

Assembly Meeting 11
Senior Council for Devon
Assembly Meeting held at the Isca Centre, Summer Lane, Exeter
on Tuesday 21st June 2011 at 10.30 a.m.

1. Attendees and Apologies: Please see Appendix I.
2. Gillie Newcombe (GN), Chairman of the Meeting – Welcome Speech: Please see Appendix II.
3. Dr. David Jenner (DJ) from the College Surgery Partnership - What is happening with the GP consortia in Devon and what are the pros and cons?

DJ introduced himself as a local GP who was schooled in Devon and works in the Cullompton surgery three days a week. For the last fifteen years he has been involved, in various incarnations of the health authorities, in helping plan their work. He explained that the GP consortia is not a new idea and is something that they have been trying to do for a long time, to bring in GPs as they tend to stay around longer than some of the other health organisations. DJ said that this is our current challenge and it looks like being amended again by the government. It will bring GPs into real accountability to manage the NHS budget, work with other organisations and to try and make the most of the NHS finances. The ageing population does put a strain on their budget and he would explain what is happening in Devon with the GP consortia but would not go into major detail of the Health Bill. He said he would be happy to answer any questions at the end of his presentation.

Please ask Sally or Andrea if you would like a copy of the slides that accompanied DJ's presentation.

His parting words were "Local Health and Wellbeing Board are very powerful and it would be the Senior Council's chance to get heard via the local authorities".

Q and A Session:

EP: Community Hospitals – Do the GPs have any influence over the decision that is to be made regarding these hospitals?

DJ: There is a simple answer – GPs will be involved and so will you. The future of community hospitals could not be decided without consultations especially if the assets would leave the NHS. We have contracts to work in community hospitals too and we are very powerful advocates of those services. We do know how much they are valued by you all and that is absolutely clear.

JB: The seemingly lack of involvement by the public is what concerns me. We have the Health and Wellbeing Board to make representations to, then there is another layer to be involved - commissioning groups – and all of this from voluntary organisations that may not have time to provide the evidence. How are the few going to be heard and how are the lay people on the commissioning group going to be appointed?

DJ: There are three points to this answer:

- i) The actual involvement with you as users with the clinicians in front of you.
- ii) Each practice will have some patient participation group who will fundraise, feedback and interpret results. They will also have representatives on forums.
- iii) When the strategy is formed, there will be a duty to consult widely with the public. There will be opportunities for oversight and scrutiny and a local health watch will subsume links and will give the public a chance to challenge. There will also be other opportunities as most providers and foundations trusts will be meeting in public, and providers of carers will have to report on patient satisfaction. I think it has to be at every level and the government is trying to capture this. Regarding the appointment of lay members – this has not yet been defined but we are expecting guidance in the next month or two.

BJ: An observation. The SCfD was instrumental in suggesting to DCC that their 2 overview and scrutiny committees should merge. What I would suggest that we go back 30 or 40 years to when we have family practitioner committees, community health care workers, liaison between councils and the health service and that worked perfectly well instead of starting from fresh and reinventing the wheel, we cull the books and look to see how we did it successfully 30 years ago – maybe I am prejudiced because I was involved at the time.

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DJ: I do share this with you - the health and community council as they did work and is something lost. We will very much listen to the community groups and we will have to have forums for engagement – some things will be dictated to on high but we will have to work within limitations and when looking at local Healthwatch and groups/forums I will remember the community health councils.

PD: Devon is one of the largest rural counties and much of government seems to run on an urban background. More than half of the population live in rural areas outside of Exeter and the main coastal and market towns. The great problem is the quality of care as there is the difficulty of getting around from place to place and if you are going to have care in the community you have to have it at great expense. Journeys take longer, therefore in order to provide the equality of service you have to put into the budget the time factor to get from one patient to another.

DJ: How money will come down to us has yet to be announced. What we know in mid Devon is that we do recognise the particular issues of rural deprivation and that is why we have many small surgeries. It will become more complex if we have to spend more money on this – rural populations are healthier than the urban ones. That challenge is definitely with us and we will do what we can do to respond.

CH: What you have explained makes sense if this is driven by wanting to save money. Will what you have described provide those savings and if not, there will have to be cut backs to save these millions – you have not mentioned that at all.

DJ: That is a good challenge. Politicians are not cutting back the budget but they are not giving us as much before. We have 2.5% extra money. Those referral pathways mentioned previously - the number of outpatient referrals is down by 5% on last year – that is effectively saving money. A GP gets £100 a year for looking after a person and if that person is older they generally visit their GP more times, the cheapest visit to a specialist is dermatology at £121. We don't deprive people of care but I think there is waste in the system, prescribing generic drugs etc. Admission to hospital costs £3 – 5,000 so it is best to see the patients in the GP surgery first. We are going to have to work harder and better at doing that and we have to reduce relying on inpatient hospital services if we are going to afford that.

BB: Thank you – I now understand it. You talk about outpatients and care at home. How will you reduce the size of the RDE without objection by the public?

DJ: We could make it smaller but we could change a ward from an inpatient facility to a day treatment unit and provide community services within that. There will be some tough decisions to make and that is why I really mean that as we are an aging population and we have an economy that is in trouble we have to jointly make these decisions. Personal health budgets, these are your choices, and if we involve you in the decisions you will probably come to the same conclusions.

DD: Do you agree that the NHS is also making unprecedented savings and this is forcing it into the biggest change in years.

DJ: My personal opinion is I wouldn't start from here but the current Health Bill is. There is a need to respond to our financial situation and the ageing population. They are keen to take out layers of democracy but managers are professionals themselves and they are not all bureaucrats. What they are trying to do is to streamline services etc. on your behalf of the NHS budget. GPs control 80% of the budget and to make them more accountable is good. I wouldn't start from here but we are where we are and we have to make the best of it. Did we need to make the change in the first place – I am not sure but we are where we are.

PR: There are more older people in Devon so have we got more facilities for them? Secondly you said about not crossing county boundaries, well I did and still have an association with Hemyock practice and I go to Musgrove.

DJ: Hemyock first. Belonging to a consortium will mean you will be with the practice and there will be a bit of fudging around the edges – there always has been. Cross border arrangements have gone on for years and will still be allowed but what not be allowed is Tiverton to become part of Somerset NHS.

GN thanked DJ for his excellent presentation and thought it was extremely stimulating. She then welcomed Rebecca Harriott.

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4. Rebecca Harriott (RH) NHS Devon's Deputy Chief Executive - What are the changes in the Health sector and what impact will they have especially keeping people at home longer and discharging them earlier from hospital? SCfD is concerned about the possible pressures on relatives and care services brought about by these changes.

RH said she was really pleased to have the opportunity to come and talk to us regarding some of the changes in the NHS. She wanted to talk to us about what the NHS and Social services meant by personalised care, and needs and preference of individual circumstances. The two organizations had been working hard over the last twelve months and were still planning to. Their intention is to make improvements - they need to provide more services outside of hospital to cope with demands of an ageing population. She said that the simple truth is in providing more personalised care outside of a hospital setting provides not only a much better personal experience for that patient but is also a more cost effective way. RH hoped to demonstrate this to the meeting. She spent some time describing the plans for patients, customers, service users etc. and explained that it was quite a complicated relationship with the NHS as the NHS needs to be more responsive to peoples' preferences, family circumstances etc. RH said that they can improve experiences for individuals by using a 'pick and mix' range of care so they can tailor to individual's needs.

Please ask Sally or Andrea if you would like a copy of the slides that accompanied RH's presentation.

Q and A Session:

GN: Thank you very much Rebecca. We have some conflicting evidence coming across this morning – evidence regarding care in the community and I have questions around that myself – domiciliary care, carers, etc.

RH: We are talking about discharging from hospital and for whom that is the best set of circumstances as not one size fits all. The evidence is that there are lots of people who stay longer in hospital but it is not right for them. The idea is about tailoring and making more choice for people and provide care that is more appropriate; it is not straight forward and easy to implement but it is the right thing to do.

AH: I know someone who is having to pay £15 an hour to make sure he gets his medication.

RH: He needs an assessment from someone who has access to all of the resources available so he must go to the doctor.

AH: TRIP in Honiton is good at assisting but it costs him £3 or £4 to go there or £22 to get into the hospital. We tried to get the bus services to divert but they said more people would be using their passes and would cost more to the bus company.

DJ: I don't understand the benefit system completely but if someone needs supervision you alert social services as that person may be eligible for a certain benefit because that person is vulnerable. There is a falls team, they may renew medication etc. and put him on the computer system so he is monitored. What you have described you can't do in 10 minutes but needs the involvement of lots of people and he, like others, may need specific help.

JCJ: Regarding help and information that is available to disabled people for equipment and for those who suffer from incontinence.

GN: This is something the SCfD could look at eg educational videos for application of pads, and I would like to take up some of your ideas.

JM: With all of these changes, are the out of hours doctors going to stay the same? Most complaints I hear are people trying to get out of hours doctors getting someone to visit you, the GPs used to be fine.

DJ: Community hospitals and out of hours doctors issues bubble up quickly. I very much hear your concerns and note them. When there was an annual audit of out of hours services, Devon came top of the list as 60% of the Devon doctors' shifts are done by local GPs. There were problems when GPs did it ourselves with the pressure being up all night but now you get a doctor fresh with a car and driver. When commissioning in future, we will commission more out-of- hours medical cover for people that are housebound. If people need a series of visits (a district nurse visits cost £50 each) we may need to make shifts in funding in the community to make the services available. I don't always think it needs to be a doctor as it could be properly trained paramedic, district nurse or MacMillan nurse are all good.

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BC: Funding question. Strategically, have you noticed any problems with this underspend – are we really saying 2.5% increase is the most you have?

RH: Over the last 2 to 3 years we have suggested that good practice is to save up some money from one year to reinvest for the next year so you have a financial buffer. The money always comes back to the local area to which it comes from in the first place. This year we made a surplus in keeping with the strategic health authority's requirements. This year's growth is probably better so this is the year to make that money count and spend it wisely. Things are very tight financially and we can't all say we are going to carry on in the same way as we know there are ways of spending money cost effectively. We are spending a lot of money on our out of hospital services as we can save money from acute hospital expenditure.

KS: Referring back to the video about Eric and his physiotherapy. How much time would be spent with him at home as he is obviously struggling with walking and cooking, and what other help are you giving him when you send him home?

RH: It is different for every individual and it is personalised. One person may need 6 or 7 different people visiting them at home to make sure everything is in place but some people only may need one visit. What you need to be confident about is if there couldn't be a safe package in place then that person would stay in hospital. What we have done is added another option and given the person a choice.

KS: You may set up this package but what if someone rings in sick and can't provide a meal for example?

RH: this scheme we are setting up is not reliant on just one person – it is a whole rota of care and there is a backup system that an equally qualified person is available. It is hard not to be sceptical about this but these are clinical professionals – they are not going to send people home unless they think it safe.

JC: People told me they have become carers because their partners have had stroke but have not received information about how the illness and how to care before the patient leaves hospital. Could information be handed out in some sort of leaflet form prior to discharge?

RH – The national stroke strategy will be producing resource packs to support professionals and patients.

JB: Whilst I accept all you say is totally evidence based but the one reason patients wish to go home is because the hospital environment is so unfriendly. They have to pay for TV etc. and are sometimes treated badly. The RDE holds listening events but we are told “that this is not part of the agenda and we are not going to listen to it”. If you are going to gain evidence ensure you get it.

RH: We have forgotten that there is an individual there with own needs and we know there is more work to do there - transparency and more choice, and be responsive to people that use their services.

5. Ian Hobbs (IH) Interim Assistant Director of Strategic Planning and Commissioning DCC - What is DCC's response to the NHS changes and how it will reflect on them? Where does preventative care and rehabilitation stand in this structure?

Paul Collinge (PC) Joint Strategic Commissioning Manager – Older People also attended with IH. IH set the context by saying that this is a time of great change – both specifically in relation to health and social care and more generally in the restructuring of the County Council. IH showed slides highlighting demographic trends, the ageing population and the growing numbers of carers. He explained that the financial context in which everyone has to operate is very difficult and presented a graph that demonstrated the growing gap between available resources and demand that showed that continuing as we have been is unsustainable. Part of the debate that he thought the Senior Council well placed to contribute to was that of the changing balance between the role of the state and that of individuals and communities.

He also presented some of the latest information about reablement. This is a new service that is focusing on helping people to get early support to regain or retain their independence and to divert them from hospital or care homes and from long term dependence on social care services. Early results are very promising and offer an important contribution to the range of social care needs referred to by other speakers.

Ian also referred to the discussions taking place with the NHS in relation to the money central government has determined should be made available for social care outcomes through the NHS. This amounts to a substantial amount of money and agreement will shortly be reached between the NHS and DCC about how that should be spent.

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IH went on to say that it remains a challenge for social care to invest in preventive services whilst also meeting the needs of people in greatest need but he was pleased to say that investment in areas such as support to carers had been protected and a greater investment is being made in a range of community supports in the coming year.

In response to a question IH said that if information is not getting out to people, despite all the efforts that are made to get this right, then he would take that criticism on the chin and the Council would need to see how it could improve further. He also responded to another issue raised regarding assistance and said that Care Direct have a comprehensive advice service and if the public cannot reach them and vice versa, then they must try and see how they can improve that two-way communication. He also acknowledged that further work was required to continue to improve hospital discharge arrangements and that all parties wish to avoid situations where people have to wait to get back to the community.

Q and A Session with all speakers:

MT: I helped set up the Primary Care Group in West Devon and the presentations that we have had this morning read very much like the Green Paper we worked on, and the role of the voluntary sector was far greater than I ever thought possible. What, in this whole picture, is the place for the voluntary sector?

IH: I think it is huge in several ways. DCC investment and the quality of involvement we have with service users and organisations like SCfD is important and we draw huge amounts of information from them for the way we set our contracting etc. The voluntary sector gives a huge input especially on a practical level eg dementia. One of the most successful area is the memory cafes and if you look what DCC put in it is very small as the time is put in by voluntary organisations and that is a huge amount of work. The third point is the Localism Bill which is all about The Big Society and how do you encourage groups and local organisations to take a role, but if we can put our resource there as well then we can achieve more.

RT: What do you most fear from the changes?

DJ: To be given accountability without authority. If we are going to have that true localism we need to have that local authority.

EP: Could you speak re the issue that if you are using the local voluntary sector how can you provide quality?

IH: That is a good question. It first depends on what the relation is between the voluntary sector and us and as we are buying a service we would expect quality and the contract monitoring to be good – that is if it is a contract. The other side is equity across the county and I am not sure that is what we are trying to achieve any more. As there is are different levels of needs then it may be we need to tolerate different levels around the county, and if we are empowering local communities to take responsibility and then make it difficult, there needs to be a floor to which quality can't go below but flexibility above that, so there will be more variation in future.

EP: What if the voluntary sector is not there?

IH: Our job is to look at local need and the availability. If it is not there and the need is not being met, our job has to be about stimulating the provision. Our job as a council has to be to look at the whole picture and stimulate when things are not there.

LH: what are the roles of all the parish and town councils?

IH: I think the Localism agenda - services to communities – look around Devon with roughly 28 market towns with their parish hinterland. There are parish and town plans that have been put together and are a really important part as we can see what they are telling us they need. There will be more activity at local level and delegate services. Some of them are saying we could mobilise with voluntary organizations, but if we could work with you we could bring a lot to the party – experience - not necessarily money. This is a big role for parish and town councils.

GN thanked everyone for their really good questions, and thanked DJ, RH and IH and apologised to IH for not giving him a great deal of time for this presentation.

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Afternoon Session

GN offered congratulations on behalf of the SCfD to PD, an Exeter member who had received an MBE in recognition of his work with the rural communities.

6. Minutes of the last meeting on 11th March 2011 and matters arising

There were no amendments to the Minutes so GN proposed and RA seconded that they be accepted as a true and accurate record. There were no matters arising.

7. Progress with the Consortium – Margaret Coles (MC) Director

MC explained to the meeting about the Devon Countywide Engagement Service and the involvement of the SCfD within the Consortium. This was accompanied by a PowerPoint presentation (See Appendix VI) that had been given to DCC as part of the bidding process.

Q and A Session:

JC: Do we know if there were any opposition bidders? Why have DCC not told us quite clearly what they mean by Health and Social Care?

MC: They offered it to us – the consortium. SCfD were the preferred partners for older people and if we turned it down at the last minute they would have still put in a bid and then looked for another organisation to work on the older people part.

JC: Was it all one tender?

MC: No.

RT: I think the whole thing has been disastrous. I am not blaming anyone but for example, the Ageing Well document (RT read out a few lines). DCC are funding us for Health and Care and in this document they are asking us to do work which is outside Health and Care. It is important that branches know how this will affect them at branch level.

MC: We have set up a funding group. I brought up Ageing Well as it hasn't come under this remit. How do you specify which bits? That is what is going to be sorted out. £80,000 is the amount that DCC has given this organisation this year. Next year it is up to the consortium to sort out and I see no reason why they should change the way things are set up.

RT: Has anything been creamed off the £80,000?

MC: No.

RT: How much can be passed on to local branches and how much can local branches use of that money that is not health and social care work?

GN: £550,000 was given to the consortium then a division of amounts to each organisation which was decided by DCC and that has been top sliced for money to run the consortium. Next year the funding will be agreed between the consortium board and which we are part of, but as far as how much is agreed to give to each branch, the consortium will have nothing to do it as it will be a Board decision on consultation with branches and to see what particular projects they have got. It will be rather than giving out a set amount to each group, the Board will be looking in more detail which project each group has as some groups work hard and some groups do nothing. We are going to have to know more details and how the money will be allocated. We need to go back to DCC and Social Services to ask for extra monies for specific issues re health and social care. This consortium is just about joint engagement. In the meantime the funding group will be looking at other avenues for raising money – KC will be speaking to you on that one.

SL: Ageing Well doesn't come into our existing contract nor does taking on Senior Voice. This was dropped in our lap and we were told in 2010 if we take on SV we would be in much better position for funding in the future. Next time, we will go back and tell DCC if you want us to go on doing these things, you have to pay us for it.

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KC: The Ageing Well policy was always above what our existing brief was – technically we should be billing DCC for all of the work we do on Ageing Well and it was minuted in one of the Older Persons Strategy Group meetings and this is over and above what we are supposed to be doing over the last 3 years.

MC: Fusion did say they do not take on project until they have the funding to do it – we must learn from that.

TL: I am a new board member. Branch funding did come up with Diana Crump (Chief Executive of Living Options/Fusion) and one point she did make was that she would be happy to fund a branch meeting as long as at the start of the meeting there were joint engagement topics, then the rest of the meeting would be funded.

JC: What do they mean by health and social care?

GN: I think that from this Assembly and with the Board's permission, I will go back to DCC (Jenny Stevens and Stuart Barker) and ask for their definition of health and social care as everything we do is wellbeing – it involves rural transport, social isolation – it involves everything SCfD stands for. I will copy groups in and I will come back with the answer as soon as I receive it.

JB: We are going to have links on our website but they only want to have links with Fusion. They envisage that organisations and joint engagement issues will have to go through the gateway – anything to do with us stays the same.

MC: We have to very precise how we monitor things – feedback from branches will be extremely important.

JB: We will have to very political, and there are bodies who will dominate. The project manager will be able to pick and choose as they are a paid employee and we have to priorities.

MC: We will fight our corner and they genuinely want to work with us – I don't think people are there to see how they can marginalise us.

BJ: An important aspect of our work has been intergenerational work. Is this relevant to this exercise? The fact is DCC put great credence on that bit of our work. As far as health and caring is concerned we are told that people should start thinking of this as early as possible so therefore it is important that we get the necessary funding to carry on with an important aspect of our work.

GN: ARC and JC are doing fantastic work and we are very proud of this - Exeter college fundraising as an example. DCC will not be funding intergenerational work as they just had to look at where they were going to make cutbacks. To be fair, we are going to get money but in other counties there is no money for senior councils and we are fighting our corner. Other groups are working really hard on intergenerational and we will go on working for it.

JM: Does this mean that we no longer report to DCC and we don't get direct access to them?

GN: The only thing we involve ourselves with Fusion is on joint engagement. We have to define clearer lines and hopefully the letter I send will make this clear. Our health and social care group are having Paul Giblin and Paul Collinge from DCC coming to talk to us about residential homes and domiciliary care on the 4th July. We will talk to them and say OK, you want us to do this so where is the money?

JM: What is our role to be in the future and what do you want us to do, is it cost effective and do you want us to carry on?

GN: It is very worthwhile continuing.

8. Funding Update – Ken Crawford (KC) Funding Group

KC gave a presentation which he followed up with a booklet which is available from him.

Q and A Session:

JB: This ties in with the presentation. I am a new member and we don't seem to have a strategy of aims and objectives or a cycle of that. We need to have dimension and the directive must come from the Board and devolve down to the various branches, we then progress reports which will produce the results automatically.

KC: It has been quite difficult to look at areas of funding at the moment. We have taken the core of the SCfD at the moment and the core of what we must do at the future.

JB: That is fine as an aim, but what are the objectives that I can evaluate the Board are achieving?

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KC: We are putting in thoughts and ideas to the Board where we should be going and training on the monetary side of it. I read a number of articles on the National Monetary Council and the bid with Exeter college will take us to what the government are expecting. Yes we do need objectives but those have got to come through the members to the Board.

GN: We have a set of objectives – we produced them at the last AGM that went out to all members. I have revisited them and I have done a table of objectives showing where we have got with them, whether they are ongoing or if they have been done and this will be circulated shortly.

MC: We have spent the last six months basically looking at our naval we have been trying to suss out what line we should be taking and not getting anywhere but we have made the decision so now we have to go forward and be practical.

KS: I would like to know how much it costs per year to keep our offices with Andrea, Tim and Sally – what money are we talking about?

SL - £60, 000 for salaries, office costs, stationery, phones, internet, everything. This is extremely good value for the money.

JC: Being imaginative in the future. So many charitable funds, the lottery and Comic Relief are now stressing the fact “show us how you are going to make a difference”, “how are you are coping with the needs of the so called disadvantaged?” and we have to show quite clearly eg remote hamlets are disadvantaged so we have to hammer that home and unless we can get that over we won't bring big money in.

RT: Ken – could I firstly thank you for the clear presentation on funding. This is all about resources. Can I thank you then again for the Listening Exercise. We know there is another Health and Care forum – Devon. They are an excellent resource and I would encourage the Board to make a close link with them and it will help save money. Assuming Fusion getting the contract, the first thing to put in for is Healthwatch because in the consortium there are all of the elements of a Healthwatch and DC is good at getting funding so this is something that could be achieved and a feather in everyone's cap.

GN: DC is aware and she is looking at it.

PD: We in Exeter have a particular problem when you talk to the City Council as they only want to do things within the bounds – we do have an hinterland of 29 parishes who are left in no man's land and we cannot help them so we need to look into that. We need to get this across and with a lack of co-operation between DCC and Exeter CC for number of years has put us at a great disadvantage to raise funds from anywhere as we are in this limbo and we will try personally to do what we can.

LH: What is the role of the Senior Council and I would like to ask, if I was living in a small hamlet in the middle of the Devon how would the SCfD make life better for me? What is the effectiveness of the SCfD to date and should we be more political with a small p? Patient Participant Groups - make sure we are all represented. How can we get help during the snow – go to parish councils for better clearance of snow?

GN: Firstly I would suggest to you that many of the groups did work on snow relief in the various areas and we sent out info to group about keeping warm, flu jabs etc. but each group is also expected to do what is needed within their own areas. We have not always monitored and that is one of the aims of this year is to have better communication between us all. Seaton - roads, bus stops, Exmouth – pensioners passes, etc. etc. Accept what the SCfD is about, and we were also asked to look at intergenerational work, not just from the Board but from the members. We are not always good at passing information around. We have a list of what we have achieved and I will ask each of the board members to attend branch AGMs.

KC: The last two winters. After 2010, DCC did set up a group to look at what they should be doing during bad weather. SCfD were a part of that and made an active contribution to it. This year a lot of the parishes have taken notice but a lot of the towns have not. Where I live, a lot of the farmers took control and kept roads clear. West Devon had put in almost the double number of grit bins and it has had an effect, and we have had an effect, but I agree with you and we need to do a lot more.

NE: Regarding HealthWatch – Devon LINK have tried to take over and Westbank have just had a big grant from the Lottery.

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9. Closing Remarks – GN

We will try to improve, I think we are beginning to get better and we will communicate with you. Everybody has been fantastic today and we will respond to any questions that we have not adequately done so. Please continue to hassle the Board and send us information on what your groups have been doing and let us know when your AGMs are so that a Board member can attend.

Appendix I

Attendees

Sylvia Allcock	Bideford	Liz Hitchins	Ivybridge
Richard Ashby	Okehampton	Ian Hobbs	DCC
Eileen Barber	Exeter SV	David Jenner	GP
Cliff Bell	Barnstaple	Pamela Johnson	Axminster
James Bradley	Okehampton	Bill Jordan	Exmouth
Bob Bryant	Exmouth	Jane Jordan	Exmouth
Jo Butters	Culm Valley	Beryl Lambert	Exmouth
Tim Butters	Culm Valley	Tony Langmead	Exeter
Andrea Chick	Admin	Lucy Langmead	Exeter
Abdhul Choudhary	Exeter SV	Peter Lineham	Tiverton
Brian Clifton	Barnstaple	Sally Lougher	Admin
Margaret Coles	Holsworthy	Iris Mackie	Crediton
Mary Collins	Crediton	John Maycock	Barnstaple
Paul Collinge	DCC	Carol McCormack-Hole	Barnstaple
Jim Corben	Teignmouth	John Montgomery	Ivybridge
Mary Cox	Exeter	Gillian Newcombe	Exmouth
Ann Crawford	Okehampton	Eli Pang	
Ken Crawford	Okehampton	Alan Rayner	Bideford
Janet Crocker	Exeter	Dave Regardsoe	Culm Valley
John Crowter-Jones	Exeter	Pat Regardsoe	Culm Valley
Ron Cuthbertson	Crediton	Joyce Smith	Exeter SV
Jean Daley	Exeter	Peter Spackman	Dawlish
Pat Davey	Bideford	Kathleen Swain	Honiton
Don Davis	Honiton	John Tavener	Exeter
Ethel Davis	Honiton	Martin Taylor	Tavistock
Roy Deeks	Exeter	Roger Trapani	Seaton
Peter Dunning	Exeter	Tina Trapani	Seaton
Cecily Easden	Crediton	Molly Walker	Exeter
Neil Easden	Crediton	Sue Watkins	Tiverton
Tim Hall	P & D Officer	Barbara Whiting	Crediton
Rebecca Harriott	NHS	Derek Woolacott	Okehampton
Ann Hill	Culm Valley	Margaret Woolacott	Okehampton
Chris Hill	Culm Valley		

Apologies

Anne McClements	Culm Valley	Carol Barkwell	Okehampton
Bob Buskin	Seaton	Graham Bowen	Great Torrington

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Rita	Brickill	Axminster	Tony	Simpson	Honiton
Bob	Deed	Tiverton	Tony	Smith	Honiton
Michael	Dennis	Tavistock	Margaret	Spencer-Brown	Axminster
Frank	Hartley	Teignmouth	John	Stedman	Tiverton
Roma	Patten	Exmouth	Yvonne	Wardrop	Exmouth
Vernon	Patten	Exmouth			

Appendix II

Gillie Newcombe - Introduction to Assembly and Speakers

A big welcome to you all.

Today you have the opportunity to listen and to ask questions at what is a really relevant time. We only had to open our newspapers or turn on our tele's yesterday to hear this.

At our last AGM we presented a list of objectives for the Senior Council, one of these to make our main aim for the future Health and Well Being. Hopefully today will make inroads into this. The forthcoming changes in the provision of both the Health Service and Social Services will have an on-going affect whether for better or worse will I guess be up to the providers of the services, plus I am sure they will argue the government allocating enough to finance and to support them. (Personally I am not sure it is all down to funding). But it will definitely be up to us to monitor. Senior citizens are after all the biggest users of both Health and Social care. What a position for BRITAIN to find itself in. BASIC HUMAN RIGHTS ARE BEING OVER LOOKED states the Equality and Human rights commission. It sounds as if we are living in a third world country. And maybe if I was confined to one room in a tower block or in a small cottage in the middle of Dartmoor I might just believe I was. In third world countries families often live closer to each other and are able to give more support to their revered elderly. Here we find the rights of Senior citizens are being ignored. Pensioners having to choose between food and a wash!! Being left for up to 17 hours in bed and those beds often being soiled. Imagine being put into bed at 5.00pm and not being got up until 10.00am. When you cannot get out of bed on your own and you cannot get to a drink??? 15 minute visits - not allowing time for care staff to complete their allotted duties let alone being able to talk to the persons they are looking after. 32 different carers in a few weeks? Staff unable to understand what is being said to them. No choice. The basic human rights of respect and dignity being ignored because of lack of time and training. Depression. Isolation. Feelings of imprisonment. Hunger. Thirst. Bedsores. Pain. I could go on. The Dillon report will be out in a few weeks' time and I dread to think what is going to be in it. I am sure each and every one of us could tell a story of need.

However we are not unrealistic, we are very aware of the increasing cost of care. We all know we are living longer, much of this due to the great advances in health care, plus the higher standards of living so hard fought for by ours and the previous generation. We do not want to be a burden to society, far from it. But we do wish to ensure that the most vulnerable amongst us are looked after appropriately.

We would as the Senior Council for Devon, like to continue to be consulted by the providers of our care. After all, everyone who lives long enough is going to become a senior citizen. We might even be able to assist with some ideas of our own We need to know what exactly is happening in our own area. How is Devon faring? What changes will be involved when GP consortiums are responsible for the purchasing of care? What affect will earlier discharge and fewer admissions have on GPs and their already hard working staff? What affect will there be to Social Care providers of services? Are teams already set up and trained to take this on? Are there enough resources to undertake new roles? If so why is there a question mark over existing provision? Do we still need to recruit from Europe? Do we have enough beds in our nursing and residential care beds if or when large providers of care become bankrupt? Or will we in the future have enough hospital beds following closures in the cost reduction process if there is flu endemic?

Today we have three speakers each very much involved in the forthcoming proposed changes in both Health and Social Care Provision and hopefully these questions will be answered by the speakers.

Let's listen and question and find out if we can help.

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