worcestershire countycouncil

Health Overview and Scrutiny Committee
24 January 2013, County Hall, Worcester – 2.00pm

Minutes

Present:

Worcestershire County Council:
Mr A C Roberts (Chairman), Mr M H Broomfield, Mrs M Bunker, Mr B F Clayton, Mr A P Miller, Mr J W Parish, Mr T Spencer.

Bromsgrove District Council: Dr B T Cooper
Malvern Hills District Council: Mrs J Marriott
Redditch Borough Council: Mrs P Witherspoon
Worcester City Council: Mr R Berry
Wyre Forest District Council: Mrs F M Oborski

Officer Support:
Suzanne O'Leary – Overview and Scrutiny Manager
Sandra Connolly – Overview and Scrutiny Officer

Available papers:

A. The Agenda papers and appendices referred to therein (previously circulated);

B. Presentation on the Joint Commissioning Unit (circulated at the meeting);

C. Presentation on the Older Adult Mental Services Strategic Modernisation Programme – Berkeley Ward (circulated at the meeting);

D. The minutes of the meeting held on 6 November 2012 (previously circulated).

A copy of documents A-C will be attached to the signed Minutes.

600. (Agenda item 1) Apologies

Apologies were received from Penelope Morgan and Gerry O'Donnell.

601. (Agenda item 2) Declarations of Interest and of any Party Whip

None.

602. (Agenda item 3) Public Participation

None.

603. (Agenda item 4) Confirmation of Minutes

The Minutes of the meeting held on 6 November 2012 were confirmed as a correct record and signed by the Chairman.

604. (Agenda item 5) Joint Services Review – The Future Configuration of Acute Services in Worcestershire – Next Steps

Attending for this item were Eamonn Kelly, Senior Responsible Officer for the Joint Services Review and from Redditch and Bromsgrove Clinical Commissioning Group and Wyre Forest Clinical Commissioning Group, Simon Hairsnape, Chief Officer (Designate).

Members were advised that the Joint Services Review (JSR) had been established to identify the configuration of acute services in the County to be provided by Worcestershire Acute Hospitals NHS Trust (the Trust) with the aim of clinically and financially sustainable services for the next 5 years, ensuring the right services for the population of Worcestershire. The JSR was a clinically-led process and initially identified 13 potential service models. Before the Phase 1 pre-consultation engagement, JSR leaders gave clear advice that models A and B were not clinically sustainable and this formed the focus of much of the debate at this early stage. Clear messages emerged from this phase of engagement and whilst the discussions were still site neutral, assumptions were made by many in the Redditch community about the future of the Alexandra Hospital.

Further work was undertaken to develop the models and further conversations were had and at the end of 2012 the JSR team acknowledged that the Alexandra Hospital was the site which was likely to be most affected under the review. Messages from the JSR had been consistent, confirming over recent months that 2 A&Es in Worcestershire would not be sustainable and that the Alexandra Hospital was most likely to be affected.

The JSR team was very clear how the people of Redditch felt and all continued to work with the Trust to respond to the messages being heard, particularly working on how many services it might be possible to retain at the Alexandra Hospital. It was also clear that the majority of care needed for Worcestershire's population would need to continue to be provided in-County as its neighbouring healthcare providers would not be able to take the County's patients to any great extent.

As made clear in previous statements, there was ongoing dialogue with out-of-county providers. This work with alternative potential service providers made the review more complex, raising other issues, for example, if another provider ran one of the County's sites, what the impact might be on countywide services.

The review was not yet at the stage to undertake the Phase 2 engagement and the review team had avoided falling into the trap of identifying specific dates for meetings. The current timescale and work was that the work on modelling and clinical specification was now frozen and was subject to quality assurance and sign off before identifying potential options at the end of February to take to the Phase 2 engagement.

As there had been a reference in today's Redditch Advertiser from a local MP to discussions with University Hospital Birmingham, this now needed to be clarified. It was reiterated that the key objective of the review had been to find a sustainable solution of service configuration for Worcestershire Acute Hospitals NHS Trust. At the start of the process the focus had been a solution delivered by the Trust. Whilst this was still the model, if this was not possible, other options needed to be looked at. It was highlighted that any discussions with other acute service providers were very embryonic and there were no detailed plans. The focus of the review remained with Worcestershire Acute Hospitals NHS Trust. Whilst it was possible that this might change by the end of February, the Trust continued to work closely in the JSR and would also want the best outcome for Worcestershire's population.

If options with other providers were to develop, it needed to be acknowledged that there would be competition law constraints and the review remained under the requirements of NHS competition policy. If an option was chosen which involved an additional acute provider, this would change the nature of the JSR and would require more detailed work to be undertaken.

It was reiterated that the JSR continued to try to respond to messages being received and to deliver the review's original objectives.

During the ensuing discussion, the following main points were raised:

- as the forthcoming new health scrutiny regulations would formalise consultation with joint committees, it was questioned whether plans for consultation could already give an indication of whether a Joint HOSC would need to be formed to respond to the consultation to emerge from the JSR. Members were advised that consultation plans were not yet known. However, the review had engaged with neighbouring commissioners who could be affected by the outcomes of the review and they were keeping a watching brief at this stage. As the review progressed, disucssions with them would need to be revisited. As soon as clinically and financially sustainable options were reached, Phase 2

pre-consultation engagement would be undertaken, then there would be local elections, with consultation to follow. If options involved other providers, detailed work would be needed to work up those options. Between now and the summer, it was anticipated that the JSR governance arrangements would be reviewed to reflect ongoing changes such as the formal establishment of the CCGs who would take on leading the consultation. It was anticipated that the review would see greater involvement of other commissioners and therefore HOSCs. Members were assured that new CCGs also had a statutory duty to engage and consult. As any changes from the review would impact on the County's 3 CCGs, they would be likely to come together to consult with the populations concerned. It would be for individual HOSCs to decide whether or not to participate in the consultation;

- it was highlighted that Worcestershire's commissioners were in discussion with a number of other providers, not just University Hospital Birmingham and also with West Midlands Ambulance Service NHS Trust. Of those, all supported that there was a need for change and the status quo could not be sustained. Additionally, it was highlighted that a national review of urgent and emergency services had recently been announced. This review would not distract the JSR which could benefit from the national review;

- Members were advised that Redditch & Bromsgrove CCG would be putting out a statement about the article which had appeared in today's Redditch Advertiser. It was known that change was needed and that there would be changes in services at the Alexandra Hospital and the CCG was in the process of working through the potential range of service options. The CCG was committed to the local provision of the greatest range of services and whilst it was too early to say what these might be, service provision would be different to now;

- it was clarified that model C would see the centralisation of a properly staffed and resourced A&E in Worcester with the Alexandra Hospital becoming a 'warm site' which would not have a consultant-led A&E. Recent work had been to identify how much could be retained and how much further it was possible to go in keeping emergency care in Redditch and it was believed that 80% of that activity could be maintained on the site in addition to 65% of urgent care. Similar issues were being faced nationally and it was highlighted that models were needed which would select the right patients to go to the right hospital. The key issue related to medical emergency care and whether

patients, other than trauma or heart attack patients, could be maintained or treated and it was being explored how far it would be possible to go and maintain services. Service changes would also mean workforce challenges. It was reiterated that Worcestershire Acute Hospitals NHS Trust was fully committed to the review too and commissioners continued to work principally with the Trust but if other providers were able to help more and to the benefit of the Trust, this would be explored. Under this model in-patient obstetrics and paediatrics would also be centralised but commissioners wanted services in the north of the County too so that not all patients needed to travel to Worcester. Options were being explored and commissioners were talking to other providers too. Under model C, Worcestershire Royal Hospital would be one of the best hospitals nationally and would provide a standard not achieved in the County before;

- the aim was to complete the work on developing the models and their clinical and financial sustainability by the end of February, then fit in the Phase 2 engagement before the start of the purdah period before the County Council elections. If appropriate, detailed work would then be needed with other providers, with options available for consultation in the summer;

- it was highlighted that the news article in today's Worcester News was based on the minutes of a meeting of the Clinical Senate, an executive committee of the PCT. The clinicians were entitled to their views but Members were assured that this did not represent a decision, but a view and it would have been wrong of the PCT to have censored the views. It was considered disappointing that parties had heard a lot in recent months and been advised it was not for public discussion, then when some of those things appeared in the press, it antagonised and upset people and morale amongst staff was now lower than it had been before Christmas. Members were assured that the review was doing all it could to respond to people and the population of Redditch in particular. Eamonn Kelly advised that he would be the first to admit that there could be lessons learned about transparency and apologised if they had not got this right, recognising that services belonged to Worcestershire's population and their involvement was important. Whilst information had been shared in confidence, it was acknowledged that it might be appropriate to reflect on whether there had been too much caution. It was reiterated that the advice of the Clinical Senate was not binding and that the review was committed to ensuring the brightest possible future for the Alexandra Hospital. Members were advised that the minutes of the Clinical Senate

had featured the JSR as a major agenda item for a number of months, had considered that models A and B were not viable and that Redditch would be the most affected so the news coverage did not say anything new and current conversations were about what could be the biggest possible range of service provision;

- it was noted that early discussions in the JSR had covered the savings needed and the importance of services running differently with increased community services and it was questioned whether there was any evidence yet of a reduced pressure on acute and A&E services. Members were reminded of the previous presentation they had received regarding the Integrated Care Project and it was highlighted that whatever option was ultimately chosen would be dependent on a reduced reliance on acute beds therefore community services would be crucial and work had started on initiatives such as assistive technology, virtual wards and improved end of life options. A&E attendances had gone down in the last month or so which could be put down to the community-based initiatives and it was known that the downward trend needed to be maintained to achieve the necessary reductions. It was also recognised that it was better for patients to be in the community rather than an acute hospital;

- concerns were expressed about the feasibility of conducting the Phase 2 public engagement before purdah yet after the end of February. Members were advised that provisional bookings were being made for events and the review team wanted to do the engagement at this time as people wanted to hear about options, but advice would be taken. Concern was also expressed that pre-election public engagement could see the JSR becoming part of the political football of the election and it was suggested that it should be kept out of the political arena until after the local elections. It was noted that this was one HOSC Member's view and others might have different views. The JSR team would reflect on the timing issues highlighted; and

- concern was expressed about the impact of the JSR delays on the Acute Trust's bid for foundation trust (FT) status, questioning whether the Trust could run out of time with its application and fold. Members were assured that there was full support from the Strategic Health Authority and Trust Development Authority for the review process and timescales and were aware of the implications for the FT application. It was suggested that nationally there were many others in a similar position and it was indicated that the 2014

deadline was likely to be extended. It was key that the Trust achieved FT status and financial sustainability.

The Chairman thanked attendees for their attendance.

605. (Agenda item 6) The Role of Worcestershire Joint Commissioning Unit, its Development and Work Plan and its Relationship with the Health Overview and Scrutiny Committee

Attending for this item were Richard Harling, Joint Director of Public Health, Richard Keble, Head of Joint Commissioning Unit and from Redditch and Bromsgrove Clinical Commissioning Group and Wyre Forest Clinical Commissioning Group, Simon Hairsnape, Chief Officer (Designate).

Members received a presentation on the background to the Joint Commissioning Unit (JCU), services it commissioned, governance, the new Unit and future commissioning intentions.

A Joint Commissioning Unit covering adults' social care and NHS services started in Worcestershire in 2007, building on existing joint commissioning and partnership working and in 2010 joint commissioning was extended to children's services. The 2 separate units were integrated in 2012 and were currently undergoing reorganisation and restructuring. External factors were also key with the Health and Social Care Act 2012 giving a high priority to integration of services and personalisation and there were opportunities in joint commissioning to drive this agenda much harder. The agenda for the JCU was set through the Health and Well-being Board. The Integrated Care Programme was also key for the JCU with its outcomes producing savings and efficiencies. Clinical Commissioning Groups were also critical for the JCU and they had made an ongoing commitment to joint commissioning.

Services commissioned by the JCU were outlined and covered a wide breadth and required significant interface with CCGs and with service providers. The Unit's work ranged from commissioning preventative services, for example, sexual health, to specialised services like substance misuse services and the Unit's work covered all age ranges from pre-birth through to death. Acute services were not commissioned by the Unit. The JCU held a significant number of contracts, particularly with Worcestershire Health and Care NHS Trust and also with independent providers and the County Council.

The JCU accounted to the Joint Commissioning Executive (JCE), a very senior group covering public health, CCGs, Children's Services and Adult Social Care Services, which considered the JCU's recommendations and took decisions based on them. The JCU worked under a Section 75 agreement. The JCE was accountable to the County Council's Cabinet and Council and to the commissioners' Boards. A report would be presented to the March 2013

Cabinet regarding an updated Section 75 agreement. Reports were also provided to the Health and Well-being Board who also ensured delivery. The Children's Trust Board was also referenced in the governance structures due to the JCU's role in commissioning children's services.

Under the Council's future organisational structure, the Head of Joint Commissioning would report to the Director of Adult Services and Health with dotted line accountability to the Director of Children's Services and the accountable officers of the 3 CCGs.

From July 2012 adult and children's commissioning had come together under a single management structure. From 1 April 2013 this would be within the new Directorate of Adult Services and Health and its vision, values, functions and structures were currently under development. The aim of the unit was to improve quality and value for money, driving out savings and efficiencies and improving outcomes and quality. The JCU's budget for 2013/14 would be about £200 million including services and staffing costs. A key expectation of the Unit was relationship management with the Council, NHS providers and CCGs.

Reporting to the Head of the JCU were 3 lead commissioners for children and families, older people and vulnerable adults and mental health and learning disabilities as well as a Contracts and Quality Assurance Manager and Brokerage Manager.

Commissioning intentions were outlined and these demonstrated that the JCU could not work in isolation and was about partnerships and relationships with providers, particularly the Health and Care Trust and the County Council.

During the ensuing discussion, the following main points were raised:

- it was questioned what was left for the CCGs to commission given the range of services commissioned by the JCU. Members were advised that CCGs commissioned all hospital services. Joint commissioning principally covered services where there was a joint health and social care interest and it was highlighted that Worcestershire did more joint commissioning than other similar counties;

- it was noted that the JCU was the main commissioner of services from the Health and Care Trust, commissioning about 60% of its services whilst CCGs commissioned about 40% of services, including community services and community hospitals, with

Redditch & Bromsgrove taking the lead on this on behalf of the County's CCGs;

- Members were advised that most places nationally had started joint commissioning with learning disabilities and then mental health but that Worcestershire had gone further than this and might even want to take joint commissioning further forward;

- it was questioned how clinicians were involved in joint commissioning. Members were assured that the statutory partners, including the CCGs, retained responsibility for the commissioning undertaken by the JCU. The JCU was more than a 'commissioning support unit' and the CCGs received the CSU support from Arden CSU. The JCU would look at population needs, design services, procure services and monitor their provision. It was noted that the JCU was currently in a state of development and it was hoped that it would continue to be successful and to extend the range of services commissioned;

- in response to a question about the impact of 1 CCG potentially deciding to contribute less to the JCU than others and the impact of this, Members were advised that in the past there had been 2 key players, the County Council and the PCT who needed to agree the funding for the Section 75 agreement each year. With the establishment of the 3 CCGs in place of the single PCT, this did make things more complex, although all CCGs had signed up to joint commissioning and there would be some solutions found about the right levels of investment required. Many of the services commissioned by the JCU were countywide services and the CCGs would individually commission the more locally discrete services. Selective commissioning by the JCU for individual CCGs could evolve but working with 3 NHS commissioners was uncharted territory at this stage. It was highlighted that joint commissioning was a voluntary arrangement which the County Council and PCT had been very committed to and there was no evidence of any less commitment from the CCGs. All would work to make it work. The JCE comprised very senior management and there would be early warnings through this body if there were any problems. It was also highlighted that where local differences might be seen would be in service delivery, with the overall commissioned service the same, but with differences in local delivery and pathways for example;

- it was questioned what role the CCGs would have in monitoring services commissioned through the JCU, for example if they were under-performing. Members were assured that CCGs would also monitor performance as

they remained accountable for service provision. With the CCG Chief Executives jointly chairing the JCE they ensured clinical input and safety and quality control. CCGs recognised that some services were high risk and needed to be kept as a particular focus and it was important for the CCGs to keep a tight grip on service performance and was the reason CCGs were embedded in the joint commissioning system to ensure they retained a very clear oversight;

- it was highlighted that real integration of services would see health and social care workers based in the same offices able to use the same computer systems to best work together. It was acknowledged that joint commissioning made commissioning simpler but the real purpose of joint commissioning was to commission integrated services better and success would not be about joint commissioning but about whether integrated services were commissioned. This was a work in progress. It was noted that in Wiltshire, domiciliary care providers also had access to local shared IT systems and Members were advised that there were similar aspirations in Worcestershire although it was a complex area and there were data sharing issues but it was a focus for the future;

- it was questioned what extra resources would be available to the JCU to monitor quality. Members were advised that initially there had been 3 contract monitoring officers but under the new structure this would increase to 8 from 1 April and this was welcomed. It was also highlighted that all parties should take a more active role to ensure quality services;

- Members were advised that the new governance and accountability structures with matters being reported early and formally to CCGs had been developed in order to address any concerns about any of the mechanisms of joint commissioning. The new structures would see more generic roles, ensuring staff were appropriately skilled and better able to move between priorities, making staff more flexible and responsive to the nuances of what CCGs needed. The Head of Joint Commissioning advised that he was happy with the mechanics established to support joint commissioning;

- in response to a question about how much of public health services were commissioned jointly, Members were advised that school nursing and sexual health services were commissioned by the JCU;

- the Chairman advised that HOSC Members needed to think about the future and how it would scrutinise the work of the JCU, using for example plenary cross-committee sessions. Consideration would also need to be given to whether scrutiny should be involved pre or post Cabinet when there were significant changes or developments being proposed and it was suggested that this should be considered further after the elections in May; and

- it was questioned how, if the JCE agreed to a significant service change, that decision would be known by the HOSC. Members were advised that such decisions would be reserved to the CCGs and Cabinet as appropriate and the JCE could not take a decision to close a service for example. There would remain an expectation of an early conversation with the HOSC to inform its work programme. Members were advised that the future of the Berkeley Ward, the next item on the agenda, had been to the JCE as well as the PCT and CCGs. It was suggested that the HOSC might want to consider looking at joint commissioning by service portfolio or alternatively consider the effectiveness of the joint commissioning process itself.

The Chairman thanked the guests for their attendance.

606. (Agenda item 7) Older Adult Mental Health Services Strategic Modernisation Programme – Berkeley Ward Proposal

Attending for this item from Worcestershire Health and Care Trust were Jan Ditheridge, Director of Service Delivery, Sue Harris, Director of Business Development, Matt Stringer, Head of Community Care Service Delivery Unit and George Theodoulou, Older Adult Psychiatrist, Clinical Lead for South Worcestershire and from the Joint Commissioning Unit, Richard Keble, Head of Joint Commissioning Unit.

The Chairman advised that when an issue felt as if it could be considered by the public to be substantial it should be brought to the HOSC. This would apply to a proposed ward closure and was the reason this item was on the agenda.

Members were reminded of Worcestershire Health and Care NHS Trust's vision for older adult mental health services including dementia and how the Trust had proposed to achieve it. The Trust aimed to enhance community services, improve support to carers and ensure all admissions were meaningful. Specific programmes implemented to achieve these aims included early intervention, Admiral nursing, in-reach to care homes, personal budgets and support in community hospitals. Under the Transforming Community Services agenda, there had been further opportunities and massive engagement between mental health and physical health

services to provide wrap-around services for patients in their own homes, residential or nursing homes. Optimising the benefits of the new organisation which was formed saw, for example, older adult mental health nurses embedded in intermediate care teams, dementia care nurses in community hospital settings and more in-reach into care homes.

When the Trust attended the HOSC in September 2012, Members were advised that as a result of the above changes, there were now improved choices for older people with mental health problems and an improved patient and carer experience. There was now early intervention to help people plan care and there was greater choice of care options. The care pathway had now changed with patients with dementia no longer being admitted to an acute or specialist bed and then automatically transferring into residential care. Services now reduced the possibility of a crisis arising with care needs being managed instead. Such changes had resulted in the Berkeley Ward, which provided South Worcestershire's specialist dementia beds, being empty. Whilst the Trust had anticipated that this would happen, it happened sooner than expected with only 2 or 3 patients in the 18 bedded ward, resulting in its temporary closure at that stage. Commissioners had asked the Trust to monitor the situation to determine whether the reduced demand was real or an aberration, whether there was an impact of the closure elsewhere in the system, to seek views of the public and to ask patients and carers about their experiences. The Trust also talked regularly to staff.

The Berkeley Ward remained closed and there had been very small numbers in South Worcestershire needing admission and those requiring admission had been accommodated in the Clent Ward in Bromsgrove. The Trust had received very positive feedback, with clinicians having asked patients and carers about what it was like for them to not have a service available in South Worcestershire. Interestingly, no-one had mentioned transport being an issue and it seemed that they were more interested in the service provision than access issues, aware that patients would return to a community setting with significant support as soon as this was possible.

The Trust had sought the views of the public, using an on-line survey which received 12 responses and presentation and discussions with Worcester City and South Worcestershire Locality Fora as well as with the patients who were admitted to hospital and their carers. All staff from the Berkeley Ward had been redeployed, with the Trust using the opportunity to place them in various roles around the County, in community hospitals, in Clent Ward

and in the Acute Trust and the liaison team.

Berkeley Ward needed 12 patients in order to provide an appropriate environment for patients and to be cost effective but this number would not have been achieved given the low numbers of patients in South Worcestershire who had required an admission in recent months. Activity and demand did not point to re-opening the Berkeley Ward.

The temporary closure had had no adverse impacts elsewhere in the system, Clent Ward had not been full and there were no waits or pressures in the system with all admissions having been to age and illness appropriate beds. Very constructive comments had been received from patients, carers and the public and staff supported the changes and no redundancies were planned through this process. The Brookhaven development in Bromsgrove remained on target to open in July 2013 for dementia and functional illness care for those aged over 65 years. The liaison service would continue to be enhanced and would make a significant difference, reducing patients' length of stay and improving discharge to where patients wanted to be.

The Trust would continue to develop services for older people with mental health problems, developing community services further and now wanted to close the Berkeley Ward. The Trust also wanted to develop similar pathway models for all older people.

During the ensuing discussion, the following main points were raised:

- in response to a question about what measures the Trust had put in place for patients and carers adversely affected by the centralisation of the service, particularly those from Pershore, Evesham and West Malvern for example, Members were advised that there had been admissions from this area, with 7 from Malvern. However, none had raised access or transport as an issue;

- it was questioned whether Brookhaven was being developed to the right size given the decrease in demand. Members were advised that Brookhaven would be a 30-bed unit and was the first mental health development in Worcestershire for a long time. The unit included a movable wall which would enable the Trust to change the balance as needed between beds for patients with dementia for those with psychoses. The Trust was confident that there would be sufficient beds for the County's population even with the anticipated demographic changes, given the earlier intervention, improved community services and

avoidance of crisis situations. Members were assured that there would not be large numbers of patients needing admission and it was the community end of services rather than the specialist end which needed growth and it was also highlighted that in-patient length of stay was also increasingly becoming shorter;

- it was highlighted that a lot of older people were not on-line yet would have been interested to have responded to the consultation on the future of the Berkeley Ward and the Trust should have also contacted the Older People's Fora in the County. Members were advised that the Trust had also consulted its locality fora;

- Members were assured that current and future service provision complied with single sex standards;

- in response to a question about whether the proposed model would be sustainable, Members were assured that the Trust was not concerned about there being any upward blips in demand, but if the Trust had got things completely wrong, it could respond as an organisation. Members were advised that it was only a small number of patients who needed inpatient care and the Trust was confident it had the right numbers and it was now community services which needed to be addressed. Inpatient care was very specialised and was needed only for a small but complex population and this population was becoming increasingly small as community support developed. A key need was continuity of support for patients and their carers. It was believed that the County was probably approximately in the middle of the predicted demographic changes;

- it was queried whether the reduced demand had been achieved by changing the admission criteria. Members were advised that the decrease in admissions was due to the changes in the provision of community based care;

- Members were advised that the Trust's strategy was well-exercised with commissioners;

- in response to a question about what triggered the Trust providing training in nursing homes, Members were advised that this was normally as a result of a referral, for example if a GP or a family raised any concerns. An older adult consultant would be involved as well as nurses to undertake an assessment and work with the home on why certain behaviours were being exhibited, for example, being linked to the physical environment, and to work with homes on person-centred care;

- it was queried whether GPs received advice from the Trust's specialists about medication prescriptions and conflicts between medications. Members were advised that previously, strong tranquilising medication had been prescribed indiscriminately but the main message to GPs was now about doing more before prescribing anti-psychotic drugs when there was concerning behaviour and the message had got over as GPs were now referring more to the in-reach team;

- financial issues were questioned in relation to the sustainability of community services and the overspend on domiciliary care and the impact on the Trust. Members were advised that this was being watched closely by the Trust as it would impact somehow, although possibly not negatively. A key concern was that service reductions might impact on the preventative agenda;

- it was highlighted that the specialist service providers needed to take more of a leadership role and spread best practice. There was now countywide dementia training which it was hoped would help reduce any 'clunks' between services. The wider market was already being asked to take on the care of more people with dementia and it was anticipated that dementia care would become everybody's business and the challenge for the Trust was give to support and ensure a resilient system of care. It was highlighted that Manchester had established a dementia-friendly community, looking at what could be done to help people continue to have an independent life;

- it was acknowledged that there would be less money in the system for the next 5 years and there would therefore need to be more integration and with voluntary services too; and

- in response to a question about the services provided at the Robertson Centre, Kidderminster, Members were advised that the Witley Ward for older adults would close when Brookhaven opened but had provided a lot of the learning used in developing Brookhaven. The Harvington Ward was for adults and would remain open. There was also a number of community teams based at the Robertson Centre.

The Chairman advised that the HOSC had heard evidence of clinical and financial sustainability and evidence of adequate consultation being undertaken with the caveat about the concern about the narrowness of the Trust's on-line survey.

The Chairman thanked the guests for their attendance.

607. (Agenda item 8) Health Overview and Scrutiny Committee Round-up

As the next meeting of the HOSC was only a few weeks away it was agreed to defer this agenda item.

The meeting ended at 4.26pm.

Chairman .....