PETERBOROUGH CITY COUNCIL

MINUTES OF A MEETING OF THE SCRUTINY COMMISSION FOR HEALTH ISSUES HELD IN THE BOURGES / VIERSEN ROOMS, TOWN HALL ON 20 JUNE 2013

Present:	Councillors B Rush (Chairman), D Lamb, N Arculus, D McKean, K Sharp, N Shabbir and A Sylvester	
Also present	Councillor Sandford,	Group Leader, Liberal Democrats
	David Whiles,	Healthwatch
	Matthew Purcell	Youth Council
	Rob Hughes,	Chairman, Peterborough and Stamford Hospital NHS Foundation Trust
	Caroline Walker	Director of Finance, Peterborough and Stamford Hospital NHS Foundation Trust
	John Randall	Medical Director, Peterborough and Stamford Hospital NHS Foundation Trust
	Chris Wilkinson	Director of Care Quality and Chief Nurse, Peterborough and Stamford Hospital NHS Foundation Trust
	Damien Ashford	Financial review lead and Project Manager, Price Waterhouse Cooper
Officers Present:	Jana Burton	Interim Director of Adult Social Care
	Sue Mitchell	Interim Director of Public Health
	Tina Hornsby	Assistant Director, Quality Information & Performance
	Paulina Ford	Senior Governance Officer
	Gurvinder Kaur	Lawyer

1. Apologies

Apologies for absence were received from Councillor Allen. Councillor Arculus was in attendance as substitute.

2. Declarations of Interest and Whipping Declarations

There were no declarations of interest or whipping declarations.

3. Minutes of Meeting held on 12 March 2013.

The minutes of the meeting held on 12 March 2013 were approved as an accurate record.

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

There were no requests for Call-in to consider.

5. Peterborough and Stamford Hospital NHS Foundation Trust – Update

The purpose of this report was to provide the Commission with an update on the Trust's current regulatory, strategic performance and financial position. Members were advised that a Contingency Planning Team (CPT) from Price Waterhouse Cooper (PwC) had been appointed by Monitor in December 2012 to review the operational, clinical and financial

sustainability of the Peterborough and Stamford Hospital NHS Foundation Trust due to financial issues. It was stressed that the reason was not due to the quality of care. The areas the CPT were looking at were sustainability of the Trust; the PFI and options for the future. The report covered what had been found so far. Members were also advised that there was a more detailed public report available on Monitor's website.

The review so far had found the Trust to be financially unsustainable but operationally and clinically sustainable. There had therefore been a lot of research looking at how to improve financial sustainability without reducing quality of care. There was extra space in the building that was not currently being used and this was being looked at to see how it could be used as an option to improve the financial position.

The Board highlighted that they aim to focus on future care of patients and how this could be improved whilst becoming more efficient; rather than focus on the fact that there was a financial problem of which everyone was now aware.

Observations and questions were raised and discussed including:

- David Whiles from Healthwatch Peterborough assured Members that they had been fully involved in the review process representing patients and had found the process to be very transparent and inclusive.
- Members noted a concern was raised during presentations last year around boundaries with regard to Lincolnshire patients being admitted to the hospital. Members asked if this had been taken into account. *Members were advised that the Trust was subject to a national payment tariff for care to patients and was Payment by Results. The national menu was adjusted for local areas so that the price related to the area the care had taken place in. There was therefore a slight pricing difference between Lincolnshire and Cambridgeshire but the Trust had no influence over this. The Trust had been in a 'block arrangement' with Cambridgeshire and Lincolnshire but this year both of the areas were paying the same based on a national tariff basis.*
- Members were also concerned that all the work carried out for the review could be diverting hospital staff from achieving clinical deliverables. *Members were advised that the Trust has tried to perform this process with minimal disruption to staff members. PwC had achieved this by using a range of different skills within the team who had the necessary knowledge to achieve this work which was similar to those skills and knowledge within the Trust. It was stressed that while this did take a bit of time now it was important for the future. The potential benefits far outweighed any disruptions that may have been caused by this work now. It was further noted that from a clinical point of view the engagement has been very good. PwC has used meetings that were already set up and information already available and thereby minimised disruption to frontline clinical staff. There was still a lot of work to do but the priority remained to not negatively affect patient care. If it was necessary to do so more expertise would be bought in to help.*
- Members noted that the aim of the review may be to get more business in to the Trust however Patient Participation Groups and Local Commissioning Groups were trying to get cheaper business. Members asked how budgets were being predicted for these two conflicting approaches. *Members were advised that this had been considered and budgeted for and only patients in acute setting would come to the hospital. The Commissioners were looking to treat patients who did not have to be treated at an acute hospital setting.*
- Members asked for clarification on the reference to the Trust having a good mortality performance, but that the mortality rate was above average (rather than below average). *The CPT thanked the member for the question and clarified that the intention was to communicate that the Trust had a mortality rate that was below average.*
- Members commented on the Trusts aim to get away from the focus on financials and move toward focusing on patient care and felt that in the past it had been difficult to not focus on financials as any financial issues always caused distractions.

- Members raised concern about the PFI contract and were surprised that there was nothing central government could do to help with redrafting the contract. *Members were advised that it was difficult to redraft a new agreement due to legal obligations. The PFI was underwritten by the Department of Health and therefore if the Trust could not pay the costs the Department of Health would pick this up. It had been considered but nothing could be done about the contract without having huge ramifications for the whole PFI market and PFI's in the future. Members were advised that the PFI was not the major reason behind the financial issues and the report had made this clear. There were other reasons for the financial challenge such as the size of the hospital being too big for the amount of patients admitted.*
- Members sought assurance that the Trust was not considering getting rid of Stamford Hospital. *Members were advised that while looking at options for both hospitals it had become clear that the connection between Peterborough and Stamford was a positive one and the sense of direction was that Stamford was helpful to Peterborough City Hospital.*
- Members sought assurance that the Trust was not being complacent about the level of care delivered to residents in the community. *Members were assured that the Trust was not complacent with regard to this and there was an ongoing quality improvement plan underway. Members were further advised that in order to effectively keep patient care as a top priority a new non Executive Director had recently been appointed who was a clinical person.*
- Members asked about the efficiency savings that were being proposed. Was the figure of 4.5% per annum or a total? Members asked for some examples of what the Trust was considering implementing in order to achieve this. *Members were advised that the proposed savings were 4.5% a year and that this was a figure the NHS expected of all hospitals and services. The following areas were being looked at in order to achieve such savings: procurement and buying things cheaper; productivity and clear pathways, external reports and external bench markings that would help improve efficiency; workforce and money spent on temporary staff and recruitment of more permanent staff. Whilst there was not a lot that could be done to redraft the PFI contract, they were looking at the soft Facility Management services within the contract such as the domestic catering costs.*
- Members asked about utilising the surplus space available and whether hiring this out to private healthcare providers would bring additional income. *Members were advised that this did have potential in that the healthcare provider using that space would need to pay rental for it and would give rise to opportunities for improving patient care. It was something for the Trust to consider more in the future than at the current time as the Trust was effectively already giving the private sector business and they would like to take that business back by being more efficient themselves.*
- Members asked if the fourth floor of the hospital could be rented out to a private company (not in the health service) under the PFI Agreement, or would the private company have to be within the health service? *Members were advised that the restriction was that things which were contrary to health could not be provided in the hospital. An example would be cigarette suppliers but the space could be used for office space. The Trust was conscious that the space had been designed for care of patients and would prefer to use the space for its intended design.*
- Members asked for clarification on what the major reason for the financial difficulty was if it was not the PFI. Members questioned how with all the emphasis being put on preventative care the Trust was planning on increasing income other than by renting space to private care facilities without making tremendous cuts in capital expenditure. *Members were advised the Trust was looking at various efficiencies to save money. An example would be if there was a national specialist service that could be used in the space available that would be paid for by commissioners all around the country then this would be another way of making more money. Some of the other causes of the financial challenge included the type of contracts the Trust had been put on in the past which had now been addressed. The PFI contract included maintenance costs and stated that the estate had to be maintained and kept at the level at which it was when the contract was*

written which was another reason PFI estates were more costly. It was also mentioned that every hospital received payment according to a national tariff based on average costs. The NHS gave each hospital the average cost of a hospital but Peterborough was not an average hospital and had a premium PFI cost which added to the financial challenge. Also a lot of patients were treated that the Trust were not paid for due to the Commissioners preferring the patients to be treated in alternative settings. The plan was to involve the whole pathway for patients including integration with other services to ensure patient care was correct.

- Members asked about the process for delayed discharges and whether these followed the Department of Health guidance. *Members were informed that all patients were tracked during the time they were with the Trust and any patients with a complex discharge needed to follow the Department of Health guidance procedures. Any patients who were medically fit to go home but were delayed were monitored and it was then established whether the delay was on social care grounds or health grounds. The Trust would then work with their partners to facilitate the discharge as soon as possible.*
- Members were concerned about the number of readmissions particularly for older people and asked for comment on this. *Members were advised that this was being monitored. The Trust looked at what the cause for readmission was and in looking at this they found patients were not necessarily readmitted for the same reason as their initial hospitalisation. If there was a link to the original problem then further investigation took place as to why the patient was discharged and if there was a problem with the discharge process it was followed up.*
- Members asked if the Trust could look at something in the Adult Social Care report which was item 6 of the agenda and comment on paragraph 2 of page 20, as well as paragraph 4 with regard to readmissions and delayed discharges due to non social care reasons. Members were concerned at the statistics regarding readmissions in the report and this seemed to be in conflict with the above answer given by the Trust. Members also asked what the reasons for delay in discharges were if the reasons were not social care reasons. *Members were advised that the detail was not available to answer the questions immediately but it could be provided after the meeting. It was noted that the Cambridge Scrutiny Panel had asked for a report about delayed discharges and that this report could be given to this Commission. It was further noted that the hospital had recently been removed from their 'red status' with regards to delayed discharges due to health reasons.*
- Members asked what information was given to patients prior to discharge. *Members were advised that patients who were going home on medication were spoken to by their nurse or if the medication was more complex a pharmacist would speak to them. This would take place after the Doctor had spoken to the patient about their discharge plan. All medication had written information provided but this tended to be in small print and incomprehensible. The hospital was working to create easier to read and understand information sheets for the more common drugs that were used. Patients who used medication for long-term conditions were spoken to by specialist nurses who worked intensively with the patients to ensure the patients understood their medication.*
- Members highlighted concern that one of the 'Patient Safety' targets or priorities was not eating and drinking for elderly patients in the hospital. *Members were informed that this priority was part of the first item in the 'Effectiveness' targets. This involved making sure patient's needs were clearly documented in a timely way and that the care given was evaluated carefully. Part of this involved performing a very detailed assessment of the patient's nutritional status and then an action plan would be compiled. It was confirmed that the patients were reassessed regularly and that there was a rule in place that if a ward hostess found more than 50% of a patient's food left uneaten they were to inform the nurses so that they could address this with the patient. It was confirmed that there were fluid balance charts and nutrition assessments recorded and a food chart if that was deemed necessary for the patient. It was recognised by the hospital that these were not consistently completed but due to this they were now audited on a regular basis.*
- Members referred to the A&E targets and the hospital's underperformance regarding this and asked what the figures were for this at the end of Qtr1 of 2013 and what were the predicted figures for end of Qtr2. *Members were informed that for May the performance*

was 94.6%. January to March was a very challenging quarter and noted this picture was reflected across the country around pressures in the emergency departments. The picture was now looking much better and the current week's performance had been 96%.

- Members asked what the annual cost of the maintenance of the Peterborough District Hospital site was and what were the Trust's plans for this estate. *Members were advised that the hospital was due to be sold and the Trust hoped to complete the sale by July or August. The current running cost of the site was about £240K and this would be an expected saving from July/August when that property was no longer the Trust's responsibility.*
- Members referred to the last paragraph on page 15 of the report which stated:

  "Improvements that are being made with our local partners are subject to a system-wide plan, co-ordinated through our health commissioners, which is to be submitted to NHS England by 30 June 2013"

  and asked if the Trust was on target with regards to submitting plans to the NHS by 30 June. *Members were advised that the Trust was on target and a report had been submitted at the last Board Meeting which was now being refined in readiness for submission to the NHS.*

The Chair thanked the officers of the Trust for attending and for the presentation from the Contingency Planning Team.

ACTIONS AGREED

The Commission noted the report and requested that:

1. The Director of Care Quality and Chief Nurse provide the Commission with a copy of the report that was submitted to the Cambridge Scrutiny Panel detailing the reasons for readmissions and delayed discharges.
2. The Trust provides a report to the Commission regarding their response to the Francis Report.
3. The CPT presents their final report to the Commission when completed.

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

The Assistant Director Quality Information and Performance introduced the report which provided the Commission with an update on the delivery of Adult Social Care services in Peterborough against the key priorities identified in the department's business plan, linked against the four outcome domains contained within the national Adult Social Care outcomes framework. The report covered the fourth quarter of 2012-13 (January to March 2013).

It was acknowledged that the Commission was not content with the current format of the report and that a working group was being established in order to refine and improve the report. The major issues for Adult Social Care Services were highlighted including Safeguarding where a lot of focus was being placed in order to drive forward improvements in that area.

It was noted that information around home transfers had been provided as requested as well as a copy of the first Quality report which had been submitted to the Quality Board.

Observations and questions were raised and discussed including:

- Members wanted to know what the key issues were regarding Safeguarding and when an action plan would be in place or full analysis completed. *Members were advised that there were two key issues. One was around the process in terms of reporting which was the ability to evidence the speed and workflow for investigations. This was mostly due to*

the technical nature of recording and the fact that it was a new system being used and that some of the forms were cumbersome but were being reviewed. The second set of issues was around consistency and quality of practice. There was a substantial improvement plan being developed. Members were further advised that given the scale of transformation taking place within the department in order to ensure business as usual was adhered to a set of meetings had been put in place. The first scoping meeting had already been held and this would be followed by monthly meetings working on an action plan. The action plan would be worked on and ready to present every month until the beginning of next year at which point an external organisation would be brought in to conduct a Peer review of the practice.

- Members referred to paragraph 5.2.1 of the report on page 21 which referred to the resettlement of permanent residents from Greenwood House and Welland House. The report had stated that all residents had initial reviews carried out and that there would be a further review after six months. The Commission had requested that quarterly reviews be carried out in the first year of resettlement and wanted to know why it had been changed to six monthly. *Members were advised that the reviews that had taken place had indicated that it was safe to leave the reviews for six months. Members were further advised that the report did show that when the residents were being settled in it was felt that some of them would benefit from receiving weekly support. If the view was that the visits should take place more frequently then this could be arranged.*
- Members noted that the initial agreement of quarterly reviews was based on an informative study in terms of death rates after removal to alternative locations and one of the ways of mitigating this was to have frequent follow up visits and monitoring which was why quarterly reviews were agreed to. *The Officer responded that quarterly reviews could be reinstated and advised Members that it had been found that the care that was being provided in the new homes was over and above the residential category that they should have been. This was why some moved to nursing care and others to residential care or specialist care. Members were informed that the average length of stay of elderly people in residential care was around three years nationally. Some of the residents in Peterborough had been in residential care for much longer and that given the conditions of these people one might naturally expect death to take place within a short period of time after being moved.*
- Members commented that the Commission had also requested an audit of the new accommodation for the residents on a quarterly basis and wanted to know why these were not included in the reports. *Members were advised that when workers went in to visit the residents they would include a review of whether the residents were happy with the accommodation and the social interaction opportunities etc. ASC also conducted contract monitoring reviews of homes on a regular basis or where they had concerns. Any concerns were shared with the Care Quality Commission. Members were further advised that the accommodation the residents were getting after being moved was of a higher standard than what they had before. Members were advised that those residents who had chosen to go to homes outside of Peterborough were able to be visited and personal reviews would be undertaken but ASC were unable to conduct contract reviews with those homes as they did not have contracts with them.*
- Members referred to page 21 section 5.2.1, the last paragraph and asked about what would have been the cause of the death of the five residents who had passed away after the move. *Members were advised that the pre-existing conditions of these people were that they were very elderly and had dementia. It was confirmed that ASC did look into this and none of the deaths were felt to have been linked to the move.*
- Members referred to page 24 of the report and asked if the reporting of delayed transfer of care from hospitals per 100K population could be split into two measures: social care reasons or other reasons.
- Members referred to page 25, Intensive Community Support. The report stated that 72 adults with learning disabilities were living outside of the Peterborough area and that work was continuing to bring people back to Peterborough. The report indicated that 15 of these have returned, 40 wanted to stay where they were and there were 17 left to resolve. Members asked when the remaining 17 would be resolved and would there be

any growth again of adults being placed outside of the area? *Members were advised that the remaining 17 were expected to return to Peterborough within the current financial year and this was being monitored. Members were advised that in terms of adults the numbers of admissions into residential care was under control. ASC were working on transition planning in order to try and stop young people being placed outside the Peterborough area and then not wanting to return when they reached adult age. Members were informed that residents who were in medium secure accommodation had been reviewed as a result of the Winterbourne view. Of those residents, the expectation was that ASC would be able to offer them placements from early in the next financial year. There was a significant cost pressure relating to these service users as a lot of them would require two to one support. The anticipation of costs for these service users was £135K per annum which was a significant financial pressure on the council's budget going forward.*

- Members referred to page 29 of the report and asked about adults and older people receiving self-directed support and the ambitious new national target of 70% by 2015. How was this going to be achieved? *Members were informed that this was an ambitious target and a significant jump from the 43% who were currently receiving self directed support. There were two areas where personalised budgets were not being offered and they were equipment (there is still a block contract with the NRS) and residential and nursing care. Part of the transformation programme was to look at how they ensure people who required these items of care were able to do that via personalised budget as well.*
- Members asked what was being done to recover from the 'red status' of the Safeguarding SLA performance indicators. *Members were informed that this was being worked on at the monthly 'raising the bar' meetings referred to earlier. The delay was due to process and systems not due to insufficient amount of staff.*

ACTIONS AGREED

1. The Commission requested that the Assistant Director, Quality Information and Performance work with Members of the Commission to agree a format for future presentations of the Adult Social Care Performance report to the Commission. The Senior Governance Officer to obtain nominations from the Commission members to undertake this work.

2. The Commission also requested that:

    (i) Regional benchmarking figures are provided within the Quarterly report.

    (ii) Quarterly reviews of residents in their new locations to take place and to be included in future reports.

    (iii) Quarterly accommodation reviews for residents in new locations to be carried out within the Peterborough catchment area.

    (iv) When reporting on delayed discharges from hospitals split the data to show if they are due to social care reasons or other reasons.

7. Introduction to Public Health

The report provided the Commission with an overview of Public Health responsibilities that had been transferred to the Local Authority and details of how those responsibilities would be delivered during 2013/14. It was noted that the key role of the interim Director of Public Health during the first six months was to ensure safe transfer of public health from the Primary Care Trust to PCC. Part of this work had been to produce a business plan that clearly outlined what Public Health was doing as well as a way of monitoring the facets of work being transferred.

It was noted that the business plan had unfortunately not been issued with the agenda and therefore any comments or questions should be forwarded to the Senior Governance Officer who would forward them to the Interim Director of Public Health.

A brief presentation of the business plan was given which included the following highlights:

- Public Health England Priorities
- Transformational change to improve health outcomes
- Role and Functions of Public Health
- Finance and resources
- Vision and Objectives for 2013/14

Members were informed how the Public Health staff and resources had been integrated into the Local Authority. The Public Health delivery team had been integrated within the Neighbourhoods team and other areas including Children's Services. The Public Health directorate also shared a Health Care Specialist Advice service with Cambridgeshire County Council. The funds available to the Local Authority for the transfer of responsibilities was £8.446 million and Public Health reported quarterly on financial spend against these areas.

Observations and questions were raised and discussed including:

- Members referred to page 5 of the business plan and asked about the phrase 'good mental health' and whether this should be 'good mental health services' instead. *Members were informed that this was one of the priority areas within the Health and Wellbeing strategy and that was the heading. Under the heading there was a list of five objectives covering elements of service delivery. The word 'services' was not used because they were not only talking about improving services they were also talking about improving an individual's mental health and well being.*
- Members referred to the Public Health outcomes and asked if there was a time frame for achieving these targets. *Members were advised that the Public Health outcomes were targets for the current year.*
- Members asked for a report which would break down the targets and show deadlines throughout the year by quarter.
- Members were concerned with the recent Public Health England statistics recently published showing Peterborough as 87th on the list of Local Authorities. Peterborough was also 14th out of 15 on two of the measures. Members asked if these areas were being addressed. *Members were advised that there was a close correlation between education achievement and these items and therefore this was probably not exclusively a Public Health matter. Members were further advised that the report showed nothing new and that the Public Health team was already aware of the statistics. Peterborough was doing very well with cancers, for example, but that there were specific cancers where they were not and those were the priorities. More of the financial allocation had been invested into the NHS health checks programme which provided checks for people between the ages of 40 and 74. This was in order to do more to identify undiagnosed people and try to reduce these statistics.*
- Members asked if the Public Health team have enough resources. *Members were advised that they did not have enough resources. While they had a reasonable financial allocation there was a shortage of specialist staff. There had been a delay in getting more resources due to the integration within the Local Authority and once this had been completed they would be able to see what skills and capacity there was within the team. It would not be useful to recruit more resources before this has been identified. One of the reasons it was decided to bring Public Health into the Local Authority was the concept of integration so that health concerns could influence the entire range of activities that Local Authorities were concerned with.*

- Members referred to the action plan on page 13 where it talked about tackling obesity and utilisation of green space. It was noted that Peterborough was undergoing a lot of growth and new housing developments were taking place. Did the Public Health team get involved in liaising with the planners to ensure that when the developments were built people were provided with green space? *Members were advised that they would like to have a consultant who was an expert in planning and sustainability that was able to work closely with planners in terms of health assessments. Some years ago a lot of work was done with planners to look at how Public Health could integrate public health issues into new developments. The Public Health team did consult with the Operations Management Team on a regular basis and also worked closely with the Head of Planning.*
- Members commented that the local transport fund budget had been cut and wanted to know if public health were able to make representation to the people involved in these decisions. *Members were advised that the Public Health team was aware of the work involving the cuts in transport and they had had discussions around the impact on health.*
- Members referred to page 9 of the business plan: Vision and Objectives. It stated '*delivery through the neighbourhood functions'* and asked if this meant the Neighbourhoods Team and if so, how would the Public Health team work with them while they were already under immense pressure. *Members were advised that this referred to embedding the Public Health team within Neighbourhoods and thereby enabling cross-working.*
- Members noted all the objectives in the business plan but suggested that it should specifically mention stopping excessive alcohol consumption. *Members were advised that alcohol and drugs came under the remit of the 'Safer Peterborough Partnership' and the Public Health team worked closely with colleagues across the police, probation and others. Decisions around this were taken at the Joint Alcohol Commissioning Group, which reported into the SPP Board. The Local Authority now had the responsibility for commissioning alcohol treatment services; however the Public Health team had secured £105K over two years from the Clinical Commission Group for a piece of work to deliver in-reach services into the hospital. There was a team of 'Drink-sense' workers who went into the hospital daily to identify admissions that could be due to alcohol consumption. They then find those people and start to get direct referrals into treatment services if that was appropriate.*
- Members felt that health checks should take place earlier than the age of 40 and suggested the ages of 20 to 21. *Members were informed that the health checks were funded by the Public Health team. There was £150K going into this at the moment and it was a mandated service. If more health checks were to be provided it would cost the Local Authority. It would first need to be established whether 21 year olds were the most 'at risk' group. Members were advised that free health-checks were already being offered to smaller/ medium sized employers as well as additional support, advice and training.*
- Members were concerned about mental health in Peterborough. It was noted that people who are off sick with stress could then turn to alcohol, drugs, etc. Members felt this particular group should have more information on mental health. *Members were advised that more information on mental health in Peterborough could be brought to the Commission.*

ACTIONS AGREED

The Commission requested that the Director of Public Health provide reports on the following:

(i) Quarterly report on the Public Health Outcomes Framework.
(ii) A report which addressed the Francis Report from the Local Authority's point of view.
(iii) A report on mental health in Peterborough.

8. Review of 2012/2013 and Work Programme for 2013/2014

The Senior Governance Officer introduced the report which provided the Commission with:

- a review of work undertaken during 2012/13 and recommendations made
- the terms of reference for the Commission and
- a draft work programme for 2013/2014 for consideration

The Commission considered the report and decided that there were no recommendations from last year that required further monitoring.

- Members requested that the 'Carer's Strategy' to be added to the work programme. *Members were advised that the 'Carer's Strategy' was almost finished and was just having final touches added to the action plan.*
- Members asked about the follow-up presentation from the Ambulance Service regarding Ambulance support in taking patients home from the hospital. *It was confirmed that the report was due to be submitted in January.*

ACTION AGREED

The Commission requested that Carer's Strategy be bought to the Commission as soon as it was ready.

9. Notice of Intention to Take Key Decisions

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

ACTION AGREED

The Commission noted the Notice of Intention to Take Key Decisions.

10. Date of Next Meeting

Tuesday 16 July 2013

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