PETERBOROUGH CITY COUNCIL

SCRUTINY COMMISSION FOR HEALTH ISSUES

WEDNESDAY 23 JANUARY 2013
7.00 PM

Bourges/Viersen Room - 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.

3. Minutes of meetings held on: **1 - 18**

- 1 November 2012
- 13 November 2012

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

The decision notice for each decision will bear the date on which it is published and will specify that the decision may then be implemented on the expiry of 3 working days after the publication of the decision (not including the date of publication), unless a request for call-in of the decision is received from any two Members of a Scrutiny Committee or Scrutiny Commissions.. If a request for call-in of a decision is received, implementation of the decision remains suspended for consideration by the relevant Scrutiny Committee or Commission.

5. East of England Ambulance Service **19 - 24**

6. Peterborough and Stamford Hospitals NHS Foundation Trust - Quality Account Progress Report **25 - 38**

7. Financial Position of Peterborough and Stamford Hospitals NHS Foundation Trust **39 - 60**

8. Consultation on Proposed Changes to Eligibility Criteria and Charges for Adult Social Care **61 - 92**

9. Safeguarding Vulnerable Adults Board Annual Report 2011/2012 **93 - 130**

10. Notice of Intention to Take Key Decisions **131 - 146**

11. Work Programme **147 - 152**

12. Date of Next Meeting

- Wednesday 6 February 2013 - Joint Meeting of the Scrutiny Committees and Commissions
- Tuesday 12 March 2013 – Scrutiny Commission for Health Issues

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.

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Committee Members:

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

Substitutes: Councillors: D Harrington, M Jamil and Y 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 1 NOVEMBER 2012

Present:	Councillors B Rush (Chairman), J Maqbool, J Stokes, D McKean, D Harrington, N Shabbir and A Sylvester
Also present	David Whiles, LINks Representative Alex Hall, Youth Council Representative Matthew Purcell, Youth Council Representative Councillor Fitzgerald, Cabinet Member for Adult Social Care Councillor J Davidson, Representing the Liberal Democrats Group Leader
Officers Present:	Terry Rich, Director of Adult Social Care Tim Bishop, Assistant Director Strategic Commissioning Paul Stevenson, Interim Head of Adult Social Care Finance Paulina Ford, Senior Governance Officer Marie Southgate, Lawyer

1. Apologies

Apologies for absence were received from Councillor Lamb and Councillor Sharp. Councillor Maqbool was in attendance as substitute for Councillor Lamb and Councillor Harrington was in attendance as substitute for Councillor Sharp.

2. Declarations of Interest and Whipping Declarations

Councillor Maqbool declared that one of the Care Homes was in her ward.

3. Proposed Closure of Greenwood House and Welland House

The Chairman introduced the item and advised that five 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 Chair also advised that since receiving the papers the Committee had requested a further financial breakdown and this would be explained by the Director of Adult Social Care during the meeting.

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 which had recommended to Cabinet the proposed closure of two care homes: Greenwood House and Welland House. 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 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. The closure of the homes would reduce financial implications and allow investment in a new dementia facility. Members were informed of the wide range of support that would be given to residents, families of residents and staff throughout the consultation process and if the homes were to close. Support would be given to residents on an individual basis to support their needs. Members were assured that alternative day care and respite care would continue to be provided to meet the individual needs of the service users.

The Director of Adult Social Care provided further financial information which consisted of the following:

- Breakdown of costs for the closure of both homes and when the break-even point would be.
- Breakdown of redundancy costs
- Costs of moving people to new accommodation (permanent, respite or day care)
- Costings of the proposed new Dementia Resource Centre
- Residential Care Home Budgets

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

Donna Bennett, Peri Night Care Assistant at Welland House and Greenwood House and a member of UNITE made a statement which included the following:

- The services that the two care homes provided were specialist services that were not met in the private sector.
- It had been stated that there was up to 60 places a week available in the private sector but they did not offer the type of places required by the service users of the two homes.
- Peterborough older people population projections showed that there would be an increase from 1686 people to 1882 people by the year 2015 in Peterborough suffering from dementia. This would increase to 2142 people by the year 2020.
- The money in the Adult Social Care budget should be used to build a state of the art building that would facilitate all the services that the current homes offered.
- Welland House provided a home to clients with dementia and should remain open until a new facility was built.

Richard Reeves, wife attended Welland House made a statement which included the following:

- Wife who was 65 had alzheimer's and dementia for the past six years and attended Welland House for respite care and to have a bath. She was safe, secure and well looked after there.
- The carers at Welland House were one of the Councils biggest assets.
- Better accommodation was needed and therefore recommend a newly built home and also a specialist dementia unit.
- Other care homes provided universal services and did not give the same type of specialist care provided at Welland House.

Sylvia Robins, mother was a resident at Welland House made a statement which included the following:

- Mother had been a resident at Welland House for 3 1/2 years and 4 years at the day centre before that.
- Worried about moving her mother as she felt Welland House was her home and was used to her surroundings and carers. It was known that a lot of elderly people died when moved from long term accommodation.

Marie Scales, mother aged 98 was a resident at Welland House made a statement which included the following:

- Mother resident at Welland house for just over 4 ½ years where she received the best possible care in Peterborough. All of her needs had been met in a most professional manner and she considered her carers to be her family.
- One of the reasons given for the closure of the homes was that they did not meet the Care Quality Commission Standards. Having looked at other homes in the private sector it appeared that not every home in the private sector had private facilities.
- Providing respite care at home was not the answer.
- What had happened to the £6m that was previously set aside to build a new care home?
- Peterborough had a constant demand for dementia services and if a new build was to be considered then part of it should be dedicated to dementia services.
- There were no homes in the private sector offering specialist dementia care.

John Toomey, Unison Regional Officer made a statement which included the following:

- Felt that the report was full of hollow promises.
- The new dementia resource centre would be of little use at 2.00am in the morning when a person with dementia was causing problems for their family at home.
- It was wrong for Peterborough City Council to spend £2m making caring staff redundant.
- The homes were the last of the public resources in terms of care and the Council wants to get rid of them.
- There was a higher turnover of staff in the private sector care homes because of low pay and because they can not do the job that they want to do because they were constantly being squeezed.
- Do not take the decision to close the homes and use the £2m redundancy money to build a state of the art home.

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

Observations and questions were raised and discussed including:

- Why were new residents continuing to be taken into the homes when the proposal was to close them? *Members were informed that no new permanent residents had been accepted into the homes however short term respite and day care continued to be provided.*
- What happened to the petition presented to council requesting a referendum and what was the response to it. *Members were informed that the report had acknowledged all petitions that had been received. This had been responded to in that it was considered that having a referendum was not the appropriate route to go and the legal consultation should be directly with those affected by the proposals.*
- One of the reasons given for the closure of the homes was that they had not met the Care Quality Commission Standards which inferred that the council was bound by legislation to close them. Was this correct? *Members were advised that the original legislation did apply to all homes but that was subsequently changed and now only apply to new homes.*
- Was the financial modelling based on the full capacity of Welland House including the King Fisher Wing? *Members were advised that the figures were based on the homes being fully occupied.*
- Members pointed out that the costs included in the report for refurbishment of the two homes did not add up and appeared to be incorrect. *Members were informed that there had been an error in the way the figures had been presented and that it would be corrected before the report was presented to Cabinet. It should have read £4,300,000 not £931,800.*

- The report stated under the Trade Union Feedback section "that residential staff previously based at the Peverils and the Croft had received a written commitment that new homes would be built to replace these facilities, once they closed." It also stated that the letter had been provided by UNITE. This letter had not been provided in the report. *Members were informed that a copy of the letter was within the separate pack which had been made available for all Members to see. The letter however did not prevent an employer from future consultation about employment.*
- Members commented that they had seen a copy of a Residential Rag which had talked about the future of Residential Homes which had been published in January 2011. This publication had mentioned that the Council's capital programme had set aside funding to rebuild the homes but this had not been a letter. Members wanted to know if this publication was what was being referred to as the 'letter'.
- Councillor Fitzgerald responded that he had seen the letter which had been written some time ago and circumstances had since changed. The letter had not expressly stated the council's position. At the time of the letter being written the homes were the responsibility of the NHS. There were currently no care homes that specialised in dementia and the £6.5m could be used to build a specialist dementia centre.
- Members wanted to know if the council were legally committed to follow through on a commitment made by another organisation which in this case was the NHS. *The Legal Adviser stated that legal advice could not be given on the matter unless she was in possession of the letter.*
- The Director of Adult Social Care advised that no legal undertakings had been given to build new care homes when the services were transferred back to the Council.
- Members sought clarification on how many of the private care homes had private facilities. *Members were advised that approximately 80% of them had private facilities.*
- Members sought clarification as to what respite at home was. *Members were advised that it provided an option for a carer to go into the home of the older person while the family carer went away. Evidence had shown that for some people it had proved a better option than the older person having to go into a home for respite care as this often caused confusion.*
- Members sought clarification on the proposed new dementia resource centre verses the current care package. *Members were informed that a full specification had not been produced yet but it was envisaged that it would provide a comprehensive day care facility which would replace the day care facility that Welland House currently provided. This would be focused around people with dementia. It would also provide assisted bathing and a broader range of services including support for carers.*
- If Greenwood House closed first what would happen to the people currently receiving day care provision there. *Members were informed that there was enough capacity at Welland House and at other providers of day care within the city.*
- Members sought assurance that there would be no more than two moves for the residents requiring day care once Greenwood House was closed. Members also sought assurance that the residents moving would be supported by the current staff. *Members were informed that the day care staff would be moving with the day care users as they were not subject to the same consultation around their jobs as the residential care staff. There would be individual assessments of those current day care centre users to look at the best options for them. For some people that might mean a series of moves.*
- Will you have commissioned enough day care provision in the other homes by the time Welland and Greenwood House close? *Members were advised that there was provision in the existing capacity at other homes to accommodate people receiving day care at Greenwood House when it closed. By the time Welland House closed sufficient interim spaces will have been commissioned but the new dementia resource centre would not be up and running by then.*
- The Cabinet Member for Adult Social Care clarified that when the new dementia resource centre was commissioned it did not mean that all other services disappeared. The new dementia resource centre was an additional investment in day care and respite care.

Those people currently attending Greenwood House and Welland House may not go to the new centre because they may not want to move again.

- How many residents and day care users were there in Greenwood House and Welland House? *Members were advised that there were 2 remaining permanent residents at Greenwood House and 27 remaining permanent residents at Welland House. There were 12 beds used for interim care at Greenwood House and across the two there was the equivalent of 9 beds in terms of the weeks of respite care. There were 18 day care users at Greenwood House and 24 day care users at Welland House.*
- A member of the Youth Council wanted to know why the £6m was not going to be used to build a new care home and was concerned that with regard to the new dementia resource centre that a Private Finance Initiative (PFI) was going to be used. *Members were informed that no PFI would be used. Places for the permanent residents would be purchased in the same way as the other 90% of the people that were currently being supported. A very small proportion of elderly people in Peterborough were in the council run care homes. The £6M that the council indicated could be made available in its capital programme for investment in care homes was not free money. It would either have to be borrowed or if it was available in the bank it would have to forgo the interest it would have earned on it. £6M would cost the council £400,000 per year to use.*
- Members wanted to know if there was any guarantee in place that if the service was handed over to the private sector today that the service would remain at the same level in the future. *Members were informed that the majority of Adult Social Care was already being delivered by the independent sector. The role of the Local Authority was to commission the care and to manage the market. The task was to ensure that the providers of the care adhered to the standards. This would be done in a variety of ways; the Care Quality Commission who was the regulator, the councils contracting team who regularly reviewed compliance of contracts. The Care Managers also undertook regular reviews. It was not a case of handing over a service to the independent sector but a continuation of purchasing care from the independent sector and holding them to account for the way in which they delivered that service on behalf of the council.*
- Could the council assure Members that the independent sector would provide good care? There had been many instances quoted of abuse and bad care in the independent sector. *The Director for Adult Social Care acknowledged that there had been instances in the media where providers had failed in the delivery of care. There was no guarantee that this would not happen again in either the public or private sector in the future. It was therefore important to have systems in place to monitor, regulate and oversee the care providers.*
- Regarding the rates charged in the independent care homes. What would happen if they all got together and decided to raise their rates? What would the financial impact be on the Local Authority? *Members were advised that there were laws against raising the rates. The majority purchaser of care in Peterborough was the Local Authority and therefore had a significant influence over admission rates and their business. The Local Authority negotiated with the care home sector the rates that would be paid and the circumstances in which extra would be paid if needed. The purchasing power of the Local Authority was the biggest guard against rates rising. The ceiling rate was set on an annual basis.*
- Councillor Davidson felt that the report needed more clarity and transparency.
- Current census data showed an increase in older people population aged between 74-84 of 300 more than the original mid-year 2011 data and 300 more for aged 85+ population totalling an additional 600 older people. Had the report been remodelling to include this new data? *Members were advised that the model was continually being remodelling to include the new data and projections had shown a continued increase in the older people's population.*
- Was Welland House a specialist provider for dementia suffers? *Members were advised that it was registered to take people suffering from dementia but not a specialist provider. Staff at Welland House had received training to assist them to deal with dementia.*

- How many care homes in the independent sector were registered to take people suffering with dementia? *Members were informed that there were approximately 8 or 9 homes that were specifically registered to take people with dementia in the city.*
- What support are you providing to the people who are being made redundant*? Members were advised that the Unions had been consulted as to how staff could be best supported through the process. All staff affected had attended a 1:1 meeting where a series of options had been discussed on an individual basis. Opportunities of redeployment within the council had been explored where possible. If the homes were to be closed a package of support would be put together including help with CV writing and interview techniques.*
- What was the Shared Lives Scheme? *Members were informed that the Shared Lives Scheme was a service provided by individuals and families in their own home who wanted to offer a vulnerable person a short break, day care or long term care.*
- If the proposals to close the homes went forward when would Greenwood House close? *Members were advised that if the proposal to close the homes was approved and had been through the democratic process then Greenwood House would probably close before Christmas.*
- What contingency plans do you have in place should those staff at risk of redundancy decide to leave before the homes close. *Members were advised that all the staff at risk of redundancy would need to stay on until their redundancy date which would have been agreed with individuals to receive their redundancy payment. If they resigned and left before they were made redundant they would not receive their redundancy payment. It was therefore unlikely that they would leave before their date of redundancy.*
- How long would staff be retained to support residents in their move to new accommodation? *Members were advised that staff could not be retained and placed in another care home after the council homes were closed. Key workers would support and assist people in their moves prior to the move taking place.*
- A member of the Youth Council noted that it would take £5.4M to build a new care home and that net savings would be £1.5M. Would this therefore equate to a short to medium term deficit of £4M. *The Director of Adult Social Care advised that the recommendation was not to build a new care home. There was no justification to spend the £5.4M to build a new care home because there were sufficient places in existing care homes for the residents. To build and staff a new 86 bedded home and to pay the capital financing costs would end up with an average cost of £900 per week per bed which was twice as much as purchasing the same care in the independent sector.*
- Members sought clarification that the ICT migration from the NHS platform over to the PCC ICT system had been completed and that the difficulties that had been in place had been resolved and had not impacted on the information in the report. *Members were assured that the ICT issues had not impacted on the recommendations made within the report and that all ICT issues would be resolved within the following week.*
- Members commented that the consultation pack which had included all responses to the consultation had not been made available for Members to see as had been initially indicated that it would be. *Members were advised that the dossier containing all the consultation responses could not be left in public areas as it contained personal information. Members could request to see the information through Tim Bishop.* Members were unhappy that they had not been advised of this prior to the meeting.

The Chair asked the Committee to take a vote with regard to the recommendations put forward in the report. A vote was taken and recorded as follows with regard to the following recommendations:

Recommendation 1

That Cabinet approves the closure of Greenwood House and Welland House care homes and that all current permanent residents are provided with suitable and appropriate offers of alternative accommodation that meets their assessed needs and choice at no additional cost to the resident;

The Committee voted in favour of recommendation 1 (4 in favour, 3 against)

Recommendation 2

That Cabinet affirms that there should be no loss of access to day care, respite or interim care for current service users as a result of these closures providing the Commissioning of respite care and day care is in place before the closure of the homes.

The Committee voted unanimously in favour of recommendation 2.

Recommendation 3

That Cabinet endorses the commissioning plans to secure: a) alternative interim care beds in the independent sector; b) replacement respite care facilities; and c) interim and long term day facilities including a dementia resource centre. The respite care and day care should not be on an interim basis and permanent contracts should be in place before the closure of the homes to avoid moving the clients more than once.

The Committee voted unanimously in favour of recommendation 3.

Recommendation 4

That the Cabinet Member for Adult Social Care reports back on: progress with a) progress with closure; and b) progress with commissioning plans for replacement services in March 2013.

The Committee voted unanimously in favour of recommendation 4.

RECOMMENDATIONS

The Commission recommends the following to Cabinet:

1. That Cabinet approves the closure of Greenwood House and Welland House care homes and that all current permanent residents are provided with suitable and appropriate offers of alternative accommodation that meets their assessed needs and choice at no additional cost to the resident;

2. That Cabinet affirms that there should be no loss of access to day care, respite or interim care for current service users as a result of these closures providing the Commissioning of respite care and day care is in place before the closure of the homes.

3. That Cabinet endorses the commissioning plans to secure: a) alternative interim care beds in the independent sector; b) replacement respite care facilities; and c) interim and long term day facilities including a dementia resource centre. The respite care and day care should not be on an interim basis and permanent contracts should be in place before the closure of the homes to avoid moving the clients more than once.

4. That the Cabinet Member for Adult Social Care reports back on: progress with a) progress with closure; and b) progress with commissioning plans for replacement services in March 2013.

The Commission further recommend the following:

5. That if the decision is taken to close Greenwood House and Welland House and permanent residents are moved to alternative accommodation in the private sector that an audit of the new accommodation takes place on a quarterly basis during the first year

and then on an annual basis. The audit reports to be presented to the Scrutiny Commission for Health Issues with the quarterly Adult Social Care performance report.

6. That if the decision is taken to close Greenwood House and Welland House that key staff are retained for a suitable period of time after the closure to ensure the safe resettlement of residents into their new homes.

7. Given the lessons learnt and the assessments that have now taken place it is recommended that the good practice established during this consultation be continued going forward as established practice. That a review is undertaken of all older people who are currently in receipt of respite care and day care under Adult Social Care.

4. Date of Next Meeting

Tuesday 13 November 2012

The meeting began at 7.00pm and finished at 9.45pm CHAIRMAN

PETERBOROUGH CITY COUNCIL

MINUTES OF A MEETING OF THE SCRUTINY COMMISSION FOR HEALTH ISSUES HELD AT THE COUNCIL CHAMBER, TOWN HALL ON 13 NOVEMBER 2012

Present:	Councillors B Rush (Chairman), D Lamb, 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 Andy Vowles, Chief Operating Officer, Cambridgeshire & Peterborough CCG Catherine Mitchell, Local Chief Officer, Peterborough & Borderline Local Commissioning Groups Dr Paul Van Den Bent, Peterborough Local Commissioning Group Dr Gary Howsam, Borderline Local Commissioning Group Jessica Bawden, Director of Communications, Membership & Engagement, Cambridgeshire & Peterborough CCG Bob Dawson, Project Manager, Health & Wellbeing Strategy
Officers Present:	Terry Rich, Director of Adult Social Care Dr Andy Liggins, Director of Public Health Sue Mitchell, Associate Director of Public Health Tina Hornsby, Assistant Director, Quality Information & Performance Paulina Ford, Senior Governance Officer Kim Sawyer, Head of Legal Services

1. Apologies

No apologies for absence were received.

2. Declarations of Interest and Whipping Declarations

Item 5 Update on the Development of the Shadow Cambridgeshire & Peterborough Clinical Commissioning Group and the Peterborough and Borderline Local Commissioning Groups

Councillor McKean declared a interest in that he was a member of the Patient Participation Group for Eye and Thorney.

3. Minutes of Meeting held on 20 September 2012.

The minutes of the meeting held on 20 September were approved as an accurate record.

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

The Commission had been asked to consider a Call-In request that had been made in relation to the decision made by Cabinet and published on 5 November 2012, regarding Consultation on the Proposed Closure of the Two Care Homes: Greenwood House and Welland House - NOV12/CAB/133.

The request to Call-In this decision was made on 7 November 2012 by Councillor Saltmarsh and supported by Councillors Harrington and Sylvester. The decision for Call-In was based on the following grounds:

(i) The decision does not follow the principles of good decision making set out in Article 12 of the Council's Constitution specifically that the decision maker did not:

(a) Act for a proper purpose and in the interests of the public.

The reasons put forward by the Councillors were:

1. Financial reasons have been considered above the care provision and the wellbeing of the permanent residents and the day care centre users.
2. The public have felt very strongly about the closure of the homes, almost 6000 signatures were received against closure as were all the letters received, the publics opinion has not been taken into account.

After considering the request to call-in and all relevant advice, the Committee were required to decide either to:

(a) not agree to the request to call-in, when the decision shall take effect;
(b) refer the decision back to the decision maker for reconsideration, setting out its concerns; or
(c) refer the matter to full Council.

The Chairman read out the procedure for the meeting.

Councillor Saltmarsh, Harrington and Sylvester each addressed the Committee stating why they had called the decision in.

Questions and Comments from Members of the Commission in response to the Councillors statements:

- Members commented that all recommendations previously made by the Commission at the extraordinary meeting held on 1 November 2012 had been accepted by Cabinet.
- The Financial model had been based on full occupancy of both homes.
- Members sought clarification that any councillor could attend any Scrutiny meeting and ask questions and put forward their points on a matter so that they could be assured that Councillors had had an opportunity to comment on this issue. *The Head of Legal Services confirmed that they could.*
- Members sought assurance that the council had taken all the correct legal steps for reviewing the decision, scrutinising it, calling the decision in and taking everything into account legally. *The Head of Legal Services confirmed that all the correct legal procedures had been taken.*

The Cabinet Member for Adult Social Care made a statement in answer to the Call-In request which included the following:

- It had been a very difficult decision to make.
- Financial considerations were not put above the consideration of the people affected. There were however financial implications.
- Cabinet Members had an opportunity to see the letters that had been submitted as part of the consultation and they had been available for any Member requesting to see them.
- The 6000 signatures included in the response to the consultation had been taken into account.

- The report presented to Cabinet had provided a fair and balanced view for consideration but acknowledged that it may not have pleased everyone.

The Director of Adult Social Care responded in answer to the Call-in request:

- In response to the call-in reason of "Financial reasons have been considered above the care provision and the wellbeing of the permanent residents and the day care centre users", Members were advised that the report had presented in a balanced way the rational for the decision. The route of the decision lay within the Older Peoples Accommodation Strategy. The financial implications of continuing to run the two Care Homes, rebuilding them or building a new one were clearly laid out in the report.
- Regarding the second point **'**The public have felt very strongly about the closure of the homes, almost 6000 signatures were received against closure as were all the letters received, the publics opinion has not been taken into account'. The issues raised by those responding to the consultation had been grouped together and responded to in the report.
- The Scrutiny Commission had scrutinised the report in detail at its meeting on 1 November 2012 and recommendations were made to Cabinet.

Comments and questions from Members of the Commission

- Councillor Shape made a statement which included the following:
    - Additional alternative proposals should have been considered
    - A phased approach should be taken regarding the transfer of the elderly people so that they were not put under stress.
    - The decision should be made at Full Council.

As there was no further debate the Committee took a vote to decide on whether they should:

(a) not agree to the request to call-in, when the decision shall take effect;
(b) refer the decision back to the decision maker for reconsideration, setting out its concerns; or
(c) refer the matter to full Council.

The Committee voted in favour of (a) not agree to the request to call-in the decision (4 in favour, 3 against)

ACTION AGREED

The request for Call-in of the decision made by Cabinet and published on 5 November 2012, regarding Consultation on the Proposed Closure of the Two Care Homes: Greenwood House and Welland House - NOV12/CAB/133 was considered by the Scrutiny Commission for Health Issues. Following discussion and questions raised on each of the reasons stated on the request for call-in, the Committee did <u>not</u> agree to the call-in of this decision on any of the reasons stated.

It was therefore recommended that under the Overview and Scrutiny Procedure Rules in the Council's Constitution (Part 4, Section 9, and paragraph 13), implementation of the decision would take immediate effect.

5. Update on the Development of the Shadow Cambridgeshire & Peterborough Clinical Commissioning Group and the Peterborough and Borderline Local Commissioning Groups.

The report informed the Commission on the development of the shadow Cambridgeshire & Peterborough Clinical Commissioning Group and the Peterborough and Borderline Local Commissioning Groups. The Chair welcomed the Chief Operating Officer, Cambridgeshire &

Peterborough CCG and colleagues. The Chief Operating Officer introduced the report and provided the Commission with the following information:

- An update on the Cambridgeshire & Peterborough Clinical Commissioning Group and the developing priorities.
- An overview of the new NHS architecture.
- Local decision making and planning for next year 2013/2014.

The Commission were informed that from April 2013 Primary Care Trusts would be abolished and the functions discharged by PCT's would go in three main directions:

- Clinical Commissioning Groups
- A new body called the NHS Commissioning Board
- Public Health functions would be transferred over to the Local Authority and some areas would go into a new body called Public Health England.

Clinical Commissioning Groups were statutory bodies set up through the Health and Social Care Act but were membership organisations which were built on GP Practices. Peterborough had 109 member practices spanning the County of Cambridgeshire and Peterborough city and also entering into Northamptonshire and Hertfordshire. Under the Clinical Commissioning Group which would be the statutory body from April 2013 there would be eight Local Commissioning Groups constituted of local practices that then elected their leadership. The Governing Body has decided on three main priority areas:

- Frail elderly
- End of life care
- Health inequalities, particularly in relation to coronary heart disease

The business plans for the Clinical Commission Groups were being developed and would be brought before the Commission in March 2013.

Observations and questions were raised and discussed including:

- Members sought clarification on End of Life Care. Was there a legal requirement for all doctors to fully explain and obtain consent from the patients, relatives or carers before placing someone on the End of Life pathway? *Members were advised that this was correct.*
- Members wanted to know how doctors could ensure that the procedure for placing people on the End of Life pathway would be followed. *Members were informed that there had been a programme of work around End of Life Care looking at consent issues and services that people need. A register was in place for people on the End of Life Care pathway and GP's would gain consent to put people on the register. An assessment would then take place as to what services that person would need as they progressed along the End of Life pathway at each stage. The Multi Disciplinary Teams would also follow this process.*
- Had the report taken into consideration the latest Census figures when considering the growth in the older population over the next four to five years? *Members were advised that the population projections in the report were based on the Office of National Statistics (ONS) data and these would be updated as new data was received.*
- What patient representatives and other groups were represented on the new Clinical Commissioning Groups. *The Director of Communications, Membership & Engagement, Cambridgeshire & Peterborough CCG informed Members that there was a sub committee of the Shadow Clinical Commissioning Group Governing Body called a Patient Referencing Group. This group was made up of patient representatives from each Local Commissioning Group Board. The Peterborough Consultation Forum also sat on this group. It was hoped that the new HealthWatch would also sit on the group in the future. Dr Gary Howsam, Borderline Local Commissioning Group advised Members that for*

Borderline there were ten practices and ten Patient Participation Groups. One or two representatives were sent from these groups to the Patient Forum. The patients were at the heart of the decisions made and could veto a decision made by the Board. Every other month a Borderline Jamboree was held. It would be based on a different clinical project and was open to all patients, patient groups, all staff and all clinicians working throughout Borderline. 80 to 100 people usually attended. Dr Paul Van Den Bent, Peterborough Local Commissioning Group advised that when developing patient pathways for specific diseases invitations went to groups like Age UK and the Asthma Society. Patients were central to the development of pathways.

- Members were advised that the Statutory Duties to engage and consult with patients would be transferred to the Clinical Commissioning Groups.
- The report stated that Clinical Commissioners would be responsible through the CCG for managing prescribing based on clinical and cost effectiveness and best value prescribing. How would the cost effectiveness and best value be worked out whilst ensuring the patient was given the best prescription? *Members were advised that best value would be about the 1:1 consultation with the patient as each patient had a different requirement regarding prescribing. The price of drugs varied greatly and the technology of the drugs changed over time but prescribing would be based on what was best for the patient.*
- How many professional commissioners would be employed in the new commissioning structure? *Members were informed that there was about 200 staff employed across the whole CCG which was a reduction in staff than was employed through the PCT.*
- Members sought clarification that Peterborough's interests would be taken into account at all times and that Peterborough would receive its fair share of National Health resources. *Members were informed that the CCG operated a devolved structure which was a federation of the eight local commissioning groups. When the allocation of resources was received it would be distributed on a fair shares basis to relevant communities.*
- What did the Cambridgeshire & Peterborough Clinical Commissioning Group and the Peterborough and Borderline Local Commissioning Groups think of the draft Health and Wellbeing Board Strategy and priorities. *Members were informed that the CCG and Health and Wellbeing Board had worked closely together and therefore the priorities of both were aligned.*
- Mary Cook, Vice Chair of Peterborough Pensioners Association addressed the committee and made a statement which highlighted points concerning generic drugs and the End of Life Strategy referral system.
- Annette Beaton a member of Peterborough LINks and a Governor at the hospital addressed the committee and commented that she was very pleased to see that the CCG's were taking on the responsibility of the patients.

ACTION AGREED

The Commission noted the report and requested that the Commission be kept updated on the development of the Clinical Commissioning Groups.

6. Draft Health and Wellbeing Strategy 2012-15

The Director of Public Health introduced the report which presented the Commission with the draft Health and Wellbeing Strategy 2012-15. This was the first strategy of the Health and Wellbeing Board and the Commission had been asked to give their views and comments as part of the consultation process.

The three year strategy was set out to:

- Identify health and wellbeing priorities
- Set clear markers for NHS and Local Authority commissioners as they acted to put in place the right mix of services and initiatives to meet the needs of the population

- Enable commissioners to mutually hold each other to account for their commissioning decisions
- Help to develop partnerships that provided solutions to commissioning challenges

Members were informed that the Health and Wellbeing Board was about partnership and seeing the best possible way to deliver service. The priorities selected in the strategy related closely to the findings of the Joint Strategic Needs Assessment (JSNA):

1. Securing the foundations of good health
2. Preventing and treating avoidable illness
3. Healthier older people who maintain their independence for longer
4. Supporting good mental health
5. Better health and wellbeing outcomes for people with life-long disabilities and complex needs

The consultation would close on 23 November and the final draft including feed back from the consultation would be presented to the Health and Wellbeing Board on 10 December to confirm the priorities and finalise the strategy.

Observations and questions were raised and discussed including:

- Members noted that under the priority *'Healthier older people who maintain their independence for longer*' there was evidence that flu vaccination for over 65s was below average. Members had felt that it had not been well advertised and this could be the reason for it being below average. *The Director of Public Health responded that most practices should have written to all eligible patients advising them of the availability of the vaccination. The national flu vaccination campaign had not run for the last two years but the government had agreed to reinstate it.*
- How had the consultation been promoted and how many responses have been received so far. *Members were advised that the consultation process was still running. On 21 November there would be a stakeholder event for 60 delegates. The feedback through the written consultation route had been relatively limited. The main feedback would come through the stakeholder event. There had also been several press releases and the draft strategy had been put on various partnership agendas.*
- Members noted that under the priority '*Supporting good mental health'* there was evidence of high level of school exclusions and out of city placements for children and young people with statements with the primary category being behavioural emotional and social difficulties. Why were children sent to out of city placements? *Officers were unable to comment on Children's Services but advised Members that it might be because they were children with special needs. This was in the strategy because it had been an issue of concern.*
- How could you ensure that this strategy would work and improve things when previous ones have failed? *The Director of Public Health responded that the strategy was based on evidence and the findings of the Joint Strategic Needs Assessment. The priorities identified within the strategy were some of the most difficult issues across society and within Peterborough. A key determinant for the successful delivery of the strategic priorities and associated outcomes would be the robustness of the interagency planning, commissioning and delivery arrangements for Peterborough.*

The Strategy included a series of questions which the Commission were required to respond to as part of the consultation process to obtain their views on the strategy. It was agreed by the Members that they would respond outside of the meeting and the responses would be emailed to the officers as this would allow more time to consider the response.

ACTION AGREED

1. The Commission noted and commented on the draft Health and Wellbeing Strategy for Peterborough.

2. The Commission to respond to the Director of Public Health on the questions in the draft Health and Wellbeing Strategy for Peterborough by 23 November 2012.

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

The report provided the Commission with an update on the delivery of Adult Social Care services in Peterborough against the key priorities identified in the business plan, linked against the four outcome domains contained within the national Adult Social Care outcomes framework. The report covered the second quarter of 2012-13. The Assistant Director, Quality Information & Performance informed the Commission that the report was in a slightly different format than previously presented in that it had been mapped to the departmental priorities as well as the national priorities. New information sets had been included such as reablement statistics which had been identified as a major priority for this year. Highlights included:

Priority One – promoting and supporting people to maintain their independence
The operating model for Adult Social Care to promote independence and support people for longer in lower care environments was being remodelled. In particular the reablement service was expanding and delivering good outcomes in respect of the levels of need with which people leave the service.

Priority 2 – delivering a personalised approach to care
Progress was being made against the key enablers of this priority. Numbers of Learning disabled people receiving annual health checks was increasing and expected to hit the target of 16% by the end of the year. Numbers using the shared lives scheme was increasing and the recent campaign had created interest from prospective carers. The national carer's survey was currently underway, with just under one thousand carers being sent a survey.

Priority 3 – Empowering people to engage with their communities and have fulfilled lives
Supporting adults with learning disability into employment had continued to do well. However, numbers in settled accommodation was still comparatively low. There was still a need to improve availability of information for all client groups. Work to introduce an online directory of services was now underway with an expected delivery date of January 2012.

Safeguarding Vulnerable Adults
Progress had been made in the process of conducting safeguarding investigations. The backlog of cases previously reported had now been cleared and the performance against process indicators for alerts, referrals and investigations for quarter 2 have shown a marked improvement. Focus was now moving on to quality monitoring and a case audit tool for safeguarding investigations was being piloted.

A permanent strategic lead had been appointed for Safeguarding and would be in place by the end of November.

Observations and questions were raised and discussed including:

- Priority 3 – Empowering people to engage with their communities and have fulfilled lives. What was being done to help, support and facilitate those in elderly residential care bungalows and supported living and volunteers on those sites? *Members were informed that work was being done on a Prevention Strategy around supporting people at*

the level of need prior to them needing high levels of intervention. Volunteer schemes were key to the strategy. More information would be provided to the Commission at a later date.

- Had audits now been put in place for the care homes as recommended by the Commission at its meeting on 1 November 2012? *The Director of Adult Social Care advised Members that the frequency of the reviews of those people moving from Greenwood House and Welland house had been increased to three monthly reviews instead of six monthly during their first year at the new care home. Additionally the contract management visits would continue at each of the homes.*
- Had the issues with the IT systems now been sorted? *The Director of Adult Social Care confirmed that all staff had now been transferred onto the new IT system.*
- Members were pleased to note that there were no indicators in the progress report marked as red but that there were some indicators marked as Amber and wanted to know if there was a timescale for those indicators to turn green. *Members were informed that some indicators like the safeguarding ones would remain Amber for the year to date position but others were working towards turning green. The department was in a phase of continuous challenge and improvement and therefore the report would continually reflect both red and amber indicators as some indicators turned green and were removed others would be added that would be red or amber.*
- Members sought clarification on the Shared Life Scheme. *The Director of Adult Social Care advised Members that the scheme was about carers who were assessed and agreement reached to provide professional care in their own home for an individual. It was a contractual arrangement with care support going into it. If the relationship broke down in that care scenario then care professionals would work with them to resolve the issue or move the person. It was part of a nationally recognised scheme to provide care for a number of individuals.*
- Members wanted to know if there was evidence that the Shared Life Scheme had been successful in other places. *Members were advised that there had been evidence of good outcomes from schemes around the country and the Peterborough scheme could also evidence good outcomes. A presentation on the Shared Life Scheme could be brought to the Commission at a future meeting.*
- Members requested that future progress reports should include targets and date to be achieved.
- Members noted in the report that under 'Support Planning' a specialist agency had undertaken around 500 reviews of support plans for clients that had not received a review in the previous 12 months. Members wanted to know why there was such a backlog and going forward would they be able to ensure no further backlogs occurred. *Members were informed that in Qtr 1 it had been identified that there was a back log of people who had received an Adult Social Care service but had not been reviewed in the last 12 months. The decision was made to bring in a specialist organisation to clear the backlog. It was anticipated that now the backlog had been cleared current reviews would take place on time.*

ACTION AGREED

1. The Commission noted the report and requested that The Assistant Director, Quality Information & Performance provide in future performance reports targets and timescales for achieving those targets.

2. The Commission also requested that the Director of Adult Social Care provide further information on the Shared Life Scheme.

8. Notice of Intention to Take Key Decisions

The Commission received the latest version of the Council's Notice of Intention to Take Key Decisions, 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 Notice of Intention to Take Key Decisions and, where appropriate, identify any relevant areas for inclusion in the Commissions work programme.

ACTION AGREED

The Commission noted the Notice of Intention to Take Key Decisions and requested further information on Healthwatch Commissioning – KEY/30NOV12/02.

9. Work Programme

Members considered the Commissions 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.

10. Date of Next Meeting

Wednesday, 23 January 2013

The meeting began at 7.00pm and finished at 9.25pm CHAIRMAN

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SCRUTINY COMMISSON FOR HEALTH ISSUES	Agenda Item No. 5
23 JANUARY 2013	Public Report

Report of the East of England Ambulance Service

Contact Officer(s) – Chris Hartley, Associate Director of Communications & Engagement
Contact Details - Chris.Hartley@eastamb.nhs.uk

EAST OF ENGLAND AMBULANCE SERVICE

1. PURPOSE

1.1 The report is being presented to the Commission at the request of the Chair.

2. RECOMMENDATIONS

2.1 The Commission to note and comment on the contents of the report.

3. BACKGROUND

3.1 Background information has been detailed in the attached report at Appendix 1.

4. KEY ISSUES

4.1 Key issues have been highlighted in the attached report at Appendix 1.

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

5.1 None

6. APPENDICES

6.1 East of England Ambulance Service Report – Appendix 1

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East of England Ambulance Service NHS Trust

Background

The East of England Ambulance Service NHS Trust (EEAST) has put in place a number of initiatives to improve its service to patients and the public should start seeing these bear tangible benefits over the next few months. This is part of a wider strategy to deliver a more tailored service to patients whilst meeting the challenges EEAST faces – an ever increasing number of 999 calls, the ongoing drive to improve the quality of our services and the need to make efficiency savings of over £50 million in a five year period.

As a result, EEAST is implementing a new integrated service model to deliver this strategy. At the heart of this is a more in depth telephone assessment for those patients with less serious conditions to get them the help they really need (which could be advice over the phone or referral to a more appropriate health service such as their GP or minor injuries unit) rather than sending an ambulance.

This is being carried out by Clinical Support Desks who are now saving around 900 ambulance journeys a weeks. This is better for the patients as they get the help they need without needing to go to hospital, better for the NHS and hospitals and it frees up ambulances to respond to patients who really need an emergency response.

However, this alone will not meet all the challenges. Therefore EEAST is redesigning front line rotas to make sure its resources are in the right place at the right time to help patients and the revisions are based on a sophisticated demand analysis. This also means that by working more efficiently and effectively for patients EEAST can protect front line staffing and make no front line staff redundant.

Rota redesign is not about taking resources out – EEAST is making no front line staff redundant. Indeed EEAST has recruiting over 100 new Emergency Care Assistants to the front line so far this year and is looking to recruit over 190 additional paramedics and ECAs as well.

How 999 calls are prioritised

All 999 calls received into our control rooms (Health & Emergency Operations Centres) are triaged by call handlers using software called the Advanced Medical Priority System. The purpose of the triage is to identify the seriousness of the patient's condition by asking a series of focussed questions around the chief complaint to determine the priority of the call.

The call priority then determines the level and type of response sent in line with Trust policies and national and government targets, so that those in most need get the fastest response. The call priorities and level of response are broken down into red and green categories nationally:

- Red 1 and red 2
  These are calls that are classified as immediately life threatening and require an emergency response (with blue lights). The target is to arrive at these patients within 8 minutes irrespective of location in 75% of cases.

- Green 1
  These are serious calls but not life threatening which require an emergency response to arrive in 20 minutes.

- Green 2
  These are serious calls, but not life threatening, which require an emergency response to arrive in 30 minutes

- Green 3
  These are low acuity calls which require a phone assessment within 20 minutes (a clinician calling back for a secondary telephone triage to establish the best pathway of care) or an ambulance response at normal road speed within one hour.

- Green 4
  These are the lowest acuity calls which require a response within 60 minutes or a phone assessment within 60 minutes (as described above).

As part of our new integrated service model the Trust has developed Clinical Support Desks. The clinicians who work on these call back patients with less serious conditions to undertake a more in depth assessment to understand what they really need which could be referral to a more appropriate health service provider, advice over the phone or the dispatch of an ambulance resource.

Rota redesign
The impact of rota redesign in Peterborough is that there will be more hours per week of emergency cover provided, although there will be changes to when resources are scheduled to better meet patient demand. In Peterborough the changes to hours of cover per week are as follows:

Emergency vehicle type	Existing planned weekly hours of cover	Future planned weekly hours of cover
Rapid response vehicle	644	696.5 (+52.5 hours)
Intermediate tier vehicle (crewed by two Emergency Care Assistants)	155.5	140 (-15.5 hours)
Double staffed ambulance	774.5	889 (+ 114.5)

In effect this investment in hours results in the creation of 8 new whole time posts at Peterborough ambulance station.

Patient handover delays
Across the region, the Trust continues to see significant patient handover delays despite continuous partnership work. However, The Trust works closely with Peterborough City Hospital and is pleased to report that it does not have any significant patient handover delay problems here. Indeed it is regarded as an example of best practice across the region.

Peterborough
Cambridgeshire has made dramatic improvement to its core standards over the past 12 months. Its estate has been updated in many areas and now is considered a top performer on a consistent basis regarding Infection Prevention and Control.

Peterborough is managed as part of the Trust's North West sector. The table below shows time response performance for the Peterborough Primary Care Trust (PCT) area for April to November 2012 and shows the Trust's activity and performance for category A patients or red calls – i.e. those in potentially life threatening conditions.

PCT area	Category A activity	A8 %	A19 %
Peterborough PCT	6,348	85.65%	98.23%

The Trust is funded to hit a regional target for A8 and A19, with the target to get to 75% of category A calls within 8 minutes (the A8 target) and providing a transportable resource within 19 minutes of request for such patients (the A19 target). As this table shows, performance within the Peterborough PCT area is very strong.

The local team is performance managed on the ambulance quality indicators and is pushing forward with the stroke 60 targets (60 minutes from time of the call to the patient receiving thrombolysis in an hyper acute stroke centre). The team have also continued to deliver a gold standard of service directly conveying patients who experience a heart attack to their respective PPCI centre. And the service has recently extended its range of pain relief to encapsulate those patients with mild to moderate pain using co-codamol.

The Trust has also progressed and developed a major trauma pathway model, identifying quickly patient's conditions and quick referral pathways to regional trauma centres. The service has also introduced a new drug called Tranexamic acid as a means to reduce blood loss for severely injured trauma patients. This assists patients in severe trauma cases with significant blood loss in stabilising their pre hospital experience.

The Trust will be shortly introducing as a trial a new transport model, called UCAS. UCAS is a resource that allows clinicians to dictate what type of transport a patient needs to convey them to hospital, out of hours service, dentists or GP surgery. Historically the Trust has transported patients in double staffed ambulances to the acute settings, sometimes in a level of transport that was not reflective of their needs. UCAS brings a different type of transport dependant on medical need to the clinicians making their initial medical assessment, allowing life saving ambulances to be targeted to those patients that need them most.

Understanding the importance of providing the right care to patients, at the right time, local managers continue to work with alternative care pathway providers to identify ways to avoid inappropriate admissions to hospital when options to manage patients in a more suitable setting exists. Examples of these include work with Intermediate Care Service beds at the City Care Centre and the potential to refer patients to specific Mental Health Services.

Calls to patients who have fallen make up a significant number of our 999 responses across the region. In Peterborough we are working closely with the commissioners to develop a falls car service crewed with a Paramedic and Social Worker or Therapist. This would aim to review those patients who have fallen to reduce the risk to them falling again in the future and linking in with other healthcare providers to offer the appropriate levels of support.

We continue to look at opportunities in the Peterborough area to develop standby locations for crews in order that they can base themselves around the city and thus reduce the travel distance to emergency calls in the city and surrounding area. We currently have full standby posts in Werrington, Hampton, Parnwell and the facility to standby in locations in Dogsthorpe, Stanground and Bretton. We are looking to develop the Bretton standby location into a full response post with better facilities for crews in 2013.

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SCRUTINY COMMISSION FOR HEALTH ISSUES	Agenda Item No. 6
23 JANUARY 2013	Public Report

Report of the Executive Director of Care Quality and Chief Nurse, Peterborough City Hospital

Contact Officer(s) – Chris Wilkinson
Contact Details – 01733 677927; chris.wilkinson@pbh-tr.nhs.uk

PETERBOROUGH & STAMFORD HOSPITALS NHS FOUNDATION TRUST – QUALITY ACCOUNT PROGRESS

1. PURPOSE

1.1 To meet the requirement for an update on quality performance in year made by the Scrutiny Commission for Health Issues in their comments for inclusion in the Trust's Quality Account for 2011/12.

2. RECOMMENDATIONS

2.1 Consider and comment on the contents of the Quality Report as at Month 9 and note the invitation to the Stakeholders Event at which attendees will be invited to comment on and challenge the Quality Account content and presentation, and contribute to the setting of priorities around quality improvement for 2013/14.

3. LINKS TO THE SUSTAINABLE COMMUNITY STRATEGY

3.1 Priority 1 Creating opportunities – tackling inequalities – improving health and supporting vulnerable people.

4. BACKGROUND

4.1 All Trusts are required to submit a Quality Account annually. There are explicit requirements around content for this report as set out in the Department of Health Quality Account Toolkit. In addition, Monitor sets requirements of Foundation Trusts, the final details for 2012/13 are currently under consultation.

4.2 The document should be written in an open and transparent way that is reader friendly to the public while at the same time meeting the requirements as set out by the Department of Health and Monitor. The content should reflect reporting that has taken place in year and the Board of Directors are required to comment on the quality of the data included.

4.3 Stakeholders are invited each year to provide comments; this includes comments from the Scrutiny Commission for Health Issues.

4.4 The document is subject to external audit each year. This year, a dry run month 9 report is being produced, which will then be added to to incorporate year end data

5. KEY ISSUES

5.1 The report (attached) demonstrates some positive quality improvements achieved in year, including 97.3% harm free care for hospital associated care as measured by the Safety Thermometer, good progress in the wards engaged in the 'Stop the Pressure' collaborative to reduce the risks of pressure ulcer formation, and good progress in the national CQUIN work around early dementia assessment and diagnosis. Areas where there are particular challenges

this year are around the number of hospital acquired *Clostridium difficile* infections, falls, and pressure ulcers.

6. IMPLICATIONS

6.1 The Trust strives to deliver high quality care in order to provide positive patient experiences, clinical effectiveness and safe care. Where this is not optimally achieved the potential implications are poor patient experience that may result in prolonged hospital stays with uncomfortable symptoms and complaints, reduced efficiency, failure to achieve financial incentives (e.g. the CQUIN schemes), or activation of contractual penalties. Where outcomes are very poor, there may be reputational issues that may impact on confidence in the hospital amongst the community.

7. CONSULTATION

7.1 Stakeholders were involved in selecting the priorities for quality improvement for 2012/13. The Quality report is presented at the Board of Director's meeting which is held in public and questions are invited from those present at the end of the meeting. Involvement of stakeholders is invited in relation to the content and presentation of the Quality Account through distribution of the draft document for comment/challenge and attendance at the Stakeholder event held on an annual basis.

8. NEXT STEPS

8.1 Please see Appendix 2 for the schedule of next steps including the date by which the Commission will be circulated with the draft document for comment, and the date for the Stakeholder Event.

9. BACKGROUND DOCUMENTS

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

9.1 Monthly Quality Reports produced by the Trust
Department of Health Quality Account Toolkit 2010/11
Monitor Annual Report Manual
The National Health Service (Quality Accounts) Regulations 2010 Statutory Instrument 2010 No. 279

10. APPENDICES

10.1 Appendix I – Quality Report to the Board of Directors meeting – 18 December 2012
Appendix II - Quality Account preparation 2012/13

Appendix I

Presented for:	Discussion		
Presented by:	Chris Wilkinson, Director of Care Quality and Chief Nurse		
Strategic objective:	Excellent Patient Care - Patient Safety		
Date:	10 December 2012		
Regulatory relevance:	CQC Registration:	Quality and Management	Outcome 16
	CQC Registration:	Personalised Care, Treatment Support	Outcome 4
	NHSLA Risk Mgt:	Clinical Care	Not applicable

Quality Report

Overview

This report summarises performance across the three domains of quality (safety, clinical effectiveness and patient experience) and highlights quality governance issues. It updates board members on issues raised by or with the regulators in relation to quality of care and covers the areas highlighted in the Quality Account and priorities for 2012/13 along with other key indicators monitored in year. Some priority areas are reported in the Management Information Report and others are under development.

Key achievements of note

1. 'Harm free' care: 97.3%
2. Pilot ward in 'Stop the Pressure' collaborative: 111 days without a Grade 2, 3 or 4 pressure ulcer
3. Sustained improvement in dementia risk assessment figures

Key points for discussion

1. Falls (two grade 3 patient falls)
2. Pressure ulcers (one grade 3)
3. *Clostridium difficile* infections (3 hospital acquired infections)

The following papers make up this report:

- Quality Report

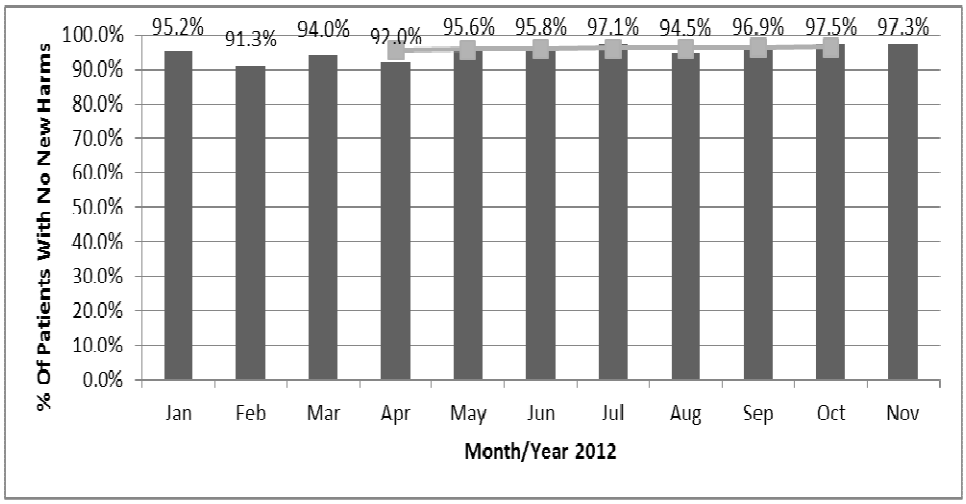
1. Safety

The total number of patients surveyed during the data collection period each month is seen in the table and the graph shows the percentage of patients who have received harm free care within the Trust.

Table to show number of patients surveyed January to September 2012

Month	Patients Assessed In Month
Jan	582
Feb	573
Mar	521
Apr	590
May	589
Jun	598
Jul	594
Aug	567
Sep	588
Oct	606
Nov	586
Total	**6394**

Graph to show percentage of patients receiving harm free care within the Trust and a line to show the national average



The Trust is required to assure the Commissioners that all 'relevant' patients are surveyed (*relevant patients are all admitted in patients except day cases, outpatients, ED attendances, well babies, renal dialysis patients, regular day attenders such as chemotherapy patients) and this month the Information Services Department produced a list of 'relevant' patients at 09.00 on the day to be surveyed. All 586 relevant patients were surveyed and this process will now continue monthly.

Occupied	Surveyed	Excluded:	Day Cases	Well Babies
649	586	63	45	18

Well babies have been defined as children less than 29 days (neonates) not on the Transitional Care Unit or the Neo natal Intensive Care Unit

1.1.1 Reducing the number of patient falls

The table below shows the total number of falls by month with the breakdown by severity against the trajectory set for a 20% reduction in the number over the year. The figure presents a month on month comparison of reported falls.

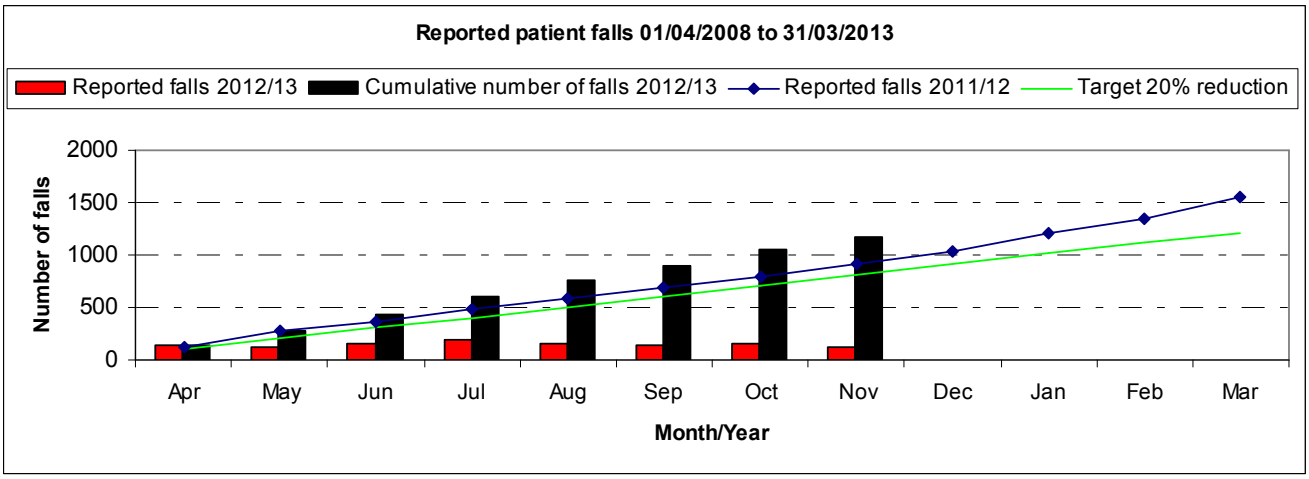
Table to show number of falls by severity and against a ceiling trajectory to achieve a 20% reduction with zero tolerance for grades 3-5

M/Y	Grade 0		Grade 1		Grade 2		Grade 3		Grade 4		Grade 5		Total	
10/11	**867**		**150**		**161**		**23**		**0**		**0**		**1201**	
11/12	**1052**		**250**		**215**		**34**		**0**		**0**		**1551**	
	T	**A**	**T**	**A**	**T**	**A**	**T**	**A**	**T**	**A**	**T**	**A**	**T**	**A**
Apr	71	**98**	17	**22**	15	**17**	0	**4**	0	**0**	0	**0**	103	**141**

May	71	**89**	17	**21**	15	**15**	0	**4**	0	**0**	0	**0**	103	**129**
Jun	70	**107**	17	**27**	15	**19**	0	**2**	0	**0**	0	**0**	102	**155**
Jul	70	**137**	17	**22**	15	**19**	0	**5**	0	**0**	0	**0**	102	**183**
Aug	70	**112**	17	**19**	14	**20**	0	**3**	0	**0**	0	**0**	101	**154**
Sep	70	**102**	17	**19**	14	**15**	0	**2**	0	**0**	0	**0**	101	**138**
Oct	70	**119**	17	**10**	14	**18**	0	**3**	0	**0**	0	**0**	101	**150**
Nov	70	**72**	17	**25**	14	**25**	0	**2**	0	**0**	0	**0**	101	**124**
Dec	70		16		14		0		0		0			
Jan	70		16		14		0		0		0			
Feb	70		16		14		0		0		0			
Mar	70		16		14		0		0		0			
Total	842		200		172		0		0		0		1214	**1174**

Source: Peterborough and Stamford Hospitals NHS Foundation Trust Datix

Figure to show reported falls in 2011/12 and 2012/13 with target 20% reduction



The Quality Improvement Programme supported by the Midlands and East Multiprofessional Deanery has begun with the formation of a steering group and priority actions agreed. These include:

- the provision of supportive slippers recommended for use on hospital surfaces for a trial period on ward B14 as a Trust has reported up to a 30% reduction in patient falls with this intervention
- the completion of a pilot phase of updated hands on practical competency assessed training for nursing staff
- the use of the TABBS sensor pads to alert staff to patient movement which will be in the Trust from 12 December 2012.

A joint project about reducing falls risks associated with medications across the whole health economy is being discussed with our commissioners.

1.1.2 Reducing the number of hospital acquired pressure ulcers

The table below shows the total number of pressure ulcers acquired in hospital with a breakdown by severity against a trajectory set to achieve the ambitious target set through the Quality Schedule in the contract.

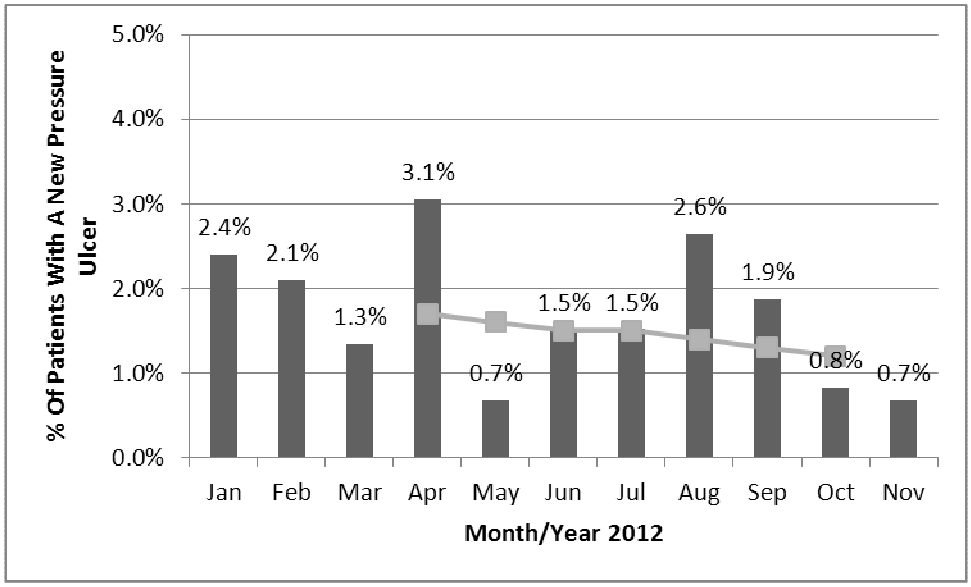
Table to show number of hospital associated pressure ulcers

	Grade1	**Grade2**	**Grade 3**		**Grade 4**		**Total**
10/11	63	103	3		0		169
11/12	99	191	21	9 un + 5	1 un		312

					av				
	T	**A**	**T**	**A**	**T**	**A**	**T**	**A**	**T**	**A**
Apr	14	**14**	30	**30**	3	**3**	0	**0**	50	**47**
May	14	**7**	28	**18**	3	**3**	0	**0**	45	**28**
Jun	14	**13**	23	**23**	3	**0**	0	**0**	40	**36**
Jul	14	**10**	17	**28**	2	**2**	0	**0**	33	**40**
Aug	14	**10**	11	**26**	2	**5**	0	**0**	27	**41**
Sep	14	**10**	7	**16**	2	**6**	0	**0**	23	**32**
Oct	14	**8**	4	**14**	1	**1**	0	**0**	19	**23**
Nov	14	**12**	2	**11**	1	**1**	0	**0**	17	**24**
Dec	14		1		1		0			
Jan	14		0		0		0			
Feb	14		0		0		0			
Mar	14		0		0		0			
Tota l	168		126		18		0		312	**271**

Source: Peterborough and Stamford Hospitals NHS Foundation Trust
**the grade 4 pressure ulcer in 2011/12 was agreed as unavoidable*
Key: T- trajectory; A - actual; Un - unavoidable; av - avoidable

The Stop the Pressure Collaborative based around the Midlands and East SHA ambition to eliminate grade two, three or four pressure ulcers continues. The pilot ward, B12, has now reached an impressive 111 days with no grade two, three or four pressure ulcers. The second tranche of wards, B14, Haematology/Oncology and A4 have all reached 36 days respectively and ward A3, A9 and B5 are the latest wards to join the campaign. The collaborative, led by our two Tissue Viability Nurse Specialists, consists of training, a focus on essential assessment and nurse documentation and primarily the development of a culture where staff believe the ambition can be realised. Ward B12 will be presenting their work on 13 December 2012 at a region wide meeting and this will then be used to demonstrate good practice to the other wards in the Trust. The graph below shows the reduction in prevalence of new pre3ssure ulcers as recorded on the Safety Thermometer data collection day each month this year.



1.1.3 Venous thrombo-embolic (VTE) prevention

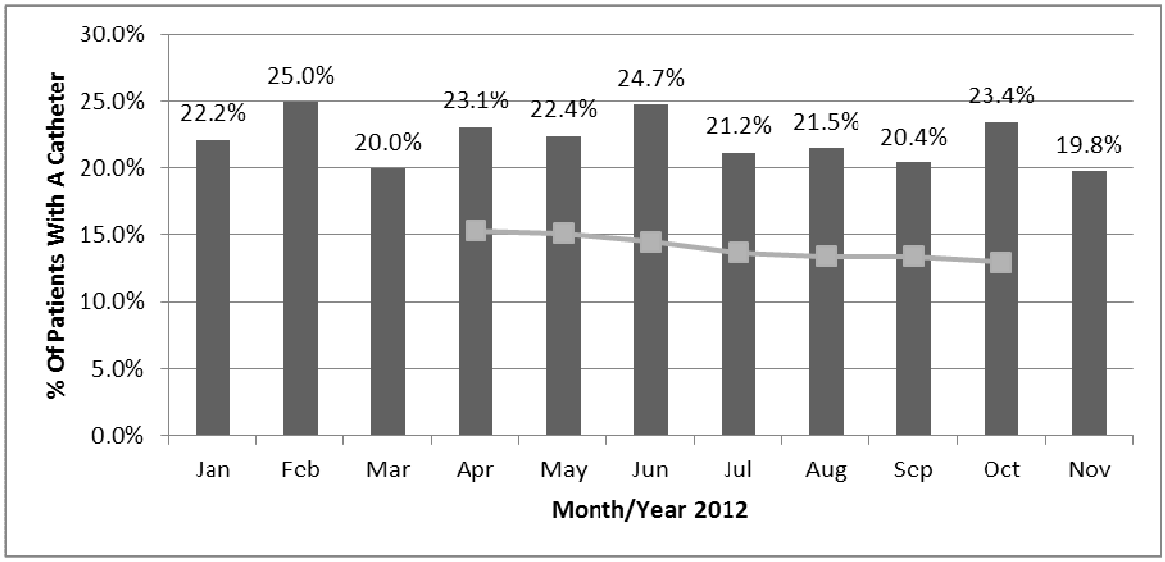
VTE risk assessment compliance in November was 96.9% (aggregated monthly data) whilst the VTE thromboprophylaxis compliance on 14 November 2012 was 100% (from NHS Safety Thermometer survey November 2012)

The VTE scrutiny panel met on 8 November 2012 and reviewed four patients who had developed a hospital associated VTE. The panel found that one patient developed the VTE despite treatment in line with NICE Guidance and whilst two other patients had blood clots deemed to be not preventable the reviews found errors in the timeliness and/or the accuracy of the risk assessment which will be reported back to the Thrombosis Committee. A fourth patient had a blood clot that the panel assessed as potentially preventable and this has been discussed with the relevant Clinicians and at the Thrombosis and Patient Safety Committees.

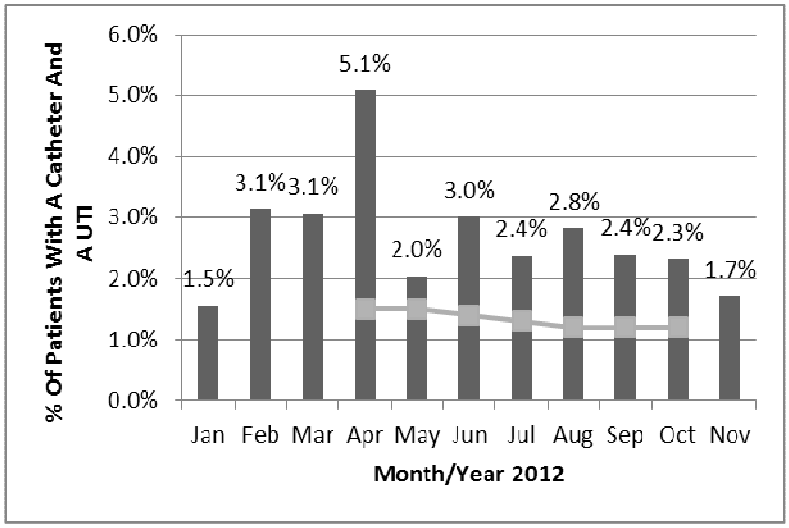
1.1.4 Reduction in catheter associated urinary tract infection (CAUTI)

The Urinary Continence Expert Group has continued to work to reduce the number of catheters inserted and the associated urinary tract infections. The graph below shows data from the Safety Thermometer collection with some progress made in both indicators.

Graph to show percentage of patients with an indwelling urinary catheter (not suprapubic)

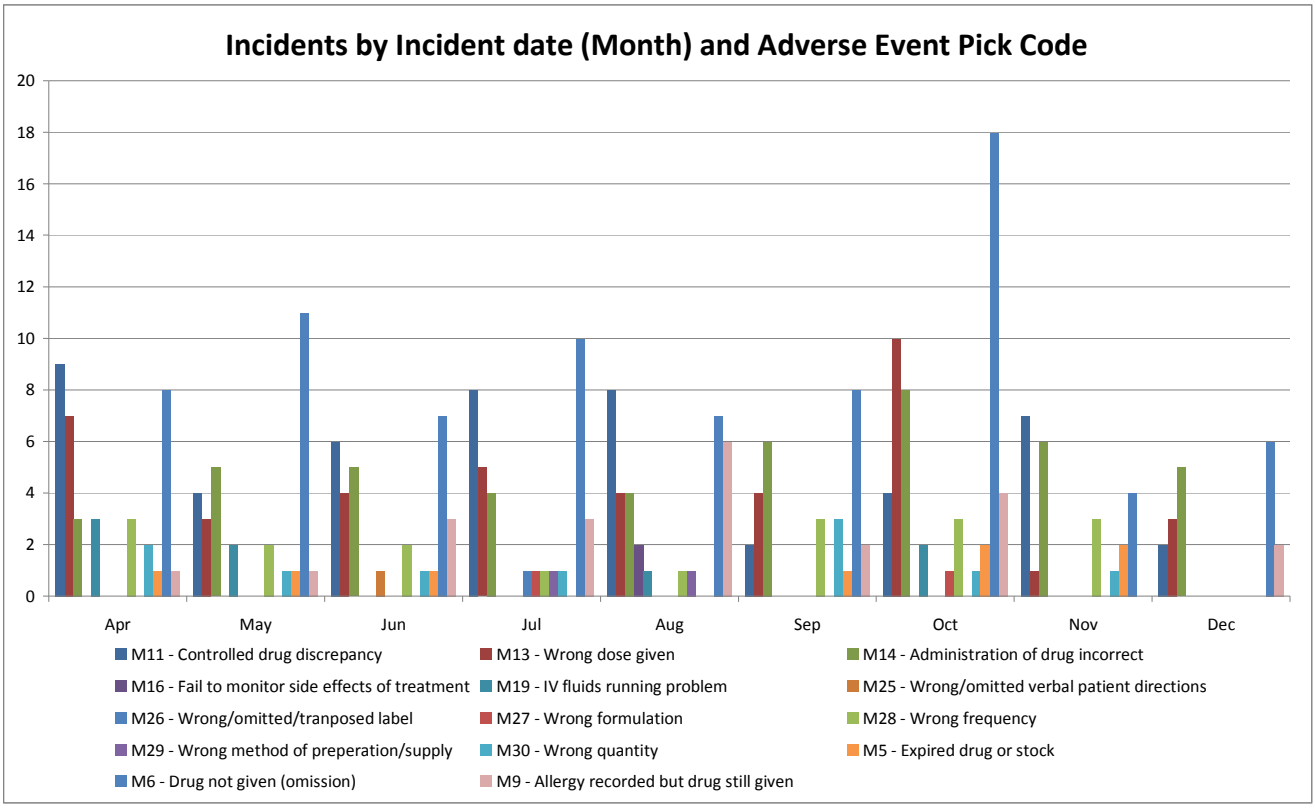


Graph to show percentage of patients with an indwelling urinary catheter (not suprapubic) and a urinary tract infection



1.2 Reduction in prescribing errors

The Trust continues to be in the highest 25% reporting medium acute organisations as per the Commissioning Board's Organisation Patient Safety Incident Report (October 2011-March 2012) at 9.4 reported incidents per 100 admissions. This is seen to be indicative of a better and more effective safety culture providing the opportunity to learn from reported incidents. The report shows a breakdown of the type of incidents reported comparing the top 10 for our organisation with all the medium acute trusts. This breakdown shows that medication incidents account for 13.7% of incidents reported in our trust compared to 11.2% for all trusts. The graph below shows a breakdown by type of drug error by month for this year. The group leading on improving this safety issue is specifically targeting omission errors which is the most common error in this reporting period.



1.3 Healthcare associated infection

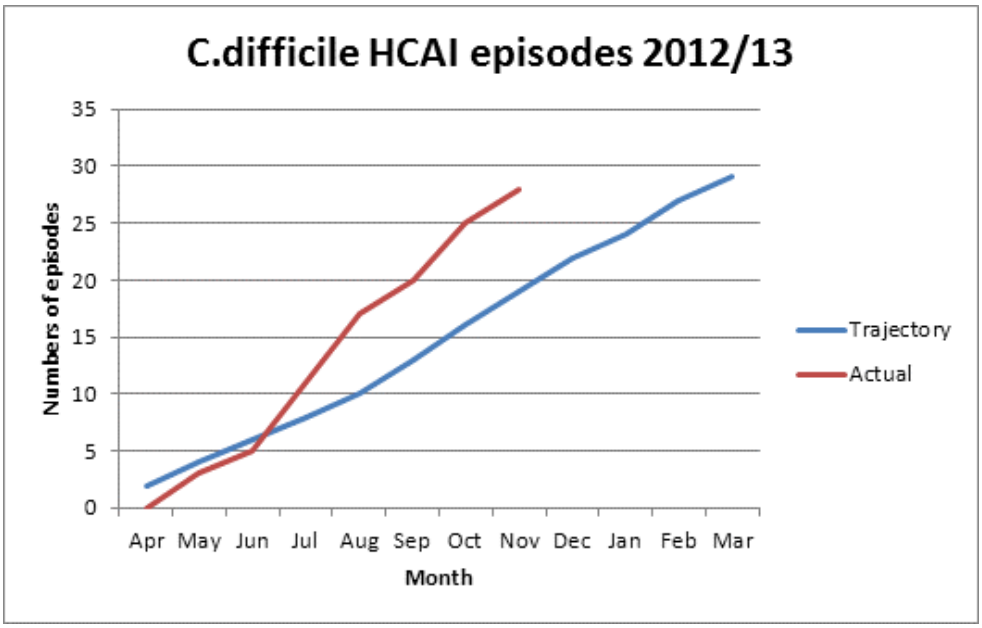
1.3.4 MRSA

There were no cases of MRSA bacteraemia diagnosed after 48 hours of hospital admission during November 2012. The two cases diagnosed in October 2012 have been investigated and found to be contaminated samples. Actions have been taken around reinforcing vigilance around asepsis. In terms of benchmarking with other Trusts in the Midlands and East SHA the Trust is ranked 27 of 46 (up to September) for the MRSA rate per ten thousand bed days.

Compliance with MRSA screening for elective patients in November 2012 was 100% and 87.9% for patients admitted as an emergency.

1.3.2 *Clostridium difficile*

There were three cases of hospital acquired *Clostridium difficile* infections reported in November 2012. The graph below shows performance against the trajectory for meeting the ceiling target for the year: the Quarter 2 has been breached and the risk of breaching the year end target has been raised to 20 (year to date performance is 28 infections against a year end ceiling target of 29). In terms of benchmarking with other Trusts in the Midlands and East SHA the Trust is ranked 39 of 46 for the C diff rate per thousand bed days.



1.3.3 MSSA and E. coli

There was one cases of *E. coli* bacteraemia and no cases of hospital acquired MSSA bacteraemia reported in November 2012.

1.4 Adverse event reporting and Never Events

There were 990 safety incidents reported during the month of November 2012, a reduction of 81 compared to the October figure. Falls and pressure ulcers present on admission remain the two most reported incidents. The number of interpreter related incidents fell from 36 reported in October to 19 reported in November and continues to be monitored. There was one grade 3 pressure ulcer reported in November.

The CLAEP report for Quarter 2 has been circulated to Board members: this report collates various governance reports and compares them seeking any patterns or trends and early warning signs of quality issues.

1.5 Safeguarding

Following a letter from Sir David Nicholson we were asked by our commissioners to provide assurance that we had robust processes in place in relation to:

- Safeguarding
- Access to patients (including that afforded to volunteers or celebrities); and
- Listening to and acting on patient concerns.

Following the submission of our evidence we received confirmation from our commissioners that they were reassured about our safeguarding practices and processes.

In November 2012 there was an increase in activity related to the safeguarding of vulnerable adults. There were six alerts related to care received by adult patients prior to hospital admission in either the patients own home or the care home they were residing in and 2 alerts related to the care given to patients whilst in hospital. Neither of these alerts have resulted in any findings against the Trust.

2. Effectiveness

Several indicators in this quality domain are reported within the Management Information Report, including:

- 4 hour Emergency Department (ED) wait and progression of new quality indicators for ED patients
- Reduction of emergency readmissions within 30 days of discharge following a day case, ordinary elective, regular day or night admission
- % time spent in a stroke unit
- Reduction in the number of cancelled elective operations for non-clinical reasons on the day

2.1 Completion of nutritional risk assessment and food intake monitoring

The Trust wide score for compliance with nutritional risk assessment as recorded by audit of ten patient records in each ward area during the month of November was 99.7%.

2.2 Completion of risk assessment for patients over 75 for dementia

November has seen sustained improvement. Compliance with all three indicators has now been achieved for 2 consecutive months (see table below). The target for all three indicators is 90% and must be met for three consecutive months in order to achieve the CQUIN payment. Dementia training for staff continues throughout the remainder of the year and has been well received. We have also secured £28K from Midlands and East SHA to improve the Dementia care experience.

Table to show % monthly compliance with CQUIN indicators

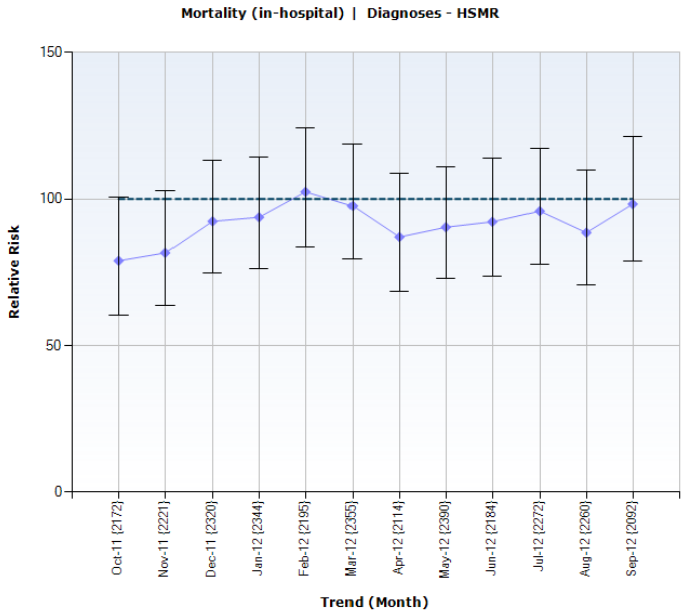
CQUIN Indicator	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March
1. Dementia case finding	9.3%	93.2%	84.2%	88.6%	91%	92.2%				
2. Diagnostic risk assessment for dementia	85.4%	88.6%	89.8%	89.3%	97.3%	98.3%				
3. Referral for specialist diagnosis	81.3%	93.6%	92.8%	94.2%	97.4%	98.4%				

2.3 Reducing mortality rates

The graph below shows the Hospital Standardised Mortality Ratio (HSMR) data for October 2011 - September 2012 and shows the rolling annual HSMR relative risk currently as 91.9. This benchmarks well with Trusts across the SHA where the HSMR for all Trusts is 95.3.

The Standardised Hospital Mortality Indicator (SHMI) for April 2011 to March 2012 was 101.28 compared to 104.03 for April 2010 to March 2011.

Rolling annual HSMR (October 2011 to September 2012)
Relative Risk (RR) = 91.9



Data source: Dr foster RTM Clinical Benchmarking data

3. Patient experience

3.1 Patient satisfaction monitoring including the 'Net Promoter' or Friends and Family test

In November the Friends and Family Test submitted score was 75 (volunteer acquired and face to face) compared to 74 for October. This is the second highest score since starting the data collection in April 2012 (the highest being in August when we scored 78). The score based on the Friends and Family Test question being asked by the receptionists post discharge was 41 (compared to 50 last month). There is a separate report showing a breakdown of scores by ward together with any comments made that has been circulated to Board members by e-mail. There are multiple positive comments included in this report but areas where concerns are being raised are around communication with patients not being made aware of their treatment pathway and also patients commenting that they did not feel that there were enough nurses on duty.

The action plan that each ward is required to produce in respect of their NPS score is available should they be required as evidence of this work. The action plans are monitored by the Directorates and progress checked at the Conformance Committee.

We continue to collect data for the Access and Radiotherapy Survey, Inpatient Survey, Radiotherapy Survey and the new Chemotherapy Patient Survey. The action plan from the Cancer Survey has been submitted to our Commissioners for review and work is currently underway within that Directorate in respect of the survey results.

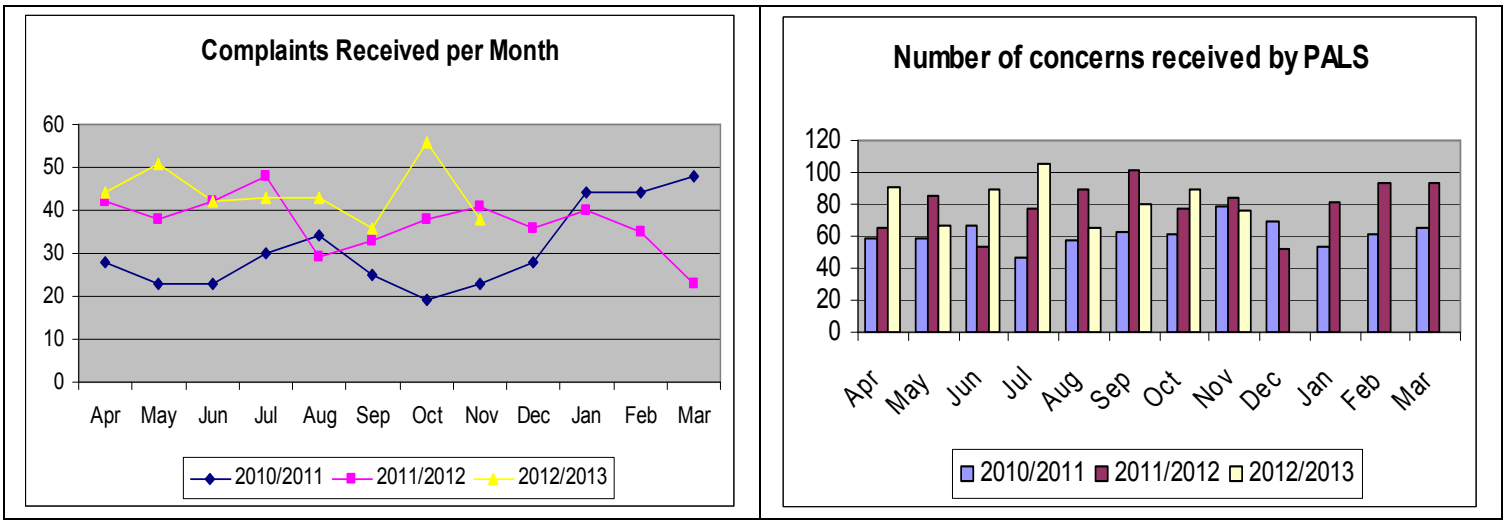
The Emergency Department National Patient Survey report published by the Care Quality Commission became public on 6 December 2012. Each trust is assigned to a category, to identify whether their score is 'better', 'about the same' or 'worse' than other Trusts. For our Trust in all but one of the categories we came out as 'about the same' however in one area 'patients leaving hospital without test results' we came out as worse compared to other Trusts. An action plan is already being devised to address the details of the report and this coupled with

ED now being included in the Friends and Family Test we are confident we will be able to improve our scores for next year.

3.2 Complaints and PALS

The number of formal complaints for this month was 38 (56 last month). The complaints and PALS data is again varied in nature but we have seen an increase in concerns being raised about appointments being delayed in clinics especially in Ophthalmology and some other out patients areas. We have also seen a rise in complaints about discharge in that there is a feeling that the patient may have been discharged too early or with insufficient information and follow up given following discharge.

The right hand graph shows the number of concerns raised and investigated by PALS in November 2012 compared to the other months this year and previous years. The November data demonstrates there has been a decrease in the number of concerns raised. Trends will be discussed and triangulated through the CLAEP meeting and report.



Our second report from Patient Opinion has been sent out to all wards and departments. This has shown all of the postings we have responded to since July and details the actions we have taken as a result of these postings. We have been pleased to see that one patient who had previously posted some negative comments about the Trust has now posted a very complimentary comment following a meeting with the Assistant Director of Nursing and Care Quality (patient experience) and the PALS Manager, which occurred as a result of the concerns she raised on Patient Opinion. We have also been held up as an example of good practice in the eastern region following our utilisation of Patient Opinion.

3.3 Delivering same sex accommodation

In November 2012 there were no reported breaches in relation to the same sex sleeping accommodation policy.

4. Regulators

4.1 Care Quality Commission (CQC) – visit to John van Geest Ward

The CQC report following their unannounced visit to John van Geest Ward on Saturday 4 August has been received for accuracy checking.

4.2 Nursing and Midwifery Council (NMC)

The triennial review by the NMC of entry to register nursing and midwifery programmes run by Anglia Ruskin University included visits to the clinical placement areas of Peterborough City Hospital. Verbal feedback was positive about the mentorship and support offered to the students, the quality of care observed in the ward settings and the environment in which the patients were being cared for. A formal report will be supplied in due course but a summary of the ratings is provided in the table below:

KEY RISK	LEVEL OF ACHIEVEMENT
1. Resources	Good
2. Admissions and Progression	Good
3. Practice Learning	Good
4. Fitness for Practice	Outstanding
5. Quality Assurance	Good

5. Feedback from Quality Governance Operational Committee

Quality Governance Operational Committee
The December meeting included the following issues and discussed actions required:

- Serious incident reports and adverse events
- Infection control - increase in *Clostridium difficile* numbers
- Medicines management report
- Mortality data
- Information governance incident action plan update
- Policy endorsement
- Quarter 2 CLAEP report

Recommendations

Board members to note the report and to raise questions or concerns as appropriate.

Appendix II: Quality Account preparation 2012/13

It is important that all the individual contributions are combined in to one document with a consistent style of delivery and language. It is also essential that all key stakeholders have the opportunity to shape the development of the document and its final presentation. The following timeframes will allow this:

Timeframe	
12/12/12	Set up meeting – Stakeholder and KPMG representatives invited
13/12/12	Council of Governor engagement in selecting mandated local indicator for 2012/13 and selection of priorities for 2013/14
09/01/13	Final chance for Governor involvement in selection of indicator
Dec & Jan	Compile M9 Quality Account
Feb	KPMG testing of indicators x 3
Feb – Apr	Contributors to add M9 -12 data to draft report
25/02/13	Circulation of draft M9 report
11/03/13	Governors Development and Assurance Committee review of M9 draft
14/03/13	Audit Committee review of M9 draft
27/03/13	Community Engagement Committee review of M9 draft
15/03/13	Audit Committee
11/04/13	Board of Governors NB CW on leave
16/04/13	Submission by all contributors to CW
23/04/13	Final draft submitted to key stakeholders
26/04/12	Trust Management Board
02/05/12	Stakeholder event
08/05/13	All comments and Stakeholders comments for inclusion in QA to CW by 12 midday Audit Committee workshop – review of final draft
13/05/13	Final content completed incorporating comments and styling
14/05/13	Quality Assurance Committee
16/05/13	Audit Committee sign off
28/05/13	Board sign off
30/05/13	9 am - submission to Monitor by courier and via portal
TBC	Publication deadline for NHS Choices website Publication on Trust web site

SCRUTINY COMMISSION FOR HEALTH ISSUES	Agenda Item No. 7
23 JANUARY 2013	Public Report

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

Contact Officer(s) – Jane Pigg, Company Secretary
Contact Details - jane.pigg@pbh-tr.nhs.uk

FINANCIAL POSITION OF PETERBOROUGH AND STAMFORD HOSPITALS NHS FOUNDATION TRUST

1. PURPOSE

1.1 The report is provided to enable an overview to be given to the Scrutiny Commission regarding the Trust's current financial position. The attached report is the most recent financial report from the Trust.

2. RECOMMENDATIONS

2.1 The Commission is asked to review this report which will be presented by the Interim Chief Executive and Director of Finance, and to receive any further update on actions from the Independent Regulator of NHS Foundation Trusts (Monitor) and arising from the recent Public Accounts hearing. No written information has been made available to the Trust for this report.

3. LINKS TO THE SUSTAINABLE COMMUNITY STRATEGY

3.1 This issue links to the priority to deliver substantial and truly sustainable growth and the need to build the sustainable infrastructure of the future.

4. BACKGROUND

4.1 The Trust attended the Commission's meeting in 20 September 2012, this report and the Trust's attendance is to provide the Commission with an update on the Trust's position.

5. KEY ISSUES

5.1 The Commission is asked to consider the Trust's on-going financial position and to receive further updates as work proceeds on the Trust's plans and the Contingency Planning Team actions.

6. IMPLICATIONS

6.1 Implications of this report are related to financial issues and actions required to progress to financial sustainability.

This report is city-wide and its implications extend from the Greater Peterborough area into neighbouring authorities.

7. CONSULTATION

7.1 There has been no specific consultation – however the Commission will be aware of the Trust's attendance at the Public Accounts Committee in December, and the decision made by Monitor, the Independent Regulator of NHS Foundation Trusts to commission a Contingency Planning Team to review the Trust's position.

8. NEXT STEPS

8.1 The Trust expects to keep the Commission updated with any developments in this area.

9. BACKGROUND DOCUMENTS

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

9.1 The document attached to this report is that provided to the Board of Directors and Council of Governors.

10. APPENDICES

10.1 Director of Finance Report – 17 December 2012

Peterborough and Stamford Hospitals NHS
NHS Foundation Trust

Finance Report and Trading Results – November 2012	**TBC**

Title	Finance Report – 2012/13 Month 8
Sponsoring Director	Chris Preston, Director of Finance
Author(s)	Maxime Hewitt-Smith, Deputy Director – Financial Management
Purpose	To provide the Trust Board with the Trust's financial performance report for Month 8.
Date of Report	17th December 2012

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1. Executive Summary

Key Issue	Executive Summary	Year to date vs budget	Forecast Outturn	Action Plan
EBITDA	EBITDA was (£5.8m) against a planned (£11.2m) for the year to date. This favourable variance relates to overperformance (mainly on the Lincolnshire contract) totalling £5.2m, overspend on pay of (£1.8m) and underspend on non-pay of £0.7m. Other income is also higher than budget by £1.3m. Risk remains around the delivery of CIP plans and recovery of income relating to over-performance on PCT contracts.	G	G	An Activity Review process was initiated to address concerns about over-performance with both host commissioners, (Peterborough & Cambridgeshire, and Lincolnshire.) Lincolnshire – A teleconference took place on the 4th December. Progress continues to be made towards agreeing next year's baseline and demand management plans for 2013/14 are still in development. Peterborough and Cambridge – The Trust received a further formal response from Peterborough PCT relating to the issue of contract over-performance on 23rd November. In that letter, the PCT requested a costed proposal for the additional activity in 2012/13, based on the three principals that we outlined in our letter of 12th October, although re-iterated that they did not accept any obligation above £116m. The Trust is in the process of producing a draft proposal for discussion at the next escalation meeting, which is scheduled to take place on the 20th December.
Surplus/ (Deficit)	The Trust is reporting a (£24.8m) deficit which is £7.5m ahead of plan YTD, the full year forecast of (£51.0m) deficit which is £3.2m ahead of plan. The RAG ratings reflect the comments shown for EBITDA above.	G	G	As above.
CIP Programme	November performance was behind target by (£0.7m) and YTD performance is behind by (£1.0m) with £6.4m delivered to date (plan of £7.4m). The planned savings requirement increased from £1.0m to £1.4m from October onwards, predominantly in the pay budget. Significant concern remains over the achievement of the full year CIP target with £2.0m of schemes yet to be identified for the current year and £1.6m of schemes to be identified with a recurrent FYE.	G	A	Additional recurrent and non-recurrent schemes will continue to be identified to bridge the gap in our full year CIP plans which amount to £2.0m in the current year and £1.6m of full year effect to be carried forward into next year. Further pipeline schemes are being developed to increase recurrent savings in 12/13 and beyond.
Cash and Liquidity	The Trust received cash advances from its two main commissioners to improve liquidity through the summer of 2012. These advances are repayable in year and are planned to be replaced by support from the DoH.	G	A	The Trust continues to receive verbal assurance that external funding will be provided by the Department of Health. Discussions continue about process and precise timings.
Capital Expenditure	Capex YTD is £0.7m which is slightly behind the capital expenditure plan of £0.8m resubmitted to Monitor in September 2012.	G	G	The Trust's current forecast of £4.0m is lower than the revised plan of £4.2m and is therefore within Monitor's thresholds. There are on-going capital forecasts being performed and the Trust will perform a detailed capital reforecast for Monitor as part of quarter 3 procedures.
Monitor Financial Risk Rating	The Trust's risk rating is 1 and is forecast to remain at 1 for the financial year in line with the plan.	G	G	The trust remains at an overall FRR of 1 both in terms of year to date and full year performance. Work continues on developing a turnaround plan that returns the trust to a sustainable financial position.

	EBITDA / surplus		**Capital Expenditure (rating against a revised plan)**
G	On or better than target	G	Within 10% of target
A	Between 0% and 5% below target	A	Between 11% and 25% of target
R	Greater than 5% below target	R	Greater than 25% of target
	CIP Programme		**Cash and Liquidity**
G	On or better than target	G	Higher cash balance than plan or within 10% lower than plan
A	Between 0% and 10% below target	A	Cash balance lower than plan by 10% up to 20%
R	Greater than 10% below target	R	Cash balance lower than plan by greater than 20%

Deficit Actual / Forecast v Plan

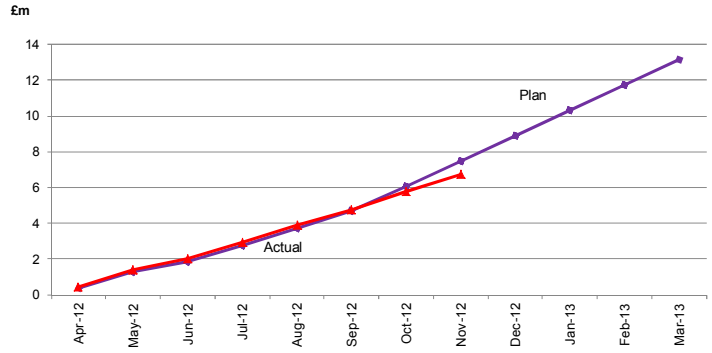
Income: Forecast favourable variance of £6.7m due to over-performance, mainly of NHS Lincs contract (after penalties); higher than expected other income of £2.8m, mainly relating to RTA, R&D and other SLA income.

Pay: Forecast (£6.5m) over-spend due to increased agency/locum cover of vacancies and additional activity.

Non-pay: Forecast (£1.6m) over-spend predominately due to cost of out-sourcing in support of 18 week elective target.

Other: Forecast under-spend of £1.3m in restructuring and £0.5m on delivery costs of turnaround.

CIP Programme Savings

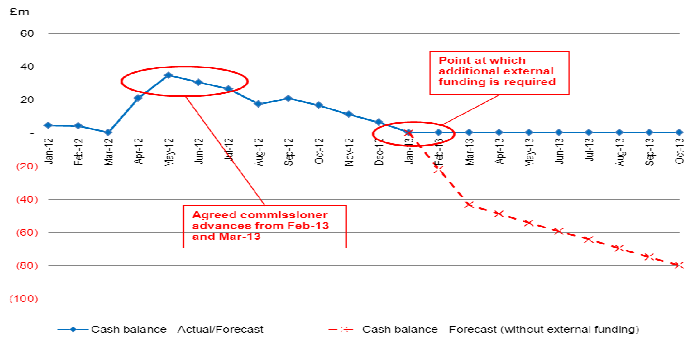


Actual YTD performance of £6.4m is (£1.0m) behind the plan of £7.4m.

£2.0m of within year CIPs are yet to be identified. Further work has been undertaken to develop additional pipeline CIPs and as a result it is expected that this gap will reduce next month.

Full year forecast remains at £13.2m.

12 Month Cashflow Forecast



Cash and Liquidity

The long term cash-flow forecast shows a need for external financing from January 2013.Key uncertainties regarding timing of;

1. redundancy payments (we are constantly reviewing the expected level of redundancies during the remainder of the year which is linked to the acceleration of pipeline CIP schemes);
2. costs relating to the delivery of turnaround;
3. over-activity income receipts and income receipts for the Stamford Hospital ward; and
4. the R12 system upgrade.

Capital Expenditure Plan v Forecast

Capital Expenditure

Projects	Revised Capex Plan £000s	Spend In Month £000s	Spend To Date £000s	Forecast For 2012/13 £000s	Variance To Plan £000s
Property- new land, buildings or dwellings	300	-	-	-	(300)
Property- maintenance expenditure	303	-	106	349	46
Plant and equipment - Information Technology	1,154	27	254	899	(255)
Property, plant and equipment - other expenditure	2,477	32	309	2,759	282
Total	**4,234**	**59**	**669**	**4,007**	**(227)**

Total forecast spend has reduced from the revised plan by £227k to £4,007k, with £2,818k of spend still forecast for the final quarter. On-going detailed forecasting work is being performed. We have seen a marked increase in the number of bids for capital funding in recent months, which reflects the above spend profile.

Financial Risk Rating / Monitor Compliance

Monitor Financial Risk Rating

Financial Risk Rating / Monitor Compliance				
Measure	Criteria	YTD Performance		Weight
		M8 Actual	M8 Rating	
EBITDA Margin	Underlying performance	(4.1%)	1.0	25%
EBITDA % achieved	Achievement of plan	0.0%	1.0	10%
Net return after financing	Financial Efficiency	(11.3%)	1.0	20%
I&E Surplus margin	Financial Efficiency	(16.8%)	1.0	20%
Liquidity Ratio	Liquidity (days)	(51)	1.0	25%
Overall FRR Score			**1.0**	
Financial Risk Rating Forecast			**1.0**	

Monitor Rating Ranges					
Good ←					→ Bad
5	4	3	2	1	
11%	9%	5%	1%	<1%	
100%	85%	70%	50%	<50%	
3%	2%	-0.5%	-5%	<-5%	
3%	2%	1%	-2%	<-2%	
60	25	15	10	<10	

The trust remains at an overall FRR of 1 both in terms of year to date and full year performance. Work continues on developing a turnaround plan that returns the trust to a sustainable financial position.

2. Overview of Financial Performance

2.1 Income and Expenditure Statement

Income and Expenditure	In Month			Year To Date			Full Year			Full Year	
	Budget	Actual	Var.	Budget	Actual	Var.	Current Forecast	Previous Forecast	Forecast Change	Annual Budget	Forecast Variance
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
Clinical Income (inc MOD)	16.2	16.7	0.5	126.1	131.3	5.2	195.9	196.1	(0.2)	189.2	6.7
Other Income	1.7	2.1	0.4	13.9	15.2	1.3	22.0	21.6	0.4	19.2	2.8
Total Income	**17.9**	**18.8**	**0.9**	**140.0**	**146.5**	**6.5**	**217.9**	**217.7**	**0.2**	**208.4**	**9.5**
Pay	(11.3)	(12.8)	(1.5)	(96.3)	(98.1)	(1.8)	(149.5)	(149.1)	(0.4)	(143.0)	(6.5)
Non Pay	(5.4)	(5.4)	-	(42.9)	(42.2)	0.7	(66.4)	(66.6)	0.2	(64.8)	(1.6)
PFI Unitary Charge	(1.5)	(1.5)	-	(12.0)	(12.0)	-	(18.0)	(18.0)	-	(17.9)	(0.1)
Total Expenses	**(18.2)**	**(19.7)**	**(1.5)**	**(151.2)**	**(152.3)**	**(1.1)**	**(233.9)**	**(233.7)**	**(0.2)**	**(225.7)**	**(8.2)**
EBITDA	**(0.3)**	**(0.9)**	**(0.6)**	**(11.2)**	**(5.8)**	**5.4**	**(16.0)**	**(16.0)**	**(0.0)**	**(17.3)**	**1.3**
Technical items	(2.2)	(2.2)	-	(17.7)	(17.4)	0.3	(28.2)	(28.2)	-	(28.3)	0.1
Underlying Surplus/ (Deficit)	**(2.5)**	**(3.1)**	**(0.6)**	**(28.9)**	**(23.2)**	**5.7**	**(44.2)**	**(44.2)**	**(0.0)**	**(45.6)**	**1.4**
Delivery costs of turnaround	(0.3)	(0.2)	0.1	(2.5)	(1.4)	1.1	(3.1)	(3.6)	0.5	(3.6)	0.5
Restructuring	(0.1)	(0.1)	-	(0.9)	(0.2)	0.7	(3.7)	(3.7)	-	(5.0)	1.3
Retained Surplus/ (Deficit)	**(2.9)**	**(3.4)**	**(0.5)**	**(32.3)**	**(24.8)**	**7.5**	**(51.0)**	**(51.5)**	**0.5**	**(54.2)**	**3.2**

Memorandum Items	Budget	Actual	Var.	Budget	Actual	Var.	Current Forecast	Previous Forecast	Forecast Change	Annual Budget	Forecast Variance
Penalties	(0.4)	(0.4)	-	(4.6)	(8.1)	(3.5)	(11.6)	(11.2)	(0.4)	(6.1)	(5.5)
CQUIN	0.4	0.1	(0.3)	3.0	2.2	(0.8)	3.6	3.8	(0.2)	4.5	(0.9)
CIP Programme	1.4	0.7	(0.7)	7.4	6.4	(1.0)	13.2	13.2	-	13.2	-
P&C Contract Settlement	-	(1.3)	(1.3)	-	(4.6)	(4.6)	(6.8)	(6.9)	0.1	-	(6.8)

The underlying deficit (before one-off costs) at the end of M8 is (£23.2m) compared to a planned loss of (£28.9m) (£5.7m favourable to plan). The main driver of this variance is over-performance on contracted activity volumes.

A large part of the favourable variance on clinical income is driven by over-performance related to the NHS Lincolnshire contract of £3.4m (after penalties have been applied). Further income improvements include non-recurrent funding for the ward at Stamford Hospital (£0.9m full year) supporting its transition from an acute to an intermediate care facility and higher than planned other clinical income (for example, Cancer Fund Income). Other income is £1.3m better than plan year to date, the main variances relating to better than planned RTA, R&D, and other SLA revenue.

Pay is overspent by (£1.8m) year to date. This is predominantly due to overspends in Month 7 and 8. The underlying overspend is driven by broadly the same levels of expenditure in month as in previous months; however, there has been a significant reduction in budget from October due to the CIP phasing, increasing the monthly variance. Further work has been undertaken to establish the marginal cost of additional activity and focus attention on the residual gap to the original budget.

Non-pay is underspent by £0.7m year to date. The key area of cost pressures is the out-sourcing of activity to 3rd parties to support the 18 week elective target, with the key area of underspend being "other non-pay costs" as the actual costs have been recorded against more relevant non-pay classifications.

CIP financial performance year to date is £6.4m against a plan of £7.4m. Further detail is provided in section 6 of this report and the full year forecast remains at £13.2m. £2.0m of within year CIP savings remain unidentified and in addition some risk still remains around the delivery of the identified pay savings.

3. Income

Gross income	In Month			Year To Date			Full Year			Full year	
	Budget	Actual	Var.	Budget	Actual	Var.	Current Forecast	Previous Forecast	Forecast Change	Annual Budget	Forecast Variance
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
Electives	3.9	3.5	(0.4)	27.3	28.3	1.0	42.1	41.3	0.8	39.3	2.8
Non-electives	4.8	5.5	0.7	38.5	42.1	3.6	63.0	64.2	(1.2)	58.9	4.1
Outpatients	2.6	3.7	1.1	21.6	24.5	2.9	36.4	36.4	-	31.9	4.5
A&E	0.6	0.7	0.1	4.9	5.9	1.0	8.8	8.8	-	7.3	1.5
Maternity	0.9	0.9	-	7.5	7.9	0.4	12.1	12.3	(0.2)	11.5	0.6
Critical Care	0.7	0.8	0.1	5.5	5.7	0.2	8.6	8.6	-	8.3	0.3
Direct Access	1.0	1.3	0.3	8.3	8.9	0.6	13.2	13.2	-	12.4	0.8
Excluded Drugs	0.8	1.0	0.2	7.0	8.2	1.2	12.2	12.0	0.2	10.6	1.6
Other clinical income	0.9	0.9	-	7.1	10.3	3.2	14.3	13.6	0.7	10.6	3.7
Total	**16.2**	**18.3**	**2.1**	**127.7**	**141.8**	**14.1**	**210.7**	**210.4**	**0.3**	**190.8**	**19.9**
Penalties											
Emergency Readmissions	(0.2)	(0.2)	-	(1.9)	(1.6)	0.3	(2.4)	(2.2)	(0.2)	(1.0)	(2.4)
Emergency Marginal Tariff	(0.1)	(0.1)	-	(0.5)	(4.0)	(3.5)	(6.0)	(5.8)	(0.2)	(2.7)	(2.3)
A&E Metric	-	-	-	(1.5)	(1.3)	0.2	(1.3)	(1.3)	-	(1.4)	0.1
New to follow-up	(0.1)	(0.1)	-	(0.7)	(0.8)	(0.1)	(1.2)	(1.1)	(0.1)	(1.0)	(0.2)
18 weeks	-	-	-	-	(0.3)	(0.3)	(0.5)	(0.6)	0.1	-	(0.5)
A&E 4 hour target	-	-	-	-	(0.1)	(0.1)	(0.2)	(0.2)	-	-	(0.2)
Total	**(0.4)**	**(0.4)**	**-**	**(4.6)**	**(8.1)**	**(3.5)**	**(11.6)**	**(11.2)**	**(0.4)**	**(6.1)**	**(5.5)**
P&C Contract Settlement	**-**	**(1.3)**	**(1.3)**	**-**	**(4.6)**	**(4.6)**	**(6.8)**	**(6.9)**	**0.1**	**-**	**(6.8)**
CQUIN	**0.4**	**0.1**	**(0.3)**	**3.0**	**2.2**	**(0.8)**	**3.6**	**3.8**	**(0.2)**	**4.5**	**(0.9)**
Total	**16.2**	**16.7**	**0.5**	**126.1**	**131.3**	**5.2**	**195.9**	**196.1**	**(0.2)**	**189.2**	**6.7**

3.1 Income - Summary by Commissioner

- Clinical Income for M8 is showing a favourable variance of £5.2m year-to date. This is after allowing for a £4.6m contract risk share deduction associated with NHS Peterborough and Cambridgeshire.

- Emergency readmissions within 30 days are assumed to be penalised at 25% (based on a crude average of audits that have taken place at other Trusts). Audits are currently on-going; initial feedback from NHS Peterborough and Cambridgeshire has been received and is being reviewed, and the audit by NHS Lincolnshire is yet to be undertaken.

3.1.1 NHS Peterborough and Cambridgeshire

- The Trust has over-performed by £4.6m on the Peterborough and Cambridgeshire contracts to M8 (the gross value of this activity was £6.5m, but would have been partially offset by payment at marginal rate/re-admission penalties under PbR). Key areas of over-performance include:
  - A&E attendances and emergency admissions £2.5m;
  - Outpatient activity £1.3m;
  - Elective activity £0.4m (primarily due to outsourced activity for 18 week breach patients);
  - Maternity £0.3m (activity for Peterborough and Cambridgeshire maternity is forecast to be 80 deliveries above plan);
  - Excluded drug prescribing £0.6m;
  - Best practice tariffs £0.5m;
  - PbR based penalties (£2.1m).

- The Trust received a further formal response from Peterborough PCT relating to the issue of contract over-performance on 23rd November. In that letter, the PCT requested a costed proposal for the additional activity in 2012/13, based upon the three principals that we outlined in our letter of 12th October, although re-iterated that they did not accept any obligation above £116m. The Trust is in the process of producing a draft proposal for

discussion at the next escalation meeting, which is scheduled to take place on the 20th December.

3.1.2 NHS Lincolnshire

- The Trust has over-performed by £3.4m year to date on the Lincolnshire contract (the gross value of this activity was £4.8m, but has been partially offset by payment at marginal rate/re-admission penalties under PbR). Key areas of over-performance include:
    - A&E attendances and emergency admissions £1.8m;
    - Elective activity £1.0m;
    - Excluded drug prescribing £0.4m;
    - Outpatient activity £0.9m;
    - PbR based penalties (£1.2m).

- Non-recurrent funding for the ward at Stamford Hospital, £0.9m full year, is included in the Trust's forecast supporting its transition from an acute to an intermediate care facility.

- We have received assurance that commissioned activity undertaken will be paid for. A further teleconference took place on the 4th December and progress continues to be made towards agreeing next year's baseline. Demand management plans for 2013/14 are still in development.

3.1.3 Other Commissioners

- There has been notable over performance on the Leicestershire County and Rutland contract of £0.4m (gross value £0.7m, but has been partially offset by payment at marginal rate/re-admission penalties under PbR). Key areas of over-performance include:
    - A&E attendances and emergency admissions £0.3m;
    - Elective activity £0.2m;
    - Outpatient activity £0.1m;
    - PbR based penalties (£0.3m).

- Other commissioners are broadly trading in line with contract.

3.1.4 PbR / Operational Penalties

- Total year to date penalties (both emergency and operational) have been estimated at £8.1m against a plan of £4.6m. As previously noted, some of the penalties may be recoverable if performance improves over the year, however this benefit has not currently been factored into the financial forecast due to the level of uncertainty.
- Action plans are being put in place and implemented to reduce the impact of penalties. Progress is being monitored through Directorate performance review meetings.

3.2 Income full year forecast

- The current full year clinical income forecast incorporates significant over-performance against plan, due primarily to the activity associated with the NHS Lincolnshire contract. The forecast also includes non-recurrent funding, £0.9m full year, for the ward at Stamford Hospital (which was originally planned to close during the year) to support its transition from an acute to an intermediate care facility.
- The over-performance related to the NHS Lincolnshire contract is assumed to reduce in future months as demand management programmes begin to deliver.
- Other income is expected to be £2.8m better than plan full year, the main variances relating to better than planned RTA, R&D, and other SLA revenue.

4. Expenditure

4.1 Pay Expenditure

Pay Expenditure by Staff Group

Expenditure	In Month			Year To Date			Full year			Full year	
	Budget	Actual	Var.	Budget	Actual	Var.	Current Forecast	Previous Forecast	Forecast Change	Annual Budget	Forecast Variance
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
Consultant	(1.9)	(2.1)	(0.2)	(16.2)	(15.9)	0.3	(24.2)	(24.1)	(0.1)	(24.5)	0.3
Junior Medical	(1.2)	(1.2)	-	(10.4)	(9.5)	0.9	(14.3)	(14.5)	0.2	(15.6)	1.3
Nurses, Midwives & HCA	(4.5)	(4.6)	(0.1)	(37.5)	(36.4)	1.1	(56.9)	(56.8)	(0.1)	(57.4)	0.5
Scientific and Technical	(1.3)	(1.4)	(0.1)	(11.4)	(11.1)	0.3	(16.7)	(16.7)	-	(17.1)	0.4
Non-Clinical Staff	(2.2)	(2.3)	(0.1)	(18.8)	(17.8)	1.0	(27.2)	(27.2)	-	(25.7)	(1.5)
Agency/Locum	(0.2)	(1.2)	(1.0)	(2.0)	(7.4)	(5.4)	(10.2)	(9.8)	(0.4)	(2.7)	(7.5)
Total Pay	**(11.3)**	**(12.8)**	**(1.5)**	**(96.3)**	**(98.1)**	**(1.8)**	**(149.5)**	**(149.1)**	**(0.4)**	**(143.0)**	**(6.5)**

- This month's underlying pay expenditure is above plan by (£1.1m) although an additional (£0.4m) non recurrent adjustment has been made to reflect the estimated value of a number of historic employment liabilities. As in previous months the majority of this adverse variance is due to the planned reduction in budget from October due to the stepped changes in the planned CIP delivery.
- The total pay spend for the Trust continues to be driven by the additional agency and locum staff required to cover a significant number of substantive vacancies compounded by the additional staffing needed to support the increase in activity.
- As previously agreed, unidentified CIPs are no longer included as a separate line in the forecast. The Trust is still fully committed to driving the maximum possible cost savings during the remainder of the year and as such is continuing detailed reviews of future pay costs, which are being led by the Director of HR and OD, and the Chief Operating Officer.
- The agency/locum forecast includes additional spend to cover the Director of Finance post on an interim basis from January to March.

4.2 Non-Pay Expenditure

Non-Pay Expenditure by Classification

Expenditure	In Month			Year To Date			Full year			Full year	
	Budget	Actual	Var.	Budget	Actual	Var.	Current Forecast	Previous Forecast	Forecast Change	Annual Budget	Forecast Variance
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
Clinical Supplies & Services	(1.5)	(1.6)	(0.1)	(11.4)	(11.1)	0.3	(17.0)	(16.5)	(0.5)	(17.2)	0.2
Drugs - Included	(0.7)	(0.7)	-	(5.6)	(4.8)	0.8	(7.1)	(7.7)	0.6	(8.5)	1.4
Drugs - Excluded	(0.9)	(1.1)	(0.2)	(7.1)	(8.2)	(1.1)	(12.2)	(12.3)	0.1	(10.4)	(1.8)
General Supplies & Services	(0.4)	(0.4)	-	(2.9)	(2.9)	-	(4.2)	(4.9)	0.7	(4.3)	0.1
Ext. Healthcare Providers	(0.4)	(0.3)	0.1	(3.1)	(4.6)	(1.5)	(7.5)	(7.5)	-	(4.6)	(2.9)
Utilities, Rent and Rates	(0.5)	(0.5)	-	(4.3)	(4.0)	0.3	(6.5)	(6.6)	0.1	(6.4)	(0.1)
Estate Maintenance	(0.2)	(0.3)	(0.1)	(1.9)	(1.8)	0.1	(2.7)	(2.6)	(0.1)	(2.8)	0.1
Insurance	(0.4)	(0.3)	0.1	(3.6)	(3.4)	0.2	(5.4)	(5.4)	-	(5.4)	-
Professional Services	(0.2)	(0.3)	(0.1)	(1.8)	(1.5)	0.3	(2.2)	(1.8)	(0.4)	(2.6)	0.4
Other Non Pay Costs	(0.2)	0.1	0.3	(1.2)	0.1	1.3	(1.6)	(1.3)	(0.3)	(2.6)	1.0
Total Non Pay	**(5.4)**	**(5.4)**	**-**	**(42.9)**	**(42.2)**	**0.7**	**(66.4)**	**(66.6)**	**0.2**	**(64.8)**	**(1.6)**

- This month non-pay expenditure has been within budget, however there has been the release of the bad debt provision of £0.5m which is causing a favourable in month position in other non-pay costs.
- YTD there is an adverse variance for excluded drugs of (£1.1m) which is partly offset by a favourable forecast variance for included drugs of £0.8m. A significant overspend is on external healthcare providers (£1.5m) has been incurred as a result of the Trust meeting its 18 week target during the first quarter.
- There is a favourable variance of £1.0m in other non-pay costs as these costs have been reflected in the forecast in the appropriate non-pay classification.
- The key drivers of the change in the forecast include an increase of (£0.5m) in clinical supply costs that relates primarily to continuing higher than planned activity levels, a reduction in included drugs forecast as a result of a YTD review. The professional services forecast has increased by (£0.4m) largely due to the costs of the PFI post-project review. The movement in the forecast on general supplies and services and other non-pay costs is as a result of a reclassification between the categories, which has been off-set by a release from the bad debt provision due to the recovery of a number of large historic debts.

4.3 Technical Items

Depreciation

- Year to date favourable variance of £0.3m due to lower than originally planned capital expenditure.

Impairment

- We are currently forecasting a significant impairment at the end of the financial year associated with the vacation of the PDH site. A review will be conducted before the end of the financial year to establish whether this forecast cost will be crystallised.

Restructuring Expenses

- Year to date expenditure and commitments on redundancies is £0.2m (£0.7m less than budget). We are constantly reviewing the expected level of redundancies during the remainder of the year which is linked to the acceleration of pipeline CIP schemes. We are currently forecasting that £3.7m of redundancy costs will be incurred in year, a favourable variance against plan of £1.3m. However in-line with earlier in the year we will perform a detailed review at the end of the quarter, and are currently anticipating this review may result in a reduction in the forecast expenditure.
- Delivery costs of turnaround are £1.1m underspent YTD. We have performed a detailed forecast this month with the Programme Director and are forecasting a year end underspend of £0.5m. The forecast includes £0.5m of professional services spend to provide support to the Trust during the expected period of interaction with the Contingency Planning Team.

4.4 Directorate Performance

The high level commentary in this section has been provided in conjunction with the Clinical Directorates.

During the month the financial hierarchy has been updated to reflect the Trusts new Directorate Structure. As a result Cancer and Diagnostics now includes Radiology and Pathology, which is no longer reflected in Clinical Support, however Clinical Support does now include Health Records which was previously included within Corporate. This analysis includes the transfers of budget and actuals from the beginning of the 2012/13 financial year. This was agreed with the Directorates to allow greater trend analysis.

Expenditure	In Month			Year To Date			Full year			Full year	
	Budget £m	Actual £m	Var. £m	Budget £m	Actual £m	Var. £m	Current Forecast £m	Previous Forecast £m	Forecast Change £m	Annual Budget £m	Forecast Variance £m
Clinical Support	(1.2)	(1.3)	(0.1)	(10.6)	(10.6)	-	(16.0)	(25.4)	9.4	(15.4)	(0.6)
Medicine & ED	(2.8)	(4.0)	(1.2)	(23.8)	(26.6)	(2.8)	(39.8)	(39.0)	(0.8)	(35.1)	(4.7)
Surgery & MSK	(3.0)	(3.0)	-	(25.0)	(27.6)	(2.6)	(40.4)	(40.6)	0.2	(36.5)	(3.9)
Cancer & Diagnostics	(2.6)	(2.9)	(0.3)	(21.3)	(21.7)	(0.4)	(32.6)	(22.1)	(10.5)	(31.4)	(1.2)
Family & Public Health	(2.1)	(2.2)	(0.1)	(16.9)	(16.5)	0.4	(25.4)	(25.5)	0.1	(25.3)	(0.1)
Theatres, Anaethesia & Critical Care	(1.7)	(1.9)	(0.2)	(13.9)	(14.5)	(0.6)	(21.9)	(21.6)	(0.3)	(20.7)	(1.2)
Facilities Services	(2.5)	(2.8)	(0.3)	(20.1)	(20.0)	0.1	(30.2)	(30.1)	(0.1)	(30.3)	0.1
Corporate	(5.0)	(4.0)	1.0	(40.9)	(33.9)	7.0	(62.7)	(64.9)	2.2	(67.9)	5.2
Total	**(20.9)**	**(22.1)**	**(1.2)**	**(172.5)**	**(171.4)**	**1.1**	**(269.0)**	**(269.2)**	**0.2**	**(262.6)**	**(6.4)**

Note: This table includes pay and non-pay expenditure as well as technical items, delivery costs of turnaround and restructuring.

Key:

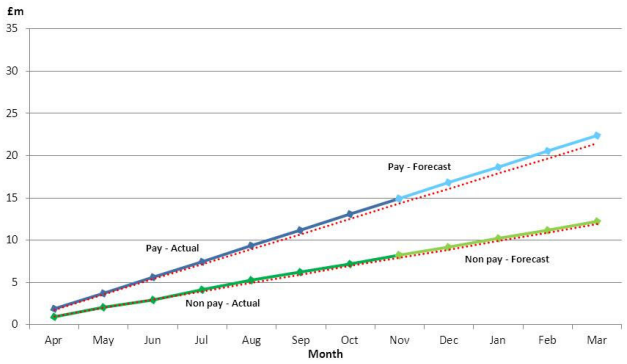
Pay – Actual

Pay - Forecast

Non pay – Actual

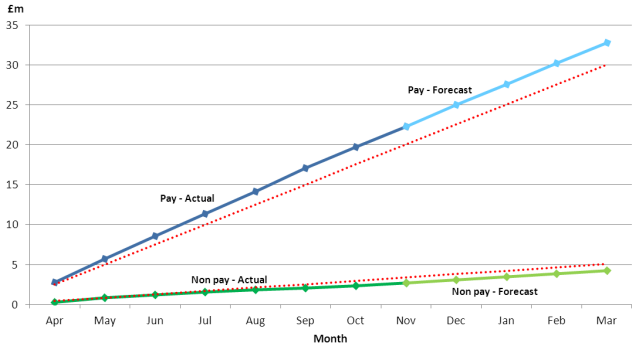
Non pay - Forecast

Budget



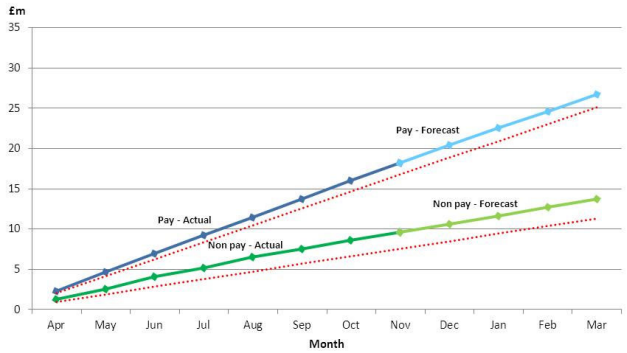
Clinical Support

- Pay: forecast over budget due to continued bank and agency cover of vacancies;
- Non-pay: overspend on drugs offset by underspend on external healthcare providers.



Medicine and Emergency Department

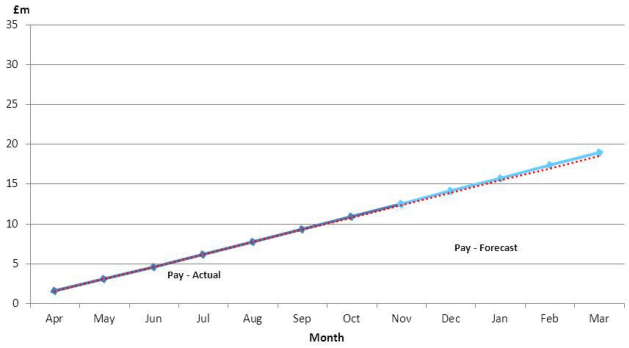
- Pay: overspend in staff and agency/locum premium to support increased activity;
- Non-pay: underspend in excluded drugs and clinical supplies and services, primarily reduced pacemaker use in cardiology.



Surgery and MSK

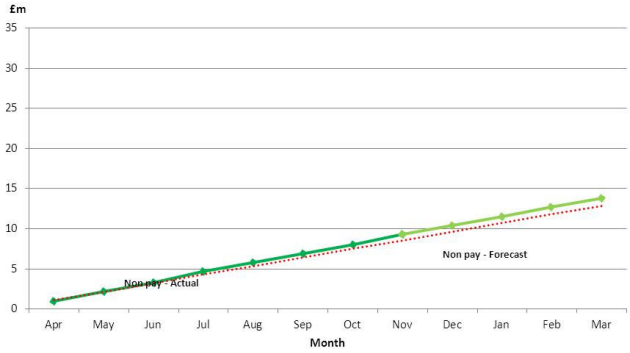
- Pay: Overspend on agency/locum and consultants extra sessions, partially offset by vacancies;
- Non-pay: Overspend on excluded Dermatology drugs, HCAH Rheumatology drugs and external healthcare providers.

Note: As in previous months pay and non-pay within Cancer has been split into two graphs below. This is due to the budget being set at the same level for pay and non-pay, as the non-pay costs are relatively higher within Cancer than other Directorates due to the higher cost and volumes of included and excluded drugs.



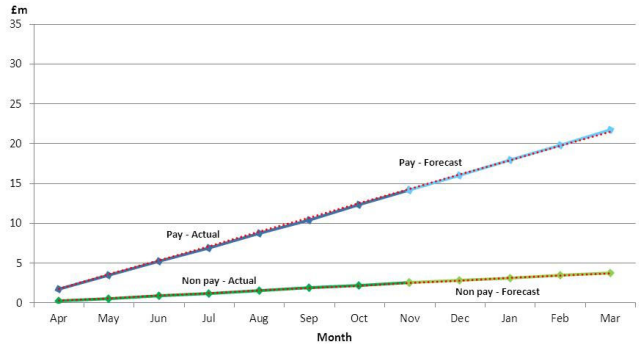
Cancer and Diagnostics – Pay

- Unfilled vacancies for first 6 months have been offset by agency and the transfer of radiology and pathology which has resulted in a small forecast overspend;



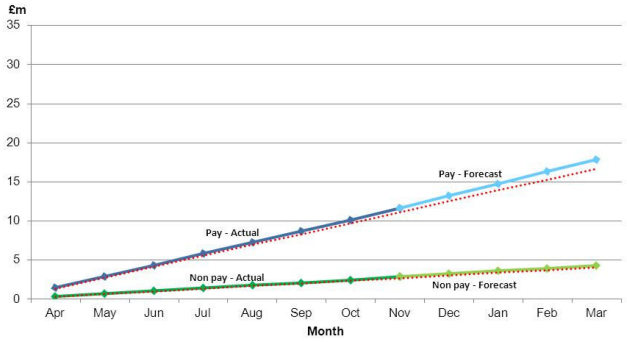
Cancer and Diagnostics – Non pay

- Overspend due to excluded drugs (balance in line with over-recovery of income),offset by underspend in included drugs;
- Further forecast overspend in clinical supplies and services within radiology and pathology, partially offset by underspend in external healthcare providers.



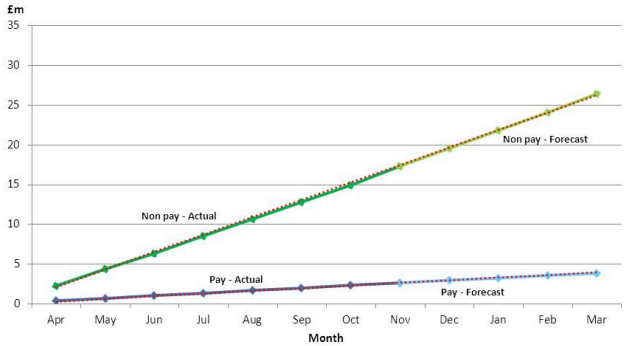
Family and Public Health

- Pay: Overspend in locum and agency due to vacancies in maternity, consultants, and breast screening staff;
- Non-pay: Small overspend due to excluded drugs offset by included drugs delivering cost savings.



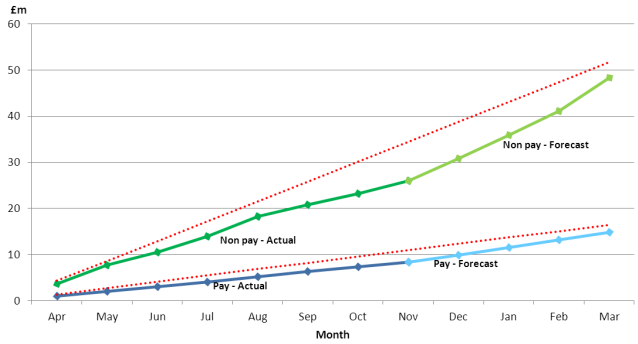
Theatres, Anaesthetics and Critical Care

- Pay: Overspend due to unfilled vacancies and increased bank and agency use;
- Non-pay: Minor overspend on theatre consumables.



Facilities

- Pay: Assistant Director vacancy savings offset by agency;
- Non-pay: Underspend on utilities and MES repairs and consumables, offset by overspend on Sharpsmart and medical gases; also overspend on the unitary payment due to service variations/volume adjs.



Corporate

- Pay: Ongoing forecast underspend;
- Non-pay: Forecast underspends on Professional Fees and other non pay costs; also Underspend on restructuring and delivery costs of turnaround.

5. Statement of Financial Position (SoFP)

	Actual position as at 31/10/12 £m	Actual position at 31/10/12 £m	Actual position at 30/11/12 £m
Intangible assets	-	-	-
Property, plant and equipment	70.0	66.9	66.4
PFI asset (finance lease) building	293.0	289.1	288.5
PFI asset (finance lease) equipment	4.0	3.7	3.6
Non PFI asset (finance lease) equipment	1.0	0.9	0.9
Trade and other receivables	0.9	1.2	1.2
M1 programme for equipment replacement (PFI)	5.8	8.2	8.6
Total non-current assets	**374.7**	**370.0**	**369.2**
Inventories	3.0	2.9	2.9
Trade and other receivables	17.4	14.1	9.8
Cash and cash equivalents	0.6	16.6	12.9
Total current assets	**21.0**	**33.5**	**25.6**
Trade and other payables	(19.9)	(19.2)	(14.7)
PFI payable, amount due by 31/03/2013	(8.8)	(9.0)	(9.0)
Non PFI payable, amount due by 31/03/2013	(0.1)	(0.1)	(0.1)
Provisions	(0.5)	(0.3)	(0.7)
Tax payable	(0.8)	(2.9)	(2.9)
Deferred income	(0.4)	(34.3)	(33.8)
Total current liabilities	**(30.6)**	**(65.8)**	**(61.2)**
Total assets less current liabilities	**365.1**	**337.7**	**333.6**
Trade and other payables	(0.1)	-	-
PFI payable, amount due after 01/04/2012	(394.5)	(389.1)	(388.4)
Non PFI payable, amount due after 31/03/2012	(0.8)	(0.7)	(0.7)
Provisions	(1.2)	(0.9)	(0.9)
Total non-current liabilities	**(396.6)**	**(390.8)**	**(390.0)**
Total assets employed	**(31.5)**	**(53.1)**	**(56.4)**
Public Dividend Capital	117.0	117.0	117.0
Revaluation reserve	33.6	33.6	33.6
Income and expenditure reserve	(182.1)	(203.7)	(207.0)
Total taxpayers' equity	**(31.5)**	**(53.1)**	**(56.4)**

Key movements in the Statement of Financial Position:

- At the end of November, the Trust has positive cash balances however as has been forecast in prior months, the Trust expects to require external financing at the end of January 2013, this is highlighted by the reduction in cash from M7 to M8;
- The deferred income balance is represented by £31.9m of contract income received in advance, training and education income received in advance and trials income received in advance, this will reduced from M9 onwards.
- Trade receivables have reduced largely due to a large value of long standing debts with Cambridgeshire and Peterborough NHS Foundation Trust being cleared along with some other large, old debts;
- Trade payables have reduced due to an improvement in speed with which invoices are being authorised, coupled with the Trust maintaining the position of paying all invoices to terms. The Trust has also cleared old Cambridgeshire and Peterborough NHS Foundation Trust invoices of in the month;

6. CIP programme

CIP Summary by Workstream

	In Month			YTD			Forecast			Recurrent Full Year Effect		
	Plan £000s	Actual £000s	Variance £000s	Plan £000s	Actual £000s	Variance £000s	Plan £000s	Forecast £000s	Variance £000s	Plan £000s	Forecast £000s	Variance £000s
Diagnostics	84	13	(71)	341	59	(282)	676	132	(544)	764	219	(545)
Elective	93	72	(20)	423	355	(68)	794	637	(157)	1,283	616	(667)
Emergency	51	72	21	355	503	148	558	790	232	608	862	254
Maternity & Paediatrics	6	-	(6)	18	-	(18)	40	-	(40)	73	-	(73)
Non Pay	264	107	(157)	1,448	1,295	(152)	2,597	2,387	(210)	3,213	3,021	(192)
Outpatients	42	-	(42)	133	-	(133)	300	-	(300)	367	-	(367)
Workforce	450	788	337	2,294	2,449	155	4,086	4,519	433	3,821	5,961	2,140
Sub Total (cost reduction)	**989**	**1,052**	**63**	**5,012**	**4,661**	**(351)**	**9,051**	**8,464**	**(587)**	**10,129**	**10,679**	**550**
Income Rec	-	87	87	-	480	480	-	798	798	-	929	929
Income Non Rec	72	78	5	461	341	(120)	750	549	(201)	1,006	-	(1,006)
Additional Non Rec	343	(542)	(885)	1,995	951	(1,044)	3,367	1,341	(2,026)	-	-	-
Additional Rec Measures	-	-	-	-	-	-	-	-		2,033	-	(2,033)
Sub Total (actual)	**1,404**	**675**	**(729)**	**7,468**	**6,432**	**(1,035)**	**13,168**	**11,153**	**(2,015)**	**13,168**	**11,608**	**(1,560)**
(Overachievement)/ Additional measures yet to be identified	-	-	-	-	-	-	-	2,015	2,015	-	1,560	1,560
Grand Total	**1,404**	**675**	**(729)**	**7,468**	**6,432**	**(1,035)**	**13,168**	**13,168**	**-**	**13,168**	**13,168**	**-**

The Trust Cost Improvement Programme (CIP) delivery year to date (YTD) for month 8 (including income contribution and other non-recurrent measures) was £6,432k which is behind plan YTD by (£1,035k). The full year forecast remains in line with the plan of £13,168k, leaving further schemes of £2,015k in year to be identified, with full year effect of £1,560k. There has been a worsening of the position when compared to Month 7, and this is due to a review of current schemes and moving some areas back into the pipeline for further validation.

In total, including recurrent and non-recurrent schemes, the planned CIP savings for month 8 were behind plan by (£1,035k). To date, CIP performance relating to the workstreams has delivered £4,661k compared with a target of £5,012k prior to income and other measures. The planned savings requirement has increased from an average per month of £0.6m in Q1 to £0.95m in Q2 with a further step change to £1.4m from this October onwards, predominantly in the pay budget.

In terms of income, the year to date contribution relates to additional new activity that is being carried out within the Directorates. In addition, various non-recurring items have also been included to support CIP delivery, partly achieved through holding vacancies. The year to date total of all these schemes amounts to £1,772k.

Additional recurrent and non-recurrent schemes will continue to be identified to bridge the gap in our full year CIP plans which amount to £2,015k in the current year and £1,560k of full year effect carried forward to 2013/14. In addition pipeline schemes are being developed to increase recurrent savings in 12/13 and beyond.

7. Key financial risks

The table below outlines risks identified for 2012/13. New comments/risks are highlighted by a blue box.

No.	Key financial risks	Mitigating Actions	Timing / responsibility	Potential financial impact
1 	Liquidity – Trust requires external financial support during 2012/13	• Ongoing dialogue with Monitor and DoH • Short and long term cash flow forecasting processes are in place and are regularly reviewed.	• Monitoring /escalation processes in place • DoF in regular contact with Monitor and DoH	Cash shortfall of c.(£47m) to 31 March 13
2 	Delivery of CIP savings/failure to reduce current run rate to meet budgeted levels.	• PMO in place. • Regular CIP performance management meetings in place both with CBUs and savings scheme leads. • Programme governance arrangements improved. • Recruitment of Programme Director – Now in post. • Unidentified CIP achievement has been removed from the current forecast mitigating the double counting risk. • There has been an increase in the CIP to be identified in month 7. However there have been significant schemes developed within the pipeline. • Further work continues to be undertaken to review, validate and capture additional areas of potential efficiency improvement. Increased focus continues to be put into the pay costs with the aim of driving out further CIPs in the last quarter of 2012/13.	• Monitoring /escalation processes in place • On-going review and action from Programme Director • CEO driving performance through monthly CIP programme board	(£1m)
3 	Activity associated with Peterborough and Cambridgeshire PCTs exceeds contract value – additional marginal	• Performance monitoring of all activity being enhanced. • Additional monitoring of referral patterns and	• Regular reporting to PCT – DDPIC • Escalation through CMB	(£1m) – (£3m)

	costs	other lead indicators of demand being developed specifically for Peterborough and Cambridgeshire. • Referral Management Board introduced to ensure that referrals follow the planned trajectory. • Over-performance risk has been escalated and a response received from NHS P&C. • Letter received from commissioners on 23rd November. Draft proposal being prepared for presentation to commissioners at next meeting on 20th December.	– DoF, MD and COO	
4	Operational penalties exceed forecast amounts	• Monitoring of penalties and actions plans. • Early escalation of issues. • Potential penalties relating to CDiff were discussed during the teleconference on 4th December. The Trust confirmed its understanding of the measurement criteria included in the contract and are awaiting a response from commissioners.	• Regular reporting to PCT – DDPIC • Improvement driven through CBU performance management meetings – COO	(£0m) – (£1m), EM commissioners only
5	Delivery of CQUIN targets falls below forecast levels – lower than expected CQUIN revenue	• Director of Nursing leading CQUIN work programme. • Project Lead to be appointed to co-ordinate and assist with implementation of schemes. • Reporting mechanisms are now in place to performance manage delivery.	• Performance managed as a programme of work by the CNDoCQ	(£0.5m)
6	Reduction in income - the Trust received notice in May that the funding that it	• This is a national issue, on-going dialogue is taking place with MoD, DoH and relevant PCTs.	• Ongoing dialogue with MoD and DoH - HoBD	(£1m)

	currently receives from the MoD will cease in September	• The Trust attended a national meeting on 22/10/12 at which it was confirmed verbally that PCTs would be expected to fund this activity and that they would receive an equivalent amount of central support from the DoH. • The first month's invoices have now been issued to the relevant commissioners and the Trust is expecting payment to be made shortly.	• Lead executive - DoF	
7	Emergency readmission target to be agreed with PCT following an audit at the end of Q1. This could materially impact on income due from all PCTs other than Peterborough and Cambridge.	• Engagement of contracts, Information and Operation teams with the audit. • Evaluation of potential risks following the outcome of the audit. • Audits are currently on-going; initial feedback from NHS P&C has been received and is being reviewed, and the audit by NHS Lincs is yet to be undertaken.	• Day to day management - DDPIC • Lead executive - DoF	(£1.6m)
8	Ability of Lincolnshire to pay for activity.	• Contract escalation invoked. Further work is now underway to review detailed activity forecasts for the remainder of the year. • NHS Lincolnshire continue to provide assurance that commissioned activity undertaken will be paid for.	• Lead executive - DoF	(£3.0m)
9	A number of quality-related business cases are currently being prepared and if approved would put further pressure on the pay budget.	• Business cases to be reviewed through IMG, F&I and Board as necessary	• Lead executive - COO	(£0m) – (£1m)
10	Winter pressures result in additional costs.	• Resolve staffing issues in the emergency department and improve emergency pathway.	• Lead executive - COO	(£1m)-(£1.5m)

		• Close monitoring of elective waiting lists. • Front load elective activity.		
11 	Additional energy consumption and higher energy prices causes above forecast expenditure.	• Peter Northmore have been engaged to review the PFI contract and perform an energy review. • On-going review of energy usage.	• Day to day management ADE&F • Lead executive - COO	(£0.5m)
12 	Non-recurrent funding for the ward at Stamford Hospital supporting its transition from an acute to an intermediate care facility, based on the achievement of 3 milestones.	• Monthly reporting to commissioners on progress. • Final two milestones agreed and signed off by the commissioners.	• Lead executive - COO	(£0.4m)

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SCRUTINY COMMISSION FOR HEALTH ISSUES	Agenda Item No. 8
23 JANUARY 2013	Public Report

Report of the Executive Director of Adult Social Care

Contact Officer(s) - Jana Burton, Assistant Director - Care Services Delivery
Contact Details - 01733 452440

CONSULTATION ON PROPOSED CHANGES TO ELIGIBILITY CRITERIA AND CHARGES FOR ADULT SOCIAL CARE

1. PURPOSE

1.1 To inform the committee of the consultation with social care service users, carers and partners on proposals to revise the Council's eligibility criteria for Council supported social care services, to make changes to the charges levied for social care services and to remove the subsidy from the home meals service.
To seek the views of the committee on these issues and of measures that should be taken to promote a more preventative approach if the Council decides to revise eligibility as proposed.

2. RECOMMENDATIONS

2.1 To ask the committee to comment as part of the consultation process.

3. LINKS TO THE SUSTAINABLE COMMUNITY STRATEGY

3.1 Priority 1 Creating opportunities – tackling inequalities – improving health and supporting vulnerable people.

4. BACKGROUND

4.1 Background details are provided in the 10 December 2012 Cabinet report, attached as appendix 1.

5. KEY ISSUES

5.1 Key issues are outlined in appendix 1.

6. IMPLICATIONS

6.1 The implications are outlined in appendix 1.

7. CONSULTATION

7.1 The consultation started in early January 2013 and ends on 13 February 2013. All service users were written to following the Cabinet meeting in December, and again after the Christmas break. A questionnaire has been prepared and is in use to collect views of service users, their families and carers, partner agencies and staff.

7.2 A member briefing has been held and a further one is planned. Comments can be provided via written questionnaire, email or via a dedicated voicemail. A series of Focus Groups, briefings and presentations are scheduled throughout January at a range of locations as follows:

Deafblind Conference Centre, John and Lucille van Geest Place, Cygnet Road, Hampton, Peterborough

- Friday 11 January 10am to 12noon
- Friday 11 January 1pm to 3pm
- Tuesday 15 January 7pm to 9pm
- Friday 18 January 1pm to 3pm
- Thursday 24 January 7pm to 9pm
- Friday 25 January 10am to 12noon

Westgate Church, 68/70 Westgate, Peterborough

- Tuesday 29 January 2pm to 4pm
- Thursday 31 January 2pm to 4pm

The briefing paper and questionnaire on the proposed changes are attached as appendix 2.

7.3 The consultation was extended and additional venues added following representations from partner agencies.

8. NEXT STEPS

8.1 The outcome of the consultation process will be reported to Cabinet in late February and if approved will be included within the Adult Social Care budget proposals recommended to Council.
If approved the changes will be implemented from April 2013.

9. BACKGROUND DOCUMENTS

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

9.1
- DH White Paper: Caring for Our Future Reforming Care and Support July 2012-11-16.
- Fair Access to Care Services (FACS) Assessment Criteria among Local Authorities in England.
- DH Guidance on Eligibility Criteria for Adult Social Care 2012.
- PCC Medium Term Financial Strategy and Plan to 2015/16.

10. APPENDICES

10.1
- Cabinet Report "Consultation on Proposed Changes to Eligibility Criteria and Charges for Adult Social Care, 10 December 2012 – Appendix 1
- Briefing paper and questionnaire on the proposed changes to Peterborough City Council's Eligibility Criteria and Charges for Adult Social Care. – Appendix 2

CABINET	AGENDA ITEM No. 4
10 DECEMBER 2012	PUBLIC REPORT

Cabinet Member(s) responsible:	Councillor Fitzgerald, Cabinet Member for Adult Social Care	
Contact Officer(s):	Terry Rich, Executive Director of Adult Social Care	Tel. 452407
	Jana Burton, Assistant Director Care Services Delivery	Tel. 452440
	Paul Stevenson, Head of Finance, Adult Social Care	Tel. 452306

CONSULTATION ON PROPOSED CHANGES TO ELIGIBILITY CRITERIA AND CHARGES FOR ADULT SOCIAL CARE

R E C O M M E N D A T I O N S	
FROM : Executive Director of Adult Social Care	**Deadline date :** n/a

Cabinet is asked to:

1. Approve the commencement of consultation with social care service users, carers and partners on revising the Council's eligibility criteria for Council supported social care services.

2. Include within that consultation, proposals to enhance the range of preventative services available to people with care needs who fall below current or any revised eligibility criteria.

3. Approve consultation on a series of modifications to the Adult Social Care charging policy including a review of the treatment of Disability Related Expenditure in the financial assessment, the introduction of charges for the supply of assistive technology and the "Appointeeship Service" (as detailed in paragraph 4.15) and the removal of the subsidy to the home meals delivery service (as detailed in paragraph 4.16).

4. To note that phase three of the increases in charges agreed in 2010/11 is due to be implemented in April 2013 as set out in the attached schedule.

1. ORIGIN OF REPORT

1.1 The report arises out of a continuing review of the operation of Adult Social Care following its transfer back to the Council from the NHS in March 2012.

1.2 It is part of the way in which services are brought in line with good practice and address an historic gap between demand and available resources.

2. PURPOSE AND REASON FOR REPORT

2.1 The purpose of this report is to seek approval to commence consultation on a number of measures designed to increase the emphasis on promoting independence and prevention amongst people with developing social care needs and to revise the eligibility criteria for Adult Social Care from April 2013.

2.2 It also proposes some changes to the Adult Social Care charging policy, including a review of the Disability Related Expenditure Disregard in the financial assessment and the introduction of new charges for assistive technology and the appointeeship service.

2.3 This report is for Cabinet to consider under its Terms of Reference No. 3.2.1, to take responsibility of the delivery of all strategic Executive functions within the Council's Major Policy and Budget Framework and lead the Council's overall improvement programmes to deliver excellent services.

3. TIMESCALE

Is this a Major Policy Item/Statutory Plan?	**NO**

4. BACKGROUND AND KEY ISSUES

Eligibility Criteria

4.1 Adult Social Care services are subject to eligibility criteria which were introduced by the Department of Health in 2003 (see appendix 1). This is the Fair Access to Care Services (FACS) framework. The principle was that there should be one single process to determine eligibility for adult social care and to provide a fairer, more transparent and consistent system for allocation of social care support.

4.2 FACS identifies four levels of need: Critical, Substantial, Moderate and Low. Councils are required to determine which bands of eligibility they will provide to, taking into account factors including the resources available to them to deliver care.

4.3 Peterborough City Council has operated at a level which is essentially Critical and Substantial – in common with an estimated 84% of Social Services authorities, but also included a variation, defined as "High Moderate".

4.4 Many authorities have undertaken regular reviews of eligibility criteria together with their charging policies. There are fewer than 16% of authorities remaining that operate eligibility below the level of Critical and Substantial. Public funding for social care will always be limited in the face of demand for resources and the majority of Councils have tightened eligibility criteria to shift their focus to groups with the highest needs.

4.5 Since 2003, there have been significant changes in the delivery of Adult Social Care in line with 'Putting People First: a shared vision and commitment to the transformation of Adult Social Care.' This sets out the approach to personalisation and culminated in the White Paper published earlier this year.

4.6 The White Paper signals that there is likely to be national guidance for local authorities on eligibility criteria by 2015. It is expected that the national threshold will be set at substantial. There has been an increasing move by some authorities to consider tightening of eligibility criteria to include only "critical" and the White Paper discourages such further eligibility tightening in advance of a national threshold being set. However, in Peterborough, eligibility is more generous than is provided in the majority of Councils and the level anticipated within a future national threshold.

4.7 In addition, the criteria have not been reviewed for nine years and have not been considered either in relation to the resources available to the Council, or in the light of the transformation of adult social care and the increased emphasis on personalisation and promoting independence.

4.8 Over the last decade our average length of stay in residential and nursing home settings in the city would indicate that in the past many people were admitted to long term care at too early a stage rather than being supported to maintain their independence at home. Today people with similar levels of needs are successfully being supported either in supported housing, including extra care housing, or in their own homes. This option is now routinely available for people who fall within the substantial and often the critical bands of eligibility.

4.9 More recently the development of reablement for people at the point where they first enter the social care system is also being successful in helping people, often with lower levels of need and dependency, regain full independence and be free of funded social care support for longer.

4.10 Greater emphasis is also being given to providing information, advice and guidance to people with developing care needs and their families and signposting them to services which may be provided within the community or through voluntary organisations rather than offering to provide formal, funded care.

4.11 As well as ensuring the council's resources are deployed to prioritise those in greatest need of social care support, it is also the intention to better identify and address the needs of the wider community including self funders. There are already a number of services which are provided or commissioned by Adult Social Care and the wider Council which form a preventative strategy. The intention is to cost, quantify, strengthen and include these services as part of a more universal offering from information and advice to low level support, brokerage and other support to enable the wider population to benefit.

4.12 It is intended that the proposed consultation will both outline the range of preventative services already available and to seek views on the types of services which might be required to help people to remain independent for longer and, therefore, not need to become reliant on council-funded social care services.

Charging policy

4.13 Members agreed at the last review of the Council's Adult Social Care charging policy in 2011 to allow care charges to rise to the level of their actual cost for those service users who can afford to pay (either because they have capital above the funding threshold of £23,250, or have high incomes); and approved phased increases of these charges for existing service users over three financial years to protect them from the impact of steep increases.

4.14 The first two phased increases have been applied, and the third and final phased increase is due to be applied from April 2013, and will affect the following services:

Respite	Increase from £364 to the full cost (£387 to £430pw).
Day care	Increase from £24 to £35 per day care session.
Homecare x 2 carers	Increase from £21.94 per hour to £26.32 per hour.

4.15 In addition to the charge increases to be applied from April 2013, it is now proposed to consult on the introduction of further amendments to the charging policy to be introduced at the same date:

- Disability Related Expenditure disregard - within the financial assessment calculation for people who pay an assessed charge towards the cost of their care, there is a deduction for additional costs they might expect to incur relating to their disability - known as the Disability Related Expenditure (DRE) disregard. Peterborough currently operates a flat rate DRE of £32 applied to all those with an assessed charge. A comparison with other local authorities has identified that the level of this disregard is both comparatively high and unusual in that it is applied universally. It is proposed to consult on the introduction of a banded Disability Related Expenditure disregard, applied only where specific evidence of additional costs of living with a disability is identified. If implemented, this change could affect around 600 people and generate in the region of £250,000 per annum, depending on the bandings introduced.

- Assistive Technology - to be included as a chargeable service both when part of a personal budget or as a commissioned service. Those over the upper income or capital threshold would meet the full cost whilst the majority of service users will continue to pay an affordable charge towards the total cost of their personal budget following a financial assessment. The charge will range from £2.88 to £6.40 per week depending

on the equipment provided. There are currently 229 service users in receipt of an AT service. Some of these service users are already in receipt of care services and paying their maximum assessed charge, so there would be no additional impact from these. There are around 60 service users whom these changes would affect, and could generate additional income of around £9,000 per annum.

- Protected levels of income used in the charging policy are based on Department for Work and Pension's original Pension Credit qualifying age of 60. As the qualifying age for Pension Credit will increase to 66 by 2020, it is proposed to substitute "Pension Credit qualifying age" in order to reflect this change in place of "at age 60".

- Adult Social Care acts as "appointee" for a number of service users who lack mental capacity to manage their own finances and who have no next of kin or representative who can do so. No charge is currently made for this service. However the Association of Public Authority Deputies (APAD) has advised that Councils can charge for the provision of an appointee client income management service, and has provided comprehensive good practice guidance. This emphasises that charges should not be applied if it is likely to cause financial hardship. Adult Social Care is currently appointee for approximately 160 clients and it is estimated that, if introduced, a minimum of a third of this group would be subject to a charge of the APAD recommended figure of £5 per week. This could generate additional income of £13,000 per annum.

4.16 In addition it is proposed to consult on the proposal to remove the subsidy from the current home meals service. If the subsidy were to be removed in a single phase, it would result in an increase from £3.20 to £5.20 per meal for hot meals and from £2.00 to £2.60 for frozen meals. The consultation will also test out alternatives, including whether there remains a case to continue with a hot meals delivery service. This would generate additional income in the region of £96,000 per annum, if the subsidy is removed in one year.

5. CONSULTATION

5.1 Changes to eligibility criteria and charging are subject to consultation with those affected by the proposal. It is intended that a questionnaire will go out to existing service users and their carers/families and to organisations representing service users and carers groups.

5.2 Consultation will take place during December 2012 and January 2013 and the results considered prior to a final decision being proposed to be taken as part of the Council's budget setting process.

5.3 The approach to the consultation needs to be handled well to ensure a coherent rationale and process as well as compliance with equalities legislation. In so doing, it is important to be mindful of two recent High Court Judgements: **R (W) v Birmingham City Council (2011)** and **JG and Another v Lancashire County Council (2011).**

5.4 Commencing consultation now would enable implementation for the new criteria from April 2013. Existing service users would be reviewed in line with the dates for their annual review. The full year savings would, therefore, come into effect from 2014 in preparation for the new national thresholds due in 2015 together with the anticipated decisions about carers. It is expected that from 2015 all carers will have a right to an assessment and clear entitlement to support so they can maintain their own health and well being.

5.5 It is proposed that consultation takes place on the proposal to tighten eligibility criteria and charging with all current service users, carers and families as well as other partners and stakeholders. Focus groups will be held with each customer group to discuss and seek input to the 'preventative offer' to help mitigate the effects of giving priority for ongoing statutory support to those in the greatest need.

5.6 The charging policy was last reviewed by Council in February 2011 when consultation about the charge increases was included in the extensive city-wide consultation undertaken for the Council's mid-term financial strategy.

6. ANTICIPATED OUTCOMES

6.1 Analysis of existing spend suggests that a change of criteria to critical/substantial could result in savings in the order of £500,000 p.a. This is based on an assumption that there would be a reduction in low value (less than £150 per week) packages of care as more people are reabled, signposted to other services or are provided with advice on how else they might meet their needs. It is acknowledged that some low value packages will continue, for example where a family carer provides the majority of the care to someone with high needs but receives a low level of funded support to help them to manage.

6.2 Should a change in eligibility criteria be agreed, changes to individual care packages would only take place following a review of needs. Such a review may well identify changes, increased needs, but may also identify reablement potential.

6.3 It is anticipated that following consultation, if the changes are to proceed, investment of part of the future savings will be recommended to be made in additional preventative services to ensure that those no longer eligible are able to access other support.

7. REASONS FOR RECOMMENDATIONS

7.1 Consultation with those affected by a change to eligibility criteria will enable implications of those changes to be fully considered. It will provide opportunities for people receiving care services, their families and carers, and for partner agencies to give their views and to outline any concerns or consequences.

7.2 The consultation will also enable views and evidence to be gathered of the effectiveness of the current range of preventative services in place and views of where these might be developed should the decision be made to implement a change in criteria.

7.3 Consultation on the proposed revisions to the charging policy will enable views to be gathered from those likely to be affected by changes and for the impact to be fully considered prior to decisions being made. In relation to the Disability Related Expenditure disregard, consultation will involve discussion with disabled service users and with disability groups, including the Disability Forum, about the best ways of targeting resources and in this case income disregards to take account of the additional costs of living as a disabled person.

7.4 Given that each of these proposals, if implemented, will result in financial savings either through reducing costs or increasing income, consultation will also ensure that when decisions are made, consideration of the availability of resources and the service implications are appropriately balanced.

8. ALTERNATIVE OPTIONS CONSIDERED

Eligibility criteria

8.1 Consideration was given to waiting for Department of Health guidance on eligibility criteria expected in 2015. However, it is felt reviewing the criteria now places the Authority in a sound position to be prepared for the national changes being signalled in line with available resources.

Charging policy

8.2 i) No review off the level of the Disability Related Expenditure disregard could be undertaken and the DRED could be retained at the current level. This option is rejected as the current scheme does not take account of differing levels of need, and people with lower level requirements, in terms of disability related expenditure requirements, currently receive the same level of disregard as people with higher requirements. In addition, it does not

take account of the higher level of disregard allowed in Peterborough in comparison with other authorities.

ii) Leave the charging policy unchanged. This option is rejected because the charging policy would be inconsistent in its treatment of charges for different care services, and would not be in-step with national changes to the state pension age.

iii) Maintain the status quo in terms of charging for the appointee client income service and meals charges. This option is rejected because additional revenue can be reasonably raised from the application of a charge / charge increase for these specific care services.

8.3 The consultation will seek to explore the implications of the proposals set out in this report and may lead to alternatives or modifications being considered prior to final recommendations being made.

9. IMPLICATIONS

9.1 Financial

These changes would result in financial savings which would contribute to meeting the significant financial pressures faced by the Council in relation to increasing demand for social care services at times of financial restraint. Failure to identify areas where costs can be reduced or income increased will place significant pressure on Adult Social Care's ability to manage within the resources available and to meet priority needs.

9.2 Legal

Consultation is a statutory requirement for eligibility criteria and charging.

9.3 Diversity and Equality

9.3.1 Should a change to eligibility criteria be agreed, consideration will need to be given to the differential access to preventative services for different groups that might be affected by a change. The preventative strategy and the implementation and access to services like reablement will ensure that people with disabilities are not disadvantaged. The 'preventative offer' will ensure that account is taken of wider equality issues to ensure advice, information and low level support can be easier to access across the community.

9.3.2 An equalities impact assessment has previously been completed in respect of the Day Care, Respite and Home Care (2 carers) charge increases. The recommended change to Disability Related Expenditure disregard will be designed to specifically take account of disadvantages faced by people living with a disability who are subject to a means test to determine their social care charges. The other changes proposed, whilst not likely to have a significant impact on any particular section of the community, will also be considered in a fresh Equality Impact Assessment prior to final recommendations being made.

10. BACKGROUND DOCUMENTS

DH White Paper: Caring for Our Future Reforming Care and Support July 2012-11-16
Fair Access to Care Services (FACS) Assessment Criteria among Local Authorities in England
DH Guidance on Eligibility Criteria for Adult Social Care 2012
PCC Medium Term Financial Strategy and Plan to 2015/16

Appendix 1

FACS bandings and eligibility criteria for individuals

Critical – when

- Life is, or will be, threatened; and/or
- Significant health problems have developed or will develop; and/or
- There is, or will be, little or no choice and control over vital aspects of the immediate environment ; and /or
- Serious abuse or neglect has occurred or will occur; and/or
- There is, or will be, an inability to carry out vital personal care or domestic routines; and/or
- Vital involvement in work, education or learning cannot or will be sustained; and/or
- Vital social support systems and relationships cannot or will be sustained; and/or
- Vital family and other social roles and responsibilities cannot or will not be undertaken.

Substantial – when

- There is, or will be, only partial choice and control over the immediate environment; and/or
- Abuse or neglect has occurred or will occur; and/or
- There is, or will be, an inability to carry out the majority of personal care of domestic routines; and/or
  Involvement in many aspects of work, education or learning cannot or will not be sustained; and/or
- The majority of social support systems and relationships cannot or will not be sustained; and/or
- The majority of family and other social roles and responsibilities cannot or will not be undertaken.

Moderate – when

- There is, or will be, and inability to carry out several personal care or domestic routines; and/or
- Involvement in several aspects of work, education or learning cannot or will not be sustained; and/or
- Several social support systems and relationships cannot or will not be sustained; and/or
- Several family and other social roles and responsibilities cannot or will not be undertaken.

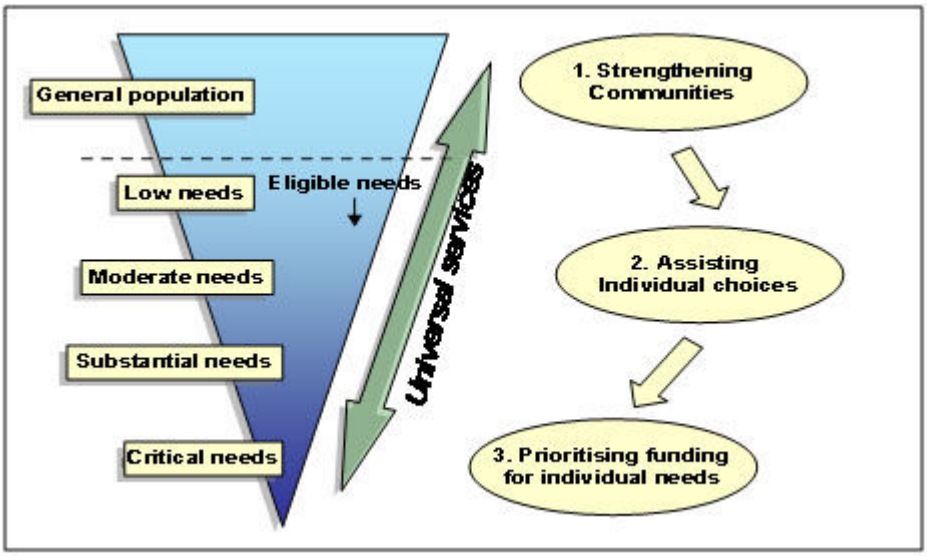
Low – when

- There is, or will be, an inability to carry out one or two personal care or domestic routines; and/or
- Involvement in one or two aspects of work, education or learning cannot or will not be sustained; and/or
- One or two social support systems and relationships cannot or will not be sustained; and/or
  One or two family and other social roles and responsibilities cannot or will not be undertaken.

As indicated in Figure 1 below, the eligibility bands are set in the context of the:

- General population recognition that universal services need to be expanded to meet the needs, demands and expectations of the general population and for individuals and carers
- Need to strengthen communities, assist individual choices and prioritise funding for individual needs.

Figure 1: Eligibility needs in the context of the environment



Case Studies

High Moderate

Mr K is an 87 year old man who was admitted to hospital with infective exacerbation of COPD on the 30 October 2012 and deemed medically fit for discharge on the 6 November 2012. Mr K lives with his wife who provides natural support in relation to general household tasks, shopping and meals. Prior to his admission to hospital Mr K was independent with washing and dressing ensuring he took his time to complete these tasks and resting intermittently when he became short of breathe. Mr K was quite anxious about returning home and less confident about being able to meet his personal care needs and therefore he was referred to the reablement service who supported him to regain his confidence, relieve his anxiety and work towards becoming independent with washing and dressing. Mr K was discharged form reablement on the 20 November 2012 and without this service he may have become more dependent and reliant on a longer term care package due to his level of anxiety which exacerbates his COPD (chronic obstructive pulmonary disease).

High Moderate

Young person, mid 20s was in foster care then Shared Lives Scheme then moved into boyfriend's family home, developing skills along the way. Boyfriend also mild LD. About to set up home with boyfriend. Requires low level support such as floating support to look at mail, direct debits set up for utilities and support to make health appointments (not to attend but to remember to make). Without this support care needs might increase.

Substantial

Mr T is a 60 year old man who lives alone in sheltered accommodation and has been diagnosed with Myotonic Dystrophy (characterised by wasting of the muscles, muscle pain and disabling distal weakness). Mr T has frequent falls and requires support to access the community and his work and support in his home environment to meet his activities of daily living safely. Mr T has a care package of four calls per day to support him with his personal care needs and meal preparation. Mr T has support from his work colleagues three mornings a week to enable him to

continue to work. Mr T is supported to remain as independent as possible and whilst the risk of falls remain due to maintaining this level of independence the number of falls resulting in injury and hospital admission have significantly decreased. Mr T is supported to make informed choices and have control over decisions, for example access to work. He is aware of the risks in terms of falls and increased pain/debility but he feels the benefits far outweigh the risks.

Substantial

Young person, 18 years of age. Has autism and severe LD, elective non-verbal communication. Isolates himself both emotionally and physically requiring significant support to participate in any activity including basic Activities of Daily Living (although technically physically able).

Critical

Mrs H is a 63 year old woman who lives with her husband. Mrs H has multiple sclerosis and is dependent on others to meet most of her activities of daily living. Mrs H spends most of her time in bed where she feels more comfortable but she will sit out in a wheelchair on occasions for short periods of time. Mrs H is unable to mobilise independently and support to meet all personal care (washing/dressing toileting) is provided by 2 carers and all transfers are carried out using a hoist. Full assistance with meal preparation is provided and her carers/ husband ensure food is cut up or finger foods are offered to give Mrs H some independence as she has no useful movement in her left hand.

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Briefing Paper on the proposed changes to Peterborough City Council's Eligibility Criteria and Charges for Adult Social Care

If you require an Easy Read, Larger Print or Audio version of this document, please email ASCConsultation@peterborough.gov.uk or call 01733 864666 and leave a message and a team member will respond to you within 10 working days.

1 Introduction

Peterborough City Council offers many different care services for adults with all types of social care needs and the Council is thinking of making some changes to these services.

The Council has agreed to:

a) review eligibility criteria for long term and ongoing social care funding, and;
b) consider five changes to the charging policy.

A consultation will open in January to get people's views on how the proposed changes might have an impact on people in the future. This consultation will help the Council create a new type of service to support people with moderate and low needs so that they don't have to go into residential care or receive formal care sooner than they need. It will also help us prioritise services for those with substantial and critical needs and allocate the right funding for new programmes in a time where there is limited financial support.

1.1 Equality Impact Assessment

When the Council is looking at changing or developing services it needs to ensure that consideration has been given to whether the proposed changes will have an unequal impact on any particular groups. To ensure the proposals for change have been looked at comprehensively, it is important to ask the people who may be affected, whether the proposals are likely to have a positive or negative impact on them.

Adult Social Care are undertaking an Equality Impact Assessment on the review of the eligibility criteria to identify the positive and negative effects that changes to the eligibility criteria will have on people who receive support from Adult Social Care.

The Council would like to hear from people who receive Adult Social Care support and what they think the positive and negative impacts of the change in Eligibility Criteria may be for them.

2 Proposed Changes to Eligibility Criteria

Eligibility Criteria is the set of measures the Council use to work out who they are able to support.

Since 2003, Adult Social Care has moved to a personalised approach which offers people more choice and control over the support people get to meet their needs. The Council's aim is to provide more personalised support rather than a limited menu of formal services. As well as this, the Council is now better able to help people stay independent for longer or regain their independence as quickly as possible. This will help to meet the needs of the wider community through integrated, community-based preventative programmes that will ensure that people are not isolated, help slow down deterioration in health and keep people in their own homes, close to family and friends.

Peterborough's eligibility criteria have not been reviewed for nine years and have not been considered in relation to the resources available to the Council, or in the light of the increasing emphasis on personalisation and promoting independence.

The White Paper: 'Caring for our future: reforming care and support' published earlier this year, shows that there is likely to be national guidance on eligibility criteria by 2015. It is expected that the national threshold will be set at substantial.

Some authorities have considered tightening their eligibility criteria to include only "critical" and the White Paper discourages such further eligibility tightening in advance of a national threshold being set. However, in Peterborough, eligibility is more generous than the majority of Councils and the anticipated future national threshold.

The proposal is to focus social care funding on the critical and substantial levels of need of the most vulnerable people. Adult Social Care would, if the policy is approved, no longer provide support for any assessed needs for social care support which are moderate or low.

If a change in eligibility criteria is agreed then changes to people's current care packages would only be made after their needs were reviewed. These reviews may well find that their needs have increased but may also identify that they might benefit from reablement or a different type of service/support available elsewhere. By reablement we mean a short period of intensive support to enable an individual to gain or regain skills in living as independently as possible.

If the proposed changes go ahead, then the Council thinks that part of the future savings should be invested in additional preventative services to ensure that those no longer eligible have access to other support.

There is a range of preventative services already available and the Council is seeking views on other types of services which might help people to remain independent for longer and, therefore, not need to become reliant on Council-funded social care services.

Some examples of preventative services being considered are:

- Developing locality based champions – working with Neighbourhoods and Voluntary Community Services to identify and develop neighbourhood assets and to develop solutions with local communities
- Improving access to information and advice – including specialist advice on financial issues and effective signposting to services and support
- Developing a universal adult social care information, advice, advocacy and brokerage service. Support for people to identify community and personal assets available to them and to organise support.
- Further developing user led organisations and support – investment in community and volunteer groups and time-banking
- Developing of leisure opportunities with Vivacity including improved access to mainstream opportunities
- Continuing support of lunch clubs
- Improving support for carers including carers support payments and emergency respite.
- Establishing dementia cafes – offering accessible support to people with dementia
- Working on a falls prevention scheme with health to reduce the number of people affected by a fall

At the same time we will be recruiting for an Adult Social Care Champion Group which will meet quarterly in 2013-14 and ensure that the voices of people receiving care services in Peterborough are heard and involved in how our services are designed and delivered.

3 Proposed Changes to the Charging Policy

The Charging Policy sets out how much we charge people for the services we deliver.

Peterborough City Council agreed in 2011 to allow care charges to rise to the level of their actual cost for those people who can afford to pay. These rises are being phased in over three financial years to protect them from the impact of steep increases.

The first two phased increases have been applied, and the third and final phased increase is due to be applied from April 2013, and will affect respite, day care and homecare where two carers are needed at the same time.

Five further amendments are proposed to be introduced from April 2013 as an addition to the increases already agreed. The proposed changes will affect people who contribute something towards the cost of their care, and may mean that some people will have to start paying a charge or pay more than they currently do.

The proposed new changes are as follows:

3.1 Revising the Disability Related Expenditure disregard

For those people who make a payment towards the cost of their care, there is a deduction within the financial assessment calculation for the additional costs relating to their disability that they might expect to incur in looking after themselves, their home and any transport/travel needs. This is known as the Disability Related Expenditure disregard.

Peterborough currently operates a flat rate Disability Related Expenditure of £32 applied to all those with an assessed charge. The level of Peterborough's disregard is high when compared to other local authorities (average £10) and unusual in that it is applied to everyone irrespective of what extra expenditure they may incur.

The proposal is to introduce a banded Disability Related Expenditure disregard with lower figures, similar to that used by other Councils. Individuals with high DRE that can be evidenced will not be required to pay more, but charges for many will increase.

Three different bandings are offered for consultation:

Welfare benefit	Proposed disregard 1	Proposed disregard 2	Proposed disregard 3
Lower rate of Disability Living Allowance	£5	£10	£10
Middle Rate of DLA/Low rate of AA	£10	£15	£10
High rate of DLA/AA	£15	£25	£20

Furthermore, two further options are also offered for consideration:

1) Reduce Disability Related Expenditure disregard for all from £32 to £10
2) Reduce Disability Related Expenditure disregard for all from £32 to £15

There is a proposed safeguard in that service users who maintain that their Disability Related Expenditure is higher than the above figures will have increased DRE figures used in their charge calculations provided that this is allowable following the National Good Practice Guide and that it is evidenced.

It is proposed that the service user will have a right to appeal to an independent panel if they are dissatisfied with a decision on their Disability Related Expenditure disregard.

If the proposed changes are agreed then they would be introduced individually at the annual review.

3.2 Introducing a charge for Assistive Technology

Assistive Technology covers things such as remotely monitored passive alarms and sensors that help people live independently.

The Charging Policy has not kept pace with the technology available and the proposal is to address this by including Assistive Technology as a chargeable service, whether it's provided as part of a personal budget or as a commissioned service.

This proposal would not affect people who already receive care services and pay their maximum assessed charge. Most people will continue to pay an affordable charge towards the total cost of their personal budget following a financial assessment and those people who are over the upper income or capital threshold would meet the full cost.

The proposed charges for assistive technology would range from £2.88 for Lifeline (the most common assistive technology) to £6.40 per week depending on the equipment provided and provided they were chosen as part of a package of services purchased with a personal budget.

3.3 Harmonise the Qualifying Age for Pension Credit

The protected levels of income used in the Council's charging policy are based on the Department for Work and Pension's original Pension Credit qualifying age of 60. As the qualifying age for Pension Credit will gradually increase to 66 by 2020, it is proposed to substitute "*Pension Credit qualifying age*" in place of "*at age 60*" to reflect the change to the qualifying age.

3.4 Introduce a Charge for an Appointeeship Client Money Management Service

Adult Social Care acts as "appointee" for a number of people who lack the mental capacity to manage their own finances and who have no next of kin or representative who can do so.

No charge is currently made for this service. However, the Association of Public Authority Deputies (APAD) has advised that Councils can charge for the provision of an appointee client income management service, and has provided comprehensive good practice guidance about this. The guidance emphasises that charges should not be applied if they are likely to cause financial hardship.

3.5 Remove the Subsidy for Hot and Frozen Meals

It is proposed to remove the subsidy from the current home meals service. If the subsidy were to be removed in a single phase, it would result in an increase from £3.20 to £5.20 per meal for hot meals and from £2.00 to £2.60 for frozen meals.

The Council would like to consider if there are any alternatives to the home meals service, including whether there remains a case to continue with a hot meals delivery service.

4 Why has the Council proposed these changes?

The proposed changes are necessary because of the multi-million pound cuts to the funding the Council receives from the Government. The funding has been reduced by £15 million over the past two years and the cuts are expected to increase to £25 million by 2015.

The Council has to continue to provide adult social care for a rising population, with less and less money. However, the Council has to make sure that the money that is available is spent on those with the greatest need.

The savings made in these areas would help to meet the increasing demand for social care services whereas a failure to identify areas where costs can be reduced or income increased will place significant pressure on Adult Social Care's ability to manage within the resources available and to meet priority needs.

4.1 Why are the changes proposed to Eligibility Criteria?

It is timely to review the eligibility criteria set nine years ago. A change of criteria to critical/substantial could result in savings in the order of £500,000 p.a. assuming that there would be fewer low-value (less than £150 per week) packages of care as more people are reabled, signposted to other services or are advised on how else they might meet their needs. Some low value packages will continue, for example, where a family carer provides the majority of the care to someone with high needs but receives a low level of funded support to help them to manage.

The proposal is to focus the budget on higher levels of need and preventative services. This is for a number of reasons:

- At a time when there is a requirement to achieve financial savings, resources need to be targeted on those most in need of support.

- Nowadays, people who fall within the substantial and often the critical bands of eligibility are routinely being supported to maintain their independence at home.

- Reablement is helping people when they first enter the social care system to regain full independence and be free of funded social care support for longer.

- Greater emphasis is being given to provide information, advice and guidance to people with developing care needs (and their families). This helps them to access services provided within the community or through voluntary organisations.

- The Council would like improve the services it offers to help the wider population (including to those who currently buy their own services and are not supported by the Council) to remain independent for longer and, therefore, not become reliant on Council-funded social care services.

4.2 Why are the changes proposed to the Charging Policy?

The change to Disability Related Expenditure disregard, if implemented, could generate about £250,000 a year, depending on the bandings introduced.

If implemented, the change to charging for Assistive Technology could generate additional income of around £9,000 a year.

Charging for an appointee client income management service could, if introduced, generate an additional income of £13,000 a year.

If the home meals service subsidy were to be removed in a single phase, this would generate additional income in the region of £96,000 a year.

5 How is the eligibility criteria used at the moment?

Peterborough City Council currently provides social care support to those adults who have needs which are in the critical, substantial and high moderate levels. This may include access to services such as day opportunities, home care, social activities and transport.

An assessment of the person's needs identifies the level of risk a person would be in if support was not provided. Using the information about a person's circumstances, the assessor will agree with the person and their carer, (if they wish) to which level of risk the person has and consequently their eligibility for social care support.

This is based upon the risk in relation to the individual's:

- independence,
- health,
- safety,
- managing daily routines
- Involvement in family and community life.

The eligibility framework sets out four levels, which have been decided by the Government. They are described by the seriousness of the risk to independence and well-being or other consequences if needs are not addressed.

The four levels are as follows:

<u>Critical – when</u>

- Life is, or will be, threatened; and/or
- Significant health problems have developed or will develop; and/or
- There is, or will be, little or no choice and control over vital aspects of the immediate environment; and /or
- Serious abuse or neglect has occurred or will occur; and/or
- There is, or will be, an inability to carry out vital personal care or domestic routines; and/or
- Vital involvement in work, education or learning cannot or will be sustained; and/or
- Vital social support systems and relationships cannot or will be sustained; and/or
- Vital family and other social roles and responsibilities cannot or will not be undertaken.

<u>Substantial – when</u>

- There is, or will be, only partial choice and control over the immediate environment; and/or
- Abuse or neglect has occurred or will occur; and/or
- There is, or will be, an inability to carry out the majority of personal care of domestic routines; and/or
- Involvement in many aspects of work, education or learning cannot or will not be sustained; and/or
- The majority of social support systems and relationships cannot or will not be sustained; and/or
- The majority of family and other social roles and responsibilities cannot or will not be undertaken.

Moderate – when

- There is, or will be, and inability to carry out several personal care or domestic routines; and/or
- Involvement in several aspects of work, education or learning cannot or will not be sustained; and/or
- Several social support systems and relationships cannot or will not be sustained; and/or
- Several family and other social roles and responsibilities cannot or will not be undertaken.

Low – when

- There is, or will be, an inability to carry out one or two personal care or domestic routines; and/or
- Involvement in one or two aspects of work, education or learning cannot or will not be sustained; and/or
- One or two social support systems and relationships cannot or will not be sustained; and/or
- One or two family and other social roles and responsibilities cannot or will not be undertaken.

Every Council has to decide which level of need it can afford to meet, taking account of the money and resources it has. It can then review this according to what has been spent and change the level of eligibility if it needs to.

The level of need a person has will determine whether they are eligible for support from Adult Social Care. The proposed eligibility criteria says that if someone's needs are in the critical and substantial bands then they will attract social care funding (subject to a financial assessment).

If an individual was already receiving support for their moderate or low needs and the proposals are approved, the individual's current needs will be reassessed to review the current level of needs and to discuss future options for support. Support will not be withdrawn unless it is safe to do so.

Those with moderate or low needs for support would be signposted to other services available in the community, such as voluntary groups, activity groups etc. After six weeks the individual will be contacted to find out if they were able to access appropriate support.

6 Case studies of risk to independence and eligibility

High Moderate

Mr K is an 87 year old man who was admitted to hospital with infective exacerbation of COPD on the 30 October 2012 and deemed medically fit for discharge on the 6 November 2012. Mr K lives with his wife who provides natural support in relation to general household tasks, shopping and meals. Prior to his admission to hospital Mr K was independent with washing and dressing ensuring he took his time to complete these tasks and resting intermittently when he became short of breathe. Mr K was quite anxious about returning home and less confident about being able to meet his personal care needs and therefore he was referred to the reablement service who supported him to regain his confidence, relieve his anxiety and work towards becoming independent with washing and dressing. Mr K was discharged form reablement on the 20 November 2012 and without this service he may have become more dependent and reliant on a longer term care package due to his level of anxiety which exacerbates his COPD (chronic obstructive pulmonary disease).

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Young person, mid 20s was in foster care then Shared Lives Scheme then moved into boyfriend's family home, developing skills along the way. Boyfriend also mild LD. About to set up home with boyfriend. Requires low level support such as floating support to look at mail, direct debits set up for utilities and support to make health appointments (not to attend but to remember to make). Without this support care needs might increase.

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Mr T is a 60 year old man who lives alone in sheltered accommodation and has been diagnosed with Myotonic Dystrophy (characterised by wasting of the muscles, muscle pain and disabling distal weakness). Mr T has frequent falls and requires support to access the community and his work and support in his home environment to meet his activities of daily living safely. Mr T has a care package of four calls per day to support him with his personal care needs and meal preparation. Mr T has support from his work colleagues three mornings a week to enable him to continue to work. Mr T is supported to remain as independent as possible and whilst the risk of falls remain due to maintaining this level of independence the number of falls resulting in injury and hospital admission have significantly decreased. Mr T is supported to make informed choices and have control over decisions, for example access to work. He is aware of the risks in terms of falls and increased pain/debility but he feels the benefits far outweigh the risks.

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Young person, 18 years of age. Has autism and severe LD, elective non-verbal communication. Isolates himself both emotionally and physically requiring significant support to participate in any activity including basic Activities of Daily Living (although technically physically able).

Critical

Mrs H is a 63 year old woman who lives with her husband. Mrs H has multiple sclerosis and is dependent on others to meet most of her activities of daily living. Mrs H spends most of her time in bed where she feels more comfortable but she will sit out in a wheelchair on occasions for short periods of time. Mrs H is unable to mobilise independently and support to meet all personal care (washing/dressing toileting) is provided by 2 carers and all transfers are carried out using a hoist. Full assistance with meal preparation is provided and her carers/ husband ensure food is cut up or finger foods are offered to give Mrs H some independence as she has no useful movement in her left hand.

Questionnaire on the proposed changes to Peterborough City Council's Eligibility Criteria and Charges for Adult Social Care

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Peterborough City Council is thinking of making some changes to focus on delivering support services to people with critical and substantial needs and providing a service to support people with moderate and low needs so that they don't have to go into residential care or receive formal care sooner than they need.

The Council is also looking to change its charging policy in several areas. The proposed changes will affect people who contribute something towards the cost of their care, and may mean that some people will have to start paying a charge or pay more than they currently do.

The proposed changes are necessary because of the multi-million pound cuts to the funding the Council receives from the Government. The funding has been reduced by £15 million over the past two years and the cuts are expected to increase to £25 million by 2015.

If the changes are agreed, only people who start receiving services after the 1st April 2013 will be affected straight away. Nobody currently receiving services will be affected until their annual review. At that review, if their needs are critical or substantial then they will continue to receive services. If their needs are moderate or low then they will be offered reablement and the opportunity to access a range of preventative services.

No one wants to see services reduced, however, we have a finite amount of money to spend and we would like to ensure that the money we do have is spent in a way that supports the most vulnerable people.

The Council would very much like to hear your views on the suggested changes and offers this questionnaire as one way for you to make your voice heard.

Questionnaire

Please refer to the leaflet for further information on each question.

1. Are you:
   a. Receiving social care support from Peterborough City Council ☐
   b. Providing care or support for a family member or friend ☐
   c. Working for a partner organisation or within the voluntary sector ☐
   d. Working for Peterborough City Council ☐
   e. A council member ☐
   f. None of the above, but live in Peterborough ☐

2. The council believes that it should change the eligibility level to substantial and critical to ensure that its resources are targeted on those most in need of support. Do you:
   a. Agree ☐
   b. Disagree ☐

3. If you disagree with the changes that the Council would like to make, please tell us why. You may also like to suggest other ways for the Council to make savings.

4. Do you agree that the Council should help people with moderate levels of need by giving money to support the voluntary sector to provide services that can be purchased?

   a. Yes, I agree ☐
   b. No, I do not agree ☐

5. People sometimes lose confidence and the skills to live independently through deterioration in their health or some other change in their circumstances. The Council's Reablement Service is there to help people learn or relearn these skills so that they can look after themselves as far as possible. Currently the Council offers the Reablement Service to people who meet its eligibility criteria. Do you think that the Council should offer reablement to everybody who might benefit from it?

   a. Yes ☐
   b. No ☐

6. Do you think money should be spent to support people with moderate needs in the following ways?

   Help with daily activities

   - Help with shopping ☐
   - Help with keeping the home clean, safe and in good repair ☐
   - Help with gardening ☐
   - Help with laundry ☐
   - Easy access to equipment that helps you to stay independent and safe ☐

   Support with leisure activities, social opportunities and clubs

   - Support getting out and about in the community ☐
   - Support meeting other people ☐
   - Finding out about voluntary and community groups ☐
   - Befriending schemes ☐
   - Support with learning and work opportunities ☐
   - Support keeping in contact with friends and family ☐

   Carers support

   - Breaks for carers ☐
   - Carers support groups ☐

- Specialist advice for carers ☐
- Sitting services ☐

Help to find the support people need

- Information and advice about available services ☐
- Support to work out what help would work best for you/someone you care for ☐
- Support to set up new opportunities or services for you and others ☐

What other types of support do you thinkpeople would like to know about in their community?

7. The Council thinks that having a banded Disability Related Expenditure disregard, charging for an Appointeeship Client Money Management Service and harmonising the qualifying age for Pension credit are a fair and equitable way to raise charges. Do you:

   a. Agree ☐
   b. Disagree ☐

8. The Council's Charging Policy has not kept pace with the available technology (such as remotely monitored passive alarms and sensors) to assist people in their homes. It proposes to include such technology as a chargeable service for people who are eligible. Do you:

   a. Agree ☐
   b. Disagree ☐

9. The home meals service is intended to help people who cannot prepare a hot meal by themselves. It is not intended to subsidise people's income by providing food. The Council proposes to remove the subsidy from the home meals service and would like to see if there are any alternative suggestions to support people who cannot prepare a hot meal for themselves.

   Do you disagree with removing the subsidy for hot and frozen meals?

   a. Yes ☐

b. No ☐

Here are some suggestions for alternatives to the hot meals service. Which do you think would be helpful?

a. Arrange for someone to visit and heat a meal ☐
b. Arrange for a choice of food to be delivered, for example from the supermarket ☐
c. Provide support for Lunch Clubs ☐
d. Give people some money to compensate their neighbours for providing or sharing meals with an individual ☐
e. Any other suggestions?

Space for any other comments:

Please continue on an extra sheet if there is not enough space here.

Equality Impact Assessment

Peterborough City Council does not want to discriminate against any particular groups of individuals when making a decision. We would be grateful if you could complete the following section of this questionnaire to help us to do this.

Age

- Under 18 ☐
- 18 to 39 ☐
- 40 to 59 ☐
- 60 and over ☐
- Prefer not to say ☐

Disability

Do you have a:

- Physically disability ☐
- Sensory impairment ☐
- Mental health condition ☐
- Learning disability ☐
- Long term health problem ☐
- Not disabled ☐
- Prefer not to say ☐

Marriage and civil partnership

- Married ☐
- Co-habiting ☐
- Single ☐
- Civil Partnership ☐
- Other ☐
- Prefer not to say ☐

Pregnancy and maternity

- Are you pregnant? ☐
- Have you given birth within the last six months? ☐
- Prefer not to say ☐

Race

- White ☐
- Black or Black British ☐
- Mixed ☐
- Group ☐
- Asian or Asian British ☐
- Other ethnic group ☐
- Prefer not to say ☐

Religion and belief

- Christian ☐
- Hindu ☐
- Jewish ☐
- None ☐
- Muslim ☐
- Sikh ☐
- Other ☐
- Prefer not to say ☐

Gender

- Male ☐
- Female ☐
- Prefer not to say ☐

Gender reassignment

Have you had your gender reassigned?

- Yes ☐
- No ☐
- Prefer not to say ☐

Sexual orientation

Are you:

- A gay man ☐
- A gay woman/lesbian ☐
- Bisexual ☐
- Heterosexual ☐
- Prefer not to say ☐

Thank you for your input.

SCRUTINY COMMISSION FOR HEALTH ISSUES	Agenda Item No. 9
23 JANUARY 2013	Public Report

Report of the Executive Director of Adult Social Services

Contact Officer(s) – Tina Hornsby – Assistant Director Quality Information and Performance
Contact Details – tina.hornsby@peterborough.gov.uk 01733 452427

SAFEGUARDING VULNERABLE ADULTS BOARD ANNUAL REPORT 2011/2012

1. PURPOSE

1.1 This report is being presented to evidence the achievements of the Safeguarding Adults Board and developments in the field of safeguarding adults during 2010/2011.

2. RECOMMENDATIONS

2.1 That the Commission adopts this report and agrees to its publication.

3. LINKS TO THE SUSTAINABLE COMMUNITY STRATEGY

3.1 This report links to Priority 1 Creating Opportunities, outcome 2 Supporting Vulnerable people of the Sustainable Community Strategy and to all aspects of the Single Delivery Plan.

Statistical information contained within this report is taken from the Abuse of Vulnerable Adults Report which is a national data collection exercise allowing comparison safeguarding activity between local authorities.

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4. BACKGROUND

4.1 Publication of an annual report is a requirement of the Safeguarding Adults Board in order to demonstrate activity and achievements as well as documenting future work plans.

5. KEY ISSUES

5.1 The Commission should be assured that the Safeguarding Adults Board continues to carry out its functions appropriately. The annual report sets out a summary of how the Safeguarding Adults Board and its member organisations have carried out and quality assured their adult safeguarding functions in the previous financial year.

6. IMPLICATIONS

6.1 It is a requirement for the Safeguarding Adults Board to publish an annual report to ensure transparency.

The report covers the whole city of Peterborough.

7. CONSULTATION

7.1 The annual report has been produced and agreed by the multi-agency Safeguarding Adults Board and contains commentary from all partner organisations.

8. NEXT STEPS

8.1 Following the submission to the Commission the report will be published on the Safeguarding Adults website.

Updates on safeguarding investigations indicators are included within the quarterly performance report provided to the Commission by Adult Social Care.

9. BACKGROUND DOCUMENTS

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

9.1
- Abuse of vulnerable Adults reports 2009/2010 and 2011/12
- Safeguarding Adults Board minutes 2011/2012
- Safeguarding Adults Board report 2010/2011

10. APPENDICES

10.1 Appendix 1 - Safeguarding Adults Board Annual Report

Peterborough Safeguarding Adults Board

Annual Report
2011/2012

Contents

Foreword

It is my pleasure to introduce this annual report on behalf of Peterborough Adult Safeguarding Board. I took over as the first independent chair of the Board in February 2011, coinciding with the appointment of our first (interim) Safeguarding Coordinator. These were the foundations upon which we have sought to move safeguarding work forward over the year.

This report sets out both our achievements and the challenges that we faced during the course of the year. It also provides statistical data about safeguarding activity throughout the year. Our plans for next year are set out in the annual business plan, as an appendix.

2011/12 has been a challenging year for many of the organisations on the Board as a result of internal changes triggered by either new legislative or statutory guidance, or driven by the need to make financial savings. Such challenges will continue to face all partner organisations over the next few years. However, all Board members have acknowledged that safeguarding vulnerable adults from abuse continues to be a priority and that they will continue to be involved in this important work.

More fundamentally, the year has been one where local organisational changes and greater rigour and scrutiny of the management of safeguarding have posed particular challenges for us all.

The challenges arose from:

i) the disjointed arrangements for the delivery of safeguarding prior to the transfer of adult social care back to the City Council,
ii) an absence of firm strategic leadership,
iii) the impact of organisational changes in both the NHS and Peterborough City Council (PCC)
iv) the uncovering of significant performance issues when Adult Social Care transferred back to the Council,
v) the development and implementation of revised safeguarding procedures.

In March 2012, Adult Social Care transferred back to the City Council from the NHS after 8 years. This organisational change has impacted on the day to day safeguarding work as well as the board's accountability routes. With the aid of strong leadership from the interim Director of Adult Services, this organisational change has led to significant improvements in safeguarding services and has addressed the challenges set out above.

Further changes to policy and legislation on safeguarding adults are currently in development and will change the way that vulnerable adults are supported. The Board will ensure that it is kept informed of such changes and plan its work accordingly. It is likely that changes to the Board's

governance arrangements will be required when legislation changes make Safeguarding Adults Boards statutory.

I should like to thank all those who have worked so hard to promote and improve our approach to safeguarding over the last year.

Felicity Schofield
Chair - Peterborough Safeguarding Adults Board
December 2012

Background

Adult Safeguarding is governed by the statutory guidance “No Secrets” issued by the Department of Health in 2000, which gave Social Services lead responsibility to co-ordinate the development of the local multi agency framework, policies and procedures. All statutory agencies are expected to work in partnership with each other and with all agencies involved in the public, voluntary and private sectors to protect vulnerable adults from abuse. Additional legislation, for example the Mental Capacity Act 2005 and the Safeguarding Vulnerable Groups Act 2006, have addressed different aspects of adult abuse. These have recognised that abuse occurs in a range of settings, is perpetrated by a range of people and that it must be made clear that this is not acceptable.

Governance and Accountability

The Board provides strategic oversight and management of multi agency safeguarding adults' work. It agrees and issues relevant policies and protocols; quality assures safeguarding arrangements across the partnership, receives and monitors safeguarding activity data (including Deprivation of Liberty Safeguards applications), approves the multi agency training strategy/monitors training take-up; approves the communications strategy and publishes this Annual Report.

The Board has had representation from the following organisations:

- Cambridgeshire and Peterborough NHS Foundation Trust
- Cambridgeshire Constabulary
- Cambridgeshire Fire and Rescue Service
- Carers Partnership Board
- East of England Ambulance Service NHS Trust
- Independent Providers
- NHS Peterborough – Peterborough Primary Care Trust
- NHSP/Peterborough City Council Adult Social Care
- Peterborough and Stamford Hospitals NHS Foundation Trust
- Peterborough City Council (representation from Community Safety, Children's Services and Adult Social Care including the lead member for adult services)
- Peterborough City Council Cabinet member for Adult Social Care
- Peterborough Community Services
- Peterborough Regional College
- Peterborough Voluntary Sector representatives (including Age UK and Mind)
- Probation Service

Towards the end of the year, individual and organisational membership of the Board changed as responsibility for Adult Social Care delivery returned to PCC and as Peterborough Community Services merged with Cambridgeshire Community Services.

The Board now has representation from the following organisations:

- Cambridgeshire and Peterborough NHS Foundation Trust
- Cambridgeshire Community Services
- Cambridgeshire Constabulary
- Cambridgeshire Fire and Rescue Service
- Carers Partnership Board
- East of England Ambulance Service NHS Trust
- Independent Providers

- NHS Peterborough
- Peterborough and Stamford Hospitals NHS Foundation Trust
- Peterborough City Council (representation from Adult Social Care, Community Safety, Children's Services and including the lead member for adult services)
- Peterborough Regional College
- Peterborough Voluntary Sector representatives (including Age UK and Mind)
- Probation Service

The Board meets bi-monthly and is chaired by an Independent Chair (Felicity Schofield). There is a commitment to adult safeguarding at political level in the Council and at senior management level in all the partner agencies. Board membership is at sufficiently senior level to provide effective strategic leadership and direction, make strategic decisions and commit appropriate resources.

The Board is supported by operational sub-groups to deliver its objectives. These groups cover:

- Quality Assurance and Performance
- Learning and Development
- Serious Case Reviews

Each group is chaired by a member of the Board, has membership from partner agencies and regularly reports on its work to the Board.

Summary of Safeguarding Board Activity - April 2011 to March 2012

Safeguarding Work

During the year, the Board has made the monitoring and understanding of safeguarding performance a key priority. Reports were received at each of its six meetings and over the course of the year; Board members have worked with the strategic safeguarding team to establish a better understanding of safeguarding activity. For example, the Board has pushed for a more sophisticated approach to reporting that provides analysis and a greater focus on outcomes. Whilst improvements were achieved, this was agreed as a continuing priority for the current year.

Late in 2011/2012 the Board was made aware of significant failings in safeguarding performance within Peterborough Community Services as the Adult Social Care function was re-established within PCC. A significant number of safeguarding cases were found to be unfinished within the case recording system leading to inaccuracies within performance data. A project group was established and immediate action was taken to rectify the situation via a dedicated group of practitioners and support staff that reviewed and completed these cases. Whilst this was a serious situation requiring urgent action it is fortunate to note that the work to recover the situation did not uncover cases where individuals had been left at significant risk.

Another area of work for the Board has been in response to the Winterbourne View investigation. The Board sought assurance on the contract monitoring mechanisms in place to review providers' readiness and capacity to manage safeguarding concerns. A series of reports were presented to the Board by officers representing the commissioning and contracting functions within Adults Social Care: the Board will continue to receive six monthly reports. Overall the Board was assured that appropriate processes were in place.

In July 2011 the multi agency referral unit (MARU) went live and included social work input from adult social care. Although it was too early to measure specific improvements in outcomes during the year, periodic updates were received by the Board with a preliminary view being expressed that a quicker response to serious domestic violence referrals was one of the early improvements. More work will be needed to test out whether the MARU should play an increasing role in the way in which we manage safeguarding referrals.

Throughout 2011/2012 work on rewriting the multi agency safeguarding policy and procedures was underway, with new draft procedures being presented to the Board in December 2011. However, Board members decided they needed considerable revision before they could be implemented. They were also concerned that the procedures did not adequately identify the differences and similarities with Cambridgeshire's procedures and thought that this would be problematic to those agencies that cover both local areas. Revised interim procedures were

approved by the Board in February 2012. Work to fully implement them together with work with Cambridgeshire with the aim of having joint procedures across the two council areas has continued to be a priority in the current year.

The preparation of this report was delayed because of the departure of an Interim Safeguarding Manager in March 2011; this resulted in a 'knowledge gap' regarding safeguarding activity in 2011/2012. Recruitment of a replacement took a few months and subsequently other issues were prioritised to ensure that safeguarding practice continued to improve.

Safeguarding Adults Training

The Safeguarding Board continues to promote and use the multi-agency Training Strategy; the strategy is based on four tiers. Different tiers of training for different groups of staff according to their identified role in the safeguarding process. Some staff will only require basic awareness in order to alert or report safeguarding concerns whilst others will require more than one, if not all, of the levels of training - for instance if they are responsible for co-ordinating and/or managing investigations.

Training Attendance April 2011 - March 2012	
Course	**Total number**
Mental Capacity 2005 Awareness	250
Adult Safeguarding Basic Awareness	557
Adult Safeguarding Enhanced	191
Mental Capacity Act – Assessments	8
Mental Capacity Act and Safeguarding	16
Deprivation of Liberty Awareness	165
Deprivation of Liberty for Managing Authorities.	6

Training opportunities are generally well attended and well received by participants. The sub - group continues to monitor evaluation forms and transfer of learning into the work place as ways of assuring quality of training events. During the current year, the training strategy has supported provision of training for managers and practitioners leading investigations and chairing case conferences.

Serious Case Reviews

There were no serious case reviews undertaken during the year. As stated above, the action plans from two earlier reviews were implemented and signed off by the Board.

Monitoring and Quality Assurance

Abuse of Adult at Risk (AVA) Return 2011/2012

Abuse of Adults at Risk (AVA) Data is gathered annually. The majority of the data collected relates to the following seven stage safeguarding process:

Stage 1: – Raising an Alert
Stage 2: – Making a Referral
Stage 3: - Strategy Discussion or Meeting
Stage 4: - Investigation
Stage 5: - Case Conference and Protection Plan
Stage 6: - Review of the Protection Plan
Stage 7: - Closing the Safeguarding Adults Process

The tables reproduced below are drawn from the information provided to the AVA data collection.

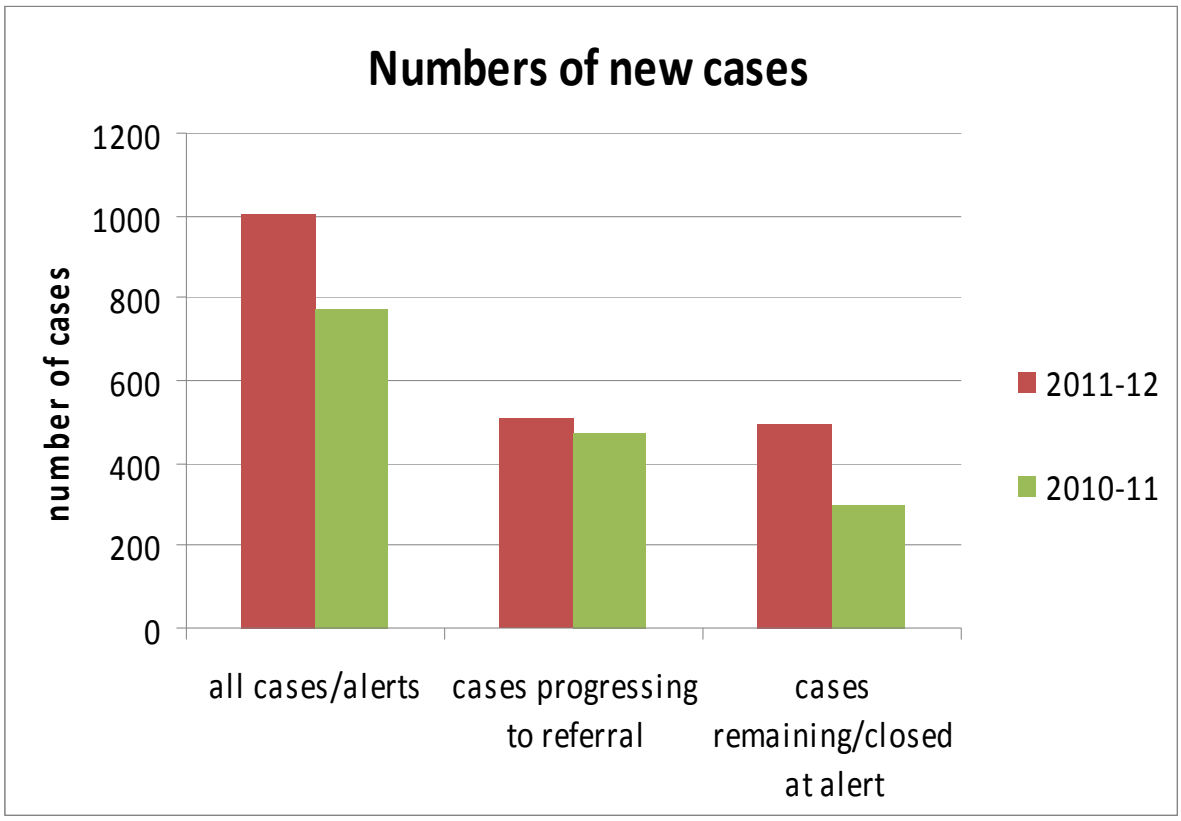
Whilst every attempt has been made to provide accurate data for this report, we are not confident that the reporting systems and recording were robust enough to provide a completely accurate reflection of adult safeguarding investigations activity for the year 2011/12.

Quality Assurance Audit

A Quality Assurance Audit tool was developed towards the end of the 2011/2012-year with a view to piloting the tool in early 2012/2013. It is intended that tool will help measure aspects of quality within the Safeguarding Adults process.

If the pilot proves successful, Audit Reports, reflecting on outcomes and quality will be presented to the Safeguarding Adults Board in 2012/2013.

Figure 1: Number of New Cases in 2011/2012



The chart above shows comparative data between the years 2010/2011 and 2011/2012.

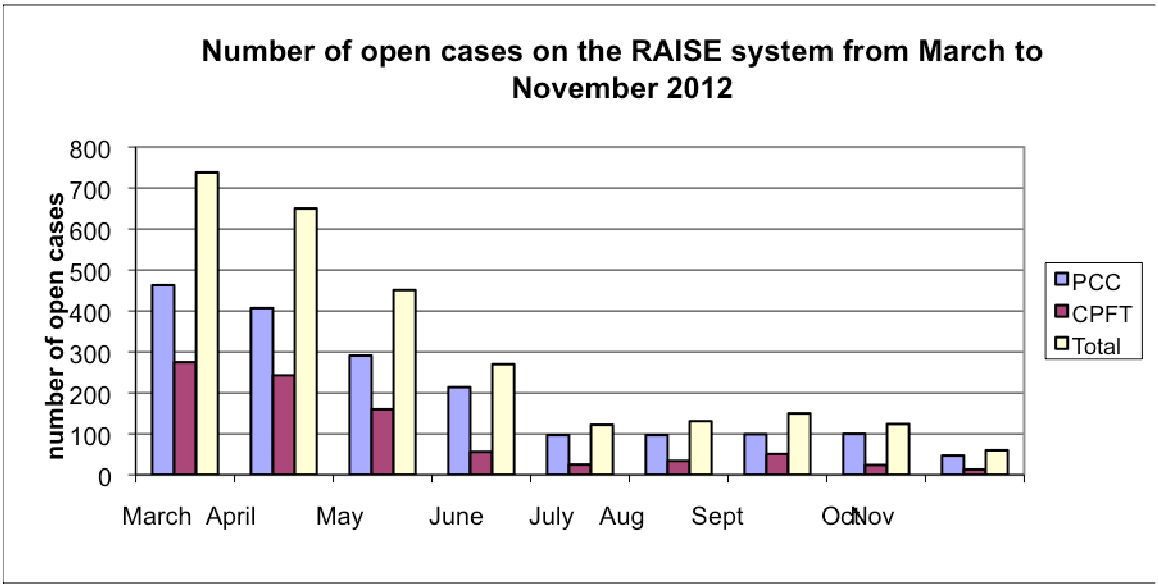
Overall there has been a year on year increase of 22.93% in all cases/alerts received. We view this not insignificant increase positively, as an indication that there is increased safeguarding awareness on the part of staff and public. This contention is supported by the smaller increase in the number of cases progressing from alert to referral being only 6.3%.

The average conversion rate for alerts to referrals in 2011/2012 was 50.66%, compared with 61.5% in 2010/2011. This suggests that staff are becoming more skilled at decision making.

By comparison, the available AVA data for 2010/2011 reports an average conversion rate of 57% suggesting that staff were perhaps being cautious in decision-making. This AVA figure is accompanied by a number of concerns about the application of definitions, the actual numbers reported and the number of councils providing information. This data set is improving over time as is local reporting.

This chart does not account for the number of cases that remained open at the end of 2011/2012; adjustments are reflected in 2012/2013 data. Please see below.

Figure 2: Open Cases March 2012 to November 2012

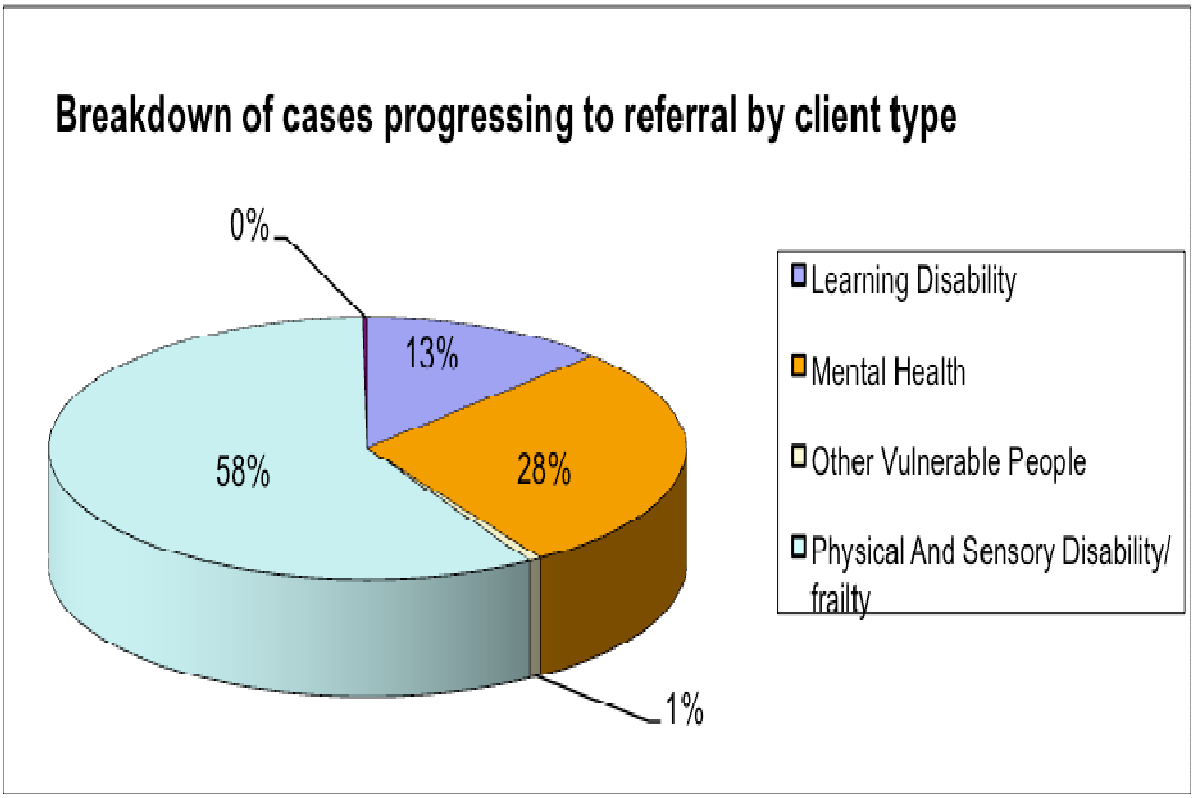


Although this chart is showing mainly 2012/2013 information it is relevant to this annual report. As previously stated approximately 600 'open' safeguarding cases were found on the case record system (RAISE) in March 2012 as the Adult Social Care Department was re-established as a separate entity. These cases had not been closed down properly on the system although the safeguarding work had been completed and service users were 'safe'. These cases had been worked on by staff in Peterborough Community Services and staff in Cambridgeshire and Peterborough Foundation Trust (CPFT).

A project was put in place to deal with these cases. Each case was scrutinised by a Team Manager and records on RAISE checked and amended accordingly. Because of the nature of the safeguarding work, there will always be a number of cases that remain open at the end of each month; the number of open cases should be proportionate to the number of referrals that are investigated.

The table above shows the successful reduction of open cases over the period March 2012 to November 2012. From July 2012 onwards the numbers of open cases have reduced to an acceptable level. Systems are now in place to prevent a repeat of this occurrence.

Figure 3: Cases Progressing to Referral by Service User Group



The chart above shows that the majority of safeguarding referrals are made for people who have a physical or sensory disability. This category includes older people (65 years and over) who represent the largest proportion of service users in the physical and sensory disability/frailty category.

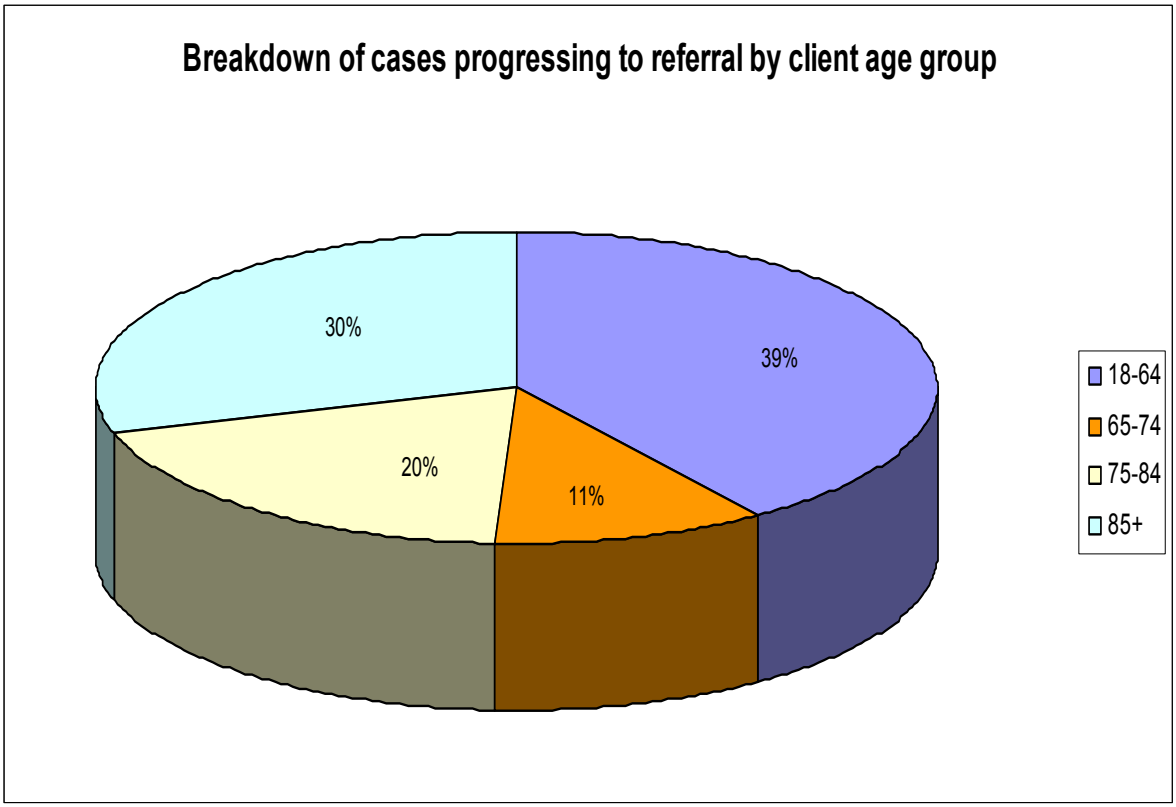
Compared with other authorities in the 'nearest neighbour' group (as defined by the Chartered Institute of Public Finance Accountants), it appears that Peterborough receives referrals on relatively high numbers of people with physical or sensory disability and relatively low numbers of people with learning disabilities.

Levels of safeguarding awareness within these user groups and/or a lack of confidence in dealing with 'authority' on the part of people with learning disabilities may explain these figures.

28% of service users with mental health needs engaged with safeguarding processes appear to be average and compare well with other authorities.

1% of referrals are for the category 'Substance Misuse'. This user group is difficult to engage in relation to safeguarding and all local authorities report small numbers.

Figure 4: Cases Progressing to Referral by Service User Age Group



65% of services users involved in the safeguarding process are aged 65 years and over, with 30% being aged 85 years and over. This is consistent with national data.

According to recently published population estimates, Peterborough's total population in 2011 (mid year) was 184,500. Of this number, 29,200 were men and women over pensionable age. There were 3,400 people aged 85 and over.

Table 1 below shows that those aged 64 and under are under-represented proportionately in the number of safeguarding referrals whilst those aged 75 and particularly those over 85 years, are over-represented. This fits with the perception that older people are more vulnerable.

Table 1: Client Age Group

Age Group	This age group as % of Peterborough's total population	The % of all safeguarding referrals that relate to this age group
18-64	**60%+**	**39%**
65-74	**7%**	**11%**
75-84	**5%**	**20%**
85+	**2%**	**30%**

Based on 2011 ONS mid-year population estimates for Peterborough

Figure 5: Cases Progressing to Referral by Ethnic Group

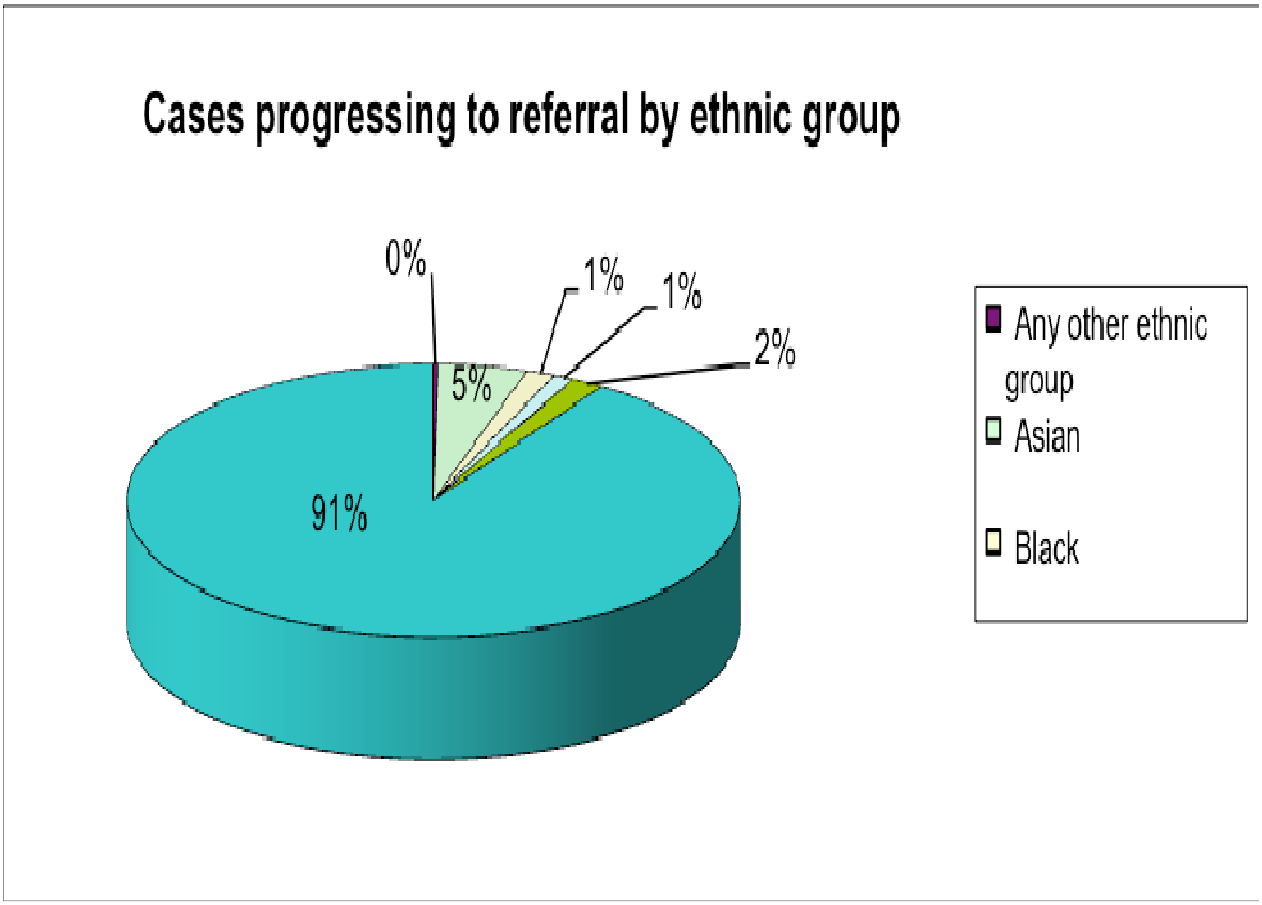


Table 2: Ethnicity

Census data (2009) showed that Peterborough's population was made up as follows:

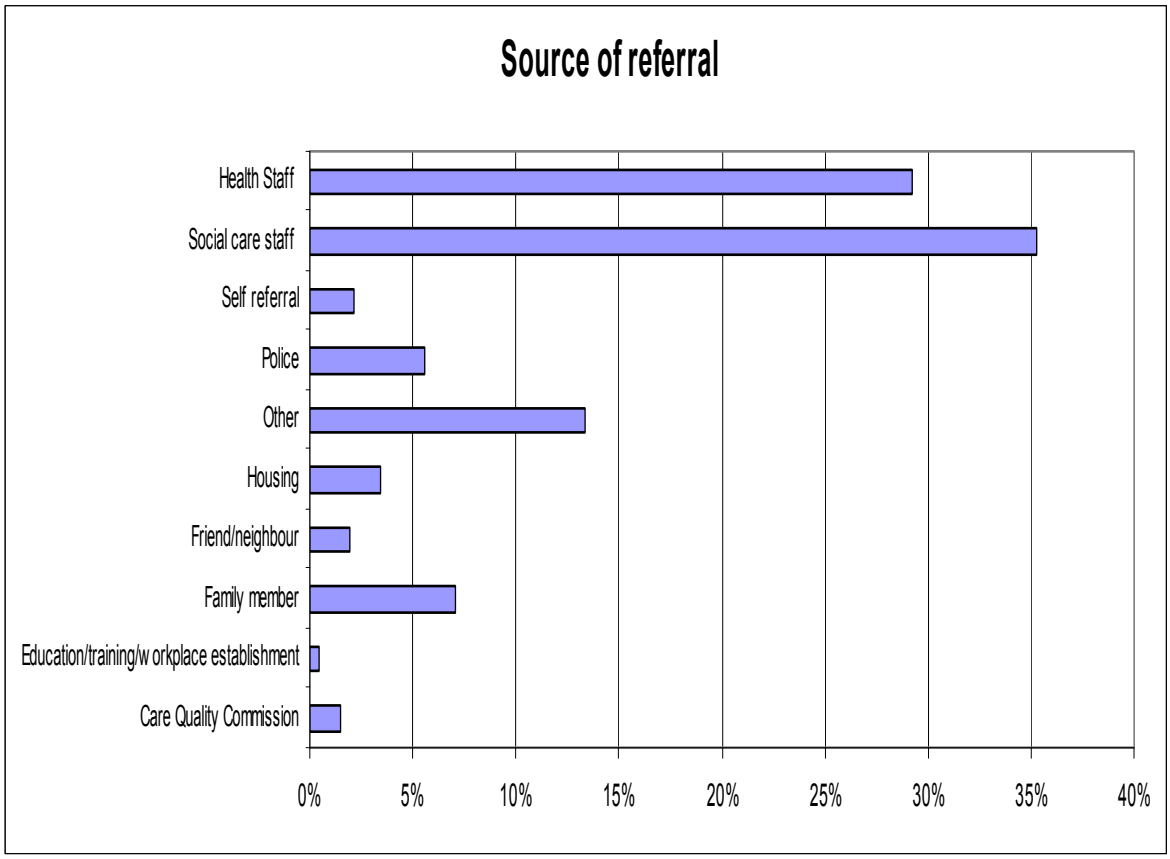
Ethnic Group	% Population	% Referrals
White	**80.02**	**91**
Mixed	**1.99**	**1**
Asian	**8.70**	**5**
Black	**2.69**	**1**
Chinese	**1.46**	**0**
Not known/Refused	**0**	**2**

Comparatively a higher percentage of referrals are made for the 'white' ethnic group than the percentage of 'white' people in the community, whilst the opposite is true for other ethnic groups.

This position is consistent with other local authorities.

It is not known if this is consistent with cultural differences or a lack of knowledge and/or understanding within minority ethnic groups.

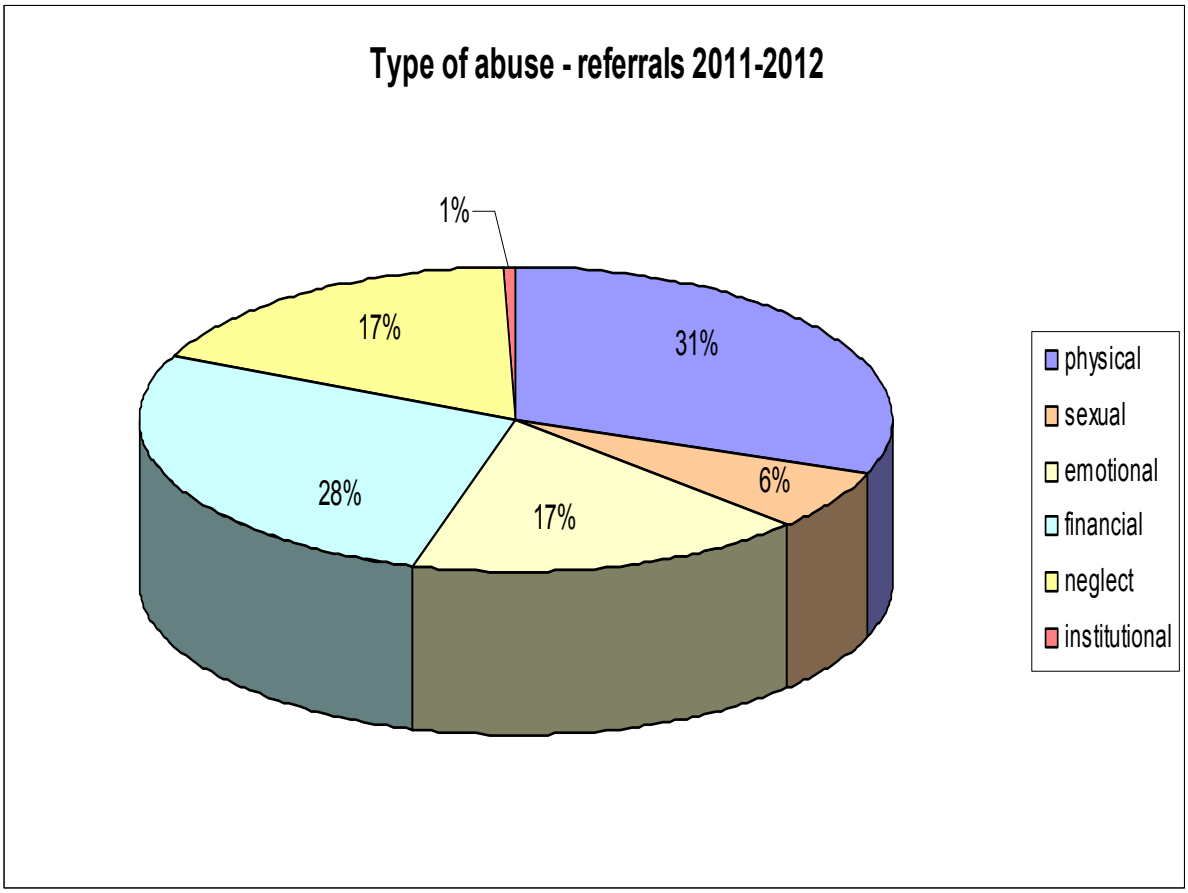
Figure 6: Referral Source



Comparing Peterborough with other authorities (CIPFA nearest neighbour group), the number of referrals made by social care staff is lower than the comparator group average whilst the number of referrals made by health staff is higher than the average. A positive interpretation of these figures suggests good levels of awareness in health and social care settings and may also indicate good partnership working. However, low percentages in other groups suggest a lack of awareness that may result in safeguarding issues going unreported.

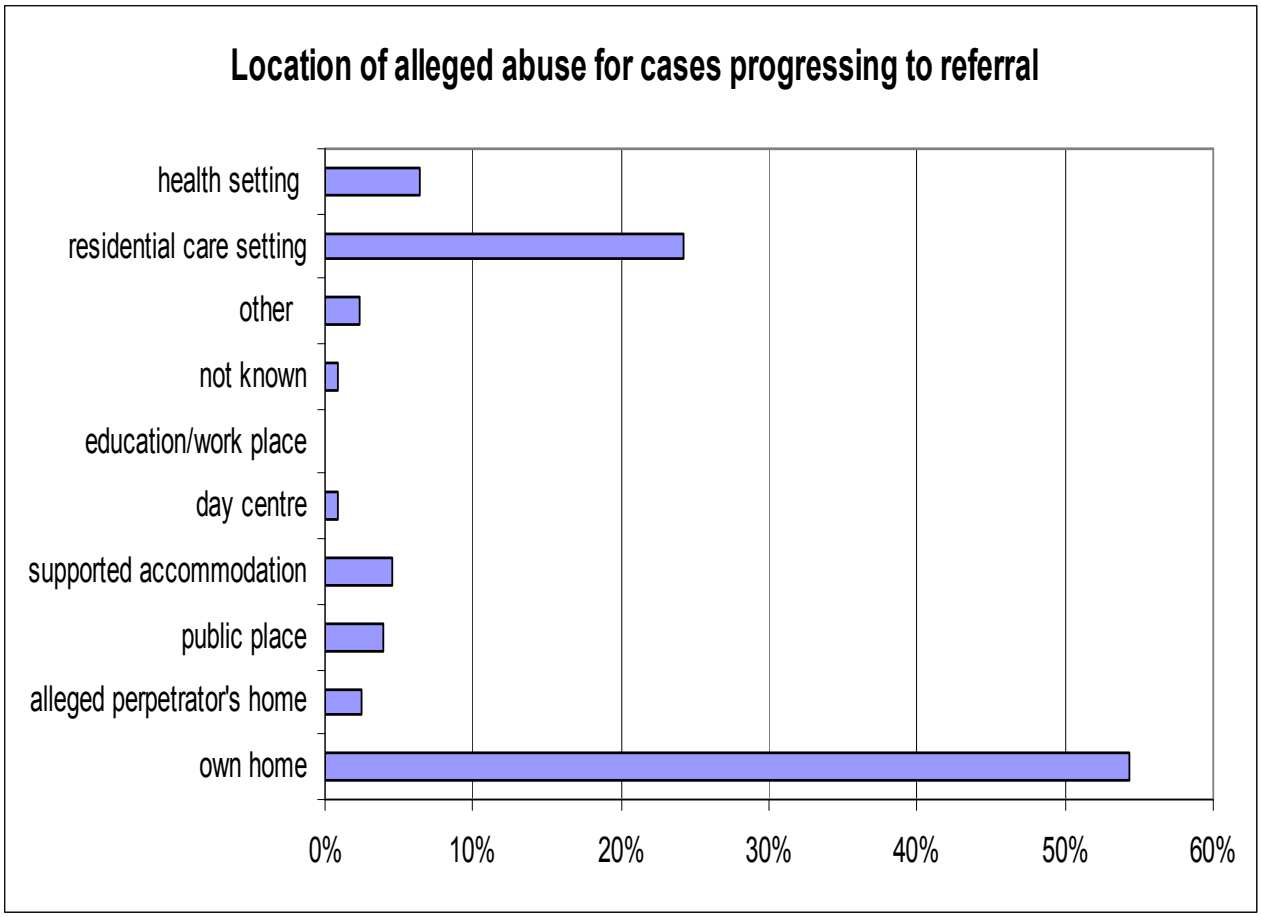
It is also interesting to note that 46% of cases referred by social care staff were concluded as 'substantiated' compared with 37% overall.

Figure 7: Abuse Type



Higher figures reported in the categories of physical and financial abuse is consistent with national data, as is small numbers of institutional and sexual abuse.

Figure 8: Location of Alleged Abuse



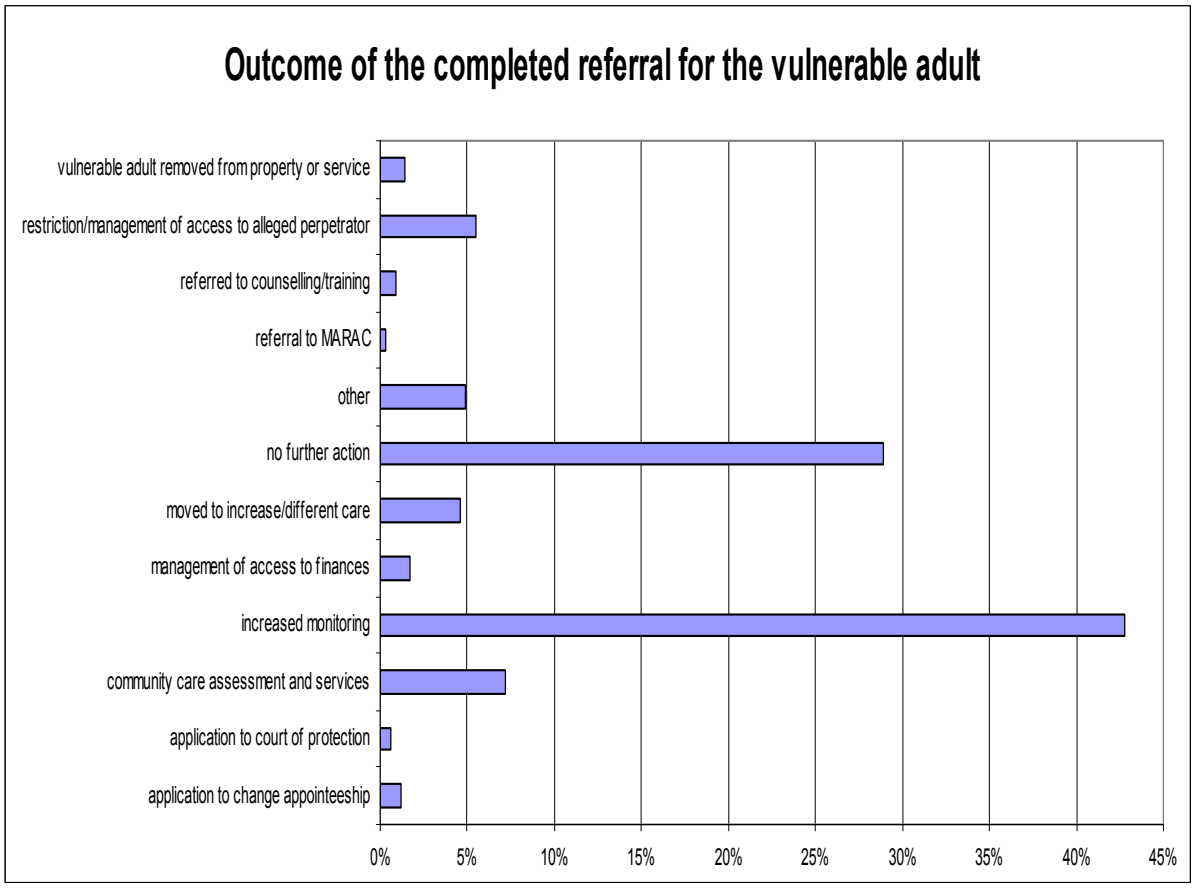
Analysis of this data is complex for a number of reasons, for example, populations in these settings are not static and there is not a consistent data set to use for comparison.

Alleged abuse occurred most frequently in the vulnerable adult's own home (54% of cases), with second highest number of alleged abuse occurring in 'residential care setting', 25% of cases. This figure is actually quite low when compared with national and comparator authorities where it runs at over 30%.

It is known that more people live in their own homes than live in residential care settings but it remains difficult to determine whether the figures above are 'appropriate' for the numbers living in each setting and the representative of levels of awareness staff in different settings should have.

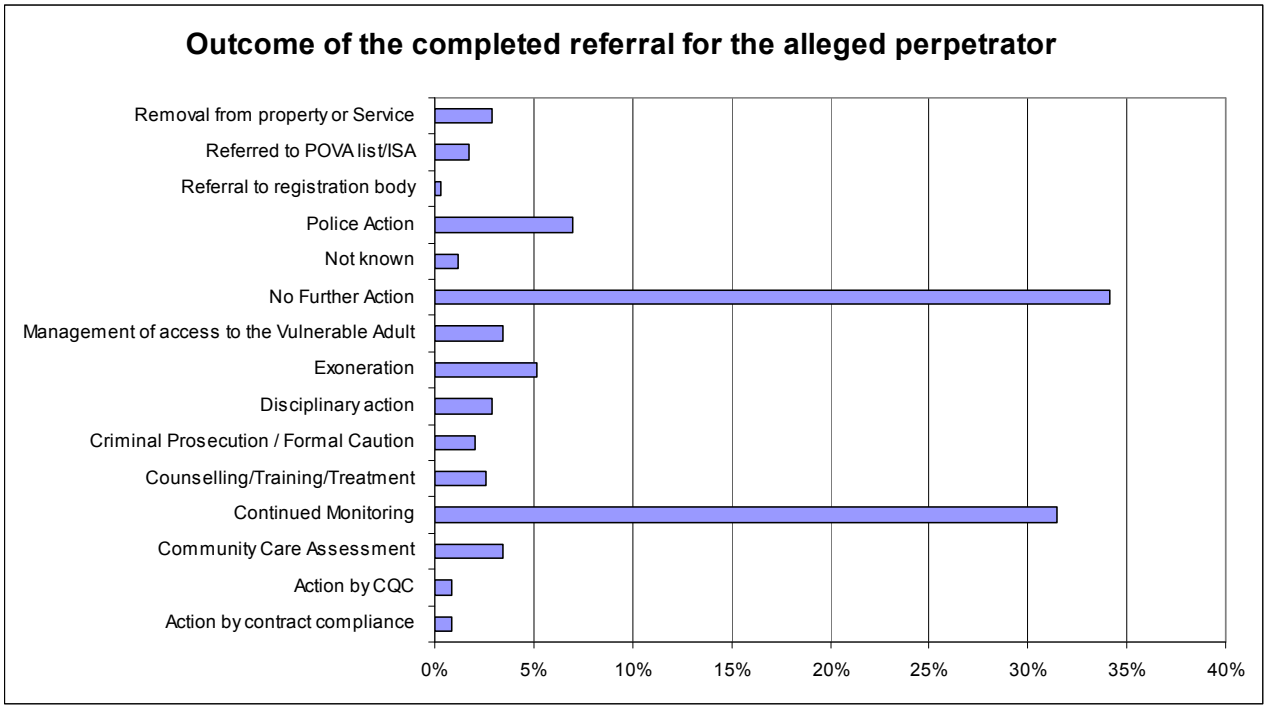
Low numbers of referrals from health settings (8%) remains concerning as it is difficult to know if this is as a result of poor awareness amongst staff in these settings or the provision of high quality care.

Figure 9: Outcome of Completed Referral for Vulnerable Adult



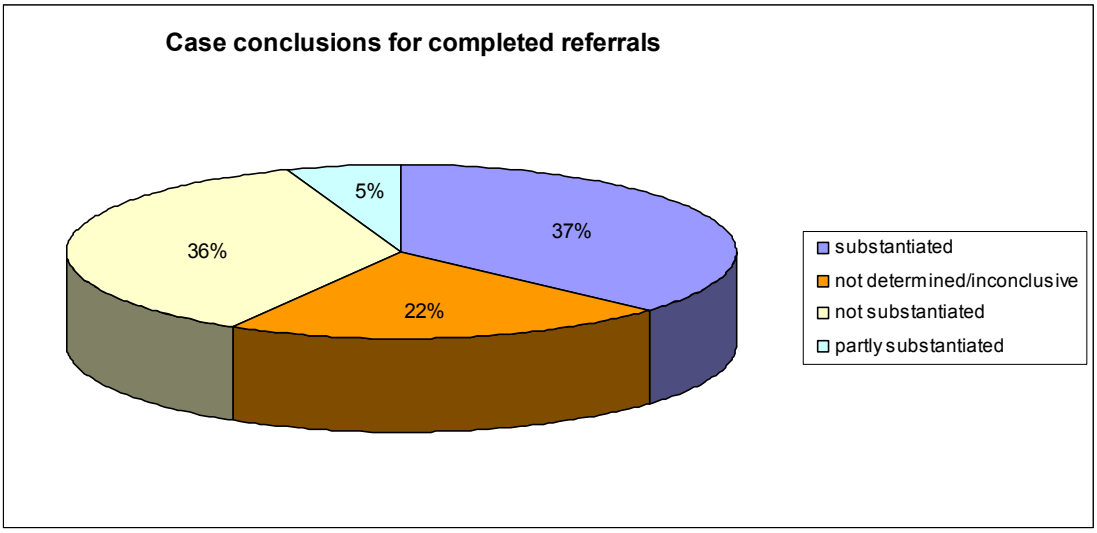
Approximately 43% of vulnerable adults became subject to 'increased monitoring'. From a quality assurance perspective further work needs to be undertaken in order to better understand how these outcomes impact on the vulnerable adults concerned.

Figure 10: Outcome of Completed Referral for Alleged Perpetrator



In 34% of cases no further action was taken against the perpetrator whilst 32% were subject to 'continued monitoring'. Approximately 3% of perpetrators were subject to a criminal prosecution or formal caution, whist 7% were subject to police action. Both figures are low and should ideally be higher; currently there is no data available for comparison.

Figure 11: Case Conclusion



The AVA definition of 'Not Determined / Inconclusive' is: **The case conclusion should only be recorded as Not Determined / Inconclusive when it is not possible to record the outcome against any of the other categories.** This is expected to be an infrequently used category.

Given that 22% (i.e. over one fifth of cases) of case conclusions have been recorded in this category and the expectation is that this category will be used infrequently, further examination of practice should be undertaken to determine the underlying reasons for this. For example, this figure may represent a lack of thoroughness in investigations leading to insufficient evidence being gathered to enable more meaningful decision-making.

This percentage is higher than our comparator authorities' average, but lower than England as a whole. Our percentage of 'substantiated' cases is slightly higher than our comparators' and England as a whole.

Partner Reports

Adult Social Care (Peterborough City Council)

The Adult Social Care Department that had previously been integrated with health care services delivered via Peterborough Community Services was re-established as a Department of the local authority (Peterborough City Council) in February 2012 after eight years of integration.

The profile of safeguarding adults has risen subsequently with the Adult Social Care Department and the Safeguarding Adults Board taking the lead.

The Strategic leadership of safeguarding and support for the Board has been located within the Department's Quality, Performance and Information Division. This provides an arms-length separation from the day to day delivery of safeguarding which is located within the operational division of the Department – Care Services Delivery.

In Care Services Delivery, posts of Consultant Practitioners in Safeguarding have been established in both the Community Team and in the Learning Disability and Autism Services to strengthen both capacity and expertise at the front line.

Numbers of alerts received have continued to rise, as has the conversion rate of alerts into referrals requiring investigation. Further details may be found in the Monitoring and Quality Assurance Section below.

A change of personnel in the post of Strategic Lead Adult Safeguarding at the end of March 2012 meant that the post was vacant for several weeks. Interim cover was arranged. The post of Data Analyst Adult Safeguarding was filled which has helped us make significant data improvements.

Age UK Peterborough

Safeguarding older and vulnerable people from abuse continues to be a priority for Age UK Peterborough.

Age UK Peterborough has embedded safeguarding training within its induction programme for all newly recruited staff and volunteers, thus ensuring that they are able to recognise the signs of abuse, react appropriately in such circumstances and report concerns to the relevant organisations.

This training is seen as essential in the context of a growing population of older people some of whom may potentially be at risk of harm.

David Bache, Chief Executive

Axiom Housing Association

Axiom Housing Association is taking a lead role in representing the interests of Peterborough's social housing providers on the PSAB.

A significant proportion of social housing tenants may be regarded as living with some degree of risk to their personal safety, it is therefore important for all providers to be kept up to date with best practice and for them to access relevant training in the area of safeguarding, in order to help reduce risk to tenants.

All social housing providers aim to ensure that staff in contact with adults at risk are trained and vigilant.

Stuart Fort, Operations Director

Cambridgeshire and Peterborough NHS Foundation Trust

1. Governance and Accountability

The Chief Operating Officer is the Executive Director with Board responsibility for Safeguarding Adults, and attends the Peterborough Adult Safeguarding Board. The Head of Social Work is the Lead Officer for Adult Safeguarding with responsibility for developing processes and procedures within the Trust.

The Trust has an Adult Safeguarding Steering Group attended by senior staff across the Trust and representatives from Peterborough City Council and Cambridgeshire County Council. This group reviews and monitors safeguarding activity in the Trust and implements actions from the Safeguarding Boards.

2. Achievements (2011-2012)

Workforce

- Increased numbers of SOVA Leads trained to coordinate investigations and provide advice, support and training to teams.
- Ward staff trained as SOVA Leads.

- Development of the peer support group for Peterborough CPFT staff who undertake safeguarding work.
- As a result of the success of the Peterborough advanced practitioner post for adult safeguarding, a similar post has been developed for the Trust's Cambridgeshire services.

Training

- A bespoke training package was developed for and delivered to contracted cleaning staff.
- At March 2012 the Trust could evidence 93% of staff had completed adult safeguarding training.

Policy and Procedures

- Trust Adult Safeguarding Policy and Procedures updated.
- Thresholds Guidance implemented to provide guidance for SOVA Leads.

Audit

- Internal audit of safeguarding process and outcomes conducted and action plan implemented. Recommendations included producing clearer risk management guidance and having unified processes and documentation across Peterborough and Cambridgeshire.

Activity Monitoring

- During 2011-12 there was a 77% increase in alerts and an 18% increase in safeguarding referrals over 2010-11. The increase in alerts was largely due to relatively minor altercations between in-patients where the situation was managed on the spot by ward staff.

Work with Prisons

- A protocol for developing adult safeguarding systems for people with mental health problems was agreed with HMP Peterborough. This was the first such protocol within the region and other mental health Trusts have expressed interest in developing similar agreements.

3. Staff Training

Training for Trust staff is delivered in-house via induction, e-learning and face to face, class based learning. The E-learning module developed for Level 1 awareness training is mandatory for all CPFT staff.

The Trust currently has 44 staff trained as SOVA Investigators in Peterborough.

4. Priorities for the Coming Year

- Ensure all staff receive appropriate training and are able to Recognise, Record and Refer safeguarding issues appropriately.
- Ensure that target of 95% for staff training is met.
- Ensure that each ward has a trained SOVA Lead.

- Implement action plan as result of internal audit.

Mick Simpson, Interim Chief Operating Officer

Cambridgeshire Community Services NHS Trust

1. Introductions

CCS NHS Trust has responsibility as a provider of NHS services. This relates to all staff being aware of their responsibilities to identify, report and manage SOVA issues within the remit of their role.

Throughout this year, CCS NHS Trust has continued to strengthen the governance arrangements for SOVA activity throughout the organisation.

2. Care Quality Commission

The trust had declared non-compliance with CQC outcome 7 reg. 11 Safeguarding (Essential Standards of Quality and Safety) at the time of initial registration with CQC in April 2010. A trust wide SOVA training programme was developed during 2010/11 with full implementation occurring during Q1 and Q2 2011/12. The Trust has remained fully compliant since September 2011.

3. Poorly Performing Independent Providers and Suspension to Placements

The situation remains where large amounts of resource are required to manage the safeguarding concerns raised when a provider is not performing to expected regulatory quality standards. When placements are suspended, trust staff are involved in assessing individuals for alternative care provision whilst investigating the SOVA related concerns. This continues to impact on locality teams in managing the day to day consequences of these issues. Trust staff continues to work alongside the Local Authority in monitoring the quality of care with Independent Providers.

4. Serious Incidents (Sis)

A further requirement to report all grade 3 and 4 pressure ulcers as Sis was introduced in 2010/11. This reporting has informed further analysis of trends which may be indicative of safeguarding issues. Work has been undertaken throughout 2011/12 to clarify the reporting complexities relating to SOVA cases that may also be required to be reported as a Serious Incident.

5. Governance Arrangements including Safeguarding Adults Group

The initial CCS NHST SOVA strategy was endorsed during 2010 and highlighted the approach to Safeguarding Adults that the trust has adopted. A full review is underway in 2012/13 to outline further developments and identify key performance indicators by which the effectiveness of the strategy can be measured.

The Quality Improvement and Safety Committee is constituted to oversee all aspects of safeguarding and offer assurance to the Board that the Trust discharges its duties effectively. More detailed scrutiny is undertaken at the Trust's Adult Safeguarding Group which is a formal sub committee focusing on both strategic improvements and operational issues that may impact our ability to deliver our responsibilities effectively. This group is chaired by the Executive Lead for Safeguarding Adults.

6. Learning from Experience

Information from incidents, complaints and PALs queries are fed into the Trust's Learning from Experience Group. SOVA issues and learning is considered alongside other aspects of patient/carer/service user experience. The increase in reportable pressure ulcers and their link to SOVA issues will be explored in detail within the group where a workshop format is intended to maximise learning.

7. Safeguarding Review

During 2011/12 a comprehensive safeguarding review was progressed to confirm what currently works well, what could be improved and to identify appropriate models for future practice. The recommendations informed the Trust's reshaping exercise including a new senior post, Head of Safeguarding.

8. The Priorities for 2012/13

Priorities for each year identified on the Trust's SOVA work programme which is monitored by the Safeguarding Adult Group (sub group of the Quality Improvement and Safety Committee).

For 2012/13 they include (not exclusive):

- Fully implement the Trust's recent internal reshaping of services which includes developing a formal infrastructure to support both adults and children's safeguarding services under the leadership of a new post Head of Safeguarding.
- To continue work with PCC and other partner agencies to monitor and improve the quality of independent care provision.
- To continue to work with all regulatory authorities to build on the current SOVA training provision for staff to include more specific sessions for health based staff.
- To develop a trust wide safeguarding strategy which clearly outlines our direction of travel over the next 3 years.
- Formalise relevant KPIs that are monitored and demonstrate improvements to practice.
- Work with other stakeholders to align reporting of SOVA based information (currently reporting timescales do not facilitate comprehensive analysis of all available data).

Cambridgeshire Constabulary

Over the last year Cambridgeshire Constabulary has continued to develop and improve its practices in the arena of safeguarding of vulnerable adults. This has seen an increased professionalism and capacity to support those at risk in Peterborough.

The MARU has developed and grown in size with the introduction of co-located partners and a new investigation unit. The MARU comprises:

- Child protection desk made up of police officers, information managers and Cambridgeshire Children's Social Care.
- Domestic Abuse desk, which also contains information managers from the police and independent domestic violence advocates (IDVAs).
- Safeguarding of Vulnerable Adults (SOVA) desk containing a police officer, information managers and a social worker from Peterborough Adult Social Care.

  The SOVA team risk assesses and grades all referrals before sharing them with relevant agencies and teams. Any referrals that may require a police investigation are sent to the Adult Abuse Investigation Unit (AAIU). This unit is made up of a Detective Sergeant, 5 Detective Constables and 3 civilian investigators. The AAIU works closely with our partners, attending strategy discussion and completing joint visits and action plans to ensure the most appropriate action is taken, offenders are brought to justice and vulnerable adults are appropriately safeguarded.

Work is continuing with our partners to further enhance and consolidate the benefits identified by working in a co-located multi agency team. As part of this, discussions are on-going to increase the number of partners located within the MARU.

An additional mechanism to support and safeguard adults at risk in Peterborough has been introduced through a dedicated Missing Persons unit. This is a new team made up of a Detective Sergeant and 3 police constables to manage missing persons. This unit manages all high risk missing persons investigations from the outset along with all medium and low risk investigations after 24 hours. The team will also act as a single point of contact for all out partners for concerns in this area. We will work together to reduce the number of repeat cases, requesting and attending strategy discussions and working towards joint action plans where appropriate.

Detective Superintendent Simon Megicks

Carers Partnership Board

The Carers Partnership Board (CPB) brings together a range of carers, professionals, and interested parties to discuss issues as they affect carers in Peterborough.

The CPB's representation on and membership of the Peterborough Safeguarding Adults Board (PSAB) allows carers' perspectives, thoughts, aspirations and concerns to be properly heard by the PSAB. Two way communication is enabled, allowing CPB members to receive information and updates regarding safeguarding policies and practices, and enabling them to feedback about related carers' issues and support needs.

During 2011/2012, the CPB has received presentations and had discussions about the role and work of the safeguarding team and spent some time considering the content of the Association of Directors of Adult Social Services (ADASS) Advice Note (April 2011) to help us shape our thinking around future developments and responsibilities.

Our achievements in year include:-

- In April 2012, at the bi-annual event, the CPB consulted with carers about their safeguarding concerns and support needs. Approximately 40 carers were in attendance at what turned out to be a lively, interactive session.
- The CPB initiated, developed and delivered a Carers Safeguarding leaflet in conjunction with the PSAB. Copies of these leaflets have been distributed to approximately 2500 carers and professionals to help raise awareness and provide information.
- A safeguarding awareness training session was planned for delivery at the carers bi-annual event in April 2012 with plans to follow that up with a mailshot in September 2012 that will offer further training and awareness raising sessions.

Our challenges for the future include:

- Reaching unknown/hidden carers.
- Providing effective communication links with carers.
- Listening attentively to carers' view points and concerns.
- Responding appropriately to the degree of support that carers require.
- Providing effective support to address the stress, tension and challenges that carers experience.
- Ascertaining what carers in Peterborough need and continuing to promote and provide safeguarding awareness and training.

Tim Bishop and Sue Lilley, Co Chairs NHS Carers Partnership Board

NHS Peterborough

Adult safeguarding has maintained a high profile within NHS Peterborough despite significant organisational change during 2011/12 with senior representation on the Safeguarding Board and sub groups.

The safeguarding manager post has become fully embedded in the organisation and takes a lead role in the PCT's corporate commissioning responsibilities for adult safeguarding, advising on best practice and creating a culture of safeguarding within the organisation.

Achievements include:

- Safeguarding self-assessment audit undertaken
- Provision of safeguarding update/newsletters to providers
- Regular safeguarding reports to the PCT Board
- Safeguarding adult standards in 2011/12 NHS provider contracts
- Safeguarding adult training mandatory for all PCT staff

The adult safeguarding agenda remains firmly embedded as the Cambridgeshire and Peterborough Clinical Commissioning Group (CCG) is established. The joint adult and children safeguarding team sits within the CCG Quality Directorate and the team has been enhanced with the appointment of an Associate Director for safeguarding children and vulnerable adults and a lead nurse for adult safeguarding. The Director of Quality has the lead role in the CCG for safeguarding children and adults.

Priorities for the forthcoming year will focus on a programme of work to further develop the clinical quality assurance framework for safeguarding adults for all commissioned services including independent providers.

Paula South
Associate Director, SG Children and Vulnerable Adults, NHS Peterborough

Peterborough and Stamford Hospital NHS Foundation Trust

The following highlights some of the key activities undertaken by the Peterborough and Stamford Hospitals NHS Foundation Trust from April 2011 to March 2012 in respect of its commitment and responsibility for maintaining the safety and protection of any adults at risk who use its services.

All Trust staff have a responsibility to ensure that they can recognise an adult at risk and respond appropriately. In October 2011 the Care Quality Commission (CQC) reviewed the Trust's adult

safeguarding procedures in line with Outcome 7 of the 'Essential Standards of Quality and Safety' which states that 'people should be protected from abuse and staff should respect their human rights.' The Trust was deemed 'compliant' with this outcome, that procedures were in place and that staff understood what to do to ensure that adults at risk are safeguarded from abuse.

The Trust is represented on the PSAB by the Assistant Director of Nursing and Care Quality (Patient Experience). This enables the Trust to be an integral decision maker in the development and progress of local safeguarding agendas.

The Trust's representative plays a key role in informing the Board on the development of safeguarding pathways and initiatives specifically related to healthcare in the acute sector. Membership of the board also allows the Trust to be involved in the development of policies and procedures which is a relatively new area of integrated practice. The Trust is also represented on the serious case review and training sub-groups.

The Trust has a Safeguarding Committee (SC) which seeks assurance that the organisation meets all safeguarding commitments and responsibilities. This committee is now well established and links both the adult and children safeguarding agendas; this integrated approach affirms the Trust's commitment to its responsibilities and further strengthens its relationships with other multi agency partners.

The SC receives reports on safeguarding activity including the Trust's Deprivation of Liberty responsibilities.

Over a three year period from April 2009 to March 2012, the Trust has raised a total of 64 alerts. 17 out of these 64 related to the standard of care given to patients by the Trust. At the point of writing, 16 out of 17 alerts were found to be unsubstantiated and one was still being investigated.

The Trust raised 47 alerts about 'external incidents' which ranged from concerns about patients' families to quality of care issues in care homes.

Year on year the number of alerts raised within the Trust has increased; this is attributed to the training that has occurred and the consequent increase in staff's awareness of safeguarding.

The Trust referred one case to the Serious Case Review Group. The Coroner's report showed that the death was not related to the care given by the Trust; therefore the case was not appropriate for consideration as a Serious Case Review.

The Trust has been commended for its work with People with Learning Disabilities (PWLD), a group that is widely regarded as being at higher potential risk of harm.

Key development areas for this patient group include:

- ✓ Implementation of a computer based flagging system for PWLD
- ✓ Launch of credit card sized patient passport
- ✓ A protocol for collaborative working between community and acute Learning Disability services.
- ✓ Implementation of a maternity pathway for parents with Learning Disabilities.
- ✓ Learning disability risk assessment tool.
- ✓ Accessible satisfaction questionnaire.
- ✓ Learning Disability Awareness training jointly delivered by a Disability Adviser and a Person with Learning Disabilities.
- ✓ Participation in the Learning Disability Pathfinder Project, an initiative of the Learning Disability Partnership Board.

Lesley Crosby.
Assistant Director of Nursing and Care Quality (Patient Experience)

Peterborough City Council

Whilst the Adult Social Care Department is often seen as the department with primary responsibility for safeguarding vulnerable adults, the City Council as a whole takes its safeguarding responsibilities seriously and has endeavoured to develop an understanding of safeguarding within the frontline operations staff group. These staff regularly come into contact with adults at risk through their work in a variety of service areas such as housing, community safety, planning, transport and engineering.

Housing staff work closely with Occupational Therapy staff in an integrated approach to delivering adaptations in the homes of vulnerable people; such adaptations help to promote independence, reduce risk and promote safety within the home.

The work of the Community Safety Department has a strong connection with safeguarding and preventing harm particularly in the area of domestic abuse. The Council plans to review its domestic abuse service in the coming year which will help identify further common ground and opportunities for joint working.

The integration of public health responsibilities into the City Council's Operations Division will also identify opportunities for joint working and campaigning.

Paul Phillipson. Executive Director – Operations

City College Peterborough

City College's membership of the PSAB provides the college with up to date information about national and local developments in safeguarding as well as the opportunity to share expertise and best practice.

We are pleased to report that safeguarding arrangements within the College were graded as 'good' by OFSTED in October 2011. OFSTED acknowledged that our practice of recording 'nagging doubts' as well as alerts and referrals, was going above and beyond the practice of many post-16 education providers. OFSTED were also impressed by the 'bee symbol' that the college has developed to represent being and staying safe. This symbol has greatly assisted in raising the profile of safeguarding in the organisation. All designated personnel and the Senior Management team have this symbol on their name badges and office doors to invite learners and staff to pursue the open door policy to report any issues or concerns.

Safeguarding was graded as 'outstanding' within our Foundation Learning service. The college's Foundation Learning Programme is for 16 – 19 years olds and supports them in learning vocational skills or qualifications; students benefit from the help of a dedicated support worker during their attendance.

The college held a very successful two-day awareness raising event aimed at staff and students in June 2011. Safeguarding information has been developed in a range of accessible formats including those learners with learning difficulties or disabilities (LLDD) in collaboration with Sense, the charity that supports people who are deaf/blind.

In our most recent learner survey,

- ✓ 96% of respondents said that they felt safe when studying at the college and
- ✓ 100% said that if they had not felt safe, they knew how to report it and who to report it to.
- ✓ 99.13% of learners on discrete LLDD provision felt safe in the college and knew how to report a problem.

The College remains committed to safeguarding learners and intends to involve learners, but particularly young learners and adults at risk, in reviewing and developing our policies and procedures in the light of best practice.

Janet Bristow, Vice Principal

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Priorities for the Coming Year

Safeguarding Adults Board Business Plan 2012/13

Priority Area 1: Effective Safeguarding Policies, Procedures and Governance

Outcome	Milestone	Lead	Timescale	Notes/Comments
Effective Multi agency processes, procedures and governance.	Complete work to clear backlog of 'open' safeguarding cases in ASC and CPFT	ASC Heads of Service. Head of Social Care, CPFT	June 2012	
	Ensure systems are in place to prevent a similar occurrence in the future.	ASC Heads of Service. Head of Social Care, CPFT Strategic Safeguarding Lead.	September 2012	
	Joint safeguarding Procedures agreed with Cambridgeshire County Council	Strategic Safeguarding Lead	October 2012	
	Discrete budget for the Board identified with agreed contributions from partners	Tina Hornsby and SAB Chair	July 2012	
	Strategic Safeguarding Team establishment agreed with posts filled by permanent staff	Tina Hornsby	September 2012	
	Annual Report	Quality Audit Manager and SAB Chair	September 2012	
	Performance Management Framework developed	Quality and Performance Sub Group	October 2012	

Priority Area 2: Improve Response to Safeguarding Concerns

Outcomes	Milestone	Lead	Timescale	Notes/Comments
The SAB is confident that safeguarding concerns are reported and responded to appropriately	Identify the difference made by the MARU and its benefits for adult services	Trudie Skeels (MARU)	June 2012	
(Proportionality)	Ensure that data recording improves to enable more understanding of performance	Tina Hornsby	September 2012	
(Protection)	Ensure thresholds for safeguarding referrals are clear, and understood by referring agencies (aim to reduce the proportion of alerts to referrals)	Safeguarding Training and development post	September 2012	
	Review the contribution of Peterborough Direct to safeguarding referrals.			
	Develop guidance with regard to the relationship between self neglect and safeguarding	Strategic Safeguarding Lead.	November 2012	

Priority Area 3: Increased Access and Involvement

Outcome	Milestone	Lead	Timescale	Notes/Comments
Ensure that information about safeguarding adults is accessible and that users are involved in policy development.	Improve safeguarding information on website	Safeguarding adults co-ordinator	September 2012	
(Empowerment)	Develop a systematic approach to involving service users and their families	Strategic Safeguarding Lead	November 2012	
(Prevention)				

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SCRUTINY COMMISSION FOR HEALTH ISSUES	Agenda Item No. 10
23 JANUARY 2013	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

NOTICE OF INTENTION TO TAKE KEY DECISIONS

1. PURPOSE

1.1 This is a regular report to the Scrutiny Commission for Health Issues outlining the content of the Notice of Intention to Take Key Decisions.

2. RECOMMENDATIONS

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

3. BACKGROUND

3.1 The latest version of the Notice of Intention to Take Key Decisions is attached at Appendix 1. The Notice contains those key decisions, which the Leader of the Council believes that the Cabinet or individual Cabinet Member(s) can make after 8 February 2013.

3.2 The information in the Notice of Intention to Take Key Decisions provides the Committee 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 Committee 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.

3.4 As the Notice is published fortnightly any version of the Notice published after dispatch of this agenda will be tabled at the meeting.

4. CONSULTATION

4.1 Details of any consultation on individual decisions are contained within the Notice of Intention to Take Key Decisions.

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

None

6. APPENDICES

Appendix 1 – Notice of Intention to Take Key Decisions

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PETERBOROUGH CITY COUNCIL'S NOTICE OF INTENTION TO TAKE KEY DECISIONS

PUBLISHED: 11 JANUARY 2013

PETERBOROUGH CITY COUNCIL

NOTICE OF INTENTION TO TAKE KEY DECISIONS

In the period commencing 28 days after the date of publication of this notice, 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.

If the decision is to be taken by an individual cabinet member, the name of the cabinet member is shown against the decision, in addition to details of the councillor's portfolio. If the decision is to be taken by the Cabinet, it's members are as listed below:
Cllr Cereste (Leader); Cllr Lee (Deputy leader); Cllr Scott; Cllr Holdich; Cllr Hiller; Cllr Seaton; Cllr Fitzgerald: Cllr Dalton: Cllr Walsh.

This Notice should be seen as an outline of the proposed decisions for the forthcoming month and it will be updated on a fortnightly basis. Each new notice supersedes the previous notice and items may be carried over into forthcoming notices. Any questions on specific issues included on the Notice should be included on the form which appears at the back of the Notice 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.

Whilst the majority of the Executive's business at the meetings listed in this Notice will be open to the public and media organisations to attend, there will be some business to be considered that contains, for example, confidential, commercially sensitive or personal information. In these circumstances the meeting may be held in private, and on the rare occasion this applies this is indicated in the list below. A formal notice of the intention to hold the meeting, or part of it, in private, will be given 28 clear days in advance of any private meeting in accordance with The Local Authorities (Executive Arrangements) (Meetings and Access to Information) (England) Regulations 2012.

The Council invites members of the public to attend any of the meetings at which these decisions will be discussed (unless a notice of intention to hold the meeting in private has been given).

You are entitled to view any documents listed on the notice, or obtain extracts from any documents listed or subsequently submitted to the decision maker prior to the decision being made, subject to any restrictions on disclosure. There is no charge for viewing the documents, although charges may be made for photocopying or postage. Documents listed on the notice and relevant documents subsequently being submitted can be requested from Alex Daynes, Senior Governance Officer, Chief Executive's Department, Town Hall, Bridge Street, PE1 1HG (fax 01733 452483), e-mail to alexander.daynes@peterborough.gov.uk or by telephone on 01733 452447. For each decision a public report will be available from the Governance Team one week before the decision is taken.

All decisions will be posted on the Council's website: www.peterborough.gov.uk/executivedecisions. If you wish to make comments or representations regarding the 'key decisions' outlined in this Notice, 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 notice.

KEY DECISIONS FROM 8 FEBRUARY 2013

KEY DECISION REQUIRED	DECISION MAKER	MEETING OPEN TO PUBLIC	RELEVANT SCRUTINY COMMITTEE	CONSULTATION	CONTACT DETAILS / REPORT AUTHORS	DOCUMENTS RELEVANT TO THE DECISION SUBMITTED TO THE DECISION MAKER (IF ANY OTHER THAN PUBLIC REPORT)
Budget 2013/14 and Medium Term Financial Strategy 2023/2024 - KEY/08FEB13/01 To approve the final proposed budget including Council Tax for submission to full Council.	**Councillor David Seaton, Cabinet Member for Resources Cabinet**	**Yes**	Sustainable Growth and Environment Capital	Relevant Internal and external stakeholders.	Steven Pilsworth Head of Strategic Finance Tel: 01733 384564 Steven.Pilsworth@peterborough.gov.uk	It is not anticipated that there will be any further documents
Transfer of Public Health - KEY/08FEB13/02 To agree the transfer of Public Health services to the City Council.	**Councillor Wayne Fitzgerald, Cabinet Member for Adult Social Care / Cabinet**	**Yes**	Health Issues	Relevant internal stakeholders.	Dr Andy Liggins Director of Public Health Tel: 01733 207172 andy.liggins@peterborough.gov.uk	It is not anticipated that there will be any further documents
Local Transport Board - KEY/08FEB13/03 To agree the framework for the establishment of the Local Transport Board and accept the appointment opportunity as an external organisation.	**Councillor Gr. Uff. Marco Cereste Leader of the Council and Cabinet Member for Growth, Strategic Planning, Economic Development, Business Engagement and Environment**	**N/A**	Sustainable Growth and Environment Capital	Relevant internal and external stakeholders.	Mark Speed Transport Planning Team Manager Tel: 317471 mark.speed@peterborough.gov.uk	It is not anticipated that there will be any further documents

	Capital					

PREVIOUSLY ADVERTISED DECISIONS						
Moy's End Stand Demolition and Reconstruction - KEY/03APR/12 Award of Contract for the Demolition of the Moy's End Stand and Reconstruction	**Councillor David Seaton Cabinet Member for Resources**	**N/A**	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	It is not anticipated that there will be any further documents.
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.	**Councillor David Seaton Cabinet Member for Resources**	**N/A**	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	It is not anticipated that there will be any further documents.
Rolling Select List - Independent Fostering Agencies - KEY/01JUL/12 To approve the list for independent fostering agencies.	**Councillor Sheila Scott OBE Cabinet Member for Children's Services**	**N/A**	Creating Opportunities and Tackling Inequalities	Internal and external stakeholders as appropriate.	Oliver Hayward Commissioning Officer - Aiming High Tel: 01733 863910 oliver.hayward@peterborough.gov.uk	It is not anticipated that there will be any further documents.

Write off approval for debts over £10,000 in relation to Non Domestic Rates - KEY/31OCT12/01 Authorise the write off of debt shown as outstanding in respect of non domestic rate accounts.	**Councillor David Seaton Cabinet Member for Resources**	**N/A**	Sustainable Growth and Environment Capital	Internal and External Stakeholders as appropriate.	Richard Godfrey ICT and Transactional Services Partnership Manager Tel: 01733 317989 richard.godfrey@peterborough.gov.uk	It is not anticipated that there will be any further documents.
Expansion and Refurbishment of Hampton Vale Primary School - KEY/31OCT12/04 Award of Contract for the expansion and refurbishment of Hampton Vale Primary School.	**Councillor John Holdich OBE Cabinet Member for Education, Skills and University**	**N/A**	Creating Opportunities and Tackling Inequalities	Internal and external stakeholders including ward councillors as appropriate.	Brian Howard Programme Manager - Secondary Schools Development Tel: 01733 863976 brian.howard@peterborough.gov.uk	It is not anticipated that there will be any further documents.
Council Tax Base 2013/14 - KEY/13NOV12/02 To agree the calculation of the council tax base for 2013/14.	**Councillor David Seaton Cabinet**	**Yes**	Sustainable Growth and Environment Capital	Internal and external stakeholders as appropriate.	Steven Pilsworth Head of Strategic Finance Tel: 01733 384564 Steven.Pilsworth@peterborough.gov.uk	It is not anticipated that there will be any further documents.
Budget and Medium Term Financial Strategy - KEY/13NOV12/03 Draft budget for 2013/14 and Medium Term Financial Strategy to 2023/24 to be agreed as a basis for consultation. This will include the Council's Capital Strategy, Asset Management Plan and Draft Annual Accountability Agreement between Peterborough City Council	**Councillor David Seaton Cabinet**	**Yes**	Sustainable Growth and Environment Capital	Internal and external stakeholders as appropriate.	Steven Pilsworth Head of Strategic Finance Tel: 01733 384564 Steven.Pilsworth@peterborough.gov.uk	It is not anticipated that there will be any further documents.

and Peterborough Primary Care Trust.						
Mental Health Services at Clare Lodge - KEY/13NOV12/05 Undertake a tender to secure Mental Health Services for Clare Lodge Secure Unit.	**Councillor Sheila Scott OBE Cabinet Member for Children's Services**	**N/A**	Creating Opportunities and Tackling Inequalities	Internal and External Stakeholders as appropriate.	Oliver Hayward Commissioning Officer - Aiming High Tel: 01733 863910 oliver.hayward@peterborough.gov.uk	It is not anticipated that there will be any further documents.
Clare Lodge Service Review Outcome - KEY/13NOV12/06 To approve the outcome of the service review of Clare Lodge Secure Unit.	**Councillor Sheila Scott OBE Cabinet Member for Children's Services**	**N/A**	Creating Opportunities and Tackling Inequalities	Internal and External Stakeholders as appropriate.	Oliver Hayward Commissioning Officer - Aiming High Tel: 01733 863910 oliver.hayward@peterborough.gov.uk	It is not anticipated that there will be any further documents.
Family Support Framework - KEY/13NOV12/07 Create a framework for Family Support services.	**Councillor Sheila Scott OBE Cabinet Member for Children's Services**	**N/A**	Creating Opportunities and Tackling Inequalities	Internal and external stakeholders as appropriate.	Oliver Hayward Commissioning Officer - Aiming High Tel: 01733 863910 oliver.hayward@peterborough.gov.uk	It is not anticipated that there will be any further documents.
Residential Approved Provider List - KEY/13NOV12/08 Create a compliant Approved Provider List for Residential units for children and young people.	**Councillor Sheila Scott OBE Cabinet Member for Children's Services**	**N/A**	Creating Opportunities and Tackling Inequalities	Internal and external stakeholders as appropriate.	Oliver Hayward Commissioning Officer - Aiming High Tel: 01733 863910 oliver.hayward@peterborough.gov.uk	It is not anticipated that there will be any further documents.
Children's Play Services Review - KEY/13NOV12/09 To undertake a review of the Play Services in the city	**Councillor Sheila Scott OBE Cabinet Member for Children's Services**	**N/A**	Creating Opportunities and Tackling Inequalities.	To be undertaken with key stakeholders.	Oliver Hayward Commissioning Officer - Aiming High Tel: 01733 863910 oliver.hayward@peterborough.gov.uk	It is not anticipated that there will be any further documents.

Superfast Broadband - KEY/13NOV12/10 To authorise the award of the contract for the provision of Superfast Broadband in Peterborough and Cambridgeshire	**Councillor David Seaton Cabinet Member for Resources**	**N/A**	Sustainable Growth and Environment Capital	Relevant internal departments.	Richard Godfrey ICT and Transactional Services Partnership Manager Tel: 01733 317989 richard.godfrey@peterborough.gov.uk	It is not anticipated that there will be any further documents.
Healthwatch Commissioning - KEY/30NOV12/02 Approval of the proposed approach to commission Healthwatch Peterborough.	**Councillor Wayne Fitzgerald Cabinet Member for Adult Social Care**	**N/A**	Health Issues	Internal and external stakeholders as appropriate.	Nick Blake Improvement & Development Manager Tel: 01733 452406 nick.blake@peterborough.gov.uk	It is not anticipated that there will be any further documents.
Care and Repair Framework Agreement - KEY/18DEC12/01 To approve a framework agreement and schedule of rates to deliver disabled facility grant work. specifically providing disabled access to toilet and washing facilities and associated work in domestic properties.	**Councillor Peter Hiller Cabinet Member for Housing, Neighbourhoods and Planning**	**N/A**	Strong and Supportive Communities	Relevant Internal Departments.	Russ Carr Care & Repair Manager Tel: 01733 863864 russ.carr@peterborough.gov.uk	It is not anticipated that there will be any further documents.
Capital Programme of Works - KEY/18DEC12/02 To agree the Capital Programme of Works for 2013-14.	**Councillor Peter Hiller Cabinet Member for Housing, Neighbourhoods and Planning**	**N/A**	Sustainable Growth and Environment Capital	Members of public, external stakeholders and internal departments.	Mark Speed Transport Planning Team Manager Tel: 317471 mark.speed@peterborough.gov.uk	It is not anticipated that there will be any further documents.

Extension of Homecare Contracts - KEY/18DEC12/03 To extend the current contracts for a further period of 9 months.	**Councillor Wayne Fitzgerald Cabinet Member for Adult Social Care**	**N/A**	Health Issues	Internal and external stakeholders.	John Cremins Head of Service, Contracts Procurement & Compliance Tel: 01733 384608 john.cremins@peterborough.gov.uk	It is not anticipated that there will be any further documents.
Award of Contract for the 413 Bus Service - KEY/27DEC12/01 Award of Contract for Route 413 (Maxey to City Centre) from 1 April 2013.	**Councillor Peter Hiller Cabinet Member for Housing, Neighbourhoods and Planning**	**N/A**	Sustainable Growth	Relevant internal departments and external stakeholders.	Mark Speed Transport Planning Team Manager Tel: 317471 mark.speed@peterborough.gov.uk	It is not anticipated that there will be any further documents.
Award of Insurance Contract - KEY/10JAN13/01 To authorise the awarding of the contract for provision of the Council's insurances for the next five years.	**Councillor David Seaton Cabinet Member for Resources**	**N/A**	Sustainable Growth and Environment Capital	Relevant Internal Departments.	Sue Addison Insurance Manager Tel: 01733 348560 sue.addison@peterborough.gov.uk	It is not anticipated that any further documents will be required.
Extension to various Highways Related Contracts to July 2013 - KEY/24JAN13/01 To extend the existing Highways Maintenance, Professional Services, Street Lighting and Gully Cleansing Contracts until July 2013 pending the review of alternative procurement options.	**Councillor David Seaton Cabinet Member for Resources**	**N/A**	Sustainable Growth and Environment Capital	Consultation with senior officers has been undertaken including the Director of Operations and Head of Business Transformation.	Simon Machen Head of Planning, Transport and Engineering Services Tel: 01733 453475 simon.machen@peterborough.gov.uk	It is not anticipated that there will be any further documents.
Environment Capital Action Plan - KEY/24JAN13/02	**Councillor Gr. Uff. Marco Cereste Cabinet**	**YES**	Sustainable Growth and Environment	Four week public consultation.	Charlotte Palmer Climate Change Team Manager	It is not anticipated that there will be any further

Approve the Plan for public consultation.			Capital		charlotte.palmer@peterborough.gov.uk	documents.
Risk Based Verification Policy - KEY/24JAN13/03 To approve the policy for online Housing/Council Tax Benefit claim forms.	**Councillor David Seaton Cabinet**	**NO**	Sustainable Growth and Environment Capital	Relevant Internal and External Stakeholders.	Amanda Stevens Head of Shared Transactional Services Tel: 01733 317941 amanda.stevens@peterborough.gov.uk	It is not anticipated that there will be any further documents.
Religious Education Syllabus - KEY/24JAN13/04 To approve the Locally Agreed Syllabus for Religious Education (RE).	**Councillor John Holdich OBE Cabinet Member for Education, Skills and University**	**N/A**	Creating Opportunities and Tackling Inequalities.	SACRE and other key stakeholders.	Sally Weald Governor Services Assistant Manager Tel: 01733 763720 sally.weald@peterborough.gov.uk	It is not anticipated that there will be any further documents.
Review of Eligibility Criteria for Adult Social Care Services - KEY/24JAN13/05 Agree recommendations following the review of Eligibility Criteria.	**Councillor Wayne Fitzgerald Cabinet**	**YES**	Health Issues	Social Care users, carers and partners.	Jana Burton Assistant Director Care Services Delivery Tel: 01733 452440 jana.burton@peterborough.gov.uk	It is not anticipated that there will be any further documents.
Review of Charging Policy for Adult Social Care Services - KEY/24JAN13/06 Agree recommendations following the review of Adult Social Care charging policy.	**Councillor Wayne Fitzgerald Cabinet**	**YES**	Health Issues	Social Care users, carers and partners.	Paul Stevenson Interim Head of Finance Tel: 01733 452306 paul.stevenson@peterborough.gov.uk	It is not anticipated that there will be any further documents.
Fletton Parkway Junction 17 to 2 improvement scheme - KEY/24JAN13/07 To agree funding is brought forward between 2012 and	**Councillor Peter Hiller Cabinet Member for Housing, Neighbourhoods and Planning,**	**N/A**	Sustainable Growth and Environment Capital	Relevant internal and external stakeholders.	Mark Speed Transport Planning Team Manager Tel: 317471 mark.speed@peterborough.gov.uk	It is not anticipated that there will be any further documents.

2015 in Medium Term Financial Strategy and the contract awarded for the works.	**Cabinet Member for Resources**					

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

Care Services Delivery (Assessment & Care Management; Integrated Learning Disability Services and HIV/AIDS; Regulated Services)
Strategic Commissioning (Mental Health & Integrated Learning Disability; Older People, Physical Disability & Sensory Impairment; Contracts, Procurement & Compliance)

Quality, Information and Performance (Performance & Information; Strategic Safeguarding; Business Support & Governance; Business Systems Improvement; Quality and Workforce Development)

Updated: 15 January 2013

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.

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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.

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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**	Recommendations made to Cabinet
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**	
	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**	
	Call-In of Consultation on the Proposed Closure of the Two Care Homes: Greenwood House and Welland House - NOV12/CAB/133	
	Development of the Shadow Cambridgeshire & Peterborough Clinical Commissioning Group and the Peterborough and Borderline Local Commissioning Groups To scrutinise and comment on the Development of the Shadow Cambridgeshire & Peterborough Clinical Commissioning Group and the Peterborough and Borderline Local Commissioning Groups **Contact Officer: Jessica Bawden**	

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Meeting Date	Item	Progress
23 January 2013 *Draft report 7 Jan* *Final report 14 Jan*	**East of England Ambulance Service** To note and comment on developments within the East of England Ambulance Service. **Contact Officer: Chris Hartley, Associate Director of Communications & Engagement, East of England Ambulance Service NHS Trust**	
	Peterborough and Stamford Hospitals NHS Foundation Trust – Quality Account Progress Report To Consider and comment on the contents of the Quality Report and make any recommendations. **Chris Wilkinson, Director of Care Quality and Chief Nurse**	
	Financial Recovery Update - Peterborough and Stamford Hospitals NHS Foundation Trust To consider and comment on the Financial Recovery Update of the Peterborough and Stamford Hospitals NHS Foundation Trust. **Contact Officers: Chris Preston / Louise Barnett**	
	Consultation on Proposed Changes to Eligibility Criteria And Charges For Adult Social Care To consider and comment on the Proposed Changes to Eligibility Criteria and Charges for Adult Social Care as part o the consultation process. **Contact Officer: Director of Adult Social Services / Jana Burton, Assistant Director of Care Services Delivery**	
	Safeguarding Vulnerable Adults Board Annual Report 2011/2012 To comment on and endorse the Safeguarding Vulnerable Adults Board Annual Report 2011/2012. **Contact Officer: Tina Hornsby / Diane Brown, Interim Strategic Safeguarding Adults Lead**	

Meeting Date	Item	Progress
6 February 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 2013/14 and Medium Term Financial Plan. **Contact Officer: John Harrison/Steven Pilsworth**	
12 March 2013 *Draft report 22 Feb* *Final report 1 March*	**Portfolio Progress Report from Cabinet Member for Adult Social Care**	
	Older Peoples Accommodation Strategy – Progress Report **Contact Officer: Director of Adult Social Care**	
	Dementia Strategy and Plans for Dementia Resource Centre **Contact Officer: Terry Rich, Director of Adult Social Services**	
	Clinical Commissioning Group Business Plan **Contact Officer: Jessica Bawden**	
	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**	

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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
Public Health Transition, Contact Officer: Andy Liggins	