' responsibility and accountability as the RMO role no longer exists. In line with recent GMC recommendations consultants have medical responsibility for their own work and that of junior doctors in training under their supervision. They may provide medical advice to the multi-disciplinary team for their cases but are not responsible for those cases unless formally involved in the care plan.

Consultants will be part of locality teams, providing direct care to an agreed number of complex cases. They will have a responsibility to participate in the care of urgent and high priority cases.

Job Plans will reflect direct clinical work, supervision and consulting to staff with input into a specialist area as agreed with Clinical and Service Directors.

Each Consultant will have an area of clinical expertise, covering Autistic Spectrum disorders, ADHS, Conduct disorder, depression, self harm anxiety and OCD, Looked After Children, Eating Disorders, learning disability, services for black and ethnic minorities, early intervention in psychosis. They will develop links across the county for that expertise consulting to other teams and providing some direct care, second opinion and supervision for complex cases. This will help ensure equity of provision across each county.

Consultants and the MDT will be able to access the remodelled Tier 4 services, as well as the Assertive Outreach Team within each county.

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CAMHS Psychological Services

There will be a Head of Psychological Services (8d) across the two counties with responsibility for the delivery of psychological services across the service. The postholder could come from any psychological profession (Psychology, child psychotherapy, Family Therapy). In addition there will be two 8c posts from the other two professions also with service wide remits around their own profession. While their direct clinical work will be within their teams, their professional and supervisory roles will be service wide in order to ensure a robust structure of supervision and professional support across the service. They will be line managed by team managers as part of the MDT. They will develop a tiered approach within the team which develops staff skill in delivering treatments at a range of levels

- Awareness of a range of theoretical frameworks
- Short in-house training courses
- Supervision of direct case work
- Formal training

A new job description has been created for the Head post and all therapists meeting the person specification will be eligible to apply, through a competitive process.

Care Co-ordinators

The vision is that integrated support will be most effectively delivered through SpCAMH practitioners acting as Care co-ordinators within their designated role. Therefore a portion of their clinical and administration time will be allotted to this role but as care co-ordinators are often providing the therapeutic input to the case, development and maintenance of effective therapeutic skills remains crucial.

The Care co-ordinator role will follow the Care Programme Approach (CPA)

- Act as a single point of contact for the child, YP or family within SpCAMHS. They will be able to offer direct support helping them to navigate their way around the system and make choices
- Ensure that Children and YP get the appropriate interventions when they are needed in a well planned, regularly reviewed and effectively delivered way, these interventions can be delivered by the care co-ordinator, associate worker or specialist therapist as appropriate
- Reduce duplication, overlap and inconsistency from other agencies.

The majority of the workforce will be Specialist CAMHS practitioners (Band 6) who can take on the role of care co-ordinator both for the cases to whom they are directly delivering therapeutic interventions and for the more complex cases where a care co-ordinator links with several other therapists. Typically these co-ordinators will have a professional qualification in Nursing, OT, Social work or Psychology and delivering within that professional role within the CAMHS team. The majority of their time will be spent in direct case work,

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including the full range of therapeutic interventions (eg CBT informed therapy, solution focussed interventions, family work etc.) co-ordinating care, developing care plans and liaison with other agencies. Numbers of cases to be held will be agreed using demand and capacity modelling. CPA and risk assessment protocols will be used.

Staff Nurses and Support Workers

Staff Nurses and support workers will be involved in delivering the care as set out within the care plan. Their focus will be on engaging young people, developing therapeutic relationships, helping to address practical issues and linking with other agencies.
For example they may be involved in supporting young people with eating disorders, supporting the families at home through meal planning, shopping and mealtimes, linkages with schools.

OXFORDSHIRE CAMHS TIER 3 REMODELLED SKILL MIX

	Current WTE	Current Actual in Post	Staff affected Head Count	New model WTE	Net change
Senior Manager Band 8	2.00	2	2	3.00	+ 1.00
Psychological Therapist Band 8	3.14	3.73	7	3.00	- 0.14
Psychologist Band 7	4.77	4.30	6	4.76	- 0.01
Dietician Band 6	0.00			0.99	+ 0.99
Band 7	0.78	0.70	1	0.80	+ 0.02
Band 6	11.20	11.39		11.38	+ 0.18
Nurse Band 5	1.00	2	2	4.60	+ 3.60
Nurse Band 3	1.00	2	2	3.00	+ 2.00
Admin & Clerical Band 5	0.00			3.00	+ 3.00
Admin & Clerical Band 4	9.94	8.14	13	6.95	- 2.99
Admin & Clerical Band 3	1.03	2.03	3	1.00	- 0.03

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TOTAL	**34.86**	**36.29**		**42.48**	**+ 7.62 (Additional Post)**

Skill mix

The skill mix review is key to the delivery of the new service model; we have remodelled resources against 0-19 population figures, creating a three locality model using Children, Young People and Families Directorate school boundaries to develop services in the South, North, and City. This will support interagency development of locality working, Team around the Child, and Lead Professional.

We have added a 5% deprivation weighting to Oxford City.

Resources have been allocated against the population %, except where single posts have been created and a population split would make the post untenable.

The new skill mix provides a broader range of mental health workers including, support workers and Mental Health Practitioners, maximizing the number of care co-ordinator posts, maintaining a good range of Psychological Therapists, and improving the governance structure for the Therapist.
We have created a new, full time Dietician post, and developed a new structure for the Administration services.

Buckinghamshire

We will apply the same principles to reviewing skill mix across Buckinghamshire once the tier 3 remodelling principles have been worked through in a multi agency way.

Implementing the model

We will manage the implementation of the model in a phased way, initially making the changes utilizing vacancies, and moving to the final model over a period of time as staff move on in a natural way.

Medical input

Consultant and associated SHOs have been redistributed in accordance with the skill mix review principles.

Consultant Distribution Oxfordshire

South	3 includes 2 PAs for EIP
North	3
City	2.5 Includes 5 PAs for Assertive Outreach

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Total	8.7

Current Consultant Distribution Buckinghamshire

Wycombe	2.6 includes 2 PAs EIP; 4 PAs for Assertive Outreach and 2PAs for CASS
Aylesbury	2.2 includes 2 PAs for Paediatric Liaison
Amersham	2.0
Total	6.8

Psychologists

Psychologists will remain relatively unchanged with only a slight redistribution of WTE against the new localities.

Dietician

We have developed a new full time Community Dietician post, the post will work across the three localities, and we will advertise the post during the summer.

Care co-ordinators

All Band 6 posts will be care co-ordinator posts and can be recruited to from a range of professional backgrounds, Psychiatric Nursing, OT, and Social Worker. There are no changes expected at this grade.

Mental Health Practitioner

We have created a range of new Mental Health Practitioner posts at Band 5, and will be working to fully recruit.

Support Workers

Each locality will have a dedicated support worker, and we will work to fully recruit over the next month.

Administration

Each Locality will have a band 5 Clinic Administrator, who will work to the Team Manager and be responsible for the management of the other Admin staff. They will develop structures that support the teams meet their performance targets.
The process to appoint into the new posts will be agreed with HR.

9. DEVELOPMENT OF OBMH CAMHS ASSERTIVE OUTREACH SERVICES

The Oxfordshire Service (based in Oxford City) has been developing over the last three years and has been a national pilot in working with Looked After Children for the past two years. This approach has been successful in working with a number of complex high needs cases and has contributed to bringing a number of young people back into Oxfordshire. As well as providing direct care the team also work with other professionals including in special schools and residential placements to provide support and management plans for some young people presenting with extremely challenging and risky behaviours. Within Oxfordshire high level inter-agency care co-ordination is provided through a Community Matron for Mental Health and Learning Disability currently employed by Oxfordshire PCT.

We will use the experience gained in Oxfordshire to develop the new Buckinghamshire Team in partnership with Social and Healthcare (to be based in Aylesbury). We hope to have the team in place by September 2007.

The client group will be young people with a range of complex needs which are difficult to meet using standard services and who may be at risk of being placed out of county.

The key components of the Outreach Model are:

- To engage a complex group of young people
- Develop a therapeutic relationship
- Deliver services in a flexible way that meets individual user needs
- Deliver services wherever the young person feels comfortable, e.g. home, youth club, café
- Frequent contact 4+ each week
- Worker takes responsibility for overall package of care.
- Dialectical Behaviour Therapy (DBT) will be embedded within the model

The purpose of the service is:
- To reduce out of county placements for all agencies
- To reduce frequency, length and number of sectioned admissions to inpatient care
- To identify most complex young people at earliest opportunity
- To help sustain family relationships
- Prevent relapse
- Improve life skills and access and ability to maintain access to education
- Increase social support network
- Offer evidence based treatment to hard to engage young people
- Provide services in a multi-agency approach
- Reduce staff burn out

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10. Tier 2 Services

Oxfordshire

PCAMHS (currently provided by the PCT) is fully in place across the county and we are seeking to co-locate PCAMHS and Specialist CAMHS as opportunity arises (eg at the Resource Centre in Oxford City). Waiting times for Specialist CAMHS have reduced considerably and over 90% of referrals are now seen within four weeks.

The PCAMHS service model comprises three components:

- To provide support, advice and joint working to front line staff from all agencies
- To provide direct work for mild to moderate mental health problems with support and consultation from Tier 3 specialist services as appropriate
- To provide a fast track single point of access to Tier 3.

Having achieved the single point of access, there is now further work underway in Oxfordshire in order to develop a slightly more sophisticated approach. The aim of integrated CAMHS is to deliver the right intervention, at the right time, at the right place and we need to ensure that PCAMHS focuses on problems which can be appropriately addressed through a six session model. We also need to ensure that young people with complex needs are not rerouted through a single point of access but rather, where they are already at Tier 3 within another agency; they can directly access specialist services, e.g. YOT, Special Schools.

Buckinghamshire

Within Buckinghamshire, Tier 2 services are currently delivered in a mixture of functional and locality teams through the County Council, the PCT and OBMH. Buckinghamshire Commissioners have decided that the provision of a Tier 2 and Tier 3 Services is go to out to tender. The timescale for this has been potentially identified as April 2009. It seems clear that Tier 2 in Buckinghamshire should have a locality focus and be managed by a single agency if the stated strategic aims of single point of access and implementation of the CAF are to be delivered.

11. Conclusion

The Directorate's view is that the proposed service model will provide a robust, integrated service across Tiers 3 and 4 which will enable us to manage clients with the whole range of mental health difficulties in both counties. It will enable us to deliver on our key targets in terms of

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performance and quality and provide us with an ability to deliver services that will support multi-agency working and increased capacity.

The implementation process has begun with a single management and operational framework in place across the two counties. We have begun to embed the new ways of working with the appointment of Clinical Team Managers, the appointment of Consultant Psychiatrists and embedding CPA and risk management at the core of clinical practice.

Yvonne Taylor
Service Director
CAMHS and Specialist Services
14 October 2007

Appendix A Example care pathways
Appendix B Clinical Team Mgr JD
Appendix C Referral Criteria and Thresholds

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APPENDIX A

Example Care Pathways

1. Not engaged, mild/moderate emotional/behavioural problems
e.g. conduct disorder, learning difficulties, children looked after, substance misuse, mild depression, deliberate self harm, school refusal

Lead professional from Tier 1. PCAMHS offer assessment after CAF and discuss with SpCAMHS in supervision if necessary. If SpCAMHS assessment thought to be needed, Tier 3 Mental Health worker facilitates engagement for specialist assessment by Tier 3 in acceptable environment. SpCAMHS contribute to Tier 1-2 management.

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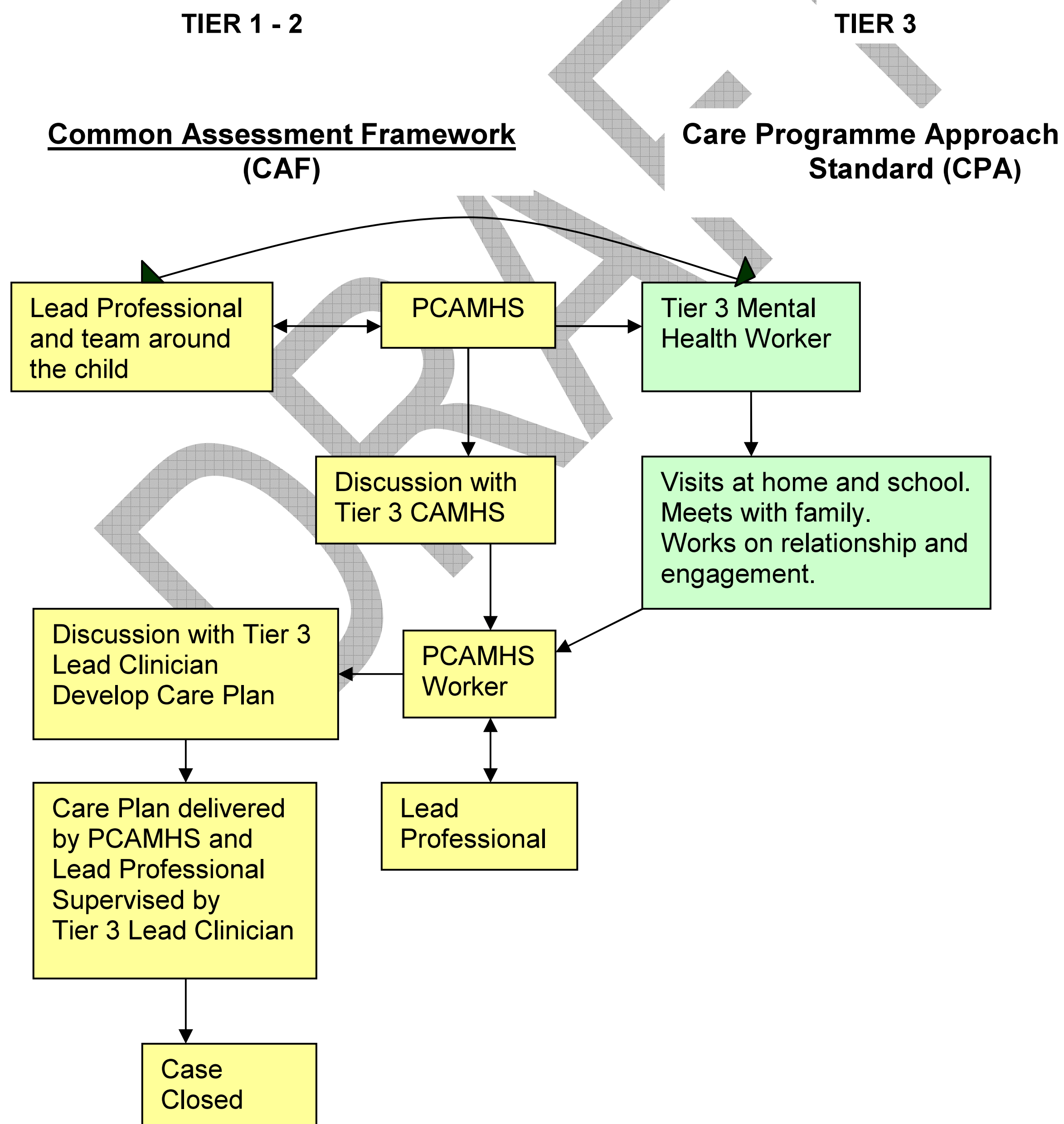
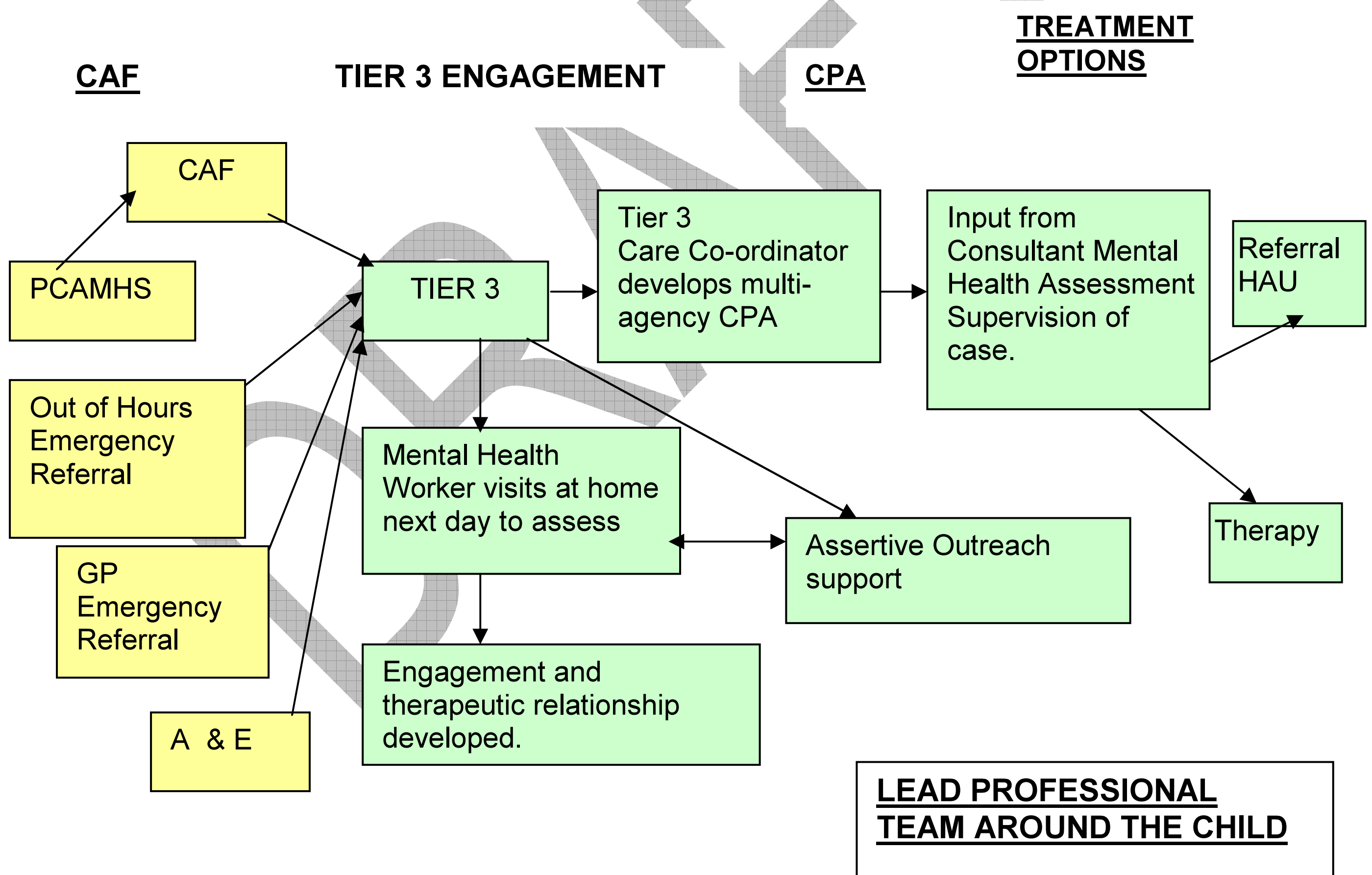


2. Not engaged, severe mental health problems likely
e.g. school refusal with depression or anxiety, social anxiety, early eating disorder, psychotic illness, developing borderline personality disorder, deliberate self harm, conduct disorder, sexually inappropriate behaviour, acting out in educational setting

PCAMHS, GP, social worker, teacher, out of hour's service may facilitate referral.

Mental health support worker may need to visit home, school, youth club to engage and start assessment. SpCAMHS care co-ordinator will undertake assessment with Consultation from lead clinician and consultant psychiatrist. This may be in the community rather than in SpCAMHS premises at first.

Assertive outreach with DBT may be one treatment option. Other treatments available. Full CPA with all agencies, and carer and users.



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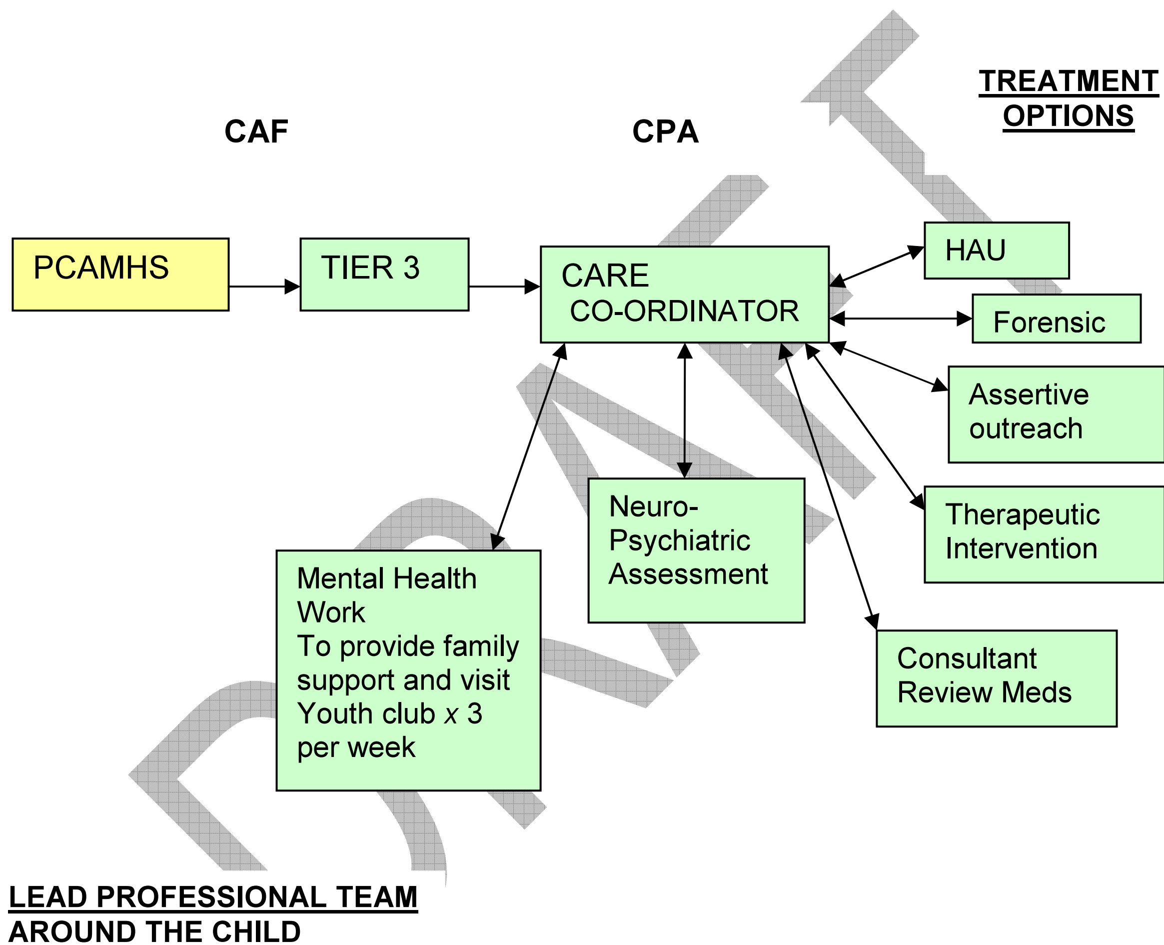
3. Engaged, severe mental illness, needs additional support
E.g. psychosis, severe eating disorder, severe anxiety/depression, autistic spectrum disorder with psychiatric co-morbidity, ADHD with psychiatric co-morbidity e.g. anxiety, depression, Tourettes, OCD

CPA, SpCAMHS care co-ordinator and treatment, multi agency working,

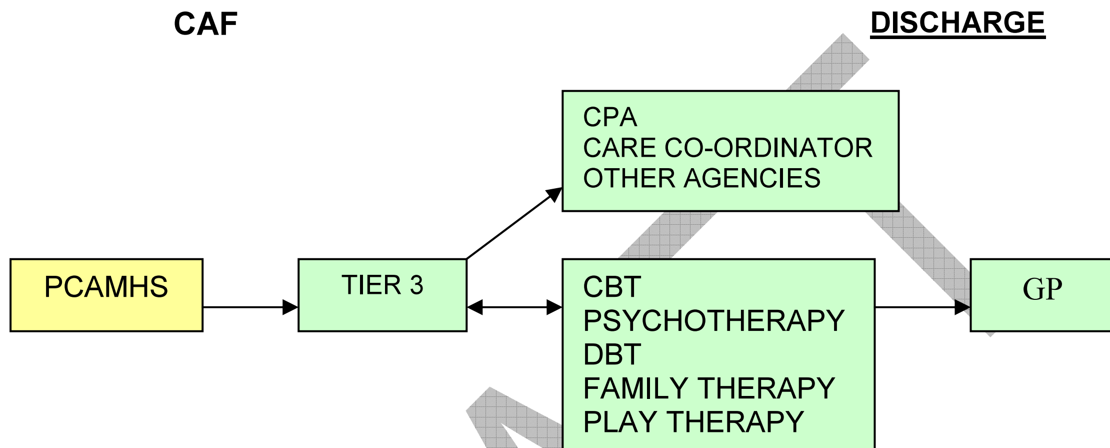
Needs mental health support worker to help engage, deliver some home treatments, or assertive outreach to provide additional support to prevent need for admission to adolescent unit.



LEAD PROFESSIONAL TEAM AROUND THE CHILD

4. Engaged with severe mental health problems
e.g. PTSD, severe depression, severe anxiety/OCD, eating disorder

CPA including other agencies, SpCAMHS care co-ordinator, therapeutic package.



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APPENDIX B

OXFORDSHIRE AND BUCKINGHAMSHIRE MENTAL HEALTHCARE NHS TRUST

Child and Adolescent Mental Health Services (CAMHS)

DRAFT JOB DESCRIPTION

<table>
<tr><td>Job Title :
Team Manager</td><td>Grade / Salary :
TBC</td><td>Hours :
37.5 per week</td></tr>
<tr><td colspan="2">Accountable To :
CAMHS Service Manager</td><td>Reports To :
CAMHS Service Manager</td></tr>
<tr><td colspan="2">Locality :
TBC</td><td>Base :</td></tr>
</table>

Job Overview :

The primary functions of this post are:

1. To take overall management responsibility for all aspects of service delivery and operational matters, for one of the three locality CAMH Community teams.
2. To assist with the modernisation and redesign of the CAMHS tier 3 teams leading on agreed projects across the county.
3. To develop robust interagency relationships with PCAMHS, Children, Young people and Families directorate, and other key agencies, supporting the development of integrated care pathways,

Key Relationships

- Service Manager CAMHS
- CAMHS Management team
- Clinical teams
- PCAMHS
- Tier 4 services

Key Objectives

- To take operational responsibility for the Locality Team. This includes monitoring and managing workloads, use of time, operational supervision, authorising leave and expenses.
- To take a lead role in the implementation of the tier 3 review, this will include leading on particular projects across the County these will include embedding CPA , case management , developing a community focussed model of service delivery.
- To work in partnership with key agencies to support, the roll out of Lead Professionals, team around the Child, the use of CAF and single point of access

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- To support the development of integrated care pathways
- To manage the pay and non-pay budgets for the Locality team and to keep costs within these agreed budgets. Where appropriate, and with agreement, to apply these budgets flexibly to develop evidence based services in line with local needs and national drivers.
- Develop robust case management supervision structures.
- To ensure Young People and Carers are included in all the work we do and structures are developed to incorporate users at all levels
- To work closely and co-operatively with professional leads to recruit, retain, supervise and develop clinical staff. To jointly manage, as appropriate, appraisals and disciplinary processes.
- To oversee and improve the running and organisation of the CAMHS Teams and to ensure there is effective and efficient use made of multi-disciplinary working.
- To ensure that there are good operation procedures for all aspects of the Service.
- To build strong strategic and operational relationships between the CAMHS Locality Teams and services for children with PCAMHS, Children Young people and Families, in-patient services and with adult mental health services.
- To ensure that all sites and services have, and use, adequate and up to date policies including those for fire, health and safety and environmental risk.
- To contribute to the overall management, running and development of CAMHS at all Tiers.
- To ensure that the Service is friendly and responsive and deals with complaints and suggestions in a timely and efficient manner.
- To coordinate and investigate complaints and SUI's
- To provide cover for the other Team Managers or the Service Manager as required.

Key Success Areas

- Embed CPA and Care Coordination within the team.
- Play a lead role in supporting and developing a new workforce to provide a flexible community based service
- To be a key change agent modernising CAMHS within a multi agency context.
- To work in partnership with CYP and Families Locality Managers to roll out Common assessment Framework, team around the child and Lead Professional.
- Ensure ECM and NSF performance targets are met.
- Undertake Project work (for example implementation of the choice and partnership approach).
- Represent CAMHS at a range of multi agency forums Demonstrate understanding of Education, CYP and Families, DAAT, YOT.
- CAMHS mapping lead for locality team.

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This job description should be regarded only as a guideline and may be amended in the light of changing circumstances following consultation with the post holder.

Dated September 2006

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Appendix C

Referral Criteria for Specialist Child and Adolescent Mental Health Services (CAMHS) 2006

The Core business of Specialist CAMHS is:
The specialist assessment and treatment of serious mental health disturbances and associated risks in young people under the age of 18 years.

Emergency criteria:-
To be discussed with the duty Clinician for the Specialist CAMHS team and assessment arranged as is clinically indicated and as a maximum within 24 hours

- Presentation of symptoms of severe depression with suicidal ideation
- Presentation of severe psychotic symptoms
- Presentation of anorexia with severe physical signs (e.g. BMI below 15)
- Significant risk of harm to self or others

Urgent criteria:-
To be discussed with the duty Clinician for the Specialist CAMHS team and assessment arranged as is clinically indicated and as a maximum within 7 days.

- Severe symptoms of depression with or without suicidal ideation
- Symptoms of anorexia with a BMI of 18 or below and /or low physical observations
- Severe unexplained deterioration in emotional state and behaviour at home and school not thought to be due to drugs, alcohol or physical illness.
- Assessment following deliberate self harm following presentation at accident and emergency services

All standard referrals should be sent to PCAMHS in the first instance.
The referrer needs to identify the level of urgency of the case. If in doubt the referrer should contact SpCAMHS

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Standard Criteria

There will be an emphasis on the need for assessment to ascertain presence or not of severe mental ill health and Specialist CAMHS contribution to management of complex cases. Factors to consider include: severity, complexity, enduring difficulties over time, difficulties in one or more domain, impairment of function at home, school or socially.

- Eating Disorders

- ➢ Anorexia – At least 10-15% deficit from ideal weight.
- ➢ Bulimia –Engaging in binge and purge behaviour.
- ➢ Eating Disorders Not Otherwise Specified (EDNOS) –.

- Psychotic illness

- ➢ Positive symptoms - Paranoia, delusional beliefs, abnormal perceptions (hallucinations on all sensory modalities)
- ➢ Negative, symptoms - deterioration in self care and daily personal, social and family functioning
- ➢ Disinhibited behaviour, overactivity, risk taking, with pressure of speech and agitation
- ➢ Severe depression with psychomotor retardation, social withdrawal, suicidal ideation

- Attention Deficit Hyperactivity Disorder

Follow the CAMHS protocol

- Anxiety disorders

- ➢ Anxiety Panic attacks
- ➢ Separation anxiety
- ➢ Phobias including phobic anxiety related to school.

- *Depression*

- ➢ Physical symptoms – poor sleep/appetite/ libido
- ➢ Cognitive symptoms – negative thoughts about self/others/ world
- ➢ Suicidal ideation
- ➢ Co-morbidity – depression often occurs concurrently with other presenting mental health problems.

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- Post Traumatic Stress Disorder

➢ Symptoms occurring more than 3 months after a recognised traumatic event.
➢ Intrusion and avoidance of thoughts and memories about the trauma.
➢ Hyper-vigilance, hyper-arousal and emotional numbing

- Obsessive Compulsive Disorder & Tourettes

➢ Obsessions and/or compulsions with functional impairment.
➢ Tourettes Syndrome with complex motor and vocal tics, particularly with co-morbidity with OCD and rage.

- Deliberate Self Harm

➢ If accompanied by significant suicidal ideation.
➢ If presenting with a pattern of emotional deregulation, interpersonal difficulty and maladaptive coping strategies.

- Attachment Disorders

➢ If presenting with a persistent pattern of abnormal functioning in interpersonal relationships.

Specialist CAMHS will also see individuals with the following presentations if there is evidence of **co-morbidity** with a serious mental health condition.

- Drug and Alcohol Problems

- Conduct Disorder

- Children with Learning disabilities

➢ Assessment and interventions with children who have an IQ of between 50 and 70 and functional impairment

- Obesity

- Enuresis/Encopresis

- Autistic spectrum disorders

- Chronic fatigue /somatisation syndrome

DRAFT

Oxfordshire & Buckinghamshire NHS
Mental Health Partnership NHS Trust

MEETING WITH BUCKS OSC 2 NOVEMBER 2007
OBMH CAMHS SERVICE MODEL: SUMMARY OF KEY ISSUES

- National Policy – National Service Framework, Every Child Matters
- CAMHS Strategy developed by inter-agency CAMHS Strategy Group (representation from commissioners and all agencies) reporting to Children's Trust Board. Local Children and Young People's Plan, Local Area Agreement.
- This document describes the range of specialist services and the changes in train. We are asking OSC to approve the direction of travel for CAMHS Services
- Inpatient Services – reprovision of Highfield.
- Development of Assertive Outreach – supported by national pilot status in Oxfordshire. Commissioned service for Buckinghamshire focusing on young people with most complex needs as part of an inter-agency approach.
- Changes at Tier 3. Need to be developed through multi-agency working groups/stakeholders and staff groups to provide a broad range of skill mix within our teams, care co-ordination and use of care programme approach. Work in Oxfordshire completed and being implemented. Inter-agency development group commenced in Buckinghamshire reporting to Project Board which includes Commissioners.
- Workforce Development. New Ways of Working, National CAMHs Workforce Development Project and National pilot New Consultant Contract.
- Development of Young People's Panel as part of Big Ideas Project in partnership with Children's Fund. Service Users but also young people who traditionally have found difficulty in accessing services. Operational in Oxfordshire. Developing in Buckinghamshire underway
- Tier 2 in Buckinghamshire currently provided through County Council and PCT on functional basis. Need locality model in order to deliver single point of access and common assessment framework. New model dependent upon tendering but work on improving care pathways and joint working and interface issues already underway.

Yvonne Taylor, Service Director, CAMHS and Specialist Services
Dr Rosie Shepperd, Clinical Director, CAMHS

18 November 2007

EAST BERKSHIRE JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE
Terms of Reference

1. These terms of reference together with the health scrutiny code of practice for East Berkshire provide a framework for carrying out joint health scrutiny work in East Berkshire under powers to scrutinise the NHS contained in the Health and Social Care Act 2001.

2. The East Berkshire Joint Health OSC has been formed by Bracknell Forest Borough Council, Slough Borough Council and the Royal Borough of Windsor and Maidenhead;

a) To look at strategic, regional, sub-regional or locality related health issues or look at a specific review as determined by the joint health overview and scrutiny committee (working as a *discretionary* committee).

b) To form a *statutory* Joint Health Scrutiny Committee i.e. as required under law where the local authorities whose residents are affected by a particular course of action by a NHS body, consider the proposals to be "substantial" and wish to review the NHS decision/action or where the NHS body requires it.

3. The Committee will comprise of nine Councillors; three members elected annually from each of the individual three local authorities in East Berkshire. The three authorities have agreed to waive the requirement for the committee as a whole to have proportional political representation. However, each local authority may decide whether to maintain political proportionality for its seats on the committee or not.

4. Appointments to the committee will be for a term of office one year from the date of each authority's annual council meeting. Substitutions may be made by each authority for their own representatives if they so wish. Substitutes may attend meetings of the joint committee as non-voting observers in order to familiarise themselves with the issues under review.

5. Once established the Joint Committee will meet quarterly and rotate the venue for the meeting between the three authorities. Special meetings may be called in addition to the quarterly meetings if the need arises. The joint committee will meet in public and be advertised as such in each authority area in accordance with the local government acts.

6. The Joint Committee may ask individuals to assist it on a review by review basis. Independent professionals or those with specialist knowledge may be requested to give their expert advice to the joint committee during a review, without being co-opted.

7. The quorum for the main joint committee meetings shall be 6, provided that each authority is represented. The quorum for review meetings shall be 3, provided that each authority is represented or that joint agreement is reached for one or two authorities to lead/act for the joint committee.

8. The Chairmanship of the joint committee will be rotated annually between the three East Berkshire authorities. The Joint Committee will appoint two vice-chairmen from each of the other participating authorities.

9. Officer support i.e. the administration of agendas and minutes will follow annually with the rotation of the Chairman. Please refer to the joint health scrutiny protocol for details of the administration of specific reviews and the balance of administration between health trusts and local authorities.

10. Health scrutiny reviews undertaken on specific topics over a specific length of time, may be delegated to review groups of the joint committee with membership of between 3 and 6 Councillors, and with at least 1 member from each authority. This may be waived if an authority does not wish to take part, as the review will not affect their area, and if the involvement of the two remaining authorities is agreed.

11. Each separate review must be accompanied by a pro forma, covering the following items; description of the subject, identification of the health bodies involved/leading the issue, review group membership, issues to be addressed, officer support and the evidence gathering process proposed.

12. At the end of each review, a report must be produced and signed off by the Joint committee and considered by each individual participating authority.

13. The joint committee will also receive and consider responses by NHS bodies to its reports and reviews as empowered under the Act.

14. The schedule of Joint Committee meetings may include flexibility if required, for example; to give a break in the timetable to allow individual authorities to evaluate responses to the Joint Committee's report and return with comments.

15. The terms of reference and the working arrangements for the joint health overview and scrutiny committee will be kept under annual review and amended as necessary with the committee's agreement.