Adult Social Care and Health Overview and Scrutiny Committee

5 September 2012

Agenda

A meeting of the Adult Social Care and Health Overview and Scrutiny Committee will be held at the **SHIRE HALL, WARWICK on WEDNESDAY, 5 SEPTEMBER 2012 at 10:00 a.m.**

The agenda will be: -

1. General

(1) Apologies

(2) Members' Disclosures of Personal and Prejudicial Interests.

Members should declare any interests at this point, or as soon as the interest becomes apparent. If the interest is prejudicial, and none of the exceptions apply, you must withdraw from the room. Membership of a district or borough council only needs to be declared (as a personal interest) if you wish to speak in relation to this membership.

(3) Minutes of the meeting of the Adult Social Care and Health Overview and Scrutiny Committee held on 19 June 2012

(4) Chair's Announcements

2. Public Question Time (Standing Order 34)

Up to 30 minutes of the meeting is available for members of the public to ask questions on any matters within the remit of this Committee. Questioners can speak for up to three minutes.

For further information about public question time, please contact Ann Mawdsley on 01926 418079 or e-mail ***annmawdsley@warwickshire.gov.uk***.

3. Questions to the Portfolio Holders

Up to 30 minutes of the meeting is available for Members of the Committee to put questions to the Portfolio Holders (Councillor Izzi Seccombe (Adult Social Care) and Councillor Bob Stevens (Health) on any matters relevant to the remit of this Committee.

4. Commissioners report on Child and Adolescent Mental Health Service (CAMHS) Improvements

This report is provided by the Warwickshire County Council Commissioners of the CAMHS service.

5. Child & Adolescent Mental Health Services (CAMHS) Waiting times - September 2012 Update

This report from the Coventry and Warwickshire Partnership Trust gives an update on a number of issues raised by the Committee at previous meetings.

6. Ofsted/CQC Inspection

Wendy Fabbro will give a verbal report on the initial learning and findings from the thematic inspection of mental health and drug/alcohol services where the patient/ service user is a parent of a child in need or child being protected.

7. Public Health

This report gives an update on Public Health.

8. Hospital Discharge and Reablement Services

This report is a progress report on hospital dischanges and reablement services, including an update on the recommendations made by the Hospital Discharges and Reablement Services Task and Finish Group agreed by Cabinet on 14 July 2011.

9. Q1 Performance Report

This report presents Quarter 1 performance, including trend data and benchmarking information.

10. Crisis House Provision

This report from Coventry and Warwickshire Partnership Trust gives an update on Crisis House Provision.

11. George Eliot Hospital

Wendy Fabbro will give a verbal progress report on the preparation for the franchise tender of George Elliot trust and its services.

12. Department of Health Consultation on Health Scrutiny

The Committee is asked to consider the Warwickshire County Council response to the Department of Health Consultation on Health Scrutiny. This document will be forwarded to members of the Committee as soon as it is available.

13. Quality Accounts

Martyn Harris will give a verbal update on the Quality Accounts Task and Finish Groups.

14. Work Programme

This report contains the Work Programme for the Adult Social Care and Health Overview and Scrutiny Committee.

15. Any Urgent Items

Agreed by the Chair.

16. Reports Containing Confidential or Exempt Information

To consider passing the following resolution:

'That members of the public be excluded from the meeting for the items mentioned below on the grounds that their presence would involve the disclosure of exempt information as defined in paragraph 3 of Schedule 12A of Part 1 of the Local Government Act 1972'.

17. Exempt Minutes of the Meeting of the Adult Social Care and Health Overview and Scrutiny Committee held on 19 June 2012

JIM GRAHAM
Chief Executive

Adult Social Care and Health Overview and Scrutiny Committee Membership

Councillors Martyn Ashford, Penny Bould, Les Caborn (Chair), Jose Compton, Richard Dodd, Mike Gittus, Carolyn Robbins, Kate Rolfe (S), Dave Shilton (Vice Chair), and Sid Tooth (S)

District and Borough Councillors (5-voting on health matters) One Member from each district/borough in Warwickshire. Each must be a member of an Overview and Scrutiny Committee of their authority:

North Warwickshire Borough Council:	Councillor Derek Pickard
Nuneaton and Bedworth Borough Council:	Councillor John Haynes
Rugby Borough Council	Councillor Sally Bragg
Stratford-on-Avon District Council	Councillor George Mattheou
Warwick District Council:	Councillor Michael Kinson OBE

Portfolio Holders:- Councillor Izzi Seccombe (Adult Social Care)
Councillor Bob Stevens (Health)

General Enquiries: Please contact Ann Mawdsley on 01926 418079
E-mail: annmawdsley@warwickshire.gov.uk.

Minutes of the Meeting of the Adult Social Care and Health Overview and Scrutiny Committee held on 19 June 2012 at Shire Hall, Warwick

Present:

Members of the Committee Councillor Les Caborn (Chair)
" Martyn Ashford
" Penny Bould
" Jose Compton
" Richard Dodd
" Carol Fox (replaced Councillor Carolyn Robbins for this meeting)
" Mike Gittus
" Kate Rolfe
" Dave Shilton
" Sid Tooth

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

Other County Councillors Councillor Jerry Roodhouse (Chair of Warwickshire LINk)
Councillor Izzi Seccombe (Portfolio Holder for Adult Social Care)
Councillor Bob Stevens (Portfolio Holder for Health)
Councillor Angela Warner
Councillor Claire Watson

Officers Wendy Fabbro, Strategic Director of People Group
Kate Harker, Joint Commissioning Manager
Martyn Harris, Democratic Services Officer
Ann Mawdsley, Senior Democratic Services Officer
Tim Willis,
Rob Wilkes, Service Manager – Care Accommodation and Quality

Also Present: Ann Aylard, Coventry and Warwickshire Partnership Trust (CWPT)
Mike Caley, Public Health
Jed Francique, CWPT
Dr Charlotte Gath, Coventry and Rugby CCG
Mr and Mrs Peter Jackson
John Linnane, Public Health
Dr Helen Rostill, CWPT

Martyn Scott, West Midlands Ambulance Service (WMAS)
Bryan Stoten, Chair of the Warwickshire Health and Wellbeing Board (HWBB)
Mandy Whateley, CWPT
Press representative from Coventry Telegraph

1. General

(1) Apologies for absence

Apologies for absence were received on behalf of Councillor Carolyn Robbins (replaced by Councillor Carol Fox for this meeting), Nigel Barton (CWPT) and Jane Ives, South Warwickshire Foundation Trust.

(2) Members Declarations of Personal and Prejudicial Interests

Councillor Penny Bould declared a personal interest as:

- A disabled person in receipt of Direct Payments
- a Psychotherapist in private practice, making referrals to the CAMHS services.

Councillor Richard Dodd declared a personal interest as an employee of the West Midlands Ambulance Service and a prejudicial interest in Item 10 in relation to the Quality Accounts of the WMAS.

Councillor Michael Kinson declared a personal interest in relation to a relative working for the NHS.

Councillor Angela Warner declared a personal interest as a GP practicing in Warwickshire.

Councillor Claire Watson declared a personal interest as the Rugby Borough Council representative on the Coventry and Warwickshire CCG.

(3) Minutes of the meeting of the Adult Social Care and Health Overview and Scrutiny Committee held on 11 April 2012

The minutes of the meeting of the Adult Social Care and Health Overview and Scrutiny Committee held on 11 April 2012 were agreed as a true record and signed by the Chair.

Minutes if the special meeting of the Adult Social Care and Health Overview and Scrutiny Committee held on 24 May 2012

The minutes of the special meeting of the Adult Social Care and Health Overview and Scrutiny Committee held on 24 May 2012 were agreed as a true record and signed by the Chair.
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Matters Arising

None.

(4) Chair's Announcements

The Chair announced that he and Ann Mawdsley, in their roles as West Midlands Regional Representatives on the Health Accountability Forum, had attended a seminar earlier in the week updating Scrutiny members and officers on the Caring for our Future consultation and the delays on the White Paper and Social Care Bill. Ann Mawdsley would prepare a briefing from the day and circulate this to the Committee.

2. Public Question Time

1. Mr Peter Jackson, Rugby resident, put the following questions to the Committee:

"I would wish to refer you to the Department of Health Guidelines which deal with Learning Disabilities. These place a responsibility upon Family Carers to 'Hold Statutory Agencies to Account'. In order to fulfil this role it is necessary from time to time for Family Carers to seek additional information from your Council Officials. To achieve this within an effective time-span has often proved difficult and I cite the following by way of examples.

- *Some 3 years ago, we were instructed not to make direct contact with the Carer representative on the Learning Disability Partnership Board – thus making it difficult to keep in touch with the activities of that Board and making it necessary to submit more questions direct to your Council officials.*
- *Board Minutes can take up to six weeks to receive.*
- *When you instigated your 2011 consultation on your proposed Learning Disability Strategy we submitted a number of questions in order that we might make valid responses. We received partial answers after the expiry date for the consultation process and further partial answers something like a year later after we had raised the matter with the Local Government Ombudsman.*
- *In the course of the presentation made in October 2011 there was a commitment to provide answers to a number of questions which the presenter was unable to answer at the time – we still await answers.*

- *It was necessary to go to the Freedom of Information people to override a refusal to make available recordings made at one of your presentations.*

As Family Carers we believe that good communications, particularly during a period of change, are very important and I would on their behalf ask you as a Committee to examine the situation in order to establish what can be done to effect improvements. Surely, it should not be necessary to have to spend weeks, months and even years going through your own complaints people, the Freedom of Information people and the Local Government Ombudsman to get answers."

Wendy Fabbro responded that the Council did encourage and would want carers on the Learning Disability Partnership Board to have good communication with their representatives of the Board. The role of the carer representatives was to hear and disseminate the voices of other carers. She added that Mr Jackson had made reference to a number of issues included minutes and the recording of meetings, and undertook to take the questions away and to provide a written response to all the points raised by Mr Jackson.

Councillor Izzi Seccombe noted that she had had a meeting with Mr Jackson and a number of other carers to discuss these issues and that the Council had moved forward to ensure a wider carer group to get feedback and more representation for carers.

Councillor Claire Watson, a member of the Learning Disability Partnership Board, stated that there were two carer representatives on the Board, and from a Board perspective there was an assumption that these carers were representative of the caring communities. She added that the Board already had a large membership and that ultimately it was most important to have the voices of people with learning disabilities represented, and that the Board was working well.

The Chair thanked Mr Jackson for his question and asked Wendy Fabbro and Councillors Seccombe and Watson to ensure that a response was provided for Mr Jackson.

2. The Chair read out a question received from Mr Robert Grainger, in relation to the Dialysis Unit at Whitnash / Heathcote Hospital

"I attend the above unit as a patient on Tuesday, Thursday, and Saturday mornings, with 4hrs dialysis on each visit. The unit operates Monday to Saturday with sessions both morning and afternoon. When we turned up for our session on Thursday 14th June we were shocked to be told that the Tuesday, Thursday, and Saturday sessions were being cancelled due to

long term staff sickness, and most of the patients will be transferred to other units in Stratford or Rugby where twilight shifts will be organised, meaning you would not get home until at least 11-30 at night. The unit is a satellite of the main dialysis centre at University Hospital Coventry. There is such a good atmosphere at this unit, with a friendly and caring staff whom I know never seen this bombshell coming either. What I cannot understand is, that anywhere else when they have a staff shortage they get agency workers in or bank staff. If at the end of the day its all down to money then this feels like a significant change to what has been provided for before, and I would be grateful if you would look into obtaining some answers for us."

Councillor Jerry Roodhouse, Chair of Warwickshire LINk undertook to look into the question.

3. Children and Adolescent Mental Health Services (CAMHS) – Waiting Lists, Current Position and Action Plan

Jed Francique, Ann Aylard, Dr Helen Rostill and Mandy Whateley presented the report, which provided an update for the committee on the information provided to the April meeting. The headline information was:

i. There had been reduction of approximately 40% in the number of children on waiting lists in Warwickshire, with the vast majority of children and young people having received an assessment.
ii. There had been a strengthening of operational and procedural management arrangements, which had resulted in better management of the service.
iii. There had been a significant investment in additional clinical capacity.
iv. The service were looking to the future and projecting what would be needed in order to eradicate waiting lists, but this would require significant investment to achieve.
v. There was more effective partnership working in place, with improved engagement and greater transparency.
vi. There was a clear focus on the experience of children and young people and their families.
vii. CWPT were investing the resources to ensure the improvements were ongoing and sustainable with a clear service that worked for children and young people.
viii. Internal clinicians had been brought together to develop the Autistic Spectrum Disorder (ASD) pathway to move away from the previous fragmented service towards a more streamlined, high quality process. This work was ongoing and involved working with local strategic partners, including Warwickshire County Council.

During the ensuing discussion, the following points were raised:

1. Members expressed concern at the high number of Warwickshire children and young people entering the CAMHS service with high levels of complex needs. There was currently no evidence to support any reasoning for this.
2. There were different pressures in different parts of the county, but the data in the report referred to Warwickshire as a whole.
3. Members recognised the challenge the service had faced and welcomed the improvements that had been made.
4. In response to a query about benchmarking data, both regionally and nationally, it was stated that CWPT were engaged with benchmarking, but that the focus had been on reducing the high levels of waiting in Warwickshire. Once there was a clear picture of the service without any bottlenecks, comparative analysis would be done. The Chair noted that this would be picked up in ongoing work with CWPT.
5. There was a national challenge around increasing core competence of CAMHS workforce. CAMHS were in the process of recruiting, and due to the range of different interventions and combination medicines, it was important any new staff were able to evidence their competence and skills.
6. Although the national RTT pathway treatment target was 18 weeks, CAMHS were aiming for a target of 14 weeks, which was extremely challenging, with a focus on children and young people with the most complex needs.
7. Part of the work being done was to map out clinical capacity, which would enable greater flexibility and responsiveness by the service, which was an aspiration of patients and families. It was pointed out however, that this was a debate that was taking place across the whole health sector.
8. The historical delivery of service had to be unpicked to ensure waiting lists were reduced and that there was one equitable service for Warwickshire that reflected need.
9. In response to a query asking whether CAMHS accepted verbal referrals, it was confirmed that they did, but that these needed to be followed with written confirmation as soon as possible.
10. Work was being carried out to engage with young people. Councillor Jerry Roodhouse reported that Warwickshire LINk were producing a report about engaging with young people and invited CAMHS to work together on this.
11. CAMHS needed to investigate the best ways of delivering services, working with partners, including the third sector to develop clear roles to deliver different elements of mental health support and care. It was noted that many voluntary sector services focussed on Tier 2 needs, while the focus for CAMHS was the more severe Tier 3 needs. There needed to be better partnership working around the transitioning between tiers.
12. Members agreed that mental health needed to be integral to the health and wellbeing agenda.
13. Members emphasised the importance of accurate data definition that was up-to-date.

Kate Harker, Joint Commissioning Manager, responsible for the commissioning of CAMHS services made the following points:

a. There needed to be a degree of caution in accepting the improvements, as the Committee and Council had been in this position before, and any improvements made had to be sustainable.
b. In order for waiting lists to stay down, CAMHS needed to change their ways of working, and there was evidence this was happening.
c. She had seen a huge amount of action and effort from all CWPT staff to get this right, and this needed to be recognised.
d. The Committee needed to continue to monitor CAMHS to ensure data was robust and sustainable.
e. The Council was already commissioning a range of services from the third sector which complemented the services commissioned from CAMHS.
f. Baseline evidence was key to understanding how our services were working against other areas in the West Midlands and wider.
g. As previously requested, once CWPT was clear about need and capacity, they would need to produce a business case if additional resources were required.

The Committee agreed to receive a further update report at their meeting on 5 September, to include:

- An update on waiting times
- An update on staffing
- Progress in relation to benchmarking activities
- Improvement in equity of service delivery across the county
- Continued evidence of smarter working
- A clear indication from the Trust that they were clear on what was needed and their capacity to deliver against that need.

The Chair thanked CWPT for the work that had been done and for presenting the report to this meeting.

4. Coventry and Rugby Clinical Commissioning Group – Progress towards Authorisation

Dr Charlotte Gath, a GP with the Coventry and Rugby CCG presented the report, which also included comments that had been made by the HWBB. She made the following points:

1. Dr Gath noted that she had been incorrectly quoted (line 3 at the top of page 2 of 4 of the report) and that what she had said was that CCGs were not obliged to formally consult Health and Wellbeing Boards on configuration.
2. GPs in Coventry and Warwickshire had voted with a clear majority to combine, and the combined CCG had begun operation on 1 June 2012.
3. Authorisation was expected to take place in November/December 2012.

4. Steve Allen had been appointed as the Chief Executive of the CCG and Adrian Canale-Parola was the Interim Chair.

The following points were raised:

a. When asked how the Committee could be assured that the health and wellbeing of Rugby residents was kept integrated in Warwickshire, Dr Gath responded that there would be no loss of Warwickshire focus with a strong physical base retained in Rugby and the CCG seat on the Warwickshire HWBB. The CCG were also commissioned to deliver against the Warwickshire Joint Strategic Needs Assessment and had a strong link to Public Health in Warwickshire.
b. When questioned about the allocation of resources, Dr Gath responded that she expected resources to be better with these arrangements than if they had stood alone.
c. The CCG had a good strong working relationship with Wendy Fabbro and other Warwickshire partners.

Councillor Bob Stevens stated that Warwickshire's concerns had been made clear and that the situation would be monitored through the Health and Wellbeing Board, with a focus on outcomes for Warwickshire residents.

The Chair thanked Dr Charlotte Gath for speaking to the Committee.

5. Shadow Health and Wellbeing Board – Update

Bryan Stoten gave a verbal update to the Committee on the Health and Wellbeing Board, making the following points:

i. The Board was still in shadow form and would not be a statutory body until April 2013.
ii. The membership of the Board had been deliberately kept small and was made up of:
    - Four Warwickshire Cabinet members
    - Strategic Directors of the Peoples and Communities Groups
    - Director of Public Health
    - Representatives of the three CCGs
    - Three District/Borough representatives
    - Chair of Warwickshire LINk.
iii. Board meetings were public and contributions from outside the Board were welcomed.
iv. The Health and Wellbeing Board was a committee of the Local Authority, and from 2013 would be the only body responsible for the overall view of what health and social care would look like for the authority as a whole. The intention of the Secretary of State had been for the HWBB to fill the democratic deficit and to ensure a democratically accountable body was responsible for the strategic delivery of health and social care.

v. In line with Sir Michael Marmot's report on Health Inequalities, the HWBB have looked at ways local society in Warwickshire shapes health and wellbeing, including education, housing, social care, employment, opportunities and income, and ways these areas can be improved.
vi. Education and educational outcomes were crucial to health and wellbeing. 40% of Warwickshire children leave school without 5 good GCSEs, and evidence showed that this would have a detrimental impact on their health and wellbeing for the rest of their lives, regardless of further education or employment.
vii. Housing, police and probation, spatial planning and leisure all shaped life expectancy and infant mortality rates.
viii. Against the national average Warwickshire did well, but on similar comparators they did not.
ix. The Board were also concerned with environment and individual lifestyles and choices.
x. Two areas of particular focus for the Board were the integration of health and social care and how services would be brought together to shape health and wellbeing.
xi. The Health and Wellbeing Strategy was more primary focussed than hospital based. 35% of hospital users should not be in hospital and there needed to be an increase in community care to avoid this.
xii. The Board was not concerned about which hospitals should exist, but about what hospitals should do.
xiii. The Board needed to focus on:
    - A strategic vision and direction
    - The ageing population
    - Complex, troubled families
    - Changing sexual mores
    - Widening inequality
    - Earlier and later pregnancies
    - Ethnic pluralism.

Bryan Stoten noted that this thinking had underpinned the Health and Wellbeing Strategy.

6. Health and Wellbeing Strategy

Bryan Stoten and Mike Caley introduced the Health and Wellbeing Strategy (HWBS), which set out the broad direction of travel based on the JSNA and which would be used to judge the clinical groups plans. The following points were noted:

a. The HWBS was a new concept aimed at bringing together health, social care, public health and social determinants of health.
b. The Strategy had been agreed by the HWBB and was now out for public consultation, which would close on 3 September 2012.

A discussion followed and these points were raised:

1. Members acknowledged that the HWBS was a wider umbrella document and welcomed the aspirational messages, but there was general agreement that the document was too “mother and apple pie” and did not include any detail on how these ambitions would be achieved. Bryan Stoten responded that the Board would expect commissioning plans to set out how the actions would be achieved. Mike Caley added that commissioning plans were obliged to take note of the Strategy.
2. There was some discussion about whether parts of the Strategy were achievable in the current climate of deficit reduction. Bryan Stoten noted that in many cases such as cycling, the costs of not pushing these aspirations forward were much greater in the longer term, and that there were many areas that could be achieved through rearranging current work with a greater focus on health and wellbeing, and through working together.
3. Concern was raised that the Strategy relied heavily on goodwill and there needed to be stronger executive direction from the Board. There would also need to be an ongoing journey to get people to understand the Strategy.
4. There needed to be a greater emphasis in the Strategy on the life course in Warwickshire, looking at areas such as families, mental health and wellbeing and “happiness”, with further exploration behind the reasons for Warwickshire not performing as well as it should.
5. There was a risk of tension between the aspirations of the Strategy and the national priorities and indicators that health providers were required to report against. There needed to be greater synergy between the two so that the outcomes reflected back through achieved the aspirations.
6. There was a need to ensure that health and wellbeing was embedded within all decision-making processes, including District and Borough Councils.
7. Members agreed that education was key to improving health and wellbeing, and felt that there needed to be greater emphasis on this in the Strategy.
8. Members welcomed the emphasis on primary and community health services and expressed a hope that GPs would engage with the Strategy and look at issues such as out of hours services.
9. Bryan Stoten stated that the Strategy would be used as a measure against which commissioning plans of CCGs would be assessed to ensure they were going in the right direction. He added that the HWBB, ASC&H O&S and HealthWatch would all have an overview responsibility, and that O&S would also scrutinise CCGs and Foundation Trusts. He expected the HWBB to look at the policies of all commissioners, and expected to do this in concert with O&S and HealthWatch.
10. Members agreed that they were responsible for health and wellbeing and in order to carry out their roles properly they needed to have a clear idea of what had to be delivered and how that would be done.

Bryan Stoten summed up by saying that the next three months were key for the Strategy and the Board would start to pull together the final document towards the end of August, beginning of September. At that time there would need to be enough substance included to be clear about what the signpost said, without second guessing what the CCGs would do.

The Chair thanked Bryan Stoten and Mike Caley for their contributions. The Committee welcomed the Strategy as an aspirational document and reinforced their agreement that there needed that there needed to be more focus and a clear understanding of how the aspirations would be delivered. It was agreed that the Chair and Party Spokes would agree with the HWBB and LINk (HealthWatch) how to move forward.

Councillor Bob Stevens gave his apologies and had to leave to attend another meeting.

7. Questions to the Portfolio Holders

There was a further discussion about the management of the agenda and it was agreed that in future, unless otherwise notified, all ASC&H meetings would start at 9:30 am and that the agenda would alternative between Health and Adult Social Care at the start. At the meetings where Adult Social Care was first, health colleagues would be invited to join the meeting at 11:00 am.

Councillor Angela Warner (on behalf of Councillor Bob Stevens)

1. Members noted their concern about the possible impacts for Warwickshire residents of the proposed GP strike on Thursday 21 June 2012.

   John Linnane noted that the Arden Cluster was putting together a plan in terms of maintaining the health service. He agreed to provide a briefing note for the Committee on what had been done (retrospectively), the impact on residents and the impact on the WMAS.

2. Councillor Dave Shilton stated that there was talk of Worcestershire A&E Services being reduced and the possible impact on Warwickshire residents. The Chair noted that this will be looked into.

3. Councillor Penny Bould noted her concern at the BBC report that "The Royal College of Surgeons (RCS) has condemned NHS trusts in England for changing the criteria for operations, leading to some patients being taken off operation waiting lists". John Linnane reassured Members that the Arden Cluster had a range of policies based on evidence of benefit, seeking to maximise outcomes for patients and optimise time for treatment. He undertook to provide a briefing note for the Committee.

8. Partnership with Health - Update

Wendy Fabbro gave a verbal update to the Committee to reassure Members that although the Concordat with the PCT was no longer possible, discussions were taking place to continue that work with the relevant people. She added that it was difficult for Social Care to be clear about integration with health as the changes with the CCGs were still fresh. She stated however that the focus for her Directorate was in preparing functional descriptions of how services might be aligned.

There was work already underway between WCC, SWIFT and the South Warwickshire CCG aligning assessment and reablement services, ensuring quick access to the right services. There was also work being done on occupational therapy, working closely with hospital occupational therapists on functional discharge, which was likely to be mirrored with UHCW. All of this work would stand in good stead for the future direction of travel.

The Chair thanked Wendy for her update.

9. 2011/12 Performance Report for Adult Social Care

Members welcomed the report and commended the Adult Social Care staff for the improvements achieved, despite the cut in their budget.

Councillor Izzi Seccombe reminded that Committee that the service had seen massive change over the past two years with a significant loss of staff, and had still achieved significant improvements, and continued to do a very good job in challenging times.

During the ensuing discussion the following points were noted:

1. The decrease of the proportion of older people who are still at home after 91 days following discharge from hospital into reablement, was the result of a loosening of criteria resulting in a big increase in the number of people accessing the service.
2. The reasons for peak in demand for hospitals described in 2.4 (page 3 of 8) were unclear, but the Directorate had had to direct resources to help ease the pressure for hospitals.
3. The red triangles showing for supporting carers on page 7 of 8 of the report were due to a redefinition of the provision of day-care – to a service for users and not a service for carers.
4. Members congratulated the Directorate on the number of people using personal budgets.

The Chair thanked Wendy Fabbro and asked her to pass the thanks of the Committee on to her staff for the encouraging performance.

Councillor Richard Dodd left the room

10. Quality Accounts

The Committee agreed the responses to the Quality Accounts, with the only addition being the inclusion of the membership of the Task and Finish Groups for each.

Martyn Harris outlined the proposals for dealing with Quality Accounts going forward, which would involve a new and better working relationship with between the Trusts and the Council.

Members agreed that there should be five working groups set up with representatives from the County Council, District/Borough Councils and LINks. The role of the working groups would be to look back at previous Quality Accounts and to engage in developing the priorities for the Trusts. Agreement had been reached with the Chair and Party Spokes as well as with the Trusts, and discussions would now be held with the District/Borough Councils and LINk. This process would be managed by Martyn Harris, who would be contacting Members in the near future.

11. Work Programme

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

12. Any Urgent Items

None.

13. Reports Containing Confidential or Exempt Information

The Committee resolved that:

“Members of the public be excluded from the meeting for the items mentioned below on the grounds that their presence would involve the disclosure of exempt information as defined in paragraph 3 of Schedule 12A of Part 1 of the Local Government Act 1972”.

14. Care and Choice Accommodation Programme – the future of Warwickshire County Council’s Residential Care Home Provision for Older People and Extra Care Housing in Warwickshire – Progress Report

Councillor Izzi Seccombe, Rob Wilkes and Tim Willis presented the report updating Members on the above programmes.

The recommendations set out in the report were agreed.

Members were reminded that the information contained in the report was exempt and should not be disclosed without express agreement from Wendy Fabbro or Rob Wilkes.

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Chair of Committee

The Committee rose at 1.15 p.m.

Item 4

Item No. 4

Adult Social Care and Health Overview and Scrutiny Committee

5th September 2012

Commissioners report upon Child and Adolescent Mental Health Service (CAMHS) Improvements

Recommendations

It is recommended that the committee:

1. Considers and comments on the effort and resource that Coventry and Warwickshire Partnership Trust (CWPT) have applied to driving down CAMHS waiting times and to transforming services to better manage future demand.

2. Agree to CWPT attending the Overview and Scrutiny Committee meeting at the end of December 2012 (Quarter 3) and again at the end of March 2013 (Quarter 4) to report upon their progress in remodelling services and the resulting performance in bringing waiting times down to within the contractually agreed maximum waiting times.

3. Support the recommendation that commissioners explore soft market testing, the possibility of a franchise arrangement and interest in a tendering process should CWPT fail to meet their contractual waiting times targets and report back to the December Committee.

1.0 Key Issues

1.1 Warwickshire's Specialist Child and Adolescent Mental Health Services (CAMHS) are commissioned by NHS Warwickshire (NHSW) as part of a £63 million, cradle to grave block contract from CWPT. The CAMHS element of the block contract equates to approximately £3.7 million. The service is commissioned through joint commissioning arrangements between NHSW and Warwickshire County Council located within the People Group.

1.2 Waiting times for CAMHS have been a matter of concern for a number of years. These concerns have been raised at Warwickshire County Council's Adult Social Care and Health Overview and Scrutiny Committee (ASC&HOSC) a number of times. During 2010/11 NHS Warwickshire applied a Commissioning for Quality and Innovation (CQUIN) incentive to reduce the referral to treatment waiting time to a maximum of 14 weeks. At the end of this period CWPT achieved 50% of their waiting times being under the 14 weeks. However this was not sustained into the following year.

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

1.4 In February 2012 the Committee also agreed to the recommendation that the CAMHS Commissioning Manager report back in September 2012 with the results of a CAMHS benchmarking exercise and the exploration of the viability of tendering CAMHS services.

1.5 In April 2012 CWPT reported to ASC & HOSC that there were no children or young people awaiting initial assessment from CAMHS, although there were 473 children awaiting treatment, 134 of these were reported to have neuro-developmental conditions.

1.6 At the June 2012 ASC & HOSC CWPT reported that they had calculated that waiting times could be eradicated completely by the end of October 2012 should they be able to recruit 15 whole time equivalent (wte) staff. However of the 15 wte 6.6 wte were recruited with investment of £130,000 creating a range of additional clinical capacity to include psychological therapists, psychiatrists & nursing to undertake a waiting list initiative Members were informed that this increased capacity resulted in a 40 % reduction in the total number of children and young people waiting to be seen, with numbers falling from 473 to 282 by the end of June 2012.

1.7 In addition CWPT reported that they had held a Stakeholder Workshop, 26th March 2012 and Project Initiation Workshop, 16th April 2012 to scope and implement a formal service transformation project to drive service redesign and improvements. CWPT estimated that it will take approximately 6 to 9 months to complete these work streams.

1.8 The Arden Cluster contract with CWPT for 2012/13 set the waiting times target on a downward quarterly trajectory Table 1.

Table 1

By 30.06.2012 (Q1)	Q1 targets are currently being reviewed and agreed
By 30.09.12 (Q2):	<9 weeks for referral to assessment <9 weeks for referral to treatment
By 31.12.12 (Q3)	<8 weeks for referral to assessment <8 weeks for referral to treatment
By 31.03.13 (Q4)	<7 weeks for referral to assessment <7 weeks for referral to treatment

2.0 Proposal

2.1 Although the focus of this report is the waiting times the overall aim of holding CWPT to account with regards to meeting their performance targets is to ensure that we have a CAMHs service that is able to offer timely, needs led, geographically equitable, evidence based interventions to young people with mental health problems and through this process enhance their mental health and reduce levels of distress. CWPT are expected to work in partnership with other agencies to provide a high quality service that:

- Engages effectively with stakeholders
- Collects and reports accurate and robust performance/outcome data
- Has clear and well communication referral criteria and pathways through services
- Works effectively with partners in meeting the needs of their client group.

2.2 In previous reports CWPT have indicated, through calculating intervention times, capacity and demand, that waiting times can be within target limits by the end of October 2012 and that the first phase of service transformation will be complete by the end of February 2013 (within 9 months of the June ASC & HOSC).

2.3 CWPT have invested considerable resources and waiting times continue to fall. The Commissioners recognise that the transformation project is still in its early stages and would like CWPT to report back to ASC &HOSC at the end of December 2012 and March 2013, when details of the future sustainability of the redesigned model for the CAMHS service can be fully considered.

2.4 To better meet current and future demand CWPT have initiated a Project Management approach to tackling the key issues they see as impacting on the effective working of the CAMHS service. On 26th March stakeholders and commissioners were invited to a CWPT CAMHS event where concerns were examined and subsequently the key areas for improvement and project work streams were identified to drive forward the necessary changes.

2.5 It is these significant changes and associated performance improvements that the Committee need to assure themselves are fully implemented, producing the necessary effectiveness of the service to meet the needs of the children and young people of Warwickshire and to meet the contractual obligations with the Arden Cluster.

2.6 The four specific work streams that have been devised by CWPT to transform CAHMS services:

- Capacity and Demand Work
- Data Quality and Validation
- Development of Integrated Care Pathways

- Stakeholder Engagement and Communications

2.7 Commissioners consider that there is an element of risk regarding two of these work streams that should be noted in case these manifest themselves as problems at a later date;

- Data accuracy - Commissioners understand that the Epex data management system used by CAMHS is capable of supporting the measurement and reporting of the full range of CAMHS activity and performance. However it appears that Epex has not been used to its full functionality in the past and in addition there is a large amount of work to do to embed processes and ensure staff are competent and committed to the necessary data capture. Demonstrating the success of the Trusts work in minimising waiting times depends on robust data capture and reporting, commissioners need to be assured that processes are in place to guarantee future data is accurate and reliable.

- Pathways – Autistic Spectrum Disorder (ASD) – CWPT have identified a number of internal pathways to ensure that young people receive precisely the right treatment once they have been assessed. One of these pathways is the ASD pathway where a multi agency diagnosis is required across health services. CWPT are exploring an alternative pathway to include additional paediatric capacity.

2.8 If CWPT fail to meet their waiting times target, testing the market and tendering the service is one way of pursuing change and is an exercise that has become more common for CAMHS services nationally over the last three years. The CAMHS commissioner has been in contact with other PCT's and local authorities who have taken this approach to investigate the potential benefits and outcomes achieved and to inform our processes should this be the preferred commissioning option.

2.9 Of particular note is that Hampshire, Gloucestershire, Buckinghamshire and Swindon have all tendered out their CAMHS services in the last three years. Their reasons for this course of action vary but the majority report a positive experience and good outcomes to date. One of the Health Trusts actively pursuing additional contracts and the winning bidder for the Buckinghamshire and Swindon processes is the Oxford and Buckinghamshire Mental Health Trust who could potentially be a serious contender should our CAMHs services be tendered out due to their favourable geographic location.

2.10 Another option might be that of franchising, with the control of CAMHS being passed over to another party who would take over the management of the service. There are allowances for this option under the Health and Social Care Act; however how this might work is not as yet completely clear. The CAMHS Commissioning Manager will explore this option further in preparation for the December 2012 meeting.

2.11 The proposed benchmarking exercise to compare Warwickshire Specialist CAMHS service's activity with statistical neighbours has not been possible due to the fact that there are a wide range of service models in operation with different CAMHS teams across the country offering different elements of specialist mental health services. Some CAMHS services include prevention or early intervention work, where others do not and this data is included in their overall activity statistics. In addition activity is measured in different ways across these services. This makes direct comparisons of activity to inform any understanding of levels of productivity difficult. One measure that has been utilised by the NHS Benchmarking exercise is that of 'contacts' which is a uniform measurement collected by all CAMHS teams, although this measure too will be affected by the service model adopted locally. The NHS Benchmarking report shows that partnerships included in their data collection reported:

- An average of 3,021 contacts by their CAMHS services per 100,000 PCT weighted population.
- Warwickshire's CAMHS service, for 2011/2012 averaged 2,867 contacts per 100,000 PCT weighted population.

A comparison of investment into Specialist CAMHS has been possible and shows broadly that the investment locally is similar to that of our statistical neighbours (Appendix A). Comparison of both activity through contacts and investment has to be treated with caution due to the variety of service models that exist across the country, but the data does show that Warwickshire's CAMHS services are not an outlier with regards to having comparably similar investment and activity with other CAMHS.

3.0 Timescales associated with the decision/Next steps

3.1 CWPT to be invited back to ASC&HOSC at the end of December 2012, Q3 and again at the end of the March 2013, Q4 to report on the waiting times and the progress of the transformation and sustainability project.

3.2 The CAMHS Commissioning Manager to report back to the December Meeting with the results of exploration into the possibility of franchise arrangements and of soft market testing.

Background Papers

1. ASC &H OSC – 19th June 2012, CAMHS current Position and Action Plan and minutes
2. ASC &H OSC - 11th April 2012, Child and Adolescent Mental Health Services (CAMHS) Waiting Times – current position & action plan and minutes
3. ASC &H OSC - 15th February 2012, Child and Adolescent Mental Health Services Waiting Times and minutes
4. ASC &H OSC - 13th April 2011, Scrutiny of CAMHS - Progress Report
5. Minutes of the Meeting of the Adult Social Care and Health Overview and Scrutiny Committee held on 13 April 2011 at Shire Hall, Warwick

6. Scrutiny Review Implementation Plan – CAMHS Waiting Times (Joint document produced by Loraine Roberts, General Manager, CAMHS, CWPT and Kate Harker, Joint Commissioning Manager – CAMHS.
7. Report to ASC&H OSC dated 16 September 2010 and to Cabinet dated 16 December 2010 and the associated minutes
8. Report of the Joint Scrutiny Panel of the Children, Young People and Families and the Health Overview and Scrutiny Committees, June 2010

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Appendix A

20012 data

Statistical Neighbours	PCT spend (1)	No of 0-18 year olds	Approx spend per population	Last update
East Riding of Yorkshire	£1,596,119	66822	23.89	Nov 11
Leicestershire/Leicester	£5.85 m	218,264	26.80	July 12
Northamptonshire	£5.4 m	170,000	31.7	July 12
Staffordshire	£7,527,559	179721	41.88	Nov 11
Worcestershire	£4.12m	119,557	34.46	June 12
Essex	£14m	293747	47.66	July 12
Cheshire West and Chester	£2.3m	71,800	32.03	Dec 2011
Warwickshire	£3.7m	110798 (0-17 only)	33.39	July 12
Average			33.97	

Item 5

Item No 5

Coventry and Warwickshire NHS Partnership Trust

Adult Social Care and Health Overview and Scrutiny Committee, 5th September 2012

Child & Adolescent Mental Health Services (CAMHS) Waiting times - September 2012 Update

1. INTRODUCTION

1.1 This paper provides an update on the following:

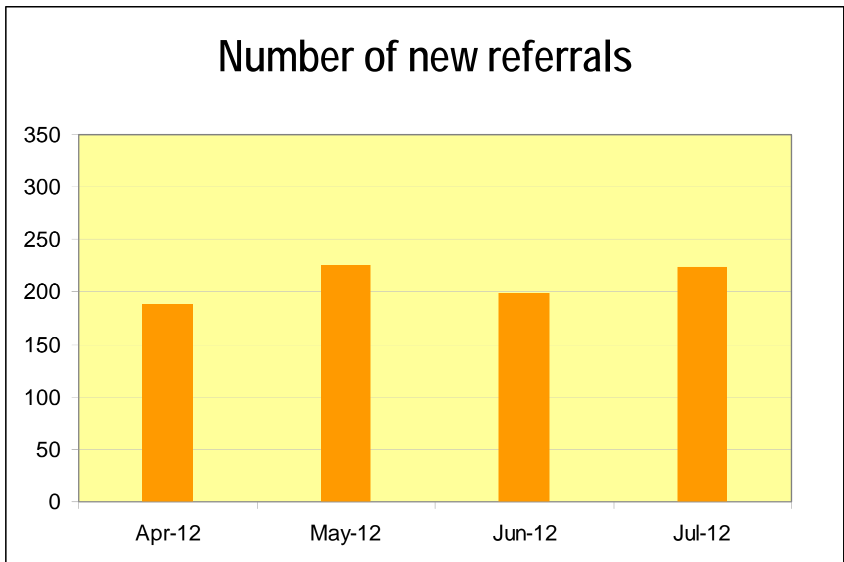
a) The current picture of waiting lists and waiting times;
b) Service outcomes and service user satisfaction;
c) An update on service improvement action.

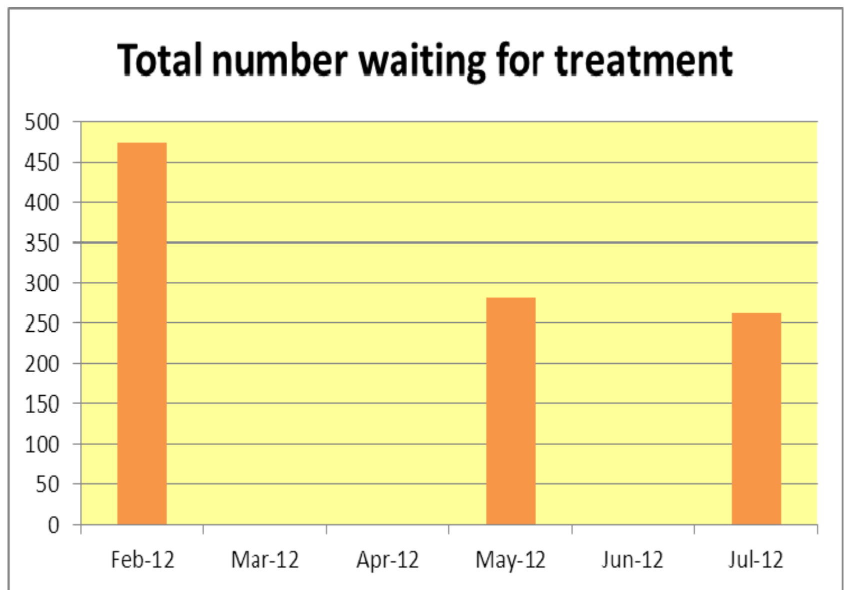
2. CURRENT WAITING LISTS / TIMES

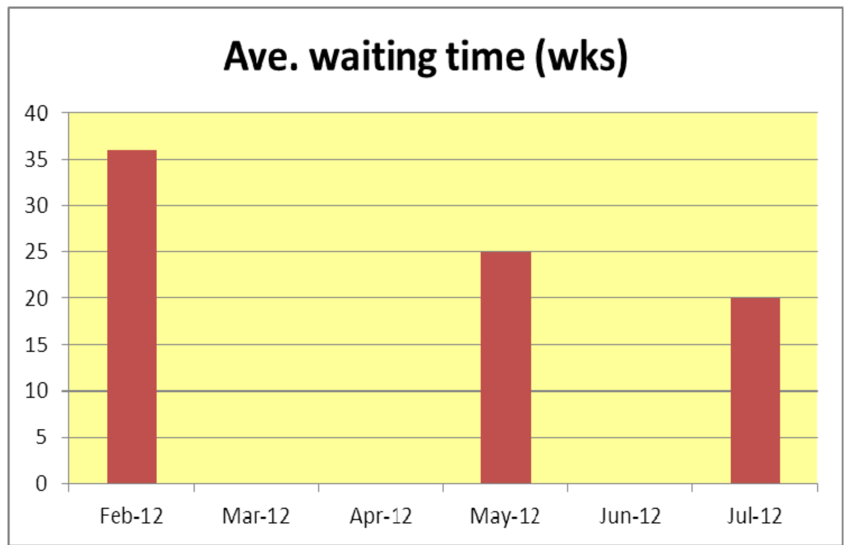
2.1 The following section sets out information about Warwickshire waits as of 31st July 2012.

Warwickshire	At 29.02.12	At 31.05.12	At 31.07.12
Number of Children & young people waiting	473	282	263
Average waiting to access treatment	36 weeks*	25 weeks	20 weeks

*(*Based on data available for children & young people who had been allocated to care pathways).*


Number of new referrals
350
300
250
200
150
100
50
0
Apr-12
May-12
Jun-12
Jul-12


Total number waiting for treatment
500
450
400
350
300
250
200
150
100
50
0
Feb-12
Mar-12
Apr-12
May-12
Jun-12
Jul-12


Ave. waiting time (wks)
40
35
30
25
20
15
10
5
0
Feb-12
Mar-12
Apr-12
May-12
Jun-12
Jul-12

2.2 The key points of the current picture are:

a) From the end of February to the end of July 2012 there has been a 44% reduction in the total number of children & young people waiting for treatment, from 473 to 263.

b) From the end of February to the end of July 2012 there has been 44% reduction in the overall average waiting time for treatment, from 36 weeks to 20 weeks.

Please see appendix for a more detailed breakdown.

2.3 As previously highlighted, Commissioners have included referral to assessment and assessment to treatment waiting time targets for CAMHS within the current contract.

For Quarter 1 (1st April to 30th June 2012), performance against contractual targets were as follows:

- **Referral to assessment:** 132 waiters, 89% seen within 9 weeks;
- **Assessment to treatment:** 249 waiters, 54% seen within 9 weeks.

The non-achievement of the targets for forthcoming quarters – 95% within 18 weeks, 16 weeks and 14 weeks respectively - will attract financial penalties.

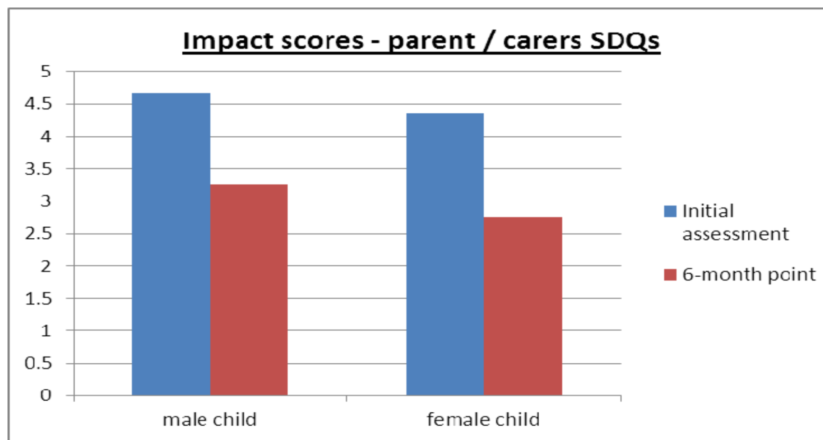
It should be noted that an 18 weeks referral to treatment timeline, is the national norm in relation to health services. So, the contractual targets are more demanding in Quarter 3 and Quarter 4 than the national norm.

3. SERVICE OUTCOMES

3.1 Strength and Difficulty Questionnaires (SDQs) are currently provided to children / young people and their parents / carers respectively at 2 points of the patient journey - initial assessments and follow-up appointments approximately 6 months into treatment. The feedback from these questionnaires provides key outcome data.

3.2 During the 1st Quarter (April – June 2012), 168 SDQs were completed by parents / carers and 78 were completed by children and young people (over 11s, as per guidance).

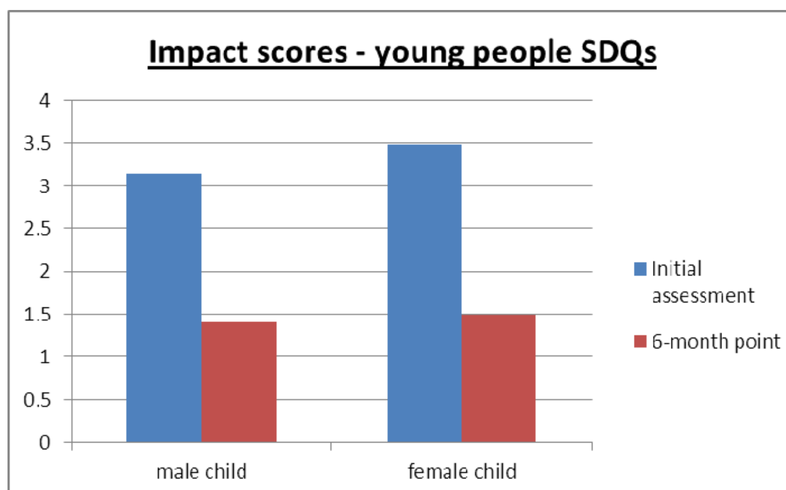
3.3 **Parent / carer SDQ reports:** The SDQ impact score measures the degree of reported impairment, distress and burden caused by difficulties. The CAMHS Outcome Research Consortium (CORC) data gathered for 62015 children/young people attending CAMHS services in the UK showed the average impact score from parent SDQ's as 3.8 (scores higher than 2 are 'abnormal'). The average figures for Warwickshire are higher, indicating that children / young people are seen as being more severely affected by their difficulties.



The above graph highlights that parent / carer SDQ impact scores for male and female children have decreased, suggesting a reduction in the degree of impairment, distress and burden caused by problems reported at initial appointment after a period of intervention or treatment.

SDQ impact scores of 2 and below indicate 'typical' or 'average' difficulty for males and females. Therefore, the above data highlights that according to parental reports for female children, following a period of intervention or treatment, they have moved from the 'abnormal' clinical range to 'typical' or 'average' range.

3.4 **Young person SDQ reports:** The young people's SDQ impact scores suggest that they were less affected by emotional and behavioural difficulties than their parents thought; however, it is not unusual for young people to under-report difficulties in comparison to parent ratings. The average impact rating for young people within the CORC sample was 3. Young males and females in the Warwickshire sample rate themselves slightly higher than this level.



The above graph highlights a reduction in young males and females reports of their degree of distress, impairment or burden caused by problems reported at initial appointment following a period of intervention or treatment. It is promising to see that both young males and females perceptions of their difficulties have reduced from 'abnormal' to 'typical' ranges.

4. UPDATE ON KEY ACTIONS

4.1 Additional capacity

Additional capacity continues to be provided on an interim basis to address the waiting lists. Some existing part-time CAMHS staff continue to do additional sessions. Locum / temporary staff are also being used. In total this constitutes an additional 7 whole time equivalent staff.

4.2 Clinical pathway development – Autistic Spectrum Disorder

Partners from health, social care and education in Warwickshire have continued to meet to discuss the development of a shared service delivery model and a supporting business case.

A task and finish group met on 19th July to begin drafting the business case to support the proposed ASD service delivery model, drafted by Integrated Children's Services. The meeting was attended by a range of parties, including SWFT (Paediatricians, SALT), Warwickshire Educational Psychology, Warwickshire Integrated Disability Services, CWPT (CAMHS and Paediatricians), Coventry CAMHS Commissioner, Warwickshire CAMHS Commissioner (Chair).

Although the fundamental principles of the draft model were largely accepted, it was agreed that a further meeting involving a sub-group from the above attendees would be required to agree, cost, and risk assess a series of workforce options. A meeting subsequently took place on 2nd August and a follow-up meeting is planned for the 6th September to evaluate the workforce options and complete the business case.

4.3 Waiting list management & booking centre arrangements:

Processes are being put in place to enable CAMHS to better manage the patient journey. The objective is to introduce a streamlined, sustainable and efficient process which provides a simpler path to treatment, makes best use of clinicians' time, and is easier for families to understand.

Work includes the following:

- The proposed launch of an '0300' number, linked to a centralised booking service, as part of a single point of access (SPA).
- Electronic scheduling of all clinics to enable more efficient and effective management of clinical capacity;
- Strengthening of the clinical triaging process;
- Strengthening of the initial assessment process to help to ensure that the most effective interventions / treatment are identified at the earliest possible opportunity;

4.4 **Data quality & validation work:**

Work is continuing within CAMHS to improve data quality. Caseload and activity data is being reviewed with clinicians on a regular basis and checked against the data captured by our information systems. The information systems are also being reviewed as part of the CAMHS improvement project.

5. SUMMARY

5.1 There have been further reductions in waiting lists and waiting times, linked to the additional capacity which continues to be made available and process improvements. Outcomes data indicates that CAMHS treatment / interventions are reducing the difficulties faced by children / young people from 'abnormal' levels to 'typical' or 'average' levels. Positive steps have been taken to progress the development of an ASD care pathway which is more integrated and patient-focused.

6. LIST OF BACKGROUND PAPERS OTHER THAN PUBLISHED DOCUMENTS

None.

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APPENDIX 1: Warwickshire CAMHS Waiting List / Times

CAMHS WARWICKSHIRE WAITING LIST/TIMES End July 2012					
Pathway	North Warwickshire	Rugby	Leamington, Warwick & Kenilworth*	Stratford	Total Waiters per Pathway
Initial assessments	4	4	3	3	14
Treatment waits					
Complex behaviours	30 Ave: 24 wks Range: 7- 42 wks	5 Ave: 22 wks Range: 5 - 35 wks	3 Ave: 10 wks Range: 8 - 14 wks	1 11 wks	39
Emotional distress & wellbeing conditions	51 Ave: 20 wks Range: 1 - 42 wks	25 Ave: 19 wks Range: 5 - 26 wks	5 Ave: 15 wks Range: 10 - 20 wks	16 Ave: 17 wks Range: 9 - 30 wks	97
Neuro-developmental conditions (incl ASD)	39 Ave: 25 wks Range: 1 - 44 wks	19 Ave: 24 wks Range: 5 - 44 wks	26 Ave : 15 wks Range: 7 - 23 wks	28 Ave: 17.6 wks Range: 2 - 30 wks	112
Psychiatric	1 23 wks	0	0	0	1
Treatment waiting times total	121 Ave: 23 wks Range: 1 - 44 wks	49 Ave: 21 wks Range: 5 - 44 wks	34 Ave: 14 wks Range: 7 - 23 wks	45 A Ave: 17 wks Range: 2 - 30 wks	249
Total waiters: 263 Overall average wait: 20 weeks					

** Includes surrounding villages and Southam*

Item 7

Item No 7

Adult Social Care & Health Overview & Scrutiny Committee

Public Health Transition – Shadow Year Developments.

1. Introduction

1.1 This paper aims to provide an overview of how the new public health system will look and function post April 2013 and the work being done locally to ensure transformational change while still delivering the full range of public health responsibilities effectively and efficiently

2. National Summary

2.1 The proposals for the footprint and management arrangements for the National Commissioning Board and PHE are emerging. Regional Directors of PH across the West Midlands have responded to the PHE consultation document. The local response advocated a Solihull/Coventry/Warwickshire office and the need for much stronger liaison with local public health services with named link staff in identified roles. However, the final decisions are that the Public Health England office will be in Birmingham and cover the old West Midlands Regional footprint. For the NCB local office, this will cover Herefordshire, Worcestershire, Warwickshire and Coventry, and be most probably based in Worcester.

2.2 The Secretary of State for Health has made clear his expectation that Public Health England will provide strategic leadership and vision for the protection and improvement of the nation's health and goes on to outline that *'through the application of research, knowledge and skills we will lead nationally and enable locally a transformation in the health expectations and, in time, outcomes of all people in England regardless of where they live and the circumstance of their birth'*

2.3 The PHE leadership team will include Directors for Health Protection, Health Improvement and Population Health, Finance and Corporate Services and a Director of Human Resources a Chief Knowledge Officer. The delivery focus will be supported by a Director of Strategy and a Director of Programmes.

2.4 Public Health England will have operational independence as an executive agency where the Chief Executive will be accountable to the Secretary of State for Health. It will have a publicly appointed non-executive chair and a board with a majority of non-executive members.

2.5 The National Commissioning Board will have four regional offices for England and 8 local area offices in the Midlands and East that will:

- Carry out direct commissioning of NHS services including primary care and specialised services
- Assure CCG commissioning
- Develop key partnerships as members of the H&WBB
- Promote strategic developments of NHS services through clinical senates and clinical networks.

3. Local Context

3.1 The priority key transition issues currently in sight include:

- Sub regionally joint opportunities
- The management of change agenda and Directorate restructure in order to ensure fitness for purpose within our LA environment
- Financial transition and transfer of funds and associated contracts
- CSS developments following the extension of the population footprint and the PH core offer developments to CCGs
- Developments with DCs/BCs over the Memorandum of Understanding

4. Sub regional Joint Development Opportunities

4.1 Historically, Public Health departments have worked in a collaborative fashion. Locally, this is most evident in areas such as Dental Public Health with staff working across Warwickshire and Coventry but also in Health Protection and Communicable Disease Management with one Health Protection Agency (HPA) unit currently encompassing all three departments.

4.2 Over the past 18 months as part of the NHS Arden Cluster, Warwickshire and Coventry Public Health Departments have initiated a number of collaborative work streams. The rationale and benefits include:

a) It is an opportune time to consider joint developments given the transformation challenge around Public Health that the government has set us.
b) Within a ring fenced budget Public Health is keen to drive efficiencies and maximum efficacy.
c) Local authorities need the required range of expertise and resource to enable them to deliver their (new) public health functions and responsibilities

3.2 More recently the 3 DPHs have begun to include Solihull in discussions within this overall framework of collaboration. We are still awaiting regulation, guidance and final detail on many aspects of the Health and Social Care Bill. This will affect management responsibilities for local authorities across Public Health as well as staff transfers and employment issues for individual departments.

3.3 The main areas of Collaboration Public health are exploring include:

a) Health Protection.
We have established a Health Protection Team across Coventry & Warwickshire (and possibly Solihull) to provide a more pro-active specialist resource across this function. There may be potential savings as part of this work.

b) Emergency Planning and Resilience
Building on existing sub-regional arrangements there may be opportunities to streamline and standardise our response to this need. We await regulation and further guidance in order to progress.

c) Sexual Health Commissioning

A degree of collaboration already exists as with the Sexual Assault referral Centre (S.A.R.C.) work. This could result in contractual efficiencies. We are currently examining clinical pathways.

d) **Core Offer/Public Health Intelligence**
Under the provisions of the Act, Local Authorities have been "mandated" to provide a range of support services to Clinical Commissioning Groups. We have developed a draft standard response from both Public Health Departments. We are currently working to outline benefits such as consistency of approach, reduction in overheads such as negotiation and contracting, maximizing use of scarce resources etc.

e) **Healthy Workplace and "Every Contact Counts"**
At an early stage of development, we are keen to exploit opportunities around healthy workplaces and maximising the health of the workforce, which the LEP provides.

f) **Health and Wellbeing Board**
An outside consultancy is working with Health and Wellbeing Board members across Coventry and Warwickshire to look at opportunities for collaboration across the two boards as well as identifying how, by working together, they may influence the strategic direction for health and healthcare. An initial report is due at the end of June.

3.4 In conclusion

- A number of work streams are in train but at different stages of development
- Some efficiencies and cost saving is possible
- Main benefit is maximizing use of scarce resources and enabling authorities to address Public Health responsibilities.

4. Management of Change Process

4.1 The consultation process and proposals for the revised PH management arrangements commenced on 11 June, with feedback on proposals closing on 11 July and Phase 1 completing on 23 July. Feedback is being encouraged from staff and stakeholders on the Public Health framework document, the functionality and future operating model. (Phase 1 attached)

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4.2 Phase 1 outlines the functional and operational arrangements in line with our future within WCC . Phase 2 begins on 23 July when the revised PH structures will be launched. The structures will be finalised for implementation on 1 September 2012. The timetable is aligned to consultation across and within the Arden cluster. Consultation on a Coventry PH revised operating model will be launched in August.

4.3 The DPH is the principal health advisor for all councils and all elected members not only WCC and this is particularly highlighted by the Act where the principal health advisor role is described. This responsibility widens the role of DPH and needs to be discussed and considered as part of the next steps in the transition process.

4.4 WCC HR team will commence building the staffing requirements in the HMRS system in September. Discussions are also underway to consider CSS hosting the Public Health payroll function. Six months will be required to build the WCC structure if staff are to be included on the HRMS system from 1st April 2013.

5. Finance

5.1 Joint Finance Development Group feedback

5.2 The management of the process for the smooth transfer of PH funds into WCC continue. Following the production of the Cluster 2011/12 final accounts finance will submit a return to the DOH on 23 July on the proposed baseline allocation to CCGs. This return also includes PH elements as outlined in the final accounts for the same year.

5.3 On 19th June a joint meeting between Arden PCT and WCC senior finance and Public Health colleagues reviewed the progress to date on the transfer of funding preparations and agreed some priority actions and key decision-points.

5.4 Headlines from this discussion are:

- Public Health will identify potential budget pressures for Public Health in future years by September 2012 in line with WCC budget timetable.
- That the Department of Health, have advised Public Health and thereby Local Authorities not to expect the health premiums to be available until year commencing 2015/16
- Emergent plans with Public Health England and the National Commissioning Board (NCB) are not fully developed and some scenario planning will be required.
- That accountability for delivery to individual roles will be equally important to the location of funds – e.g. where budgets are not necessarily held in the same organisation as those who make commissioning or spending decisions. These decision and funding pathways need to be made explicit. (DAAT/Sexual Health/health checks)
- PCT Finance colleagues will submit a Department of Health Finance return by 18th July to the Strategic Health Authority (finalise 23 July). This return is primarily to determine a baseline allocation to CCGs, CSS's, PHE, NCB. Public Health allocations are included in the return. The Public Health information will be based on 2011/12 final accounts figures. This may change the proposed public health transfer value (£20.07m) originally submitted in September 2011 which was based on 2010/11 final accounts. The 2012/13 overall budget position will be reflected in the quarterly reports to WCC's Cabinet.
- Payroll Issues – payroll will need to begin building the database for transferred staff which can be confirmed by 1 September. Close liaison with WCC HR colleagues is underway and further discussions will be required on this before 1 September 2012
- Spending against the Public Health indicative allocation will be included in the

5.5 PCT health investment funds in Public Health have been confirmed for 2012/13, and are shown in Table 1 below:

Table 1: PCT additional investment in Public Health programmes – 2012/13

Investment Area	Funding 2012/13	2011/12 position
Smoking cessation Smoking in pregnancy	£105,000	Uplift from £40,000
Reinstating growth programme including (MECC)	£150,000	Unfunded in 2011/12, recurrent
Improving/tracking data and patient impact	£20,000	New
Contingency for over performance	£25,000	New
Tobacco Control	£75,000	£25,000 recurrent
DAAT allocation for 2013	£2,970,000	Recurrent
Sexual Assault Referral Centre	£50,000	New & recurrent
Affordable Warmth	£60,000	Re-ablement fund agreed with Wendy F One off
Health checks	£320,500	Uplift from £117,500
Weight Management	£445,000	Uplift from £390,000
Health visitors/ Family Nurse Partnership	£495,000k	
Total	**£4,715,500**	
Investment uplift		**£623,000**

Source: Public Health and PCT Finance

5.6 The 2012 DPH Public Health Annual report will summarise expenditure by District and Borough Councils on a weighted population basis. The investments will also be illustrated by CCG using the same formula. This approach is consistent with the baseline allocations made by the Cluster to the CCGs and will be useful in publicising our investments relative to health inequalities.

5.7 Public Health Joint Investment with Districts and Borough Councils

5.8 Public Health is keen to support joint health initiatives with the District and Borough Councils. All have agreed to identify match funded initiatives during 2012/13. Table 2 below shows the investment and improvement priorities agreed to date. Mechanisms for evaluation and a review of the success of each initiative will be integral to the partnership discussions throughout the year. A Memorandum of Understanding will be put in place to reflect the joint agreements. The existing local partnership groups will oversee the delivery of these investments. We hope that this approach will encourage increased joint health developments with the Boroughs and Districts in the future. South Warwickshire CCG has also recently confirmed that they will match fund agreed priorities from 2013/14, to support this approach for both Stratford and Warwick Districts. See table 2 summaries below.

Table 2.Joint Investment with District and Borough Councils -Health Improvement

District/ Borough	Improvement Initiative	Timescale	Funding from Council	Funding from Public Health	Funding from CCG	Total Funding
Nuneaton and Bedworth	Weight busters – 5 Weight management & exercise classes – most deprived wards	2012/13 then make sustainable	£5,000	£5,000	£5,000	£15,000
N Warks		TBC	TBC	Up to £10,000		
Rugby		2012/13	Up to £5,000	Up to £10,000		Cabinet Decision 27 August
Warwick	HiWEB Grant	2012/13	£10,000	£10,000		£20,000
Stratford	Healthy Stratford Grant	11/12 c/f 2012/13	£10,000 £5,000	£10,000		£25,000

Source: Public Health and PCT Finance

5.9 In the South of the County, Stratford District Council and Public Health have created the Healthy Stratford Grant. Both organisations have agreed that the grant will be used to fund community and voluntary sector organisations, town/parish councils or schools to carry out projects that will:

- Increase the mental health and wellbeing of the local population, particularly in relation to older people and dementia. OR
- Awareness raising around cancer and the risky lifestyle behaviors that contributes towards it. OR
- Promote affordable warmth and support local people to access information and advice to reduce fuel poverty. OR
- Activities that support people to live independently in their own homes.

5.10 Warwick District Council and Public Health have jointly contributed £10,000 each to create the HIWEB (Health Improvement and Wellbeing) Grant during 2012/13. The HIWEB Grant will be used to fund community and voluntary sector organisations and town/parish councils to carry out projects that will:

- Increase physical activity and improve healthy eating with children and their families. OR
- Promote falls reduction with older residents in the district. OR
- Promote activities that highlight the consequences and reduce risky lifestyle behaviors particularly related to alcohol/drug use and sex

5.11 Although public health projects are not yet defined in North Warwickshire and Rugby, both Councils have agreed to match funding. In Rugby, the arrangements have been reconfigured to become a Health Partnership which includes representatives of the CCG.

6. CSS Developments

6.1 The links between WCC, CSS and PH become increasingly important as we finalise our structures and establish arrangements for aligned and joint funded posts.

6.1 PH will make its core offer to CCGs through the CSS. Worcestershire CCGs of which there are three: Redditch and Bromsgrove, Wyre Forrest (North Worcestershire) and Kidderminster - chose to align their CSS requirements with Arden following a supplier presentation day in June.

6.2 CSS is currently developing the business processes and systems. A workshop on 25th July will finalise and agree the operational plan for the one front door approach to support CCGs. In August the NCB will begin a review (Checkpoint 3) of the CSS Full Business Case assessing their capability to be licensed as a CCG supplier.

6.3 PH Warwickshire and PH Coventry have an emerging opportunity with PH Worcestershire colleagues over future joint developments in making increasing efficiencies with the use of scarce resources. We need to ensure as PH Warwickshire that the core offer conditions and scope is understood by all Warwickshire CCGs.

6.4 Work is underway to determine CCGs public health needs and priorities so that the core offer is planned, agreed and affordable. Between September 2012 and March 2013 the Directorate will be able to test and shape the arrangements, ensuring agreements are clear over services that CCGs could commission but that currently sit with Public Health.

7. Consultation and Engagement

7.1 Public Health has a communications resource one day a week and has compiled a weekly bulletin to convey the key PH messages to staff and stakeholders. Staff will provide contributions to the newsletter that we intend will inform everyone about our ongoing developments until more embedded arrangements are clarified within WCC. A revised communications strategy has been drafted including recent developments and will include a costed plan to support the PH agenda and assigned responsibilities.

Summary

1. Request that the Scrutiny Committee signals their continued support for the Public Health developments as outlined in this paper.

2. That the Committee supports a further update in January/February following the clarification of the National Commissioning Board and Public Health England local arrangements as well as the checkpoint assessments of progress to be undertaken by the Dept of Health in October and January.

Item 8

Item No 8

Adult Social Care and Health Overview and Scrutiny Committee

5th September 2012

Hospital Discharge and Reablement

Recommendations

(1) It is recommended that the Overview and Scrutiny Committee consider and comment on the progress made within Social Care and Support in improving hospital discharge planning and continuing to improve delayed transfers of care.

1.0 Introduction and Key Issues

1.1 The People Group within Warwickshire County Council is responsible for the timely discharge of a customer from the following services:

- An acute bed within one of the hospitals – George Eliot Hospital, St Cross, South Warwickshire Foundation Trust, University Hospitals Coventry & Warwickshire (including St Cross Hospital)
- Other bordering acute hospitals e.g. Worcestershire
- Coventry and Warwickshire Partnership Trust acute in-patient beds.

1.2 The Community Care (Delayed Discharges) Act 2003 introduced responsibilities for the NHS to notify social services of a patient's likely need for community care services on point of discharge and to give 24 hours' notice on actual discharge. The Act also required Local Authorities to reimburse the NHS trust for each day an acute person's discharge is delayed where the sole reason for that delay is the responsibility of social services either in making an assessment for community care services or in providing those services. The Acute Trusts in Warwickshire agreed that they would not seek to pursue reimbursements, however, out of county hospitals made no such undertaking.

1.3 NHS Trusts provide weekly and monthly data to the Strategic Health Authority on all delays (either attributable to NHS ongoing care, social care or both) where a patient continues to occupy a bed after their confirmed discharge date.

1.4 The NHS Vital Signs on Delayed Transfers of Care and the Local Authority performance indicator NI131 measure all delayed transfers of care (acute and none acute) per 100,000 population.

1.5 February 2012 through to April 2012 saw unprecedented levels of activity in all the Acute Trusts serving Warwickshire residents with significantly

higher numbers of people presenting at Accident and Emergency and high numbers requiring a hospital admission. In order to improve patient flow, the Strategic Health Authority introduced further targets to improve discharges. Each hospital was given a target that comprised a number of "simple" cases that needed to be discharged each day and a smaller number of "complex" discharges. (Complex discharges included all supported discharges where an individual required Intermediate Care, Reablement or a Support Package). Warwickshire County Council achieved their targets in all three Trusts.

1.6 Very few delays are attributable as a result of delays in undertaking social care assessments, however, some of Warwickshire's more rural areas do present challenges when sourcing packages of care. Health colleagues are responding to health related delays, such as Continuing Health Care (CHC) assessments, mental health assessments and placements in NHS funded facilities. These all account for a higher number of bed days lost. Overall, the number of delayed transfers of care in Warwickshire has significantly improved, although further work is needed to match and exceed the performance of our comparators. There is strong joint commitment to deliver this.

1.7 Warwickshire Corporate Business Plan Measures for delayed transfer of care performance statistics are as follows, and are based on a national definition from the Adult Social Care Outcomes Framework (ASCOF):

Definition	**2011/12 outturn**	**Q1 outturn**	**2012/13 Predicted outturn**	**2012/13 target**	**2011/12 shire average**	**2011/12 England average**
Delayed transfers of care - **ASCOF 2C All Delays**	17	15.1	14	13	11.3	9.8
Delayed transfers of care - **ASCOF 2C Those attributable only to Social Care and those joint with health (exclude health only delays)**	7.4	4.9	4.5	4.0	4.1	3.8

ASCOF 2C (as shown above) is a measure of the total of all the different sorts of delayed transfers of care. It is the average number of delayed transfers of care (for those aged 18 and over) on a particular day, taken over the year and expressed per 100,000 of the population. The different reasons for a delayed transfer of care have been nationally defined and are:

- Awaiting completion of assessment (can be the responsibility of either health, social care or both)
- Awaiting public funding (can be the responsibility of either health, social care or both)

- Awaiting further non-acute NHS care (only the responsibility of health)

- Awaiting residential home placement (can be the responsibility of either health, social care or both)
- Awaiting nursing home placement or availability (can be the responsibility of either health, social care or both)
- Awaiting care package in own home (can be the responsibility of either health, social care or both)
- Awaiting community equipment and adaptations (can be the responsibility of either health, social care or both)
- Patient or family choice (can be the responsibility of either health, social care or both). This is the situation when a patient and family are taking time to decide which care home to move to, and the person remains in hospital while this is happening.
- Disputes (can be the responsibility of either health, social care or both)
- Housing for patients not covered by the NHS and Community Care Act (only the responsibility of health).

1.8 Warwickshire is striving to meet the aims of the 'Caring for our future: reforming care and support' Social Care White Paper, which sets out the vision for a reformed care and support system.

The new system will:

- focus on people's wellbeing and support them to stay independent for as long as possible
- introduce greater national consistency in access to care and support
- provide better information to help people make choices about their care
- give people more control over their care
- improve support for carers
- improve the quality of care and support
- improve integration of different services

This new system focus within the White Paper can be evidenced through the growing agenda between WCC and health partners. The main priorities that are currently underway for improving hospital discharge processes and the role of community support and assessment require a change in culture in the role of the acute hospital. Warwickshire is aiming to reduce hospital average lengths of stay and ensure that hospital is only utilised as a place to 'get treated'. As soon as a patient is clinically safe to be discharged, the journey of active convalescence and rehabilitation for the customer should take place out of the hospital environment, where the individual is central to the support service that they are being offered. The setting that the customer moves to after hospital, which will be their own home wherever possible, will be where they engage in their full assessment of needs / risks, which will identify the long term care and support which they need (if any). In addition to reducing the length of stay that a person remains in hospital, this will also reduce the overstatement of needs that often occurs in acute settings, when people are assessed at their most vulnerable, in an unfamiliar environment. Additionally,

it facilitates a more relaxed and appropriate environment to engage with carers and families, to enable informed long term care decisions to be made.

1.9 Following on from the Reablement and Hospital Discharge Task and Finish Group that took place in July 2011, a number of developments that were identified within the implementation plan, to improve hospital discharge and to maximise the use of the reablement service, are currently underway. This has focused partnership working between the acute hospitals, health community services and WCC to achieve the best outcomes for the customer at point of exit from hospital. The Service Manager Lead for Hospital Social Work Teams and the Service Manager Lead for Reablement Services have been working with health colleagues to agree a more co-ordinated approach to discharge planning and reducing lengths of stay in an acute medical setting.

2.0 Developments In Progress

2.1 Against a background of a series of early service integration pilots in Warwickshire, senior leaders from Warwickshire County Council, South Warwickshire Foundation Trust, NHS Warwickshire PCT and South Warwickshire Clinical Commissioning group met to discuss the way forward towards integrated / aligned services for older people. The outcomes of these discussions lead to the development of a shared purpose for integrated working.

The foundation of the new model of aligned working is defined by the development of three new 'Discharge to Assess' pathways. The aim is to establish three clearly understood pathways of care. A patient is identified for the appropriate pathway, which will depend on the complexity of need of the patient. (See Appendix A for a diagrammatic view).

The scoping work has identified the following *Shared Purpose Themes*, which we are following as we develop the new services:

- Focus on developing and implementing a complete 'Discharge to Assess' model for patients in hospital, as part of a vision to develop and deliver aligned care.
- This development process should be 'bottom-up' including patients and staff.
- The outcomes of the individual patient pathway must be recorded so that data is available to evaluate outcomes and further refine the model.

Pathway 1 – supported discharge home

This pathway will be utilised when it is identified that services can be provided which enable a safe hospital discharge for a person's return home. The majority of arrangements/services to deliver this pathway (e.g. the '5 a day' project) are already in place. Our objective is to achieve a

flow of 30 new patients a week moving to CERT/IMC for South Warwickshire and a flow target will also be set for Reablement Services.

Pathway 2 – 'Discharge to assess' where home is not an option at the point of discharge, but permanent residential care is not inevitable

This pathway should be used for individuals who cannot return home, even with availability of any of the services available in 'pathway 1'. These patient situations can be considered as medium to high complexity (or, in social care terms, 'critical' levels of need / risk). Patients will be discharged to a bed-based facility able to provide intermediate type care for a period of around 2 - 6 weeks. The anticipated exit route from the pathway is either back home (with support if needed), or to residential care. The patient will have given consent to care and support provided, along the journey.

Pathway 3 – 'Discharge to assess' to nursing home, where patient needs are very complex and where Continuing Health Care (CHC) eligibility is a possibility

This is a new pathway for Warwickshire. Patients will be discharged to a commissioned nursing home for a period of around 4 – 6 weeks. During this time, patients will be offered an environment in which to recuperate / rehabilitate as far as possible, and will be assessed for CHC eligibility. Patients assessed as eligible for CHC funding will have their long term care arrangements organised during the stay. Individuals assessed as eligible for WCC social care and support (nursing or otherwise) will have their long term care arrangements organised by an allocated Social Worker. Self-funders will be appropriately supported to identify their long term care arrangements. The patient will have given consent to care and support provided, along the journey.

Entry into the pathways will be determined by a mixture of the trusted assessment tool (outlined in section 2.2) and professional judgement, in discussion with the patient and their carers. An assessment will be applied to the customer when their acute medical phase is over and will lead to the most appropriate care setting (ideally in the person's home) being selected and accessed in a timely way. These pathways reflect ongoing assessment and support in the right place, at the right time, rather than being assessed in crisis, which may lead to creating an overstatement of dependence on community resources.

Scoping work has identified the following benefits:

- Clear and understandable pathways for all stakeholders, including patients, carers and referrers.

- A service that is timely – leading to best outcomes.
- No-one in hospital (or any of the short term rehabilitative / intermediate care services) any longer than needed – smooth 'flow' of people moving through services, without 'bottlenecks'.
- No-one makes a long term decision about their care whilst they are in hospital (unless in exceptional, appropriate circumstances).
- Decisions about long term care are made in an improved environment, with more time for engagement with carers, families and loved ones.
- More people will be able to return to their own homes to resume more independent lives. The risk of creating dependency will be minimised. (Currently, of the people who access pathway one, 16% have a need for additional support services after the period of rehabilitation / recuperation).
- Standardisation of care pathways and improved professional understanding will reduce duplication in assessments and inputs, reduce variations in practice, reduce time spent (by both patients and clinicians) in navigating a complex system, and therefore overall improve efficiency and productivity.
- These pathways are designed to deliver care close to home and to optimise health and social inclusion for vulnerable older adults. This has been identified as strategically important to clinical commissioning groups (CCG's) across Warwickshire, and the people they serve.
- A system that is transparent.
- A system that is operationally and financially sustainable with risk and remuneration clearly identified / linked for organisations.
- A system that deliberately helps its constituent members with their challenges and a culture that takes responsibility for people that are referred.

The work to date has seen significant improvements in the number of people supported who remain in their destination (usually in their own home) 91 days post discharge from hospital. This is evident within the Corporate Business Reporting for Q1:

Definition	2011/12 outturn	Q1 outturn	Predicted outturn	2012/13 outturn
%customers not needing social care 91 days after reablement	62%	55%	63%	63%

The % of customers requiring social care services 91 days post reablement for quarter 1 currently sits at 55%. This is lower than the agreed target. This may be due to the increased eligibility within reablement that has resulted in more complex customers being offered the service. Therefore the customer is likely to require an ongoing package of care following their reablement input. However, it is evident that the package of care is significantly reduced as a result of having received reablement.

2.2 Each acute trust discharge liaison team within the acute hospital or the Intermediate Care Team based in the community will use an electronic assessment tool with the customer. This approach is being developed so that health and WCC can use the same assessment process for a customer at their point of discharge from hospital. The staff member and the customer work together to answer a number of questions within the tool, which will determine which community based service the customer requires at their point of exit from an acute hospital stay or after a period of intermediate care. This trusted assessment should maximise timely discharges, as the outcomes and the content of the assessment (a pre-determined question set) will always be consistent. There will be little requirement for the service that the customer is being referred onto to chase for additional information before they can accept the customer, as the information will already be available within the electronic assessment tool. This initiative is called the Electronic Common Assessment Tool (eCAT). It is proposed that this will be rolled out within South Warwickshire Foundation Trust by October 2012. Ongoing review and monitoring will take place to ensure that the process is safe and effective. A countywide roll out of the eCAT within the acutes should be achieved by the end of the financial year.

2.3 All hospital discharge coordinators based within the acute wards will have the ability to refer directly into reablement using the trusted assessment tool (eCAT). Workshops are taking place throughout July and August 2012 to ensure the discharge teams have adequate knowledge and confidence regarding reablement eligibility. This will assist with timely discharges, as health colleagues will be able to refer directly into the reablement service.

2.4 Reablement Community Care Workers (CCW) are situated in the 3 acutes and work alongside the Hospital Social Care Team to maximise discharges into reablement for a more coordinated approach to discharge. The CCW is also used as a useful resource for the social work team to ensure customers that are considered for reablement are eligible for the service. This in turn will assist with timely discharges to the appropriate service area.

2.5 Since 8th May 2012, the South Warwickshire Foundation Trust Community Emergency Response Team (CERT) can refer directly into the reablement service. This ensures that the CERT capacity and flow remains focused on hospital discharge cases. After the 72 hours of CERT service the customer (if eligible) can move directly to reablement. Reablement respond within two hours of receipt of the customer referral and the service may start immediately using the trusted assessment documentation from CERT. Shared risk assessments are also being developed, so that the customer does not receive duplicate assessments from different organisations.

2.6 Some spare capacity within Warwickshire County Council's residential homes has temporarily been utilised to provide 'Moving on Beds'. These

are a resource for people who no longer require an acute hospital stay, but may benefit from a short period of residential care, with therapeutic input where needed, to enable them to return home. The outcome of this temporary arrangement will be evaluated and a refined model will become a crucial part of the discharge to assess pathway development outlined within section 2.1 of this report. Discharge co-ordinators based within the acutes are able to identify people that may benefit from this resource. The Residential Care Home Managers are committed to responding within two hours and admitting to the relevant home the same day where it is reasonable and safe to do so.

2.7 George Eliot Hospital and South Warwickshire Foundation Trust now have ward attached social workers to jointly agree estimated dates of discharge in a Multi-Disciplinary meeting and to improve communication between the ward and the social work team. This has led to better understanding from ward staff in what is categorised as a delay either to health or social care.

2.8 A dedicated social worker has been introduced at South Warwickshire Foundation Trust to ensure assessments are completed when a social worker may be absent and ensures discharges are not delayed. This ensures flow is not affected from reduced staffing levels within social care.

2.9 Where vacancies occur these are quickly filled and additional social workers were recruited in October 2011 to meet the increased demand that the winter months bring. We are currently scoping whether additional staffing will be required for winter 2012/13 to assist with potential winter pressures.

2.10 A fast track process has been introduced, to quickly discharge patients who were already in receipt of a package of support prior to their hospital admission and could be discharged with the same level of support without further social work assessment. Discussion with the individual, their family or carer and existing care provider are central to this process to ensure the views of all involved are taken into consideration and a safe discharge is arranged.

2.11 The Service Manager lead for Hospital Social Work Teams attends a monthly strategic meeting at George Eliot Hospital where issues are discussed relating to discharge. A similar meeting at South Warwickshire Foundation Trust also takes place, which the Reablement Service Manager attends. This ensures a joined up approach to discharge protocols and allows us to problem solve any key areas that may be contributing to delays in discharge. Similar meetings are held with UHCW and out of county hospitals.

2.12 There is good communication and relations between senior social care and Health managers and a joint approach to problem solving takes place, particularly where complex issues have been identified and a multi-disciplinary approach is required to ensure the customer receives tailored support.

2.13 All decisions for the Council funds required are made within two hours of request. This enables practitioners to secure the identified resource. All discharges referred into the reablement service are responded to within two hours of receipt of referral.

2.14 Colleagues in Strategic Commissioning are immediately alerted to provider (domiciliary or residential / nursing) resource deficiencies or quality issues within the external market. This enables commissioners to speak to external providers about the potential for additional capacity being made available and to work with them to improve standards of support where required.

3.0. Next steps

3.1 The formal project structure is being developed for the delivery of the 'Discharge to Assess' model. The key aspects of this pathway will be in place by November 2012.

3.2 Development of an Arden Cluster-wide performance database is being developed to enable stakeholders (acute, health community services and social care) to understand the performance and outcomes of the 'Discharge to Assess' system, in relation to discharges, admissions and flows. This database will be available by November 2012 and will give a more accurate picture of the activity, performance and outcomes across the whole of Warwickshire.

3.3 A review has taken place regarding CERT direct referrals into the WCC Reablement Service and lessons learned are being used to roll out the referral pathway countywide. Ongoing review will take place every three months to ensure the direct referral route remains effective.

3.4 Reconfiguration of the South Warwickshire Foundation Trust Hospital Social Care Team and the WCC Reablement Service is taking place to align with the Discharge to Assess pathways by November 2012. This will support the customer to make decisions about their future at the right time and in the right place. This will also ensure that we are as prepared as possible for the demands of the 2012/13 winter pressures.

Background Papers

1. Reablement: Data on demand. October 2011
2. Reablement Evaluation. July 2011
3. Task and Finish Group. Reablement & Hospital Discharge May 2012

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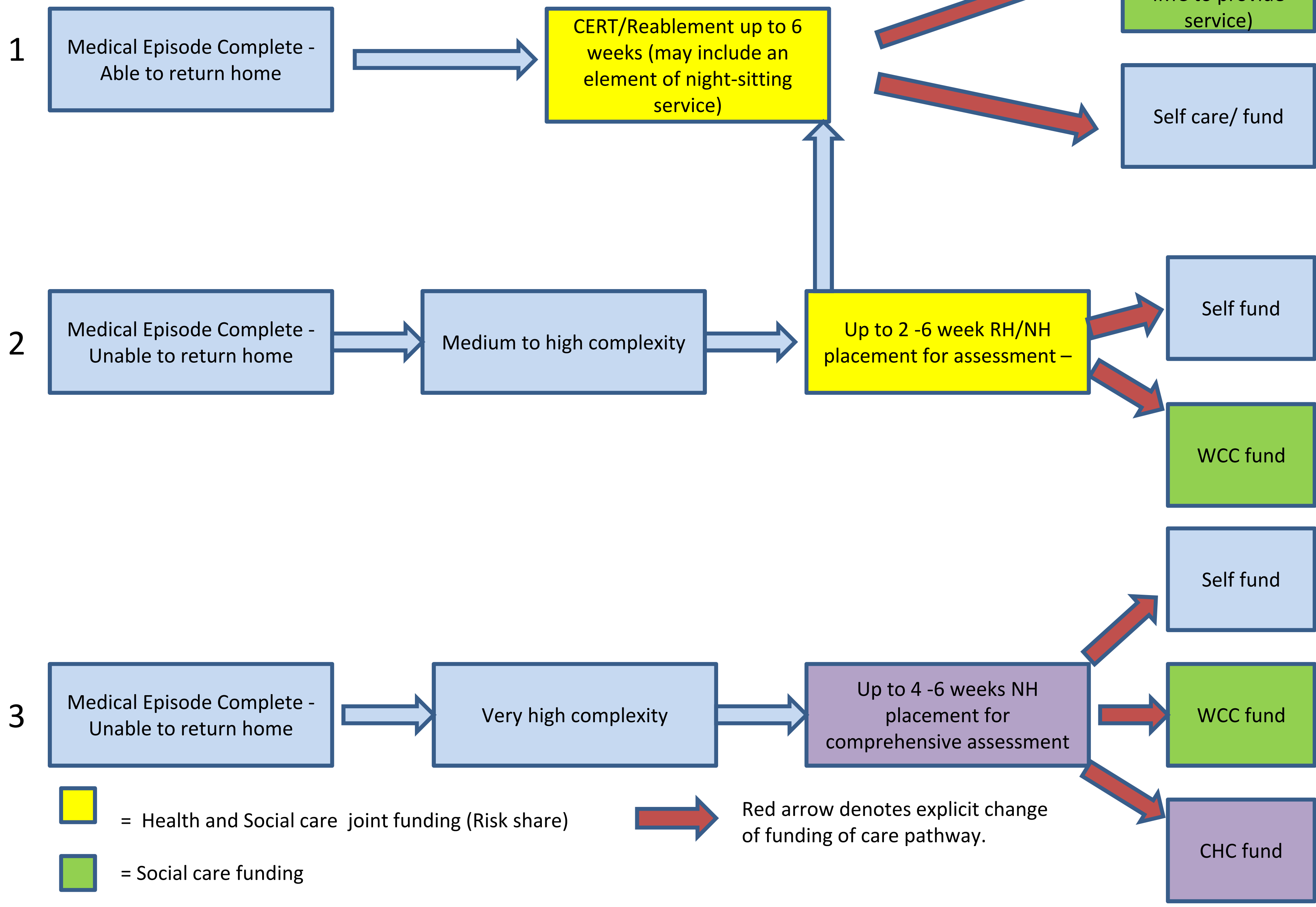
Appendix A

South Warwickshire

Discharge to Assess – Proposed Pathways and Financial Flows



Note – excludes fast track CHC

Item 9

Agenda No 9

Adult Social Care and Health Overview & Scrutiny Committee

5 September 2012

Quarter One 2012-13 Performance Report for Adult Social Care

Recommendations

That the Adult Social Care and Health Overview & Scrutiny Committee:

- Consider both the summary and detail of the performance summary for Adult Social Care
- Consider and comment on areas where performance is positive and comment on where areas are falling short of target, and the remedial action is being taken.

1. Key issues

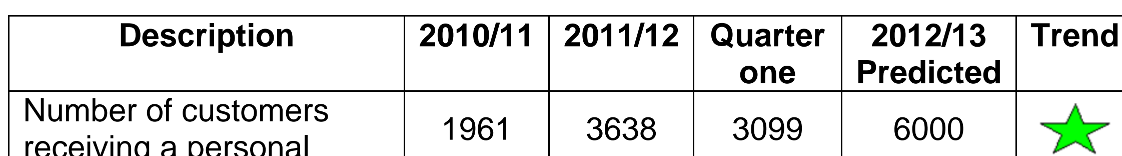
1.1 This report presents the Adult Social Care & Health Overview & Scrutiny Committee with the quarter one 2012-13 report on the performance of the Adult Social Care services within the People Group.

1.2 The report seeks to show a detailed picture of the success of the adult social care service and issues that need to be addresses. The information presented identifies a relatively positive picture in the implementation of the personalisation agenda and the transformation agenda. We recognise however the need for continuous improvement and have identified a number of areas in which actions are required to address a downward trend or no improvement.

This report doesn't provide commentary on the Adult Social Care Report Card, this is reported through the Organisational Health Report that is scrutinised by the Member Finance and Performance Working Group and reported to Cabinet in September. The Adult Social Care Report Card is included as appendix one for reference.

2. Performance and Key Messages

2.1 Below is the quarter one performance summary for Adult Social Care



Description	2010/11	2011/12	Quarter one	2012/13 Predicted	Trend
Number of customers receiving a personal	1961	3638	3099	6000	

Warwickshire County Council

budget for community services **(High is Best)**					
Proportion of personal budgets taken as a direct payment **(High is Best)**	2.6%	16.8%	19.4%	19.4%	
Proportion of customers in residential or nursing care **(Low is Best)**	30.0%	30.2%	29.7%	29.5%	
Number of people admitted to permanent residential care **(Low is Best)**	597	617	263	581	
Number of people with a learning disability in paid employment **(High is Best)**	68	70	70	70	
Average number of people whose discharge from hospital has been delayed on any one day **(Low is Best)**	71.2	72	64	66	
Proportion of customers not needing on-going social care support 3 months after their reablement service **(High is Best)**	-	62%	55%	55%	
The proportion of safeguarding referrals that are 'repeat referrals' **(Low is Best)**	-	14.7%	15%	15%	

2.2 **Personalisation**

Overall the performance picture for Adult Social Care Services in Warwickshire is a positive one. Continued improvement has been achieved in many areas with positive trends being made in many indicators. It should be noted that it is often hard to project the full year outturn on quarter one information and these projections are likely to change throughout the year when more information is gathered.

2.3 The key driver for Adult Social Care is to give all customers a personal budget. The use of personal budgets is a significant part of the personalisation agenda and can make a real difference to the lives of those who are able to access their social care support in this way. This move from traditional services to more personalised approaches can make a real difference, as evidenced by the case study below. In quarter one 74% of customers living in their own home were in receipt of a personal budget and 34% of customers in residential care had a personal budget.

In addition to measuring the number of people who have a personal budget we also measure how many people choose to take their personal budget in the

form of a direct payment. Since April 2012 over 19% of customers who have a personal budget are accessing at least some of their support through a direct payment. This proportion has increased considerably since 2010/11 when it was just 2.6%.

2.3.1 **Case Study Personal Budgets:**

"Amanda" used to attend a traditional day centre based service but following a recent review she continues to go to 'Tiger Feet' dance group on Mondays because she always enjoys this, but she now also goes bowling in the afternoon. On Tuesdays she goes to a floristry course and can choose to do either craft in the afternoon or enjoy pampering sessions.

On Thursday Amanda has been going to cookery sessions and has been cake decorating. She also attends the 'Knit and Natter' group at the church hall as this gives her an opportunity to catch up with her friends. By accessing support in this way Amanda is better able to maintain friendships and to live a more fulfilled life.

2.4 **Discharge from Hospital**

The average number of people whose discharge from hospital is delayed has improved since April. It is predicted this will be 66 in 2012/13 compared to 72 last financial year. However when expressed as a proportion (rate) of the adult population Warwickshire is in the bottom quartile compared to other shire authorities. The delays can be the responsibility of either health or social care and as our performance in this area has been recognised as below our expectations we have set a stretching target for the current year and have begun to measure the delays attributable to social care as a separate indicator.

Some of the actions taken to date include: appointing additional temporary staff to meet the increased demand of shortening lengths of stay in the Acute Trusts and to respond to the unprecedented levels of admissions in all three Trusts, introduced the Trusted Assessment process to fast track patients who were already receiving a package of support prior to their admission and could be discharged with the same level of care. In addition to this a number of beds in the Councils residential homes were identified and used as Moving On Beds when an individual no longer required acute care but for a number of reasons could not return home immediately.

Hospital teams have also been working more closely with reablement colleagues to ensure appropriate and timely referrals into this service.
Social Care and Support teams are also working with Strategic Commissioning colleagues to identify and highlight potential delays as a result of lack of service provision within the social care market. There is on-going work with our partners in the Coventry and Warwickshire Partnership Trust to agree processes for ratification of delays. In addition, an administrative officer has been recruited to closely scrutinise reported delays to the Strategic Health Authority.

2.5 **Reablement**

Since April the proportion of customers not needing on-going social care support 91 days after leaving reablement is 55% which is significantly below

the proportion in 2011/12 of 62%.

This is due to two factors: firstly now that reablement has opened up its eligibility criteria to increase the numbers of people accessing the service, customers referred to the team are in many cases more complex and therefore likely to require an on-going package of care post reablement. This is particularly the case for those customers that are referred to reablement from the community emergency response team. These customers will only have received 72 hours of intermediate care and are likely to have higher needs. Secondly, the Reablement team is receiving further training to ensure they understand the application of FACS at exit point from reablement. The aim is to ensure that an on-going package of care is only commissioned if there is a clear substantial or critical need and that the customers are sign posted to the third sector for their support if their needs are clearly low or moderate.

2.6 **Safeguarding**

The percentage of safeguarding adults referrals where the customer had at least one referral in the last 12 months has marginally increased from 14.7% in 2011-12 to 15% in quarter one.

Repeat referrals tend to cover those vulnerable adults where they are related to or well known to the alleged abuser. Examples include financial abuse of an elderly relative by a younger relative, where there is some acceptance of the abuse by the victim and the abuser leaves the area periodically before returning and a new referral is made by a concerned third party or agency, such as Housing Services or Probation. Other situations similar in their dynamics rather than circumstances include people who will collude with the abusive behaviour despite the attempts of WCC and other agencies to arrange and support a protection plan. These can be the most difficult of situations to resolve and our response tends to be one of maintaining contact with the vulnerable person and having monitoring arrangements in place with the agencies most involved.

Arguably, the percentage of repeat referrals does not in itself mean that the Council is failing to protect people from persistent abuse, so long as action is taken to risk assess each referral properly; rather it can indicate that agencies and others remain alert to the vulnerability of individuals about whom they have contact, knowledge and concern. Work is in hand with housing agencies to develop a protocol to enable better information sharing and inter agency discussion about individuals for whom there is widespread concern but no simple remedy.

3. Conclusions

3.1 This reports provide a snapshot of the progress made in quarter one of 2012/13. It is proposed that given members have access to and receive reports through the adult social care report card and performance plus, that this quarterly report provides evidence of progress and informs members of areas of concerns and the remedial actions taken to mitigate this and to ensure that targets are met within this financial year.

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Appendix One: Adult Social Care Report Card, Quarter One 2012 - 2013

Definition	High or Low is Best	2011/12 Outturn	Q1 Outturn	Predicted Outturn	2012/13 Target	Predicted Outturn Against Target
The proportion of those using social care who have control over their daily life - **ASCOF 1B**	↑	73.70%	NYA	NYA	75.0%	-
The proportion of people who use services & carers who find it easy to find information about support - **ASCOF 3D**	↑	77.40%	NYA	NYA	79.0%	-
Proportion of older people (65+) who are still at home after 91 days following discharge from hospital into rehabilitation services - **ASCOF 2B New definition (as a percentage of all hospital discharges)**	↑	4.1%	NYA	4.3%	4.3%	
Proportion of people whose outcome measures are fully or partially achieved at completion of reablement	↑	74.0%	72.6%	78.0%	80.0%	
Percentage of customers not needing on-going social care 91 days after leaving reablement	↑	62.0%	55.0%	63.0%	63.0%	
Admissions to residential care homes per 100,000 population - **ASCOF 2A**	↓	595.5	110.3	560	560	
Proportion of people using social care who receive self-directed support - **ASCOF 1C**	↑	45.2%	51.9%	65.0%	65.0%	
Delayed transfers of care - **ASCOF 2C All Delays**	↓	17	15.1	14.0	13.0	
Delayed transfers of care - **ASCOF 2C Social Care and Attributable to Both Delays**	↓	7.4	4.9	4.5	4.0	
Number of repeat safeguarding referrals	↓	14.70%	15.00%	14.00%	13.20%	
Proportion of people who use services who feel safe	↑	Top Quartile	NYA	NYA	Top Quartile	-

The number of extra care housing units available for use by customers eligible for Warwickshire County Council Adult Social Care	↑	119	119	173	173	★
Social care-related quality of life - **ASCOF 1A**	↑	18.8	NYA	NYA	18.9	-
Proportion of adults with a learning disability in employment - **ASCOF 1E**	↑	5.9%	NYA	7.0%	7.0%	★
Proportion of adults in with a learning disability in settled accommodation - **ASCOF 1G**	↑	54.5%	NYA	63.0%	63.0%	★
Proportion of adults in contact with secondary mental health services in settled accommodation - **ASCOF 1H**	↑	69.3%	NYA	70.0%	70.0%	★
Proportion of adults in contact with secondary mental health services in settled accommodation - **ASCOF 1H (Social Care Only)**	↑	79.0%	77.2%	80.0%	80.0%	★
Proportion of adults in contact with secondary mental health services in employment - **ASCOF 1F**	↑	17.2%	NYA	17.5%	17.5%	★
Proportion of adults in contact with secondary mental health services in employment - **ASCOF 1F (Social Care Only)**	↑	21.2%	16.5%	22.0%	22.0%	★
Overall satisfaction of people who use services with their care and support - **ASCOF 3A**	↑	62.6%	NYA	NYA	64.0%	-
Proportion of people who use services who say that those services have made them feel safe and secure - **ASCOF 4B**	↑	77.4%	NYA	NYA	78.0%	-

Key

★	Target has been achieved or exceeded
●	Performance is behind target but within acceptable limits (10%)
▲	Performance is significantly behind target and is below acceptable predefined minimum

Item 10

Coventry and Warwickshire NHS Partnership Trust

Item No 10

Report to Warwickshire Adult Social Care and Health Overview and Scrutiny Committee –
5 September 2012

Crisis Houses Warwickshire

1. Purpose of Report

To update the Committee as to current position on the occupancy levels of the two Crisis House facilities within Warwickshire, the report follows a previous report to committee in September 2011 where the option of a third Crisis House had been discussed as part of the overall redesign and consultation of Warwickshire Adult Mental Health services. This option was considered and a decision made not to proceed based on current demand and capacity already available. The committee supported this decision however wished to be assured that this capacity could accommodate the demand over the next 12 months and beyond. This report therefore is an update on this issue.

2. Background

Crisis Houses are used often alongside the intervention of Crisis Resolution/Home Treatment (CR/HT) to support individuals who are in a psychiatric crisis and where hospital admission can be avoided.

Respite or Crisis Houses are usually located in ordinary houses in the community and whilst there are a variety of models, they are generally run by Third Sector organisations which work in partnership with statutory services, particularly CR/HT Teams, to prevent hospital admission and more latterly to enable and support earlier discharge.

Many areas of the country have varying degrees of facilities, with some areas not having any access to such provision at all.

It is not a national or local requirement to provide a Crisis House or accommodation, for those in psychiatric crisis and who would be under the care of the Crisis Resolution/Home Treatment Team.

It is however deemed as good practice and the feedback from Service Users and Carers is that it can help to support and break the cycle of repeat admissions, where it is offered as an alternative, and robust Crisis Resolution/Home Treatment Teams are available and they work together.

Currently in Warwickshire there are two such facilities already in operation; one in Nuneaton called Gwenda House and another in Leamington called Park House.

The Crisis House

Services are commissioned and run independently from CWPT, the provider Trust. They are operated by two separate providers Rethink for Leamington and Friendship for Gwenda House however they work closely with CWPT Mental Health Services supporting service users in a crisis. With CWPT through their Crisis Home Treatment teams being the gate keeper into these houses.

A further development during 2011 was to ensure that any service user receiving home treatment from CWPT could be supported to use any of the established facilities if they meet the criteria and therefore would be offered a crisis bed in either the Leamington or Nuneaton Crisis Houses as part of their support package and to prevent an admission.

At the time of the original report September 2011 a review had taken place by the CWPT and the Crisis House providers, Rethink and Friendship Housing, this looked at current demand and capacity to ensure they could meet the expansion of this provision to all Warwickshire Service Users. This report that follows was requested by the committee to ensure that whilst at the time there was clear evidence demand could be met within the established facilities could we be assured this demand would not out way capacity for the future years?

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3. Current Position

There are two Crisis Houses in Warwickshire; one in Nuneaton and one in Leamington both of which are commissioned through Arden Commissioners.

Referring to the occupancy chart you will clearly see that capacity continues to outweigh demand and opening the referral route up to all service users living within Warwickshire has not created unmanageable demand. All of the Crisis Houses are currently operating at varying degrees of under occupancy.

The current providers share this information with commissioners and the providers by providing quarterly monitoring reports directly to the commissioners. Based on these figures it appears that the original decision that another facility was not warranted would still be our up held. .

Table 1: Crisis House Provision for Coventry & Warwickshire					
Property	Owners	**Size**	**Operators**	**Commissioning Arrangements**	**Average Occupancy Levels 2011/2012**
Park House Leamington	CWPT	6 beds plus office accommodation	Rethink	NHS Warwickshire 3 year contract - £123,000 pa	50%
Gwenda House, Nuneaton	Warwickshire County Council	3 beds	Friendship Care and Housing	NHS Warwickshire 3 year contract - £154,000 pa	80%

We have worked with the current Crisis Team Managers and Leads who inform us that should a Service User require a crisis bed to avoid admissions then they routinely consider all facilities.

3.1 Park House Leamington

The accommodation consists of 6 beds. It is currently under utilised. This figure has increased slightly since the reconfiguration of adult in-patient mental health beds; however it remains at around 50%.

The accommodation is under utilised and not in line with the expected service delivery model, as it is in a part of a building that is also used as a community accommodation base for staff from Coventry and Warwickshire Partnership Trust.

As identified in the previous position paper in April 2010, the Trust is currently the landlord without a lease. This is an ad hoc arrangement which presents a risk and cannot continue without a more formal contract in place. This will be progressed by Coventry and Warwickshire Partnership Trust.

3.2 Gwenda House Nuneaton

This Crisis House opened in June 2007, after many years of planning and advocacy for such a house by the Service User led organisation, Voices for

Choices. Located next to the Wellbeing Centre, this is a small, 3-bedroomed house, its lounge and dinning room enhanced by the imaginative provision of outside space at the end of the garden. The property is rented by Friendship Care and Housing from Warwickshire County Council.

Friendship Care and Housing, a Housing Association, provides support to guests who are able to stay in the house for up to 3 weeks. A flexible service, including day attendances if needed, is provided. Staff[1] are on site from 8.00am until 10.00pm, although the Crisis Team gate keep admissions and visit to provide clinical support. The house has 3 bedrooms, 1 en-suite, and is attractive and well-furbished, although there is no wheelchair access to the bedrooms.

The contract was tendered by NHS Warwickshire and won by Friendship Care and Housing with a value of £154.000 pa. It was then extended for another 3 year period, with the same specification as the Crisis House in South Warwickshire. Monitoring data is provided to the commissioners, covering the number of admissions and outcomes for Service Users. [2].

Established and valued by Service Users, this house is nevertheless not used to its full occupancy. With the closure of the Avenue Clinic, Nuneaton demand has been monitored closely to ensure that admissions to hospital are avoided and early discharge facilitated.

4. Recommendations

The Committee is asked to consider the following information and be assured that the two current facilities provided by third sector are meeting the current need of service users who would and could be offered a crisis bed and home treatment as an alternative to inpatient care.

We will be discussing current situation with Commissioners and will support ongoing monitoring.

Susan Smith
General Manager Age Independent Mental Health
August 2012

[1] A service manager and 4 support staff
[2] Data provided by Phil Cullen, Team Manager

Item 13

Item No 14

Adult Social Care and Health Overview and Scrutiny Committee

5 September 2012

Work Programme Report of the Chair

Recommendation

The Committee is recommended to agree the work programme, to be reviewed and reprioritise as appropriate throughout the course of the year

1. Work Programme

The Committee's Work Programme is attached as Appendix A. The Work Programme will be reviewed and reprioritised throughout the year so that the Committee can adopt a flexible approach and respond to issues as they emerge.

2. Task and Finish Groups

The Committee may wish to consider any potential future Task and Finish Groups.

3. Forward Plan

The following items that fall within the remit of this Committee are scheduled to be considered by the Cabinet:

Cabinet – 13 September 2012

Director of Public Health Annual Report
Mental Health Needs Assessment.

Background Papers

None.

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Strategic Director	David Carter	
Portfolio Holder	n/a	

Appendix A

Date of meeting	Item	Report detail	Date of last report
31 Oct 2012	Fairer Charges and Contributions – Impact of Changes – Wendy Fabbro	Annual monitoring report on charging.	25 October 2011
	UHCW – Foundation Trust Trajectory (Jenny Gardiner) *This could move to 5-12-12 – Jenny Gardiner to confirm*	Foundation Trust (FT) – A revised tripartite formal agreement is currently under discussion with the SHA / Department of Health. This report will provide an update on the Foundation Trust trajectory.	
	South Warwickshire Community Response Team (Jane Ives, SWFT))	Update report 6 months after implementation of the reconfiguration of care pathways with the closure of beds at Royal Leamington Spa Rehabilitation Hospital and an increase in community response.	25 October 2011
	Carers Strategy Refresh (Elaine Cook)	This report will present the Carers Strategy Refresh Programme.	
	Physical Disability and Sensory Impairment (PDSI) Strategy – Wendy Fabbro/William Campbell	To consider the PDSI Strategy (deferred from 11 April 2012 meeting). This report will present the draft version of the revised Physical Disability & Sensory Impairment (PDSI) Commissioning Strategy which expresses our approach to the commissioning of services to support customers across all ages as part of our joint focus upon children's and adults services as part of the People Group.	
5 Dec 2012	Serious Case Review – Lessons Learnt	An update report on lessons learnt and progress in setting up a multi-agency management plan.	7 December 2011
	Adult Safeguarding – Wendy Fabbro	An annual report setting out the implications for Warwickshire on the Adult Social Care White Paper (published in November 2012) and the strategy for the People Group in moving this forward.	
	Local Account of Social Care		
	Q2 Performance Report (Wendy Fabbro)	This report will present Q2 performance, including trend data and benchmarking, including 'best in class' information	
	Complaints – Karen Smith/Wendy Fabbro	There was some discussion about reports received in the past on Complaints/Compliments. The Committee have asked for a report to be brought to a future meeting, particularly in relation to how this will tie in with the new Local Healthwatch function.	
6 March 2012	Improving Trauma Care in the West Midlands	The Committee supported the preferred option (Option 1 for three trauma networks) and requested an update report on the implementation 12 months in requested by the	25 October 2011

		Committee on 25 October 2011	
	Virtual Wards – Bie Grobet	Update report on virtual wards including the roll-out of virtual wards across the county.	12 April 2012
Dates to be set	CWPT – Psychologist Service Review	Briefing to members on the Psychologist Service Review being carried out by CWPT	
	George Eliot Hospital – Kevin McGee	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. (Requested at the meeting on 15 February 2012 meeting – Item 3)	15 February 2012
	Transformation Programme - Adult Social Care – Emma Curtis/Gill Fletcher	A report will be brought to ASC&H O&S from the Transformation Programme Office setting out the programme for Adult Social Care. The Chair and Party Spokes will be involved in scoping exercise and the Committee will have the chance to consider the Service Review Scope. This will be followed by the Business Case.	
	Learning Disability Strategy Seminar – Chris Lewington	A seminar will be held at a date to be determined looking at the different strands of the Learning Disability Strategy	
	Dementia Seminar – Chris Lewington	A seminar will be held at a date to be determined giving an update on progress made in relation to dementia services.	

BRIEFING NOTES

SUBJECT OF BRIEFING NOTE	OBJECTIVE OF BRIEFING NOTE	COMMENT / FURTHER INFORMATION
Post Event Analysis on Winter Pressures – Jane Ives	Post Event Analysis on Winter Pressures	*Briefing Note to be requested in late spring*
Virtual Wards – Bie Grobet	The Committee requested a briefing note six months after their 11 April meeting – including an update on the development of a virtual ward in the south of the county	*Briefing Note to be requested for October 2012. Email sent on 21-08-12.*
Local HealthWatch (Monika Rozanski)	This briefing summarises the work on the establishment of Local Healthwatch in Warwickshire to date and describing commissioning and further development plans.	15 February 2012

TASK AND FINISH GROUPS

ITEM AND RESPONSIBLE OFFICER	OBJECTIVE OF SCRUTINY	TIMESCALE	MEMBERS / COMMENT
Paediatric and Maternity Services Cllrs Peter Balaam (Chair), Carolyn Robbins, Barry Longden, Sonja Wilson, Lesley Hill (LINks)	A public consultation is scheduled to begin on 5 December, seeking views on proposed future model(s) of service delivery. The role of the T&F Group is not only to formulate a response to the consultation, but also to scrutinise the pre-consultation phase - looking at the process by which the Cluster has established its proposals and determining whether appropriate engagement with stakeholders and service users has taken place.	Formal response sent on 06-08-12 - Complete	Agreed at the meeting on 15 February 2012: "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."
Older Adult Dementia Review (formerly the Older Adult Mental Health Services) Cllrs Jerry Roodhouse (Chair), Peter Fowler, Sid Tooth	To review the CWPT consultation process regarding older adult mental health services	Report to the Committee in April 2012	Agreed at the meeting on 15 February 2012: "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."
Quality Accounts 2013 (Martyn Harris)	QA Groups set up for each of the 5 Trusts to work with the Trusts on quality accounts over the year	Ongoing	Ongoing