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PETERBOROUGH CITY COUNCIL

HEALTH SCRUTINY COMMITTEE

MONDAY 17 SEPTEMBER 2018
7.00 PM

Bourges/Viersen Room - Town Hall

AGENDA

Page No

1. Apologies for Absence

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.

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 the relevant Scrutiny Committee. If a request for call-in of a decision is received, implementation of the decision remains suspended for consideration by the relevant Scrutiny Committee.

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8.	**Transforming Care - 'Building The Right Support' (BRS) - Inpatient Bed Configuration. Preferred Option Consultation**	**81 - 136**
9.	**Monitoring Scrutiny Recommendations**	**137 - 140**
10.	**Forward Plan of Executive Decisions**	**141 - 188**
11.	**Work Programme 2018/2019**	**189 - 196**

12. Date of Next Meeting

5 November 2018

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Committee Members:

Councillors: J Stokes (Chairman), K Aitken, S Barkham, S Hemraj, M Jamil, D Jones, D Over, B Rush (Vice Chairman), N Sandford, N Simons, and S Warren

Substitutes: Councillors: G Casey, R Ferris, A Joseph

Co-opted Members:
Parish Councillor Henry Clark, Independent Co-opted Member (Non-voting)
Parish Councillor Barry Warne, Substitute Independent Co-opted Member (Non-voting)
Dr Steve Watson, Independent Co-opted Member (Non-voting)

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 HEALTH SCRUTINY COMMITTEE HELD AT 7.00PM ON MONDAY 2 JULY 2018 IN THE BOURGES / VIERSEN ROOMS, TOWN HALL, PETERBOROUGH

Committee Members Present:	Councillors J Stokes (Chairman), K Aitken, S Barkham, S Hemraj, M Jamil, D Jones, D Over, Rush (Vice-chairman), B Saltmarsh, N Simons Co-opted Members - Parish Councillor Henry Clark and Dr Steve Watson	
Also present	Roxana Mojoo Jones	Commissioning Officer, NHS England, Midlands and East (East)
	David Barter	Head of Commissioning, NHS England, Midlands and East
	Stephen Graves	CEO, North West Anglia NHS Foundation Trust
	Jane Pigg	Company Secretary, North West Anglia NHS Foundation Trust
	Keith Reynolds	Assistant Director of Strategy and Planning, North West Anglia NHS Foundation Trust
	Susan Mahmoud	Healthwatch
Officers Present:	Dr Liz Robin	Director of Public Health
	Paulina Ford	Senior Democratic Services Officer
	David Beauchamp	Democratic Services Officer

1. APOLOGIES FOR ABSENCE

Apologies for absence were received from Councillor Sandford. Councillor Saltmarsh was in attendance as a substitute.

2. DECLARATIONS OF INTEREST AND WHIPPING DECLARATIONS

Item 7. North West Anglia NHS Foundation Trust – Bed Capacity

Councillor Hemraj declared an interest in item 7 in that she was an employee of the North West Anglia NHS Foundation Trust.

3. MINUTES OF THE HEALTH SCRUTINY COMMITTEE HELD ON 12 MARCH 2018

The minutes of the meetings held on 12 March 2018 were agreed as a true and accurate record.

4. CALL-IN OF ANY CABINET, CABINET MEMBER OR KEY OFFICER DECISIONS

There were no requests for Call-in to consider.

5. APPOINTMENT OF CO-OPTED MEMBERS

The Senior Democratic Services Officer introduced the report which recommended that the Committee appoint Parish Councillor, Henry Clark as a non-voting co-opted member to represent the rural communities. A further recommendation included in the report was to appoint a second Parish Councillor Barry Warne as a non-voting co-opted member also to represent the rural communities or as a substitute for Henry Clark. Both nominations had been put forward from the Parish Council Liaison Committee.

The report also recommended the appointment of Dr Steve Watson as a non-voting co-opted member for his medical expertise.

Councillor Jamil proposed that Dr. Steve Watson be appointed a non-voting co-opted member and this was unanimously agreed by the Committee.

Councillor, Jamil seconded by Councillor Hemraj proposed that both Henry Clark and Barry Warne be appointed as non-voting co-opted members. The Chairman put this proposal to the vote and it was defeated (5 in favour, 6 against, 0 abstentions). It was therefore agreed that Henry Clark be appointed as a non-voting co-opted member with Barry Warne appointed as a designated substitute for Henry Clark.

AGREED ACTIONS:

The Health Scrutiny Committee considered the report and **RESOLVED** to:

1. Appoint Dr Steve Watson as a non-voting co-opted member for the municipal year 2018/2019. Appointment to be reviewed annually at the beginning of the next municipal year.
2. Appoint Parish Councillor Henry Clark as a non-voting co-opted member to represent the rural area for the municipal year 2018/2019. Appointment to be reviewed annually at the beginning of the next municipal year.
3. Appoint Barry Warne as the nominated substitute for Henry Clark should he be unable to attend.

The nominated persons were in attendance at the meeting and the Chairman invited both Dr Watson and Henry Clark to join the Committee for the remainder of the meeting.

6. DENTAL SERVICES IN PETERBOROUGH

The Commissioning Officer accompanied by the Head of Commissioning at NHS England, Midlands and East introduced the report. The report provided information in response to questions from the Committee at their meeting held on 12 March 2018 where a previous report on Dental Services had been presented.

The Health Scrutiny Committee debated the report and in summary, key points raised and responses to questions included:

- Members requested clarification on how dentists in the Peterborough area could be underperforming and not delivering their contracted levels of service when so many people found it difficult to find an NHS dentist. Members were advised that dental practices were being commissioned with a certain number of Units of Dental Activity (UDAs) but were not

able to recruit sufficient dentists to fulfil those units. There was a national shortage of dentists so rural areas in particular sometimes struggled to recruit. NHS England Midlands and East Commissioning monitored practices closely and had discussions with them to adjust contracts depending on demand. Another factor was the oral health needs of the population or a lack of patient demand; many patients would only access oral health services when they experienced agony. A key priority was to get patients on a pathway to good oral health and build a good relationship with dental practices. There was an initiative to take two year-olds to the dentists to help build good relationships with their dentist.

- Members asked if patients visiting practices outside the area, in the East Midlands, Northamptonshire and Lincolnshire in particular, would skew the figures or would dentists outside the area charge the NHS in Cambridgeshire. It was clarified that patients could visit dentists anywhere they like. The FP17 form contained unique patient information and reports could be produced to establish where patients were migrating to.
- Each dental contract had an annual value with payments being received monthly. A certain number of units of dental activity would need to be delivered against each contract. A band 1 treatment was 1 unit, band 2 was 3 units and band 3 was 12 units. Underperforming meant that a provider had not delivered their quota of units and over performing meant the opposite and would result in an increase in the value of the contract being considered.
- Anyone could receive treatment from any dentists with free units and there were no registered lists, unlike GPs. The 111 number could be used to access out of hours services and these were available regardless of whether they had already registered with a dentist. Patients with dental pain, trauma etc. would be signposted via the 111 number.
- The Out of Hours contract would come to an end in April 2019 and the oral health needs of the population were being looked at to determine commissioning intentions. It was important that services were equal or better than at present. The Primary Care Dental Team were in the process of working with consultants in public health, dentists, current providers, patients, Healthwatch and other stakeholders to develop plans to recommission services from April 2019 onwards.
- Members noted the problems with the dentistry in Peterborough but stated that no solutions were mentioned in the report. Officers responded that NHS England, Midlands and East Commissioning were working with various stakeholders to identify future commissioning intentions. These included the local dental network, the managed clinical network, dental providers, and community dental services, out of hour's providers, Healthwatch, directly with patients and consultants in dental public health attached to the Commissioning team through Public Health in order to work out the needs of the area. Attempts were being made to work more closely with providers and stakeholders to ensure there was enough capacity to match the growth of the population.
- Much of the work needed to be led by current contract holders and clinicians that had a long term investment in Peterborough and could be part of future plans for the population of Peterborough to receive dentistry that benefited them and to make sure that they were on a good dental health pathway.
- Many dental practices in Peterborough did not deliver their contracts and detailed discussions were taking place to establish why that was and how they could do so in the future which may require more units of dental activity.
- Attracting good dentists was important to making dental services more sustainable in the future, in addition to the sustainability of the commissioned practices themselves, as dentists would become long-term members of the community. There were many reasons for the difficulties in attracting dentists. It was important to work closely with practices to ensure that newly qualified dentists built experience in a wide variety of fields by having 'training dental practices'. Many dentists qualified in certain teaching centres and preferred to work closer to London. There were considerably more applications per dentist positions in London and this number decreased the further north one went.

- The practices listed in appendix one of the report were a comprehensive list of those that held NHS contracts. Solely private or independent dentists were not mentioned due to the lack of a contractual relationship with them. Providers that were listed multiple times had different contracts. There may also have been different contracts for one provider aimed at different demographics of patients with different care needs.
- There would still be an out of hour's service when the consultation had ended.
- In most areas of England needs were higher than the level of provision and this was not unique to Peterborough. .
- No new practices or services had opened due to the lack of new funding. Under-delivering services with spare capacity had been recommissioned.
- Members asked if consideration had been given to mobile dentists in rural areas without permanent provision and potentially in some urban areas. It was noted that commissioning should be based on what was appropriate for patients and this depended on transport links and the ability of patients to travel. There was a community dental service available for patients who were unable to travel to a practice and they had a referral service. GPs, other dentists and social services were able to signpost patients to this service if needed.
- The Director of Public Health explained the term 'Principles of Proportionate Universalism' found on page 28 as follows: Disadvantaged sectors of society required more services but less deprived groups also needed provision. It was a way of describing addressing health needs in accordance with their severity but across the whole population.
- The statistics in appendix two dated from December 2016 as this was the last time that a consultant in dental public health had completed a specific piece of work in Peterborough. The conclusions were that the general oral health was good but it compared unfavourably with other areas of East Anglia and the country as a whole. The data collection would be repeated in the future to see if this situation had changed.
- Members noted that Fluoride Varnishing was beneficial for children but questioned the extent to which children were being targeted for this, suggesting it may be ad hoc in nature and enquired if there was a programme to bring children in for fluoride varnishing or if this was done when children visited the dentist for other reasons. Members were advised that all General Dental Practitioners should administer fluoride varnishing where clinically appropriate and they had the funding to do so but the key was getting children into see the dentist. The checks on dentists included the recording of the information regarding fluoride varnishing on the FP17 form. It was noted that children required parental consent up to the age of 16 to receive fluoride varnishing treatment.
- Members were informed that there was an initiative in NHS England to ensure that dentists saw children at the youngest possible age, even before teeth presented so that the children and their parents or guardians get into the routine of visiting the dentist regularly.
- The more difficult problem was the number of children who were not taken to the dentist and those who miss the treatment. When they did present this was usually because of dental pain, requiring a different course of treatment.
- Mobile Dentists came under the remit of the Special Care Dentistry team who were currently investigating all special care services within East Anglia. Scoping, groundwork and discussions with stakeholders were taking place as part of an ongoing project and nothing had been decided at this stage. It had not yet been decided if mobile dentists would been used.

AGREED ACTIONS:

The Health Scrutiny Committee considered the report and **RESOLVED** to note the report for information.

7. NORTH WEST ANGLIA NHS FOUNDATION TRUST – BED CAPACITY

The Chief Executive Officer introduced the report accompanied by the Company Secretary and Assistant Director of Strategy and Planning of the North West Anglia NHS Foundation Trust. The report provided the Committee with an update on proposals and options for increasing capacity at Peterborough City Hospital and to include an update on the financial situation.

Additional information provided by the Chief Executive Officer was that the core assumption was that care was currently being delivered in the same way as when the report was written. However, there had been some changes from the Department for Health since writing the paper. An example of this was that local authorities and healthcare services were being asked to investigate long-stay patients and to reduce the number of patients staying over 21 days by 25% ahead of the winter. Those sort of policy changes would affect the bed numbers required in the report. Planning was now based on 92% bed occupancy compared with 90% when the report was written. The report had also not looked at ways of reducing the numbers of people coming into hospital compared with the current model of discharging patients earlier although the most recent paper from the Department for Health provided many possibilities for future consideration in this area.

The Health Scrutiny Committee debated the report and in summary, key points raised and responses to questions included:

- Members asked about the likelihood of funding being made available to move offices out of the fourth Floor of Peterborough City Hospital to be converted into wards Members were informed that the NHS had to submit its five year capital plans by the middle of July 2018. This paper was therefore timely as the plan would include bed requirements in the initial stage and the four floor requirements towards 2023. It was expected that in the second half of the next five years, assuming that population and needs grow, one or two wards would be required on the fourth floor. This was the current plan and the bid process would have to be completed by the middle of July to be considered and have decisions made in the autumn.
- Plans were already in place with the money that was already available to increase bed capacity. An example would be the nine extra beds being added to the medical assessment unit this week.
- In the event of the fourth floor being used for new wards office staff would still be based on site. Although there is sometimes doubt about the usefulness of office staff taking up space in hospitals, anecdotal evidence suggested that this can actually be beneficial to medical staff.
- There was the possibility of making better use of existing office space at Peterborough City Hospital. There was a building on site that had been previously used for the storage of medical records. The plan was to convert some of this space into office space for use by support staff such as the accountancy team. Support staff would therefore still be on-site but not in the building.
- A different Clinical Commissioning Group (CCG) was responsible for Stamford Hospital. The CCG did not anticipate an increase in beds at the Stamford site. An acre of land not required for NHS use was available at the Stamford site and the correct course of action would be to use this for health and care purposes as required by the covenant. There has been some interest from nursing homes. Therefore there will be an increase in beds on the Stamford site for the people of South Lincolnshire, just not NHS beds.
- Members noted that 208 beds would be required by 2026 but the report indicated that only 186 would be provided which included the conversion of the fourth floor of Peterborough City Hospital. Given that delayed transfers of care were unlikely to drop Members sought

clarification as to where this capacity would come from. It was highlighted that not all longer stay patients (over 21 days) were delayed transfer of care and not all delayed transfer of care patients were longer stay patients. The government were targeting a reduction of 25% of longer stay patients and 3.5% delayed transfer of care. If these targets were met 26 fewer beds would be required. The move from 90% to 92% bed occupancy equated to 13 beds. These factors combined would result in more beds being provided than needed.

- It was clarified that the increase from 90% to 92% bed occupancy meant that less spare beds would be needed. It was emphasised these figures were averages, with occupancy being higher in the winter for example. The number of long stay patients must be reduced over the winter. Evidence suggests that staying in a bed over a long period of time without the appropriate physiotherapy and occupational therapy caused a notable degeneration of muscles for elderly people and it was healthier for them to go home earlier once they are medically fit.
- The reduction in long-stay patients was not about discharging patients earlier than they should be.
- 12 extra beds had been provided each year for the last three years. 30+ extra physical beds would be delivered on top of those freed up by reducing the number of longer stage patients.
- Members raised anecdotal evidence about a patient being sent home too early and asked what checks and balances were in place to prevent this from happening. Members were informed that the evidence may have pointed to discharge being appropriate. A senior doctor must approve a discharge in partnership with a nurse and where relevant, occupational therapists and physiotherapists. There would be a series of checks and balances and the aim was not to discharge patients early.
- Members asked if the hospital would cope with another Flu epidemic. It was acknowledged that Peterborough City Hospital did not cope well last winter. It was difficult for staff and patients outside as well as inside the hospital as the ability to release ambulances and get to the next patient was compromised. The government's contribution was to encourage a reduction in long-stay patients and this was something that could be worked on as well as increasing physical capacity. The 12 extra beds put in last winter were not enough. Too much reliance was placed on the number of delayed transfers of care being reduced which had not happened. Capacity could be improved by enabling the right patients to leave earlier and increase physical capacity.
- Members noted that with 208 beds and a staffing ratio of 1.8 per bed an extra 400 nurses would be required by 2026. Members were informed that doctors and nurses were being trained but it would take many years to achieve seniority. Those doctors starting this autumn would complete 5 years of active clinical work and 2 years on wards before starting their more specialist and senior training. It would take 8-10 years to become a powerful decision maker and 10-15 years to become a consultant. The Government was providing additional funding and training but it would be necessary to employ staff from overseas, both inside and outside of the European Union. Immigration rules had recently been changed to meet the need to deliver doctors more quickly. A team of people were currently in the Philippines trying to recruit nurses and this was the second time officers had been there this year to recruit.
- Nurses from the Philippines were fully qualified and generally did not face problems becoming registered with the Royal College of Nurses and were not affected by the same rules that doctors were. Some groups of doctors were not affected but the majority were. The main issue with overseas nurses from inside and outside of the E.U. was the English language test which was set at a degree to masters level of English (level 7). Dispensations from the Royal College of nurses was not possible but a dispensation down to level 6.5 was possible for some groups of doctors if the Medical Director of the North West Anglia NHS Foundation Trust agreed. The biggest challenge in the U.K. was not the ability to recruit but the ability of overseas colleagues to pass the English language test.

- Members sought clarification as to whether discharge of patients was sometimes blocked because Addenbrookes or other hospitals did not have the capacity to take the patients. The CEO advised that patients may have been waiting for either Papworth Hospital or Addenbrookes. In the bed control centre, there were always patients waiting to be transferred to other hospitals as well as waiting to come to Peterborough. The flow was not necessarily dramatically in one direction but Addenbrookes was the tertiary receiving centre for everything except cardiology for a wide range of hospitals. Sometimes patients wait in Peterborough City Hospital and sometimes patients wait in Addenbrookes to be transferred back. Generally Peterborough took one patient back and delivered one patient and this was the case for much of the winter.

Members noted that the CEO of the North West Anglia Foundation Trust was retiring soon and that this might be his last scrutiny committee meeting. His career achievements in helping the NHS were acknowledged by Members as was his openness and honesty with the Health Scrutiny Committee in notifying them of future possible problems. Members thanked him for all that he had done for the committee and wished him an enjoyable retirement. The CEO responded with thanks and advised that interviews for his replacement were taking place the day after the meeting and he would stay in place until that person was in position. The date of his retirement would become public once his replacement had been recruited.

AGREED ACTIONS:

The Health Scrutiny Committee **RESOLVED** to note the current bed capacity and the impact that this was having on flow through the hospital.

8. REVIEW OF 2017/2018 AND WORK PROGRAMME FOR 2018/2019

The Senior Democratic Services Officer introduced the report which considered the 2017/18 year in review and looked at the work programme for the new municipal year 2018/19 to determine the Committees priorities and agree the proposed way forward for monitoring future recommendations.

ACTIONS AGREED:

The Health Scrutiny Committee **RESOLVED** to note the contents of the report and

1. Consider items presented to the Health Scrutiny Committee during 2017/2018 and made recommendations on the future monitoring of these items where necessary.

2. Determine its priorities, and approve the draft work programme for 2018/2019 attached at Appendix 1.

3. Note the Recommendations Monitoring Report attached at Appendix 2 and consider if further monitoring of the recommendations made during the 2017/2018 municipal year is required.

4. Note the Terms of Reference for this Committee as set out in Part 3, Section 4, Overview and Scrutiny Functions and in particular paragraph 2.1 item 3, Health Scrutiny Committee and paragraph 3.5 Health Issues as attached at Appendix 3

9. FORWARD PLAN OF EXECUTIVE DECISIONS

The Senior Democratic Services Officer introduced the report. The Committee received the latest version of the Council's Forward Plan of Executive Decisions containing key decisions that the Leader of the Council, the Cabinet or individual Cabinet Members would make during the course of the forthcoming month. Members were invited to comment on the Plan and where appropriate, identify any relevant areas for inclusion in the Committee's Work Programme.

AGREED ACTIONS

The Health Scrutiny Committee **RESOLVED** to note the report and considered the current Forward Plan of Executive Decisions.

10. DATE OF NEXT MEETING

17th September 2018

CHAIRMAN
7.00pm – 8.16pm

HEALTH SCRUTINY COMMITTEE	AGENDA ITEM No. 5
17 SEPTEMBER 2018	PUBLIC REPORT

Report of:	Catherine Pollard, Cambridgeshire and Peterborough Sustainability and Transformation Partnership	
Contact Officer	Executive Programme Director	CAPCCG.transformationprogramme@nhs.net

STP UPDATE AND STRATEGIC DIRECTION 2018/19

R E C O M M E N D A T I O N S
It is recommended that the Health Scrutiny Committee discuss and comment on this strategic direction and review.

1. ORIGIN OF REPORT

1.1 The committee requested a six-moth review report from the STP. The STP would also like to take the opportunity to report on the proposed strategic direction for 2018/19.

2. PURPOSE AND REASON FOR REPORT

2.1 The Health Committee is asked to consider the strategic direction for the Sustainability and Transformation Partnership for 2018/19.

2.2 This report is for the Health Scrutiny Committee to consider under its Terms of Reference Part 3, Section 4 - Overview and Scrutiny Functions, paragraph No. 2.1 Functions determined by Council - Public Health and Scrutiny of the NHS and NHS providers.

3. BACKGROUND

3.1 This report sets out the future model of leadership of the Cambridgeshire and Peterborough Sustainability and Transformation Partnership (STP System).

3.2 The system is a partnership between the organisations who plan, pay for and provide health and care on behalf of patients and the population within a geography covering 900,000 people. The ideas and proposals set out in this report have been developed in conjunction with all partners and will now form the basis of further co-production and engagement over the coming months

3.3 The partners demonstrate real enthusiasm for the potential of the system; everyone wants to deliver benefits for local people. Crucially, they are also committed to tackling the profound underlying performance and financial challenges facing the system. Our approach must be grounded in our patients, citizens and staff.

4. MAIN ISSUES

4.1 **New leadership** Roland Sinker has been appointed as the Interim Accountable Officer for the Cambridgeshire and Peterborough STP for a period of six to nine months

Roland will undertake the STP Accountable Officer role on an interim basis in addition to his role as Chief Executive of Cambridge University Hospitals NHS Foundation Trust. This has been formally approved by NHS Improvement and NHS England.

4.2 **Progress**

Over the past few months, progress has been made on matters that impact 2018/19 delivery as well as matters that are of strategic significance to the System.

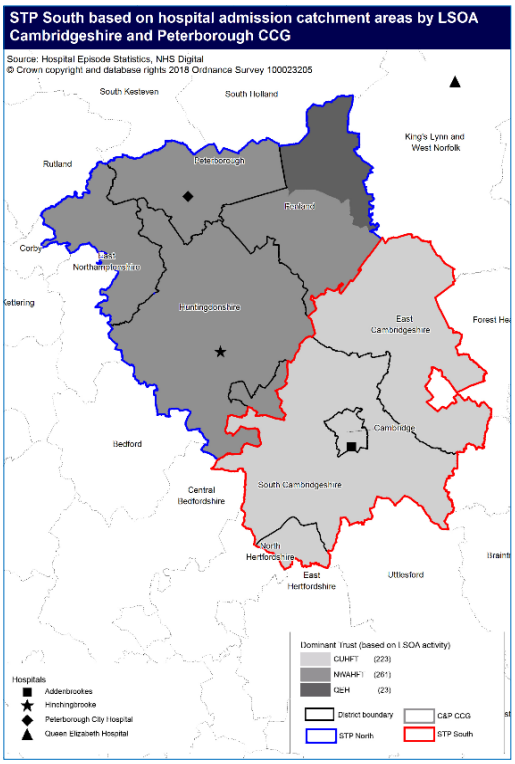
4.2.1 **North and South Provider Alliances**

At the 23 May Health and Care Executive, the Health and Care Executive agreed to shift towards a more place-based approach to delivering transformation across the system. This shift was in recognition of the important of formalising natural relationships which tend to occur between providers all caring for the same population. This has resulted in changes to the STP Delivery Groups for 2018/19, creating North and South Alliance Delivery Groups to replace Urgent and Emergency Care (UEC) and Proactive Care and Integrated and Neighbourhoods (PCIN) Delivery Groups. This took effect from 1 June 2018.

The boundary for the North area covers the local authority areas of Peterborough, Fenland, Huntingdonshire and the Papworth area of South Cambridgeshire. The registered population based on the practices within the North boundary is almost 543,000, whilst the South has almost 425,000. The boundary for the South area covers the local authority areas of Cambridge City, East Cambridgeshire (including the Isle of Ely), South Cambridgeshire and areas of North Hertfordshire. (see map below)

STP boundary	Resident population [1]	Registered population [2]
North	494,841	542,545
South	389,516	424,762
Total	884,357	967,307

The boundary is based on hospital admission catchment areas to NWangliaFT and CUHFT, as shown in the map (right)



Map 1: STP Boundaries

Each alliance, which has representation not only from health and social care commissioners and providers, but also from patients and the voluntary sector, has identified priorities for transforming care for their local people. These priorities include developing integrated neighbourhoods for populations of 30-60k, that support a preventative and holistic approach to care and support, enabling people to live longer and more independently.

Other priorities include, supporting the ongoing work around smoothing discharge pathways, ensuring consistent adoption of evidence-based care for specific groups of people (e.g., residents of care homes, or people with diabetes), enabling remote/ telephone access to hospital specialists and working with the public to adopt more healthy behaviours. These are all long-term projects to help address underlying health and care needs and are aligned with the councils' social care transformation priorities.

4.2.2 **Other System successes**
We have:

- implemented **Guaranteed Income Contracts (GICs)** between acute providers and the CCG for 2018-19 which will better incentivise whole system working, collective financial management and help to address the drivers of the deficit;
- co-ordinated CEO-level interventions to agree and implement a **plan to tackle Delayed Transfers of Care (DTOC)** in a sustainable way;
- agreed **system-level analysis to better understand and articulate the drivers of the deficit** as well as an emerging single system capacity, capital and estates plan;
- launched the stroke **Early Supported Discharge (ESD)** service from April 2018 leading to measurable reductions in length of stay within weeks of implementation –a great example of cross-organisational collaboration, including the third sector, to effect change for patients;
- implemented the **Primary Care Mental Health Service (PRISM)** across all the surgeries in Cambridgeshire and Peterborough to provide specialist mental health support so that patients with mental ill health can access prompt advice and support, receive help in a community setting and experience a more joined-up approach to care;
- put the **Epic electronic patient record into the Granta practice group,** South Cambridgeshire**,** as a first step towards wider roll-out across primary care.
- agreed an **external Communications and Engagement Plan**. This plan was endorsed by HCE on 12 July and has been published as part of the Cambridgeshire Health and Wellbeing Board papers for the meeting on 26 July. The Strategy sets out how the System plans to strengthen the role of partners, the public and key stakeholders in the planning, development and implementation of our programmes of work.
- Continued to develop **the System Road Map, and underpinning activity and finance models** to address our significant system challenges and demonstrate how we are tackling them head on, we are developing a System Road Map for discussion with Regulators in October. The Road Map represents a refreshed implementation plan for working towards an Integrated Care System.

4.2.3 **For project specific updates see appendix one**

4.3 **Continued challenges**

4.3.1 **Operational Performance**

However, a number of persistent system challenges remain, and they must be the focus of collective, targeted action over the next nine months:

- our delayed transfers of care (DTOC) are unacceptably high at 7.2% over 2017-18 (average across all acute providers) and have been as high as 8.3% in 2018-19;
- as a system we are also failing the A&E four hour wait standard (86.9% over 2017-18 and the Referral to treatment (RTT) standard (performance was 89.2% over 2017-18);
- A&E attendances were up 1.9% over 2017-18 (compared to the national average of 0.8%) and emergency admissions were up 5.5% over 2017-18 (compared to the national average of 3.4%);
- We have pockets of primary care at scale and the beginnings of integrated neighbourhood teams, but we are a long way behind other systems, including full involvement of mental health.

4.3.2 **Financial Deficits**

We are forecasting a collective system deficit of £500m by 2021 – only one system in the country has a higher deficit as a proportion of total income. We have undertaken detailed work on the drivers of our deficit and are focusing our efforts on areas within our control. Cambridge and Peterborough's emerging deficit drivers are not unique to this system, and are likely to include:

- **Funding** – Funding per head is inadequate, for both local and specialised services
- **Structural** – Some of our hospital assets are too highly-specified, purchased at a premium through lease contracts (e.g., PFI), while other hospital assets are too small
- **System capacity** – There is a lack of beds (in part due to forced closure), exacerbated by avoidable admissions & high DTOC levels
- **Disjointed commissioning** – The legacy of layered services with multiple organisations

4.4 **Strategic direction for 2018/19**

4.4.1 **Diagnostic**

Our failure to deliver greater change cannot be explained by some unique combination of underlying conditions which make it harder to progress here than elsewhere. Six key themes have come out of conversations with system partners:

- Starting with outcomes for local people
- Prioritising and planning sensibly
- Resetting accountability
- Build open, trusting relationships
- Using data to guide action
- Support Primary Care to lead

4.4.2 **System priorities for 2018-19**

Based on these themes for improvement and the core challenges faced by our system, our proposed system priorities for 2018/19 will: a) deliver core operational basics this year; and b) build for the future.

Delivering the operational basics this year

- **System finances:** collective action to tackle the drivers of the deficit and deliver whole system savings. This includes commissioner savings of £35m of which £12.9m will be delivered through the Guaranteed Income

Contracts (GIC). We will agree a single system capacity and capital plan, agree to shadow a single system control total underpinned by open book accounting, and design the whole population payment approach for 2019-20.

- **Delayed transfers of care (DTOC):** sustainable, system-wide reductions in DTOC. Our DTOCs will not exceed 3.5% over Q4 of 2018-19.
- **A&E:** interventions to reduce the growth in A&E attendances by one third when compared with the three-year run rate.

Building for the future

- **Integrated neighbourhoods:** deliver year one of a three-year plan for integrated neighbourhoods focusing on piloting with one primary care network in each of the North and South of the system, as well as supporting the development of integrated neighbourhoods covering 30,000 – 60,000 population across the whole of the patch.
- **Safe & effective hospital care:** developing networks of care that maximise use of acute capacity, spread world class research & evidence based care (GIRFT and RightCare); reimagine outpatients;
- **Digital:** improving digital capability as a vital enabler of change through the development of a Digital Innovation Hub and Local Integrated Care Record Exemplar (LICRE) and in support of cross-organisational transformation.
- **Workforce:** ensuring our workforce are fit, healthy, skilled, motivated and proud to work in our system – by providing support, development and flexible career pathways; addressing our people pipeline;
- **Estates:** capturing benefits from implementing our Estate Strategy, including progressing a range of major capital projects that address our significant capacity shortfalls and emerging safety concerns;
- **Shared services:** cost effective back office, aligned purchasing and joint contracts;
- **Continued work on existing organisational strategies:** including NWAngliaFT's clinical services strategy, the relocation to new Royal Papworth, as well as the potential developments of a Cancer Research Hospital and regional children's services.

5. WHAT'S NEXT

5.1 In addition to the priorities outlined above, we recognise we need to give more attention to how we engage our staff and local residents about system working.
We need to further encourage them to be active participants in this work in whatever way they can. This will require senior leaders to demonstrate their trust in each other and commitment to this direction of travel. In order to achieve this we must continue to develop and demonstrate a common view about approaching our longer-term financial sustainability. We must address this issue at a pace that reflects the scale of behaviour change required and enables us to redirect resources to where it needs to be. Tackling these big issues will be the focus of the STP Board at the end of September, with the aim of agreeing our Road Map for System working – in advance of conversations with the NHS regulators. We should be in a position to share publicly the conclusions of these conversations in November.

6. BACKGROUND DOCUMENTS

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

6.1 None

7. APPENDICES

7.1 Appendix one – project specific six-month update.

STP UPDATE AND STRATEGIC DIRECTION 2018/19

Peterborough Health Scrutiny Committee 17 September 2018

Appendix one – project specific six-month review

The Peterborough health Scrutiny Committee requested a six-month review of STP work. The main report gives an overview of progress so far as well as challenges and strategic direction for 2018/19. This appendix sets out specific progress made in a number of projects.

Atrial Fibrillation Stroke Prevention Programme

Atrial fibrillation (AF) is the most common form of heart arrhythmia (irregular heartbeat). Prevalence of AF increases with age and leads to an increased risk of experiencing one of the most severe forms of stroke. Improving the management of AF and increasing identification of undiagnosed AF provides an immediate opportunity to improve health and social outcomes for local residents as one stroke is prevented each year for every twenty-five AF patients treated with anticoagulants (blood thinners). Improving treatment also significantly reduces costs to the health and social care system through the avoidance of hospital admissions and care costs related to stroke.

An AF stroke prevention programme jointly funded by Peterborough City Council (iBCF funds), Public Health, Cambridgeshire and Peterborough Sustainable Transformation Partnership (STP) and NHS England has been undertaken with GP practices across Greater Peterborough and Wisbech in order to:

- Increase the proportion of people with known AF, being treated with blood thinners.
- Identify new undetected cases of AF through pulse checks in the over 65's as part of annual flu jabs.

Our work to date has led to:

- 6800 pulses checked, and 64 new cases of AF diagnosed through GP flu clinics (pilot in 9 practices across Greater Peterborough and Wisbech).
- An additional 289 patients prescribed with anticoagulation medication.

Overall, this should lead to the prevention of an estimated12 strokes over the next year across Greater Peterborough and Wisbech.
Our next step is to roll out pulse checks to 21 practices for the 2018 autumn flu clinics.

STP Falls Prevention Programme Implementation in Peterborough

A one-year STP Falls Prevention Programme to reduce injurious falls and improve the quality of life and health outcomes of older people across Cambridgeshire and Peterborough entered the delivery phase in October 2017.

A key focus of the programme is to improve the quality and quantity of multi-factorial falls risk assessments (MFFRAs) and increase the provision and uptake of strength and balance exercise programmes in line with the evidence base.

Five posts have been created to support the delivery of these core components in and around Peterborough. (Note: the posts created are not specific to Peterborough but also cover East Cambridgeshire and Fenland). Existing staff will also receive training and supervision to support the implementation.

The criteria for people accessing the CPFT service is 65+ years, fallen at least once in the last year and cannot manage activities of daily living.

A new Solutions4Health Falls Prevention Health Trainer service employing one staff member will support the implementation of MFFRAs for those 50+ years, who have fallen or become unsteady on their feet in the last year and can manage activities of daily living. Strength and balance programmes are offered to those with a deficit in balance and/or gait.

Our work to date:

- The delivery of MFFRAs and strength and balance exercise programmes by CPFT Neighbourhood Teams in Peterborough will begin in September 2018.
- An experienced Falls Prevention Wellness Coach has mobilised and begun delivering the Falls Prevention service at Solutions4Health from April 2018.
- Interdependencies with the falls prevention pathway and Peterborough City Council's Home Service Delivery Model have been explored and referral pathways agreed. Processes and communications with staff are being developed to enable implementation in line with the roll out of Neighbourhood Teams from September.
- The Peterborough based leisure provider, Vivacity has agreed to deliver evidence-based strength and balance exercise classes with funding from Public Health. The initiation of two community classes is planned from September 2018 with three more planned over subsequent months.

Next steps:

- A marketing campaign designed to encourage the uptake of strength and balance exercise programmes is in the final stages of development. A communications toolkit is being finalised following engagement with the target audience, women aged 70-79 years. The campaign will launch on 1st October in line with International Older People's Day and with support from partners.
- North West Anglia NHS Foundation Trust have set up a working group, including representation from Public Health, the Clinical Commissioning Group and the National Osteoporosis Society, to develop a business case strengthening the Fracture Liaison Service (FLS) at Peterborough City Hospital and establishing an FLS at Hinchingbrooke Hospital. The plan is for submission of a business case in summer 2018.

- The new Cambridgeshire and Peterborough Falls Prevention Strategy Group is driving forward key national priorities around falls prevention guided by recent Public Health England documents and Rightcare pathway.
- The Falls and Fractures Specialist Nurse in Peterborough City Hospital has agreed to work in partnership to strengthen links between the acute and community sector falls prevention pathways. Delivering more multi-factorial falls risk assessments in the acute setting has been identified as a priority. A workshop is being arranged to take this forward.

Expanded Community Heart Failure service in Peterborough

Referrals into the service have increased to by around 50 per month, up from 16-18 before the project began. The majority of these are from the acute Trusts, although referrals from GPs continue to increase.

97% of patients are receiving a first clinical contact within two weeks of referral.

The expanded service in Huntingdonshire is now receiving approximately 20 referrals a month.

The team attends multi-disciplinary team (MDT) meetings with the cardiologists and heart failure nurses at Peterborough City Hospital and Hinchingbrooke hospital to discuss patient management.

8/10 of Cambridgeshire and Peterborough NHS Foundation Trust (CPFT) community heart failure nurses will complete the distance learning chronic heart failure module run by Health Education England during August.

The Consultant Heart Failure Nurse continues to provide the heart failure nurses with support, education, supervision and ensures as equal service is offered to all our community patients.

Developing an Integrated Neighbourhood Team Approach in Peterborough

As a health and care system we are committed to developing a place-based approach, moving away from focusing on our own organisational needs to working collaboratively to deliver what is in the best interest of our patients and communities.

We know that by working together in an Integrated Neighbourhood Team approach, we can better identify those most at risk of becoming vulnerable or whose needs could escalate. By taking proactive steps, we can reduce their need for in hospital care.

We want to build upon the Neighbourhood Team approach that is already established and develop this further, putting in place leadership teams made up of a GP, Neighbourhood Team Manager and Social Care Lead who will jointly unblock issues, oversee the prioritisation of resources and support new ways of working.

This is an important first step to working closer together, removing barriers and supporting each other to deliver better and more joined-up care to our patients.

By bringing together the different skills, assets and resources within a neighbourhood, drawing upon the wealth of expertise and experience in a collective way will help us jointly address the challenges we all face.

Dementia update

The aims of the project are:

- A reduction in non-elective admissions of dementia patients
- Increased End of Life Care Training (EOLC) training delivered to CPFT staff
- An increased number of Care Homes receiving dementia training
- Deliver Dementia training to GP practice staff

The dementia project has been very successful in its recruitment of staff to date.

In the first six months the project has:

- Trained 51 out of the target of 100 staff in End of Life Care
- Engaged 61 members of staff in workshops on the incidence of Advanced Care Planning to support this and the conversations around this being reported by staff on the patients record
- Delivered training at 33 out of a target of 41 care homes, training 313 out of 639 staff by the end of June
- Increased Dementia Intensive Support (DIST) activity in the North of the area, with the service now having approximately two thirds more face to face contacts than before the project commenced

Diabetes Update

Cambridgeshire and Peterborough STP have been successful in securing national funding through the national diabetes treatment and care programme to help improve outcomes for people with diabetes in Cambridgeshire and Peterborough. This includes: increasing attendance at Structured Education, improving achievement of NICE recommended treatment targets, and implementation of a multidisciplinary foot care team at North West Anglia NHS Foundation Trust. We are now in year 2 of implementing the diabetes programme using the national bid funds.

- **Structured Education**. The national funding means that Diabetes Education and Self-Management for Ongoing and Newly Diagnosed (DESMOND) courses are now available for all people with Type 2 diabetes, and not just those who are newly diagnosed. In Peterborough 350 attendees were recorded from 1st April -30th June 2018 exceeding a target was 336. A big part of our plans for 2018/19 is to focus on a public communications campaign to help raise awareness of the additional sessions, and the importance of attending. An

additional 19 trainers have been trained to deliver DESMOND courses, bringing the total trained up to 41 people.

- For Type 1 diabetes education; the Peterborough Dose Adjustment Course (PDAC) 4-day courses and PDAC bites courses being offered for young people in the Peterborough area. We have exceeded the target attends for these courses.
- **Treatment & Care**. We have implemented Healthy Conversation courses for Primary Care, Virtual Clinical reviews and practice visits with diabetes specialist teams, including the new Diabetes Care Technicians team. Specifically, in Peterborough to date they have been able to offer 10 practices this specialist team support.
- The **Multidisciplinary Footcare Team** at NWAngliaFT has been in place since October 2017 and is delivering six-monthly multidisciplinary footcare clinics, alternating between Hinchingbrooke Hospital and Peterborough City Hospital. The Multidisciplinary Footcare Team has developed a foot care training programme for acute and primary care staff that is delivered by the podiatry team.
- The **National Diabetes Prevention Programme** has been rolled out across the area. We have had good engagement with practices with the programme and this has been seen particularly in the Peterborough area which has a high prevalence of type 2 diabetes. For the National Diabetes Prevention Programme, they have received 1,456 referrals (April 2018 – June 2018).
- There is a **local enhanced service** in place that 24 Peterborough practices have signed up to. This is to support their engagement with the diabetes specialist teams, and part of this is to attend Virtual Clinical Review sessions with Consultant Diabetologists and Diabetes Specialist Nurses. This is designed to be an educational session to support patient management in primary care. The aim is to support improvement in treatment outcomes for patients, specifically control of the NICE recommended treatment targets. Practices that haven't taken up the local enhanced offer can still refer to the specialist teams and virtual clinics.

Future Focus is to:

- increase attendance at diabetes structured education;
- continue improvements in achieving the NICE recommended treatment targets;
- ensure full implementation of multidisciplinary foot care team at NWAFT
- continue Implementation of the National Diabetes Prevention Programme

We have been working with Diabetes UK (DUK) to set up Public Engagement Events in each of the four localities (Cambridge, Fens, Hunts and Peterborough) to enable people to feedback their views on current diabetes services and future plans. The ones in Cambridge and Peterborough took place in November 2017, with the Hunts and Fens events taking place in April 2018. We have had good engagement with the local diabetes specialist teams and will collate and review the feedback we have received with the DUK team to help inform our plans for 2018/19.

Training GPs in Suicide Prevention Update

This project is led by the GP Training Coordinator at MIND, having engaged the community through the STOP Suicide campaign, the next stage of the project was to ensure that practical professional support is available in Peterborough and Cambridgeshire to those who need it

MIND have been implementing and delivering the evidence based 'Connecting with People' suicide prevention training to GPs.
We know that 40% of all GP appointments now involve mental health ill health but that current initial training for GPs can be limited - only one of the 21 compulsory modules is specifically dedicated to mental health.

This is an area for concern as GPs are likely to encounter individuals in mental health crisis and are in a prime position to identify the warning signs of suicide in others.

The aim of the project is to train at one GP from every surgery in Peterborough and Cambridgeshire to ensure that individuals in our community can access high-level, appropriate support when necessary.

Although still in its early stages, 35 GPs and a further 56 Primary Care staff have already been trained with more sessions planned

HEALTH SCRUTINY COMMITTEE	AGENDA ITEM No. 6
17 SEPTEMBER 2018	PUBLIC REPORT

Report of:	Cambridgeshire and Peterborough Clinical Commissioning Group	
Contact Officer(s):	Jessica Bawden, Director of Corporate Affairs, Cambridgeshire and Peterborough CCG	Tel. 01223 725400

NHS CONSTITUTION INCLUDING TARGETS AND PERFORMANCE

RECOMMENDATIONS
It is recommended that Peterborough Health Scrutiny Committee: 1. Note the NHS Constitution, as well as the current performance of local health services benchmarked against the pledges made within the Constitution.

1. ORIGIN OF REPORT

1.1 This report has been compiled in response to a question from Councillors.

2. PURPOSE AND REASON FOR REPORT

2.1 This report examines what people can expect from the NHS constitution and how the situation currently compares in Peterborough.

2.2 This report is for the Health Scrutiny Committee to consider under its Terms of Reference Part 3, Section 4 - Overview and Scrutiny Functions, paragraph No. 2.1 Functions determined by Council - Public Health and Scrutiny of the NHS and NHS providers.

3. BACKGROUND AND KEY ISSUES

3.1 The NHS Constitution for England pledges the national standards for health treatment as follows:

"This Constitution establishes the principles and values of the NHS in England. It sets out rights to which patients, public and staff are entitled, and pledges which the NHS is committed to achieve, together with responsibilities, which the public, patients and staff owe to one another to ensure that the NHS operates fairly and effectively. The Secretary of State for Health, all NHS bodies, private and voluntary sector providers supplying NHS services, and local authorities in the exercise of their public health functions are required by law to take account of this Constitution in their decisions and actions. References in this document to the NHS and NHS services include local authority public health services, but references to NHS bodies do not include local authorities." [p2 – for more see Background Documents]

3.2 The NHS Constitution Handbook sets out these standards in greater detail. *Part III: Patients and the public* covers: Access to health services; Quality of care and environment; Nationally approved treatments, drugs and programmes; Respect, consent and confidentiality; Informed choice; Involvement in your healthcare and in the NHS; Complaint and redress; and Patient and public responsibilities.

3.3 Page 25 of the Handbook refers to the responsibility Clinical Commissioning Groups have for commissioning most local health services. The CCG is expected to "assess the health

requirements of the populations they serve, take account of inequalities in access to and outcomes from healthcare services, and commission the services that they consider necessary to meet the population's needs.

"CCGs are working closely with their local authority, and its partners including Health and Wellbeing Boards and Local Healthwatch, to assess and address local needs across health, public health and social care through joint strategic needs assessments and local commissioning plans."

The CCG is pleased to report and demonstrate ongoing engagement with Local Authorities, Health and Wellbeing Boards and Healthwatch as indicated above. It continues to welcome input from Councillors on the Peterborough Scrutiny Health Committee as part of this.

3.4 Pages 31-34 of the Handbook refer to patients' right to access services within specific waiting times, and the NHS pledge "to provide convenient, easy access to services within the waiting times set out in this Handbook". This includes a 'referral to treatment' (RTT) time of 18 weeks maximum for non-urgent conditions; to be seen by a cancer specialist within a maximum of two weeks where appropriate; and for patients to wait a maximum of four hours in A&E – from arrival to admission, transfer or discharge. In detail:

"**What this right means for patients**
You have the right to:

- start your consultant-led treatment within a maximum of 18 weeks from referral for non-urgent conditions; and
- be seen by a cancer specialist within a maximum of two weeks from GP referral for urgent referrals where cancer is suspected.

If this is not possible, the clinical commissioning group or NHS England, which commissions and funds your treatment, must take all reasonable steps to offer a suitable alternative provider, or if there is more than one, a range of suitable alternative providers, that would be able to see or treat you more quickly than the provider to which you were referred. A suitable alternative provider is one that can provide clinically appropriate treatment and is commissioned by a clinical commissioning group or NHS England. You will need to contact either the provider you have been referred to or your local clinical commissioning group before alternatives can be investigated for you. Your clinical commissioning group or NHS England must take all reasonable steps to meet your request.

Your right to start treatment within 18 weeks from referral will include treatments where a consultant retains overall clinical responsibility for the service or team, or for your treatment. This means the consultant will not necessarily be physically present for each appointment, but will take overall responsibility for your care. The setting of your consultant-led treatment, for example whether hospital based or in a GP-based clinic, will not affect your right to start treatment within 18 weeks. (for information on mental health services, where the first waiting time standards are now being implemented, see *)

Exceptions
The right to treatment is subject to various exceptions. In particular, the right to treatment within 18 weeks from referral will cease to apply in circumstances where:

- you choose to wait longer;
- delaying the start of your treatment is in your best clinical interests, for example where smoking cessation or weight management is likely to improve the outcome of the treatment;
- it is clinically appropriate for your condition to be actively monitored in secondary care without clinical intervention or diagnostic procedures at that stage;
- you fail to attend appointments which you had chosen from a set of reasonable options; or
- the treatment is no longer necessary.

The following services are not covered by the right:

- mental health services that are not consultant-led*
- maternity services; and
- public health services provided or commissioned by local authorities.

*The first mental health access and waiting time standards are currently being introduced and the Government has committed that by 31st March 2016, 75% of people accessing psychological therapies should do so within 6 weeks, 95% of people accessing psychological therapies should do so within 18 weeks, and 50% of people experiencing a first episode of psychosis should access early intervention in psychosis services within 2 weeks."

"There are a number of government pledges on waiting times, including:

- a maximum one month (31-day) wait from diagnosis to first definitive treatment for all cancers;
- a maximum 31-day wait for subsequent treatment where the treatment is surgery;
- a maximum 31-day wait for subsequent treatment where the treatment is a course of radiotherapy;
- a maximum 31-day wait for subsequent treatment where the treatment is an anti-cancer drug regimen;
- a maximum two month (62-day) wait from urgent referral for suspected cancer to first treatment for all cancers;
- a maximum 62-day wait from referral from an NHS cancer screening service to first definitive treatment for cancer;
- a maximum 62-day wait for first definitive treatment following a consultant's decision to upgrade the priority of the patient (all cancers);
- a maximum two-week wait to see a specialist for all patients referred for investigation of breast symptoms, even if cancer is not initially suspected;
- a maximum four-hour wait in A&E from arrival to admission, transfer or discharge;
- patients waiting for a diagnostic test should have been waiting less than 6 weeks from referral;
- a maximum 7-day wait for follow-up after discharge from psychiatric in-patient care for people under adult mental illness specialties on Care Programme Approach.
- all patients who have operations cancelled, on or after the day of admission (including the day of surgery), for non-clinical reasons to be offered another binding date within 28 days, or the patient's treatment to be funded at the time and hospital of the patient's choice; and
- all ambulance trusts to respond to 75 per cent of Category A calls within eight minutes and to respond to 95 per cent of Category A calls within 19 minutes of a request being made for a fully equipped ambulance vehicle (car or ambulance) able to transport the patient in a clinically safe manner."

The planning guidance for 2018/19 (Refreshing NHS Plans for 2018/19) states that commissioners and providers should plan that their RTT waiting list will be no higher in March 2019 than in March 2018.

"In addition, local authorities with public health responsibilities should bear in mind that it is best practice for the care of patients and their sexual partners to offer genito-urinary medicine appointments as soon as possible, and that the clinical evidence indicates a maximum of 48 hours."

See Background Documents for further reading.

3.5 Cambridgeshire and Peterborough CCG regularly reports on its performance against these standards, as well as against its own targets, in an Activity report to the Governing Body. The latest report in July covered activity at Month 2 (CCG wide). Key points include;

- All referrals are higher than plan by 5.5% - believed to be partially due to the prolonged and severe 2017/18 winter and its subsequent impact into 2018/19
- Outpatients appointments are slightly more than 10% above plan
- Planned procedures are 2.9% below plan
- Unplanned spells for emergency activity are 0.8% above plan
- A&E attendances are 3.5% below plan

Mitigating actions to be taken are:

- GP Referrals - GP practice visits: cohort 1 (30 highest referring practices) to be visited by end of July (on track; visits commenced; all visits booked); cohort 2 (46 practices) to be visited by end of September (on track, booking commenced).
- Other referrals - patient level review of Consultant referrals; to understand adherence to policy, coding, change of pathways, tertiary referrals. Also to relieve pressure on acute medicine and patient journey. To begin mid-July.
- First Outpatients - whole system Dermatology summit took place during July 2018, to discuss provision and increased demand. Implementation of high impact interventions in Ophthalmology in July.
- Follow Up Outpatients – Trust-wide initiatives to move to telephone follow up, taking into account any risks associated with this change.
- Planned care – Clinical policy development, revision and implementation. Continue the move to Outpatient from Day Case activity.
- Unplanned care – an Ambulatory Care Summit took place on 29 June 2018 to share best practice and increase this throughout Cambridgeshire and Peterborough (specifically for Cambridge University Hospitals).

To conclude, the CCG has seen in some areas, over performance versus plan up to the end of the current reporting period. It is taking mitigating actions in all over performing areas and despite the limited 2018/19 financial impact of activity changes it is clear that it must deliver its activity plan for 2018/19.

See Background Documents for further reading.

3.6 The CCG can also report current performance, and how this compares to previous years, across three areas:

1. NHS Constitution and other Key Performance Indicators (KPIs)
2. NHS Outcomes Framework
3. Improvement and Assessment Framework clinical priority ratings: 2016, 2017 and 2018.

As follows;

NHS Constitution and other Key Performance Indicators (KPIs)

Directorate	Indicator	Target / Threshold	2016 / 17 Full Year	2017 / 18 Full Year	2018 / 19 YTD	2018 / 19 YTD is at:
Integrated Care	Estimated diagnosis rate for people with dementia	67%	61.3%	65.2%	64.2%	Jun'18
	MH - completed therapy and are moving to recovery	50%	47.7%	50.0%	51.0%	Jun'18

	Mental Health - CPA follow up < 7 days	92%	95.9%	95.9%	91.6%	May'18
Planned Care	Cancer - 2 week wait	93%	95.3%	95.2%	90.8%	May'18
	Cancer - 2 week wait breast	93%	95.9%	95.7%	94.6%	May'18
	Cancer - 31 day first definitive treatment	96%	98.0%	97.8%	97.1%	May'18
	Cancer - 31 day subsequent surgery	94%	97.5%	94.0%	95.7%	May'18
	Cancer - 31 day subsequent drug	98%	99.8%	99.0%	100.0%	May'18
	Cancer - 31 day subsequent radiotherapy	94%	97.0%	97.5%	98.4%	May'18
	Cancer - 62 day first definitive treatment	85%	84.9%	85.0%	81.3%	May'18
	Cancer - 62 day screening	90%	92.1%	87.3%	**81.4%**	May'18
	RTT % in 18 weeks	92%	93.0%	91.4%	89.9%	May'18
	Diagnostics - < 6 weeks	99%	97.7%	98.2%	96.9%	May'18
Quality and Safety	Safety - Incidence of MRSA (CCG/Trust Assigned)	0	0	4	2	Jun'18
	Safety - Incidence of C difficile	188	154	192	31	Jun'18
	Gram negative blood stream infections (GNBSI) rolling 12 month total	481	**524**	**557**	**562**	12 mths to May'18
	Respect: Mixed Sex Accommodation	0	**28**	**25**	**10**	May'18
	VTE Risk Assessment	95%	97.0%	96.5%	n/a	n/a
	Proportion of cases with a positive NHS CHC checklist, where the NHS CHC eligibility decision is made by the CCG within 28 days.	80%	n/a	**59.7%**	97.0%	Jun'18
	Proportion of all full NHS Continuing Healthcare assessments completed in an acute hospital setting.	15%	n/a	**33.9%**	3.3%	Jun'18
	Anti-microbial resistance: Appropriate prescribing of antibiotics in primary care	1.163	1.104	1.077	1.079	Apr'18
	Anti-microbial resistance: Appropriate prescribing of broad spectrum antibiotics in primary care	11%	12.4%	12.4%	12.4%	Apr'18
	Inappropriate antibiotic prescribing for UTI in primary care: Trimethoprim: Nitrofurantoin prescribing ratio	1.525	n/a	1.022	0.974	Apr'18
	Inappropriate antibiotic prescribing for UTI in primary care: number of trimethoprim items prescribed to patients aged 70 years+	21,795	n/a	19,436	19,163	Apr'18
Urgent and Emergency Care	A&E waits % in 4 hours	95.0%	**82.8%**	**86.9%**	**89.1%**	Jun'18
	Delayed Transfers of Care (bed days lost as % of occupied bed days)	3.5%	7.4%	6.7%	6.8%	May'18

	Ambulance Response Times: C1 an immediate response to a life threatening condition <7mins	07:00	n/a	08:47	08:22	May'18
	Ambulance Response Times: C2 serious condition <18mins	18:00	n/a	27:41	23:51	May'18
	Ambulance Response Times: C3 urgent problem <120mins	120:00	n/a	82:09	65:01	May'18
	Ambulance Response Times: C4 non-urgent problem <180mins	180:00	n/a	102:25	78:00	May'18

NHS Outcomes Framework (table 1 CCG; table 2 England for comparison)

Table 1: CCG

Ref	Indicator	CCG							
		2010	2011	2012	2013	2014	2015	2016	Trend
CCG OIS 1.1	Potential years of life lost (PYLL) from causes considered amenable to healthcare per 100,000	1,829.0	1,708.3	1,677.6	1,883.8	1,728.6			
CCG OIS 1.25	Neonatal mortality and stillbirth rate per 1,000 live births and stillbirths				5.0	7.9	5.3	7.3	
CCG OIS 2.1	Health-related quality of life for people with long-term conditions, average adjusted health status (EQ-5D™) score			0.779	0.769	0.763	0.769	0.761	
CCG OIS 2.2	Proportion of people who are feeling supported to manage their condition, directly standardised percentage			69.6%	67.9%	66.2%	65.4%	64.8%	
CCG OIS 3.1	Emergency admissions for acute conditions that should not usually require hospital admission, dasr per 100,000	925.2	967.3	1,040.1	1,055.0	1,147.7	1,177.8	1,204.3	

Table 2: England

Ref	Indicator	England							
		2010	2011	2012	2013	2014	2015	2016	Trend
CCG OIS 1.1	Potential years of life lost (PYLL) from causes considered amenable to healthcare per 100,000	2,082.1	2,041.7	2,003.1	2,027.4	2,064.5			
CCG OIS 1.25	Neonatal mortality and stillbirth rate per 1,000 live births and stillbirths				7.3	7.1	7.0	7.1	
CCG OIS 2.1	Health-related quality of life for people with long-term conditions, average adjusted health status (EQ-5D™) score			0.743	0.744	0.743	0.743	0.741	
CCG OIS 2.2	Proportion of people who are feeling supported to manage their condition, directly standardised percentage			66.7%	65.6%	65.1%	64.4%	64.3%	
CCG OIS 3.1	Emergency admissions for acute conditions that should not usually require hospital admission, dasr per 100,000	1,069.3	1,084.6	1,181.9	1,180.5	1,273.0	1,314.2	1,357.0	

Improvement and Assessment Framework clinical priority ratings: 2016, 2017 and 2018

Clinical Priority	Indicator	Code	Jul'16 Assessment	Jul'17 Assessment	Jul'18 Assessment
Diabetes	Patients who achieved NICE targets	103a	Greatest need for improvement	Inadequate	Not yet assessed
	Attendance of structured education course	103b			
Cancer	Cancers diagnosed at early stage	122a	Needs improvement	Outstanding	Outstanding
	Cancer 62 days of referral to treatment	122b			
	One-year survival from all cancers	122c			
	Cancer patient experience	122d			
Mental Health	IAPT recovery rate	123a	Needs improvement	Requires Improvement	Not yet assessed
	New: IAPT access rate	123b			
	EIP 2 week referral	123c			
	MH - CYP mental health	123d			
	MH - Crisis care and liaison	123e			
	MH - OAP	123f			
Learning Disability	LD - reliance on specialist IP care	124a	Needs improvement	Not assessed	Not yet assessed
	LD - annual health check	124b			
	New: Completeness of GP LD register	124c			
Maternity	Neonatal mortality and stillbirths	125a	Needs improvement	Not assessed	Requires improvement
	Experience of maternity services	125b			
	Choices in maternity services	125c			
	Maternal smoking at delivery	125d			
Dementia	Dementia diagnosis rate	126a	Greatest need for improvement	Good	Not yet assessed
	Dementia post diagnostic support	126b			
C&P CCG Overall Rating:			Inadequate	Requires Improvement	Inadequate

3.7 **Local A&E Four Hour Performance**

The CCG is furthermore able to provide data for the North West Anglia NHS Foundation Trust (NWAFT) for the months of April, May and June 2018, plus comment on next steps as follows:

Peterborough Hospital is part of the North West Anglia NHS Foundation Trust (NWAFT). NWAFT is not meeting the national target for 95% of patients to be seen within 4 hours in the Accident and Emergency department. However, as part of a plan agreed with NHS England, the Trust has a recovery trajectory to reach 90% by August 2018 and 95% by March 2019, to bring the Trust back in line with the national target. At both of the NWAFT hospitals (Peterborough and Hinchingbrooke) this trajectory is now being met.

The performances at each of the hospitals and the average across the Trust are as follows:

At Peterborough City Hospital

Target: **95%**	Recovery : **Mar'19**	Apr'18	May'18	Jun'18
	Local Trajectory	**84.90%**	**86.00%**	**87.30%**
	Actual	**81.00%**	**83.20%**	**88.50%**

At Hinchingbrooke Hospital

Target: **95%**	Recovery : **Mar'19**	Apr'18	May'18	Jun'18
	Local Trajectory	**84.90%**	**86.00%**	**87.30%**
	Actual	**84.60%**	**88.30%**	**91.20%**

Average NWAFT Performance

Target: **95%**	Recovery : **Mar'19**	Apr'18	May'18	Jun'18
	Local Trajectory	**84.90%**	**86.00%**	**87.30%**
	Actual	**86.23%**	**87.90%**	**91.41%**

The actions agreed and currently being implemented by the Trust to help them achieve the recovery trajectory are:

- Implement a robust GP streaming model, to manage patients with a minor condition who attend A&E. This will reduce the number of these patients seen in A&E, and enable the hospital to achieve an A&E performance of 98% for those minor patients who do not transfer to the GP streaming service
- Realignment of the Emergency Department staffing to match patient demand, reduce variations in clinical practice and optimise the skills available by implementing a recruitment drive has been completed
- Maximise the use of the Ambulatory Care Unit
- Review and redesign the current Medical Assessment Unit (MAU) assessment and pathways, to ensure patients have a short stay on the unit
- Design and implement discharge pathways for the 'top admitting' conditions (those which create the highest number of admissions)
- Maximise the use and efficiency of the discharge lounge, and open a discharge lounge at Hinchingbrooke Hospital
- Implement daily ward discharge target ranges, to increase discharge efficiency
- Reinforce and embed a sustainable 'Red to Green' process (a visual management system to assist in the identification of wasted time in a patient's journey through hospital)
- Additional staff engagement and training where required
- Implement a system-wide Stranded Patients Taskforce at Peterborough City Hospital and at Hinchingbrooke. These groups aim to reduce the number of patients who have been in hospital for 21 days or more by identifying what these patients are waiting for, how many could be treated in a different setting and agree a plan to facilitate their discharge
- CCG-led 12-week intensive system-wide action plan, to implement Discharge to Assess Integrated Discharge Teams, SAFER (a process blending five elements of best practice) and effective referral management of complex discharges. The system overall

is required to reduce the number of Delayed Transfer of Care (DToC) patients to 3.5% (patients clinically assessed as safe to discharge but something is delaying discharge).

4. CONCLUSION

4.1 The CCG has detailed here;

1. What national standards are set by the NHS Constitution for England
2. How the CCG is currently performing, with regards to referral times, constitutional standards and KPIs, NHS Outcomes, and the Improvement and Assessment Framework
3. How the local Trust is currently performing, with regards to waiting times at A&E
4. Next steps for addressing 2) and 3) versus the Constitution standards.

The CCG is committed to working with its partners in the local health system, including NWAFT, to ensure all efforts are made to provide patient services in line with the national Constitution.

5. BACKGROUND DOCUMENTS

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

5.1 The NHS Constitution for England:
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/480482/NHS_Constitution_WEB.pdf

The Handbook to The NHS Constitution:
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/474450/NHS_Constitution_Handbook_v2.pdf

Cambridgeshire and Peterborough CCG Governing Body paper 03.3 – Activity Report Month 2.pdf – from 03 July 2018 meeting. Accessible via:
https://www.cambridgeshireandpeterboroughccg.nhs.uk/about-us/governing-body-meetings/governing-body-papers-2018-19/ ; select **03 July 2018** from **Categories** on the right hand side. The paper is on page 2 (click through the numbered pages below the list of papers)

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HEALTH SCRUTINY COMMITTEE	AGENDA ITEM No. 7
17 SEPTEMBER 2018	PUBLIC REPORT

Report of:	Cambridgeshire and Peterborough Clinical Commissioning Group	
Contact Officer(s):	Jessica Bawden, Director of Corporate Affairs, Cambridgeshire and Peterborough CCG	Tel. 01223 725400

CAMBRIDGESHIRE AND PETERBOROUGH CCG COMMISSIONING PLANS AND RESPONSE TO PWC REVIEW

RECOMMENDATIONS

It is recommended that Peterborough Health Scrutiny Committee:

1. Note the CCG's plans to address financial and operational challenges, for 2018/19 and beyond.

1. ORIGIN OF REPORT

1.1 This report to Scrutiny follows a request from Councillors for a planning update from the CCG.

2. PURPOSE AND REASON FOR REPORT

2.1 This report has been compiled to inform PHSC of the CCG's commissioning plans following the capacity and capability review by PriceWaterhouse Coopers (PWC).

2.2 This report is for the Health Scrutiny Committee to consider under its Terms of Reference Part 3, Section 4 - Overview and Scrutiny Functions, paragraph No. 2.1 Functions determined by Council - Public Health and Scrutiny of the NHS and NHS providers.

3. BACKGROUND AND KEY ISSUES

3.1 The CCG's 2017/18 outturn was a £42.1m deficit, in comparison to the £15.5m deficit control total agreed at the beginning of the year with NHS England. The reasons for this were:

- Greater demand for acute care than was planned for, costing an additional £19m
- A £6m increase in prescribing costs, due to national pricing changes
- A rise in the number of NHS Continuing Healthcare patients and the cost of the care that they need; as well as a need to address a large backlog of assessments. This has required investment in staffing, systems and processes costing an additional £14m
- Under-delivery of savings plans totalling £7.6m

Using underspends from other areas as well as contingencies, the CCG was able to arrive at the final deficit total of £42.1m.

3.2 The CCG asked PriceWaterhouse Coopers (PWC) to conduct an external review. Their 'Capability, capacity and independent review of financial position' was received by the Governing Body on 24 May 2018 (see Appendix 1). They found:

- A history which demonstrates a lack of grip, action, financial forecasting, financial control and delivery;
- Failure to deliver reduction in demand required to offset planned growth in the system;

- Instability at leadership level impacting on delivery and causing uncertainty for staff;
- Lack of experienced leadership and capacity, resulting in insufficient grip, control and energy to drive improvement;
- Ineffectiveness of the Governing Body to ensure the CCG met its statutory duties;
- A reactive approach, rather than a focus on sustained improvement;
- Lack of direction at the STP Delivery Unit (SDU), leading to lack of focus on supporting CCG recovery;
- Breakdown in governance and control in relation to finance, of which NHS Continuing Healthcare is a clear example;
- Concerns regarding the breadth of capacity and capability to deliver plans in 2018/19.

PWC made a number of recommendations, to be incorporated into an Improvement and Delivery Plan. The CCG was instructed to agree the Plan with the Auditors and NHS England, and to monitor progress at Governing Body meetings.

3.3 A detailed Improvement and Delivery Plan was first agreed by the CCG Governing Body in May. Following due monitoring at subsequent meetings, a final version of the Plan was ratified by NHS England on 01 August 2018 (see Appendix 3). The Plan:

- Identifies clear actions to address each of PWC's 18 recommendations (see Appendix 2);
- Plans for both rapid and long term changes;
- Aims to stabilise demand, contain costs, and create an environment for sustainable, transformational change;
- Continues to be closely monitored by the Governing Body, NHS England and Auditors;
- Divides responsibility for delivery between members of the Governing Body.

3.4 The Plan is based on good data and the CCG believes a 2018/19 deficit of £35.1m is achievable. There is still a large amount of risk, and the delivery of planned savings is key to the success of the Plan. NHS England has agreed our deficit figure and signed off our Improvement and Delivery Plan. The CCG continues to work closely with NHS England to ensure that there is a shared and detailed understanding of the Plan, to deliver an agreed deficit at the end of 2018/19 and the 'must dos' set out in the National Planning Guidance; and progress to 'best in class' on benchmarking data.

3.5 **MOVING FORWARDS**

As part of the Plan delivery, the CCG has agreed Guaranteed Income Contracts (GICs) with providers. This is a different way of working that the whole health system has bought in to. It aims to give people the opportunity to change ways of working, to do things differently and reconsider patient pathways.

3.6 This is crucial as the demand for acute services is increasing, and we need to change the way that urgent care works. Primary care and community services will also be crucial to the success of the health and care system in coming years. The new approach should enable clinicians from primary and secondary care to better work together, across organisational boundaries.

3.7 Our corporate objectives for 2018/19 are:

- Delivering the Improvement Plan
- Delivering the Financial Plan
- Delivering national must dos
- Ensuring clear oversight of patient safety and quality
- Ensuring robust governance arrangements
- Ensuring delivery of robust engagement and communications plans

3.8 **ADDRESSING SERVICE PRIORITIES**

In line with national priorities (must do's) the CCG is also addressing service priorities as follows:

- Mental Health – meeting the investment standard
- Cancer – implementing regional Cancer Alliance strategy with associated funding
- Primary Care – supporting new models of care and extended access to appointments

- Urgent and Emergency Care – focus on reducing Delayed Transfers of Care (DToCs)
- Learning Disabilities – planning for growth.

4. CONCLUSION

4.1 The CCG continues to monitor progress of the Improvement and Delivery Plan 2018/19, working closely with NHS England towards financial balance and operational control. The CCG welcomes comments and support from PHSC in this and values its input as a local stakeholder.

5. BACKGROUND DOCUMENTS

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

5.1 CCG Improvement and Delivery Plan 2018-2019: Governing Body Paper 24 May 2018 https://www.cambridgeshireandpeterboroughccg.nhs.uk/_resources/assets/inline/full/0/15686.pdf

5.2 Improvement and Delivery Plan 2018-2019: Governing Body Paper 07 August 2018 https://www.cambridgeshireandpeterboroughccg.nhs.uk/_resources/assets/inline/full/0/15478.pdf

6. APPENDICES

6.1 Appendix 1 - NHS Cambridgeshire and Peterborough CCG Capability, capacity and independent review of financial position FINAL At A Glance https://www.cambridgeshireandpeterboroughccg.nhs.uk/_resources/assets/inline/full/0/13776.pdf

6.2 Appendix 2 - PWC Recommendations https://www.cambridgeshireandpeterboroughccg.nhs.uk/_resources/assets/inline/full/0/13777.pdf

6.3 Appendix 3 - Improvement and Delivery Plan 2018-2019: 30 July 2018 https://www.cambridgeshireandpeterboroughccg.nhs.uk/_resources/assets/inline/full/0/15479.pdf

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Advisory

NHS Cambridgeshire & Peterborough CCG

Capability, capacity and independent review of financial position – FINAL

FINAL

26 March 2018

pwc

At a glance

PwC view

Our view on the likely FY17/18 outturn is in line with the CCG's most recent forecast of £48.2m.

Our risk assessment indicates a potential deficit of between £45m and £55.2m for FY17/18.

There has been a significant decline in the CCG's underlying performance year on year since FY14/15.

QIPP programmes have not had a material effect on demand and the issues with the CHC backlog are indicative of a culture of poor control and ineffective governance.

1 The CCG has asked us to provide an independent view of its financial position, capacity and capability.

Given the substantial deterioration in the CCG's financial performance in-year, the CCG has asked us to undertake an independent review of its financial position and the organisation's capability and capacity to deliver its plan.

We have conducted our review over a three week period through interview, document review and financial analysis. CCG management has supported our review.

2 The underlying deficit has increased year on year since FY14/15, with non-recurrent year end deals and reserve releases being used to achieve planned outturn positions.

There has been a continued deterioration in the CCG's underlying financial position:

- FY14/15 £8.0m deficit
- FY15/16 £15.7m deficit
- FY16/17 £32.3m deficit
- FY17/18 £49.2m forecast exit underlying deficit.

The main drivers of this have been acute and community expenditure. The exit underlying position for FY16/17, which was used for FY17/18 planning, was understated by £7.1m because it did not factor in non-recurrent actions taken after the plan submission: The CCG did not adapt its plan to reflect the need for an additional £7.1m QIPP.

3 The CCG's FY17/18 financial position has worsened from a planned £15.5m deficit control total to a forecast outturn position of £48.2m. The main drivers for the deterioration are acute over performance, QIPP under-delivery and a backlog of cases for Continuing Healthcare.

The CCG's financial deterioration has been driven mainly by over performance at CUHFT (£14.6m), QIPP under delivery, particularly in relation to demand management schemes (£8.8m), NCSO prescribing pressure (£6m) and a CHC backlog (£10m). These amounts have been offset by a number of underspends including primary care and delegated commissioning, plus central budget slippages and release of reserves.

All CCGs have been impacted by the NCSO prescribing issues. The issues with CHC resulted from poor governance and control, which allowed a large backlog of cases to build up.

Whilst there are issues with governance and control in the CCG, we note that the quality of working papers to support the financial analysis are of a better standard than at other CCGs we have worked with.

4 Our risk assessment of the FY17/18 forecast outturn indicates a potential range between £45m and £55.2m. Our view on the likely outturn is £48.2m which is in line with the CCG's recent reforecast.

The CCG's FOT for FY17/18 was updated from £44.7m to £48.2m for the Month 10 return to NHSE, primarily reflecting an increase in the financial risks arising from the year end deal with CUHFT.

At a glance

PwC view

The CCG has not taken sufficient action to address its declining underlying financial position. A lack of grip and control has continued this year.

The FY18/19 'do nothing' position of £83m deficit compared to a control total of £15m deficit gives rise to a gap of £68m (5.8%). Historically the CCG has not delivered significant recurrent QIPP of this magnitude. The CCG is continuing to work on bridging the gap.

The 'do nothing' plan does not include difficult decisions on pre-committed expenditure (c.£10m) and reserves (c.£10m). Action is being taken against these in CCG's plan to close the gap to the control total.

Our assessment indicates a FOT potential range of £45m to £55.2m, with a most likely view of £48.2m.

The main risks and potential upsides to the position are:

- Year end deal with CUHFT – the settlement is based on Associate activity levels. The value of this settlement has been impacted, in part, by the impact of national guidance to cancel elective care in January. We estimate an lower and upper range of +£2.3m and -£2.2m.
- CHC Backlog – the assumptions used to determine the risk are reasonable based on the information currently available; the precision of the estimate will increase as progress is made to clear the backlog. We estimate a risk range of +£1.4m to -£3.4m based on potential changes in CHC conversion rates.
- Balance sheet releases – we estimate an upper and lower range of -£0.4m and -£1.2m.

The CCG has not received permission from NHSE to release the 0.5% uncommitted reserve. If this permission is granted, there is £5.7m of mitigation available.

5 The CCG has a 'do nothing' forecast deficit of £83m for FY18/19 prior to QIPP.

The assumptions included in the plan are primarily based on actual growth percentages together with local STP assumptions, not all of which proved valid in FY17/18. The key area where underlying assumptions may change is in relation to the CHC backlog which has been included as recurrent in the underlying position.

As at the time of our review, the FY18/19 'do nothing' plan includes some figures which are estimates. The CCG is working to refine these estimates further.

The 'do nothing' plan includes items of budgeted pre-committed expenditure (c£10m) and reserves or contingencies (c.£10m) such as an acute growth and winter pressures reserve that the CCG recognises it will need to robustly assess and address. Actions to address these items are included in the gap to the control total while the CCG develops plans to minimise the impact of taking difficult decisions against pre-committed expenditure.

The level of QIPP required to achieve the control total in FY18/19 (5.8%) is significantly higher than the CCG's previous recurrent QIPP delivery levels. Releasing reserves and contingency of c.£10m would reduce QIPP delivery target to 4.9%, however this is still higher than historically achieved levels.

Although the CCG has historically reported QIPP delivery in line with targets (FY16/17: 4.5%), a significant proportion of this has been achieved through year end deals with providers and non recurrent schemes (FY17/18: 3.6% delivery FOT).

At a glance

PwC view

At the time of our fieldwork, which commenced on 25 January 2018, the CCG only had a partially complete list of QIPP ideas for FY18/19. This is significantly behind where we would expect it to be so close to the start of FY18/19.

The opportunity for improvement has been tested through benchmarking and is between £36m and £45m. Delivery of the whole opportunity would require an improvement in performance to upper quartile in every area and leaves a residual gap to the control total of £25m - £34m.

6 QIPP planning for FY18/19 started late, and is at least two months behind where it should be. The pace of development of FY18/19 QIPP has increased to support the financial recovery of the CCG.

Financial planning for FY18/19 started later than we would have expected, and is two months behind where we would expect it to have been when we commenced our fieldwork. Whilst work had been conducted across the health system looking for system savings, the first CCG QIPP long list was produced on 29 January 2018.

As at 15 February, the CCG has a summary view of the FY18/19 programme, with a total value of £21m (including the full year effect value of schemes from FY17/18) with 99 QIPP schemes. However, only 37 PIDs exist with a total value of £10m, and these PIDs lack detail which will reduce the likelihood of successful delivery.

In addition to the urgent action being taken to address this, the planning cycle for future financial years must be brought forward to avoid this position recurring.

7 Benchmarking data indicates that the size of the opportunity to improve is substantial, between £36m and £45m, but this will require a move to upper quartile performance in every benchmarked area.

The opportunity for improvement has been tested through benchmarking and is between £36m and £45m. This would require an improvement in performance to upper quartile in every area which will require robust plans, rigorous programme management and the highest levels of clinical engagement.

The total level of opportunity identified by benchmarking is insufficient to bridge the gap between the forecast deficit and the control total by £25m-£34m.

8 The CCG's control total for FY18/19 of a £15m deficit represents a significant challenge due to both the size of the financial gap and the capacity and capability of the CCG to deliver at pace.

The 'do nothing' forecast deficit of £83m is £68m from the £15m control total. There are three main areas that must be addressed to reduce the £68m gap: a) QIPP: The CCG is planning to deliver £45.6m of QIPP net of any implementation costs; b) Mitigation of pre-committed expenditure and cost pressures; and c) Consideration of releasing reserves and contingencies.

This is a very ambitious target and will require the delivery without fail of all plans, specifically: Support from providers in relation to guaranteed income contracts (GICs), rapid PID development and resolution of significant internal capacity and capability issues.

The CCG's delivery plan does not include, in some cases, difficult decisions in relation to pre-committed expenditure (c.£10m). However , in our view, these are not sufficient to offset risks in relation to the planned QIPP delivery and bridge the gap to the control total.

Our sensitivity analysis indicates a FY18/19 outturn range of between £35.8m deficit in a better case and £68.9m deficit in a worse case. There would need to be significant support put into the CCG to lower this range.

In order to return to financial stability, a multi year recovery plan is required to address the extensive issues we have identified and which are the root cause of the current organisational crisis.

At a glance

PwC view

The instability in the leadership team has not been conducive to effective planning and delivery. The CCG urgently needs a stable leadership team to move forwards effectively.

The CCG lacks experienced leadership capacity and capability. The overall structure and posts within the leadership team should be revised to meet the current challenge.

The CCG has become very reactive and the culture is not focussed on sustainable improvement. A medium term improvement plan encompassing both financial recovery and OD is required.

9 A significant level of instability in the CCG's leadership team over the last two years has impacted on the ability of the organisation to plan effectively and has caused a high degree of uncertainty for staff.

There has been recent significant turnover in the Executive team: The Interim Accountable Officer joined the CCG in October 2017 on a fixed term contract to 31 March 2018.

The Interim Chief Financial Officer commenced in post three weeks before our review started. We note that there have been four different individuals in the AO role and four individuals in the CFO role in FY17/18.

The Chief Nurse post is being filled by the Deputy Director of Nursing on an interim basis. The Director of Transformation for Urgent and Emergency Care is due to leave the CCG at the end of the month.

The CCG's former Turnaround Director left the organisation in November 2017.

We have also been told that there has also been a significant amount of churn at all levels in the organisation.

The instability in the leadership team, with a number of recent appointments and individuals acting into posts, also means that there is a relative lack of corporate memory and experience at Executive level.

The Executive team needs to be stabilised with experienced permanent appointments made wherever possible, and long term interim appointments where substantive appointments are not viable.

10 The CCG has lacked experienced leadership capacity and capability. This has resulted in insufficient grip, control and energy in relation to driving improvement.

We have found some silo working and a lack of a corporate approach: With the significant churn in leadership roles, in our view, people have focussed on what they can control within their own portfolios and have not been held to account for delivery of performance overall. A Chief Operating Officer is needed to take responsibility for all commissioning activity and to address the silo working.

Clinical leadership is lacking within the Executive team: This should come from the appointment of a substantive Director of Nursing and the creation of a Clinical Director role.

Significant and substantial OD experience and capacity is needed within the Executive team, reporting to the Interim AO, to develop and deliver an OD plan to enable a sustained recovery. This role might have an associated system OD requirement.

The impact of the lack of experienced operational leadership has been a lack of grip and control. The issues in relation to CHC and the lack of a robust QIPP programme are a manifestation of this. There is insufficient leadership capacity and capability in relation to driving financial turnaround. A Financial Improvement Director, supported by dedicated resource, is required to drive financial recovery at pace.

Given the scale of the challenge at the CCG we believe the Interim AO should consider whether she has the capacity to deliver both the AO role and the STP leadership role in the short term.

At a glance

PwC view

Engagement and communication will be important in allaying stakeholder concerns and communicating that there is a clear plan to address the financial gap. The CCG should prioritise continuing to develop its communication with staff and health economy partners.

The System Delivery Unit (SDU) lacks direction, is not focussed on supporting the CCG's recovery and accountability is unclear.

Whilst there are several individuals with relevant skills and experience, as well as willingness within the SDU, the value of these individuals is not being realised to the benefit of the health system under the current operating model.

11 Continuous engagement and communication with CCG staff and health economy partners should be prioritised, to emphasise the scale of the financial challenge, the solutions being developed and the role of all stakeholders in developing a sustainable health economy.

The development and implementation of a clear communication and engagement plan should form part of the OD programme.

Investment in communication skills/experience will be needed to support this. We note that staff morale has been impacted by the level of management and leadership change at the CCG over the past two years. Engagement and communication will be important in allaying concerns and communicating that there is a very clear plan to address the financial gap.

12 The accountability and expectations of the SDU have not been clearly defined. The CCG should facilitate a review of the role of the SDU, to maximise its value for the health system.

The SDU accounts for a significant amount of resources, with in excess of 30 posts (albeit it there are a number of vacancies currently). A theme from our interviews is that the contribution of the SDU in relation to tangible outcomes that have provided significant value to the system has been limited. The SDU has drawn in resources from the CCG and partners, for example from the PMO at the CCG.

We note that the PMO led meetings to drive QIPP have happened less frequently and/or inconsistently at the CCG since September 2017. Therefore, the focus of CCG resources on the SDU may have had a short term negative effect on the pace and drive in relation to the CCG's own statutory responsibilities to develop robust financial plans.

The CCG should facilitate a review of the role and remit of the SDU for the STP partners' organisations. As an outcome from this review, accountability and clear objectives and outcomes for the SDU should be defined. Taking into account the level of resources available within the SDU, the CCG should ensure that the SDU role is defined to have maximum impact on recovering the overall financial position of the health system.

13 There has been a breakdown in governance and control in relation to finance, of which CHC is a clear example.

The CCG invited a peer reviewer to appraise its CHC processes and governance in November/December 2017. The peer reviewer identified weaknesses and a significant financial impact of a backlog of cases, which had not been processed and therefore were not factored into the historical financial position or forecasts.

The CCG has appointed a new lead for CHC and is currently reviewing the function. The CCG should process the backlog of CHC claims in a robust way to minimise appeals. The CCG should re-run its model with updated assumptions prior to submission of the final plan in April 2018 to ensure the estimate included for FY18/19 reflects the most up to date information.

At a glance

PwC view

Urgent action is required to regain control over CHC expenditure to address the extensive backlog and put in place appropriate management for the future. Contract management must also be reinstated to regain control over other significant areas of CCG spend.

The Governing Body has not complied with its statutory financial duty.

The CCG has largely completed the action plan from its previous Capacity and Capability review but the changes have not been embedded. There has been a tick box approach to governance rather than the required cultural change.

We have been told that contract management activity has not taken place in FY17/18 due to the system wide approach taken to population health management agreed through an MOU. We understand that the intention was to move away from enforcing contract penalties but that in practice this has resulted in an absence of contract management overall. Contract management must be reinstated as a priority in FY18/19 to ensure robust financial control is in place.

14 The Governing Body has not complied with its statutory duty in relation to the stewardship of public money. A Governing Body effectiveness review is required to define the detailed actions needed to make it fit for purpose.

The CCG has had an underlying deficit for a number of years and action has not been taken to address this in a sustainable, recurrent way. Based on our interviews, we identified that there is a perception that whilst the Governing Body asks questions, the level and type of scrutiny is less effective than it should be and information sources are not triangulated.

An updated independent review should be undertaken of the effectiveness of the Governing Body and its processes for seeking and receiving assurance over the robustness of plans and ongoing monitoring of implementation.

The effectiveness of Lay Members and Clinical Leaders should be considered on the Governing Body and its sub-committees, including clinical leadership at Clinical Executive Committee. Action should be taken to strengthen the financial capability of Governing Body members through additional training and the recruitment of one or more Lay Members with NHS finance experience.

There is also a need for a review of the governance failings in relation to CHC to identify the lessons learnt.

15 The finance function and other support functions need to be reviewed and vacancies filled.

The CCG should review the finance, contracts and BI functions to ensure that accountability is clearly defined and that the structure and roles within these functions is right, taking into account the role of the SDU and resources within it. Duplication of effort between the SDU and CCG functions is currently evident and must cease. Vacancies within the finance function and contracting team should be filled urgently in order for there to be sufficient capacity and capability within this function to support the CGG's financial information and contract management needs.

At a glance

PwC view

The PMO is not fit for purpose in its current form. A sponsoring Executive needs to be identified to re-define accountability and clarify structures and purpose.

Support functions including finance should be reviewed in the context of the SDU.

We are deeply concerned with the breadth and depth of capacity and capability issues of the CCG coupled with the scale of the financial challenge in FY18/19. There is a need for the development of an organisational improvement plan including a detailed short and long term recovery plan.

16 The PMO lacks clear leadership, clarity of purpose and a mandate to drive and objectively assess delivery of the QIPP programme. The CCG also lacks a robust Business Intelligence function

There has been a lack of clear leadership and direction of the CCG's since Q3 17/18, a situation which remains.

This has been caused in part by confusion over the intention to integrate the CCG's and SDU's PMO functions.

The CCG should redefine the CCG PMO's remit, and identify a sponsoring Executive to lead this function. A CCG Head of PMO should be appointed to provide day to day leadership.

The CCG should implement Director led weekly financial recovery meetings across the programme, with PMO support. Detailed discussions of QIPP progress and implementation should be held at these meetings and action taken to address emerging risks and issues.

The current Business Intelligence (BI) function is the result of integration of the SDU's and PMO's BI functions. It is currently not operating at the pace and extent required to drive improvement forward and to support the CCG's recovery.

17 Concluding comments: We are deeply concerned with the breadth and depth of capacity and capability issues of the CCG coupled with the scale of the financial challenge in FY18/19.

Based on our experience of working with a large number of CCGs nationally, the issues facing the CCG in relation to capacity, capability and financial recovery, combined with the financial challenge facing the local health system, are among the broadest and deepest set of issues facing any CCG we have worked with.

The Governing Body must take responsibility for the leadership and governance issues identified and urgently put in place plans to address them.

It will take the CCG and the system a number of years to achieve financial sustainability, however, with additional support and capacity the CCG should be able to make significant progress in addressing its underlying deficit in FY18/19. This will require difficult decisions to be made by the CCG and a constant focus on financial recovery at the same time as working with its system partners to ensure the deficit is not just moved around the system.

18 Next steps.

We set out on the following pages a detailed set of recommendations that should be developed into a full action plan to be owned by the Governing Body and agreed with NHSE.

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Annex B – PwC Recommendations

Ref	Area	Action
1	Leadership	A. The Governing Body must take responsibility for the leadership and governance issues identified and urgently put in place plans to address them. These plans should include, but not be limited to, the actions set out below. B. A clearly articulated leadership strategy and structure for the CCG is needed.
2	Executive team	The Executive team must be stabilised urgently, with experienced permanent appointments made wherever possible, or long term fixed appointments where substantive appointments cannot be made in the short term. *In our draft report, we set out that this should be completed by 31 March 2018. We note that this has not been achieved due to a delay in confirming the AO's role.
3	Executive team	The Executive team needs additional capability and capacity in order to address the challenges the CCG is facing: A. The CCG AO should consider whether she has capacity in the short term to continue to be the STP lead. B. A Chief Operating Officer is needed to take overall responsibility for the delivery of commissioning activities and to eliminate the current silo working. C. A Financial Recovery / Improvement Director is required to focus on the development and delivery of a multi-year financial recovery plan to return the CCG to normal business rules. The Financial Recovery / Improvement Director should be supported by appropriate delivery resource, experienced in financial recovery and improvement. D. Clinical leadership is needed within the Executive team: This should come from the appointment of a substantive Director of Nursing and the creation of a Clinical Director role. E. OD experience is needed within the Executive team, at least in the short-medium term, to develop and deliver an OD plan to enable financial recovery.
4	Improvement Plan and Financial Recovery Plan	A. A clearly defined Improvement Plan should be urgently developed to allow the CCG to map out how it will improve and by when; B. Set out a clearly defined multi-year Financial Recovery Plan, showing when the CCG will recover and return to NHS England business rules.
5	Org. recovery plan	A. A medium term organisational recovery plan should be developed, incorporating the detailed FRP, setting out the organisational development required to achieve financial recovery, including governance, leadership, structural change, culture and behaviours, training, communication and engagement. B. This should also include the consolidation of the CCG staff onto a smaller number of sites to enable the necessary increase in grip across all teams.
6	Governing Body	A. The CCG should review the effectiveness of the Governing Body and its processes for seeking and receiving assurance over the robustness of plans and ongoing monitoring of implementation. B. The effectiveness of Lay Members and Clinical Leaders should be considered on the Governing Body and its sub-committees, including clinical leadership at Clinical Executive Committee. C. Action should be taken to strengthen the financial capability of Governing Body members through additional training and the recruitment of Lay Members with NHS finance experience.
7	System support	The recovery of the CCG is necessary in order for the Cambridgeshire and Peterborough system as a whole to progress its integration agenda: In the short term the support of the system is required in order to prioritise the urgent need to stabilise the CCG, without which the system as a whole will be adversely affected.

8	SDU	A. The role and remit and leadership arrangements for the SDU should be clarified: Clear objectives, outcomes and accountabilities should be defined. B. Taking into account the level of resources available within the SDU, system stakeholders should ensure that the SDU role is defined to have maximum impact on recovering the overall financial position of the health system. C. The current overlap / duplication between SDU and CCG activities must cease.
9	CHC	A. The CCG should deliver its plan to process the backlog of CHC claims in a rapid but robust way to minimise appeals. B. The CCG should re-run its model with updated assumptions prior to submission of the final plan in April 2018 to ensure the estimate included for FY18/19 reflects the most up to date information. C. There should be an investigation into the circumstances surrounding the current CHC situation to identify the lessons learned.
10	Contract management	Robust contract management must be reinstated for FY18/19 to ensure that emerging risks to the financial position are contained and mitigated throughout the year. This should include: A. Clear ownership of each contract; B. Clear timetabling of the contract management and challenge process
11	Rapid FY18/19 QIPP development	A. The FY18/19 QIPP plan development process should be further accelerated to fill the gap with fully worked up schemes. B. Further focussed development meetings should be held to shore up the QIPP list with PIDs completed by end of March 2018. C. The timetable for this should be factored into the overall CCG improvement plan. D. Test the cost pressures, line by line, with a turnaround mindset. E. Set out lead indicators on QIPP delivery – With milestones reported regularly. F. Increase the frequency of the finance sub-committee, to scrutinise the recovery. G. Instigate a joint NHSI / NHSE steering committee, which has sight of monthly financial reports. H. Assess any additional funding options. I. Re-run unpalatable options generation and assessment process. J. Consider the need to re-run the CEP / Challenged Health Economy process.
12	PMO	A. The CCG should redefine the PMO's purpose, focussing it on the FY18/19 QIPP programme, and identify an Executive with responsibility for the PMO. B. A CCG Head of PMO should be appointed to provide day to day leadership. C. The PMO team should be appropriately retrained where necessary.
13	Monitoring financial recovery	The CCG should implement Director led weekly financial recovery meetings, with PMO support. Detailed discussions of QIPP progress and implementation should be discussed at these meetings and action taken to address any emerging risks and issues.
14	GP leadership and monitoring	The CCG should ensure that a dashboard driven system to compare GP practices is in place and is regularly discussed and monitored with GPs and practice managers. Introduction of this approach should be supported by OD focussed on GPs in delivery of the CCG's recovery. Each GP federation should have a nominated improvement lead
15	Focussed analysis of financial opportunity	The CCG should drill further into the benchmarking findings to assist with the pathway redesign process and to aid FY19/20 QIPP plan development.
16	FY19/20 QIPP planning and development	A. The planning cycle for the next financial year should be brought forward. B. The CCG should look to hold a FY19/20 kick off meeting in summer/early autumn 2018 to identify a long list of QIPP ideas. C. Further meetings should be held to identify a confirmed short list and PIDs drafted by November 2018.

		D. The timetable for this should be factored into the overall CCG improvement plan.
17	Revisit reserves and upside opportunity regularly	A. The reserves and upside areas identified in this review should be regularly reviewed and released where appropriate and possible.
18	Finance function restructure	A. The CCG should review the finance, contracts and BI teams to ensure that accountability is clearly defined and that the structure and roles within these functions is appropriate, taking into account the role of the SDU and the resources within it. B. Duplication of effort between the SDU and CCG functions should be avoided. C. Vacancies within the finance function should be recruited to in order to increase capacity to support the financial information needs of the CCG.

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Improvement and Delivery Plan 2018-2019

Date	Version	Authorised by
30th July 2018	Approved by NHSE on 1.08.2018	J Thomas (AO)
At the point of submission to NHSE, these dates and actions are finalised. The document will be reviewed and change control process applied monthly reported through NHSE and CCG Governing Body. The document is owned by the Governing Body who are accountable for its delivery.		

Content

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Summary Position – How we got here

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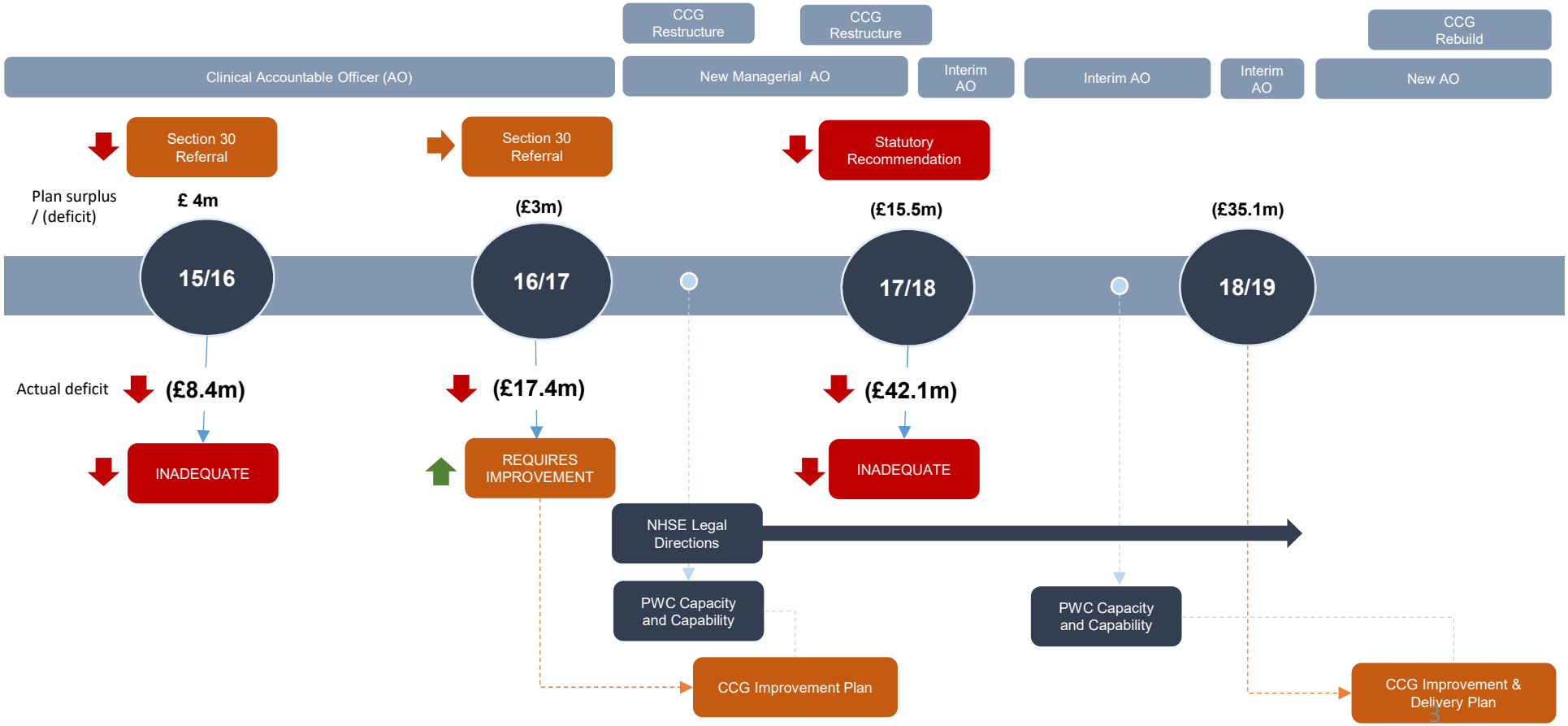
The CCG was rated "Inadequate" in the CCG Improvement and Assessment Framework for 2015/16 and was put under NHSE Legal Directions. A Capacity and Capability Review of Finance and Governance undertaken by PricewaterhouseCoopers LLP (PwC) led to the development of an Improvement Plan, progress to which contributed to a rating of "Requires Improvement" in 2016/17. The CCG remained under Legal Directions as a result of the underlying financial position.

For 2017/18, the CCG agreed a financial control total with NHSE of £15.5m deficit, however, the 2017/18 reported outturn is a £42.1m deficit, after adjusting for the release of the 0.5% national risk reserve the CCG is mandated to retain through the year. This position signals a failure in the CCG's statutory financial duties. There were four key drivers for the financial performance for 2017/18; acute over-performance, under delivery of QIPP, higher than anticipated growth in individual placements including the recognition of the backlog of cases within the CHC service and the national pricing concession issue within prescribing.



Summary Position – How we got here

Cambridgeshire and Peterborough Clinical Commissioning Group

Early in 2018, the CCG commissioned PwC to conduct a capability, capacity and independent review of financial plan which described significant failings across a number of areas of the CCG including a history which demonstrated a lack of grip, action, financial forecasting, financial control and delivery coupled with instability and lack of experienced leadership and capacity. All these issues have led to a breakdown in governance and control in relation to finance, of which NHS Continuing Healthcare was a clear example. The CCG Governing Body anticipates that the Annual Assessment rating will deteriorate and that NHS England Legal Directions will be refreshed.

External Audit has exercised its powers under Section 24 (Schedule 7) of the Local Audit and Accountability Act 2014 and has issued statutory recommendations to the CCG (which will also be reported to the Secretary of State and NHS England). These are set out below:-

a. The CCG should in response to the PwC report entitled 'NHS Cambridgeshire & Peterborough CCG – Capability, capacity and independent review of financial position (March 2018)', develop and formally agree a detailed improvement plan by 31 July 2018. The Improvement plan should be formally ratified by NHS England.
b. The CCG should report and monitor the implementation of the actions as a result of the response to the PwC report formally at each Governing Body meeting until all actions are complete.
c. The CCG must develop and formally agree a robust medium term financial plan to return to normal NHS business rules in a timeframe agreed by NHS England.

It is clear that there are three stages required to provide sustainable improvement:-

- Driving Immediate Improvement – delivering the recommendations from the PwC Report and requirements from NHSE;
- Meeting National Must Dos and CIAF Domains (Better Health, Better Care, Sustainability and Leadership);
- Transforming to an Integrated Care System.

The CCG has provided assurance to NHSE of our commitment to improve in these areas and to ensure that we deliver the Financial Plan for 2018-2019. The Governing Body will be accountable for the completion of the Improvement and Delivery Plan. Responsibility for delivering the Improvement and Delivery Plan will rest with the Chief Officer (Accountable Officer) supported by the Executive and Clinical Executive leadership team. There will also be a need to ensure close monitoring and scrutiny of actions to ensure that the improvements are effectively measured to provide assurance to the Governing Body and to NHSE. The Plan will be updated on a monthly basis and delivery closely scrutinised by the Committee Structure prior to presentation to the Governing Body at each meeting in public.

Why is 18/19 going to be different?

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Each of the below strategies on their own will not get the CCG to a sustainable position, all actions are required and are led jointly by the Chair and Accountable Officer.

1 NEW LEADERSHIP

- Newly appointed AO
- New CFO, COO and Medical Director recruitment commenced.
- Recruitment of new 2 Lay Members

2 RESULTS FOCUSED

- Clear financial plan with milestone to assure delivery
- New PMO and QIPP that triangulates QIPP with budget and activity
- Improved reporting based on data.

3 MITIGATED RISK

- Guaranteed income contracts with acute providers, limited acute overspend risk
- Increased management of risks and mitigations.

4 TRANSPARENCY

- Clear no surprises policy with NHSE and Governing Body
- Open book accounting with providers.
- Open approach internally and externally on communications (including MP's)

5 SYSTEM WORKING

- CCG at the heart of the STP and driving the ICS model.
- Focused areas for joint delivery and performance agreed as DTOC and AE.
- Integration of the SDU and CCG

2018/19 Corporate Objectives

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For 2018/19 for the CCG, we have to be very focused. Simply put we have to do what we said we would do and do it well. Our corporate objectives reflect this approach.

1. Delivering the Improvement Plan for 2018-2019 and beyond
2. Delivering the Financial Plan for 2018-2019
3. Delivering national must dos and service priorities set out in the National Planning Guidance
4. Ensuring clear oversight of patient safety and quality
5. Ensuring robust governance arrangements are in place to ensure the CCG delivers its statutory duties
6. Ensuring delivery of robust engagement and communications plans to support delivery

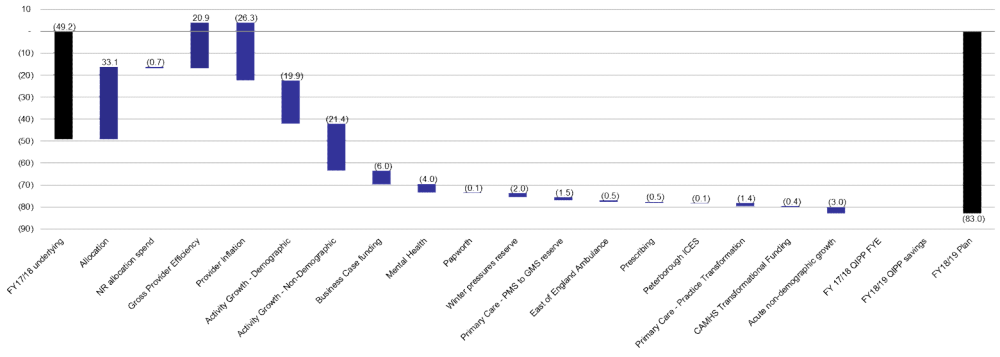
In order to deliver the above operationally we have to deliver 5 things, these 5 are all within our internal gift as an organisation:

- Create and sustain a strategic commissioning function that is fit for purpose and future proofed for development into the Integrated Care System;
- Deliver our QIPP commitment of £35m;
- Deliver specifically our medicines optimisation programme;
- Deliver improvements and results in CHC;
- Work with system partners to create tangible improvements in Delayed Transfers of Care and Emergency Department performance.

Context – 2017/18 to 2018/19

- The CCG and system do not have the capacity and capability to mobilise well worked up system plans by the start of the year.
- 2018/19 is a stabilisation and transition year for this system.
- Negotiated Guaranteed Income Contracts (GICs) with our material acutes to 'buy out' the risk of non-delivery of QIPP and in year growth, and align responsibility for reduction in activity with the investment made in admission avoidance schemes.
- QIPP progress and development is not well developed and is a priority area.
- This plan gets us to a sustainable transformed system that is an Integrated Care System and we have system buy-in to ensuring all parties understand what their role is.
- £35m deficit is a challenging and achievable plan, with several risks that are being mitigated.
- 0.5% contingency is low, therefore we would look for in year benefit against other areas like primary care and RTT to provide operational accounting flexibility.

Doing nothing is not an option …



- **FY17/18 underlying (£49.2):** Included within this underlying opening position is the CHC backlog estimate of £10m as a recurrent pressure going forward.
- **Allocation and non-recurrent allocation spend (+£32.4m):** This reflects resource uplift allocated centrally and non-recurrent allocation spend for IRS and NHS PS changes.
- **Planning adjustments (-£46.7m):** This reflects the national tariff guidance and our activity growth assumptions (primarily guided by the STP growth assumptions).
- **Pre-commitments (-£10.1m):** Business case funding (£6m): In FY17/18 the CCG made contributions to the system investment fund. Pooled funds have been used to fund schemes for 12 months.

2018/19 Financial Plan

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£m	17/18 FOT	2017/18 Recurrent Exit position	Increase in allocation	Tariff Inflator/ Inflation	Growth	MHIS & GPFV	Other recurrent investments	Non-recurrent investments	Contingency	Other reserves	Planned QIPP	2018/19 Plan	Growth on recurrent exit
Allocation	1,149,272	1,143,103	37,919									1,181,022	3.3%
Expenditure													
Acute	584,262	581,292		4,668	23,367		5,456				-13,969	600,814	3.4%
Mental Health	85,947	88,299		85	2,218	1,429					-300	91,731	3.9%
Community Health Services	129,117	128,336		231	4,410						-5,500	127,477	-0.7%
Continuing Care	71,541	72,736		73	3,273						-7,500	68,582	-5.7%
Prescribing	118,415	115,533		116	5,550			500			-5,700	115,999	0.4%
Primary Care Services	30,376	29,831		119	671	1,395					-520	31,496	5.6%
Primary Care Co-commissioning	117,318	117,292			3,541						-1,500	119,333	1.7%
Other programme	36,720	34,815		30	543					-391		34,997	0.5%
Contingency		-							5,230			5,230	
Non Recurrent headroom	5,059	5,059							-5,059			0	
Running Costs	18,717	19,022		190				1,358		15	-153	20,432	7.4%
Unidentified QIPP												-	
Total spend	1,197,472	1,192,215	0	5,512	43,573	2,824	5,456	1,858	171	-376	-35,142	1,216,091	2.0%
Surplus/(defict)	-48,200	-49,112										-35,069	

Month 3 Position

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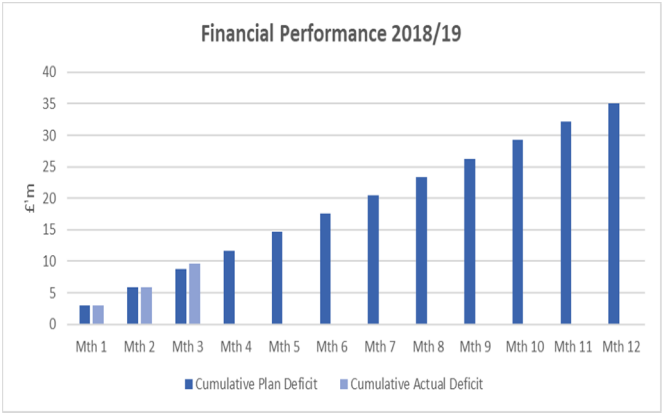
	YTD Budget £'000	YTD Actual £'000	Variance Fav/(adv) £'000	Annual Budget £'000	Forecast Outturn £'000	Variance Fav/(adv) £'000
Allocation	295,625	295,625	0	1,184,770	1,184,770	0
Acute Services	150,553	152,529	(1,976)	602,156	603,914	(1,758)
Mental Health Services	29,307	30,013	(707)	117,227	119,658	(2,431)
Community Services	25,699	25,876	(176)	102,798	102,999	(200)
Continuing Care	17,058	16,754	305	68,234	67,271	963
Primary Care	66,491	65,681	810	268,836	268,396	441
Other	10,176	9,178	998	40,156	37,169	2,986
Running Costs	5,108	5,179	(71)	20,432	20,432	0.0
Total Expenditure	304,393	305,210	(818)	1,219,839	1,219,839	0
In year deficit	(8,767)	(9,585)	(818)	(35,069)	(35,069)	0



- CCG spend is £818k over plan at month 3, and forecast outturn on plan
- Acute overspend driven by costs of Discharge to Assess (including winter beds overrun) and activity at The Queen Elizabeth, Kings Lynn. Winter beds were closed at the end of month 3. Recovering the D2A and QEKL position are 2 of the CCG's 3 priorities and the action to recover the financial position on these is detailed later in this pack.
- Mental Health YTD and FOT overspend due to the increase in s.117 placements costs
- Community YTD overspend due to slippage on QIPP delivery (plan phased in 12ths) – plan to recover by end of the year
- CHC underspend as a result of increased control on Stroke/ABI and core CHC spend
- 3 months of contingency has been released to deliver the year to date position and full contingency into FOT

Risks and Mitigations

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Risks and mitigations to 18/19 plan delivery	Total Risk	Original Plan risk comment	Mitigation comment	Mitigated Risk	In forecast	Residual risk
FY18/19 plan with QIPP	**-35.1**			**-35.1**	**-35.1**	
Plan risks and mitigations						
Acute Activity	-4	Activity and financial risk if GICs cannot be secured or are secured at higher than original planned value.	Achievement of GIC contracts – risk arises from NWAFT contract value higher than first planned but contingency vired to fund.	0	0	0
DTOC Riskshare agreement	-1.9	CCG contribution under the GIC if DTOCs increase over set amount reduced as nly applies to CUH	Implementation of Plan B DTOC transformation - Target not being achieved at start of July, assuming achievement from 1 september	-0.2	0	-0.2
Winter Beds – sustained capacity	-1	Winter beds opened as part of DTOC pressures in 17/18 – not currently able to close	System wide financial review of cost of Plan B – beds decommissioned end of Q1	-0.5	-0.5	0
Papworth contract	-0.1	Cap and collar contract +/- £100k	Delivery of QIPP to control activity	0	0	0
CPFT Contract	-0.5	Current difference between provider and commissioner assumption of contract value.	Actively mitigated through the contracting process through attachment of performance related conditions	0	0	0
Prescribing	-1	Volume and Price Increase risk	Delivery of QIPP to ensure overspend limited to National issues.	0	0	0
QIPP risks and mitigations						
Acute	-0.9	Non GIC QIPP non delivery	Rapid work up of Acute QIPP through recovery PMO and QIPP support (from national QIPP programme). Discussions ongoing with West Norfolk CCG re Aligned Incentive Contract for QEH.	0	0	0
Community	-2	The plan includes £5.5m planned QIPP of which only £3.6m has been identified.	Rapid work up of community QIPP through recovery PMO and QIPP support (from national QIPP programme).	-0.5	0	-0.5
CHC	-2	A risk assessed range of achieving 75% QIPP.	Rapid work up of CHC QIPP - To be delivered through CHC team restructure, substantial increase in grip and control and team approach cantered on improvement with subsequent financial benefit.	0	0	0
Primary Care Co-Commissioning	-0.8	The £1.5m included within the plan is not supported by detailed schemes A risk assessed range of achieving 50-75% QIPP.	Rapid work up of Primary care co-commissioning QIPP through recovery PMO and QIPP support (from national QIPP programme).	0	0	0
Prescribing	-2.9	The £5.7m included within the plan compares to £3m of identified schemes ideas. We have included a range of achieving 50-75% QIPP.	Rapid work up of Prescribing QIPP through recovery PMO and QIPP support (from national QIPP programme).	0	0	0
Running Costs	-0.75	Ambitious plan to deliver streamlined structure - details to be confirmed.	Delay the implementation of the new ways of working.	0	0	0
Delivery risks and mitigations						
s.117 Backlog	-3	New backlog cases identified in 18/19	Remedial work targeted at reducing S.117 backlog.	-1.4	-1.4	0
Delivering the DTOC recovery trajectory	-4.7	Increased acuity of DTOC patients requiring out of hospital placements	Continued use of D2A and JET schemes to address DTOCs. Regular interaction with the LA and DTOC action planning.	-0.6	-0.6	0
Paediatric Services	-0.5	Cambs Community Services have served notice and the potential re-commissioned service from NWAFT	Risk for 18/19 has been mitigated as CCS have agreed to keep the service for 18/19. Potential risk in 19/20.	0	0	0
LD pooled budget	-2.1	Pressures on the LD pooled budget	Agreement on risk share with CCC – negotiations ongoing	-0.8	-0.8	0
Total CCG budget			The CCG will review all underspends monthly and where appropriate take these into a central contingency to manage in year risk.	1	0.3	0.7
Total Risk Position	**-63.25**			**-38.1**	**-38.1**	**0**
			Contingency	**3.0**	**3.0**	**0.0**
			Net risk position after contingency	**0.0**	**0.0**	**0.0**

There are 3 main risks emerging that are critical to the delivery of the financial position. These are:

- Section 117 costs
- Spend on the D2A pathway
- Overspends on acute contracts not subject to GICs – specifically QEH Kings Lynn

Multi disciplinary task forces have been established to take urgent action on these areas.

At this point in the year the CCG have assessed we can mitigate the level of risks within the plan through the use of the contingency budget.

QIPP

- 98% delivery against £8,786 M3 target.
- The £0.18m adverse position, made up of £0.18m of Community services schemes, £0.19m of Acute services schemes, these adverse variances are offset by Prescribing over achieving by £0.2m against the QIPP target at Month 3.
- Additional recovery of the £2.1m risk adjusted QIPP schemes.

Status	RAG	Net Value	Risk adjusted		Variance
Schemes in delivery	Red	2,909	1,745	5%	-1,164
	Amber	2,310	1,617	5%	-693
	Green	29,272	29,272	89%	0
Pipeline	Red	600	300	1%	-300
		35,091	32,934	94%	-2,157

Expenditure area	0 - Pipeline		1 - Initiation		2 - Planning		3 - Delivery		4 - Monitoring		5 - Closure		Totals - Excluding		Totals - Including		QIPP Target (£'000s)	GAP EXCLUDING PIPELINE (£'000s)	GAP INCLUDING PIPELINE (£'000s)
	No.	Value (£'000s)	No.	Value (£'000s)	No.	Value (£'000s)	No.	Value (£'000s)	No.	Value (£'000s)	No.	Value (£'000s)	No.	Value (£'000s)	No.	Value (£'000s)			
Prescribing	0		11	1,955	13	2,047	1	150	8	771			33	4,924	33	4,924	5,700	776	776
Community / CSI	1	600	5	720									5	720	6	1,320	1,000	280	-320
Mental Health	0						1	200					1	200	1	200	300	100	100
Primary Care	0						1	2,000					1	2,000	1	2,000	2,000	0	0
CHC	0		1	7,500									1	7,500	1	7,500	7,500	0	0
Corporate Affairs	0		2	102					1	500			3	602	3	602	0	-602	-602
Contract Adjustments (CSI)	0						1	4,500					1	4,500	1	4,500	4,500	0	0
Acute (GIC)							1	12,900					1	12,900	1	12,900	12,900	0	0
Acute (PbR)			1	709			7	437					8	1,146	8	1,146	1,100	-46	-46
Totals	**1**	**600**	**20**	**10,986**	**13**	**2,047**	**12**	**20,187**	**9**	**1,271**	-	-	**54**	**34,491**	**55**	**35,091**	**35,000**	**509**	**-91**
Memorandum Acute GIC and PbR																			
Planned	2		2	325	8	2,361	8	3,621					18	6,307	20	6,307			
UEC	4		6	1,435			7	4,610					13	6,045	17	6,045			
Community / CSI - GIC							7	837					7	837	7	837			
Acute GIC and PbR Total	**6**	-	**8**	**1,760**	**8**	**2,361**	**22**	**9,068**	-	-	-	-	**38**	**13,189**	**44**	**13,189**			

Improvement Plan 2018/19

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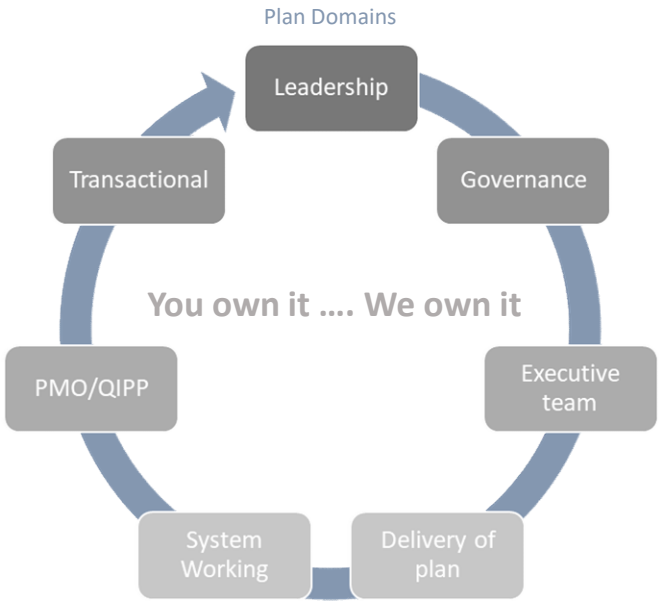
This improvement plan is the owned by Cambridgeshire and Peterborough CCG Governing Body (GB).

- Accountability for delivering the Improvement and Delivery Plan will rest with the Chief Officer (Accountable Officer)supported by the Executive and Clinical Executive leadership team.
- It is based around the PwC Capacity And Capability Review recommendations presented on 23rd March 2018.
- PwC were asked to review the plan at the end of May whilst it was in draft form to assure us that the plan addresses the significant issues raised (See comment box below).
- Since this time we have increased the actions we are to complete from 66 to 77.



Improvement plan coverage of PwC report recommendations

"Following our conversation yesterday, and as discussed I have been through the latest version of the Improvement Plan and cross-referenced the planned actions set out with the recommendations made in our final report 'Capability, capacity and independent review of financial position' dated 23 March 2018.

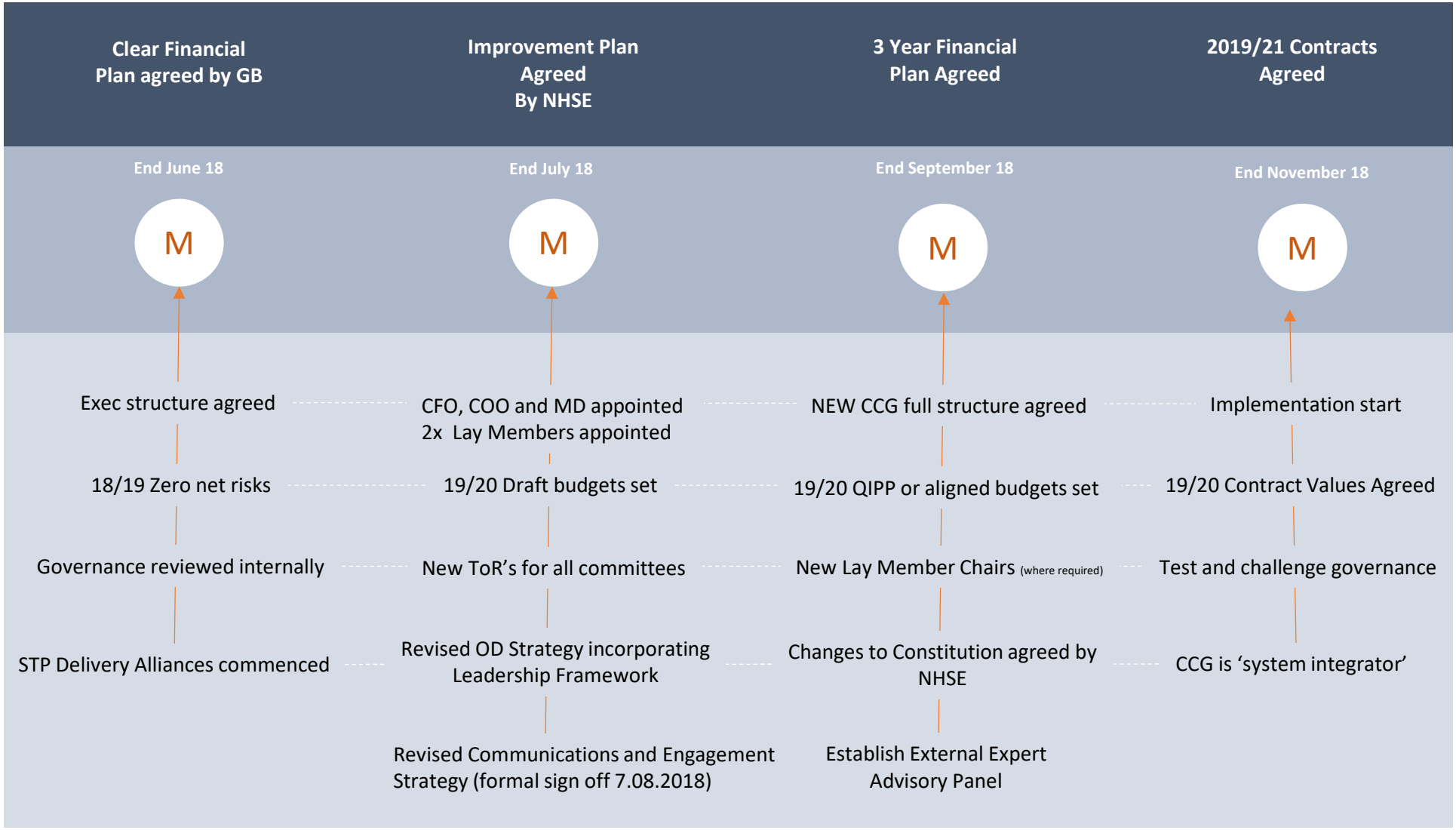
My view is that the improvement plan does cover the same points as the recommendations from the final report, as well as a number of additional points which go beyond the recommendations from our report. The IP has 65 individual actions, and our final report has 48 actions.

In a number of cases the original timetable for completion of the recommendations has elapsed and the IP therefore considers the action which is relevant now, for example 12b 'CCG GB agreement on SDU and CCG integration' has replaced 8A ' The role and remit and leadership arrangements for the SDU should be clarified: Clear objectives, outcomes and accountabilities should be defined'. This doesn't affect my view on coverage but it does highlight the need for the whole organisation to continue to act rapidly to address all action points and prevent slippage against the deadlines set out in the IP."

Matt Lynn, Director - PwC
30th May 2018 – by email

Key Documents and Milestones

Cambridgeshire and Peterborough Clinical Commissioning Group



M3 – Improvement Plan Progress

Cambridgeshire and Peterborough Clinical Commissioning Group

Operational Delivery

- On track for all items
- Focus on delivery in the organisation
- Agreement on shared leadership
- Test and challenge session confirms progress

Financial Delivery

- On plan for month 2
- On a risk adjusted basis £2.2m of QIPP gap
- S117 over performance
- QEH over performance

Last 30 Day progress:

- GB approval of changes to Constitution – application to be sent to NHSE w/c 30.07.18
- CFO, COO and MD appointed. Other Top Line Executives on plan to appoint as per plan
- One Lay Member appointed, one Lay Member in progress
- OD Plan and Leadership Framework – informal sign off – formal sign off 7.08.2018
- GB development session, staff briefings and managers briefings all held with positive feedback.

Next 30 day priorities:

- NHSE approval of plan
- Finalise appointment of new top line exec team
- Conclude Deloitte review of CHC and re-run of 2018/19 position for assurance
- Finalise OD and Leadership plans with the staff.

Relook and step up actions on:

- S117 delivery and the rigour in the process and financial planning.
- Review the activity and demand plans to ensure increase in activity is mitigated.
- Implementation of full invoice validation for the acute non-GIC providers

External decisions impacting plan

1. STP Chair has asked to postpone SDU integration with CCG until further notice – this element will be put on hold in the plan.

2. STP agreed with NHSE to delay system 5 year financial plan until October 2018.

Leadership

NHS
Cambridgeshire and Peterborough
Clinical Commissioning Group

Ref	Requirement		Action	Due Date	GB Owner	RAG	Status
1	The Governing Body must take responsibility for the leadership and governance issues identified and urgently put in place plans to address them.	a	GB to formally sign off the CCG Improvement and Implementation plan (IIP)	24-May	Chair	Complete	Closed
2	A clearly articulated leadership strategy and structure for the CCG is needed.	a	Interim Structure signed off by GB	24-May	AO	Complete	Closed
		b	Leadership strategy to be outlined in IIP	24-May	AO	Complete	Closed
		c	New full organisational structure agreed for consultation	31-Aug	AO	On-Track	Open
		d	Appoint to vacant lay member posts	20-Aug	Chair	On-Track	Open
		e	New structure implementation	03-Dec	AO	Not Started	Not Started
		f	Revise CCG Constitution to reflect changes	30-Sep	Chair/CCG Sec.	On-Track	Open
		g	Identify GB Leads for each IDP Domain	30-Jun	CCG Sec.	Delayed	Open
3	Clear accountability for delivery and outcomes to be embedded within the Governing body and CEC.	a	CIAF to be used as core delivery structure and focus in the CCG. With Executive and Clinical ownership	Ongoing (Start in June)	AO	Complete	Live
		b	Strengthen Clinical Leadership	Ongoing (Start in June)	Chair/AO	Complete	Live
		c	Clear Clinical and Executive ownership of corporate and Directorate risks.	Ongoing (Start in June)	AO	Complete	Live

Governance

NHS
Cambridgeshire and Peterborough
Clinical Commissioning Group

Ref	Requirement		Action	Due Date	GB Owner	RAG	Status
4	The CCG should review the effectiveness of the Governing Body and its processes for seeking and receiving assurance over the robustness of plans and ongoing monitoring of implementation.	a	Agree and deliver an improved governance approach	31-Jul	AO	On-Track	Open
		b	Review effectiveness and Terms of Reference (TORs) of each CCG committee and GB sign off of all TOR's	02-Jul	CCG Sec.	Complete	Live
		c	Agree Chair of each Committee for 18/19	31-Jul	Chair	Complete	Closed
		d	Complete a Q1 test and challenge session on governance and delivery of the CCG - with PWC	26-Jun	AO	Complete	Closed
		e	Complete end Q3 review of all YTD governance and adapt as required	21-Dec	AO	Not Started	Not Started
		f	Complete the Deloitte Review of 'look forward implementation plan' for CHC	03-Aug	COO	On-Track	Open
5	Ensure that all members of the Governing Body receive the training, education and performance feedback required to improve overall CCG performance	a	Complete annual performance review and plan for each GB member, including 360.	03-Aug	Chair/AO	Delayed	Open
		b	Provide a rolling programme of Subject Matter Experts training events on specialised areas of CCG delivery	Ongoing (Start in June)	COO	Delayed	Open
		c	Implement GB Development Programme	31-Jul	AO	On-Track	Live
		d	Quarterly individual performance session	Ongoing (Start in October)	Chair/AO	Not Started	Not Started
6	Strengthen Risk Management processes across the CCG in line with the recommendations from the Internal Audit Review of Assurance Framework and Risk Management	a	Improve Risk Management Strategy to align to the three lines of defence assurance model	30-Sep	Dir. Gov	On-Track	Live
		b	Incorporate training for GB and Executive Managers in risk management techniques as part of GB Development Programme	31-Oct	Dir. Gov	Not Started	Not Started
		c	Improve triangulation of information with CAF Risks with CCG Reports	30-Jun	Dir. Gov	Complete	Live
		d	Improve actions to mitigate likelihood and consequences and challenge delivery	31-Jul	All	Complete	Live
		e	Enhance Directorate Risk Registers and implement risk management refresher training for Risk Co-ordinators	31-Jul	All	Complete	Live

Executive team

NHS
Cambridgeshire and Peterborough
Clinical Commissioning Group

Ref	Requirement		Action	Due Date	GB Owner	RAG	Status
7	The Executive team must be stabilised urgently, with experienced permanent appointments made wherever possible, or long term fixed appointments where substantive appointments cannot be made in the short term.	a	AO of CCG Appointed	08-Jun	Chairman	Complete	Closed
		b	Turnaround/Improvement Interim Appointment	01-Jun	AO	Complete	Closed
		c	COO Appointed	31-Jul	AO	Complete	Open
		d	DOF Appointed	31-Jul	AO	Complete	Open
		e	DON Appointed	18-Aug	AO	On-Track	Open
		f	Clinical Director Appointed	20-Jul	AO	Complete	Open
8	Sustainable OD knowledge is needed within the Executive team, to enable financial recovery.	a	Draft OD strategy	22-Jun	Dir. Gov	Complete	Closed
		b	Ensure OD/HR lead part of executive team	25-May	AO	Complete	Live
		c	CCG system participation in CPP (PWC programme)	Oct (Start date)	AO	On-Track	Open
9	Drive a rigour an operational delivery within the CCG	a	Design and implement an 'operating rhythm' for the executive team that drives a focus on the CCG's delivery and results.	25-May	COO	Complete	Live
		b	Design and implement weekly and monthly performance reporting that is scrutinised regularly	01-Jun	COO	Delayed	Open

Improvement Plan and System Working

NHS
Cambridgeshire and Peterborough
Clinical Commissioning Group

Ref	Requirement		Action	Due Date	GB Owner	RAG	Status
10	A clearly defined Improvement Plan should be urgently developed to allow the CCG to map out how it will improve and by when	a	IIP framework agreed by GB	01-May	Chief Officer	Complete	Live
		b	NHSE Approval of recovery plan	31-Jul	Chief Officer	On-Track	Open
		c	Agree IIP governance and assurance process	24-May	CFO	Complete	Live
		d	IIP sign off by GB	24-May	CFO	Complete	Live
11	Set out a clearly defined multi-year Financial Recovery Plan, showing when the CCG will recover and return to NHS England business rules.	a	In year financial plan sign off by GB	01-May	CFO	Complete	Live
		b	In year financial plan sign off NHSE	25-May	CFO	Complete	Live
		c	3 Year financial plan draft	20-Jul	CFO	Complete	Open
		d	3 Year financial plan final	28-Sep	CFO	Not Started	Not Started
12	The role and remit and leadership arrangements for the SDU should be clarified. The current overlap / duplication between SDU and CCG activities must minimise	a	HCE agreement for the merging of SDU and CCG over time	NA	AO	Complete	Closed
		b	CCG GB agreement on SDU and CCG integration	01-May	AO	Complete	Closed
		c	Commence Consultation on future structures	July (Start date)	AO	STP AO/Chair decision to pause	
		d	Full organisational integration	03-Dec	AO		

PMO & QIPP

NHS
Cambridgeshire and Peterborough
Clinical Commissioning Group

Ref	Requirement		Action	Due Date	GB Owner	RAG	Status
13	Implement a robust and embedded PMO	a	Redefine the PMO's purpose, focussing it on the FY18/19 QIPP programme.	25-May	CFO	Complete	Live
		b	Identify an Executive with responsibility for the PMO.	25-May	CFO	Complete	Live
		c	Head of PMO appointed to provide day to day leadership.	07-May	CFO	Complete	Closed
14	Rapid FY18/19 QIPP development	a	The FY18/19 QIPP plan development process should be further accelerated to fill the gap with fully worked up schemes.	Immediate	CFO	Complete	Live
		b	Further focussed development meetings should be held to shore up the QIPP list with PIDs completed	Immediate	CFO	Complete	Live
		c	Set out lead indicators on QIPP delivery – With milestones reported regularly.	25-May	CFO	Complete	Live
		d	Instigate a CCG and NHSE advisory committee, which has sight of monthly financial reports.	30-Sep	CFO	Not Started	Not Started
		e	Re-run unpalatable options generation and assessment process.	15-Jun	CFO	Complete	Live
		f	Weekly QIPP review by CCG executive team	07-May	CFO	Complete	Live
		g	Delivery of QIPP oversite through CEC every 2/52	07-May	CFO	Complete	Live

Transactional Improvements

NHS
Cambridgeshire and Peterborough
Clinical Commissioning Group

Ref	Requirement		Action	Due Date	GB Owner	RAG	Status
15	Continuing Healthcare delivery and reduction of backlog	a	The CCG should deliver its plan to process the backlog of CHC claims in a rapid but robust way to minimise appeals.	Ongoing	COO	Delayed	Open
		b	CHC back to be cleared within NHSE agreed trajectory	26-Oct	COO	Delayed	Open
		c	Re-run its model with updated assumptions prior to submission of the final plan in April 2018 to ensure the estimate included for FY18/19 reflects the most up to date information	22-Jul	COO	Complete	Live
16	Contract Management	a	Each contract has a named manager and clinical owner	22-Jun	CFO	Complete	Live
		b	A clear timetable and operational process needs to be in place for the contracting management and challenge process.	22-Jun	CFO	Complete	Live
		c	GP Primary care dashboard for performance and communications should be implemented	31-Aug	CFO	On-Track	Open
17	Communications	a	Implement internal communications plan owned by Executive Team	14-May	Dir. Gov	Complete	Live
		b	Agree and implement stakeholder communications plan	24-May	Dir. Gov	Complete	Live
		c	Refresh external communications and engagement plan, including STP communications	04-Jun	Dir. Gov	Complete	Live

Governance Structure

Cambridgeshire and Peterborough Clinical Commissioning Group

Set out below is the CCG's Governance Framework. The Improvement and Delivery Plan will be updated on a monthly basis and delivery closely scrutinised by the Committee Structure prior to presentation to the Governing Body at each meeting in public.

As part of the Improvement Plan, the CCG will be optimising the effectiveness of each Committee, and reviewing the Executive Membership to align with the Executive Structure, and reviewing Chairs and Vice-Chairs for each Committee.

	Frequency/Chair	Summary of Objectives	Membership
Clinical Executive Committee	• 2/52 • Chief Officer (Chair) • Chief Finance Officer (Deputy Chair)	• Supports GB to set and deliver the strategic direction and priorities; • Development and delivery of clinical engagement and clinically led plans; • Delegated day to day operational responsibility for running the organisation;	• GP Chair / Chief Clinical Officer • GP Governing Body Members • All Executive Directors • CCG Secretary
Quality, Outcomes and Performance Committee	• Monthly • Lay Member Assurance (Chair)	• Provides scrutiny of performance and processes relating to patient safety and quality and patient outcomes within the services we commission; • Provides the link to the Multi-Agency Local Adult Safeguarding and Multi-Agency Local Children's Safeguarding Boards.	• 2 GP GB Members , Chief Officer • Chief Nurse, Secondary Care Doctor • Service Leads, CCG Secretary
Finance Committee	• Monthly • Lay Member Finance (Chair)	• Provides scrutiny of the CCG's financial functions • Ensures that the CCG meets its statutory financial duty • Monitors oversight of financial risk and delivery of QIPP	• 1 Lay Member • 2 GP GB Members • Chief Officer and Chief Finance Officer • Executive Directors
Audit Committee	• Quarterly • Lay Member Governance (Chair)	• Independent and objective view of legal compliance, regulation and directions • Ensures an effective system of internal control • Assurance all areas of governance are conducted within best practice	• 2 Lay Members • 3 GP Members • CFO and CCG Secretary (in attendance)
Remuneration & Terms of Service Committee	• Quarterly • Clinical Chair (Chair)	• Determines remunerations fees and other allowances for employees and other people providing services to the CCG • Agrees all HR and associated policies and procedures • Responsible for workforce strategy performance; OD Plan oversight	• 2 Lay Members • Chief Officer • Secondary Care Doctor • 1 GP Governing Body Member
Patient Reference Group	• Monthly • Lay Member Patient and Public Involvement (Chair)	• Provides an independent view of the work of the CCG that is external to the day to day running of the CCG • In all aspects of the CCG business, ensures the public voice of the local population is heard and patients and the public are empowered	• Mandated patient representatives from each local area • Local Healthwatch representatives • Member of CEC
Primary Care Commissioning Committee	• Monthly • Lay Member Patient and Public Involvement (Chair)	• Oversees commissioning of primary care services; • Ensures the CCG delivers its Delegation Agreement with NHSE	• 1 Lay Member • Chief Officer and Chief Finance Officer • Executive Director • Chief Nurse

Leadership Framework

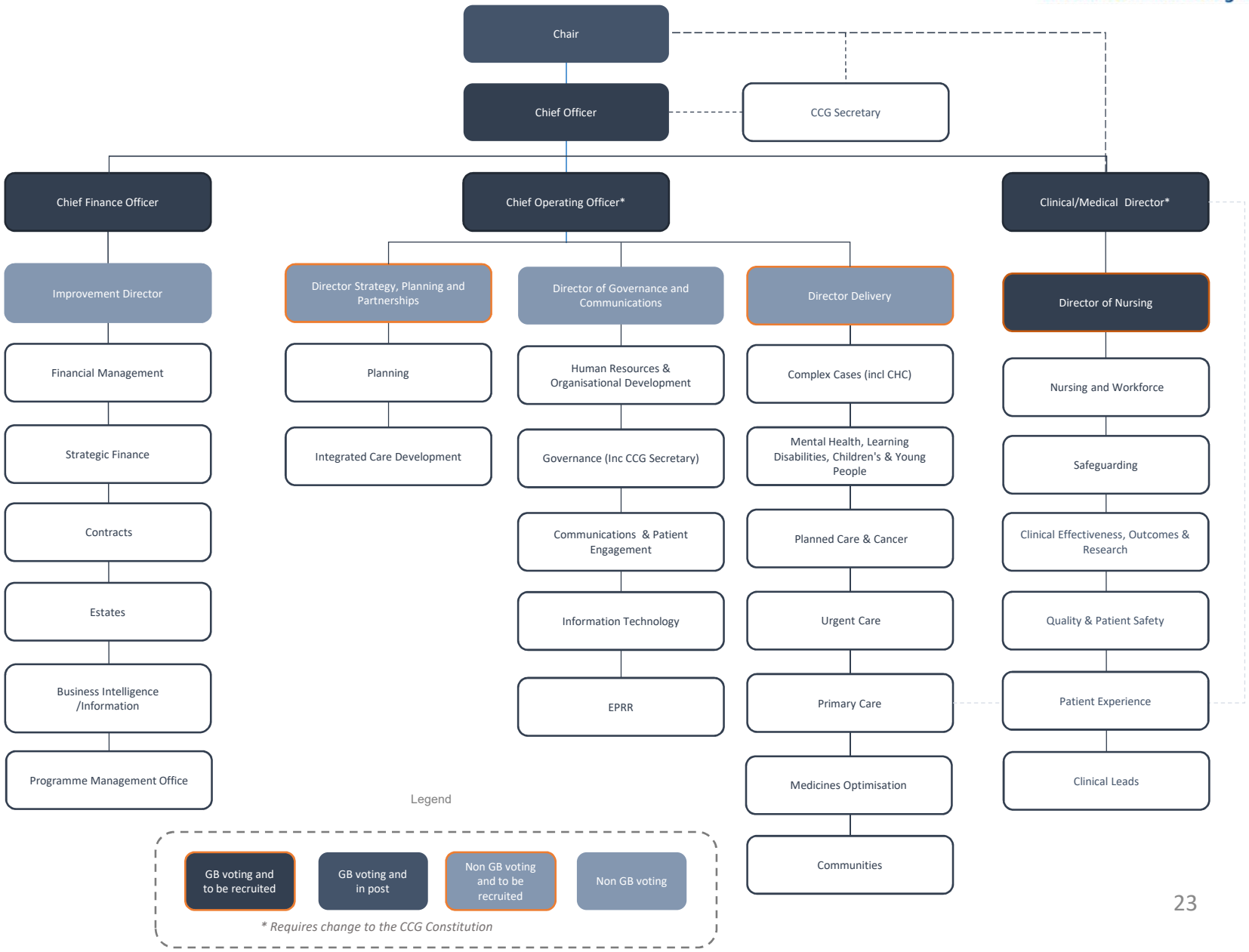
There is a need for shared ownership, accountability and responsibility for delivery of the CCG's Improvement and Delivery Plan. The aim of the CCG's Leadership Framework is to provide a clear description of the standards and expectations of what good leadership and management looks like at all levels. This sets the standards of how as organisation we are expecting our leaders to deliver together, in collaboration with the whole CCG. The current Leadership Framework is set out below and will reviewed to reflect the Improvement and Delivery Plan.

Our objectives are to:

- Create a meaningful plan that will build the capacity and skills of the workforce thus ensuring the organisation is excellent in the commissioning of its services;
- Link leadership and management development to improving services and patient experiences;
- Retain and grow the knowledge and skills of our leaders and managers and provide opportunities for aspiring managers and leaders;
- Encourage a culture of learning in the organisation in which managers and leaders take responsibility for the learning and development of their staff;
- Ensure a range of tools are embedded and work alongside the training and development plan to support leaders and managers in the organisation;
- Describe how and what is needed to perform successfully in a management or leadership role, and provide a consistent approach to appraising leaders' and managers' performance and capability in leading the organisation towards its strategic goals;
- Give examples of what a person operating in such roles will do (competence) and guidance on how they will conduct their leadership and management role (behaviour) to inform recruitment processes and succession planning.

Executive Structure

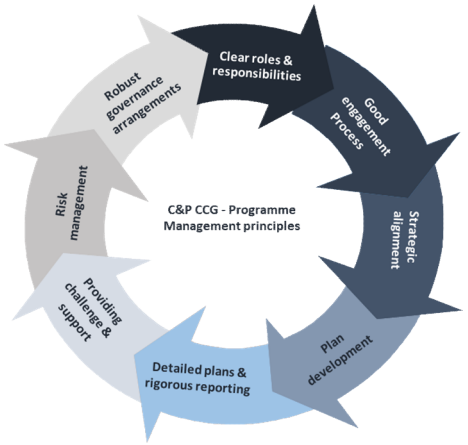
NHS
Cambridgeshire and Peterborough
Clinical Commissioning Group



QIPP Delivery

Cambridgeshire and Peterborough Clinical Commissioning Group

- Successful QIPP development and delivery is a key priority for the CCG, and is a central component of the improvement plan.
- Delivery of schemes with a minimum value of £35m is essential, with a strong ambition to deliver more than this to reduce run rate and position the CCG well going into FY2019/20.
- The programme has a clear focus on quality as well as financial recovery, taking difficult decisions but not at the cost of an erosion of quality of care.
- This process draws upon Rightcare, Hospital Episode Statistic, Continuing Healthcare and other benchmarking to identify those areas with most opportunity, as well as cross-referencing the programme with NHS England's Menu of Opportunities.
- Existing schemes have been stretched wherever possible.
- Further work is urgently underway to fill the remaining gap. An exercise to compare QIPP schemes across multiple CCGs across Midlands and East and the rest of England is in process, with buy-in from NHS England.



Stage description	Gateway approval required to progress to next stage
0. Pipeline	Finance review, Management executive review
1. Initiation	CEC review, Impact assessors sign off
2. Planning	PMO review of finalised plans
3. Delivery	PMO able to monitor – KPIs, finances in place
4. Monitoring	PMO records all scheme benefits delivered
5. Closure	PMO records scheme as closed

- Weekly meetings are held with directorates / workstream teams to drive development and delivery, clearly measured by financial and delivery metrics.
- Teams are held to account by an embedded QIPP PMO, which has been re-focused on 2018/19 planning and delivery.
- Encouraging cross directorate working to cut through silos, and increasing system interaction without loss of grip of CCG driven schemes.
- There is regular reporting to the Management Executive (weekly) and CEC (fortnightly). Cases for change are scrutinised before acceptance into the programme.
- MS Office 365 tools and MS Project are used to measure delivery with a composite RAG measure used to give a balanced view of progress.
- Monthly management accounts information will be used going forwards to further scrutinise delivery.

Operational Delivery Plan

NHS
Cambridgeshire and Peterborough
Clinical Commissioning Group

The Operational Delivery Plan is based around the four Domains in the CCG Improvement and Assess Framework (CIAF).

- Better Health: this domain looks at how the CCG is contributing towards improving the health and wellbeing of its population, and bending the demand curve;

- Better Care: this domain principally focuses on care redesign, performance of constitutional standards, and outcomes, including in important clinical areas; these are mental health, dementia, learning disabilities, cancer, diabetes and maternity;

- Sustainability: this domain looks at how the CCG is remaining in financial balance, and is securing good value for patients and the public from the money it spends;

- Leadership: this domain assesses the quality of the CCG's leadership, the quality of its plans, how the CCG works with its partners, and the governance arrangements that the CCG has in place to ensure it acts with probity, for example in managing conflicts of interest.

The 2018/19 CIAF has yet to be published but it is anticipated that the Domains will remain the same. The Framework will be updated to reflect any changes identified. The Operational Delivery Plan is based around the following principles:-

- Action and Outcome focussed with clear milestones and deliverables;
- The need for financial stability;
- Quality of care and patient safety is central to the organisation now and the future.

The Operational Delivery Plan will be underpinned by a clear Communications and refreshed Organisational Development Strategy, to ensure ownership and delivery across the organisation, and with our wider partners and stakeholders.

The Operational Delivery Plan is set out at Appendix A.

Operational Risks

Cambridgeshire and Peterborough Clinical Commissioning Group

Risk	Year Start Risk Score (April 18)	Current Risk Score	Target Risk Score 2018/19 -	Impact	Actions / Mitigations	Senior Risk Owner (SRO)
Service/Transformation Delivery						
Risk to delivery of QIPP Plan (Transformation)	**20 4x5 Red**	**20 4x5**	**10 2x5 Amber**	Failure to improve CCG CIAF Rating 2018-2019 (Sustainability Domain) Referral letter to the Secretary of State under Section 30(b) of the Local Audit & Accountability 2014 Act. Statutory Recommendations under the Local Audit and Accountability 2014 Act Section 24 Schedule 7 Potential referral for a Public Interest Report	CCG Improvement and Delivery Plan - approved by NHSE and monitored via GB, External Audit as required	Chief Finance Officer
Failure to deliver a safe, high quality Integrated Urgent Care (IUC) Service by Herts Urgent Care (HUC)	**20 5x4 Red**	**16 4x4**	**8 2x4 Amber**	Failure to improve CCG CIAF Rating 2018-2019 Rating (Better Care Domain) Increase in patient experience and complaints Reputational damage to CCG and to NHS	Remedial Action Plan, Contract Monitoring, Increased clinical leadership	Chief Nurse
Failure to meet National Framework for NHS Continuing Healthcare and NHS funded Nursing Care compliance	**16 4x4 Red**	**16 4x4**	**12 3x4 Amber**	Failure to improve CCG CIAF Rating 2018-2019 (Better Care & Sustainability Domains) Increase in patient experience issues Breach in Statutory Duties Reputational Damage to the CCG and to the NHS	CHC Improvement Plan, Deloitte Review	Chief Operating Officer
Failure to provide accurate data on activity and finance for complex cases - Continuing Healthcare & Section 117 cases	**16 Red**	**16 4x4**	**12 Amber**	Failure to improve CCG CIAF Rating 2018-2019 (Sustainability and Well Led Domains)Referral letter to the Secretary of State under Section 30(b) of the Local Audit & Accountability 2014 Act. Statutory Recommendations under the Local Audit & Accountability 2014 Act Section 24 Schedule 7 Potential referral for a Public Interest Report Reputational damage to the CCG and NHS	CHC Improvement Plan, Deloitte Review	Chief Operating Officer
Failure to address Section 117/CHC disputes with Local Authorities	**16 4x4 Red**	**20 4x4**	**4 1x4 Yellow**	Failure to improve CCG CIAF Rating 2018-2019 (Sustainability Domian) Referral letter to the Secretary of State under Section 30(b) of the Local Audit & Accountability 2014 Act. Statutory Recommendations under the Local Audit & Accountability 2014 Act Section 24 Schedule 7 Potential referral for a Public Interest Report Reputational damage to the CCG and NHS	CHC Improvement Plan, Deloitte Review	Chief Operating Officer
Failure to address quality improvement in Primary Care	**15 3x5 Red**	**15 3x5**	**10 2x5 Amber**	Failure to improve CCG CIAF Rating 2018-2019 (Better Care Domain) Breach in statutory duty under the Health and Social Care Act 2012 Increased risk of patient complaints, claims and serious incidents Reputational damage to the CCG and NHS	Remedial Action Plans, Close working with CQC and other Regulators, Contract Monitoring	Director of Planned & Primary Care
Impact on quality as a result of workforce capacity within all providers	**16 4x4 Red**	**16 4x4**	**12 3x4 Amber**	Failure to improve CCG CIAF Rating 2018-2019 (Better Care Domain) Impact on performance leading to failure to deliver NHS Constitution Targets Increased risk of patient complaints and serious incidents	Remedial Action Plans, Close working with CQC and other Regulators, STP Workforce Strategy and Delivery Plan, Contract Monitoring	Chief Nurse

Operational Risks

Cambridgeshire and Peterborough Clinical Commissioning Group

Risk	Year Start Risk Score (April 18)	Current Risk Score	Target Risk Score 2018/19 -	Impact	Actions / Mitigations	Senior Risk Owner (SRO)
Stakeholder Management						
Failure to engage with Member Practices and wider stakeholders	**12 3x4 Amber**	**16 4x4 Red**	**8 2x4 Amber**	Failure to improve CCG CIAF Rating 2018-2019 Rating (Well Led Domain) Additional NHSE Legal Directions Lack of engagement, poor performance Reputational damage to CCG and to NHS	CCG Improvement and Delivery Plan, Communications and Engagement Plan	Director of Corporate Affairs
Quality Management						
Potential for poor quality in the services which the CCG commissions from the East of England Ambulance Trust.	**16 4x4 Red**	**12 3x4 Amber**	**12 3x4 Amber**	Failure to improve CCG CIAF Rating 2018-2019 Rating (Better Care Domain) Increase in patient experience and complaints Reputational damage to CCG and to NHS	Remedial Action Plan Quality Risk Summit Quality Surveillance Group oversight	Chief Nurse
Risk of poor quality care being delivered to patients in residential and nursing care homes and domiciliary care providers	**16 4x4 Red**	**16 4x4**	**9 3x3 Amber**	Failure to improve CCG CIAF Rating 2018-2019 Rating (Better Care Domain) Increase in patient experience and complaints Reputational damage to CCG and to NHS	Remedial Action Plans, Close working with CQC, Contract Monitoring	Chief Nurse
Failure to comply with lawful requirements for DoLs safeguards to be in place for CCG funded patients	**16 4x4 Red**	**16 4x4**	**4 1x4 Yellow**	Failure to improve CCG CIAF Rating 2018-2019 (Better Care Domain) Breach of Statutory duty Reputational damage to CCG and NHS	CHC Improvement Plan, Deloitte Review	Chief Nurse
Financial Management						
Failure to achieve the Financial Control total agreed with NHS England	**20 4x5 Red**	**20 4x5**	**10 2x5 Amber**	Failure to improve CCG CIAF Rating 2018-2019 (Sustainability Domain) Referral letter to the Secretary of State under Section 30(b) of the Local Audit and Accountability 2014 Act. Statutory Recommendations under the Local Audit and Accountability 2014 Act Section 24 Schedule 7 Potential referral for a Public Interest Report Reputational damange to the CCG and NHS	CCG Improvement and Delivery Plan - approved by NHSE and monitored via GB, External Audit as required	Chief Finance Officer
Failure to deliver key NHS Constitution Targets	**16 4x4 Red**	**16 4x4**	**3 1x3 Green**	Failure to improve CIAF 2018-2019 (Better Care Domain) Failure to comply with the Health & Social Care Act 2012 Poor quality of services to patients across Cambridgeshire and Peterborough Reputational damage to the CCG, NHS Trusts and the NHS nationally Increased risk of complaints and serious incidents Potential for increased NHSE Legal Directions	Remedial Action Plans Close monitoring of improvements via governance framework	Chief Officer
Failure to Improve Value For Money Rating In-Year (Efficiency, Economy and Effectivess	**20 4x5 Red**	**20 4x5**	**10 2x5 Amber**	Failure to improve CCG CIAF 2018-2019 Rating (Sustainability Domain) Potential for referral for a Public Interest Report Reputational damage to CCG and NHS Further instability at leadership level Potential for increased NHSE Legal Directions	CCG Impovement and Delivery Plan - approved by NHSE and monitored via Governing Body, NHSE and External Audit	Chief Finance Officer
Governance/Leadership						
Failure to deliver the CCG's Improvement Plan for 2018-2019.	**16 4x4 Red**	**16 4x4**	**4 Yellow**	Failure to improve CCG CIAF 2018-2019 Rating (Well-Led Domain) Potential for referral for a Public Interest Report Reputational damage to CCG and NHS Further instability at leadership level Potential for increased NHSE Legal Directions	CCG Impovement and Delivery Plan - approved by NHSE and monitored via Governing Body, NHSE and External Audit	Chief Officer
Risk to maintaining robust CCG Governance Arrangements	**16 4x4 Red**	**16 4x4**	**4 1x4 Yellow**	Failure to improve CCG CIAF Ratings 2018-2019 Rating (Well-Led Domain) Potential for Public Interest Report - Local Audit and Accountability Act 2014 Increased NHSE Legal Directions	CCG Improvement and Delivery Plan - approved by NHSE and monitored via GB, External Audit as required	Director of Corporate Affairs

Activity Plans

Cambridgeshire and Peterborough Clinical Commissioning Group

- Whilst as a CCG our accountabilities and responsibilities are wider than acute care, we have committed as an organisation to the activity profile below with NHSE.
- This profile is base on the TnR subset of the total activity data we receive from the providers or through the national HES and PBR data.
- Monthly, the Executive and Governing Body will be required to understand our position against this plan and provide recovery and mitigation plans if it is not being achieved.

Code	Title	17/18 OT	18/19 Do Nothing	18/19 QIPP	18/19 Plan	17/18 to 18/19	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
E.M.7	Total Referrals (Specific Acute)	318,285	330,640	-15,388	315,252	-1%	25,761	27,776	26,576	27,433	26,199	24,340	28,016	27,513	22,285	27,119	25,088	27,146
E.M.7a	Total GP Referrals (G&A)	178,715	185,649	-8,640	177,009	-1%	14,778	15,677	15,025	15,238	15,072	13,733	15,699	15,334	12,070	15,022	14,116	15,246
E.M.7b	Total Other Referrals (G&A)	139,570	144,991	-6,748	138,243	-1%	10,983	12,099	11,551	12,195	11,127	10,607	12,317	12,179	10,215	12,097	10,972	11,900
E.M.8	Consultant Led First Outpatient Attendances (Specific Acute)	346,115	355,707	-14,381	341,326	-1%	26,950	29,002	28,350	28,015	27,169	26,330	30,290	31,572	25,236	30,792	28,184	29,437
E.M.9	Consultant Led Follow-Up Outpatient Attendances (Specific Acute)	414,136	420,753	-15,729	405,024	-2%	31,752	33,409	33,061	31,964	32,115	31,481	36,444	37,768	30,241	38,219	33,248	35,321
E.M.10	Total Elective Admissions (Spells) (Specific Acute) [Ordinary Electives + Daycases]	103,535	110,452	-1,983	108,469	5%	8,696	9,271	8,897	9,179	9,228	8,440	9,857	9,591	7,860	9,511	8,682	9,256
E.M.10a	Total Elective Admissions - Day Cases	86,649	90,797	-1,532	89,265	3%	7,173	7,617	7,299	7,565	7,640	6,962	8,125	7,864	6,473	7,908	7,102	7,537
E.M.10b	Total Elective Admissions - Ordinary	16,886	19,655	-451	19,204	14%	1,523	1,654	1,598	1,614	1,588	1,478	1,732	1,727	1,387	1,603	1,580	1,719
E.M.11	Total Non-Elective Admissions (Spells) (Specific Acute)	85,708	89,176	0	89,176	4%	7,138	7,478	7,356	7,543	7,149	7,267	7,566	7,465	7,823	7,561	7,006	7,825
E.M.11a	Total Non-Elective Admissions - 0 LoS		25,437	0	25,437		2,001	2,079	2,134	2,130	2,027	2,054	2,136	2,194	2,293	2,077	2,015	2,297
E.M.11b	Total Non-Elective Admissions - +1 LoS		63,739	0	63,739		5,137	5,399	5,222	5,413	5,122	5,213	5,430	5,271	5,530	5,484	4,991	5,528
E.M.12	Total A&E Attendances excluding planned follow ups	303,404	318,066	0	318,066	5%	25,826	27,582	26,788	28,240	25,913	25,588	27,207	26,316	26,695	25,513	24,404	27,993

- For the avoidance of doubt, this is aligns to but not directly map to the provider activity plans due to it being a subset of data. Provider activity plans will be separately monitored.

Moving to Integrated Care

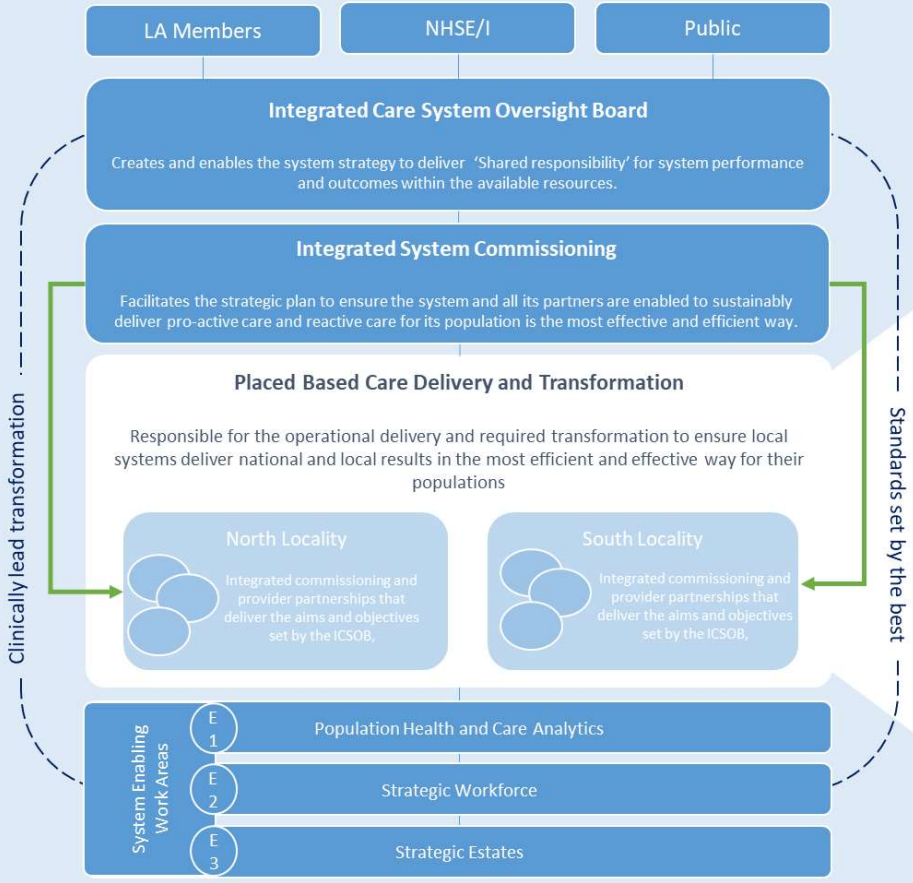
NHS
Cambridgeshire and Peterborough
Clinical Commissioning Group

As an CCG the Accountable Officer is also responsible for the Delivery of the Sustainability and Transformation Partnership (STP). The STP has a 3 year plan and strategy and as an organisation we are supportive of the direction and understand the need to move into a year focused on delivery. In order for us as a commissioner within the system, we need to work in 2018/19 be driving all our teams to work in a partnership way and be able to describe what this means. Therefore we are going to work with all stakeholders (internal and external) to test ourselves against the following characteristics required and essential jobs of an integrated acre system.

- ✓ Build **collaborative leadership** around a shared local vision for the Integrated Care System, with mature relationships including local Government.
- ✓ **Effectively engage** and involve clinicians and staff, the third sector, service users in the public in developing the shared local vision and throughout implementation;
- ✓ Create a **dedicated 'engine room'** to drive and manage the local transformation programme, with adequate dedicated resources and capabilities.
- ✓ Establish **a transparent governance structure** so that everyone knows how decisions are made, and to ensure collective responsibility across the Integrated Health System;
- ✓ Understand the **different needs of our diverse population**, and segment into different population groups, designing the Integrated Care System to reflect patient flows and contiguous with local government boundaries.
- ✓ Develop and maintain a clear and explicit description (**a 'logic model'**) that explains how the Integrated care system will transform care to expected and agreed outcomes.
- ✓ Establish the financial case (a **'value proposition'**) for developing the Integrated Care System with collective commitment from all partners to system planning and shared financial risk management. Commit to a clear return on investment, so that there is a compelling and credible proposition for service change. This includes setting out how the Integrated Care System will help moderate demand, and increase provider efficiency to deliver the STP
- ✓ Design **and document each component parts** of the care transformation. This includes clinical and business processes and protocols, team design and job roles. Do these work with and for patients, carers and clinicians? For the most complex services, develop a clear understanding of the different costs, the expected throughputs, and the methods for selecting patients for proactive care.
- ✓ **Systematically plan**, schedule and manage the implementation of the changes in line with the emerging design specifications, and the value proposition timetable. Achieve effective clinical, service user and patient participation.
- ✓ **Learn and adapt quickly**. Generate timely monitoring and evaluation loops covering (a) initial implementation of change, broken down change-by-change, team-by-team; (b) the ongoing management of the services; and (c) the quantified impact on outputs and outcomes. Identify successes and rapidly address the inevitable teething problems that will occur, and failures in design or execution. Scrap the interventions that don't work. Commission and contract so that organisational forms and financial flows are supporting the transformation rather than get in the way.

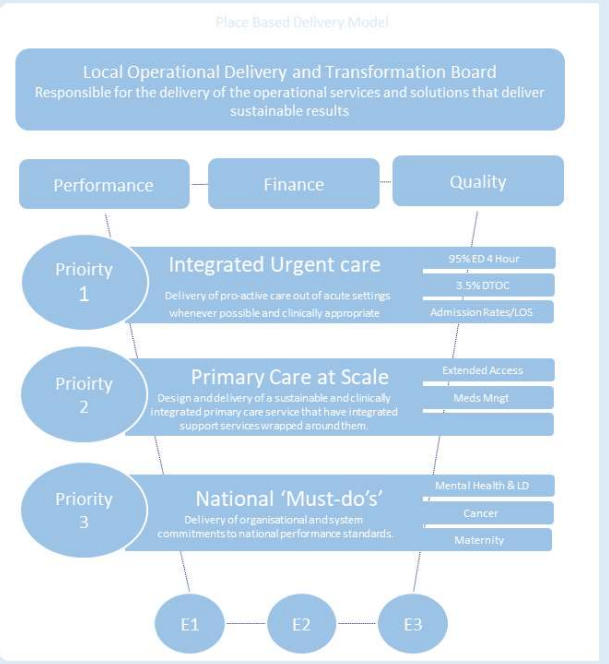
Model ICS Framework – for Discussion

Cambridgeshire and Peterborough Clinical Commissioning Group



"Integrated Care Systems are those in which commissioners and NHS providers, working closely with GP networks, local authorities and other partners, agree to take shared responsibility (in ways that are consistent with their individual legal obligations) for how they operate their collective resources for the benefit of local populations. "

Refreshing NHS Plans for 2018/19
Published by NHS England and NHS Improvement



DRAFT

HEALTH SCRUTINY COMMITTEE	AGENDA ITEM No. 8
17 SEPTEMBER 2018	PUBLIC REPORT

Report of:	Cambridgeshire and Peterborough Clinical Commissioning Group (CCG)	
Contact Officer(s):	Mark Hall, Commissioning & Contracts Manager LD and Marek Zamborsky, Head of Contracting & Commissioning Adult MH & Adult LD, Cambridgeshire and Peterborough CCG	

TRANSFORMING CARE – 'BUILDING THE RIGHT SUPPORT' (BRS) - INPATIENT BED CONFIGURATION. PREFERRED OPTION CONSULTATION

R E C O M M E N D A T I O N S

It is recommended that the Health Scrutiny Committee:

- Note the report and
- Support a nine-week formal consultation, on the reconfiguration of the LD bed base and development of Community Services.

1. ORIGIN OF REPORT

1.1 Report to the Health Scrutiny Committee regarding the upcoming consultation for inpatient beds for people with learning disabilities reconfiguration and a preferred community service model option consultation.

2. PURPOSE AND REASON FOR REPORT

2.1 This document sets out the CCG proposal to consult on closure of inpatient beds, in order to invest in alternatives to hospital and community based services for patients with learning disabilities and autism in Cambridgeshire and Peterborough, in line with the recommendations of the Department of Health review of care at the Winterbourne Hospital.

2.2 This report is for the Health Scrutiny Committee to consider under its Terms of Reference Part 3, Section 4 - Overview and Scrutiny Functions, paragraph No. 2.1 Functions determined by Council - Public Health and Scrutiny of the NHS and NHS providers.

3. BACKGROUND AND KEY ISSUES

3.1 A number of Department of Health reports concluded that commissioning across health and care services should aim to reduce the number of inappropriately placed people in treatment and assessment centres. This is now known nationally as the Transforming Care (TC) Programme for people with learning disabilities and autism.

In Cambridgeshire and Peterborough, there are currently sixteen beds in total. This is broken down into six beds at the Intensive Assessment and Support Service (IASS) on the Ida Darwin site in Cambridge which were closed due to falling demand in 2016 and ten beds at The Hollies at the Cavell Centre in Peterborough. Of these:

- all six beds at the IASS were commissioned by the Learning Disability Partnership (LDP)

and have been closed since 2016 and funding was a proportion of funding was re-invested into Community Services.
- five beds at The Hollies are commissioned from Cambridgeshire and Peterborough NHS Foundation Trust (CPFT) by the Cambridgeshire Learning Disability Partnership (LDP) Pooled Budget for patients from Cambridgeshire
- five beds at The Hollies are commissioned by the CCG for patients from Peterborough.

The local TC Programme is proposing the reconfiguration of the current 10 beds in The Hollies, due to low occupancy levels and also to meet national requirements to reduce the number of inpatient beds for people with a learning disability and/or autism.

This would mean:

- the ratification of the formal closure of the six beds in IASS Ward which have been closed since 2016;
- the need to consult on the closure of the service in The Hollies, currently 10 beds;
- commissioning 5 beds for LD patients.

The proposed changes are achievable within existing local budgets, and the savings would be reinvested into community services and a 'crash pad' resource – a non-hospital based crisis management service.

The proposed changes deliver positive patient clinical outcomes, enhance patient experience, and maintain patient safety and will allow people to receive care closer to home when their clinical needs change.

Supporting Information for the reduction of local beds

Number of beds and utilisations

- Bed occupancy at The Hollies has been between consistently low for the last two years in the region of 30–60%.
- The local system has not been using the IASS beds from 1 April 2016 due to low demand.
- The TC Partnership do, however, have out of area placements where patients from Cambridgeshire and Peterborough have to go to a hospital in another part of the country (Norfolk and Hertfordshire borders) for treatment. Out of area placements account for 60% of current admissions due to acuity and The Hollies' inability to support for reasons other than bed availability.
- The average length of stay in a hospital for people with a learning disability and/or autism is measured in years in many cases. Most admissions in Cambridgeshire and Peterborough are short term with 80% of all admissions discharged within 90 days.

The local service at The Hollies is not able to support all patients for reasons other than just acuity. Analysis shows that the make-up of the local inpatient population currently consists of several groups:

- Patients that can be supported by the assessment and treatment unit locally.
- Patients that can be supported in the mental health ward with reasonable adjustments, but end up in a specialist learning disability bed because they have a learning disability.
- Patients that require appropriate, more specialist inpatient provision, such as autism services, locked rehabilitation, or any other expert skill not available locally due to scale of economy

Preferred Option

The local TC Partnership is proposing to contract and commission five beds in the new service model for assessment and treatment with reasonable adjustments to local mental health inpatient ward(s), for people with a learning disability who can be safely and appropriately supported.

This will mean a formal closure of the six beds in the IASS Ward which have not been used since 2016, and formal closure of the 10 beds at The Hollies. The total number of specialist inpatient treatment and assessment beds for people with a learning disability and/or autism would then be five locally for the purpose of assessment and treatment.

The actual location of the five beds and the actual provider of the beds will need to be determined as the post consultation model is implemented and finalised.

The new service model would be cost neutral as the savings from closing the beds would be reinvested into services for people with a learning disability and/or autism. The reduced number of beds will be supported by the enhancement of community teams and crash pad (non-hospital based crisis management service), as well as enhancement of community autism services.

What are people with a learning disability are getting now	What we propose people with a learning disability get in the future
• Beds at IASS (not used, building not suitable) • Ten beds at The Hollies (30-60% occupancy) • Out of CCG area placements for specialist - and sometimes non specialist - treatments • 9-5 community mental health services and Intensive Support Team in Peterborough • 9-5 and when required out of hours integrated health and social care team in Cambridgeshire	• Five treatment and assessment beds for people with a learning disability, as the very last resort of support when really needed • Extended community support in terms of extra capacity and out of hours support as required (note not 24/7) – from a unified, integrated team across Peterborough and Cambridgeshire, based on the LDP model (another milestone of the local TC Programme) • Crisis house - a "crisis pad" for when the reason for hospital admission is a breakdown of social care placement only due to changes in Clinical Needs • Out of CCG area placements for specialist needs (1-5 placements maximum) • Enhanced adult autism services compared to the current baseline

Recommendation

The Health Committee is therefore asked to:

- Note the report and
- Support a nine-week formal consultation, on the reconfiguration of the LD bed base and development of Community Services.

4. CONSULTATION

4.1 The public consultation is scheduled for a period of nine weeks, from Friday 10 August until 5pm Friday 12 October 2018.

5. ANTICIPATED OUTCOMES OR IMPACT

5.1

Area	To Note

Clinical Effectiveness	• Community enhancement is already taking root with enhanced provision locally. • Occupancy levels within commissioned inpatient provision have reduced significantly since the time when the beds were originally commissioned. • Systemic qualification of need for admission through the national TC Review process and scheduled multi-agency review of all hospital admissions ensure that support is in place for hospital admission and alternatives to admission as required.
Patient Experience	• Alternatives to hospital admission are at the centre of implementation of the proposed model. • Specialist inpatient beds will be retained to care for and support those that require admission and these facilities will be more closely aligned to community pathways to facilitate timely discharge and more robust discharge arrangements.
Patient Safety	• Community provision will be enhanced to support individuals in crisis through increasing hours of operation (8am until 8pm and weekends). • 'Crash pad' facilities will be commissioned to accommodate and support individuals in a crisis, where previously hospital admission might have been an option. • A defined number of specialist beds for people with a learning disability and/or autism will continue to be commissioned to facilitate hospital admission where absolutely necessary. • In addition, mainstream adult mental health wards will 'reasonably adjust' to accommodate the needs of some patients that can function well and safely in an adult mental health ward setting.

6. REASON FOR THE RECOMMENDATION

6.1 The Cambridgeshire and Peterborough TC Partnership requires the support of the CCG and the local statutory partners to deliver the TC Programme.

The proposed consultation:

- is in line with national and CCG policies;
- delivers better clinical outcomes, and improves patients experience and provides care closer to home.
- is supported by Impact Assessments and support the change in service model;
- is consistent with models of care which have been implemented in other localities across the country;
- delivers within existing budgets and allows efficient use of money by reinvesting resources into community services, to support people to remain in a community setting.

7. ALTERNATIVE OPTIONS CONSIDERED

7.1 Below are the options that have been considered by the Transforming Care Partnership.

Full details are provided in the Consultation Documents (Appendices 1 and 2) and Impact Assessments (Appendix 3).

Option 1- Do Nothing
Continue to commission the 10 beds at the Hollies as per the current use and close six beds at IASS.
Option 2 – Retain local beds only with no option of out of area beds or further community investment

Consolidate all bed requirements to a local Assessment and Treatment Unit (ATU) based at The Hollies and close six beds at IASS.
Option 3- No dedicated local beds
Move to a 'No Bed Model' and develop spot purchase arrangement for beds in other hospitals with some local reasonable adjustments for patients with learning disabilities and/or autism that can function on mental health wards in addition to the enhancement to community teams.
Option 4 –5 beds and expand community services
Move to 5 beds model, spot purchase for speciality needs, reinvest the money to enhance local community services for people with learning disabilities.

8. IMPLICATIONS

Financial Implications

8.1 The preferred option is possible within the existing budgets by investing back into the community services.
Proposed utilisation of released finances from beds reconfiguration:

Area of Investment	Investment
Extended Community Service capacity and crisis management	£635,000
Crisis Pad	£240,000
Autism Post Diagnostic Services Support/Treatment	£240,000
Forensic Community Support	£200,000

Equalities Implications

8.2 The future service model will increase accessibility with reasonable adjustment arrangements within mainstream mental health inpatient services, and increase capacity to better support people with autism across the health and social care system in the community.

9. BACKGROUND DOCUMENTS

9.1 CCG Governing Body Report
https://www.cambridgeshireandpeterboroughccg.nhs.uk/easysiteweb/getresource.axd?assetid=15485&type=0&servicetype=1

National Guidance: Building the Right Support
https://www.england.nhs.uk/wp-content/uploads/2015/10/ld-nat-imp-plan-oct15.pdf

10. APPENDICES

10.1 Appendix 1: Consultation Document
Appendix 2: Consultation Document – Easy Read
Appendix 3: Impact Assessments

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NHS
Cambridgeshire and Peterborough
Clinical Commissioning Group

‘Community First’ - consultation on proposed changes to the provision of inpatient beds for people with a learning disability in Cambridgeshire and Peterborough

10 August 2018 to 5pm 28 September 2018

Consultation extended to 5pm on Friday 12 October 2018

This consultation is aimed at patients registered at GP practices within Cambridgeshire and Peterborough Clinical Commissioning Group's area.

This document is available in other languages and formats, including Easy Read, on request.

To request alternative formats, or if you require the services of an interpreter, please contact us on:

- 01223 725304
- CAPCCG.contact@nhs.net

Pokud byste požadovali informace v jiném jazyce nebo formátu, kontaktujte nás

જો તમને માહિતી બીજી ભાષા અથવા રચનામાં જોઈતી હોય તો, કૃપા કરી અમને વિનંતી કરો.

Se desiderate ricevere informazioni in un'altra lingua o in un altro formato, siete pregati di chiedere.

Jei norėtumėte gauti informaciją kita kalba ar formatu, kreipkitės į mus.

Jeżeli chcieliby Państwo uzyskać informacje w innym języku lub w innym formacie, prosimy dać nam znać.

Se deseja obter informação noutro idioma ou formato, diga-nos.

اگر آپ کو معلومات کسی دیگر زبان یا دیگر شکل میں درکار ہوں تو برائے مہربانی ہم سے پوچھئے۔

Amended on 22 August 2018

The consultation process

You can give your views in a number of ways:

- Fill in the questionnaire found online on the CCG's website at www.cambridgeshireandpeterboroughccg.nhs.uk

- Fill in the paper copy of the questionnaire in this consultation document at page 18 and send it FREEPOST to Freepost Plus RSCR-GSGK-XSHK, Engagement Team, Cambridgeshire and Peterborough CCG, Lockton House, Clarendon Road, Cambridge CB2 8FH (you do not need a stamp).

- Telephone the Communications and Engagement Team on 01223 725304.

- Attend one of the public meetings detailed below and tell us what you think:

Date	Venue	Time
Thursday 16 August 2018	Forli Room, Town Hall, Bridge Street, **Peterborough, PE1 1FH**	**1.30pm - 3.30pm**
Thursday 23 August 2018	Suite 1, Stanton Training and Conference Centre, Stanton House, Stanton Way, **Huntingdon, PE29 6XL**	**1pm - 3pm**
Thursday 6 September 2018	The Meadows Community Centre, Arbury, **Cambridge, CB4 3XJ**	**1pm - 3pm**
Thursday 11 October 2018	Forli Room, Town Hall, Bridge Street, **Peterborough, PE1 1FH**	**1pm - 3pm**

* Please note that we are unable to provide refreshments at meetings

- If you belong to a group or organisation, you can invite us along to one of your meetings by contacting the Communications and Engagement Team on 01223 725304 or by emailing CAPCCG.contact@nhs.net

- Current patients and carers will be contacted directly about how they can discuss these changes and feedback their views.

Who we are and what we do

Cambridgeshire and Peterborough Clinical Commissioning Group (the CCG) is a statutory body set up to commission health services on behalf of patients registered at a GP practice in our area. The CCG and GP member practices work together collaboratively to fulfil the purpose of the CCG. The CCG's Constitution sets out how the organisation is governed and how commissioning decisions are made.

The CCG is a membership organisation. We are one of the largest CCGs in England, by patient population. We have 101 GP practices as members, which cover all GP practices in Cambridgeshire and Peterborough as well as three practices in North Hertfordshire (Royston) and two in Northamptonshire (Oundle and Wansford).

We have a patient population of around 967,000 which is diverse, ageing, and has significant inequalities. We manage a budget of around £1.2bn to spend on healthcare for the whole population of this area, which is just over £1,000 per person.

The NHS receives a fixed budget to buy and provide health services for the local population. When commissioning (the process of planning and buying) health services we do so specifically for the health needs which have been identified locally for our population. We make decisions about which health services to purchase, based on these identified needs. Like many CCGs up and down the country, there is greater demand on our budget than we have the budget to spend.

The challenge faced by all organisations across the NHS is how to spend the available budget in ways that most benefit the health of the whole population and which deliver good value for money. We have a growing population, which is also an ageing population that is diverse and has significant inequalities. We have a limited budget and a growing demand for all types of healthcare services, as well as a financial deficit that needs to be cleared.

The CCG has to evaluate every service that it commissions to see if it offers good quality, good outcomes, and good value for money, as well as whether it is an effective and equitable way of allocating our resources for the benefit of the whole population.

What is this document about?

This document is about proposed changes to the commissioning of adult inpatient beds – beds in hospitals - for people with a learning disability who need extra support, including a mental health condition; and reinvestment in community services to ensure care and support is provided at home or in the normal care setting wherever possible.

The consultation applies to people registered at a GP practice in Cambridgeshire and Peterborough but not those in Hertfordshire or Northamptonshire.

What are the issues that need to be addressed?

People with a learning disability and/or autism have the right to the same opportunities as anyone else; to live satisfying and varied lives and to be treated with dignity and respect.

Like everyone else, people with a learning disability and/or autism should be able to expect to live in their own home or another place of care within their local community, to develop and maintain positive relationships, and to receive the support they need to be healthy, safe, and an active part in society. See 'Building the Right Support'[1].

The national Transforming Care Programme was established in 2012 following the Department of Health review[2] into poor treatment and abuse of people with a learning disability and/or autism at Winterbourne View.

The Transforming Care Programme aims:

- to reduce the use of specialist hospitals, especially where people were being placed a long way from home and spending a significant period of time there
- to develop robust, community based services that can offer support in a crisis
- for assessment and treatment beds in hospitals to be used only where absolutely necessary, and with timely discharge back into the community.

In 2014 Sir Stephen Bubb undertook a further review[3] that led to a more structured approach to the Transforming Care Programme, with greater oversight and monitoring by NHS England through a national board. Local boards have also been set up to ensure that targets are met locally, with a focus on developing community services for people who have been in hospital for over five years. Developing community services to respond in a crisis, as well as developing the workforce and services, continue to be key in avoiding admitting people to hospital.

The CCG, Cambridgeshire County Council, Peterborough City Council, and Cambridgeshire and Peterborough NHS Foundation Trust (our local mental health and community services provider), with others, have written a strategy for delivering the Transforming Care Programme locally. The local strategy, Building on Strong Foundations (June 2016), aims to help people live satisfying and fulfilling lives as close to home as possible and with the right support. The aim is to ensure that the right care and support is delivered in the community wherever possible.

We would like to invest more money in community services and reduce the need for inpatient beds. In most circumstances, if community services are able to support more people to live at home or closer to home, then we can reduce the need for inpatient services.

[1] https://www.england.nhs.uk/learning-disabilities/natplan/

[2] https://www.gov.uk/government/publications/winterbourne-view-hospital-department-of-health-review-and-response

[3] https://www.england.nhs.uk/wp-content/uploads/2014/11/transforming-commissioning-services.pdf

However, it is important to emphasise that where a hospital admission is the most appropriate option for a person with a learning disability and/or autism then they should be able to access inpatient services as required. Our aim is that these services should be a last resort, of high quality, integrated with community services, and focus on people's recovery so that they can be discharged back to the community in a timely way.

To do this we are planning to redesign inpatient services and to invest in community and primary preventative services for people with a learning disability and/or autism. We are asking for your views on our proposals.

In Cambridgeshire and Peterborough, inpatient services for people with a learning disability and/or autism who need extra support, including a mental health condition, are commissioned by:

- Cambridgeshire and Peterborough CCG and Learning Disability Partnership for patients living in the Cambridgeshire County Council area
- Cambridgeshire and Peterborough CCG for patients living in the Peterborough City Council area.

Across Cambridgeshire and Peterborough there is currently a total of 16 inpatient beds, commissioned by the CCG and the Learning Disability Partnership, for people with a learning disability and/or autism. Six of the beds are at the IASS ward on the Ida Darwin site at Fulbourn and ten beds are at The Hollies at the Cavell Centre in Peterborough.

The IASS was a six-bed inpatient ward for people with a learning disability. It was commissioned by the Learning Disability Partnership and was run by Cambridgeshire and Peterborough NHS Foundation Trust, our local NHS mental health and community services provider. The unit has not been used since 1 April 2016 due to very low demand and the building not being fit for purpose. This allowed commissioners to temporarily consolidate the beds into The Hollies.

The Hollies is a specialist, ten-bed unit which provides assessment and treatment for adults with a learning disability. The service at The Hollies is commissioned as follows:

- Five beds commissioned from Cambridgeshire and Peterborough NHS Foundation Trust by the Learning Disability Partnership for patients from Cambridgeshire
- five beds commissioned by the CCG for patients from Peterborough.

In addition, the Learning Disability Partnership and the CCG commission Cambridgeshire and Peterborough NHS Foundation Trust to provide community services across the whole of the Cambridgeshire and Peterborough Transforming Care Partnership area.

We also commission a small number of 'out of area' beds as required. These are inpatient beds outside of Cambridgeshire and Peterborough CCG's area which are

additional to the number of locally-commissioned beds, and usually purchased to meet particular special needs or requirements.

By reducing the number of inpatient beds we will be able to reinvest the money we save into strengthening community services. This will help us to achieve the Transforming Care Programme's aim of commissioning and delivering better care closer to home, and improved services for people with a learning disability and/or autism and their families.

Why are we consulting with you now?

In line with the progress of the national and local programme, we have analysed our local use of inpatient beds and believe that the proposed changes will provide better clinical and patient experience outcomes for our patients, whilst delivering more effective and safe services.

What we are asking you

We have set out the options that we have considered, below. Having reviewed all of these options, we have agreed a **preferred option (Option 4)** that we are now seeking views and comments on. We believe that Option 4 will be the best option to deliver the future model of service provision as well as the objectives of the local Transforming Care Plan ('Building on Strong Foundations' 2016), in line with the expectations of the national policy called 'Building the Right Support'.

Option 1 – Do nothing

Continue to commission the 10 beds at the Hollies as per the current use and close six beds at IASS. This in brief includes five beds commissioned through Cambridgeshire and Peterborough CCG and five beds commissioned through the Learning Disability Partnership. This would also include the continuation of spot purchasing out of area beds as required.

Pros	Cons
No Change.	The Hollies ward is not used fully, because the unit cannot support all the people that would need hospital admission, so we need to buy other hospital beds out of area.
	Not cost effective because commissioners are required to 'double fund' placements by placing patients out of area whilst there are vacant beds at the local ward.
	Outcomes for Transforming Care Programme and NHS England would not be met.

Option 2 – Retain local beds only with no option of out of area beds or further community investment

Consolidate all bed requirements to a local Assessment and Treatment Unit (ATU) based at the Hollies and close six beds at IASS, with no spot purchased out of area beds which are currently used in situations where the Hollies is not able to support the person.

Pros	Cons
Inpatient services would remain local and provide greater accessibility for patients and visitors including family members.	Capacity of local ATU to care effectively and safely for a range of needs that may require a diversity of support and treatment including intermediate care or 'safe and secure' rehab type pathways.
Existing skill set and staff experience would be retained.	Experience of existing provision and the reality, even with enhanced 'safer staffing' levels, of not being able to meet the needs of local patients having to be placed out of area sometimes at the behest of the local ATU itself.
Eliminate the need to send patients out of area away from their families and local communities making it, in theory, easier to facilitate timely discharge with local community services.	Limitation of commissioners to purchase bespoke inpatient services for patients with highly complex needs that may require highly specialised provision or hospital care within a single occupancy setting.
Provide greater cost effectiveness with commissioners no longer required to 'double fund' placements by placing patients out of area whilst there are vacant beds at the local ATU.	Impact on alternatives to admission and the capacity to change the service across the health system with resources tied up in bed based provision, hampering the requirement to build up new and innovative community alternatives in 'cash flat' times.
Improve monitoring of care and treatment and consistency of quality with provision consolidated in one inpatient setting.	Future intent of current provider regarding hospital estate and service development beyond provision of inpatient services for people with learning disabilities.
	Significant environmental changes would need to be made to the Hollies ward to meet the needs of patients.

	Significant changes to and for staff would need to be made and accommodated for increased intensity and complexity of patient needs.
	With increase in intensity, unpredictability, complexity, and nature of this cohort of patients, there will be increased risks associated both to staff and to other patients on the ward.

Option 3 – No dedicated local beds

Decommissioning of local ATU (10 beds at the Hollies) and six beds at IASS. Instead move to a 'No Bed Model' and develop spot purchase arrangement for beds in other hospitals with some local reasonable adjustments for patients with learning disabilities and/or autism that can function on mental health wards in addition to the enhancement to community teams.

Pros	Cons
Secure a funding stream that would guarantee re-investment in community services and alternative inpatient services as and when required. This means expansion of specialist community services including larger community teams with broader skills, which would reduce the need to admit patients. Investment into crisis accommodation called 'crash pad'.	There will be a risk of increased out of area admissions which does not support the outcomes of the national Transforming Care Programme.
Patient centred spot purchased beds may best ensure highly complex patient needs are met, which could result in shorter hospital admissions and timely patient discharges.	Out of area admissions at a distance from the person's home would be contrary to Transforming Care agenda and counterproductive, with care being provided away from local community, potential for increased length of stay in institutional settings, and the practical difficulties of monitoring quality of care and slowdown in discharge preparation.
Create new pathways and better integration with other specialist and mainstream services including the local First Response Service and access to existing community provision with reasonable adjustment as examples.	Loss of skills as specialist inpatient staff may be redeployed outside of specialty or transferred to newly commissioned alternative providers.

Create the capacity to recycle specialist skills within enhanced community services and share skills with wider provision to embed reasonable adjustments and make it a reality.	Integration of patients with a learning disability in mental health wards may work for some but not all within the spectrum of learning disabilities, placing the most complex and vulnerable people at further risk.
Better meeting the needs and preferences of people with learning disabilities and their families as support and interventions are provided in the least restrictive manner in their own homes within the community.	Capacity and willingness of providers of non-learning disability services to want to embrace a model that may impact negatively on existing mental health pathways.
Develop a robust independent and in house (council) community provider marketplace that supports the prevention agenda with a skilled and trained workforce.	May require additional money to support 'reasonable adjustment' in mental health inpatient settings with the assumption that the existing estate could accommodate any necessary capital work.
	Potential issues with sourcing and securing an out of area specialist bed when needed (as the last resort) if on a spot purchase basis; as experience is that bed capacity is limited, and will be further limited as the Transforming Care Programme progresses nationally with sites affected across the independent hospital sector.

Option 4 – preferred option

Decommissioning of the local ATU (10 beds at the Hollies) and six beds at IASS with reinvestment to develop the following services:

- Investment to enhance the local community teams, to provide more capacity for early intervention to prevent crises developing, and more capacity to support people intensively who do reach crisis.

- Strengthening the expertise of staff in local care, support, and housing agencies to support people who need extra support.

- Development of more 'crash pad' facilities that can offer a break from current living arrangements, with support and interventions from experienced staff who know the person, to avoid admission to hospital.

- Where a mental health condition is the overriding issue and where this is considered the most appropriate response, make reasonable adjustments for

people with learning disabilities and/or autism to access mainstream mental health wards (ideally one in Cambridgeshire and one in Peterborough).

- Commission five specialist inpatient beds to meet the needs of those people who cannot be supported on mainstream mental health wards, or for whom this would not be appropriate. This could be commissioned from Cambridgeshire and Peterborough NHS Foundation Trust, another NHS trust, or an independent sector provider. The CCG will want to consider all options.

Pros	Cons
Continuity of medical professional for patients admitted in area would reduce the risk of delayed discharges and best ensure focused and holistic assessment and treatment.	Economy of scale cannot be ensured with a reduced number of beds thus this arrangement may be more expensive for a commissioned service.
The enhanced local forensic pathway* linked with the mainstream pathway would better ensure targeted assessment, treatment, and after care support. (*Forensic mental health services work with people who have mental health conditions and have committed a serious criminal offence, or are thought to be at high risk of committing an offence. (Definition taken from South West London and St George's Mental Health NHS Trust website)).	Retain resources disproportionately in bed based provision which may significantly compromise capacity to develop and deliver community based alternatives.
Create new pathways and better integrate with other specialist and mainstream services, including the local First Response Service, and access to existing community provision with reasonable adjustment as examples.	Impact of decommissioning intent in the Independent sector and commitment and mandate from NHSE not to place in such services
Reassure medical professionals treating patients with a learning disability that bed availability is within the new model when absolutely required.	Flexibility of provision and contract as new provider may require a significant financial commitment in order to undertake provision including 'locking' commissioners into a block contract arrangement.
Create the capacity to recycle specialist skills within enhanced community services and share skills with wider provision to embed reasonable adjustment and make it reality.	Risk that mainstream beds become blocked if they are not ring-fenced for patients with a learning disability which would result in increased out of area placements.

Release money to invest in ‘alternative to admission’ provision including ‘crash pad’ type facilities locally.	Risk that the reasonable adjustments to mainstream beds, including Learning Disability Nurses, may not be consistently available which may result in unnecessary out of area placements.
Better meeting the needs and preferences of people with learning disabilities and their families, as support and interventions are provided in the least restrictive manner in their own homes within the community.	
Develop a robust independent and in house (council) community provider market place that supports the prevention agenda with a skilled and trained workforce.	
Expansion of specialist community services by investing in larger community teams with broader skills would reduce need for patients to be admitted.	
Use of spot-purchased out of area beds would be reduced thus meeting TCP and NHS England outcomes and trajectories.	
Local commissioned ATU beds could be enhanced and underpinned by medical professionals in the community within the enhanced community model; thus maximising investment and reducing a fragmented approach which will result in improving the patient ‘experience’ and outcomes	

Engagement to date

We have engaged with stakeholders, including people with a learning disability and/or autism and their carers, through a range of meetings, including:

- the Transforming Care Partnership Board
- other cross agency meetings.

We also held a health and social care event called ‘Community First’ in Cambridgeshire in October 2017 and presented to a Cambridgeshire-wide Speak Out Council event in Isleham about our transforming care plan. We realise that we need to engage much further as part of this consultation.

How to tell us your views

- Fill in the questionnaire on our website: www.cambridgeshireandpeterboroughccg.nhs.uk/get-involved/consultations

- Fill in the paper copy of the questionnaire found on page 18 of this consultation document and send it FREEPOST to: Freepost Plus RSCR-GSGK-XSHK, Cambridgeshire and Peterborough CCG, Lockton House, Clarendon Road, Cambridge CB2 8FH. You do not need a stamp.

- Telephone the Communications and Engagement Team on 01223 725304.

- Current patients and carers will be contacted directly about how they can discuss these changes and feedback their views.

- We will attend meetings organised by groups who are interested in the proposed changes. If you would like us to attend your meeting please contact us as below:

    - Phone: 01223 725304

    - Email: capccg.contact@nhs.net

Why we consult

Legal requirements

This consultation document has been drawn up in accordance with the following legal requirements and guidance:

Cabinet Office Consultation Principles July 2012

This guidance sets out the principles that Government departments and other public bodies should adopt for engaging stakeholders when developing policy and legislation. It replaces the Code of Practice on Consultation issued in July 2008. The governing principle is proportionality of the type and scale of consultation to the potential impacts of the proposal or decision being taken, and thought should be given to achieving real engagement rather than merely following bureaucratic process. Consultation forms part of wider engagement and decisions on whether and how to consult should in part depend on the wider scheme of engagement.

Policy makers should bear in mind the Civil Service Reform principles of open policy making throughout the process and not just at set points of consultation, and should use real discussion with affected parties and experts as well as the expertise of civil service learning to make well informed decisions. Modern communications technologies enable policy makers to engage in such discussions more quickly and in a more targeted way than before, and mean that the traditional written consultation is not always the best way of getting those who know most and care most about a particular issue to engage in fruitful dialogue.

The full consultation principles document can be accessed via the Cabinet Office website at:
https://www.gov.uk/government/publications/consultation-principles-guidance

Section 14Z2 Health and Social Care Act 2012

14Z2 Public involvement and consultation by clinical commissioning groups

(1) This section applies in relation to any health services which are, or are to be, provided pursuant to arrangements made by a clinical commissioning group in the exercise of its functions ("commissioning arrangements").

(2) The clinical commissioning group must make arrangements to secure that individuals to whom the services are being or may be provided are involved (whether by being consulted or provided with information or in other ways)—

> (a) in the planning of the commissioning arrangements by the group,
>
> (b) in the development and consideration of proposals by the group for changes in the commissioning arrangements where the implementation of the proposals would have an impact on the manner in which the services are

delivered to the individuals or the range of health services available to them, and

(c) in decisions of the group affecting the operation of the commissioning arrangements where the implementation of the decisions would (if made) have such an impact.

(3) The clinical commissioning group must include in its constitution—

(a) a description of the arrangements made by it under subsection (2), and

(b) a statement of the principles which it will follow in implementing those arrangements.

(4) The Board may publish guidance for clinical commissioning groups on the discharge of their functions under this section.

(5) A clinical commissioning group must have regard to any guidance published by the Board under subsection (4).

(6) The reference in subsection (2) (b) to the delivery of services is a reference to their delivery at the point when they are received by users.

For more on the Section 14Z2 Health and Social Care Act 2012 see http://www.legislation.gov.uk/ukpga/2012/7/section/26/enacted

Assurance of service change

The five tests of service change:

There must be clear and early confidence that a proposal satisfies the government's four tests, NHS England's test for proposed bed closures (where appropriate), best practice checks, and is affordable in capital and revenue terms. The government's four tests of service change are:

- Strong public and patient engagement.
- Consistency with current and prospective need for patient choice.
- Clear, clinical evidence base.
- Support for proposals from clinical commissioners.

NHS England introduced a new test applicable from 1 April 2017. This requires that in any proposal including plans to significantly reduce hospital bed numbers NHS England will expect commissioners to be able to evidence that they can meet one of the following three conditions:

i. Demonstrate that sufficient alternative provision, such as increased GP or community services, is being put in place alongside or ahead of bed closures, and that the new workforce will be there to deliver it; and/or
ii. Show that specific new treatments or therapies, such as new anti-coagulation drugs used to treat strokes, will reduce specific categories of admissions; or

iii. Where a hospital has been using beds less efficiently than the national average, that it has a credible plan to improve performance without affecting patient care (for example in line with the Getting it Right First Time programme).

CCG Constitution Section 5.2.

5.2. General Duties - in discharging its functions the NHS C& P CCG will:

5.2.1. Make arrangements to ***secure public involvement*** in the planning, development and consideration of proposals for changes and decisions affecting the operation of commissioning arrangements by:

a) ensuring that individuals to whom the services are being or may be provided are involved:

(i) in the planning of the CCG's commissioning arrangements;
(ii) in the development and consideration of the proposals by the CCG for changes in commission arrangements;
(iii) in the decisions of the CCG affecting the operation of commissioning arrangements, where the decisions would, if made, impact on the manner in which the services are delivered to the individuals or the range of health services available to them;

b) in order to understand the views of patients and the public and to disseminate relevant information to them, establishing and working closely with:

(i) a Patient Reference Group which is constituted as a committee of the Governing Body in accordance with this Constitution; membership will be formed from patient representatives elected by local patient forums;
(ii) the Quality, Outcomes and Performance Committee which is constituted as a committee of the Governing Body and considers patient experience, complaints and feedback;
(iii) Patient Participation Groups which will seek the views of local populations and assist with the dissemination of information, and representatives of which will sit on each local patient forum;

c) in order to understand the views of patients and the public and to disseminate relevant information to them, ensuring regular liaison and the development of close working relationships with each of the following bodies:

(i) Patient Forums, which are intended to give individuals the opportunity to raise questions or concerns about the provision of healthcare services at the wider county level;
(ii) Healthwatch, which gathers views of local people on local health services;
(iii) Health Overview and Scrutiny Committees which review the planning, commissioning and delivery of health services;
(iv) Health and Wellbeing Boards, each of which is a group of key leaders representing health and care organisations who work together to understand what their local communities need from health and care services and to agree priorities;

d) publishing a Communications Membership and Engagement Strategy, approved by its Governing Body and regularly revised to take into account any new guidance published by NHS England, which will be designed to ensure that the CCG involves patients and the public by a range of means that are suitable to different aspects of its commissioning arrangements, those means to include as appropriate:

(i) the publication of documents to disseminate relevant information about the commissioning arrangements;
(ii) regular attendance at key meetings, forums and events for the purpose of listening to the views of patients and the public, providing information about and explaining actions being taken or considered by the CCG, and answering questions;
(iii) the dissemination of information by means of the CCG website, emails, newsletters targeted at specific groups, media campaigns, advertising, and targeted engagement events;
(iv) the provision of an opportunity for patients and the public to make their views known via the CCG website, emails and other suitable means;
(v) the publication of consultation documents in relation to certain planning and commissioning activities, and the creation of specific engagement opportunities such as the use of public surveys and feedback forms;

e) in the implementation of the arrangements described above, acting consistently with the following principles:

(i) ensuring that appropriate time is allowed for the planning of activities and commissioning arrangements;
(ii) proactively seeking engagement with the communities which experience the greatest health inequalities and poorest health outcomes;
(iii) commencing patient and public involvement as early as possible and allowing appropriate time for it;
(iv) using plain language, and sharing information as openly as is reasonably practicable;
(v) treating with equality and respect all patients and members of the public who wish to express views;
(vi) carefully listening to, considering and having due regard to all such views;
(vii) providing clear feedback on the results of patient and public involvement.

You can read more about the CCG's duties to engage and consult in section 5.2 of the CCG's Constitution

https://www.cambridgeshireandpeterboroughccg.nhs.uk/easysiteweb/getresource.axd?assetid=4360

The questionnaire

1. Do you agree with our preferred option 4 starting on page 10?

2. If yes, why?

3. If not, why not?

4. Are there any other comments you would like to make in relation to the proposals outlined in this consultation document?

If organisations or groups would like to respond to this consultation, we are happy to receive letters or emails using the contact information below. In our end of consultation report we enclose full copies of these responses so please indicate if you wish your organisation or group response to remain private:

By post: (no stamp required)

Freepost Plus RSCR-GSGK-XSHK
Engagement Team
Cambridgeshire and Peterborough CCG
Lockton House
Clarendon Road
Cambridge
CB2 8FH

By email: capccg.contact@nhs.net

The closing date for receipt of responses to this consultation has been extended to 5pm on 12 October 2018.

Finally, to understand who has given their views, we would like to collect some details.

Any information provided in this section will only be used by Cambridgeshire and Peterborough Clinical Commissioning Group for the purpose of understanding who has responded to this consultation.

Can you tell us which of the following age bands you belong to?

	16-29 years		30-44 years		45-59 years		60-74 years		75+ years

How would you describe your gender?

How would you describe your ethnic background?

Do you consider yourself to have any disabilities and/or impairments?

Yes ☐ No ☐ Prefer not to answer ☐

Finally, please could you tell us the first part of your postcode?

Thank you for taking the time to complete this questionnaire.

The closing date for receipt of responses to this consultation has been extended to 5pm on 12 October 2018.

Through this public consultation your views will be fed into the development of the final proposal. All of the feedback received from all of the responses to this consultation will be collated into a report for the CCG's Governing Body to consider before it makes any decisions on the future of these services.

NHS
Cambridgeshire and Peterborough
Clinical Commissioning Group

CONSULTATION

Transforming Care for Adults with Learning Disabilities and/or Autism

10 August 2018 to
5pm 28 September 2018

Consultation extended to
5pm on Friday 12 October 2018

What will you read about?

Amended on 22 August 2018

Introduction

The care and treatment of patients at Winterbourne View was very bad.

People should have good and safe care. People should feel safe and happy.

Care and support needs to be better for people with a learning disability or autism.

This plan is about how we would like to make care and support better for adults with a learning disability or autism in Cambridgeshire and Peterborough.

And **we want your opinions.**

What we plan to do

This **consultation** is about plans to pay for specialist hospital beds for people who have a learning disability or autism.

This change is needed so that we can make services in your **community** better.

This is so patients get care and support closer to their homes.

It is also about how we support people with a learning disability or autism out of hospital.

The Hollies in Peterborough

In this document we are talking about hospital beds at the Hollies (Cavell Centre). They are specialist beds for people who have learning disabilities.

We want you to have your say on how we plan to make services better for adults with a learning disability or autism in Cambridgeshire and Peterborough.

When we have your views at the end of the **consultation** we will make a final plan on how we can make services better for you and need less **specialist hospital beds**.

Why we need to do it

The need to transform care started after people with a learning disability were abused at **Winterbourne View**.

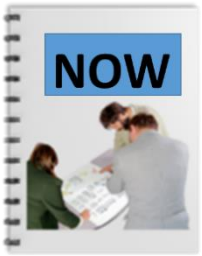
After what happened at Winterbourne View, a Government report called **Building the Right Support** told us what we needed to do to start making things better.

This job was given to Transforming Care Partnerships (TCPs).

Transforming Care is about making care and support better for people with a learning disability, autism, or both who need extra support during times of distress or illness**.**

We want there to be less specialist hospitals in the future.

With the right support people should be able to live in their own homes they have chosen in their **communities.**



At the moment in Cambridgeshire and Peterborough we pay for 10 hospital beds at the Hollies and support in the community. We also pay for some patients to be in hospital beds outside of Cambridgeshire and Peterborough.

What we need to do

Fewer hospital beds

People should only go into specialist hospital if:

- they are at risk of hurting themselves or other people
- when assessment and treatment cannot safely be given in the community.

Care and treatment in hospital must be what is right for the patient.
It must aim to get people well and back in to the community.

People should be in hospital for as little time as possible.

Plans for people to come out of hospital should be made as soon as the person goes in to hospital.

Hospitals should work with community services to make sure people get the right support when they leave hospital.

Better support in the community

Enhanced community support.
It means expert community support in the community for people with a learning disability or autism and who need extra support.

How you can contact us

Legal requirements
The full consultation principles document can be accessed via the Cabinet Office website at:
https://www.gov.uk/government/publications/consultation-principles-guidance
For more information please call the Communications and Engagement Team on 01223 725304.

Languages
This document is available in other languages and formats on request.
To request alternative formats, or if you require the services of an interpreter, please call us on 01223 725304.

Information on this consultation
Please call the Communications and Engagement Team on 01223 725304.

How we plan to do it

Option 1
Stay the same


The Hollies in Peterborough

✓ 10 beds at the Hollies in Peterborough.

Beds outside of Cambridgeshire and Peterborough.

Option 2
Use one hospital in Cambridgeshire/Peterborough


The Hollies in Peterborough

✓ 10 beds at the Hollies in Peterborough.

No beds outside of Cambridgeshire and Peterborough.

Option 3
No hospital beds – all community support


The Hollies in Peterborough

No hospital beds.

Enhanced community support.

Option 4 – The preferred option
Fewer hospital beds and better community support

Five hospital beds in Cambridgeshire and Peterborough.

Use the money saved from hospitals to provide more community services.

The Questionnaire

1. Which is your preferred option? ☑

	Option 1
	Option 2
	Option 3
	Option 4

2. Why is this your preferred option?

3. Is there anything you would like to say about any of the proposals outlined in this consultation document?

At the end of our consultation report we use copies of your questionnaires so please ☑ if you would like your questionnaire to be private:

☐ Yes, I am happy for my response to be seen by others.

☐ No, I would like my response to be private.

To have your say

Fill in the questionnaire on our website: www.cambridgeshireandpeterboroughccg.nhs.uk/get-involved/consultations

Send a completed copy of page 8 to:

Freepost Plus RSCR-GSGK-XSHK
Cambridgeshire and Peterborough CCG
Lockton House, Clarendon Road
Cambridge CB2 8FH.

You do not need a stamp.

Attend one of the public meetings detailed below and tell us what you think:

Peterborough
Date: Thursday 16 August
Time: 1.30pm - 3.30pm
Venue: Forli Room, Town Hall, Bridge Street, Peterborough, PE1 1FH

Huntingdon
Date: Thursday 23 August 2018
Time: 1pm - 3pm
Venue: Suite 1, Stanton Training and Conference Centre, Stanton House, Stanton Way, Huntingdon, PE29 6XL

Cambridge
Date: Thursday 6 September 2018
Time: 1pm - 3pm
Venue: The Meadows Community Centre, Arbury, Cambridge, CB24 5NW

Peterborough
Date: Thursday 11 October 2018
Time: 1pm - 3pm
Venue: Forli Room, Town Hall, Bridge Street, Peterborough, PE1 1FH

* Please note that we are unable to provide refreshments at meetings.

If you would like us to attend your meeting, please contact us on the number below.
www.cambridgeshireandpeterboroughccg.nhs.uk or contact the Communications and Engagement Team:

Phone: 01223 725304
Email: capccg.contact@nhs.net

Telephone the Communications and Engagement Team on 01223 725304.

The closing date for receipt of responses to this consultation is 5pm on 12 October 2018.

More information for you

Building the Right Support

https://www.england.nhs.uk/wp-content/uploads/2015/10/ld-net-plan-er.pdf

Winterbourne View Report

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/213216/easy-read-of-final-report.pdf

Transforming Care

https://www.england.nhs.uk/wp-content/uploads/2015/10/ld-serv-model-er.pdf

https://www.england.nhs.uk/wp-content/uploads/2017/02/easy-read-model-service-pec.pdf

Words section

Commission = planned services that we pay for.

Proposal = option.

Funding = pay for a service.

Specialist hospital bed = a bed in a hospital for people with a learning disability and / or autism who need assessment and treatment for mental health problems or who need extra support. They are NOT general hospital beds where patients go for an operation or after an accident.

Programme = a plan for the future.

Communities = for this document we mean the area that you live in because it means ‘home’ for you.

Enhanced = improvement or making services better.

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Impact Assessments for;

Project 110123 – Learning Disabilities – BRS Model

QIA

Project Name	**110123 - Learning Disabilities - BRS Model**
Is a QIA required?	Yes
Reason why a QIA is not required*	
Clinical Effectiveness Description	Community enhancement is already taking root with enhance provision locally and the implementation of 'wrap around' support for individuals in crisis and acuity this has effectively prevented and avoided hospital admission. Occupancy levels within commissioned inpatient provision has reduced significantly in recent years as clinical services and health and social care professionals develop and implement community solutions to effectively manage crisis, risk and behaviours that challenge.
Clinical Effectiveness Consequence	3
Clinical Effectiveness Likelihood	3
Clinical Effectiveness Risk	9
Clinical Effectiveness Mitigating Actions	Systemic qualification of need for admission through the Transforming Care CTR process and scheduled multi-agency review of all hospital admissions ensure that support is in place for hospital admission and alternatives to admission as required.
Clinical Effectiveness Post Mitigating Risk	9
Patient Experience Description	Hospital admission can be a highly distressing experience for people with learning disabilities and /or autism. Admission periods are often lengthy and can lead to loss of accommodation and support. Some admissions require Out of Area placement due to inability of local services to support individuals within their home communities. A small number of people will require hospital admission where absolutely necessary and provision should be in the most appropriate setting linked to a community pathway to facilitate timely discharge and on-going support.
Patient Experience Consequence	4
Patient Experience Likelihood	3
Patient Experience Risk	12

Patient Experience Mitigation	Alternatives to hospital admission are at the centre of implementation of the BRS model. The preferred option invests and implements community solutions including enhanced community provision available out of hours and local facilities such as a 'crash pad' to accommodate and support individuals during crisis. Specialist inpatient beds will be retained to care and support those that require admission and these facilities will be closer aligned to community pathways to facilitate timely discharge and more robust discharge arrangement.
Patient Experience Post-mitigation Risk	6
Patient Safety Description	Future BRS model will invest resources in community pathways as an alternative to hospital admission. This may increase risk within the community and to the individual patient if effective community responses are not in place and accessible at the point of need. The proposed BRS model (preferred option) seeks investment and realignment of resources toward community solutions such as enhanced intensive support teams and 'crash pad' facilities. The preferred option also includes access to a reduced number of hospital beds when absolutely necessary and when all other least restrictive arrangements have been exhausted.
Patient Safety Consequence	5
Patient Safety Likelihood	3
Patient Safety Risk	15
Patient Safety Mitigation	Community provision will be enhanced to support individuals in crisis through increasing hours of operation (8am till 8pm and weekends). 'Crash pad' facilities will be commissioned to accommodate and support individuals in crisis where previously hospital admission may have been an option. A defined number of specialist LD and /or Autism beds will continue to be commissioned to facilitate hospital admission where absolutely necessary. In addition mainstream AMH wards will 'reasonably adjust' to accommodate the needs of some patients that can function well and safely in an AMH ward setting.
Patient Safety Post Mitigation Risk	9
IA Submitted for Review	To be reviewed
Impact Assessment Approved	To be reviewed

EIA

Project Name	110123 - Learning Disabilities - BRS Model
What are the aims and objectives?	Consultation on the implementation of the 'Building the Right Support' (BRS) model for people with learning disabilities and/or autism across Cambridgeshire and Peterborough. Specifically engagement and views sought on a preferred option. The preferred option requires investment in community based provision and least restrictive alternatives to hospital admission. This will include enhancement of intensive support provision and extension of operating hours of community teams. The establishment of a 'crash pad' facility in support of crisis in the community and further investment in Positive Behavioural Support training to upskill workforces to better meet need and acuity in the community. The preferred option is part of the local Transforming Care Partnership work plan 'Building on Strong Foundations' (2016) linked to the NHS England hospital bed trajectory target for Cambridgeshire and Peterborough. The proposal calls for a reduced number of commissioned learning disabilities specialist beds based on national directive and evidence of reducing occupancy levels in recent years as alternatives to admission and better ways of managing need in community settings take root.
What are the desired outcomes?	To provide contemporary care and support in the least restrictive environment. To secure investment and enhancement in community based provision. To continue to provide a reduced number of inpatient beds to be used only as a last resort when all least restrictive alternatives have been exhausted. To deliver 'parity of esteem' and 'reasonable adjustment' in services that could meet the needs of some people with learning disabilities and /or autism with better access and support i.e. AMH wards To consult and engage with people with learning disabilities and/or autism about a future model / preferred option and utilise those views positively.
What changes or actions changes or actions do you propose to take as a result of any consultation	The outcome of the consultation will shape preferred option proposal and may change the way community services are delivered and bed configuration. Consultation phase June/July. Outcome of consultation and preferred option changes august / sept. Implementation phase beginning 1 October 2018.
What changes or actions do you propose to make or take as a result of research and/or consultation?	Consultation and engagement planned for June 2018. Consultation period will be lengthened to account for needs of people with learning disabilities and others. Advocacy agencies will work in partnership with regard to engagement strategies including user accessible material and community meetings throughout consultation period.

What factors could contribute to the desired outcomes?	Transforming Care Partnership committed to community model of investment and service delivery. Performance management arrangements and KPI's set and monitored by NHS England. Positive outcome from consultation and engagement on the preferred option proposal. Evidence base locally and reduced occupancy levels in inpatient settings overtime.
What factors could detract from the desired outcomes?	Outcome of intended consultation and engagement. Commitment of commissioners and providers to make the required changes. Progress on project plan within expected timeframes. Financial pressures within the local health and social care economy.
What monitoring/evaluation/review systems have been put in place?	There is a robust project plan in place which has been positively received at NHS England. A steering Group will support the consultation, engagement and implementation of preferred option outcome. TCP Board and TCP executive direct monitor and support all activities within the TCP work plan and associated milestone targets.
What was the outcome of the consultation, if undertaken?	Yet to take place.
When will it be reviewed?	Weekly/monthly
Which of the following protected characteristics could be disadvantaged	Groups listed below
Who are the main stakeholders?	Service users and their families Care providers and care professionals Commissioners and contracting
Who is responsible?	Transforming Care Partnership - SRO's
Who will benefit?	Service users and their families will benefit from securing care and support in their own homes or homely settings. Health and social care provision will benefit from investment in contemporary models of service delivery. Commissioning authorities will benefit as resources are targeted more effectively and efficiently and not locked up in traditional outmoded models of care that are not optimally performing.
Will the planned changes lower any negative impacts?	Yes
Will the planned changes to the proposal provide an opportunity to promote equality, equal opportunity	Yes
Will the proposed changes ensure the remaining negative impacts are legal	Yes
Proposal impact on groups identified	Better meeting the needs and preferences of people with learning disabilities and or autism and their families as support and intervention during periods of crisis and raised acuity are provided in the least restrictive arrangements in their own homes within their communities.
Age	Yes
Race	Yes
Disability	Yes

Religion and Belief	Yes
Religious/Cultural Observance	No
Sex/Gender	Yes
Sexual Orientation	Yes
Employment/Training	Yes
Taking into account the views of the groups consulted and the available evidence, please clearly sta	Consultation has not yet taken place. Local evidence would indicate need for inpatient provision is falling both local occupancy rates and OOA placements. Enhanced arrangements in community i.e. IST in Peterborough and 'wrap around' support in Cambridgeshire is taking root. However research into the effectiveness of such models is limited and the evidence base is not strong enough to determine which model(s) provides the most effective care (community - based Services for People with Intellectual Disability and Mental Health problems - faculty report, May 2015 - The Royal Colleague of Psychiatry.
Pregnancy Leave Related and Maternity Leave Related	No
Pregnancy and Maternity	Yes
Marriage and Civil partnership	
Positive Impacts	Sustain community presence and continuity of living. Improve access to wider provision, securing right care in right place at right time. Meet diversity and cultural needs in own home or community setting. Prevent restrictive practice and inappropriate care regimes Reduce stigmatization linked to hospital admission Reduce out of area placement and institutionalised care pathways.
Negative Impacts	Could lead to further out of area placement by default if reduced local beds become 'blocked' and community infrastructure fails to sustain people at risk of admission in community setting.
Has the E&D Advisor requested that the EIA form below is completed?	No
Has the equality and Diversity Advisor seen and approved the screening tool above?	No
Have you consulted on the proposal, if so, with whom, if not why not?	The intention is to consult and engage fully pending approval at GB on 24th May 2018
Date Submitted	
Date Reviewed	
Assessor Comments	
Assessment Approved	

Initial IA

Project Name	**110123 - Learning Disabilities - BRS Model**
Q1 How many people will be affected by this change?	30 -50
Q2 What is their age range?	18 - 75
Q3 Where is they living?	Cambridgeshire and Peterborough
Q4 What are their other defining features?	Adults with learning disabilities and /or autism
Q5 Are there existing inequalities within the group?	The persistence of health inequalities between different population groups has been well documented, including the inequalities faced by people with learning disabilities. Today (2018), people with learning disabilities die, on average, 15 -20 years sooner than people in the general population, with some of those deaths identified as being potentially amenable to good quality healthcare.
Q6 Are there existing inequalities between groups of patients?	People with learning disabilities and /or autism who come into contact with specialist provision often have a complex mix of co-morbidities including developmental disorders, mental illnesses, personality disorders, substance misuse, and physical disorders including epilepsy. Some of these present with challenging behaviour others do not. This cohort within the larger learning disabilities and /or autism population are more likely to be subject to specialist hospital admission and restrictive practices of care and for some involvement in the criminal justice services. criminal
Q7 Have the communications team been consulted around a consultation?	Yes
Q8 Is a consultation required?	Yes
Date Submitted for Review	
Date of first review	
Assessor Comments	
Date Assessment Approved	

HIA

Project Name	**110123 - Learning Disabilities - BRS Model**
Q1 What type of impact will the proposal have on health, mental health and wellbeing?	Positive
Rationale for Q1	The BRS model preferred option will realise a substantial shift away from reliance on inpatient care with a clear commitment to support people to live in their own homes within the community, supported by local services and community pathways. The preferred option recognises the need for retention of access to some inpatient provision but only when absolutely necessary and as a consequence of when all alternative to admission are fully exhausted.
Q2 What will the impact be on an individual's ability to improve their own health and wellbeing?	Positive
Rationale for Q2	The BRS model and preferred option moves away from historical solutions in supporting individuals in crisis and poor mental health through overreliance on inpatient care or other restrictive approaches. Investment in community solutions means people can recover in their own home environment with early intervention and 'wrap around' support.
Q3 What will the impact be on social, economic and environmental living conditions?	Positive
Rationale for Q3	The intensive community support based model evidence base is small however Mineen et al (1997) compared 25 patients treated in a hospital with 25 patients who recieved outreach treatment from the community learning disability team. They found that outreach treatment was equally effective as reducing psychiatric symptoms and was also more cost effective.
Q4 What will the impact be on demand/access to health and social care?	Positive
Rationale for Q4	The 'mixed economy' arrangement of enhanced community support and reduced inpatient reliance - but there when absolutely required will remove inappropriate access and perverse incentive in the health and social care economy. This however may lead to an increase in social care costs as community solutions tale precedent.
Q5 Will the proposal on global health be positive, neutral or negative?	Positive
Rationale for Q5	Hassiotis et al (2000) found that, in people with psychosis and learning disabilities (borderline intellectual functioning), intensive support community care led to significantly less time spent in hospital in comparison to standard care.
Q6 Are any outcome risks on your Risk Register?	Yes

Q7 Has the HIA Advisor seen and approved a screening tool?	No
Q8 Has the HIA Advisor requested that the full form be completed?	No
Q9 Will the health impacts be medium to long term?	
Rationale for Q9	
Q10 Do each of the negative health impacts have a mitigation in place?	
Rationale for Q10	
Q11 Are the health impacts likely to generate public concern?	
Rationale for Q11	
Q12 Are the health impacts likely to generate cumulative and/or synergistic impacts?	
Rationale for Q12	
Q13 will the health impacts have an overall positive or negative impact on health of the local popul	
Rationale for Q13	
Q14 Quantify or describe important health impacts	
Q15 Recommendations to improve the project to maximise the health outcomes for the local population	
Top Indicator 1.Title	
Impact Indicator 1	Neutral
Rationale for Indicator 1	
Top Indicator 2.Title	
Impact Indicator 2	Neutral
Rationale for Indicator 2	
Top Indicator 3.Title	
Impact Indicator 3	Neutral
Rationale for Indicator 3	
Top Indicator 4.Title	
Impact Indicator 4	Neutral
Rationale for Indicator 4	
Top Indicator 5.Title	
Impact Indicator 5	Neutral
Rationale for Indicator 5	
Top Indicator 6.Title	
Impact Indicator 6	Neutral
Rationale for Indicator 6	
Top Indicator 7.Title	
Impact Indicator 7	Neutral
Rationale for Indicator 7	
Other Indicators	

Impact for Other Indicators	Neutral
Rationale for Other Indicator	
Submitted for Review	FALSE
IA Submitted for Review	
IA Reviewed	
IA Approved	
Assessor Comments	

HIIA

Project Name	110123 - Learning Disabilities - BRS Model
Q1 What evidence have you considered to determine what health inequalities exist in relation to your	Health status from the Public Health Observatory profiles for both Cambridgeshire and Peterborough. Data from LD health registers and forward strategic planning Data and narrative from 'Building on Strong Foundations' C & P Transforming Care Partnership Plan Bed Occupancy and CTR data since September 2015 National service specifications detailed in NHSE Guidance Data provided by NHS England regarding patient trajectory performance
Q2 Will this work produce any specific changes in inequalities in access?	yes
Impact Q2	Positive
Rationale for Q2	Improvement in crisis response provision specifically for people with learning disabilities and /or autism. Access to mainstream AMH provision including inpatient beds through 'reasonable adjustment' and parity of esteem
Q3 Will this work produce any specific changes in inequalities in health outcome?	yes
Impact Q3	Positive
Rationale for Q3	Inequalities in accessing provision should be reduced and more responsive local provision secured which will reduce the need for restrictive forms of care including out of area placement.
Q4 If this service was provided in an integrated way within NHS what would be the impact?	Service is in part provided by the NHS within an integrated model commissioned through Section 75 arrangement, block and spot. Revising the Section 75 arrangements based on implementation of the BRS Model will further improve integration and reduce health inequality.
Impact Q4	Positive
Rationale for Q4	Realisation of the local TCP Plan and key milestone targets including specific pathways that will address in part inequity.
Q5 If this service was provided in an integrated way with Social Care, what would be the impact?	As above the service is in part integrated with social care and in the case of the LDP, CCC fully integrated on both a commissioning and provision level (health and social care)
Impact Q5	Positive
Rationale for Q5	See above

Q6 What is the potential overall impact of your work on health inequalities?	Development of a community based model that facilitates greater access to relevant support and care which will reduce the historical reliance on restrictive options that habituate and sustain inequity and at times remove people with learning disabilities and/or autism from their families and communities for significant periods of time.
Impact Q6	Positive
Rationale for Q6	Commitment to Building the Right Support (2015) and the three year national Transforming Care programme.
Date Submitted	
Date Reviewed	
Date Approved	

PIA

Project Name	**110123 - Learning Disabilities - BRS Model**
Q1 Will the project involve any data from which individuals can be identified	No
Rational for Q1	
Q2 Will the project result in you making important decisions about individuals?	No
Rationale for Q2	
Q3 Will the project require you to contact the individuals in ways they may find intrusive?	No
Rationale for Q3	
Q4 Will the project involve the collection of new information about individuals?	No
Rationale for Q4	
Q5 Will the project compel individuals to provide information about themselves?	No
Rationale for Q5	
Q6 Will information about individuals be disclosed to new organisations/people?	No
Rationale for Q6	
Q7 Are you using information about individuals for a new purpose/in a new way?	No
Rationale for Q7	
Q8 Will you be using a new system or using an existing system in a different way?	No
Rationale for Q8	Not in relation to data
Q9 Does the project involve you using new technology which might be perceived as being intrusive?	No
Rationale for Q9	
Q10 Is this project using the same processes and procedures that have historically been in place?	Yes
Rationale for Q10	
DPO Sign-off	Yes

SIRO Approval	No

SIA

Project Name	**110123 - Learning Disabilities - BRS Model**
Q1 Offer employment opportunities to local people	Yes
Impact Q1	Positive
Rationale for Q1	RS Model will provide new community pathways and encourage new social care providers into Cambridgeshire and Peterborough. The enhanced community services will required additional health and social care professionals and may afford redeployment opportunities for inpatient staff making transition to community services.
Q2 Offer employment opportunities to disadvantaged groups	Unsure
Impact Q2	Neutral
Rationale for Q2	There is potential to secure experts by experience in support of community pathways but this would have to be worked through in the context of staffing requirements relating to the community pathways and provision ie enhanced community teams and 'crash pad' facilities.
Q3 Promote and encourage a sustainable local economy	Yes
Impact Q3	Positive
Rationale for Q3	Changes to commissioned services will be through reinvest of resources traditionally locked into inpatient services and made available to fund and sustain the BRS community preferred option.
SIA Q4 Does this change affect other providers?	yes
Impact Q4	Positive
Rationale for Q4	Encourage new social care providers to the localities. Existing providers may have to realign their provision in order to support implementation of community pathways and future. inpatient bed configuration
SIA Q5 Does this change minimise care miles?	yes
Impact Q5	Positive
Rationale for Q5	BRS Model is about local community provision and solutions to crisis and ill health that sustains people in their home settings. In line with the vision of 'Transforming Care' and Cambridgeshire and Peterborough TCP bed trajectory target. - Out of Area placements will continue to reduce and not be required as community provision including the use of assisted technology provide least restrictive solutions.
SIA Q6 Promote prevention of LTC and improve self-management	yes
Impact Q6	Positive

Rationale for Q6	Preventative solutions including the 'upskilling' of workforce and carers with Positive Behavioural Support (PBS) training will help providers and individuals better manage periods of crisis and potential heightened distress and give a range of solutions other than hospital admission
SIA Q7 Provide evidence-based, personalised care that provides VFM	yes
Impact Q7	Positive
Rationale for Q7	Though the enhanced intensive community support evidence base is small as it is across much of learning disabilities research - Mineen et al (1997) compared 25 patients treated in a hospital with 25 patients who received outreach treatment from the community learning disability team. They found that outreach treatment was equally effective as reducing psychiatric symptoms and was also more cost effective. Hassiotis et al (2000) found that, in people with psychosis and borderline intellectual functioning, intensive community care led to significantly less time spent in hospital in comparison to standard care. Locally the use of the Transforming Care Local Area Emergency Protocol (LEAP) and community CTR process has resulted in fewer hospital admissions as community options are formally agreed between statutory agencies and put into place to prevent admission.
SIA Q8 Deliver integrated care, that improves coordination and removes duplication	yes
Impact Q8	Positive
Rationale for Q8	BRS Model has explicit support from the local Transforming Care Partnership with all statutory agencies committed to providing integrated care. The Section 75 agreements between both LA's and CPCCG are based on the premise of integrated health and social care provision and work particularly well in Cambridgeshire through the Learning Disability Partnership.
SIA Q9 Support the CCG's objectives to reduce carbon emissions and become more sustainable?	Not applicable
Impact Q9	Neutral
Rationale for Q9	
SIA Q10 Affect the use of energy or water?	Not applicable
Impact Q10	Neutral
Rationale for Q10	
SIA Q11 Affect pollution to air, land or water?	Not applicable
Impact Q11	Neutral
Rationale for Q11	

SIA Q12 Will specific environmental outcomes to be accounted for in procurement?	Yes
Impact Q12	Positive
Rationale for Q12	Social outcome of sustaining people with needs in their home communities through least restrictive practices will be made explicit within procurement framework based upon the principles of BRS Model
SIA Q13 Will the change stimulate innovation among providers to reduce environmental impact?	yes
Impact Q13	Positive
Rationale for Q13	Providers will need to demonstrate innovative ways of supporting people that may challenge in community settings including alternative to admission responses ie 'crash pad' facilities.
SIA Q14 will implementation promote ethical and sustainable procurement?	Not applicable
Impact Q14	Neutral
Rationale for Q14	
SIA Q15 Will implementation promote greater efficiency of resource use?	yes
Impact Q15	Positive
Rationale for Q15	Sustaining people locally is far more efficient and effective than costly and distant out of area placement. Bed occupancy levels throughout the three-year Transforming Care programme and reliance on out of area placement often at the behest of the current local bed provider suggests that the model of service delivery within the block contract arrangement is not working optimally with monies locked into underutilised and inappropriate provision.
SIA Q16 Will implementation obtain maximum value for money?	Not applicable
Impact Q16	Neutral
Rationale for Q16	
SIA Q17 Will implementation support local or regional supply chains?	Not applicable
Impact Q17	Neutral
Rationale for Q17	
SIA Q18 Will implementation make current activities more efficient or alter service delivery models?	yes
Impact Q18	Positive
Rationale for Q18	The reinvestment from bed reduction and subsequent enhancement of community provision with the option of individualized bed procurement if required is financially more viable and sustainable as available resources are focused on presenting need as required as oppose to being locked into inflexible block arrangements that are over commissioned locally with further resources tied up in 'double funding' of out of area placements.

SIA Q19 Will it provide / improve / promote alternatives to car based transport?	Not applicable
Impact Q19	Neutral
Rationale for Q19	
SIA Q20 Support more efficient use of cars	Not applicable
Impact Q20	Neutral
Rationale for Q20	
SIA Q21 Promote active travel (cycling, walking)?	Not applicable
Impact Q21	Neutral
Rationale for Q21	
SIA Q22 Affect vehicle use, mileage or other transport or travel activity?	Yes
Impact Q22	Negative
Rationale for Q22	Potentially more vehicle use by providers to support enhanced community based working
SIA Q23 Improve the resource efficiency of new or refurbished buildings?	Not applicable
Impact Q23	Neutral
Rationale for Q23	
SIA Q24 Increase safety and security in new buildings and developments?	Yes
Impact Q24	Positive
Rationale for Q24	Former specialist LD ward (Hollies) at Cavell Centre being utilized to provide safer settings for other service users i.e. female PICU
SIA Q25 Reduce greenhouse gas emissions from transport?	no
Impact Q25	Neutral
Rationale for Q25	
SIA Q26 Provide sympathetic and appropriate landscaping around new development?	Not applicable
Impact Q26	Neutral
Rationale for Q26	
SIA Q27 Support adaptation to the likely effects of climate change?	Not applicable
Impact Q27	Neutral
Rationale for Q27	
Submitted for Review	FALSE
IA Submitted review	
Assessor Comments	
Impact Assessment Approved	

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HEALTH SCRUTINY COMMITTEE	AGENDA ITEM No. 9
17 SEPTEMBER 2018	PUBLIC REPORT

Report of:	Interim Director of Law and Governance	
Contact Officer(s):	Paulina Ford, Senior Democratic Services Officer	Tel. 01733 452508

MONITORING SCRUTINY RECOMMENDATIONS

RECOMMENDATIONS	
FROM: Interim Director of Law and Governance	**Deadline date:** *N/A*

It is recommended that the Health Scrutiny Committee:

1. Considers the responses from Cabinet Members and Officers to recommendations made at previous meetings as attached in Appendix 1 to the report and provides feedback including whether further monitoring of each recommendation is required.

1. ORIGIN OF REPORT

1.1 The Health Scrutiny Committee agreed at a meeting held on 19 June 2017 that a report be provided at each meeting to note the outcome of any recommendations made at the previous meeting held thereby providing an opportunity for the Committee to request further monitoring of the recommendation should this be required.

2. PURPOSE AND REASON FOR REPORT

2.1 The report enables the Scrutiny Committee to monitor and track progress of recommendations made to the Executive or Officers at previous meetings.

2.2 This report is for the Health Scrutiny Committee to consider under its Terms of Reference No. *Part 3, Section 4 - Overview and Scrutiny Functions, paragraph 3.3:*

The Scrutiny Committees will:

(a) Review and scrutinise the Executive, Committee and officer decisions and performance in connection with the discharge of any of the Council's functions;

(b) Review and scrutinise the Council's performance in meeting the aims of its policies and performance targets and/or particular service areas;

(c) Question Members of the Executive, Committees and senior officers about their decisions and performance of the Council, both generally and in relation to particular decisions or projects;

(d) *Make recommendations to the Executive and the Council as a result of the scrutiny process*.

3. TIMESCALES

Is this a Major Policy Item/Statutory Plan?	**NO**	If yes, date for Cabinet meeting	N/A

4. BACKGROUND

4.1 Appendix 1 of the report sets out the recommendations made to Cabinet Members or Officers at previous meetings of the Scrutiny Committee. It also contains summaries of any action taken by Cabinet Members or Officers in response to the recommendations.

4.2 The progress status for each recommendation is indicated and if the Scrutiny Committee confirms acceptance of the items marked as completed they will be removed from the list. In cases where action on the recommendation is outstanding or the Committee does not accept the matter has been adequately completed it will be kept on the list and reported back to the next meeting of the Committee. It will remain on the list until such time as the Committee accepts the recommendation as completed.

5. ANTICIPATED OUTCOMES OR IMPACT

5.1 Timelier monitoring of recommendations made will assist the Scrutiny Committee in assessing the impact and consequence of the recommendations.

6. REASON FOR THE RECOMMENDATION

6.1 To assist the Committee in assessing the impact and consequence of recommendations made at previous meetings.

7. BACKGROUND DOCUMENTS

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

7.1 Minutes of meetings held on 4 September 2017 and 12 March 2018.

8. APPENDICES

8.1 Appendix 1 – Monitoring Recommendations

RECOMMENDATION MONITORING REPORT 2018/2019 **Appendix 1**

HEALTH SCRUTINY COMMITTEE

Meeting date Recommendations Made	Portfolio Holder / Directorate Responsible	Agenda Item Title	Recommendation Made	Action Taken	Progress Status
4 September 2017	Councillor Lamb, Cabinet Member for Public Health / Dr Liz Robin, Director of Public Health	PETERBOROUGH ANNUAL PUBLIC HEALTH REPORT	The Health Scrutiny Committee considered the report and **RECOMMENDED** that the Director of Public Health include in future Annual Public Health Reports details on healthy eating habits and statistics on air quality as both have an impact on the health of local people.	Updated at 6 November meeting: the Director of Public Health advised that the request from the Health Scrutiny Committee has been logged and will be taken in to consideration when preparing the Annual Public Health Report for 2018, next year.	On-going – next Annual Public Health Report to be presented in January 2019.
12 March 2018	Ian Weller, Head of Urgent and Emergency Care Cambridge and Peterborough CCG	**UPDATE ON THE SUCCESSESS AND FAILURES OF INTEGRATED URGENT CARE 1 YEAR ON**	The Health Scrutiny Committee noted the report and **RECOMMENDED** that; The 111 Service enter into discussions with officers in Cambridgeshire and Peterborough to instigate an 'option 3' route which would direct patients calling in with a social care need straight to the social care call centre without the need to call a separate social care helpline.	Awaiting Response	On-going

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HEALTH SCRUTINY COMMITTEE	AGENDA ITEM No. 10
17 SEPTEMBER 2018	PUBLIC REPORT

Report of:	Interim Director of Law and Governance	
Cabinet Member(s) responsible:	Cabinet Member for Resources	
Contact Officer(s):	Paulina Ford, Senior Democratic Services Officer	Tel. 01733 452508

FORWARD PLAN OF EXECUTIVE DECISIONS

RECOMMENDATIONS	
FROM: Senior Democratic Services Officer	**Deadline date:** *N/A*

It is recommended that the Health Scrutiny Committee:

1. Considers the current Forward Plan of Executive Decisions and identifies any relevant items for inclusion within their work programme or request further information.

1. ORIGIN OF REPORT

1.1 The report is presented to the Committee in accordance with the Terms of Reference as set out in section 2.2 of the report.

2. PURPOSE AND REASON FOR REPORT

2.1 This is a regular report to the Health Scrutiny Committee outlining the content of the Forward Plan of Executive Decisions.

2.2 This report is for the Health Scrutiny Committee to consider under its Terms of Reference No. Part 3, Section 4 - Overview and Scrutiny Functions, paragraph 3.3:

The Scrutiny Committees will:

(f) Hold the Executive to account for the discharge of functions in the following ways:

ii) By scrutinising Key Decisions which the Executive is planning to take, as set out in the Forward Plan of Executive Decisions;

3. TIMESCALES

Is this a Major Policy Item/Statutory Plan?	**NO**	If yes, date for Cabinet meeting	N/A

4. BACKGROUND AND KEY ISSUES

4.1 The latest version of the Forward Plan of Executive Decisions is attached at Appendix 1. The Forward Plan contains those Executive Decisions which the Leader of the Council believes that

the Cabinet or individual Cabinet Member(s) can take and any new key decisions to be taken after 1 October 2018.

4.2 The information in the Forward Plan of Executive Decisions provides the Committee with the opportunity of considering whether it wishes to seek to influence any of these executive decisions, or to request further information.

4.3 If the Committee wished to examine any of the executive decisions, consideration would need to be given as to how this could be accommodated within the work programme.

4.4 As the Forward Plan is published fortnightly any version of the Forward Plan published after dispatch of this agenda will be tabled at the meeting.

5. CONSULTATION

5.1 Details of any consultation on individual decisions are contained within the Forward Plan of Executive Decisions.

6. ANTICIPATED OUTCOMES OR IMPACT

6.1 After consideration of the Forward Plan of Executive Decisions the Committee may request further information on any Executive Decision that falls within the remit of the Committee.

7. REASON FOR THE RECOMMENDATION

7.1 The report presented allows the Committee to fulfil the requirement to scrutinise Key Decisions which the Executive is planning to take, as set out in the Forward Plan of Executive Decisions in accordance with their terms of reference as set out in Part 3, Section 4 - Overview and Scrutiny Functions, paragraph 3.3.

8. ALTERNATIVE OPTIONS CONSIDERED

8.1 N/A

9. IMPLICATIONS

Financial Implications

9.1 N/A

Legal Implications

9.2 N/A

10. BACKGROUND DOCUMENTS

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

10.1 None

11. APPENDICES

11.1 Appendix 1 – Forward Plan of Executive Decisions

FORWARD PLAN

PART 1 – KEY DECISIONS

In the period commencing 28 clear days after the date of publication of this Plan, Peterborough City Council's Executive intends to take 'key decisions' on the issues set out below

PETERBOROUGH CITY COUNCIL'S FORWARD PLAN OF EXECUTIVE DECISIONS

PUBLISHED: 31 AUGUST 2018

in **Part 1**. 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, this too is shown against the decision and its members are as listed below:
Cllr Holdich (Leader); Cllr Fitzgerald (Deputy Leader); Cllr Ayres; Cllr Cereste; Cllr Hiller, Cllr Lamb; Cllr Smith; Cllr Seaton and Cllr Walsh.

This Plan should be seen as an outline of the proposed decisions for the forthcoming month and it will be updated on a fortnightly basis to reflect new key-decisions. Each new Plan supersedes the previous Plan and items may be carried over into forthcoming Plans. Any questions on specific issues included on the Plan should be included on the form which appears at the back of the Plan and submitted to philippa.turvey@peterborough.gov.uk, Democratic and Constitutional Services Manager, Governance Department, Town Hall, Bridge Street, PE1 1HG (fax 08702 388039). Alternatively, you can submit your views via e-mail to or by telephone on 01733 452460. For each decision a public report will be available from the Democratic Services Team one week before the decision is taken.

PART 2 – NOTICE OF INTENTION TO TAKE DECISION IN PRIVATE

Whilst the majority of the Executive's business at the Cabinet meetings listed in this Plan 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, notice will be given within **Part 2** of this document, 'notice of intention to hold meeting in private'. A further formal notice of the intention to hold the meeting, or part of it, in private, will also 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).

PART 3 – NOTIFICATION OF NON-KEY DECISIONS

For complete transparency relating to the work of the Executive, this Plan also includes an overview of non-key decisions to be taken by the Cabinet or individual Cabinet Members, these decisions are listed at **Part 3** and will be updated on a weekly basis.

You are entitled to view any documents listed on the Plan, 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 Philippa Turvey, Democratic and Constitutional Services Manager, Governance Department, Town Hall, Bridge Street, PE1 1HG (fax 08702 388038), e-mail to philippa.turvey@peterborough.gov.uk or by telephone on 01733 452460.

All decisions will be posted on the Council's website: www.peterborough.gov.uk/executivedeisions. If you wish to make comments or representations regarding the 'key decisions' outlined in this Plan, please submit them to the Democratic and Constitutional Services Manager using the form attached. For your information, the contact details for the Council's various service departments are incorporated within this Plan.

PART 1 – FORWARD PLAN OF KEY DECISIONS

KEY DECISIONS FROM 1 OCTOBER							
KEY DECISION REQUIRED	***DECISION MAKER***	***DATE DECISION EXPECTED***	***RELEVANT SCRUTINY COMMITTEE***	**WARD**	***CONSULTATION***	***CONTACT DETAILS / REPORT AUTHORS***	***DOCUMENTS RELEVANT TO THE DECISION SUBMITTED TO THE DECISION MAKER INCLUDING EXEMPT APPENDICES AND REASONS FOR EXEMPTION***
Permanency Services Contract Variation – KEY/01OCT18/01 To agree a variation to the Permanency Services Contract	**Councillor Smith, Cabinet Member for Children's Services**	**October 2018**	Children and Education Scrutiny Committee	All Wards	Relevant Internal and External Stakeholders	Helene Carr, Head of Children's Social Care Commissioning - Peterborough & Cambridgeshire, 07904 909039, helene.carr@peterborough.gov.uk	It is not anticipated that there will be any documents other than the report and relevant appendices to be published

KEY DECISION REQUIRED	*DECISION MAKER*	*DATE DECISION EXPECTED*	*RELEVANT SCRUTINY COMMITTEE*	**WARD**	*CONSULTATION*	*CONTACT DETAILS / REPORT AUTHORS*	*DOCUMENTS RELEVANT TO THE DECISION SUBMITTED TO THE DECISION MAKER INCLUDING EXEMPT APPENDICES AND REASONS FOR EXEMPTION*
Amendment to Loan Facility- KEY/01OCT18/02 A loan facility previously approved by Cabinet requires approval of an amendment to that facility	**Councillor Seaton, Cabinet Member for Resources**	**October 2018**	Growth, Environment and Resources Scrutiny Committee	All Wards	This decision will be taken after consultation with the Council's legal and financial advisors	Peter Carpenter, Acting Corporate Director Resources, 01733 384564, peter.carpenter@peterborough.gov.uk carole.coe@peterborough.gov.uk	It is not anticipated that there will be any documents other than the report and relevant appendices to be published ***The decision will include an exempt annexe. By virtue of paragraph 3, information relating to the financial or business affairs of any particular person (including the authority holding that information).***

PREVIOUSLY ADVERTISED KEY DECISIONS								
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1.	**Affordable Warmth Strategy 2017 – 2019 KEY/17APR17/03** Recommendation to approve the Affordable Warmth Strategy 2017 – 2019	**Councillor Walsh, Cabinet Member for Communities**	**September 2018**	Adults and Communities Scrutiny Committee	All wards	Relevant internal and external stakeholders. The draft strategy will be placed on PCC Consultation pages for 3 week consultation period	Sharon Malia, Housing Programmes Manager, Tel: 01733 863764 sharon.malia@peterborough.gov.uk	It is not anticipated that there will be any documents other than the report and relevant appendices to be published. BRE Integrated Dwelling Level Housing Stock Modelling Report July 2016 Housing Renewals Policy 2017 – 2019

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2.	**Approval to award places on the Pseudo DPS for Residential Care Providers - KEY/29MAY17/04** Provide permission for the Council to enter into contractual arrangements with Residential Care Providers following the publication of a PIN notice inviting providers to submit prices and sign up to the Council's Residential Care Terms and Conditions. This ensures compliance with the Public Procurement Regulations 2015 and the Care Act 2014	**Councillor Fitzgerald, Deputy Leader and Cabinet Member for Integrated Adult Social Care and Health**	**October 2018**	Adults and Communities Scrutiny Committee	All wards	Relevant internal and external stakeholders.	Gary Jones, Interim Head of Adults Commissioning Social Care Tel: 01733 452450, Email: gary.jones@peterborough.gov.uk	It is not anticipated that there will be any documents other than the report and relevant appendices to be published.

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3.	**Award of Contract - Social Care Platform - KEY/24JULY17/01** To approve the award of a contract to develop and implement a technology platform that would sit across the current adult and children's social care IT systems	**Councillor David Seaton Cabinet Member for Resources**	**September 2018**	Growth, Environment & Resources Scrutiny Committee	All Wards	Relevant internal and external stakeholders. N/A	Peter Carpenter, Acting Corporate Director, Resources Tel: 01733 384564 Email: Peter.carpenter@peterborough.gov.uk	It is not anticipated that there will be any documents other than the report and relevant appendices to be published. ***The decision will include an exempt annexe. By virtue of paragraph 3, information relating to the financial or business affairs of any particular person (including the authority holding that information).***
4.	**Award of Contract - Social Care e-marketplace – KEY/24JULY17/02** To approve the awarding of a contract to provide a social care e-marketplace IT system	**Councillor David Seaton Cabinet Member for Resources**	**September 2018**	Growth, Environment & Resources Scrutiny Committee	All Wards	Relevant internal and external stakeholders. N/A	Peter Carpenter, Acting Corporate Director, Resources Tel: 01733 384564 Email: Peter.carpenter@peterborough.gov.uk	It is not anticipated that there will be any documents other than the report and relevant appendices to be published. ***The decision will include an exempt annexe. By virtue of paragraph 3, information relating to the financial or business affairs of any particular person (including the authority holding that information).***

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5.	**Award of Contract - Social Care Operating Model – KEY/24JULY17/05** To approve the awarding of a contract to develop a social care operating model	**Councillor David Seaton Cabinet Member for Resources**	**September 2018**	Growth, Environment & Resources Scrutiny Committee	All Wards	Relevant internal and external stakeholders. N/A	Peter Carpenter, Acting Corporate Director, Resources Tel: 01733 384564 Email: Peter.carpenter@peterborough.gov.uk	It is not anticipated that there will be any documents other than the report and relevant appendices to be published. ***The decision will include an exempt annexe. By virtue of paragraph 3, information relating to the financial or business affairs of any particular person (including the authority holding that information).***

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6.	**Acquisition of Regeneration Site – KEY/24JULY17/06** To approve the acquisition of a local regeneration site.	**Councillor David Seaton Cabinet Member for Resources**	**September 2018**	Growth, Environment & Resources Scrutiny Committee	Central	Relevant Internal and External Stakeholders.	Jane McDaid Head of Peterborough Property services Tel: 01733 384540 Email: Jane.mcdaid@peterborough.gov.uk	It is not anticipated that there will be any documents other than the report and relevant appendices to be published. ***The decision will include an exempt annexe. By virtue of paragraph 3, information relating to the financial or business affairs of any particular person (including the authority holding that information).***

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7.	**Continuation of Housing Renewal Policy grants through the Care & Repair Agency – KEY/18SEP17/02** Permission is sought to continue to use the current tendering processes for non framework works funded through Repairs Assistance Grants and Disabled Facility Grants. A full procurement process is being undertaken to introduce frameworks for all of this work which is aimed to be in place by the 1st May 2018. This interim arrangement will allow the capital programme to be continued	**Councillor Hiller, Cabinet Member for Growth, Planning, Housing and Economic Development**	**September 2018**	Adults and Communities Scrutiny Committee	All	Relevant internal and external stakeholders. CMDN published on website	Sharon Malia, Housing Programmes Manager, Tel: 01733 863764 Email: sharon.malia@peterborough.gov.uk	It is not anticipated that there will be any documents other than the report and relevant appendices to be published.

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8.	**Award of contract for the expansion and partial remodelling of Ken Stimpson Community School – KEY/18SEP17/03** The intention is to expand the school by 2 forms of entry (300 additional pupils plus 150 sixth form) to meet the growing need for secondary school places. A new building block is planned on the site with an extension to the dinning hall and minor remodelling to an adjacent building. As part of the remodelling the on site library will be demolished - following its relocation to a suitable site close by.	**Councillor Lynne Ayres, Cabinet Member for Education, Skills and University**	**September 2018**	Children and Education Scrutiny Committee	Werrington	Relevant internal and external stakeholders. Consultation will include: Senior School Management team, Sport England, local residents and the Department For Education	Stuart Macdonald. Schools Infrastructure. Tel: 07715 802 489. Email: stuart.macdonald@peterborough.gov.uk	It is not anticipated that there will be any documents other than the report and relevant appendices to be published. School Organisation Plan 2015 -2022

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9.	**Approval of contract for the delivery of Lot 1 - General Information, Advice and Guidance Services and Lot 2 - Specialist Information, Advice and Guidance Services – KEY/16OCT17/04** Following competitive procurement of these services, to approve the contract to deliver Lot 1 Generalist Information, Advice and Guidance Services - Homelessness Prevention; and Lot 2 Specialist Information, Advice and Guidance Services - supporting protected characteristic groups.	**Councillor Seaton, Cabinet Member for Resources**	**September 2018**	Adults and Communities	All Wards	Relevant internal and external stakeholders. Voluntary sector advice agencies consulted in service design. Market testing of providers has also taken place.	Ian Phillips, Senior Policy Manager Tel: 01733 863849 Email: ian.phillips@peterborough.gov.uk	It is not anticipated that there will be any documents other than the report and relevant appendices to be published

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10.	**ICT Infrastructure works for Fletton Quays – KEY/13NOV17/02** To agree to the procurement of ICT infrastructure works for Fletton Quays	**Councillor Seaton, Cabinet Member for Resources**	**September 2018**	Growth, Environment & Resources Scrutiny Committee	N/A	Relevant internal and external stakeholders	Peter Carpenter, Acting Corporate Director, Resources Tel: 01733 384564 Email: Peter.carpenter@peterborough.gov.uk	It is not anticipated that there will be any documents other than the report and relevant appendices to be published. The decision will include an exempt annexe. By virtue of paragraph 3, information relating to the financial or business affairs of any particular person (including the authority holding that information).

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11.	**Expansion and Remodelling of Marshfields School – KEY/11DEC17/03** To approve the proposed expansion and remodelling of Marshfields school	**Councillor Lynne Ayres, Cabinet Member for Education, Skills and University**	**September 2018**	Children and Education Scrutiny Committee	Dogsthorpe Ward	Relevant internal and external stakeholders. Public Consultation Meeting	Sharon Bishop, Capital Projects & Assets Officer Tel: 01733 863997 Email: Sharon.bishop@peterborough.gov.uk	It is not anticipated that there will be any documents other than the report and relevant appendices to be published. School Organisational Plan
12.	**Purchase of land and building in the centre of Peterborough – KEY/11DEC17/06** To delegate authority to the Corporate Director of Growth and Regeneration to purchase the property	**Councillor David Seaton Cabinet Member for Resources**	**September 2018**	Growth, Environment and Resources Scrutiny Committee	Central	Relevant internal and external stakeholders	Jane McDaid Head of Peterborough Property services Tel: 01733 384540 Email: Jane.mcdaid@peterborough.gov.uk	It is not anticipated that there will be any documents other than the report and relevant appendices to be published. ***The decision will include an exempt annexe. By virtue of paragraph 3, information relating to the financial or business affairs of any particular person (including the authority holding that information).***

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13.	**Purchase of building in the centre of Peterborough – KEY/11DEC17/08** To delegate authority to the Corporate Director of Growth and Regeneration to purchase the property	**Councillor David Seaton Cabinet Member for Resources**	**September 2018**	Growth, Environment and Resources Scrutiny Committee	Central	Relevant internal and external stakeholders	Jane McDaid Head of Peterborough Property services Tel: 01733 384540 Email: Jane.mcdaid@peterborough.gov.uk	It is not anticipated that there will be any documents other than the report and relevant appendices to be published. ***The decision will include an exempt annexe. By virtue of paragraph 3, information relating to the financial or business affairs of any particular person (including the authority holding that information).***
14.	**Purchase of land to the east of the city - KEY/25DEC17/02** Delegate authority to the Corporate Director of Growth and Regeneration to purchase the property.	**Cabinet Member for Resources, Councillor Seaton**	**September 2018**	Growth, Environment and Resources Scrutiny Committee	East	Relevant internal and external stakeholders	Jane McDaid Head of Peterborough Property services Tel: 01733 384540 Email: Jane.mcdaid@peterborough.gov.uk	It is not anticipated that there will be any documents other than the report and relevant appendices to be published. ***The decision will include an exempt annexe. By virtue of paragraph 3, information relating to the financial or business affairs of any particular person (including the authority holding that information).***

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15.	**A605 Whittlesey Access Phase 2 - Stanground Access - KEY/25DEC17/03** To approve the design and construction of the A605 Stanground East Junction Improvements for the financial year of 2017/18 - 2018-19 and authorise the associated package of work to be issued to Skanska Construction UK Limited under the Council's existing agreement with SKANSKA dated 18th September 2013 (the Highways Services Agreement).	**Councillor Hiller, Cabinet Member for Growth, Planning, Housing and Economic Development**	**September 2018**	Growth, Environment and Resources Scrutiny Committee	Stanground South	Relevant internal and external stakeholders. The scheme is included in the fourth Local Transport Plan. Further consultation will be undertaken during the design process, including ward Councillors.	Lewis Banks, Principal Sustainable Transport Planning Officer. Tel: 01733 317465, Email: lewis.banks@peterborough.gov.uk	It is not anticipated that there will be any documents other than the report and relevant appendices to be published. Fourth Local Transport Plan: www.peterborough.gov.uk/ltp National Productivity Investment Fund for the Local Road Network Application Form: https://www.peterborough.gov.uk/upload/www.peterborough.gov.uk/residents/transport-and-streets/A605Application.pdf?inline=true

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16.	**Approval of funding allocation for the improvement to open spaces in the CAN Do area of the city as part of the capital regeneration programme for the area - KEY/25DEC17/04** Improvement to open spaces in the CAN Do area of the city as part of the capital regeneration programme for the area	**Councillor Cereste, Cabinet Member for Waste and Street Scene**	**September 2018**	Growth, Environment and Resources Scrutiny Committee	Central, North & Park wards	Relevant internal and external stakeholders. Community engagement with local residents, businesses & partner organisations	Cate Harding, Community Capacity Manager. Tel: 01733 317497. Email: Cate.harding@peterborough.gov.uk	It is not anticipated that there will be any documents other than the report and relevant appendices to be published. Budget allocation in MTFP 2017/18
17.	**Approval of funding allocation for community facility improvements in the CAN Do area of the city as part of the capital Regeneration Programme for the area - KEY/25DEC17/05** community facility improvements in the CAN Do area of the city as part of the capital Regeneration Programme for the area	**Councillor Seaton, Cabinet Member for Resources**	**September 2018**	Growth, Environment and Resources Scrutiny Committee	Central, North & Park wards	Relevant internal and external stakeholders. Community engagement with residents, groups, businesses and partner organisations	Cate Harding, Community Capacity Manager. Tel: 01733 317497. Email: cate.harding@peterborough.gov.uk	It is not anticipated that there will be any documents other than the report and relevant appendices to be published. Budget allocation of £4m in MTFP 2017/8

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18.	**Approval of funding allocation for the public realm improvements within the CAN Do area of the city as part of the capital regeneration programme for the area - KEY/25DEC17/06** public realm improvements within the CAN Do area	**Councillor Hiller, Cabinet Member for Growth, Planning, Housing and Economic Development**	**September 2018**	Growth, Environment and Resources Scrutiny Committee	Central, North & Park wards	Relevant internal and external stakeholders. Community engagement with local residents, groups, businesses and partner agencies	Cate Harding, Community Capacity Manager. Tel: 01733 317497. Email: cate.harding@peterborough.gov.uk	It is not anticipated that there will be any documents other than the report and relevant appendices to be published. Budget allocation £3m in MTFP 2017/18
19	**Extension to the Section 75 Agreement for Learning Disabilities Services KEY/30APRIL18/01** Extension of the existing staff and commissioned arrangements for a period of 12 months	**Councillor Fitzgerald, Deputy Leader and Cabinet Member for Integrated Adult Social Care and Health**	**September 2018**	Health Scrutiny Committee	All wards	Consultation with key stakeholders to agree this interim approach	Cris Green Tel: 01733 207164 Email: cris.green@peterborough.gov.uk	It is not anticipated that there will be any documents other than the report and relevant appendices to be published.

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20.	**Authority to enter into contracts with suppliers following termination of the Amey Contract – KEY/14MAY18/01** To authorise the Corporate Director for Growth & Regeneration to enter into contracts for a limited period with suppliers originally subcontracted by Amey whose arrangements will cease in September 2018. The services supplied are managed by NPS Ltd and will be included in an upcoming tender as follows: (i) Building Management Services (Plumbing and Water, Gas Maintenance, Fire Equipment, Lifts etc. (ii) External Maintenance (iii) General Repairs	**Councillor Hiller, Cabinet Member for Growth, Planning, Housing and Economic Development**	**September 2018**	Growth, Environment and Resources Scrutiny Committee	All Wards	Extensive consultation with colleagues within the Council and the subcontracted suppliers. The consultation with suppliers has focused on the immediate arrangements post Amey and alerting them to the fact that this business will be subject to full procurement within the next 3 months.	Andy Cox, Senior Contracts & Partnerships Manager, Tel: 452465, Email: andy.cox@peterborough.gov.uk	It is not anticipated that there will be any documents other than the report and relevant appendices to be published

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21.	**Construction of new school building - Heltwate School - KEY/14MAY18/02** Construction of a new school building to accommodate the expansion of Heltwate School	**Councillor Ayres, Cabinet Member for Education, Skills and University**	**October 2018**	Children and Education Scrutiny Committee	East Ward	Relevant internal and external stakeholders	Sharon Bishop, Capital Projects & Assets Officer, 863997, sharon.bishop@Peterborough.gov.uk	It is not anticipated that there will be any documents other than the report and relevant appendices to be published. School Organisational Plan 20017

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22.	**Approval for contract to be awarded to Skanska to deliver widening of the A605 Oundle Road between Alwalton and Lynch Wood Business Park** - **KEY/11JUN18/03** Approval for contract to be awarded to Skanska to deliver widening of the A605 Oundle Road between Alwalton and Lynch Wood Business Park. The council has received funding (£720k) from the Cambridgeshire and Peterborough Combined Authority to deliver the scheme. In addition the council has also allocated internal funding (£773k) towards the scheme.	**Councillor Hiller, Cabinet Member for Growth, Planning, Housing and Economic Development**	**September 2018**	Growth, Environment and Resources Scrutiny Committee	Orton Waterville	Relevant internal and external stakeholders Consultation will take place once the scheme design is completed. This is expected to be later this summer.	Lewis Banks, Principal Sustainable Transport Planning Officer. Tel: 01733 317465, Email: lewis.banks@peterborough.gov.uk	It is not anticipated that there will be any documents other than the report and relevant appendices to be published. Cambridgeshire and Peterborough Combined Authority meeting notes confirming grant funding allocation. Also CMDN for award of contract to Skanska for provision of Professional Services under Peterborough Highway Services partnership.

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23.	**Disposal of freehold in Centre of the City - KEY/12JUN18/01** To delegate authority to the Corporate Director of Growth and Regeneration to sell the property	**Councillor Seaton, Cabinet Member for Resources**	**September 2018**	Growth, Environment and Resources Scrutiny Committee	Central	Relevant internal and external stakeholders	Jane McDaid, Head of Peterborough Property, Tel: 07970 024 893 Email: jane.mcdaid @Peterborough.gov.uk"	It is not anticipated that there will be any documents other than the report and relevant appendices to be published. ***The decision will include an exempt annexe. By virtue of paragraph 3, information relating to the financial or business affairs of any particular person (including the authority holding that information).***

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24.	**Disposal of part of freehold in West of the City - KEY/12JUN18/02** Disposal of part of freehold in West of the City	**Councillor Seaton, Cabinet Member for Resources**	**September 2018**	Growth, Environment and Resources Scrutiny Committee	Bretton	Relevant internal and external stakeholders	Jane McDaid, Head of Peterborough Property, Tel: 07970 024 893 Email: jane.mcdaid@Peterborough.gov.uk"	It is not anticipated that there will be any documents other than the report and relevant appendices to be published. ***The decision will include an exempt annexe. By virtue of paragraph 3, information relating to the financial or business affairs of any particular person (including the authority holding that information).***

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25.	**Approval of funding for the provision of accommodation to reduce homelessness - KEY/25JUNE18/01** Following Cabinet Decision JAN18/CAB/18 this is a new project to increase the supply of housing and address the demand for accommodation resulting from the increase in homelessness.	**Councillor Seaton, Cabinet Member for Resources**	**September 18**	Growth, Environment and Resources Scrutiny Committee	All Wards	Relevant internal and external stakeholders The issues associated with homelessness in Peterborough have been subject to significant discussion in various forums, including the Council's Adults and Communities Scrutiny, Cabinet and Full Council	Adrian Chapman, Service Director for Communities and Safety. Tel: 01733 863887 Email: adrian.chapman@peterborough.gov.uk	It is not anticipated that there will be any documents other than the report and relevant appendices to be published. The decision will include an exempt annexe. By virtue of paragraph 3, information relating to the financial or business affairs of any particular person (including the authority holding that information).

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26.	**To approve the awarding of contracts to external providers following a competitive tender exercise led by Cambridgeshire County Council. - KEY/25JUNE18/02** Cambridgeshire County has recently conducted a tendering exercise to establish a Dynamic Purchasing System for the provision Supported Living Services for Adults with a Learning Disability (Reference number: DN311905). Peterborough City Council is the named authority under this arrangement and would want to commission care and support packages (call-off).	**Councillor Fitzgerald, Deputy Leader and Cabinet Member for Integrated Adult Social Care and Health**	**September 18**	Adults and Communities Scrutiny Committee	All Wards	Relevant internal and external stakeholders Relevant consultations has been carried out with the service users, family carers, Health colleagues and care and support providers across Cambridgeshire and Peterborough.	Mubarak Darbar, Head of Integrated Commissioning, Tel: 07718654207, Email: mubarak.darbar@peterborough.gov.uk	It is not anticipated that there will be any documents other than the report and relevant appendices to be published.

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27.	**Amendment to Loan Facility - KEY/09JUL18/02** A loan facility previously approved by Cabinet requires approval of an amendment to that facility	**Councillor Seaton, Cabinet Member for Resources**	**September 18**	Growth, Environment and Resources Scrutiny Committee	All Wards	Relevant internal and external stakeholders This decision will be taken after consultation with the Council's legal and financial advisors	Peter Carpenter, Acting Director of Corporate Resources, Tel: 01733 452520, Email: peter.carpenter@peterborough.gov.uk	It is not anticipated that there will be any documents other than the report and relevant appendices to be published. ***The decision will include an exempt annexe. By virtue of paragraph 3, information relating to the financial or business affairs of any particular person (including the authority holding that information).***

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28.	**To lease the North Wing of the Town Hall - KEY/09JUL18/03** Delegate authority to the Corporate Director of Growth and Regeneration to let the property	**Councillor Seaton, Cabinet Member for Resources**	**September 2018**	Growth, Environment and Resources Scrutiny Committee	Central	Relevant internal and external stakeholders	Jane McDaid Head of Peterborough Property services Tel: 01733 384540 Email: Jane.mcdaid@peterborough.gov.uk	It is not anticipated that there will be any documents other than the report and relevant appendices to be published. ***The decision will include an exempt annexe. By virtue of paragraph 3, information relating to the financial or business affairs of any particular person (including the authority holding that information).***

DECISION REQUIRED		*DECISION MAKER*	*DATE DECISION EXPECTED*	*RELEVANT SCRUTINY COMMITTEE*	**WARD**	*CONSULTATION*	*CONTACT DETAILS / REPORT AUTHORS*	*DOCUMENTS RELEVANT TO THE DECISION SUBMITTED TO THE DECISION MAKER INCLUDING EXEMPT APPENDICES AND REASONS FOR EXEMPTION*
29.	**Provision of accommodation to reduce homelessness KEY/23JULY18/01-** This is a new project to increase the supply of housing and address the demand for accommodation resulting from the increase in homelessness	**Councillor Seaton, Cabinet Member for Resources**	**September 2018**	Growth, Environment and Resources Scrutiny Committee	All Wards	The issues associated with homelessness in Peterborough have been subject to significant discussion in various forums, including the Council's Adults and Communities Scrutiny, Cabinet and Full Council	Adrian Chapman, Service Director for Communities and Safety. Tel 01733 863887 Email adrian.chapman@peterborough.gov.uk	It is not anticipated that there will be any documents other than the report and relevant appendices to be published. ***The decision will include an exempt annexe. By virtue of paragraph 3, information relating to the financial or business affairs of any particular person (including the authority holding that information).***

DECISION REQUIRED		*DECISION MAKER*	*DATE DECISION EXPECTED*	*RELEVANT SCRUTINY COMMITTEE*	*WARD*	*CONSULTATION*	*CONTACT DETAILS / REPORT AUTHORS*	*DOCUMENTS RELEVANT TO THE DECISION SUBMITTED TO THE DECISION MAKER INCLUDING EXEMPT APPENDICES AND REASONS FOR EXEMPTION*
30.	**Approval of funding for the provision of accommodation to reduce homelessness KEY/23JULY18/02** Following Cabinet Decision JAN18/CAB/18 this is a new project to increase the supply of housing and address the demand for accommodation resulting from the increase in homelessness	**Councillor Seaton, Cabinet Member for Resources**	**September 2018**	Growth, Environment and Resources Scrutiny Committee	All Wards	The issues associated with homelessness in Peterborough have been subject to significant discussion in various forums, including the Council's Adults and Communities Scrutiny, Cabinet and Full Council	Adrian Chapman, Service Director for Communities and Safety. Tel 01733 863887 Email: adrian.chapman@peterborough.gov.uk	It is not anticipated that there will be any documents other than the report and relevant appendices to be published. ***The decision will include an exempt annexe. By virtue of paragraph 3, information relating to the financial or business affairs of any particular person (including the authority holding that information).***
31.	**Budget Approval - KEY/20AUG18/01** Approve the refurbishment of the Town Hall North within an agreed budget and authorise the Corporate Director Growth and Communities to enter into a design and build contract with the procured contractor.	**Councillor David Seaton Cabinet Member for Resources**	September 2018	Growth, Environment and Resources Scrutiny Committee	All wards	Not applicable	Stuart Macdonald. Strategic Development Consultant (Property) 07715 802 489. stuart.macdonald@peterborough.gov.uk	It is not anticipated that there will be any documents other than the report and relevant appendices to be published.

	DECISION REQUIRED	DECISION MAKER	DATE DECISION EXPECTED	RELEVANT SCRUTINY COMMITTEE	WARD	CONSULTATION	CONTACT DETAILS / REPORT AUTHORS	DOCUMENTS RELEVANT TO THE DECISION SUBMITTED TO THE DECISION MAKER INCLUDING EXEMPT APPENDICES AND REASONS FOR EXEMPTION
32.	**IT Strategy – KEY/3SEP18/01** Approval of an IT Strategy and associated investment for the 2019 to 2022 time period	**Councillor Seaton, Cabinet Member for Resources**	**September 2018**	Growth, Environment and Resources Scrutiny Committee	N/A	Relevant internal and external stakeholders	Peter Carpenter, Acting Corporate Director, Resources Tel: 01733 384564 Email: Peter.carpenter@peterborough.gov.uk	IT Improvement Plan 23/07/18. There will be the possibility of an exempt annex if the report contains commercial information. It is not anticipated that there will be any documents other than the report and relevant appendices to be published.
33.	**University Delivery Vehicle – KEY/3SEP18/02** Approval and setting up of an appropriate delivery vehicle with University project partners to move council assets to enable the deliver of the university.	**Councillor Lynne Ayres, Cabinet Member for Education, Skills and University**	**September 2018**	Growth, Environment and Resources Scrutiny Committee	Central	Relevant internal and external stakeholders	Peter Carpenter, Acting Corporate Director, Resources Tel: 01733 384564 Email: Peter.carpenter@peterborough.gov.uk	It is not anticipated that there will be any documents other than the report and relevant appendices to be published. ***The decision will include an exempt annexe. By virtue of paragraph 3, information relating to the financial or business affairs of any particular person (including the authority holding that information).***

DECISION REQUIRED		*DECISION MAKER*	*DATE DECISION EXPECTED*	*RELEVANT SCRUTINY COMMITTEE*	**WARD**	*CONSULTATION*	*CONTACT DETAILS / REPORT AUTHORS*	*DOCUMENTS RELEVANT TO THE DECISION SUBMITTED TO THE DECISION MAKER INCLUDING EXEMPT APPENDICES AND REASONS FOR EXEMPTION*
34.	**To retain the footbridges on junction 18 / Rhubarb Bridge – KEY/17SEP18/01** In a previous CMDN reference was made that the bridges would be demolished. Subject to a Cross Party Working Group recommendation and Cabinet approval, it is the intention that these bridges will remain and that we will reassign the proportion of the overall budget allocated to demolish the footbridges to instead make significant repairs to the bridge structures.	**Councillor Hiller, Cabinet Member for Growth, Planning, Housing and Economic Development**	**23 September 2018**	Growth, Environment and Resources Scrutiny Committee	A number of wards in the urban area	This is the result of previous consultation where a number of people said they wanted the bridges to remain	Lewis Banks, Principal Sustainable Transport Planning Officer, 01733 317465, lewis.banks @peterborough.gov.uk	It is not anticipated that there will be any documents other than the report and relevant appendices to be published

DECISION REQUIRED		*DECISION MAKER*	*DATE DECISION EXPECTED*	*RELEVANT SCRUTINY COMMITTEE*	**WARD**	*CONSULTATION*	*CONTACT DETAILS / REPORT AUTHORS*	*DOCUMENTS RELEVANT TO THE DECISION SUBMITTED TO THE DECISION MAKER INCLUDING EXEMPT APPENDICES AND REASONS FOR EXEMPTION*
35.	**Approval of funding for the provision of accommodation to reduce homelessness – KEY/17SEP18/02** Following Cabinet Decision JAN18/CAB/18 this is a new project to increase the supply of housing and address the demand for accommodation resulting from the increase in homelessness	**Councillor Seaton, Cabinet Member for Resources**	**October 2018**	Growth, Environment and Resources Scrutiny Committee	All wards	The issues associated with homelessness in Peterborough have been subject to significant discussion in various forums, including the Council's Adults and Communities Scrutiny, Cabinet and Full Council	Adrian Chapman, Service Director for Communities and Safety. adrian.chapman@peterborough.gov.uk carole.coe@peterborough.gov.uk	***The decision will include an exempt annexe. By virtue of paragraph 3, information relating to the financial or business affairs of any particular person (including the authority holding that information).*** It is not anticipated that there will be any documents other than the report and relevant appendices to be published.

PART 2 – NOTICE OF INTENTION TO TAKE DECISIONS IN PRIVATE

KEY DECISIONS TO BE TAKEN IN PRIVATE

KEY DECISION REQUIRED	*DECISION MAKER*	*DATE DECISION EXPECTED*	*RELEVANT SCRUTINY COMMITTEE*	*WARD*	*CONSULTATION*	*CONTACT DETAILS / REPORT AUTHORS*	*DOCUMENTS RELEVANT TO THE DECISION SUBMITTED TO THE DECISION MAKER*
Approval of Company Business Plan – KEY/17SEP18/03 New Council Company needs to be set up and ready to trade from 2 February 2019.	**Cabinet**	**3 December 2018**	Growth, Environment and Resources Scrutiny Committee	All wards	Affected Amey employees and union representatives.	Annette Joyce Service Director – Environment and Economy,01733 452280 alexandra.maxey@peterborough.gov.uk	It is not anticipated that there will be any documents other than the report and relevant appendices to be published. ***The decision will include an exempt annexe. By virtue of paragraph 3, information relating to the financial or business affairs of any particular person (including the authority holding that information).***

PART 3 – NOTIFICATION OF NON-KEY DECISIONS

NON-KEY DECISIONS							
DECISION REQUIRED	***DECISION MAKER***	***DATE DECISION EXPECTED***	***RELEVANT SCRUTINY COMMITTEE***	***WARD***	***CONSULTATION***	***CONTACT DETAILS / REPORT AUTHORS***	***DOCUMENTS RELEVANT TO THE DECISION SUBMITTED TO THE DECISION MAKER INCLUDING EXEMPT APPENDICES AND REASONS FOR EXEMPTION***
No new items							

NON-KEY DECISIONS

PREVIOUSLY ADVERTISED DECISIONS

DECISION REQUIRED		*DECISION MAKER*	*DATE DECISION EXPECTED*	*RELEVANT SCRUTINY COMMITTEE*	*WARD*	*CONSULTATION*	*CONTACT DETAILS / REPORT AUTHORS*	*DOCUMENTS RELEVANT TO THE DECISION SUBMITTED TO THE DECISION MAKER INCLUDING EXEMPT APPENDICES AND REASONS FOR EXEMPTION*
1.	**Proposal for Loan of Senior Management Staff Under Joint Arrangements –** To approve a sharing agreement for senior management staff.	**Councillor David Seaton Cabinet Member for Resources**	**September 2018**	Growth, Environment & Resources Scrutiny Committee	All wards	Relevant internal and external stakeholders.	Fiona McMillan Interim Director of Law and Governance Tel: 01733 452361 Email: Fiona.McMillan@peterborough.gov.uk	It is not anticipated that there will be any documents other than the report and relevant appendices to be published.
2.	**Funding of Information, Advice and Guidance services within the voluntary sector -** To authorise award of grants.	**Councillor David Seaton Cabinet Member for Resources**	**September 2018**	Growth, Environment & Resources Scrutiny Committee	All wards	Relevant internal and external stakeholders	Ian Phillips Senior Policy Manager Tel: 01733 863849 Email: ian.phillips@peterborough.gov.uk	It is not anticipated that there will be any documents other than the report and relevant appendices to be published.

	DECISION REQUIRED	DECISION MAKER	DATE DECISION EXPECTED	RELEVANT SCRUTINY COMMITTEE	WARD	CONSULTATION	CONTACT DETAILS / REPORT AUTHORS	DOCUMENTS RELEVANT TO THE DECISION SUBMITTED TO THE DECISION MAKER INCLUDING EXEMPT APPENDICES AND REASONS FOR EXEMPTION
3.	**Daily cleanse around Gladstone Street and nearby streets -** Daily mechanical cleanse in the area focused around Gladstone Street and other nearby streets. This will encompass a mechanical sweeper and operative.	**Councillor Cereste, Cabinet Member for Waste and Street Scene**	**September 2018**	Growth, Environment & Resources Scrutiny Committee	Central Ward	Relevant internal and external stakeholders. Cross party task and finish group report which went to the Growth, Environment and Resources Scrutiny Committee	James Collingridge, Amey Partnership Manager, Tel: 01733 864736 Email: james.collingridge @peterborough.gov.uk	It is not anticipated that there will be any documents other than the report and relevant appendices to be published.
4.	**A Lengthmans to be deployed on Lincoln Road Millfield -** There will be a daily presence along Lincoln Road, the operative will litter pick, empty bins as well as report fly-tips and other environmental issues.	**Councillor Cereste, Cabinet Member for Waste and Street Scene**	**September 2018**	Growth, Environment & Resources Scrutiny Committee	Central Ward	Relevant internal and external stakeholders. Cross party task and finish group report which went to the Growth, Environment and Resources Scrutiny Committee and it was also approved at Full Council as part of the 2017-18 Budget.	James Collingridge, Amey Partnership Manager, Tel: 01733 864736 Email: james.collingridge @peterborough.gov.uk	It is not anticipated that there will be any documents other than the report and relevant appendices to be published.

DECISION REQUIRED		*DECISION MAKER*	*DATE DECISION EXPECTED*	*RELEVANT SCRUTINY COMMITTEE*	*WARD*	*CONSULTATION*	*CONTACT DETAILS / REPORT AUTHORS*	*DOCUMENTS RELEVANT TO THE DECISION SUBMITTED TO THE DECISION MAKER INCLUDING EXEMPT APPENDICES AND REASONS FOR EXEMPTION*
5.	**2017/18 VCS grant funding -** Award of grant to VCS organisations to provide Information, Advice and Guidance services	**Councillor Seaton, Cabinet Member for Resources**	**September 2018**	Adults and Communities Scrutiny Committee	All wards	Relevant internal and external stakeholders.	Ian Phillips Senior Policy Manager Tel: 863849 Email: ian.phillips@peterborough.gov.uk	It is not anticipated that there will be any documents other than the report and relevant appendices to be published.
6.	**Inclusion of Investment Acquisition Strategy in the Council's Medium Term Financial Strategy (MTFS**) **-** To recommend to Council that the Investment Acquisition Strategy be included in the Medium Term Financial Strategy to enable the Council to acquire investment properties	**Cabinet**	**3 December 2018**	Growth, Environment and Resources	N/A	Relevant internal and external stakeholders	Jane McDaid Head of Peterborough Property services Tel: 01733 384540 Email: Jane.mcdaid@peterborough.gov.uk	It is not anticipated that there will be any documents other than the report and relevant appendices to be published.

DECISION REQUIRED		*DECISION MAKER*	*DATE DECISION EXPECTED*	*RELEVANT SCRUTINY COMMITTEE*	**WARD**	*CONSULTATION*	*CONTACT DETAILS / REPORT AUTHORS*	*DOCUMENTS RELEVANT TO THE DECISION SUBMITTED TO THE DECISION MAKER INCLUDING EXEMPT APPENDICES AND REASONS FOR EXEMPTION*
7.	**Grant funding for voluntary organisations –** To provide funding for voluntary organisations in Peterborough to carry out essential support for vulnerable people, particularly in relation to welfare benefits assistance and other crisis support.	**Councillor Seaton, Cabinet Member for Resources**	**September 2018**	Adults and Communities Scrutiny Committee	N/A	Relevant internal and external stakeholders.	Ian Phillips Social Inclusion Manager Tel: 01733 863849 Email: Ian.Phillips@peterborough.gov.uk	It is not anticipated that there will be any documents other than the report and relevant appendices to be published.
8.	**Public Space Protection Order -** The Cabinet Member to authorise commencement of the necessary public consultation for the Public Space Protection Order under Section 72 (3) of the Anti-Social Behaviour, Crime & Policing Act 2014	**Councillor Walsh, Cabinet Member for Communities**	**September 2018**	Adults and Communities	Fletton and Woodston	Police, Fire Service, Internal PCC departments, local residents	Laura Kelsey, Senior PES Officer E-mail: laura.Kelsey@peterborough.gov.uk Tel: 01733 453563	It is not anticipated that there will be any documents other than the report and relevant appendices to be published.

DECISION REQUIRED		*DECISION MAKER*	*DATE DECISION EXPECTED*	*RELEVANT SCRUTINY COMMITTEE*	**WARD**	*CONSULTATION*	*CONTACT DETAILS / REPORT AUTHORS*	*DOCUMENTS RELEVANT TO THE DECISION SUBMITTED TO THE DECISION MAKER INCLUDING EXEMPT APPENDICES AND REASONS FOR EXEMPTION*
9.	**Approval of Additional Powers to the Combined Authority (Transfer of Powers) -** Approve additional powers for the Combined Authority via a Statutory Instrument for Adult Skills Commissioning.	**Councillor Holdich, Leader of the Council and Member of the Cambridgeshire and Peterborough Combined Authority**	**September 2018**	Growth, Environment and Resources Scrutiny Committee	All	All Councils in Peterborough and Cambridgeshire have to agree to the transfer	Peter Carpenter, Acting Corporate Director, Resources Tel: 01733 384564 Email: Peter.carpenter@peterborough.gov.uk	It is not anticipated that there will be any documents other than the report and relevant appendices to be published. Combined Authority Statutory Instrument Request

DECISION REQUIRED		*DECISION MAKER*	*DATE DECISION EXPECTED*	*RELEVANT SCRUTINY COMMITTEE*	**WARD**	*CONSULTATION*	*CONTACT DETAILS / REPORT AUTHORS*	*DOCUMENTS RELEVANT TO THE DECISION SUBMITTED TO THE DECISION MAKER INCLUDING EXEMPT APPENDICES AND REASONS FOR EXEMPTION*
10.	**Food and Feed Service Plan -** This plan sets out how the council will meet its statutory food safety, food standards, and animal feed duties across its shared services.	**Councillor Walsh, Cabinet Member For Communities**	**September 2018**	Growth, Environment and Resources Scrutiny Committee	All Ward	All relevant internal and external stakeholders. This plan has been consulted on with our shared service partners Cambridgeshire County Council, and Rutland County Council, in addition the plan has been shared with the Food Standards Agency.	Liz Adamson, Principal Environmental Health Officer - Food and Safety Tel: 01733 453542 Email: liz.adamson@peterborough.gov.uk	It is not anticipated that there will be any documents other than the report and relevant appendices to be published.

DECISION REQUIRED		*DECISION MAKER*	*DATE DECISION EXPECTED*	*RELEVANT SCRUTINY COMMITTEE*	**WARD**	*CONSULTATION*	*CONTACT DETAILS / REPORT AUTHORS*	*DOCUMENTS RELEVANT TO THE DECISION SUBMITTED TO THE DECISION MAKER INCLUDING EXEMPT APPENDICES AND REASONS FOR EXEMPTION*
11.	**To approve the write-off of any uncollectable debts in excess of £10,000 -** Authorisation of the write-off of the debts in excess of £10,000 in respect of non-domestic rates, council tax, housing benefit overpayments and sundry debt (including property debt) accounts, in accordance with standard financial practices. All cases requested for write-off follow a lengthy process to recover the outstanding money, and only once all avenues have been exhausted will the council consider writing off debt as part of recommended budget management processes.	**Councillor Seaton, Cabinet Member for Resources**	**September 2018**	Growth Environment & Resources Scrutiny Committee	N/A	N/A	Peter Carpenter, Acting Director of Corporate Resources, 01733 452520, peter.carpenter@peterborough.gov.uk.	It is not anticipated that there will be any documents other than the report and relevant appendices to be published.

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12.	**Discretionary Rate Relief -** To determine various discretionary rate reliefs for 2018/19 and future years. This will cover standard council reliefs funded in the usual manner, the 2018/19 local DRR, pub relief for 2018/19 and relief for small businesses for 2018/19 onwards all of which are government funded.	**Councillor Seaton, Cabinet Member for Resources**	**September 2018**	Growth Environment & Resources Scrutiny Committee	All	No other consultation required.	Bruce Bainbridge, Finance Manager Tel: 01733 - 384583, Email: bruce.bainbridge@peterborough.gov.uk	It is not anticipated that there will be any documents other than the report and relevant appendices to be published.
13.	**Recommendation for Cabinet to adopt Peterborough City Council's Tree and Woodland Strategy** Consideration and adoption of the Trees and Woodland Strategy by Cabinet and then Full Council	**Cabinet**	**Cabinet – 24th September**	Growth, Environment & Resources Scrutiny Committee	All	Formal public consultation following submission to Cabinet 15th Jan 2018	Darren Sharpe, Natural & Historic Environment Manager Email:darren.sharpe@peterborough.gov.uk Tel: 01733 453596	It is not anticipated that there will be any documents other than the report and relevant appendices

PART 4 – NOTIFICATION OF KEY DECISIONS TAKEN UNDER URGENCY PROCEDURES

DECISION TAKEN:		*DECISION MAKER*	*DATE DECISION TAKEN*	*RELEVANT SCRUTINY COMMITTEE*	WARD	*CONSULTATION*	*CONTACT DETAILS / REPORT AUTHORS*	*DOCUMENTS RELEVANT TO THE DECISION SUBMITTED TO THE DECISION MAKER INCLUDING EXEMPT APPENDICES AND REASONS FOR EXEMPTION*
	No new items							

DIRECTORATE RESPONSIBILITIES

RESOURCES DEPARTMENT Corporate Director's Office at Town Hall, Bridge Street, Peterborough, PE1 1HG
City Services and Communications (Markets and Street Trading, City Centre Management including Events, Regulatory Services, Parking Services, Vivacity Contract, CCTV and Out of Hours Calls, Marketing and Communications, Tourism and Bus Station, Resilience)
Strategic Finance
Internal Audit
Schools Infrastructure (Assets and School Place Planning)
Waste and Energy
Strategic Client Services (Enterprise Peterborough / Vivacity / SERCO including Customer Services, ICT and Business Support)

PEOPLE AND COMMUNITIES DEPARTMENT Corporate Director's Office at Bayard Place, Broadway, PE1 1FB
Adult Services and Communities (Adult Social Care Operations, Adult Social Care and Quality Assurance, Adult Social Care Commissioning, Early Help – Adults, Children and Families, Housing and Health Improvement, Community and Safety Services, Offender Services)
Children's Services and Safeguarding (Children's Social Care Operations, Children's Social Care Quality Assurance, Safeguarding Boards – Adults and Children's, Child Health, Clare Lodge (Operations), Access to Resources)
Education, People Resources and Corporate Property (Special Educational Needs and Inclusion, School Improvement, City College Peterborough, Pupil Referral Units, Schools Infrastructure)
Business Management and Commercial Operations (Commissioning, Recruitment and Retention, Clare Lodge (Commercial), Early Years and Quality Improvement)

GOVERNANCE DEPARTMENT Director's Office at Town Hall, Bridge Street, Peterborough, PE1 1HG
Legal and Democratic Services
Electoral Services
Human Resources (Business Relations, HR Policy and Rewards, Training and Development, Occupational Health and Workforce Development)
Performance and Information (Performance Management, Information Governance, Systems Support Team, Coroner's Office, Freedom of Information)

GROWTH AND REGENERATION DEPARTMENT Corporate Director's Office Town Hall, Bridge Street, Peterborough, PE1 1HG
Development and Construction (Development Management, Planning Compliance, Building Control)
Sustainable Growth Strategy (Strategic Planning, Housing Strategy and Affordable Housing, Climate Change and Environment Capital, Natural and Built Environment)
Opportunity Peterborough
Peterborough Highway Services (Network Management, Highways Maintenance, Street Naming and Numbering, Street Lighting, Design and Adoption of Roads, Drainage and Flood Risk Management, Transport Policy and Sustainable Transport, Public Transport)
Corporate Property

PUBLIC HEALTH DEPARTMENT Director's Office at Town Hall, Bridge Street, Peterborough, PE1 1HG
Health Protection, Health Improvements, Healthcare Public Health.

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Health Scrutiny Committee Work Programme 2018/2019

Updated: 6 September 2018

Meeting Date	Item	Indicative Timings	Comments
18 JUNE 2018 Joint Scrutiny of the Budget Meeting	**Medium Term Financial Strategy 2019/20 to 2021/22 - Tranche One** To scrutinise the Executive's proposals for the Medium Term Financial Strategy 2019//20.to 2021/22 Tranche One Proposals. **Contact Officer: Peter Carpenter**		
2 JULY 2018 *Draft Report 11 June* *Final Report 20 June*	**Appointment of Co-opted Members** To agree to the appointment of co-opted members to the committee for the municipal year 2018.2018. **Contact Officer: Paulina Ford, Senior Democratic Services Officer**		
	Dental Services in Peterborough To receive a follow up report to the report presented to the Committee in March 2018. **Contact Officer: Roxana Mojoo Jones, NHS England**		
	North West Anglia NHS Foundation Trust – Bed Capacity To receive a report on proposals and options for increasing capacity at Peterborough City Hospital. **Contact Officer: Stephen Graves, Chief Executive**		

Meeting Date	Item	Indicative Timings	Comments
	Review of 2017/2018 And Work Programme For 2018/2019 To review the work undertaken during 2017/18 and to consider the work programme of the Committee for 2018/2019 **Contact Officer: Paulina Ford, Senior Democratic Services Officer**		
	Forward Plan of Executive Decisions That the Committee identifies any relevant items for inclusion within their work programme which are relevant to the remit of this Committee. **Contact Officer: Paulina Ford, Senior Democratic Services Officer**		
17 SEPTEMBER 2018 *Draft Report 24 August* *Final Report 5 August*	**STP Update and Strategic Direction 2018/19** To scrutinise and consider the strategic direction for the Sustainability and Transformation Partnership for 2018/19. **Contact Officer: Aidan Fallon**		
	NHS Constitution including Targets and Performance To receive a report from the C&PCCG on the NHS Constitution including performance against targets. **Contact Officer: Jessica Bawden**		

Meeting Date	Item	Indicative Timings	Comments
	Cambridgeshire and Peterborough Clinical Commissioning Group (C&PCCG) Commissioning Plans and response to PWC Review To receive a report on the (C&PCCG) Commissioning Plans and response to the capacity and capability review by PricewaterhouseCoopers (PWC). **Contact Officer: Jessica Bawden**		
	Transforming Care - 'Building The Right Support' (BRS) - Inpatient Bed Configuration. Preferred Option Consultation To scrutinise the proposed changes to the provision of inpatient beds for people with a learning disability in Cambridgeshire and Peterborough. **Contact Officer: Jessica Bawden**		
	Monitoring Scrutiny Recommendations To monitor progress made on recommendations made at the previous meeting. **Contact Officer: Paulina Ford, Senior Democratic Services Officer**		
	Forward Plan of Executive Decisions That the Committee identifies any relevant items for inclusion within their work programme which are relevant to the remit of this Committee. **Contact Officer: Paulina Ford, Senior Democratic Services Officer**		

Meeting Date	Item	Indicative Timings	Comments
	Work Programme 2018/2019 To consider the Work Programme for 2018/2019 **Contact Officer: Paulina Ford, Senior Democratic Services Officer**		
5 NOVEMBER 2018 *Draft Report 15 October 2018* *Final Report 24 October 2018*	**Recommissioning of Sexual Health and Contraception Service** **Contact Officer: Dr Liz Robin**		
	North West Anglia NHS Foundation Trust Winter Pressures Plans **Contact Officer: Jane Pigg**		
	Primary Care Changes To receive a report detailing Primary Care Changes to include mergers and Federations, customer service aspect and access to GP's. **Contact Officer: Jessica Bawden**		
	Procurement for the MIIU Minor Injury and Illness Unit Nov **Contact Officer: Jessica Bawden**		
	Monitoring Scrutiny Recommendations To monitor progress made on recommendations made at the previous meeting. **Contact Officer: Paulina Ford, Senior Democratic Services Officer**		

Meeting Date	Item	Indicative Timings	Comments
	Forward Plan of Executive Decisions That the Committee identifies any relevant items for inclusion within their work programme which are relevant to the remit of this Committee. **Contact Officer: Paulina Ford, Senior Democratic Services Officer**		
	Work Programme 2018/2019 To consider the Work Programme for 2018/2019 **Contact Officer: Paulina Ford, Senior Democratic Services Officer**		
28 NOVEMBER 2019 Joint Scrutiny of the Budget Meeting	**Medium Term Financial Strategy 2019/20 to 2021/22 - Tranche Two** To scrutinise the Executive's proposals for the Medium Term Financial Strategy 2019//20.to 2021/22 Tranche Two Proposals. **Contact Officer: Peter Carpenter**		
21 JANUARY 2019 *Draft Report 14 December* *Final Report 9 December*	**Portfolio Progress Report for Cabinet Member for Public Health** To Scrutinise the portfolio of the Cabinet Member for Public Health and make any recommendations. **Contact Officer: Dr Liz Robin**		

Meeting Date	Item	Indicative Timings	Comments
	Annual Public Health Report 2018 To scrutinise and comment on the Annual Public Health Report and make any recommendations. **Contact Officer: Dr Liz Robin**		
	Monitoring Scrutiny Recommendations To monitor progress made on recommendations made at the previous meeting. **Contact Officer: Paulina Ford, Senior Democratic Services Officer**		
	Forward Plan of Executive Decisions That the Committee identifies any relevant items for inclusion within their work programme which are relevant to the remit of this Committee. **Contact Officer: Paulina Ford, Senior Democratic Services Officer**		
	Work Programme 2018/2019 To consider the Work Programme for 2018/2019 **Contact Officer: Paulina Ford, Senior Democratic Services Officer**		
12 FEBRUARY 2019 Joint Scrutiny of the Budget Meeting	**Medium Term Financial Strategy 2019/20 to 2021/22 - Tranche Three** To scrutinise the Executive's proposals for the Medium Term Financial Strategy 2019//20.to 2021/22 Tranche Three Proposals. **Contact Officer: Peter Carpenter**		

Meeting Date	Item	Indicative Timings	Comments
18 MARCH 2019 *Draft Report 25 February 2019* *Final Report 6 March 2019*	**Healthy Peterborough Programme Progress Report** To scrutinise the progress of the Healthy Peterborough Programme and impact of reduced funding and make any recommendations. **Contact Officer: Stuart Keeble / Karen Cornish**		
	Review of Impact of Discontinuation of IVF Provision **Contact Officer: Jessica Bawden**		
	Monitoring Scrutiny Recommendations To monitor progress made on recommendations made at the previous meeting. **Contact Officer: Paulina Ford, Senior Democratic Services Officer**		
	Forward Plan of Executive Decisions That the Committee identifies any relevant items for inclusion within their work programme which are relevant to the remit of this Committee. **Contact Officer: Paulina Ford, Senior Democratic Services Officer**		

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