MINUTES OF A MEETING OF THE COMMUNITY WELLBEING & OLDER PEOPLE POLICY AND SCRUTINY COMMITTEE HELD AT COUNTY HALL, CHELMSFORD ON 14 APRIL 2011

Membership

*	W J C Dick (Chairman)		
	L Barton		R A Pearson
	J Dornan		Mrs J Reeves (Vice-Chairman)
	M Garnett	*	C Riley (as substitute)
*	C Griffiths	*	Mrs E Webster
*	E Hart (as substitute)	*	Mrs M J Webster (from the end of Item 31)
*	T Higgins (as substitute)	*	Mrs J H Whitehouse (Vice-Chairman)
*	S Hillier	*	B Wood
*	L Mead		

* Present

The following also were in attendance: Cabinet Member A Naylor, Deputy Cabinet Member A Brown, Councillors G Butland and J Schofield, and Ms M Montgomery, Deputy Co-chair of Essex AH&CW Older People's Planning Group.

27. Attendance, Apologies and Substitute Notices

The Committee Officer reported apologies had been received from Councillors L Barton (for whom Councillor T Higgins attended as substitute), M Garnett, R Pearson (for whom Councillor C Riley attended as substitute), and Mrs J Reeves (for whom Councillor E Hart attended as substitute).

28. Declarations of Interest

No declarations of interest were declared.

29. Minutes of last meeting

The Minutes of the Committee held on 10 March 2011 were approved as a correct record and signed by the Chairman.

30. NHS White Paper

The Committee received a further briefing note (CWOP/15/11) from Clare Hardy, Senior Manager, Executive Office, Adults Health and Community Wellbeing, on the Council responsibilities in light of proposals published in the Health and Social Care Bill in January 2011 ("the Bill"). The Bill had confirmed the government's intentions for health and social care as set out in the NHS White Paper with some minor amendments. In particular, the suggestion that the Health and Wellbeing Board should incorporate local authority Health

Overview and Scrutiny functions had been removed. A Social Care White Paper was also expected later in the year.

The Government had announced the previous week that there would be a pause for further consultation on the Bill. Subsequent discussion in the meeting was based on the premis that the main proposals in the Bill would remain after the consultation. ECC's current implementation plans for the Bill included four main work streams indicated below.

(b) Developing relationships with GP commissioning consortium

Nine GP consortia across Southend and Thurrock/Essex had applied for pathfinder status and, so far, six consortia had been successful. In the south of the county there were a higher number of single doctor GP practices which made the establishment of consortia more challenging.

The two Essex Primary Care Trusts (PCT) clusters (North and South), together with the Strategic Health Authority and Local Medical Committee (LMC), were responsible for supporting GP consortia to emerge. Meetings had been held with each established consortia to discuss, depending upon their stage of development, infrastructure support, areas of joint commissioning, and governance.

Members were concerned that there was no uniform development of consortia across the county and pressed for re-assurances that the pattern of development of the consortia that was emerging was appropriate, and that there was suitable monitoring so that consistent standards could be maintained across different geographical areas. ECC were building good relationships with both the LMC and GP consortia but it was acknowledged that establishing a uniform approach in all areas would be a challenge. The Government had taken a bottom-up approach to develop measures to encourage localised structures and commissioning and that this could lead to differences between areas. ECC were aware of certain tensions where there were particular locality differences but were also working with GP consortia on some wider commissioning initiatives. It was stressed that a system allowing local variations should not offset the routine day to day running of GP surgeries. Some Members highlighted inadequate coverage of GP surgeries in some areas and queried whether the establishment of GP consortia would improve or worsen such distribution. It was stressed that each GP consortia would be responsible for ensuring that their services were evenly spread throughout their respective administrative area.

It was anticipated that the Health and Wellbeing Board (see below) would provide strategic leadership, encouraging commonality of services and ensuring effective coverage.

It was noted that the Chairman of the North Essex LMC would be attending the Health Overview and Scrutiny Committee the following week to give an overview of GP issues and planning for GP commissioning.

(c) Develop the new local public health service

National deadlines around upper tier local authorities establishing local public health services had evolved and PCT health improvement functions would now transfer to ECC in April 2013. ECC were looking to move to shadow form as soon as possible and expected to have agreed stages for this transition set out imminently. It was stressed that ECC was keen to develop a holistic approach to Public Health with all the Council's services inputting to the public health agenda and that work was already underway to explore these cross functional linkages. A meeting of all stakeholders had been planned in May but the timing of this would be reviewed in light of the Government announcement of a pause for further consultation on the Bill.

In discussion Members acknowledged that public health provision should be needs based which consequently might not lead to equal provision in all areas.

Members were concerned that public health had a very low profile at present and that high expectations of a new infrastructure would be difficult to meet in the current economic climate. Public Health England would take on the national responsibility for public health campaigns and outcomes and allocate funding to upper tier local authorities. It was expected that there would be no extra funding to that which currently resided with the PCTs although there might be more opportunity to add value to campaigns by 'joining up' different initiatives.

(d) Establish local HealthWatch representing patients and service users

The Local Involvement Networks (LINks) would be replaced by local HealthWatch, accountable to the national HealthWatch and the upper tier local authorities who establish them. A representative from the local HealthWatch would have a seat on their local Health and Wellbeing Board.

It was felt that LINks needed to be included in the design of future health pathways. A recent ECC stakeholder event to focus on the service user/patient and discuss the development of HealthWatch had included LINks. Members queried why representatives from both CWOP and HOSC had not also been invited but were re-assured that the event had been aimed specifically at patient and service user representatives (including LINk) and evaluating the current patient experience and related issues. ECCs approach had now evolved, due to changes made since the White Paper (and now published in the Bill), which was felt to have removed some of the earlier anticipated flexibility for further developing the role of Healthwatch. The approach for a communication exercise with stakeholders was being developed and it was acknowledged that there would be differing ways to engage different stakeholder groups.

It was confirmed that ECC was not looking at medical representatives, such as GPs, to comprise the membership of the HealthWatch and instead would be looking for wider representation. Members suggested that they should

have a further opportunity to comment prior to ECC conducting further stakeholder consultation as, in particular, they would be able to suggest local interest groups and consultation forums who would be interested in participating.

Members emphasised that the Council's scrutiny committees should continue to be consulted.

(e) Essex Health and Wellbeing Board

Shadow Health and Wellbeing Boards were due to be established by upper tier local authorities in shadow form by April 2012 and would become statutory boards in April 2013. There would be a separate board for each of Essex County Council, Southend Unitary and Thurrock Unitary Council. In view of the recent statement by the Government that it would pause for further consultation on the Bill, the Essex Shadow Health and Wellbeing Board would remain in non public pre-shadow mode until the consultation was finished and the Government's intentions on the matter were reconfirmed.

The ECC Chief Executive and the Chief Executive NHS Mid Essex were members of the NHS Future Forum which was coordinating the latest Government consultation process. The Government had made clear that they intended to continue with the main thrust of the Bill and specifically to create a more enhanced role for local government. The ECC implementation programme would be refreshed thereafter and any updated programme would be presented to a future meeting of the Committee.

31. Essex, Southend & Thurrock Dementia Strategy/ECC Action Plan Consultation

(a) Introduction

The Committee received a report (CWOP/16/11) from Sheila Davis, Strategic Commissioning Officer, OAMH and Craig Derry, Director of Strategic Planning and Commissioning, incorporating a local Dementia Strategy agreed between ECC, Southend and Thurrock Unitaries, and other partner organisations, stating how they could collectively meet the objectives of the National Dementia Strategy which had been published in 2009 (the Local Strategy). The NHS Operating Frameworks for 2010-11 and 2011-12 had identified dementia as an area for local prioritisation.

(b) Age profile in Essex

Essex had a higher than average population of people both aged over 65 and over 85. The Essex Joint Strategic Needs Assessment (JSNA) had reported that across Essex the population aged over 65 was expected to increase by 45% by 2021, with the numbers of people aged over 85 expected to rise by 75%. With such an increasing ageing population, the numbers of people in Essex living with dementia was set to rise by a higher rate than across England. As there had been significant reference to the JSNA in the Local

Strategy, Members requested that the three relevant scrutiny committees at ECC (Children and Young People, Community Wellbeing and Older People, and Health Overview and Scrutiny) should be provided with a copy of the latest document and given the opportunity to comment on it. A web link to the JSNA internet site would be provided to Members. It was noted that the Audit Commission had been satisfied with the JSNA process.

(c) Action Plan

A draft Essex County Council Dementia Services Action Plan (the Action Plan) had been included for information and discussion whilst acknowledging that some progress had already been achieved against some identified actions as the document was a work-in-progress. It was also stressed to Members that the Action Plan served to raise awareness of dementia issues to agencies and stakeholders. Members stressed that it was important that the final Local Strategy clearly identified gaps and actions required and that an Action Plan was finalised that ascribed target times against which performance could be monitored and evidence of improvement judged. Each PCT would have their own action plan.

(d) Personal budgets

Members discussed the use of personal budgets and ECCs Dementia Pledge. As of April 2010, 353 people who were identified as diagnosed with dementia were receiving personal budgets (a larger total of 429 people identified with dementia were receiving either a personal budget and/or assistive technology). This figure had increased to 377 by December 2010 (665 people).

(e) Consistency of service

Members highlighted the statement in the Local Strategy that services were fragmented. In particular, it stated that as people were often seen within adult mental health services, there was not necessarily access in those services to appropriate and effective ongoing support for people with the complex needs arising from early onset dementia. Members were keen to see how this fragmentation could be stopped and cited improved training and monitoring of standards as some possible changes to move towards service consistency. It was noted that there were some providers within Essex, and Southend and Thurrock unitaries who had developed expertise in specialist dementia home support rather than standard home care services. Further work was needed to ensure that there was access to such specialised support across all areas where it was needed. Members stressed that it was important to identify good practice in some areas and spread it. It was confirmed that work was being developed to identify such gaps in service and that targets would be established .

Members discussed the provision of a consistent memory service in the county and its coordination with other services. One of the areas identified in the Local Strategy was to strengthen the link between Mental Health Services

and care homes and to improve the quality of care to enable people to live well in care homes. Further information on the assessments would be provided to Members.

(f) Equality Impact Assessments

Members also stressed that Equality Impact Assessments should be undertaken on the final Local Dementia Strategy and Essex County Council Action Plan so as to include a variety of needs groups, including those with learning difficulties and younger people.

(g) Formal consultation

Members questioned the detail of the formal consultation on the Local Strategy and, in particular, the intended consultees. The consultation would start for three months after the local elections had been held in May. Members stressed that the membership of the three relevant scrtutiny committees at ECC (Children and Young People, Community Wellbeing and Older People, and Health Overview and Scrutiny) , should be included in the consultation.

Members suggested that formal consultation should not be commenced until the the conclusions of the Dementia Task and Finish Group had been received by the Strategic Commissioning team and this was **Agreed**. It was also **agreed** that details on the dementia witnesses be provided to Sheila Davis.

It was confirmed to Members that with GP consortia still being established GP involvement would remain an ongoing and developing process. There had been individual conversations with GP practices and it was acknowledged that there would need to be more contact as part of the formal consultation.

(h) Conclusion

Thereafter the Chairman thanked both Sheila Davis and Craig Derry for attending and it was **agreed** that they be invited to provide a further update to the Committee on the Local Dementia Strategy and the ECC Action Plan in six months time.

32. Occupational Therapy Service review

The Committee's final scrutiny report of Occupational Therapy Services in Essex (CWOP/17/11) was received. Karen Wright, Internal Standards and Governance Director ASC, and Ann Naylor, Cabinet Member, were in attendance to receive recommendations from the report.

(a) Introduction

The Committee had recognised that, whilst there was an internal service review running alongside the scrutiny review, it should continue to scrutinise occupational therapy services to give assurance that the service would be

easily accessible and available to those that needed it and to ensure procedures for the assessment of need. The report had concluded that Occupational Therapists were a service provider and, as such, it was difficult to place them within a commissioning organisation such as Essex County Council. This had been made even more apparent with GPs being able to commission services. The report suggested that there should be rationalisation between local authority and NHS OTs to ensure greater cohesion. Recommendations from the report would be taken to ECCs Commissioning Board for consideration in line with the service future vision. Discussion particularly centred on the following recommendations made in the draft report:

(b) Recommendation 1: the Committee recommends that the Occupational Therapists currently employed by the authority become self-employed

The Cabinet Member advised that at present this recommendation could not be accepted and acted upon. To change the current staffing model could disrupt the Target Operating Model. Whilst some private practitioners were used, primarily to clear back logs, it was felt that the majority use of in-house teams encouraged and supported a common message, vision and service delivery. Whilst acknowledging that there could be some movement towards the use of self employed occupational therapists in future it would need to be done in conjunction with the implementation of the Target Operating Model.

Members discussed the governance required if self employed OTs were considered in future to be both commissioner and provider of services.

(c) Recommendation 3: The Committee recommends that family assessments are undertaken on the whole, rather than divided between Adult and Children's Services. Joined-up working would reduce bureaucracy and delays in cases where a family assessment was required.

The Cabinet member advised that this was a strategic commissioning issue and would be considered in the future as part of the review that was looking at integrated care pathways for both health and social care.

(d) Recommendation 4: The Committee recommends that there should be liberalisation of the OT service to give people the opportunity to buy-in to the service. This would enable those who may not currently meet eligibility criteria to privately seek the service of an OT to consider what adaptations they may need in the near future. This may be utilised through the use of pre-payment cards.

Members stressed the importance of having a timely initial assessment irrespective of eligibility for a statutory assessment and whether one was going to be a self-funder thereafter. The Cabinet member acknowledged that the recommendation could be followed-up as part of future development of the service.

(e) Conclusion

It was noted that the Committee would revisit whether OT complaints and delays had been reduced and would undertake a separate scrutiny review of the Disabled Facilities Grant process, seeking evidence from selected District and Borough Councils.

On a vote of hands the draft report was approved as submitted by eight votes to nil with three abstentions. Councillors Higgins and Whitehouse abstained as they felt that insufficient evidence had been heard to conclude the scrutiny, including having service users as witnesses so as to provide more detailed good and bad user experiences.

33. The Learning Revolution (Implementation Review Date)

Consideration of a report (CWOP/18/11) on the implementation of recommendations made in the final report from the Learning Revolution Task and Finish Group was deferred until the next meeting.

34. Forward Look

The Committee received and noted the Forward Look (CWOP/19/11) for the May – September 2011 period. It was noted that an item on Essex Assist scheduled for May would be deferred as it was being considered by the Outcomes Board in June or July, and that consideration of the Learning Revolution (Implementation Review Date) would now be at the May meeting. In addition, the Chairman suggested that there should be a future scrutiny of the effectiveness of Day Centres to be scheduled into the Future Look.

35. Dates of Future Meetings

It was noted that the next meeting would be held on Thursday 19 May 2011. The future meeting dates were noted as follows (with all meetings starting at 10am in Committee Room 1):

- Thursday 9 June;
- Thursday 14 July;
- Thursday 8 September;
- Thursday 13 October;
- Thursday 10 November;
- Thursday 8 December;
- Thursday 12 January 2012;
- Thursday 9 February 2012;
- Thursday 8 March 2012;
- Thursday 12 April 2012.

There being no further business the meeting closed at 11.55am

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Chairman