Minutes of the Meeting of the Adult Social Care and Health Overview and Scrutiny Committee held on 15 February 2012 at Shire Hall, Warwick

Present:

Members of the Committee Councillor Les Caborn (Chair)
" Martyn Ashford
" Penny Bould
" Jose Compton
" Richard Dodd
" Kate Rolfe
" Dave Shilton
" Sid Tooth
" Angela Warner
" Claire Watson

District/Borough Councillors Sally Bragg (Rugby Borough Council)
John Haynes (Nuneaton and Bedworth Borough Council)
George Mattheou (Stratford-on-Avon District Council)
Derek Pickard (North Warwickshire Borough Council)

Other County Councillors Councillor Peter Balaam
Councillor Jim Foster
Councillor Jerry Roodhouse (Chair of Warwickshire LINk)
Councillor Izzi Seccombe (Portfolio Holder for Adult Social Care)
Councillor Bob Stevens (Portfolio Holder for Health)

Officers Dave Abbott, Democratic Services Officer
Georgina Atkinson, Team Leader
Wendy Fabbro, Strategic Director of Adult Services
Kate Harker, Joint Commissioning Manager
Chris Lewington, Service Manager - Learning Disability, Mental Health, Carers and Customer Engagement
Ann Mawdsley, Senior Democratic Services Officer
Monika Rozanski, Senior Projects Manager
Mark Ryder, Head of Localities and Community Safety

Also Present: Ian Andrew, Coventry and Warwickshire Partnership Trust (CWPT)
Paul Baker, West Midlands Ambulance Service (WMAS)
Nigel Barton, CWPT
Jayne Blacklay, South Warwickshire Foundation Trust (SWFT)
Craig Cooke, WMAS
Roger Copping, Warwickshire LINk

Chris Edgerton, Warwickshire Link
Darren Fradgley, WMAS
Dr John Linnane, Public Health
Kevin McGee, George Eliot Hospital NHS Trust (GEH)
Rachel Newson, CWPT
Heather Norgrove, GEH
Ham Patel, WMAS
Lorraine Roberts, CWPT
Dr Helen Rostill, CWPT
Deb Saunders, Warwickshire LINk
Josie Spencer, CWPT

1. General

(1) Apologies for absence

Apologies have been received on behalf of Cllr Michael Kinson (Warwick District Council) and Chris Kowalik (WMAS).

(2) Members Declarations of Personal and Prejudicial Interests

Councillor Penny Bould declared a personal interest as:

- a service user of Warwickshire County Council services
- a member of Disabled People Against the Cuts (DPAC)
- a member of GMB
- a member of Unite
- a private practitioner in psychology
- having received training with CWPT

Councillor Richard Dodd declared a personal interest as an employee of the WMAS NHS Trust and a prejudicial interest in Item 5 as above.

Councillor Angela Warner declared a personal interest due to her employment as a GP in Warwickshire.

(3) Minutes of the meeting of the Adult Social Care and Health Overview and Scrutiny Committee held on 7 December 2011

The minutes of the meeting of the Adult Social Care and Health Overview and Scrutiny Committee held on 7 December 2011 were agreed as a true record and signed by the Chair.

Matters Arising

Page 3 – 3.2 Questions to the Portfolio Holder

Councillor John Haynes stated that people who were forced to access treatments only available at SWFT, access was difficult due to the distance having to be travelled.

Minutes of the special meeting of the Adult Social Care and Health Overview and Scrutiny Committee held on 16 December 2011

The minutes of the special meeting of the Adult Social Care and Health Overview and Scrutiny Committee held on 16 December 2011 were agreed as a true record and signed by the Chair.

Matters Arising

Councillor Claire Watson asked for an update regarding recommendation 5. The Chair responded that an update report on bed occupancy and repatriation would be requested for the 11 April 2012 meeting.

(4) Chair's Announcements

Members were informed that scrutiny would be hosting a health roundtable event in April. The event would bring together all commissioning partners to consider connections, communication, overlap of work and culture differences, with the intended outcome of forging good relationships for the future. The two dates being considered were 27 April and 30 April and these would be circulated to committee members for availability.

The Chair asked for volunteers to consider the Quality Accounts for 2011/12, which would be managed differently to past years with as much pre-work being done as possible to ease the pressure of final signing off of the Quality Accounts. Councillors Ashford, Bould, Warner and Watson agreed to participate.

2. Public Question Time

1. Question from David Gee, Warwickshire LINk to OSC

Much is heard about health inequality in the north of Warwickshire, but there is one area where the south of the county is poorly provided for – mental health services.

For example, three patients at the Rehab Hospital in Leamington have been bed-blocking for between <u>*4 and 5 months*</u> *as they needed mental*

health care and there was none available. I therefore ask the Committee to ask when an adequate service will be provided in the south.

Response from Fay Baillie, Director of Nursing, Arden Cluster

“I would like to thank Mr Gee for asking about a small group of patients who are currently in the Royal Rehabilitation Hospital Leamington.

The patients are young brain injury patients who do not have continuing health needs. They are currently having long term rehabilitation as in patients and have almost reached their full potential. Their consultant believes that with specialist cognitive rehabilitation therapy over 6-12 months they may be able to make some progress to allow them to integrate into normal life style.

The patients currently are extremely difficult to manage in community setting because of their extreme behaviour

This therapy is not available locally and would need to be provided in a specialist unit away from the young person’s home.

This is not currently a commissioned rehabilitation service. Commissioning is reviewing the evidence that cognitive behavioural therapy improves patient potential. Currently individual patients who may benefit are reviewed in individual funding panels. 3 patients have been supported to date though re-ablement monies. Further re-ablement funding has been set aside this year for this group of patients who are surviving brain injury.

2. Question from David Gee, Warwickshire LINk to PH

Bed blocking is a major problem, costing the NHS a serious amount of money and causing delays for patients.

For example, for the stroke service in the south alone, in the last 6 months there has been the equivalent of 1,000 bed blocking days. At £278 per night that is a considerable amount of money. It is worse, because it causes hold-ups elsewhere in the system, the final cost just could be approaching half a million pounds.

In Worcestershire they have combined health and social care services, which has resulted in a reduction of 75% in bed blocking. The Council state that they are co-operating, but this is not the answer as it still implies two separate bodies. The financial savings can only be achieved by totally merging and I would ask what steps are the Council taking to achieve this?

Councillor Izzi Seccombe responded that the publicity about Warwickshire's performance in relation to bed blocking had been investigated and the numbers that had been quoted did not relate to the data held by the County Council and there was some question about the dissemination of the information. Wendy Fabbro added that this was not unusual nationally and there were several groups meeting across the West Midlands to ensure robust processes to get reliable data, which was crucial for planning purposes.

She acknowledged the importance of health and social care services being streamlined and joined up and reported a project had been developed to share information sources to create a "data warehouse".

Additional project funding had been received from the Department of Health for winter pressures which had enabled spot beds to be made available for re-ablement. Safeguards were being put in place so that older people in acute hospital settings could be transferred to social care beds for re-ablement purposes and returned to their own homes as soon as was possible. Wendy Fabbro recorded her gratitude to colleagues from the Hospital Trusts for their contributions to achieving this, including extra physiotherapists and assessment staff in hospitals. She added that while there would inevitably be peaks in demand, there was a commitment from health and social care to provide the best possible streamlined services.

Councillor John Haynes made reference to the closure of Bramcote Hospital and Jayne Blacklay, Director of Development (Deputy Chief Executive) at SWFT responded that the success of the Community Emergency Response Team in the north who were responsible for facilitating the discharge of an average of five patients a day from GEH was to be rolled out in the south of the county.

Councillor Derek Pickard noted the importance of clearly defined data for planning and operations.

3. George Eliot Hospital – Update

Kevin McGee, Chief Executive of the GEH thanked the Committee for inviting him to speak. He introduced Heather Norgrove, informing the Committee that her role at the Hospital had changed to Commercial Director with a more external focus, working with stakeholders and GPs.

He outlined the four areas he would be speaking on, namely the future of GEH, the Women and Children Services Review, Mortality Rates and recent press coverage. He made the following points:

i. GEH was aiming for Foundation Status by April 2013, but as a small hospital, this would have to be in a partnership arrangement that would give the greatest security and protection to local services.

iii. The sustainability of services provided by small general hospitals was being debated across the country, but for GEH decisions made with partners now had to maintain its role as a centre of the local community.

iv. The debate on services for women and children was longstanding and the hospital was working with partner organisations to produce a strong sustainable model which would retain the majority of paediatric services and the lowest level neo-natal services. He added that there were 2,500 births a year at GEH and any alternative provision would have to be safe and sustainable.

v. Kevin McGee gave credit to SWFT for producing a joint model that would develop a paediatric network across Warwickshire covering a population of more than 500,000 with a strong cohort of paediatric care across the sites. This proposal was currently being considered by the Arden Cluster and the Royal College of Paediatricians.

vi. GEH's high mortality figures (measured by the Dr Foster hospital guide and the Standard Hospital Mortality Index) had been reported in both local and national press. The hospital had instigated an independent external review to look into this which had identified three main causes:
   - the clinical model, specifically areas such as patient flow;
   - coding issues, which had been corrected resulting in a reduction from 117 to 106 in October 2011;
   - environmental factors which were outside of the control of the hospital such as the average number of deaths in any location and a lack of external provision of hospice beds. GEH was keen to work with Social Services and the local community to improve in these areas.

vii. GEH had received negative publicity in relation to pressure sores. Kevin McGee outlined the difficulties around the definition of pressure sores and the reporting of these, but acknowledged that numbers were too high and an active approach had been taken to reducing the numbers of pressure sores.

During the discussion that ensued the following was noted:

1. Members agreed that any pressures sores were unacceptable and proper nursing practices should prevent these. Kevin McGee agreed there should be zero tolerance and noted that an additional £1.5m had been invested in nursing at GEH to try to achieve this aspiration.
2. GEH was a small hospital with limited capacity (approximately 350 beds), which could impact on the flow of patients, particularly with the additional pressures during the winter months. Work was being done to get the capacity right within the organisation to ensure patients received immediate care and treatment.

3. GEH had clinical networks with a number of other hospitals including University Hospital Coventry and Warwickshire (UHCW), SWFT and Birmingham, but was a standalone organisation. It was suggested that there was an overwhelming clinical case for GEH to team with UHCW and Kevin McGee responded that there was a clear distinction to be made between clinical partnerships and organisational link-ups.
4. GEH had not met the target for the amount of time spent in A&E for admitted patients (<4 hours) at any time in 2011. Kevin McGee said that some Acute Trusts had difficultly delivering this target, particularly in light of the growing activity in A&E. He added that four senior A&E Consultants had been appointed, bringing the number to five and work was being done with GP commissioners to try to understand these trends so that partners could tackle this issue together. The Chair noted that this was an issue that needed to be considered during the consideration of all Quality Accounts.
5. Reasons were requested for the level of cancellation of elective operations. Kevin McGee responded that while he agreed that any cancellation was unacceptable, GEH figures were not excessively high. He added that there were times where medical patients had to take precedence over elective surgery, but only as a last resort.
6. While there was some palliative and day care provision in the north, there were no inpatient hospice beds, which resulted in some patients being brought to the hospital to die, which was believed to have a direct correlation to the mortality figures. GEH did not commission hospice services but would support the development of inpatient hospice services in North Warwickshire.
7. Following general discussion around contributing factors towards high mortality rates such as health inequalities and funding, Kevin McGee acknowledged that there were some issues that were within the control of the hospital. He added however that the real task would be to understand the causes behind health inequalities and to develop a strategy for dealing with them.
8. Wendy Fabbro stated that the business case for change would have to be built on sound information with the future of services such as paediatrics, older people services and discharges determined by all partners. Kevin McGee agreed the business case would have to be based on the most accurate data possible and added that GEH were building their business case with commissioners and the Strategic Health Authority.
10. Councillor Jerry Roodhouse asked what was being done at GEH to deliver the Liverpool Pathway Gold Standards. Kevin McGee stated that the aspiration for the hospital was to have all Gold Standard pathways in place. There was a piece of work that needed to be done to link all providers to deliver these standards. The Chair requested a Briefing Note on the Liverpool Pathway and Gold Standards Framework.
11. Kevin McGee emphasised the importance of the Health and Wellbeing Strategy to Warwickshire and recorded his desire to be invited to Health

and Wellbeing Board meetings to participate in developing the Strategy. The Chair asked Councillor Bob Stevens to pick this up.

The Chair thanked Kevin McGee for the frank and honest discussion. He added that the Committee, in their role as critical friend, wanted to work with the hospital to improve services.

The Committee asked for a further update report at a date to be determined and requested that the issues raised above be considered with the GEH Quality Accounts.

4. Report of the Chair of the Paediatric and Maternity Services Task and Finish Group

Councillor Peter Balaam, Chair of the Paediatric and Maternity Services Task and Finish Group introduced the interim report. He informed the Committee that this should have been the final report, but there had been significant delays with the consultation. He added the following points:

i. The future focus would concentrate on:
   - the impact on users, particularly transport and access,
   - the reach of the consultation and the consultation process.

ii. Transport issues had been insufficiently addressed in the Business Case, which had only dealt with possible financial help for travel. A letter to this effect had been sent to the Arden Cluster, but no response had been received to date.

iii. Option C was a popular choice, but was dependent on the proposed partnership with the SWFT. In light of the concerns that had been raised with access and transport, members of the Task and Finish Group were of the opinion that if option C were removed, action would need to be taken to question the Quality v Access balance.

iv The latest date given for the consultation was May 2012 and the next step was to wait for the outcome of the Royal College and the National Clinical Advisory Team reports on the proposed partnership with SWFT.

A discussion ensued and the following points were raised:

1. There were approximately 2,500 births a year at GEH, which would be difficult for another hospital to absorb.
2. At a Joint Review of Antenatal and Postnatal services for Teenage Parents in Warwickshire carried out in the autumn of 2010, the work being done with midwives and in particular the Providing Information and Positive Parenting Support (PIPPS) team at the GEH had been commended. Councillor Claire Watson stated that it would be tragic if this service was lost and the continuity of trust for these vulnerable young girls broken. Kevin McGee added that GEH provided a holistic service and the transferral of any part of that service would break that trust.

3. Members noted their concerns about accessibility and transport, particularly for people from North Warwickshire.

The Chair thanked Councillor Balaam and his Task and Finish Group for the work they had done to date. The Committee agreed to:

(1) Endorse the progress of the Task and Finish Group

(2) Endorse the proposed next steps

(3) Hold a special meeting to consider the response of the Task and Finish Group if required.

Councillor Richard Dodd left the room.

5. West Midlands Ambulance Service

The Committee received presentations from Ham Patel, General Manager for the Coventry and Warwickshire area, Craig Cooke, Resilience & Support Services Director and Darren Fradgley, Head of Performance Improvement giving an operational overview for Warwickshire and updates on the Make Ready and NHS Pathways & the Capacity Management System Directory of Services (CMS DOS).

During the discussion that followed it was noted:

1. Performance had dipped slightly following the relocation of the control room to Staffordshire, but only for a short period of time.
2. Service and resource allocation was equitable across Coventry and Warwickshire, with the process aimed at putting more resources into the rural areas in Warwickshire.
3. The Warwick fire station had not been fit for purpose for some years and alternative locations were being considered.
4. In response to a query regarding wastage with drugs and air it was noted that at present there were 65 locations holding time limited stock. Some locations did not have stock managers, resulting in greater wastage.
5. There was already a strong ambulance fleet base across the region, although there would be rationalisation in some areas. Under the Make Ready Programme the actual stock across the region would grow slightly.
6. Most ambulance transportation passed through Emergency Departments and a lot of work was done with partners to get the flows right, including basing Hospital Liaison Officers (WMAS staff) in hospitals to ensure patient transfer was appropriate.
7. The biggest challenges foreseen by WMAS in moving forward was changing the culture of staff, finding appropriate hub sites and getting communication right. In terms of the model, staff was well geared for training and the process had already begun.

8. Turnaround times at hospitals were reported on a monthly basis and Brierley Hill Centre coordinated across all hospitals in an effort to smooth out peaks across all trusts. Work had been done with UHCW which had resulted in improvements this year, but it was agreed that a second access road was needed.
9. By training paramedics to a higher standard and making greater use of community systems, numbers to hospitals would be reduced.
10. First Response Officers would play an increasing role in the service offer of the service. Craig Cooke undertook to provide a briefing note for the Committee on the offer from the Ambulance Service with First Response Officers and the contact details for the dedicated officer in Coventry and Warwickshire.
11. Clinicians had been embedded into the Capacity Management System (CMS) at both Brierley Hill and Tollgate, to ensure clinical support where needed.
13. The CMS DOS system had not been developed to make wholesale savings, but to bring about working more efficiently to accommodate the increasing demand.
14. The Directory of Services (DOS) would include any services that could help health with the flow of patients, including details for services such as Meals on Wheels, dog walking services and funeral directors. Councillor Izzi Seccombe noted that a resource centre was being developed for social care and there would be obvious benefits to linking the systems.

The Chair thanked Ham Patel, Craig Cooke and Darren Fradgley for their presentations and welcomed the positive approach of the organisation.

Councillor Richard Dodd returned to the meeting.

6. Children and Adolescent Mental Health Services (CAMHS) Update

Kate Harker, Joint Commissioning Manager (CAMHS) introduced the report giving the second update on the Action Plan which was produced following the Scrutiny Review of CAMHS carried out in 2010. She outlined areas that had gone well and areas that continued to cause concern, including:

- waiting times
- outcome data
- financial reporting
- the need for a business case outlining where additional resources were needed and why.

Nigel Barton, Director of Operations, CWPT noted that there had been a lot of progress since the 2010 review and made the following points:

i. A baseline had needed to be set to monitor outcome measurements against, and this had taken time to agree.

ii. The money that had been put in by WCC to support Choice and Partnership Approach (CAPA) initially had improved waiting times.
iii. The CAMHS resource across Warwickshire was insufficient to meet demand so either the threshold and pathways had to be changed or more resources put in. A strategic workshop day had been jointly arranged between CWPT and WCC which would bring together all stakeholders, and would demonstrate the case for more resources.

Wendy Fabbro added that there had been ongoing concerns from a number of sources and an urgent solution was required. She echoed the comments made by Nigel Barton, noting the importance of ensuring that the shape of the service was right for the future to achieve the right outcomes for children in Warwickshire.

Councillor Izzi Seccombe highlighted the open and frank report, adding that this had been a long journey and there was a lot of work to be done to improve the situation, particularly under the current financial circumstances. She noted her disappointment that WCC had not been consulted about the structural changes at CWPT. Nigel Barton responded that the changes were only to the management structure of the Trust and that there had been no changes to the structures beneath.

During the ensuing discussion the following points were raised:

1. Members noted their disappointment that after two years, targets were still not being met, particularly waiting times, and that a business case had still not been produced. Nigel Barton responded that thresholds and pathways had to be sorted so the shape of the service was clear before a business case could be produced.
2. CAMHS and CAPA both had capacity limitations and in Warwickshire there were less clinicians than referrals. Dr Helen Rostill, lead clinical psychologist for CAMHS, added that CAPA was very goal-focussed based on the needs of families and therefore produced better outcomes. She added that the figures for Q3 were encouraging and that benchmarked against other authorities, CAMHS was doing very well.
3. Members asked what initiatives besides CAPA, were available for reducing waiting times, Kate Harker reported that there were a number of services put in place to ensure children were placed in the right service, including primary mental health workers, Relate, Kooth and counselling services. She added that £150,000 had also been allocated from the dedicated school grant to the CAF (Common Assessment Framework).
4. Referral criteria was set and any referrals not meeting the criteria were referred back to be picked up by another service. Every quarter approximately 120 out of 600 referrals to CAMHS were assessed.
5. Dr Helen Rostill said there had been a considerable amount of work done within CAMHS on pathways and there were a number coming through. In response to a query regarding services for eating disorders, she added

that discussions were taking place to ensure the best process to deliver this service, which needed to be NICE compliant.

6. CWPT felt that four whole time therapists with a doctor would be needed to achieve a standstill position.

Lorraine Roberts, General Manager CAMHS, CWPT stated that success could only be measured taking into account the capacity of staff to meet demand. She stated that the time invested to see children on the waiting lists had moved the bottleneck further down the system and there may be a need to develop a hybrid model. She added that the difference between north and south was only due to CAPA being introduced in the south first, but both were now fully operational with CAPA and trying to clear treatment lists.

The Adult Social Care and Health Overview and Scrutiny Committee agreed to:

(1) Request that CWPT produce a report for the Committee to consider at their meeting on the 11th April 2012 outlining the precise nature of the current Child and Adolescent Mental Health Service (CAMHS) waiting lists and an action plan outlining how these will be addressed in the next six months.

(2) That CWPT bring a further report to ASC&H OSC on 5th September 2012 that provides a full account of the current waiting and the actions that have been put in place to address these waits.

(3) That commissioners explore new ways of addressing waiting times including benchmarking CWPT against statistical neighbours, the re negotiation of the contract with CWPT and testing the market for potential providers. The outcome and recommendations to move this forward will be brought back to ASC & HOSC on 5th September 2012. Any decision on changes to the current contractual arrangements will require authorisation and support from the Arden Cluster and Clinical Commissioning Groups.

(4) To record its concern with the direction of travel and progress of CAMHS and ask the Director of Operations to report back on 5th September 2012 as to whether the CAMHS is fit for purpose for Warwickshire.

7. Coventry and Warwickshire Partnership Trust

The Committee received a PowerPoint presentation setting out CWPT's plans to become a Foundation Trust and seeking the support of the Committee.

During the ensuing discussion it was noted:

1. CWPT felt they were big enough to stand alone as a Trust, as the second largest provider of services after UHCW, with three hospital sites across Coventry and Warwickshire and a large number of community teams.

2. Following the issues raised under item 6 above, concern was raised about governance, monitoring and how transparency would be managed with Foundation Status. Nigel Barton responded that while CAMHS was contentious, the Trust worked closely and well with the local authority in other areas.
3. Concern was raised about the difficulty in accessing the budget ratios and therefore the equality between Coventry and Warwickshire. Rachel Newson responded that this information was routinely provided for commissioners and all relevant data and information on CAMHS would be shared at the strategic workshop. Wendy Fabbro pointed out that this information was only provided for PCT commissioners.
4. Foundation Status would bring greater independence and enable the Trust to make financial decisions on which services to invest in and at what level, including reinvestment of savings.
5. As a Foundation Trust, performance would be overseen by Monitor, but at a local level the Trust would be accountable to local people in their roles as members and governors. CWPT was already on target for member applications and Coventry, Warwickshire and Solihull would be invited to nominate a Councillor as a Primary Governor.
6. If a Trust did not achieve Foundation Status, it would be considered to be failing and the Secretary of State would have the power to nominate a special administrator to manage the future of these services. Rachel Newson stated that if this happened, services would be provided from a clearing set of organisations within mental health and could be provided from out-of-county.
7. CWPT acknowledged the need to develop an integrated business plan which focussed clearly on outcomes and how these could be delivered. This was planned as part of the ongoing programme of redesign, and would involve partners and be informed by Joint Strategic Needs Assessments.

The Chair thanked Rachel Newson and Nigel Barton for their presentation. He summed up that while the Adult Social Care and Health Overview and Scrutiny Committee's support had been sought by the CWPT for Foundation Trust status, one of the key criteria for this was 'to be an active partner always ready to improve by working with others'. The Committee had major concerns, as set out above, and therefore agreed that lead Councillors and officers would meet after the meeting to formulate a response.

[Administrative Note: A letter was sent on behalf of the Adult Social Care and Health Overview and Scrutiny Committee to CWPT setting out their concerns and conditions for supporting Foundation Status. A copy of this was shared with members of the Committee. A separate letter was sent from Warwickshire County Council.]

8. Older Adults Mental Health Task and Finish Group – Update Report

Councillor Jerry Roodhouse, Chair of the Task and Finish Group, introduced the report setting out the frustrating setbacks that had been encountered.

Nigel Barton explained that the process had been introduced to change the model of provision from an inpatient focussed model to more community provision, but that ultimately the Arden Cluster had the duty to lead the consultation as commissioners of the service. Rachel Newson added that CWPT shared the Committee's frustration as NHS Warwickshire had chosen not to take the consultation to the Arden Board as planned, but that Steven Jones, Chief Executive of the Arden Cluster, had undertaken to review the situation.

Wendy Fabbro recorded her disappointment that her Group had not been kept informed, and that more integrated working and earlier consultation could have helped to resolve the delay.

Councillor Jerry Roodhouse noted that elected members were keen to progress this work and every effort needed to be made to sort this out.

The Committee agreed that the Task and Finish Group continue this important work and that a letter should be send from Councillors Les Caborn and Jerry Roodhouse to Stephen Jones, Chief Executive of the Arden Cluster.

9. Dementia Strategy Progress Report

Councillor Jose Compton, Chair of the Dementia Delivery Board, and Chris Lewington, Service Manager - Learning Disability, Mental Health, Carers and Customer Engagement, presented the progress report and were thanked by the Chair for the work being done in Warwickshire.

The following points were noted:

1. Dementia was very difficult to diagnose and there was a need to educate GPs on appropriate diagnosis. Concern was raised about the ability of the current system to cope with any large increase in the number of people diagnosed with dementia.
2. Members agreed that the Dementia Strategy should be adopted by District/Borough Councils and throughout primary care.

The Committee welcomed the progress that had been made to date.

10. Questions to the Portfolio Holder

Councillor John Haynes asked Councillor Izzi Seccombe what the cost of carrying out the annual review for social care was. Councillor Seccombe undertook to provide a written response to Councillor Haynes.

11. Warwickshire LINk

Deb Saunders, LINk Manager introduced the report, updating the Committee on progress since the hosting arrangements of Warwickshire LINk had been transferred to Warwickshire CAVA (Community and Voluntary Action) and Age UK. She made the following points:

i. The Health and Social Care Bill was still journeying through Parliament and that the organisation had needed to be flexible to deal with changing timescales. The current timescale for LINk to cease to exist as an organisation was April 2013, at which time there needed to be a legacy in place for HealthWatch to move forward.

ii. The summary of work carried out or commissioned by LINk was published on the LINk website and shared with relevant partners such as Overview and Scrutiny. Work was being done to strengthen and develop this further.

The Chair thanked Councillor Jerry Roodhouse and Deb Saunders for their report.

12. Staffing Capacity

Wendy Fabbro updated the Committee on the staffing capacity, adding:

1. She had reported in September 2011 that there would be a need to rebuild capacity in some areas and this had now been done and would continue to be monitored.
2. The People's Group was facing a lot of challenges including the quality of nursing home care in the county, and the capacity of the Quality Monitoring Team would have to be reviewed.
3. In response to a query about pressure sores in care homes, Wendy Fabbro reported that Tier 3 and 4 pressure sores justified a full safeguarding alert. Pressure sores were often the result of inexperienced staff or the inadequacy of equipment, but incidents were fully monitored and responded to on being reported.

The Chair thanked Wendy Fabbro for her update.

13. Warwickshire Local Account 2012

Wendy Fabbro presented the Warwickshire Local Account for 2012, which had replaced the Annual Performance Assessment. She assured Members that in the future the Local Account would be brought to Overview and Scrutiny before being considered by the Cabinet.

Councillor Jerry Roodhouse asked whether the Local Account would be subject to the Quality Account procedure to be reported to Scrutiny and LINk (and then HealthWatch). Wendy Fabbro undertook to clarify this.

Councillor Izzi Seccombe noted that this was a reflective document looking back at a year of change and providing an opportunity to reflect on performance against targets and the direction of travel for the future.

The Chair commended the style and readability of the report and welcomed the assurance that future Local Account reports would be considered by Overview and Scrutiny first.

14. Shaping Local Healthwatch in Warwickshire – Further Progress Report

Monika Rozanski, Senior Projects Manager, introduced the report which had been requested by Committee at their December meeting. She made the following points:

i. There was a level of intelligence available on the LINk work programme that could be picked up by HealthWatch.
ii. The Warwickshire HealthWatch Service Specification was the first to be developed across the country and had been benchmarked with eight other authorities. The draft had received constructive feedback from the Health Transition Strategic Group and was scheduled to be presented to the next meeting of the Health and Wellbeing Board.

During the discussion that followed the following was raised:

1. In response to a query about who would hold HealthWatch to account, Monika Rozanski acknowledged the role for scrutiny in monitoring the function and outcomes of HealthWatch and agreed that this needed to be incorporated into the specification.
2. Members agreed that 10.1 needed to be strengthened by the additional of the requirement for HealthWatch to present its annual report to Health Scrutiny.
3. Funding of HealthWatch was yet to be determined but indications were that it would be twice the current LINk budget. There was also a sum of £3.2m that was to be divided between all local authorities for start-up costs.
4. It was noted that the Government's vision for HealthWatch did not include disabled children living in residential care. Monika Rozanski said this had been raised with the Department of Health and would be included in the House of Lords debate.
5. The leadership would be determined by a tendering process and potential providers would have to demonstrate they had the right capacity and experience to deliver the functions of HealthWatch. The Local Authority would have the responsibility for putting in place different arrangements should it be decided at any time that HealthWatch was not working.

The Chair thanked Monika Rozanski for her report and good work in developing HealthWatch. The Committee asked that the final Specification be brought to the Overview and Scrutiny Committee before final approval.

15. Work Programme

The Work Programme was agreed, including the additional items requested at this meeting.

16. Any Urgent Items

None.

………………………
Chair of Committee

The Committee rose at 4.50 p.m.