PETERBOROUGH CITY COUNCIL

SCRUTINY COMMISSION FOR HEALTH ISSUES

THURSDAY 20 SEPTEMBER 2012
7.00 PM

Council Chamber - Town Hall

AGENDA

Page No

1. Apologies

2. Declarations of Interest and Whipping Declarations

At this point Members must declare whether they have a disclosable pecuniary interest, or other interest, in any of the items on the agenda, unless it is already entered in the register of members' interests or is a "pending notification " that has been disclosed to the Solicitor to the Council.

Members must also declare if they are subject to their party group whip in relation to any items under consideration.

10. Date of Next Meeting

Thursday 1 November 2012

There is an induction hearing loop system available in all meeting rooms. Some of the systems are infra-red operated, if you wish to use this system then please contact Paulina Ford on 01733 452508 as soon as possible.

Emergency Evacuation Procedure – Outside Normal Office Hours

In the event of the fire alarm sounding all persons should vacate the building by way of the nearest escape route and proceed directly to the assembly point in front of the Cathedral. The duty Beadle will assume overall control during any evacuation, however in the unlikely event the Beadle is unavailable, this responsibility will be assumed by the Committee Chair.

Committee Members:

Councillors: B Rush (Chairman), D Lamb (Vice Chairman), J Stokes, McKean, K Sharp, N Shabbir, Sylvester

Substitutes: Councillors: D Harrington, M Jamil and Maqbool

Further information about this meeting can be obtained from Paulina Ford on telephone 01733 452508 or by email – paulina.ford@peterborough.gov.uk

PETERBOROUGH CITY COUNCIL

MINUTES OF A MEETING OF THE SCRUTINY COMMISSION FOR HEALTH ISSUES HELD AT THE COUNCIL CHAMBER, TOWN HALL ON 17 JULY 2012

Present:	Councillors B Rush (Chairman), D Lamb (Vice Chair), J Stokes, D McKean, K Sharp, N Shabbir and A Sylvester
Also present	David Whiles, LINks Representative Katie Baxter, Youth Council Representative Matthew Purcell, Youth Council Representative Councillor Fitzgerald, Cabinet Member for Adult Social Care
Officers Present:	Terry Rich, Director of Adult Social Care Tim Bishop, Assistant Director Strategic Commissioning Tina Hornsby, Assistant Director Quality Information and Performance Paulina Ford, Senior Governance Officer Michelle Abbott, Lawyer

1. Apologies

No apologies for absence were received.

2. Declarations of Interest and Whipping Declarations

Item 6 - Older Peoples Accommodation Strategy

Councillor Rush declared that he had a personal interest with regard to the Older Peoples Accommodation Strategy and would therefore step down as Chairman for that item and not take part in the discussion. Councillor Lamb would take over as Chairman for item 6 on the agenda.

3. Minutes of meeting held on 21 June 2012

The minutes of the meeting held on 21 June 2012 were approved as an accurate record.

4. Call In of any Cabinet, Cabinet Member or Key Officer Decisions

There were no requests for call-in to consider.

At this point the Chairman announced that the Commission had agreed to change the order of the agenda and that item number 6 - Older Peoples Accommodation Strategy would be presented after item 8 – Work Programme on the agenda to allow more time for discussion.

5. Quarterly Performance Report on Adult Social Care Services in Peterborough

The Assistant Director Quality Information and Performance introduced the report which provided the Commission with an update on the delivery of Adult Social Care services in Peterborough against the four outcome domains contained within the national Adult Social Care outcomes framework. The report covered the fourth quarter of 2011-12 and gave the position at the end of the annual performance cycle highlighting key achievements and areas of concern. Progress had been made regarding the reviews backlog and safeguarding

investigations. The original 450 open safeguarding cases that had existed when the service was transferred had all been assessed and only 92 open active referrals remained. Areas for improvement highlighted in the National Survey which had been undertaken in February 2012 were; overall levels of satisfaction from service users, access to information and advice, and the extent to which social care services helped people to feel safe.

Observations and questions were raised and discussed including:

- Members sought clarification on the average number of open active referrals that should be open at any one time. The report had stated 77 active cases but the minutes of the previous meeting in response to a similar question had stated 54. *Members were informed that the number in the report had covered the entire number of open case loads including those investigated by the Mental Health Trust. The reference in the minutes had referred to Adult Social Care council investigations only.*
- The report had mentioned that in the Adult Social Care Survey undertaken Peterborough had been below the national average in certain areas. Why? *Members were advised that more work was needed in the area of client satisfaction to understand what the issues had been. Dissatisfaction with access to information had been because there was no on-line information advisory service available. This had therefore become a priority in the Business Plan for this year. Other areas below national average had been settled accommodation and employment for mental health.*
- Do you have enough staff to resource the service*? Members were advised that a review was currently being undertaken to assess the level of staffing required which would be concluded in September.*
- Councillor Fitzgerald advised that the Adult Social Care service would be redesigned to take the service forward.
- Members sought clarification on the statement in the report "The Adult Social Care outcomes have strong links to the health and wellbeing aspects of the community strategy". *Members were advised that the Quarterly Report reported against the four outcome domains contained within the national Adult Social Care outcomes framework which had been key priorities in all local authorities Sustainable Community Strategies. The four domains were:*
  - *Domain 1 - Enhancing quality of life for people with care and support needs*
  - *Domain 2 - Delaying and reducing the need for care and support*
  - *Domain 3 - Ensuring that people have a positive experience of care and support*
  - *Domain 4 - Safeguarding adults whose circumstances make them vulnerable and protecting from avoidable harm.*
- Members were concerned that the Peterborough Adult Social Care survey had highlighted a number of areas for improvement and wanted to know what action was being taken. *Members were advised that the overall levels of satisfaction for Peterborough were slightly below the National Average in some areas. Access to information and advice required a review of what information was available to the public. The extent to which social care services helped people feel safe had been referred back to the Adult Safeguarding board and the Quality and Performance sub group to get them to think about what it might be that made people feel that the services had not helped them to feel safe. Members were asked to note that the question was not asking if people felt unsafe but if people felt that the services had helped them to feel safe. The survey showed that 68.6% of respondents reported that the social care services they received made them feel safe and secure which had been a marked improvement on 55% in the previous year.*
- Members wanted to know how many people had joined the Safe Place Scheme. *The officer did not have the information available but would advise the Committee after the meeting.*
- Under the section Promoting personalisation and enhancing quality of life for people with care and support needs in the Performance Report it stated that the number of new recipients of direct payments had fallen to 164 in 2011/12. Members wanted to know

why this had happened. *Members were advised that the number of people already in receipt of direct payments had remained the same and that it was only new recipients that had fallen in number. The fall in numbers might have been due to the fact that all people requiring direct payment had now been captured. Members were informed that there was a review of direct payments underway and the policy and procedures for direct payments were being looked at. The Director for Adult Social Care advised that a report could be brought to the Committee on the outcome of the review in due course.*

- Mary Cook, representing Peterborough Pensioners Association addressed the Commission and voiced concerns about whether there was enough staff to deliver the service.

ACTIONS AGREED

The Committee agreed that:

1. The Assistant Director Quality Information and Performance provide them with the number of people who had joined the Safe Place Scheme.

2. The Director of Adult Social Care to provide a report on the outcome of the direct payment review to the Commission at a future meeting.

6. Forward Plan of Key Decisions

The Commission received the latest version of the Council's Forward Plan, containing key decisions that the Leader of the Council anticipated the Cabinet or individual Cabinet Members would make during the course of the following four months. Members were invited to comment on the Plan and, where appropriate, identify any relevant areas for inclusion in the Committee's work programme.

ACTION AGREED

The Commission noted the Forward Plan.

7. Work Programme

Members considered the Committee's Work Programme for 2012/13 and discussed possible items for inclusion.

ACTION AGREED

To confirm the work programme for 2012/13 and the Senior Governance Officer to include any additional items as requested during the meeting.

Members agreed that an item on HealthWatch be included in the work programme.

At this point Councillor Rush stepped down as Chairman and Councillor Lamb took the position as Chairman for Item 6 on the agenda - Older Peoples Accommodation Strategy.

8. Older Peoples Accommodation Strategy

The Chairman introduced the item and advised that two people had registered to speak at the meeting. The Chairman addressed the audience and read out the procedure for how the Commission would hear from speakers in the audience and the order in which the item would be dealt with.

The Chairman then asked the members of the audience if there were any other people wishing to speak. Each person would be allowed three minutes each to speak.

The Legal Officer then read out a press release which had been published on 17 July 2012 confirming that the consultation had commenced into the future options for care homes.

The Cabinet Member for Adult Social Care was then invited to introduce the report which asked the Commission to consider, challenge and comment on the Cabinet report recommending authorisation to consult with residents and families, and appropriate staff on the proposed closure of two care homes: Greenwood House and Welland House and approve the refreshed Peterborough Older People's Accommodation Strategy. The Cabinet Member for Adult Social Care explained the reasoning behind the recommendation to close the two homes that had been put forward to Cabinet. The Commission were advised that no decision had been reached and that all options were open for consideration.

The Assistant Director Strategic Commissioning informed the Commission that the Older Peoples Accommodation Strategy set out the need for accommodation for the medium term. It built on the previous strategy, reviewed local data and demographics and projections of need. The aim was to enable as many old people in Peterborough to maintain their independence and be able to live in accommodation which was of high quality. The Assistant Director Strategic Commissioning went through the strategy highlighting the key points and spoke about the reasoning behind the proposal to close Greenwood House and Welland House. Members were informed of the support that would be given to residents, families of residents and staff throughout the consultation process.

The Chair invited members of the public to address the Commission.

- Sally Cottington who worked at Greenwood House made a statement which drew the Commissions attention to an email which had been sent to members of the Commission from Councillor Swift on 17 July 2012. The email had put forward suggested land sites belonging to the Council around Peterborough which could be used to build a new home if it proved necessary to close the two care homes. The Director for Adult Social Care informed the Commission that he had also received the email and that it would be included in the consultation.

- Kathy Wiseman, Manager at Welland House made a statement which included the following points:
    - Kathy advised that she had worked for the department managing various homes for ten years and had managed Welland House for seven years.
    - Background information was provided on the history of care homes in Peterborough advising the Commission that there had originally been six care homes. Greenwood House and Welland House had been identified to provide respite care, interim care, dementia care and day care.
    - There had been no capital investment for many years in the care homes in terms of refurbishment. However in the last six months major refurbishment had taken place which had cost thousands of pounds.
    - The buildings had become tired due to lack of investment.
    - The internal layout of the two homes could be redesigned to bring them up to the required standard.
    - There was a long waiting list for Extra Care facilities for people with dementia in Peterborough. Clients from Extra Care facilities across the city had been accessing day care and respite services provided at Greenwood and Welland House as they had provided out of hours services.
    - Over the past two years staff at both homes had been instructed not to fill beds however the beds could have been filled many times over.
    - Consideration should be given to redevelopment of existing buildings, reorganisation of staffing and at cost saving alternatives within the service.

- Census figures had shown an increase in ageing population to be 1 in 6 people being over 65. Numbers of people with dementia was set to double over the next forty years.
- There had been a 16.6% increase in population in Peterborough since 2001 which would have a huge impact on the older people's services in years to come. Closing the two homes was a short sighted decision.

- Annette Beaton, Management Committee, Peterborough LINk made a statement which included the following:
  - LINk had carried out several reviews of care homes in Peterborough including Greenwood House in September 2011. The findings of the review had been that:
  - The Manager of the home had provided a warm welcome and comprehensive information about the home. The Manager had run the home with great consideration for the individual needs of the residents.
  - Greenwood House provided residential care, interim care and respite.
  - It had been purpose built and was now dated. No rooms had en suite facilities.
  - The home was very clean. Dietary wise it catered well for its clients and a dietician was available if required. Relatives were allowed to bring food in if something special was requested.
  - Most relatives commented that the staff were caring, friendly and understanding and could ask for anything and it was usually provided.
  - One lady had lived there for nine years and spoke very highly of the staff and wanted to stay at Greenwood House.
  - Three lounge areas were available.
  - There were lots of activities for residents.
  - There was a purpose built hairdressers on site.
  - Residents were very happy there.

- Tony Yiannis, who's wife's mother attended Welland House for day care made a statement which included the following:
  - Recognised that it was better to keep people in their own home if possible however his mother in law might need residential care in the future.
  - Before receiving day care his mother in law was very lethargic and sat watching TV. Since attending day care his mother in law had been much more positive and less lethargic. Her life style had changed and she was communicating with people more and smiling a lot more.
  - Given the right level and type of care this could have the same effect on other elderly people.
  - Concerned that dementia and Alzheimer's care was very specific. Felt that figures quoted in strategy were very low.
  - Attended the meeting at Welland House and asked about future day care. The Cresset and Copeland were mentioned. The Cresset and Copeland provided limited day care facilities but Welland House provided day care seven days a week.

- John Snell, Greenwood House made a statement which included the following:
  - He felt that the staff employed was one of the best teams in the country that looked after older people.
  - Agreed that older people did deserve new homes.
  - £6M sitting in the budget. Could this be used to build a new home? Homes should be run by the Council for residents of the authority.

- Sylvia Robins, mother resident at Welland House made a statement which included the following:
  - Mother had final stage dementia and needed continuity of care. Had looked at other homes and noted that rooms were not necessarily bigger. Some rooms had an en suite others did not. Felt that mother should die in own home which was

Welland House and requested that she be allowed to stay there. Mother received very good care in Welland House and was supervised in her personal care to allow her to keep her dignity.

- Donna Bennett, Peri Night Care Assistant at Welland House and Greenwood House and a UNITE union representative made a statement which included the following:
    - Greenwood House and Welland House offered specialist care that met the needs of dementia clients, interim clients and respite clients in Peterborough.
    - The homes were now running near to capacity as referrals were now being processed.
    - Greenwood provided excellent interim and respite care.
    - Spoken to an independent adviser who has carried out research. The research had shown that the transfer of elderly clients from an environment that they knew and trusted was more likely to lead to their deaths. The report proved that after such a move the person dies at a more rapid rate than they would have if they had not been moved. A copy of the report was handed out to Members of the Committee.
    - The best way to move elderly clients was with the carers they know and trust and at the same time as other residents. This could only be achieved with a new build.
    - Concerned that Age UK representatives did not have training or experience in mental health or dementia client needs but would be acting as advocates for those clients.
    - Would like clinical assessments for the clients so that the full impact of the home closures on the vulnerable service users could be properly assessed. Assessment would need to be carried out by consultant psychiatrists.
    - The Commission to note the promise that the councils capital programme had put aside funding to rebuild homes.
    - Cross Keys to begin building an Extra Care housing scheme at Stanground but would not be suitable for dementia care or interim care clients.
    - It was only public sector care homes that offered specialist care in dementia, interim and respite care. The only other two care homes in Peterborough that offered interim care had stated on the radio that charges started at £600 per week.
    - What was the cost of interim care at Greenwood House per week?
    - The Council had £6M for adult social care and an additional £1.5M for redundancies. A new build for two homes was £2.2M. A new build would provide continuity of care.

- Mary Cooke, Peterborough Pensioners Association made a statement which included the following:
    - Mary sought assurance that when the consultation finished that the responses would be published in full.
    - Age UK was the advocate for the clients in the homes. It would seem more appropriate that the advocates would be members of the National Pensioners Convention.
    - The Older Peoples Accommodation Strategy states under 'What is the Purpose of the Strategy "to ensure choice and a stable environment at end of life care". Older people need to be made aware of the End of Life Strategy.

The Chair thanked the speakers for attending the meeting and for their comments and statements.

Observations and questions were raised and discussed including:

- Members questioned whether enough consideration had been given to the alternative option of demolishing the existing homes and rebuilding a new one to replace them.

- If you are more successful in supporting more and more people in their own homes was there a risk of less independent sector homes in the city being required. *The Director for Adult Social Care informed Members that there had been an expansion of modern residential care homes in the city and there was no indication at the moment that this would stop. The current evidence provided including population trends in the medium term suggested that there was not a strong case for council investment to stimulate the market because there was no indication that the supply would dry up.*
- Members asked whether it was the case that public sector care homes ensure that standards and continuity of care remained consistent where as it would be more difficult to regulate independent care homes. *The Director for Adult Social Care informed Members that the Regulator and the local authority as commissioner of care were better placed today to hold to account providers in the care sector and pickup quickly where things were not going well. The authority also had the advantage of community LINks which would evolve into Healthwatch who would also play a part in the role of monitoring and reporting to the regulator when things were not going well.*
- Members noted the Councils Adult Social Care vision which was to promote and support people to maintain their independence in their own homes. There was concern that by doing this there may come a point in the future when there would be large numbers of people needing to go into residential care at the same time. Members wanted to know if this had been taken into account.
- Members commented that the new Census information had recently been published and requested that the new Census figures be used to rework the model for the strategy. Particular reference should be made to current statistics for the number of people with dementia and how much this had increased in the last 15 to 18 months.
- When is the new Extra Care Housing at Stanground due to be finished? *Members were informed that it could be up to 18months from the start of build to commissioning.*
- Members requested that further data be expanded on within the strategy to show the benefits of a 'block move' of residents if this was to be the way forward.
- Do we currently have enough resources for provision of care? *Members were informed that all Authorities were in the same position in that they were trying to work out how to make the best use of the money that the Council could put into social care to meet the needs of an increasing population. Peterborough was fortunate in that it had a young population and the recent Census figures showed fastest growth in the 4 to 25 age range. There was also a significant percentage increase in the over 85 age group but overall Peterborough was a relatively young city.*
- If we went for a closure or move in the future where would you get the resources from to support this? Members requested that the model show how long the current staff would be retained to provide care and support for the residents when they did move. Also provide a profile of how many staff would be required if one or both homes were closed, how long the staff would be retained through the move and after the move. *Members were advised that with the numbers of people affected by this project if the option was to close the homes it could be managed within the existing social work care management capacity. Two dedicated social workers had already been identified to manage the one to one consultations which included the reassessment process of where was the best place to meet the individual's needs.*
- *Members commented that there were dementia champions within the two care homes and wanted assurance that their expertise would be used in what ever option was chosen. Their experience would be valuable.*
- Members wanted assurance that the consultation responses would be published in full at the end of the consultation. *Members were informed that there would be a comprehensive report which summarised the consultation but there would also be a dossier available for member inspection containing all of the comments received.*
- Members had been advised that there was a long waiting list for people with dementia. Was this true. *Members were informed that there was currently no waiting list for residential care in Peterborough, including for people suffering from dementia.*

There was though a shortage of Extra Care housing schemes able to offer places for people with dementia. The number of places for Extra Care Housing were limited but the strategy would be to encourage new Extra Care schemes to provide more opportunities for people with dementia. Overall there was enough capacity for people with dementia today but with regard to Extra Care Housing there was a need to expand the number of places able to meet the needs of people with dementia.

- Could you provide the actual cost of providing care for residents at Welland House? *The Director referred to the figures in the report which indicated that the costs of providing care at Greenwood and Welland were £714.89 per week for Greenwood House and £665.94 per week for Welland House and that these figures were based on an assumption that the homes were fully occupied. These figures are substantially higher than the cost of equival3ent care in other homes in the City. The Director also outlined that Greenwood House provided respite and interim care beds. The cost of providing interim care was often more expensive than permanent care because of a number of factors. One factor being that the bed would not be occupied for the whole time..*
- Members noted that there was a medium term strategy supported by long term data. If the population was ageing rapidly what would happen in the future when there was a larger older population and more care homes would need to be provided. It would seem that costs were being saved now but more would need to be spent in the future. *The Director of Adult Social Care responded that it was important that the modelling was correct and there needed to be a rework of the modelling using current census data. The evidence in Peterborough was that the market was developing in a way which was consistent with demand. Originally there were six homes and this was reduced to four and then to two but this had not lead to a shortage in supply.*
- The report stated that the council care homes were providing appropriate care but with inappropriate accommodation? The provision of appropriate care and appropriate accommodation should be equal to provide appropriate care. *The staff were, in the main, doing the best possible job they could given the environmental conditions they were working within. The homes were designed at a different time when society was moving away from older people being in geriatric wards. Standards had now moved on and better provision was and should be provided for the citizens of Peterborough.*
- Members had noted that a member of the audience had stated that they had been instructed not to fill beds. *Members were advised that it was true that there had been no permanent admissions in either home for some time, people were either choosing other homes or and many more people being supported in their choice to be cared for in their own homes.*
- It was noted that a figure of £1.6M had been put aside for redundancy money. *Members were advised that if every member of staff were to be made redundant as a result of closure of the two homes the estimate was that it would cost as much as £1.6M. This was the figure before any consultation with staff had taken place or any other options had been looked at and any discussion regarding redeployment opportunities.*
- The Cabinet Member for Adult Social Care advised Members that there was a duty to the public purse and to provide best value. If things were to remain as they were it would cost the Council £8M more to continue.
- Members were concerned that national reports had quoted that there was a possibility of a 40% death rate when moving elderly people from their homes. This had not been taken into account in the report. Members requested that the strategy take this into consideration and show how this would be dealt with to reduce the risk. *The Director of Social Care advised that the 40% statistic quoted was neither accurate nor current. There had been some bad instances of poorly planned, poorly executed closure of care homes in the past. The evidence pulled together from the Association of Directors of Adult Social Services with the assistance of Birmingham University showed the amount of good practice that had developed over the years. Evidence showed better outcomes post closure if those closures were managed*

effectively through the commitment of the staff even if their own jobs were threatened to make sure that they were minimising the anxiety for every resident in those homes. It would be difficult and it would need to be done in the most appropriate and sensitive manner possible.

- Members felt that the people in the audience from both homes who had voiced their concerns should form a group to look at the proposed strategy positively and work with officers to look at a way forward to get the best possible solution. *The Director of Adult Social Care advised Members that the aim of the strategy was to ensure people were able to exercise choice. If a decision was made to keep the care homes open for a another few years because in the natural course of events people passed away that would tie up huge amounts of the social care budget which would prevent other people from making choices. The homes would not be full and therefore the cost of running those homes would escalate.*
- The Chair of LINks noted that the report stated that there were 821 beds available in the various care homes across the city. How many of those met the new room size standard of 25m². *The Director of Adult Social Care did not have the information at the meeting but he assured Members that those built within the last 5 to 10 years would be of the new room size standard.*
- Members wanted to see an indication of costs for the option of refurbishing both of the homes. *The Director of Adult Social Care advised that this was covered within the revised strategy but that m*ore *information could be provided.*
- Had the council carried out an inspection to assess the quality of dementia care in the independent sector? Although the independent care homes were registered it did not necessarily mean they were good. *Members were advised that* all pe*ople who have been or were currently being assessed as needing residential or nursing home care, including those with dementia care and were supported by the City Council were being placed in the independent sector homes. LINks soon to be Healthwatch, the Regulator and the Contracts Monitoring staff and reviews of peoples care plans would pick up any concerns regarding delivery of service.*
- Members wanted to know why both homes had recently been refurbished at a cost of in excess of £100K when there was a possibility they may close. *Members were informed that decisions were made in the councils capital programme in November 2011 to invest in the homes in essential areas that had been neglected over a period of years. This decision was made prior to the proposal to close the homes. It was important that standards did not suffer even if the home was due to close because the quality of life for the residents was very important.*
- Will the dementia day care be provided seven days a week*? Members were advised that part of the consultation process would be to assess what the respite and day care service for people with dementia needs were and to ensure that if the homes close that appropriate replacement day and respite provision was commissioned to meet those needs..*
- A Clinical assessment by medical professionals should be carried out on the residents in the homes prior to transfer to a new home*. Members were informed that e*ach individual would need to have a review of their care arrangements and the multi disciplinary team would have an input into that assessment.*
- Members advised the Director of Adult Social Care that the planning department had a specific portal on the council website which was used for consultation purposes and suggested that this could be looked at for use with this consultation.
- More information should be provided on the size of the possible resident group moves should the homes close. *Members were advised that group moves would depend on the independent choices of people and families making individual decisions with the help of the staff.*
- Consideration should be given to the importance of keeping the current staff on to help with the transition of residents to new homes to ease their transition.
- If dementia cases are going to rise in the future how will you make the independent sector provide that care. *Members were advised that there would be an expansion of*

services for dementia because there would be an increase in demand. There was no evidence to suggest that the independent sector including specialist voluntary sector organisations would not provide dementia care.

RECOMMENDATION

The Commission recommend that the Director of Adult Social Care address all the comments made by the Commission and members of the public and pay particular attention to the following:

1. Further consideration to be given to the alternative option of demolishing the existing homes and rebuilding a new one to replace them.

2. That the Strategy be remodelled to take into account the recently published 2011 Census figures. Particular reference should be made to statistics for the number of people with dementia and how much this had increased in the last 15 to 18 months.

3. Further data to be expanded on within the strategy to show the benefits of a 'block move' of residents if this was to be the way forward.

4. Consideration to be given to the importance of keeping the current staff on to help with the transition of residents to new homes to ease their transition and
   4.1. The model to show how long the current staff would be retained to provide care and support for the residents when they move.
   4.2. Provide a profile of how many staff would be required if one or both homes were closed and how long the staff would be retained through the move and after the move.

5. To ensure that the expertise of the Dementia Champions within the two care homes is used regardless of the option chosen.

6. The strategy to take into consideration the possibility of an increase in death rate through moving the residents and show how this could be dealt with to reduce the risk.

7. Officers to work with staff at both homes as a group to look at the proposed strategy positively and to look at a way forward to get the best possible solution.

8. To provide costs for the option of refurbishing both of the homes.

9. To look at using the planning department consultation portal to help with this consultation.

The Director of Adult Social Care to bring a report back to the Commission with outcomes of the consultation and all responses before going to Cabinet.

9. Date of Next Meeting

Tuesday 20 September 2012

The meeting began at 7.00pm and finished at 9.30pm CHAIRMAN

SCRUTINY COMMISSION FOR HEALTH ISSUES	Agenda Item No. 5
20 SEPTEMBER 2012	Public Report

Report of Joan Tiplady Senior Manager - Equality Delivery System (EDS), Peterborough and Stamford Hospitals NHS Foundation Trust (PSHFT)

Contact Officer - Joan Tiplady
Contact Details – Tel: 01733 677522, email: joan.tiplady@pbh-tr.nhs.uk

EQUALITY DELIVERY SYSTEM - UPDATE

1. PURPOSE

1.1 The Health Commission at its meeting on 21 June 2012 requested detailed information in respect of the Equality Delivery System (EDS) outcomes which had achieved a red rating (grading).

2. RECOMMENDATIONS

2.1 The Commission may wish to acknowledge and approve the steps taken by PSHFT in respect to the outcome with the red rating.

3. LINKS TO THE SUSTAINABLE COMMUNITY STRATEGY

3.1 Sustainable Community priority of creating opportunities by tackling inequalities through Equality and Diversity, Engagement, Inclusion.

4. BACKGROUND

4.1 There was one red rating and this was in respect of Goal 4 - Inclusive Leadership at all levels; Outcome 4.3 – 'The organisation uses the "Competency Framework for Equality and Diversity Leadership" to recruit, develop and support strategic leaders to advance equality outcomes'.

5. KEY ISSUES

5.1 The "Competency Framework for Equality and Diversity Leadership" document was published in late 2011 and therefore no action had been taken by PSHFT at the time of the rating workshop held in December 2011.

6. IMPLICATIONS

6.1 This was a national position, shared by other NHS organisations.

7. CONSULTATION

7.1 The workshop was attended by representatives of the nine protected characteristics who rated the outcome.

8. NEXT STEPS

8.1 PSHFT has since used the Performance Deliverables within the "Competency Framework for Equality and Diversity Leadership" to formulate an Action Plan which is being considered for use by the Trust's Equality and Diversity Steering Group.

In addition the Director of Care Quality and Chief Nurse and the Director of Human Resources

have ensured that Equality and Diversity and in particular the progress in respect of the EDS is regularly reported to the Trust Board, the Trust Management Board and the Board of Governors.

As suggested by the document, Equality and Diversity (E&D) is a key consideration in respect of recruitment and this is monitored by the Trust. Key phrases in respect of E&D are used in job descriptions.

The NHS E&D e-learning programme is being rolled out across the Trust with staff, including senior managers and directors expected to undertake this during 2012/13. In addition E&D is a key component of the Trust's induction programme and is available to those unable to undertake the e-learning (eg visual impairment).

9. BACKGROUND DOCUMENTS

9.1 The Equality Delivery System for the NHS and associated documents
Competency Framework for Equality and Diversity Leadership

10. APPENDICES

10.1 N/A

SCRUTINY COMMISSION FOR HEALTH ISSUES	Agenda Item No. 6
20 SEPTEMBER 2012	Public Report

Report of the Interim Chief Executive of Peterborough and Stamford Hospitals NHS Foundation Trust

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PETERBOROUGH AND STAMFORD HOSPITALS NHS FOUNDATION TRUST

1. PURPOSE

1.1 At the request of the Chair, the Interim CEO of Peterborough and Stamford Hospitals NHS Foundation Trust has been asked to attend the Commission to provide an update on the Peterborough and Stamford Hospitals NHS Foundation Trust.

2. RECOMMENDATIONS

2.1 That the Commission notes the content of the report and comment and make any recommendations.

3. LINKS TO THE SUSTAINABLE COMMUNITY STRATEGY

3.1 This links to the Sustainable Community priority area of creating opportunities and tackling inequalities.

4. BACKGROUND

4.1 Peterborough and Stamford Hospitals NHS Foundation Trust (PSHFT) is the main provider of acute hospital services to the people of Peterborough. The Scrutiny Commission has requested reports on:

a. Vision/objectives for the Trust
b. Key performance issues – A&E attendance; radiotherapy; outpatients
c. Stamford Hospital redevelopment

5. KEY ISSUES

5.1 The Board of Directors has developed a new strategy for the Trust. In addition, last month it published a summary of the five year Financial Plan which has been required to prepare by Monitor, the Regulator of foundation trusts. The summary (which includes the new strategy) is presented at Appendix A. Members of the Commission may wish to consider the strategy alongside the overall financial challenge facing the Trust.

5.2 Key performance measures are covered in Appendix B (extract from report to PSHFT Board of Directors, August 2012). Angus Maitland, Chief Operating Officer, will present this report.

5.3 The Trust has developed (jointly with South Lincolnshire Clinical Commissioning Group) a Proposed Clinical Strategy for Stamford Hospital. A stakeholder engagement paper summarising the proposals is presented in Appendix C. Mr John Randall, Medical Director, will present this report.

6. IMPLICATIONS

6.1 These are city-wide reports with no specific Financial; Legal; Human Resources; ICT, Environmental, Human Rights, Property, Procurement, LAA targets implications for the Council.

7. CONSULTATION

7.1 No consultation is required or planned with regard to the first two items. A process of stakeholder engagement is underway with regard to the Proposed Clinical Strategy for Stamford Hospital, of which presentation to this Scrutiny Commission meeting forms part. This stakeholder engagement precedes any possible formal public consultation. Lincolnshire Health Overview and Scrutiny Committee is the body responsible for determining whether such formal public consultation will be required.

8. NEXT STEPS

8.1 The Scrutiny Commission may wish to consider receiving follow-up reports at suitable future dates.

9. APPENDICES

9.1 Appendix A – Monitor Financial Plan Summary
Appendix B – PSHFT Performance Report (April – August 2012)
Appendix C – Proposed Clinical Strategy for Stamford Hospital

Monitor Financial Plan Summary

August 2012

About us

Peterborough and Stamford Hospitals NHS Foundation Trust was formed on 1 April 2004.

The Trust provides hospital services to our local community and to a catchment that extends to a 30 mile radius. We employ more than 3,500 staff across our two hospitals. This includes staff who are part of the Ministry of Defence Hospital Unit which is based at Peterborough City Hospital.

New and developing hospitals

Previously housed on three Peterborough sites - Peterborough District Hospital, Edith Cavell Hospital and the Maternity Unit - the Trust moved into its new 612-bed Peterborough City Hospital in November 2010. This move marked the dawn of a new era for the Trust - delivering healthcare in a hospital that ranks among the best facilities in the UK.

Additionally, this year, together the local Clinical Commissioning Group, we launched a clinical strategy for our Stamford and Rutland Hospital, which will offer services for the people of South Lincolnshire and beyond over the next five to 10 years. This strategy looks to improve facilities and to make better use of the extensive site.

Quality of services

Delivering the highest quality of care to our patients is the top priority of the Board and our staff – and for the most part, we do well.

Our Hospital Standardised Mortality Rates figures are consistently better than average for the NHS and have been steadily improving over the last year.

We achieved full compliance with the Care Quality Commission's essential standards. And the quality of key non-clinical services has recently been rated 'excellent' by the Department of Health's Patient Environment Action Team.

Providing a range of services

The new City Hospital's excellent facilities include:

- a state-of-the-art radiotherapy unit
- an emergency centre with a separate children's assessment unit
- a dedicated women's and children's unit
- a new respiratory investigations facility
- inpatients are cared for on wards where 57 per cent of beds are in single rooms with en-suite facilities, or in four-bedded bays which each have their own bathrooms

Last year, across the Trust, we:

- saw over 363,000 patients in new and follow-up outpatient appointments
- treated almost 85,000 patients in our emergency department
- admitted over 40,000 emergency patients
- admitted 33,500 day cases and a further 8,000 elective patients
- undertook almost 216,000 diagnostic scans
- delivered 4,680 babies

Our strategy

The Board of Directors has reviewed the Trust's strategy and agreed that we should focus on three main areas, with agreed key objectives:

1. Doing the very best inside our hospitals - through improving quality and clinical performance and organisational development

Doing the very best inside our hospitals	Key objectives
Quality & Clinical Performance	Achieving the highest quality across the three domains of Patient Safety, Patient Experience and Clinical Effectiveness, by focusing always on the needs of our customers (patients, relatives, the public). Achieving the highest performance by seeking always to treat patients in the most effective way, thereby optimising patient activity and throughput, and making best use of our staff and facilities.
Organisational development	Redesigning patient pathways, clinical and departmental relationships and workforce skill sets to ensure best practice internationally becomes our common practice. Achieving the highest standards of clinical engagement, leadership, accountability, performance and governance so as to create an organisation whose culture and behaviours can meet the challenges of the next five-10 years.

2. Getting value for money from our hospitals - through productivity and efficiency and maximising the value of the local health system's estate

Getting value for money from our hospitals	Key objectives
Productivity and Efficiency	Achieving the highest productivity through a challenging cost improvement programme and the application of 'Lean' techniques and benchmarking. Disinvesting in non-core services where we cannot cover our costs with our income.
Maximising the value of the local health system's estate	Creating space in Peterborough City Hospital to treat more patients and develop our business, by optimising our patient throughput and clinical productivity and by selective rebuilding projects. Redeveloping Stamford Hospital to offer the best facilities to local people and to make the site fully productive. Cooperating with public sector partners in Peterborough to rationalise and make fully productive the public sector estate in the city.
Potential business development opportunities	Securing our current patient base and seeking to expand it in counties to the north and west (Lincolnshire, Leicestershire, Rutland, Northamptonshire). Developing our specialist services, especially in cancer and renal medicine. Developing our elective surgical portfolio, especially in orthopaedics. Developing a private patient unit (subject to business case).
Requirement for PFI support	Seeking to minimise the cost of the PFI to the Peterborough health economy, through collaboration with partners regarding making best use of the City Care Centre. Working with Department of Health and Treasury to secure a long term solution to make the Peterborough PFI hospital affordable.

3. Making the most of our hospitals by securing and growing our business through strong relationships with others

Making the most of our hospitals	Key objectives
Securing and growing our business by getting relationships right with others	Working always in close collaboration with the regulatory authorities, the Department of Health and National Commissioning Board, Health and Wellbeing Boards, MPs and Councillors, Governors, Members and the public.

Why we need a financial plan

Whilst quality and clinical performance are our priorities, the Trust has a huge financial problem. Last year we recorded a financial deficit of £45.8m and this year we forecast a deficit of £54.3m.

Consequently, we are in breach of our terms of authorisation with Monitor, the regulator of foundation trusts.

Because of our huge financial problem and because we are in breach of our terms of authorisation, Monitor has required us to develop a strategy and a plan to tackle our deficit. The draft of this five year plan was submitted in May 2012 and over the summer; we have worked with Monitor to refine the details.

This document is a summary of that plan.

Overview of our financial plan

The plan tells us that **theoretically**, the Trust can get back into financial balance over five years. The key word (and massive caveat) here is **theoretically**. This caveat is emphasised because:

- to achieve this, the Trust must deliver a huge efficiency programme. It must attract very substantial new business (additional patients) and it must agree special Department of Health support for the excess PFI cost of the new Peterborough City Hospital

- each of these three elements of the plan carries very significant risk – and none of them can be achieved without the Trust working in close partnership with, and with the active support of, other parts of the NHS

- of these risks and dependencies, the Trust must continue to look for other, additional measures which will enable it to achieve a sustainable position.

To put it another way, the financial plan tells us how steep a hill we have to climb, financially, but it also tells us that we will only get to the top of that hill if a long list of things all come right and if we get huge support (in different ways) from other parts of the NHS and from the Department of Health.

The numbers are frighteningly large – and would require delivery of efficiency savings by years four and five which are (we believe) unprecedented in this country and which may prove well beyond our reach. The business growth we require over five years can only be achieved if health services are substantially reconfigured across a wide area – and this is something we can influence but not control. And the level of special PFI support we need from the Department of Health may be significantly more than the Department would be prepared to provide.

Background to our financial situation

Our financial plan looks forward; so it does not analyse how the Trust's deficit has arisen.

However, we know that there are three main background reasons for our financial problems:

1. Pressure on the NHS budget and on acute hospital budgets in particular, across the country, because of the position of the whole national economy and the public sector deficit. This is a national issue – not unique to us.

2. The way health services are currently configured in this country (including in our region), with too many hospitals, many of which are too small, all trying to do almost everything, and with not enough integration between hospital, community and primary care services. This is national issue – not unique to us.

3. The very high PFI cost of our new Peterborough City Hospital.

This is confirmed by a KPMG report on Peterborough and Stamford Hospitals, commissioned by Monitor and published in June 2012. KPMG used slightly different headings but basically described the same things as the main sources of our deficit:

PFI (structural costs)	£22 million
Backlog CIPs/Financial Control	£12 million
Income/Commissioning	£10 million
One-off costs for 2011/12	£2 million
	£46 million

Private Finance Initiative

The 'structural costs' of the deficit represent the difference between the actual charges for the PFI (which includes interest and depreciation) and those that are regarded as affordable based on the latest guidance for new PFI schemes.

Backlog of cost improvement plans/financial control

Between 2007/08 and 2009/10 the Trust delivered less efficiency savings than the national requirement. Consequently the Trust's cost base was higher than planned.

Income/Commissioning

Income is £10 million less than required due to a combination of penalties levied by commissioners, additional patients being treated (not all activity has been paid for), and the assumed income from the District Hospital site not having been received.

One off costs

In addition, to the elements described above, during 2011/12 a range of other costs were incurred in developing the turnaround plan for the Trust (including costs of special support and advice to drive the turnaround of the Trust and anticipated redundancy costs).

How we can return to a sound financial footing

1. Our baseline projection

Our financial plan begins with a baseline projection. This takes account of what we expect from the additional challenges which every acute hospital in the country is facing (income deflation and reduced activity) and a very ambitious cost improvement programme and one-off costs of delivering those cost improvements.

Income deflation – the NHS tariff (that drives how we get paid for each patient that we treat) is expected to be reduced by the Department of Health during each year of the plan period – i.e. we expect to get paid less for each patient year by year. The combination of reducing prices and inflation on costs mean that the Trust will need to deliver savings of between 4 and 5 per cent per annum to avoid making its financial position any worse.

Reduced activity – our commissioners are planning to develop other alternatives to in-hospital care and are planning to reduce the number of patients that we treat.

Cost Improvement Programme - our plan contains £58.7m of savings over the next five years which, if delivered, would make us one of the most efficient hospitals in the country. This includes what is called a 'stretch target' i.e. driving efficiency to the absolute maximum.

We do not believe such a high level of efficiencies could be driven through in a trust of our relatively modest size without combining their delivery with some business development and/or system re-configuration – and even then it may not be deliverable.

The beneficial impact of the cost improvements is reduced in the early years by substantial one-off costs required to drive those cost improvements, including anticipated redundancy costs.

Sadly, because of anticipated income deflation and reduced activity, even £58.7m of cost improvement savings would broadly maintain the underlying annual deficit at its current level.

Extract from Monitor Business Plan (submitted 31 May '12 - inflated)	**2012/13 £ms**	**2013/14 £ms**	**2014/15 £ms**	**2015/16 £ms**	**2016/17 £ms**	Total over 5 years £ms
Projected full year deficit	**-54.3**	**-51.8**	**-51.2**	**-50.1**	**-51.8**	
Incorporated in the plan:						
Impact of income deflation / cost inflation		-10.9	-11.2	-9.5	-9.7	-41.3
Net impact of activity reduction		-4.6	-1.7	-1.4	-1.7	-9.4
Recurrent cost improvements	13.2	12.9	12.9	9.9	9.8	58.7
One-off delivery costs	-10.8	-5.7	-5.2	-2.9	-2.9	

Funding requirements associated with our baseline projection

The Trust has sufficient cash to operate until end of November 2012, thereafter external cash funding will be required in December 2012.

In order to mitigate its funding requirement in the short term the Trust's Commissioners have agreed to accelerate contract income for both February and March 2013 to April and May 2012 respectively. Whilst this income provides sufficient cash for the Trust to operate until end of November 2012, external cash funding will be required thereafter. By 31 March 2013 the cash requirement of the Trust will be c.£50m.

2. Getting to financial balance

What else needs to be done to return the Trust to a sound financial footing?

Develop our business to optimise the use of the hospital

We are working with our commissioners and other stakeholders to identify services that could be expanded to attract more patients (new business) to our hospitals. Expansion in this way will help us to maximise the benefit that is delivered through our hospitals.

We are currently reviewing the opportunity to expand a number of services that would offer additional patient benefit and provide significant financial contribution (including radiotherapy and orthopaedics).

The Board has set an overall business development target to deliver £25m per annum of additional surplus by 2016/17.

Make our PFI hospital affordable

We are working with the Department of Health to develop a solution that makes the PFI hospital affordable.

We have assessed the size of our current estate costs and compared them to the latest Department of Health affordability guidance for new PFI hospitals. This indicates an excess cost of between £24m and £26m over the plan period (assuming that the Trust's business development/system re-configuration plans are delivered).

Additional measures that will help to return the Trust to financial balance

Additional measures	2012/13 £ms	2013/14 £ms	2014/15 £ms	2015/16 £ms	2016/17 £ms
Business development / system re-configuration (high case)	3	10	18	21	25
Support for excess PFI-related costs	24	25	25	25	26

Getting to financial balance

If we deliver our productivity savings plans, achieve our business development plans and agree a solution with the Department of Health that makes the PFI hospital affordable, the Trust could **theoretically** record a small underlying surplus in 2016/17.

	2012/13 £ms	2013/14 £ms	2014/15 £ms	2015/16 £ms	2016/17 £ms
Projected full year deficit	**-54.3**	**-51.8**	**-51.2**	**-50.1**	**-51.8**
Add : Business development / system re-configuration (high case)	3	10	18	21	25
Add : support for excess PFI-related costs (post business developments / system re-configuration)	24	25	25	25	26
Add back : One-off costs of delivery after adjusting for staff re-deployment relating to business development	10.6	3.7	3.8	2.5	2
Underlying surplus/deficit pre-delivery costs	**-16.7**	**-13.1**	**-4.4**	**-1.6**	**1.2**

Maintaining and improving patient experience

The Board of Directors is aware of the risks in delivery the financial plan which include:

- Possible deterioration of quality standards
- Possible lack of clinical engagement
- Possible gaps in workforce capability and capacity
- Possible failure to achieve cost improvements targets
- Possible lack of stakeholder support to drive the health system rationalisation and business developments necessary to support the delivery of the stretch target
- Possible lack of co-operation across whole health economy
- Possible increased national/local income penalties
- Possible reduction in or delayed receipt from either land sale proceeds and external funding support

Risk mitigation

To mitigate these risks, we are doing a number of things:

- Increasing clinical engagement in running our hospitals – clinical directorates, led by clinicians, have already been established.
- Reviewing all savings plans for their impact on the quality and safety of patient care is in place to ensure that any adverse impacts can be mitigated.
- New ways of collecting and utilising patient views are being put in place.
- Discussions are ongoing with local, regional and national organisations to clearly define our issues to ensure quality patient care in Peterborough and Stamford hospitals is supported.
- The Trust's Quality Account sets clear priorities for the year, progress on which is monitored by the Board on an ongoing basis.

Conclusion - Where does the financial plan take us?

The strategy and the financial plan give us a lot to get on with. We know we must achieve this year's efficiency target of £13.2 million and – as a minimum – the savings required from years two and three. This is to ask no more than is being asked of every acute trust in the country. We also know we must pursue business growth to make best use of our hospitals.

But the scale of the numbers – especially in years four and five – and the huge risks to delivering them, mean that this plan does not really solve our problem. All it does is offer a theoretical way of doing so.

This plan is, therefore, just the beginning. It tells us what we need to get on with now, but it also tells us that we need to find other – probably more radical - ways of solving our problems.

In particular, we need to find imaginative ways of reconfiguring services in this part of the country.

So our task is to get on with the first parts of the plan with the utmost energy, while simultaneously actively looking at how the health system locally can be adapted to make it more efficient and sustainable for the future.

Peterborough and Stamford Hospitals NHS
NHS Foundation Trust

Presented for:	Discussion		
Presented by:	Angus Maitland, Chief Operating Officer		
Strategic objective:	Excellent Patient Care – Improving Services		
Date:	28 August 2012		
Regulatory relevance:	CQC Registration:	Quality and Management	Outcome 16
	NHS LA Risk Mgt:	Governance	Not applicable

Chief Operating Officer's Report to the Board

Operational Performance Report Month 4, July 2012

Summary

Headline performance for July 2012, as shown through the attached balanced scorecard, shows an improved overall position, but with considerable progress still to be made on 4 hour wait performance and associated indicators.

Of the 3 areas which were underperforming against the Monitor performance thresholds in the first quarter, 2 (radiotherapy and 18 week waits from referral to elective treatment) have now met this target for 2 consecutive months, with all cancer wait targets being met.

The outstanding issue remained performance against the 4 hour wait in the Emergency Department, where performance improved from the last week in July and has been sustained through the first 2 weeks of August, mainly due to improved bed capacity related to slight easing of emergency admission numbers.

A consequence of the sustained capacity challenges in July was that the performance on cancelled operations was below expectation, albeit improved over recent months.

18 week referral to treatment times (RTT) for admitted patients

Performance over 90% has been maintained in July, at 90.87%.

There is still considerable work to do in this area if we are to be certain of consistency of performance which matches our commitment to patients. While most of these are for in-house resolution, through managing capacity to best effect, there has been little sign to date of an easing of demand. Performance overall in August should be maintained above 90% but will remain tight while we address certain specialty-specific issues during the month.

Performance in Orthopaedic RTT remains consistently above 90%. Demand through outpatients, which was running very high at the beginning of the financial year, appears to have stabilised.

Performance in the 3 Head and Neck specialties has been below expectations, related mainly to issues which we can resolve in-house. The consequence of this has been some short term build up of backlog for treatment which is being systematically addressed over August. While we aim to deliver specialty level performance at 90% in all 3 areas in August it is possible that if there is an opportunity to bring forward patient treatment during this time we shall do so, which may marginally impair performance.

The outstanding area of backlog and risk remains General Surgery, particularly for a small number of laparoscopic procedures, where we have flagged in previous reports that we have a shortage of surgeons trained in specific techniques. This should be largely addressed through further training and known appointments so that we are back on track from October. We are having some challenges with the timing of the reduction and are currently revising plans to look at alternative ways to accelerate this.

Diagnostic Waits

4 patients had waited more than 6 weeks for a diagnostic test at the end of July (0.09% against a contract target of no more than 1%). Year to date performance still has to be recovered, as it is running at 1.42%.

Waits for diagnostic treatment bounced back rapidly after the problems experienced in June and should now be sustained. The Trust has approved additional staffing for Endoscopy to meet the bowel screening programme waits and this will also assist us in providing a more resilient 6 week wait. The additional volumes taken on also mean that this will improve the financial performance in this area.

The Trust has a programme underway to address internally-generated diagnostic demand, both in order to speed the turnaround of appropriate tests but also to improve our financial efficiency. If successful this should help routine test turnaround as well, particularly in Imaging.

ED 4 Hour Wait

Performance in July was 91% against the 95% performance standard.

The majority of underperformance remained due to shortage of bed capacity to allow patients to be swiftly admitted to an appropriate specialty area. At the time of writing (16th August), performance has been at or above 95% for the last 3 weeks, again mainly because capacity has been improved. The level of demand has generally been steadier, with fewer peaks.

Trust focus on emergency performance as our number 1 operational priority remains absolute, and in addition to the 3 core areas of focus referred to in previous months we will build on the new clinical directorate structure to address other fundamental areas of service improvement within our emergency pathways.

In terms of specific progress against the 3 core objectives set out in previous months:

- We are continuing to progress on 7 key areas to help the discharge of patients who would have an equal or better care pathway outside an acute hospital environment. Examples of these are that we have commenced a pilot to assist patients presenting with chronic pain symptoms, we have better joined up the pathway for patients with alcohol problems, we have agreed a way to co-ordinate the discharge of people who have sustained a hip fracture and we have gained cross-community agreement to support a significant improvement in psychiatric liaison services. All of these take time to embed and implement but we are pleased with the energy and commitment shown to help progress these.
- We welcomed a new consultant to the Emergency Department in early August and have developed plans to improve the sustainability of our middle grade medical rota.
- We have agreed an approach to reconfigure our beds to match both emergency pressures and the need for more short stay or day case elective beds and this will be implemented over the next 6 weeks.

In addition, I will be working up proposals with colleagues over the next 6 weeks on improving the 7 day nature of our emergency services, supported by the opportunities the new clinical directorate structures provide to give greater influence, autonomy and accountability to certain key areas of our service.

Recommendation

Trust Board members are asked to note the report and the attached Balanced Scorecard Report.

Angus Maitland
Chief Operational Officer

Balanced Scorecard Report

Trustwide

Month End: July 2012

	Area	Tar[1]	Gov/ Tru/ M[2]	Full Year Target	YTD Target	Q1	Q2	Q3	Q4	Last Available Month	Trend	YTD	Period	Commentary
18 Week Patient Pathway - Admitted Patients														
1	**% Admitted Clock Stops**	Min	M	90%	90%	89.1%	-	-	-	90.87%	-	**89.56%**	Jul	
2	**Patient Referral to Treatment waits (95th percentile measures) Performance (weeks)**	Max	M	23.0	23.0	22.6	-	-	-	20.4	F	**21.7**	Jul	
18 Week Patient Pathway - Non Admitted Patients														
3	**% Non-Admitted Clock Stops**	Min	M	95%	95%	97.4%	-	-	-	97.32%	-	**97.38%**	Jul	
4	**Trust Wide Patient Referral to Treatment waits (95th percentile measures) Performance (weeks)**	Max	M	18.3	18.3	16.0	-	-	-	16.4	U	**16.1**	Jul	
18 Week Patient Pathway - Incomplete Pathways														
5	**% Incomplete Pathways within 18wks**	Min	M	92%	92%	96.8%	-	-	-	96.83%	-	**96.80%**	Jul	
Diagnostic 6 Week Target														
6	**Number of diagnostic breaches**	max	Tru	-	-	241	-	-	-	4	F	**245**	Jul	
7	**% waiting 6 wks or more**	Max	M	1%	1%	1.88%	-	-	-	0.09%	F	**1.42%**	Jul	
Inpatient Waiting List 26 Week Breaches														
8	**Number of Breaches**	max	Tru	0	0	0	-	-	-	0	-	**0**	Jul	
Outpatient Waiting List 13 Week Breaches														
9	**Number of Breaches**	max	Tru	0	0	3	-	-	-	0	F	**3**	Jul	
Cancer Targets														
10	**All Cancers 2 Week Wait**	min	M	93%	93%	95.6%	-	-	-	94.9%	-	**95.4%**	Jul	Unvalidated for July 2012
11	**All Cancers - 31 day wait from referral to treatment**	min	M	96%	96%	99.5%	-	-	-	99.1%	-	**98.9%**	Jul	Unvalidated for July 2012
12	**All Cancers - 62 day wait from referral to treatment**	min	M	85%	85%	88.1%	-	-	-	88.7%	U	**88.1%**	Jul	Unvalidated for July 2012
13	**CSM Upgrades**	min		90%	90%	97.9%	-	-	-	91.7%	U	**96.7%**	Jul	Unvalidated for July 2012
14	**62 Day Screening**	min	M	90%	90%	93.0%	-	-	-	100.0%	-	**94.5%**	Jul	Unvalidated for July 2012
15	**Subsequent Treatment - Drugs**	min	M	98%	98%	100.0%	-	-	-	100.0%	-	**100.0%**	Jul	Unvalidated for July 2012
16	**Subsequent Treatment - Surgery**	min	M	94%	94%	100.0%	-	-	-	100.0%	-	**100.0%**	Jul	Unvalidated for July 2012
17	**Subsequent Treatment - Radiotherapy (from Dec 2010)**	min	M	94%	94%	88.2%	-	-	-	100.0%	F	**91.2%**	Jul	Unvalidated for July 2012
18	**Subsequent Treatment - All**	min	M	96%	96%	95.5%	-	-	-	100.0%	-	**96.3%**	Jul	Unvalidated for July 2012
19	**Breast Symptomatic**	min	M	93%	93%	98.5%	-	-	-	96.0%	-	**97.8%**	Jul	Unvalidated for July 2012
Accident & Emergency														
20	**Total Time In A&E 4 Hours Or Less**	min	M	95.0%	95.0%	92.31%	-	-	-	91.00%	-	**91.97%**	Jul	
21	**Unplanned Re-attendance Rate**	max	M	5.0%	5.0%	6.06%	-	-	-	6.03%	-	**6.05%**	Jul	
22	**Total Time in the A&E Department - 95th Percentile - Admitted & Non-Admitted (minutes)**	max	M	240	240	314	-	-	-	310	-	**312**	Jul	
23	**Total Time in the A&E Department - 95th Percentile - Admitted (minutes)**	max	Gov	240	240	421	-	-	-	387	F	**415**	Jul	
24	**Total Time in the A&E Department - 95th Percentile - Non Admitted (minutes)**	max	Gov	240	240	239	-	-	-	250	U	**239**	Jul	
25	**Left Without Being Seen Rate**	max	M	5%	5%	2.77%	-	-	-	4.05%	U	**3.10%**	Jul	
26	**Time to Initial Assessment - 95th Percentile (Ambulance arrivals only - minutes)**	max	M	15	15	5	-	-	-	5	-	**5**	Jul	
27	**Time to Treatment - Median (minutes)**	max	M	60	60	62	-	-	-	77	U	**65**	Jul	

	Area	Tar[1]	Gov/ Tru/ M[2]	Full Year Target	YTD Target	Q1	Q2	Q3	Q4	Last Available Month	Trend	YTD	Period	Commentary
Day Case Rates														
28	**% of Elective Care**	min	Tru	80%	80%	80%	-	-	-	81%	-	**80%**	Jul	
Last Minute Cancelled Operations (Non-Clinical)														
29	**% of Cancelled Operations**	max	Tru	1%	1%	1.75%	-	-	-	1.16%	F	**1.59%**	Jul	
30	**Number of Cancelled Operations**	max	Tru	0	0	183	-	-	-	44	F	**227**	Jul	
31	**Breaches of 28 Day Standard**	act	Tru	0	0	41	-	-	-	3	-	**44**	Jul	
Delayed Transfers of Care														
32	**Delayed Transfers of Care - Bed Days Lost**	max	Tru	6253	2441	3082	-	-	-	717	F	**3082**	Jul	
Choose and Book														
33	**CAB Booking %**	Min		90%	90%	30.1%	-	-	-	31.4%	F	**34.2%**	Jul	
Vital Signs Indicators - Stroke Patients														
36	**% of patients spending >90% of their stay on a stroke unit.**	min	M	80%	80%	77.3%	-	-	-	91.7%	F	**80.2%**	Jul	Unvalidated for July 2012
37	**% of non admitted high risk TIA patients seen and treated in 24hrs**	min		60%	60%	65.6%	-	-	-	25.0%	U	**54.5%**	Jul	Unvalidated for July 2012
Infection Control														
38	**C-DIFF rates - Inpatients**	max	M	29	8	5	-	-	-	6	U	**11**	Jul	
39	**MRSA Bacteraemia**	max	M	1	1	1	-	-	-	0	-	**1**	Jul	
40	**MRSA Screening - Elective Admissions**	min		100%	100%	100%	-	-	-	100.0%	-	**100.0%**	Jul	
41	**MRSA Screening - Emergency Admissions**	min		100%	100%	90%	-	-	-	93.5%	F	**90.6%**	Jul	
VTE Risk Assessment														
42	**% VTE Risk Assessments completed**	min		95%	95%	94.8%	-	-	-	95.8%	-	**95.1%**	Jul	
Patient Safety Thermometer														
43	**% of patients receiving harm free care within the Trust**	min		95%	94%	94.5%	-	-	-	97.1%	-	**95.1%**	Jul	Aim is to deliver 95% harm free care by Dec 2012
Hospital Cancelled Outpatient Appointments														
44	**Cancelled Outpatient Appointments**	max		27288	10,613	6696	-	-	-	2380	F	**9076**	Jul	
Readmissions (PbR definitions)														
46	**Readmissions**			5,404	1,844	1079	-	-	-	401	-	**1480**	Jul	
Complaints/Satisfaction Levels														
47	**Complaints Received**	act	Tru	0	0	137	-	-	-	43	-	**180**	Jul	
48	**Complaints Turnaround Time (days)**	max	Tru	30	30	52	-	-	-	55	U	53	Jul	
49	**Net Promoter Score**	Min	Tru	77.56	70.29	59.15	-	-	-	47.40	U	**56.22**	Jul	

Explanatory Notes:

[1] **Tar** : Target type - Indicates if the target is a maximum, minimum or actual value to monitor

[2] **Gov/Tru/M :** Indicates if the target is Government, Trust or Monitor defined

[3] **Snapshot Data** : Indicates that the value is taken at a given point in time

na : not applicable

Traffic Light Indicator:

= below or above target tolerance

= on target or within tolerance

Trend Indicator:

F: indicates a favourable variation and **U**: indicates an unfavourable variation from the previous month that exceeds a 1.5% tolerance

-: indicates that the variation from the previous month is within a +/- 1.5% tolerance

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Peterborough and Stamford Hospitals NHS
NHS Foundation Trust

Presented for:	Discussion
Presented by:	John Randall, Medical Director
Date:	25 June 2012

The proposed Clinical Strategy for Stamford and Rutland Hospital

Stakeholder Engagement Paper – June 2012

Introduction

This Stakeholder Engagement Paper summarises the proposed clinical strategy for Stamford and Rutland Hospital.

This proposed clinical strategy has been developed jointly by the clinical leadership of Peterborough and Stamford Hospitals NHS Foundation Trust (which owns and runs the hospital) and South Lincolnshire Clinical Commissioning Group (which holds the budget for NHS care and treatment in South Lincolnshire and determines which services should be commissioned for NHS patients).

The purpose of the strategy is to determine which clinical services might be provided at Stamford and Rutland Hospital in the next 5 years.

Once the shape and scale of those clinical services is agreed between the Trust and the South Welland Clinical Commissioning Group (CCG), the Trust will prepare an investment plan for redeveloping the hospital to make its facilities fit for delivering the very best healthcare in coming years and to make best use of its extensive site.

Between June and August 2012, this paper will be discussed with key stakeholder groups (including patient and voluntary groups, GPs, hospital staff, local authorities, LINk and Friends of Stamford Hospital) to obtain their views on the proposed clinical strategy.

Subject to the views of those groups, in autumn 2012, the Trust and the CCG aim to confirm the clinical strategy and to publish the business case for the redevelopment of the hospital site in line with the clinical strategy by the end of 2012.

Why do we need a clinical strategy?

Of the many things which could be said about Stamford and Rutland Hospital, three stand out:

1. The hospital is very popular with patients, GPs, the public and hospital staff – with the number of patients attending in key areas such as out-patients, therapies and pain management growing significantly over recent years.

2. The hospital Trust as a whole (Peterborough and Stamford Hospitals) draws 30% of its patients from South Lincolnshire and sees Stamford and Rutland Hospital as a core part of the Trust's future.

3. The Stamford site urgently needs redevelopment, to improve facilities for patients and staff and to make much better use of the extensive estate (in which about half of the current buildings are either empty or under-used and many are badly in need of modernisation).

The hospital Trust wishes to redevelop Stamford and Rutland Hospital as a health campus, with the hospital at its heart, but with other healthcare providers (e.g. GPs) also operating there (as now). It also wishes to ensure that the taxpayer (through the NHS) gets best value from the hospital site.

Before it can plan how to develop the health campus with the hospital at its heart, the Trust must know what clinical services might be provided at Stamford in the future – the clinical strategy for Stamford and Rutland Hospital. This is because you cannot decide what buildings and facilities you need in the future, until you know what clinical services you expect to provide in them.

In today's NHS, it is the relevant CCG (Clinical Commissioning Group) which determines which services are offered to patients, by whom and where. The future of the hospital and its services are, to that extent, in the hands of the CCG. Consequently, the Trust has been working with leaders of Welland (now South Lincolnshire) CCG since last autumn to identify what it wants from Stamford and Rutland Hospital over coming years.

When the clinical strategy is clear, the estates and investment strategy (the plan to redevelop the hospital) can be agreed.

What is currently provided at Stamford and Rutland Hospital?

Services and number of patients for Stamford Hospital

	2008/9	**2009/10**	**2010/11**	**2011/12**
Day treatment procedures	2,750	3,125	3,090	3,235
Diagnostics – ultrasound and plain X-ray with GP access	18,370	19,487	20,373	18,336
Medicine for the elderly - John Van Geest ward	194	157	92	43*
Minor Injuries Unit (MIU)	9,011	8,792	8,707	8,594
Outpatients – new, including haematuria, dermatology, gynaecology and pain management	9,038	9,416	9,938	10,224
Outpatients - follow up	16,519	19,604	22,999	23,747
Theatres	1,865	1,862	1,986	1,838
Therapies – new	364	992	1,107	1,270
Therapies – follow up	794	2,693	2,330	2,458

* John Van Geest ward was closed for part of the year for refurbishment

The proposed clinical strategy

The following services would be provided at Stamford and Rutland Hospital:

- John Van Geest ward redeveloped as an 'intermediate' care, nurse/ therapy-led facility.
- Out-patients – as today – but probably expanded (additional services/speciality provision).
- Minor Injuries Unit (MIU) – nurse-led. Nurse-led MIUs are increasingly the norm with successful examples in Louth, Loughborough, Ilkeston, Mexborough and many other market towns. (The Trust is intending to pilot this nurse-led MIU for six months commencing in autumn 2012).
- Oncology and haematology services (including provision of chemotherapy).
- Day Treatment Unit – with two procedure rooms (including endoscopy, one stop haematuria clinic, dermatology, gynaecology and pain management).
- Substantial endoscopy service (returning to Stamford the service which recently transferred to Peterborough City Hospital, plus further provision).
- Pain Management Services (these have trebled in volume at Stamford over the last three years).
- Ante-natal services.
- Imaging (including ultrasound and plain x-ray with GP access).
- Expanded Therapy provision (these have expanded significantly at Stamford in the last four years and there is scope for further increase with better facilities).
- Phlebotomy (blood-taking) services.

The hospital Trust is keen to attract patients from Rutland, Leicestershire and Northamptonshire, in addition to South Lincolnshire and is in discussions with CCGs and GPs from these areas to seek their referrals into Stamford and Rutland Hospital.

More patients are being seen at Stamford Hospital for therapies (increased around 70 per cent in the last four years) and outpatients (increased around 25 per cent in the last four years) and we would anticipate the growth in patients continuing if we expand provision. However, we would see a significant increase if we provide new services, such as endoscopy.

Operating theatre

Currently there is an operating theatre at Stamford and Rutland Hospital. The Trust and the CCG have not yet decided if this service should be retained. A number of issues still need full evaluation, including: commissioner (CCG) requirements in light of their plan to procure through competitive tender a Primary Care Surgical Service; the long term sustainability of the current operating theatre and the capital costs of upgrading/replacing it; risks and costs associated with providing General Anaesthetics in a hospital with just one theatre; the Trust's aggregate requirements for operating theatre capacity across Peterborough and Stamford, in light of its proposals to expand planned surgery at Peterborough. The Trust will also establish the proportion of operations currently undertaken in theatre that could be undertaken more cost effectively in a new procedure room.

Neither the CCG's nor the Trust's requirements will become fully clear before the autumn. Therefore it is proposed to review the need for an operating theatre at Stamford then (i.e. at the Business Case stage).

Next steps

This paper will be discussed with key stakeholder groups (including patient and voluntary groups, GPs, hospital staff, local authorities, LINk and Friends of Stamford Hospital) between June and August 2012 to get their views on the proposed clinical strategy.

Subject to the views of those groups, the Trust and the CCG aim to confirm the clinical strategy in autumn 2012.

The Trust (with CCG support) will then prepare a Business Case for the redevelopment of the hospital site in line with this clinical strategy. This will include more detailed work (at specialty level) with relevant hospital clinicians and GPs.

We will also aim to identify a partner to work with the Trust on developing plans for the health campus, focusing on the areas of the site that are not likely to be required to directly support the Trust's clinical strategy.

The Trust (with CCG support) will aim to complete and publish (in summary form) the Business Case by the end of 2012. It is expected that this Business Case will present a costed appraisal of options for the future redevelopment of the Stamford and Rutland Hospital site to make it fit for delivery of the proposed clinical strategy.

We will undertake further stakeholder engagement to inform on progress as necessary, throughout this process. NHS Lincolnshire will determine whether there is a need for full public consultation.

Any redevelopment proposals will be subject to planning permission from South Kesteven District Council and the normal planning processes.

Mr John Randall
Medical Director
Peterborough and Stamford Hospitals NHS Foundation Trust

Dr Miles Langdon
Chair, Welland Locality,
South Lincolnshire CCG

Gary Thompson
Chief Operating Officer
Lincolnshire Primary Care Trust

SCRUTINY COMMISSION FOR HEALTH ISSUES	Agenda Item No. 7
20 SEPTEMBER 2012	Public Report

Report of the Executive Director of Corporate Development and Performance

Contact Officer(s) – Sue Mitchell Geeta Pankhania
Contact Details – Tel: 01733 758530 01733 758592 geeta.pankhania@peterboroughpct.nhs.uk
Sue.mitchell@peterboroughpct.nhs.uk

EQUALITY DELIVERY SYSTEM (EDS)

1. PURPOSE

1.1 The Health Commission at its meeting on 21 June 2012 requested detailed information in respect of the Equality Delivery System (EDS) outcomes which were 'red' rated.

2. RECOMMENDATIONS

2.1 The Commission is requested to acknowledge and accept the progress report.

3. LINKS TO THE SUSTAINABLE COMMUNITY STRATEGY

3.1 How does the report link to the Sustainable Community Strategy or Single Delivery Plan priorities/outcomes?
It links to: creating opportunities, tacking inequalities; and creating strong supportive communities, through promoting equality and diversity, community cohesion, engagement with vulnerable and disadvantaged groups and providing inclusive services.
The report concerns compliance with the legal public sector equality duty under the Equalities Act 2010.

4. BACKGROUND

4.1 In October 2010 equalities legislation was introduced. In response to this legislation the NHS has worked with others including the Equalities and Human Rights Commission to develop a new approach to ensure that all NHS bodies comply with the legislation. NHSP has worked closely with the East of England Strategic Health Authority (SHA) and other NHS providers in the area to develop the new local system, and to test it out for the first time during 2011/2012. It is called the Equality Delivery System or EDS. As part of the system, a process of reviewing commissioning plans was started in a number of areas, mapped against NHSP's new objectives. Part of this work involved a volunteer lay panel of raters examining evidence demonstrating how the interests of nine specific groups (and others likely to experience disadvantage or exclusion) now protected under the equalities legislation had been taken into account in the planning and commissioning of services. As this was the first time this exercise had been undertaken we expected there to be gaps in documented evidence. Further more, we expected the results to highlight the gaps and areas where evidence of engagement with these groups needed to be strengthened. A red rating, therefore, in this case indicated under developed documented evidence, rather than poor quality services. From this first tranche of assessments an improvement plan has been produced and progress will continue to be reviewed and monitored, as well as work to review other areas of commissioning.

The groups classified under the nine categories within the Equalities Act 2010 are: age, disability, gender, gender reassignment, race, pregnancy & maternity, sexual orientation, religion & belief and marital & civil partnership. The panel of raters referred to above is drawn from the nine groups.

The first annual report and improvement plan for Peterborough and Cambridgeshire Cluster PCT's Equality Delivery System was presented at the Scrutiny Commission meeting on 21st June 2012. Members raised concerns about areas that had received 'Red' ratings and NHSP officers were asked to report back with improvements.

The EDS requirement was to choose one area of improvement per goal. In NHSP's case it was decided to review more than one area to start with. The areas chosen are priorities for 2012/2013 however in addition we also have a plan for cancer which will roll into 2013/2014.

A detailed report has been provided specifically on areas previously red rated.

5. KEY ISSUES

5.1 To ensure that the Commission has a good understanding of the EDS process and what the ratings mean.

To reassure members that progress is being made in each of the previously red rated areas.

6. IMPLICATIONS

6.1 The Equality Delivery System (EDS) is a framework devised for the NHS to help comply with the legal Public Sector Equality Duty and through that ensure protected characteristic groups have equity of access to NHS services. It is designed by the NHS for the NHS to improve the delivery and commissioning of personalised, fair and diverse services to patients and provide working environments where staff can thrive.

7. CONSULTATION

7.1 NHS Peterborough hosted two engagement events; one in Peterborough and the other in Cambridge ensuring protected characteristic groups were represented. Interested people from these events participated in the three rating sessions which were hosted as follows: two in Peterborough and one in Cambridge. The EDS requirement is for external ratings to supersede organisational ratings.

8. NEXT STEPS

8.1 Progress is reported regularly to the shadow Cambridge and Peterborough Clinical Commissioning Group (CCG) and to the Cluster PCT Board. Preparations are underway to ensure that the EDS is embedded as core business in the proposed new statutory responsible and accountable body. EDS requirements are a core part of the authorisation process for all CCGs. It will be the responsibility of the emerging CCG to review and refresh the improvement plan for 2013/2014.

9. BACKGROUND DOCUMENTS

Used to prepare this report, in accordance with the Local Government (Access to Information) Act 1985

9.1 The Equality Delivery System for the NHS and associated documents

10. APPENDICES

10.1 Improvement plan and progress for previously red rated areas

Appendix 1 **Equality Delivery System – Goals and Outcomes**

Grading Template – Progress Report on Red rated areas

Goal	Outcome	Orig. rating	Imp Rating	Imp Rating	Progress
1 Better health outcomes for all	**1.1 Services are commissioned, designed and procured to meet the health needs of local communities, promote well-being, and reduce health inequalities**				
	(b) Weight Management – Children Weight Management clubs and Adults Let's Get Moving/Let's Keep Moving				A detailed action plan with programmes for adults and children – from age 2-older age is in place. This includes women only, disability and learning disability, long term conditions. Engagement with stakeholders and community has contributed to increased referrals
	(d) NHSP Joint Strategic Needs Assessment (JSNA)				JSNA now published. The Draft Health and Wellbeing Strategy has been launched for consultation and an Equality Impact Assessment undertaken
	(e) Autism				Autism competencies launched Nov 11. An Autism training module now developed and will be available for organisations in October.
	(g) Cancer health inequalities				A detailed plan in place identifying barriers experienced by users and carers from protected characteristic groups and opportunities to improve attendance implemented
	1.2 Individual patients' health needs are assessed, and resulting services provided, in appropriate and effective ways				
	(d) NHS Health Checks				Targets set for all practices and requirement for equalities data collection embedded. Specific engagement work with Gypsy and Traveller communities to increase uptake of health checks.
	(e) Cancer needs assessment				Data/results from the cancer patient survey and local awareness & early diagnosis initiatives is being reviewed to develop a realistic action plan with providers and monitor progress by the cancer group.

Appendix 1 **Equality Delivery System – Goals and Outcomes**

Grading Template – Progress Report on Red rated areas

Goal	Outcome	Orig. rating	Imp Rating	Imp Rating	Progress
	1.3 Changes across services for individual patients are discussed with them, and transitions are made smoothly				
	(c) Change of cancer services				A system to engage with patients and stakeholders is in place. This includes Anglia Cancer Network, Teenage & Young Adults and other local service users.
	1.4 The safety of patients is prioritised and assured. In particular, patients are free from abuse, harassment, bullying, violence from other patients and staff, with redress being open and fair to all				
	(b) Cancer screening programmes				A plan is in place to review GP Practice profiles for uptake of cancer screening programmes with view to improve on low performing practices.
	(a) Workforce health and wellbeing				Live Healthy in the workplace package is in development for all staff. Other staff support such as mentoring, counselling, occupational health already in place.
4 Inclusive leadership at all levels	**4.1 Boards and senior leaders conduct and plan their business so that equality is advanced, and good relations fostered, within their organisations and beyond**				
	(a) Boards commitment to E&D				To date the PCT Cluster Board has received regular presentations on EDS and associated developments. The EDS has been supported by the Board, driven by lead directors and EDS Board Champion. The new Shadow CCG Board received reports in June and August in preparation for handover for the future.
	4.2 Middle managers and other line managers support and motivate their staff to work in culturally competent ways within a work environment free from discrimination				

Appendix 1 **Equality Delivery System – Goals and Outcomes**

Grading Template – Progress Report on Red rated areas

Goal	Outcome	Orig. rating	Imp Rating	Imp Rating	Progress
	(a) Top down awareness/commitment to E&D				Two all staff events took place in April (Peterborough) and May (Cambs) to promote wider EDS awareness. Equality and Diversity and cultural awareness training is available for all staff. Further training sessions on EDS will be implemented in Nov for all CCG/LCG staff

Key: * Joint NHSC
EDS – Equality Delivery System
CCG – Clinical Commissioning Group
LCG – Local Commissioning Group
Imp Rating – Improved ratings against Red rated areas

Ratings: **Red** – undeveloped
Amber – developing
Green – achieving
Purple - excelling

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SCRUTINY COMMISSION FOR HEALTH ISSUES	Agenda Item No. 8
20 SEPTEMBER 2012	Public Report

Report of the Solicitor to the Council

Report Author – Paulina Ford, Senior Governance Officer, Scrutiny
Contact Details – 01733 452508 or email paulina.ford@peterborough.gov.uk

FORWARD PLAN OF KEY DECISIONS

1. PURPOSE

1.1 This is a regular report to the Scrutiny Commission for Health Issues outlining the content of the Council's Forward Plan.

2. RECOMMENDATIONS

2.1 That the Commission identifies any relevant items for inclusion within their work programme.

3. BACKGROUND

3.1 The latest version of the Forward Plan is attached at Appendix 1. The Plan contains those key decisions, which the Leader of the Council believes that the Cabinet or individual Cabinet Member(s) will be making over the next four months.

3.2 The information in the Forward Plan provides the Commission with the opportunity of considering whether it wishes to seek to influence any of these key decisions, or to request further information.

3.3 If the Commission wished to examine any of the key decisions, consideration would need to be given as to how this could be accommodated within the work programme.

4. CONSULTATION

4.1 Details of any consultation on individual decisions are contained within the Forward Plan.

5. BACKGROUND DOCUMENTS

Used to prepare this report, in accordance with the Local Government (Access to Information) Act 1985

None

6. APPENDICES

Appendix 1 – Forward Plan of Executive Decisions

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PETERBOROUGH CITY COUNCIL'S FORWARD PLAN

1 SEPTEMBER 2012 TO 31 DECEMBER 2012

APPENDIX 1

FORWARD PLAN OF KEY DECISIONS - 1 SEPTEMBER 2012 TO 31 DECEMBER 2012

PETERBOROUGH CITY COUNCIL

During the period from 1 September 2012 To 31 December 2012 Peterborough City Council's Executive intends to take 'key decisions' on the issues set out below. Key decisions relate to those executive decisions which are likely to result in the Council spending or saving money in excess of £500,000 and/or have a significant impact on two or more wards in Peterborough.

This Forward Plan should be seen as an outline of the proposed decisions and it will be updated on a monthly basis. The dates detailed within the Plan are subject to change and those items amended or identified for decision more than one month in advance will be carried over to forthcoming plans. Each new plan supersedes the previous plan. Any questions on specific issues included on the Plan should be included on the form which appears at the back of the Plan and submitted to Alex Daynes, Senior Governance Officer, Chief Executive's Department, Town Hall, Bridge Street, PE1 1HG (fax 01733 452483). Alternatively, you can submit your views via e-mail to alexander.daynes@peterborough.gov.uk or by telephone on 01733 452447.

The Council invites members of the public to attend any of the meetings at which these decisions will be discussed and the papers listed on the Plan can be viewed free of charge although there will be a postage and photocopying charge for any copies made. All decisions will be posted on the Council's website: www.peterborough.gov.uk. If you wish to make comments or representations regarding the 'key decisions' outlined in this Plan, please submit them to the Governance Support Officer using the form attached. For your information, the contact details for the Council's various service departments are incorporated within this plan.

NEW ITEMS THIS MONTH:

Jack Hunt and Ken Stimpson Schools Boiler Refurbishment - KEY/02SEP/12

SEPTEMBER						
KEY DECISION REQUIRED	**DATE OF DECISION**	**DECISION MAKER**	**RELEVANT SCRUTINY COMMITTEE**	**CONSULTATION**	**CONTACT DETAILS / REPORT AUTHORS**	**REPORTS**
Sale of surplus former residential care home - Eye - KEY/01OCT/11 To authorise the Chief Executive, in consultation with the Solicitor to the Council, Executive Director – Strategic Resources, the Corporate Property Officer and the Cabinet Member for Resources, to negotiate and conclude the sale of a former care home now surplus to requirement -The Croft, Eye.	September 2012	**Cabinet Member for Resources**	Sustainable Growth and Environment Capital	Consultation will take place with the Cabinet Member, & Ward councillors, as appropriate	Simon Webber Capital Receipts Officer Tel: 01733 384545 simon.webber@peterborough.gov.uk	A public report will be available from the Governance team one week before the decision is taken.
Award of Contract - Bus Shelter Provision and Maintenance - KEY/01APR/12 Award of contract for the provision, installation, cleaning and maintenance of Bus Shelters.	September 2012	**Cabinet Member for Housing, Neighbourhoods and Planning**	Sustainable Growth and Environment Capital	Internal and external stakeholders as appropriate.	Darren Deadman Travel Information and Monitoring Officer Tel: 01733 317464 darren.deadman@peterborough.gov.uk	A public report will be available from the Governance Team one week before the decision is taken.

Moy's End Stand Demolition and Reconstruction - KEY/03APR/12 Award of Contract for the Demolition of the Moy's End Stand and Reconstruction	September 2012	**Cabinet Member for Education, Skills and University, Cabinet Member for Resources**	Sustainable Growth and Environment Capital	Internal and External Stakeholders as appropriate.	Richard Hodgson Head of Strategic Projects Tel: 01733 384535 richard.hodgson@peterborough.gov.uk	A public report will be available from the Governance Team one week before the decision is taken.
Organic and Food Waste Treatment Services Contract - KEY/01MAY/12 To Award a contract for Organic and Food Waste Treatment Services.	September 2012	**Deputy Leader and Cabinet Member for Culture, Recreation and Strategic Commissioning**	Sustainable Growth and Environment Capital	Internal and external stakeholders as appropriate.	Amy Nebel Recycling Contracts Officer Tel: 01733 864727 amy.nebel@peterborough.gov.uk	A public report will be available from the Governance Team on week before the decision is taken.
Roundabout Junction 5 and Boongate West Widening Scheme - Contract Award - KEY/04JUN/12 To approve the award of a contract for construction of the Roundabout Junction 5 and Boongate West Widening Scheme to the successful Midlands Highways Alliance (MHA) contractor (tbc).	September 2012	**Cabinet Member for Housing, Neighbourhoods and Planning**	Sustainable Growth and Environment Capital	Consultation on scheme was carried out in 2010 /11 Financial Year and budget allocated in the Medium Term Financial Strategy for implementation in the 2012/13 Financial Year.	Stuart Mounfield Senior Engineer Tel: 01733 453598 stuart.mounfield@peterborough.gov.uk	A public report will be available from the Governance Team one week before the decision is taken.

Delivery of the Council's Capital Receipt Programme through the Sale of Dickens Street Car Park - KEY/03JUL/11 To authorise the Chief Executive, in consultation with the Solicitor to the Council, Executive Director – Strategic Resources, the Corporate Property Officer and the Cabinet Member Resources, to negotiate and conclude the sale of Dickens Street Car Park.	September 2012	**Cabinet Member for Resources**	Sustainable Growth and Environment Capital	Consultation will take place with the Cabinet Member, Ward councillors, relevant internal departments & external stakeholders as appropriate.	Richard Hodgson Head of Strategic Projects Tel: 01733 384535 richard.hodgson@peterborough.gov.uk	A public report will be available from the Governance Team one week before the decision is made.
Management and Operation of Dogsthorpe Household Recycling Centre - KEY/01AUG/12 To award the contact for Management and Operation of Dogsthorpe Household Recycling Centre (HRC) (including the supply of containers and transportation of waste from the HRC).	September 2012	**Deputy Leader and Cabinet Member for Culture, Recreation and Strategic Commissioning**	Sustainable Growth and Environment Capital	Internal and external stakeholders as appropriate.	Paul Robertson Waste Project Officer Tel: 01733 864740 paul.robertson@peterborough.gov.uk	A public report will be available from the Governance Team one week before the decision is taken.

Community Infrastructure Levy (CIL) – Preliminary Draft Charging Schedule (PDCS) - KEY/01SEP/12 To approve the draft CIL for pubic consultation.	September 2012	**Cabinet**	Sustainable Growth and Environment Capital	Six week public consultation including Planning and Environmental Protection Committee.	Richard Kay Policy and Strategy Manager richard.kay@peterborough.gov.uk	A public report will be available from the Governance Team one week before the decision is taken.
Jack Hunt and Ken Stimpson Schools Boiler Refurbishment - KEY/02SEP/12 Award of a contract to refurbish the boilers at Jack Hunt and Ken Stimpson schools under the PFI Conditions Fund works.	September 2012	**Cabinet Member for Education, Skills and University**	Creating Opportunities and Tackling Inequalities	Internal and external stakeholders as appropriate.	Sarah Walker Principal Assets Officer (Non Schools/PFI) Tel: 01733 864006 sarah.walker@peterborough.gov.uk	A public report will be available from the Governance team one week before the decision is taken.

OCTOBER
There are currently no Key Decisions scheduled for October.

NOVEMBER						
KEY DECISION REQUIRED	**DATE OF DECISION**	**DECISION MAKER**	**RELEVANT SCRUTINY COMMITTEE**	**CONSULTATION**	**CONTACT DETAILS / REPORT AUTHORS**	**REPORTS**

Rolling Select List - Independent Fostering Agencies - KEY/01JUL/12 To approve the list for independent fostering agencies.	November 2012	**Cabinet Member for Children's Services**	Creating Opportunities and Tackling Inequalities	Internal and external stakeholders as appropriate.	Wendi Ogle-Welbourn Assistant Director for Strategy, Commissioning and Prevention wendi.ogle-welbourn@peterborough.gov.uk	A public report will be available from the Governance Team one week before the decision is taken.

DECEMBER
There are currently no Key Decisions scheduled for December.

CHIEF EXECUTIVE'S DEPARTMENT Town Hall, Bridge Street, Peterborough, PE1 1HG

Communications
Strategic Growth and Development Services
Legal and Governance Services
Policy and Research
Economic and Community Regeneration
HR Business Relations, Training & Development, Occupational Health & Reward & Policy

STRATEGIC RESOURCES DEPARTMENT Director's Office at Town Hall, Bridge Street, Peterborough, PE1 1HG

Finance
Internal Audit
Information Communications Technology (ICT)
Business Transformation
Strategic Improvement
Strategic Property
Waste
Customer Services
Business Support
Shared Transactional Services
Cultural Trust Client

CHILDRENS' SERVICES DEPARTMENT Bayard Place, Broadway, PE1 1FB

Safeguarding, Family & Communities
Education & Resources
Strategic Commissioning & Prevention

OPERATIONS DEPARTMENT Director's Office at Town Hall, Bridge Street, Peterborough, PE1 1HG

Planning Transport & Engineering (Development Management, Construction & Compliance, Infrastructure Planning & Delivery, Network Management, Passenger Transport)
Commercial Operations (Strategic Parking and Commercial CCTV, City Centre, Markets & Commercial Trading, Tourism)
Neighbourhoods (Strategic Regulatory Services, Safer Peterborough, Strategic Housing, Cohesion, Social Inclusion, Neighbourhood Management)
Operations Business Support (Finance)

ADULT SOCIAL CARE DEPARTMENT Town Hall, Bridge Street, Peterborough, PE1 1FA
Care Services Delivery
Strategic Commissioning
Performance, Quality and Information

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Updated: 11 September 2012

SCRUTINY COMMISSION FOR HEALTH ISSUES
WORK PROGRAMME 2012/13

Meeting Date	Item	Progress
21 June 2012 *Draft report 6 June* *Final report 12 June*	**Equality Delivery System (EDS)** To scrutinise and approve the EDS rating templates of NHSP and PSHFT and make any recommendations. **Contact Officer: Joan Tiplady, Senior Manager**	A progress report to come back to the Commission in September.
	Redesign of mental health services across Cambridgeshire and Peterborough: Overview and Scrutiny Committee action to monitor the implementation of the proposals To agree arrangements for Overview and Scrutiny follow up of the implementation of the redesign of mental health services in Cambridgeshire and Peterborough. **Contact Officer: Paulina Ford**	Recommendation made to agree to the formation of a working group to monitor the implementation of the redesign of mental health services.
	Adult Social Care – Update Report To receive a progress report on the recent transfer of Adult Social Care from the Primary Care Trust to Peterborough City Council **Contact Officer: Terry Rich, Director of Adult Social Services**	
	Review of 2011/12 and Future Work Programme 2012/13 To review the work undertaken during 2011/12 and to consider the future work programme of the Committee. **Contact Officer: Paulina Ford**	Items to be programmed into the work programme.

Updated: 11 September 2012

Meeting Date	Item	Progress
17 July 2012 *Draft report 29 June* *Final report 6 July*	**Quarterly Performance Report on Adult Social Care Services in Peterborough** To scrutinise the performance on adult social care services and make any appropriate recommendations. **Contact Officer: Tina Hornsby**	
	Older Peoples Accommodation Strategy To scrutinise the Older Peoples Accommodation Strategy and make any recommendations. **Contact Officer: Terry Rich**	To come back to the Commission when the consultation has finished prior to presentation to Cabinet.
20 September 2012 *Draft report 4 Sept* *Final report 11 Sept*	**Equality Delivery System PSHT – Progress Report** To scrutinise and comment on the Equality Delivery System progress report and make any recommendations. **Contact Officer: Joan Tiplady, Senior Manager, PSHFT**	Requested at June meeting.
	Peterborough and Stamford Hospitals NHS Foundation Trust To scrutinise and comment on the Peterborough and Stamford Hospitals NHS Foundation Trust update report and make any recommendations. **Contact Officer: Interim CEO, Dr Peter Reading**	
	Equality Delivery System NHSP – Progress Report To scrutinise and comment on the Equality Delivery System progress report and make any recommendations. **Contact Officer: Geeta Pankhania, Public Health Specialist, NHSP**	Requested at June meeting.

Updated: 11 September 2012

Meeting Date	Item	Progress
Additional meeting **1 November 2012** *Draft Report 17 Oct* *Final Report 23 Oct*	**Older Peoples Accommodation Strategy – Outcome of Consultation** To scrutinise the Older Peoples Accommodation Strategy and make any recommendations prior to presentation to Cabinet. **Contact Officer: Terry Rich / Tim Bishop**	
13 November 2012 *Draft report 26 Oct* *Final report 2 Nov*	**Quarterly Performance Report on Adult Social Care Services in Peterborough** To scrutinise the performance on adult social care services and make any appropriate recommendations. Contact Officer: Tina Hornsby, Assistant Director Quality Information and Performance	
	Adult Safeguarding **Contact Officer: Terry Rich / Tim Bishop**	
	Health and Wellbeing Board – Draft Strategy To scrutinise and comment on the newly formed Health and Wellbeing Board Draft Strategy and make any recommendations. **Contact Officer: Sue Mitchell**	
	Public Health Transformation **Contact Officer: Andy Liggins**	
	Peterborough and Stamford Hospitals NHS Foundation Trust – Quality Account Progress Report **Chris Wilkinson, Director of Care Quality and Chief Nurse**	

Meeting Date	Item	Progress
	Clinical Commissioning Intentions and Priorities **Contact Officer: Jessica Bawden**	
23 January 2013 *Draft report 7 Jan* *Final report 14 Jan*	**East of England Ambulance Service**	
	Financial Recovery Update - Peterborough and Stamford Hospitals NHS Foundation Trust **Contact Officers: Chris Preston / Louise Barnett**	
	Dementia Strategy **Contact Officer: Terry Rich, Director of Adult Social Services**	
	Portfolio Progress Report from Cabinet Member for Adult Social Care	
9 or 21January 2013 **(Joint Meeting of the Scrutiny Committees and Commissions)**	**Budget 2013/14 and Medium Term Financial Plan** To scrutinise the Executive's proposals for the Budget 2012/13 and Medium Term Financial Plan. **Contact Officer: John Harrison/Steven Pilsworth**	
12 March 2013 *Draft report 22 Feb* *Final report 1 March*	**Quarterly Performance Report on Adult Social Care Services in Peterborough** To scrutinise the performance on adult social care services and make any appropriate recommendations.	

Updated: 11 September 2012

Meeting Date	Item	Progress
	Contact Officer: Tina Hornsby, Assistant Director Quality Information and Performance	

Possible Items for Scrutiny: 2012/13

Cambridgeshire Community Services NHS Trust • Five year plan and priorities	
Adult Social Care • Local Account – September • Transformation Programme for Adult Social Care and Business Plan • Quality Framework • Quality Care Commission • The Director of Adult Social Care brings a report to the Commission on Safeguarding – From June meeting. • A further progress report is brought to the Commission on Adult Social Care with particular reference to the progress made on the migration of ICT systems from the NHS to Peterborough City Council and the progress made on the 750 outstanding case reviews.	From June Meeting From June Meeting
Peterborough and Stamford Hospitals NHS Foundation Trust • Stamford Hospital, September, Jane Pigg	
Healthwatch	From July meeting

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