PETERBOROUGH CITY COUNCIL

SCRUTINY COMMISSION FOR RURAL COMMUNITIES

MONDAY 15 JULY 2013
7.00 PM

Bourges/Viersen Room - Town Hall

AGENDA

Page No

1. Apologies for Absence

2. Declaration 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.

9. Date of the next Meeting

16 September 2013

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

Emergency Evacuation Procedure – Outside Normal Office Hours

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

Committee Members:

Councillors: D Over (Chairman), D Lamb (Vice Chairman), D Sanders, McKean, E Murphy, D Harrington and N Sandford

Substitutes: Councillors: S Allen, J R Fox and Sylvester

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

SCRUTINY COMMISSION FOR RURAL COMMUNITIES	Agenda Item No. 3
15 JULY 2013	Public Report

Report of the East of England Ambulance Service

Contact Officer(s) – East of England Ambulance Service
Contact Details – Sheila Shaw 01954 712424 Stakeholder Officer

COMMUNITY FIRST REPSONDERS IN RURAL AREAS

1. PURPOSE

1.1 To provide information on the Community First Responder Scheme.

2. RECOMMENDATIONS

2.1 Support the on-going development of Community First Responders within rural communities, look at the possibility of Automatic External Defibrillators (AED) within rural communities for public use.

3. LINKS TO THE SUSTAINABLE COMMUNITY STRATEGY

3.1 N/A

4. BACKGROUND

4.1 Community First Responders are volunteers trained and equipped to provide lifesaving treatment to patients while the ambulance response is on its way. Community First Responders attend calls of a medical nature, and attend patients over the age of eight years of age. The type of calls attended by Community First Responders are chest pains, breathing problems, cardiac arrests, stroke patients, unconscious patients and patients found fitting.

Community First Responders are equipped with an AED, airway management equipment, oxygen, first aid equipment, glucogel. They are contacted by ambulance control (HEOC) through a mobile phone text message and/or phone call identifying the location and type of incident. Community First Responders drive under normal road conditions without lights or sirens and obey the highway code.

5. KEY ISSUES

5.1 Within Rural Peterborough we have community first responder groups based at Yaxley (2 volunteers), Wittering (6 volunteers) and Whittlesey (11 volunteers). Within these groups we have attended over 260 calls during the year 2012/13. We are looking at setting up a Community First Responder group in Eye and are actively recruiting volunteers for this group.

Community First Responder groups volunteer hours when they are within the community, they do not provide 24/7 cover but as much as possible within their work/life balance. The initial community First Responder equipment is purchased through charitable donation and the ambulance service provides replacement of consumable equipment used on patients.

6. IMPLICATIONS

6.1 Community First Responders provide lifesaving treatment and support to the local community at their time of need. They enhance the care that the patient receives prior to the arrival of the

ambulance resources.

7. CONSULTATION

7.1 N/A

8. NEXT STEPS

8.1 N/A

9. BACKGROUND DOCUMENTS

See Appendices

9.1 N/A

10. APPENDICES

10.1 Appendix 1 - Defibrillator – East of England Ambulance Service
Appendix 2 - Policy Statement Defibrillators in public areas produced by British Heart Foundation

East of England Ambulance Service NHS
NHS Trust

Please find below information that will assist you in setting up a Community Public Access Defibrillator site (CPAD site).

Q: What is a CPAD Site?

A: A CPAD site is a **C**ommunity **P**ublic **A**ccessible **D**efibrillator that can be sited anywhere within any location that is easily accessible 24 hours a day. We recommend that the cabinet that houses the defibrillator is fitted with a key coded door that ensures the defibrillator is safe from theft and vandalism. The cabinet will require a mains power supply for the heater that helps to protect the defibrillator from the frost and cold as well as the supply of a light.

Q: Do we need a CPAD site in our village?

A: Sudden cardiac arrest claims around 150,000- 200,000 lives each year in the United Kingdom, with survival rates being around 5% - 10% outside of a hospital setting.
If a person's heart has stopped due to an accident or heart attack and is in a rhythm called ventricular fibrillation, the only way to get the heart into a more regular sustaining beat is to pass an electrical charge through the heart muscle. The first three to four minutes are the most vital for the collapsed person and, if FIRST AID and a DEFIBRILLATOR are on hand, then the chance of survival will increase considerably.

Q: Where can a CPAD site be fitted?

A: The cabinet can be fitted to the external wall of any building such as a Public House, shop, village hall, community centre etc.
The only point that needs to be considered is that it is easily accessible, well illuminated and that there is room to park safely in the event that a person has to drive to collect the defibrillator.

Q: How does a CPAD site work?

A: In the event of a person collapsing you will still need to dial 999 to call for the ambulance. The ambulance service will direct the caller to where the CPAD site is and will give the caller the key code for the cabinet.
The ambulance service will have all addresses logged within the town/village location so will be able to direct the caller to the exact location of where the CPAD site is.

Q: Do I need training in how to use a defibrillator?

A: The UK resuscitation council guidelines state that there is no requirement to be trained in the use of an Automated External Defibrillator (AED) and that in the event of a person collapsing the non-trained person should still use the AED as the step by step voice prompts that are part of the AED talks the user through the process of what to do.
However, training should be encouraged for those who would be interested in learning how to do Cardiopulmonary Resuscitation (CPR) and the use of an AED. Training courses are readily available from a number of different training companies. You can access training through the ambulance service commercial training department.

Q: Is there any risk in the use of an AED?

A: If someone is having a cardiac arrest, using an AED and undertaking CPR (Cardiopulmonary Resuscitation) will improve the chances of survival.
Automated External Defibrillator's (AED's) are really safe to use. There have never been any reports of an AED harming the patient, user or bystander. In addition there have been no reports of an AED delivering any inappropriate shocks.

Q: If I set up a CPAD Site what equipment will I get?

A: Depending upon supplier, we recommend you purchase (dependent upon location) a heated mild steel or stainless steel cabinet that should be vandal resistant and IP65 rated.
It should have a thermostatically controlled heater as well as lighting and indicator lamp.
The purpose of having a heated cabinet is to ensure the AED pads do not become frozen when the temperature drops below freezing.
The cabinet will need to be fitted and installed by a suitably qualified electrician.
Please note the defibrillator does not require a power supply as they are normally supplied with a lithium battery that does not require charging.
Dependent on your choice of AED, your supplier will give you product information regarding frequency of battery and AED pad replacement.
We recommend that the defibrillator is supplied with a spare set of AED pads, as well as a towel, razor, pocket mask, scissors and a pair of disposable gloves.

Q: Where can I get a CPAD site from and how much do they cost?

A: There are a number of companies that will supply you with a cabinet and AED.

We strongly recommend that you research this area before you make your final decision.

Below a few suppliers of cabinets and defibrillators

www.communityheartbeat.org.uk

www.aedcabinets.co.uk

www.aedlocator.org

www.spservices.co.uk/

We would estimate that your community would need to budget around £2,000 to set up a CPAD site. Fundraising ideas can be found at:

http://www.heartrhythmcharity.org.uk/www/media/files/Community_AED_Placement_Toolkit.pdf

Q: Are there any on-going costs?

A: On-going running costs will depend on who you chose to get your cabinet and AED from. Most AED pads have an expiry date of 18 months, and most AEDs require battery replacement within 4 years of purchase. Ask your supplier for the information on maintaining your specific AED model.

Q: Who looks after the CPAD site?

A: We would recommend that you appoint a 'custodian' for the CPAD site. The role of this person will be to ensure the weekly/monthly/yearly checks are undertaken on the AED in line with the manufacturers guidance and in the event of the AED being deployed this person will then be responsible for ensuring that the AED is returned to operational status as soon as possible and re-stocking any used equipment.

Case Studies:

If you view the websites below you can look at a number of different case studies that have inspired communities to establish their own CPAD sites.

http://www.communityheartbeat.org.uk/casestudies.php

http://www.aedlocator.org/testimonials.php

Q: What do I need to do now - and do I need to contact the Ambulance Service?

A: We would advise you to contact the East of England Ambulance Service if you decide you would like to have a CPAD site in your area as we can offer advice as to whether you need a CPAD site, where the best possible location would be and also if there is a Community Responder Scheme in your area that you could link your CPAD site to.

Once your CPAD site is installed we will need to be informed so that we can add the information to our CAD system in ambulance control enabling 999 callers to be made aware of the location of the AED. We would also like to work with your local 'custodian' in the event of the AED being deployed which will assist you in returning the AED.

Please contact our Community Partnership administration department on:

Tel: 01954 712400 **or email:** responderadmin@eastamb.nhs.uk

You will be put in contact with your local Community Partnership Manager who will be happy to answer any questions you may have.

Community Partnership Team November 2012

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Policy statement

Defibrillators in public places

Introduction

Cardiac arrest is a medical emergency, occurring when someone's heart stops pumping blood around the body and they stop breathing normally. Around 60,000 out-of-hospital cardiac arrests occur in the UK each year.[1,2] Of these, around 30,000 are treated by emergency medical services.[3]

Bystander action in these cases can be the difference between life and death. The British Heart Foundation (BHF) is fighting for every heartbeat, determined to ensure that every person suffering a cardiac arrest has the best chances of survival.

Policy statement

In instances of an out-of-hospital cardiac arrest, immediate cardiopulmonary resuscitation (CPR) and access to an Automated External Defibrillator (AED) are all essential to maximise the chances of survival. Community First Responders also play an important role in helping to supplement ambulance services' response.

Governments and administrations in the UK should work in partnership with charitable organisations, the Resuscitation Council UK, Ambulance Trusts and Ambulance Services to map the location of existing AEDs placed within local communities across the UK. Governments and administrations in the UK should also increase the availability of public access Automated External Defibrillators (AEDs) within communities and encourage greater public confidence in their use. Within England, the Westminster Government should:

- introduce legislation requiring the installation of AEDs in high footfall areas and other places where there is an appreciable risk of cardiac arrest occurring. As part of this, an expert advisory group should be formed to determine requirements regarding the placement of AEDs in public places and develop a national strategy which would require public bodies and individual businesses to assume responsibility for the installation, training, and maintenance of AEDs.
- fund a national campaign to raise public awareness regarding CPR and AEDs and encourage members of the public to carry out CPR and use an AED if required in an emergency.
- consider the introduction of a Good Samaritan law, subsequent to a national campaign, to provide reassurance to the public in helping someone requiring CPR or use of an AED.

Within the devolved nations, each administration should explore the merits of introducing similar legislation requiring the placement of public access AEDs and additional measures aimed at improving awareness of and confidence in using AEDs in an emergency, within the context of a wider Community Resuscitation Strategy.

[1] Ambulance Service Association, 2006. *National Cardiac Arrest Audit Report*.
[2] Berdowski J, Berg RA, Tijssen JG, Koster RW. 2010. Global incidences of out-of-hospital cardiac arrest and survival rates: systematic review of 67 prospective studies. Resuscitation 2010 Nov;81(11):1479-87. Epub 2010 Sep 9.
[3] Pell JP, Sirel JM, Marsden AK, Ford I, Walker NL, Cobbe SM. Presentation, management, and outcome of out-of-hospital cardiopulmonary arrest: comparison by underlying aetiology. Heart 2003;89:839-42.

Policy statement (continued)

Finally, we are calling on all Governments and administrations in the UK to develop a strategy to improve response times to all out-of-hospital cardiac arrests (OHCA), not just those that occur in public, which would help to save the lives of the large percentage of people experiencing OHCA in the home. As part of this, we urge Governments and administrations in the UK to maintain Community First Responder groups managed by Ambulance Trusts and Ambulance Services and increase the number of Community First Responders.

Background

Around 60,000 out-of-hospital cardiac arrests happen in the UK each year.[4,5] Of these, around 30,000 are treated by emergency medical services.[6] AEDs are life-saving items of equipment which, when used with CPR, can support survival from sudden cardiac arrest. They are electrical devices that analyse the heart rhythm and administer an electric shock if necessary to try and restore a normal heart rhythm.

AEDs are specifically designed to be used by members of the public as well as first responders in the event of a cardiac arrest. Early CPR and defibrillation is essential for survival. Increasing awareness of the need for CPR and the placement of AEDs in public places helps reduce the time delay between cardiac arrest and shock, and increases the number of people able to respond to out-of-hospital cardiac arrest. It increases the chances of survival, by providing CPR and defibrillation before emergency services arrive on the scene.[7]

There are two ways of making an AED available to out-of-hospital cardiac arrest victims:

- placing them at a specific location where people gather, e.g. gyms and public buildings (also called public access defibrillators/referred to as PAD sites), and
- Emergency medical services may dispatch Community First Responders with an AED to the scene of the cardiac arrest (Community First Responder programs).[8]

For the purposes of this statement we will explore the issue of onsite AEDs.

Outcomes of the use of AEDs

The use of an AED is an essential part of the chain of survival- interventions that contribute to a successful outcome following a cardiac arrest. There is clear evidence that bystander responses can have a huge impact as part of the chain of survival (below).[9] People who are

[4] Ambulance Service Association. National Cardiac Arrest Audit Report; 2006.
[5] Berdowski J, Berg RA, Tijssen JG, Koster RW. Global incidences of out-of-hospital cardiac arrest and survival rates: systematic review of 67 prospective studies. Resuscitation 2010 Nov;81(11):1479-87. Epub 2010 Sep 9.
[6] Pell JP, Sirel JM, Marsden AK, Ford I, Walker NL, Cobbe SM. Presentation, management, and outcome of out-of-hospital cardiopulmonary arrest: comparison by underlying aetiology. Heart 2003;89:839-42.
[7] Berdowski J. et al, Impact of Onsite or Dispatched Automated External Defibrillator Use on Survival After Out-of-Hospital Cardiac Arrest *Circulation.* 2011;124:2225-2232; originally published online October 17, 2011;
[8] Ibid.
[9] Cave DM, Aufderheide TP, Beeson J, Ellison A, Gregory A, Hazinski MF, Hiratzka LF, Lurie KG, Morrison LJ, Mosesso VN Jr, Nadkarni V, Potts J, Samson RA, Sayre MR, Schexnayder SM. Importance and implementation of training in cardiopulmonary resuscitation and automated external defibrillation in schools: A science advisory from the American Heart Association. *Circulation* 2011 Feb 15;123(6):691-706. Epub 2011 Jan 10. Available at:

trained to recognise that something is wrong and provide life-saving skills will buy time for the casualty, until professional help arrives, which could improve the chance of a successful outcome.[10]

Research shows that applying a controlled shock within three to five minutes of collapse, following CPR, provides the best possible chance of survival.[11] Where an AED is used as part of the chain of survival (cardiac arrest is recognised and 999 is called quickly, bystander CPR is started early and effective post-resuscitation care is given following defibrillation) survival rates following cardiac arrest can exceed 50 per cent.[12] A lack of blood circulation for a few minutes will lead to irreversible organ damage- including brain damage, therefore bystander intervention and early defibrillation is crucial in these circumstances.

Prevalence and location of sudden cardiac arrest

The majority of cases of out-of-hospital cardiac arrests occur within the home, however, a significant proportion also occur in public places.[13,14]

Due to the devolved structure of Ambulance Trusts in the UK, statistics on the location of out-of-hospital cardiac arrests are not collated on a national basis. However, recent statistics from the London Ambulance Service indicate that in 2011/12, 67 per cent of cardiac arrests in London occurred within the home, 11 per cent occurred in care homes and 22 per cent of cardiac arrests occurred in public places. Of those that occurred in public places, 10 per cent occurred on the street and the remaining proportion occurred in other public places such as at work, a GP surgery, on public transport, or in a sports facility.[15]

Data collected by the North East Cardiac Arrest Network regarding OHCA in the North East of England in 2011, found that 81 per cent of cardiac arrests occurred within the home (including care homes) and 19 per cent of cases occurred in public places.[16]

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http://www.ncbi.nlm.nih.gov/pubmed/21220728

[10] London Assembly Health and Public Services Committee (2007): A heartbeat away – Emergency life support training in London

[11] European Resuscitation Council, 2010, European Resuscitation Council Guidelines for Resuscitation 2010 Section 2. Adult basic life support and use of automated external defibrillators, Resuscitation 81 (2010) 1277–1292

[12] Cave DM, Aufderheide TP, Beeson J, Ellison A, Gregory A, Hazinski MF, Hiratzka LF, Lurie KG, Morrison LJ, Mosesso VN Jr, Nadkarni V, Potts J, Samson RA, Sayre MR, Schexnayder SM. Importance and implementation of training in cardiopulmonary resuscitation and automated external defibrillation in schools: A science advisory from the American Heart Association. *Circulation* 2011 Feb 15;123(6):691-706. Epub 2011 Jan 10. Available at: http://www.ncbi.nlm.nih.gov/pubmed/21220728

[13] Priori, S., Bossaert, L., Chamberlain, D, Napolitano, C., Arntz, H., Koster, R., Monsieurs, K., et al, 2004. ESC-ERC recommendations for the use of AEDs in Europe. European Heart Journal. 23: 437-445

[14] Berdowski J. et al, Impact of Onsite or Dispatched Automated External Defibrillator Use on Survival After Out-of-Hospital Cardiac Arrest *Circulation.* 2011;124:2225-2232; originally published online October 17, 2011;http://circ.ahajournals.org/content/124/20/2225.full

[15] London Ambulance Service NHS Trust (2012) Cardiac Arrest Annual Report: 2011/12, Available at: http://www.londonambulance.nhs.uk/news/news_releases_and_statements/londons_cardiac_arrest_suriva.aspx

[16] North East Cardiac Arrest Network and British Heart Foundation, 2011, Out-of-hospital Cardiac Arrest Registry: First Year of Data Report, available at: http://www.networks.nhs.uk/nhs-networks/north-east-england-cardiac-arrest-network/documents/Out%20of%20Hospital%20Cardiac%20arrest%20registry.pdf

International studies have identified specific public locations at greatest risk for cardiac arrest in local communities and have recommended placement of AEDs at these locations to maximize cost-effectiveness and survival. Public locations where there is a higher incidence of cardiac arrests identified include transport terminals (airports, ferries and train terminals) large public venues (shopping centres and sports venues), sports facilities (such as gyms and golf clubs) and industrial sites.[17,18,19] A study of cardiac arrest rates in the Seattle area concluded that AED placement can be guided by site-specific incidence of cardiac arrest.[20]

Provision of AEDs

BHF has a long history of placing defibrillators within communities and began its work in this area by placing defibrillators on ambulances in the 1970s. In 2004, the BHF and the Department of Health launched the National Defibrillator Programme (NDP) in England. The NDP was a public access defibrillator programme which provided AEDs in busy public places, such as airports, railway and underground stations. The overall aim of the programme was to increase the proportion of people who survive an out-of-hospital cardiac arrest by providing training and placing AEDs in communities. 'As of February 2007, 110 live sites had received 681 automated external defibrillators (AEDs) and more than 6,000 people have received defibrillation training.' [21] Since 2007 the programme has been the responsibility of Ambulance Trusts.[22]

There is no statutory requirement regarding the placement of AEDs in public places and at present the majority of AEDs placed within communities are funded and awarded by a patchwork of charitable organisations, and Ambulance Trusts, often as part of broader community resuscitation strategies.

Due to the absence of a national register, the location and precise numbers of AEDs within communities is unknown. However, a small number of organisations have set up online national registries in an attempt to map the location of AEDs, for example, AEDLocator.co.uk and defibfinder.co.uk. However, these websites have had limited success to date.

Alongside the BHF, leading funders of AEDs within local communities include:

- Sudden Arrhythmic Death Syndrome (SADS) UK and Hand on Heart, two specialist charities who both have defibrillator initiatives in schools
- Arrhythmia Alliance, which runs a football club project and the Restart the Heart project which has placed over 100 AEDs in communities in the UK, and
- St John Ambulance and the British Red Cross – the main training providers for first aid courses & AEDs.

An example of a recent community public access defibrillator initiative is the Scottish Ambulance Service's partnership with Scotmid, a retail company, which was launched in

[17] Brooks. S et al, Determining Risk for Out-of-Hospital Cardiac Arrest by Location Type in a Canadian Urban Setting to Guide Future Public Access Defibrillator Placement, American College of Emergency Physicians, http://dx.doi.org/10.1016/j.annemergmed.2012.10.037
[18] Location of Cardiac Arrest in a City Center Strategic Placement of Automated External AEDs in Public Locations, Circulation. 2009; 120: 510-517 http://circ.ahajournals.org/content/120/6/510.full
[19] *Becker L, Eisenberg M, Fahrenbruch C, et al.* Public locations of cardiac arrest: implications for public access defibrillation. Circulation. 1998;97: 2106–2109. http://circ.ahajournals.org/content/97/21/2106.full
[20] Becker, L. *et al* (1998) Public Locations of Cardiac Arrest: implications for public access defibrillation *America Heart Association*
[21] Department of Health, 2010, National Defibrillator Programme, available at : http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/Healthcare/Longtermconditions/Vascular/Coronaryheartdisease/Coronarypromotionproject/index.htm
[22] Ibid.

2011 to support the business to purchase and install AEDs in their stores and train their staff to use them.[23]

Public awareness of AEDs

AEDs are specifically designed to be used by members of the public as well as first responders in the event of a cardiac arrest. However, research shows a lack of public awareness and willingness to use them.[24] A research study in 2011, which surveyed 1,081 people in 38 nations, found that 53 per cent of all respondents were unable to identify an AED and 47 per cent of all respondents said they would be willing to use an AED. [25]

The Netherlands Heart Foundation launched a "6 Minutes" campaign in response to a lack of public awareness of what to do in the event of an out-of-hospital cardiac arrest the campaign aimed to:

- educate the Dutch public of the importance and use of AEDs,
- encourage and help the public along with local and national governments to establish 6 minute zones, to increase the availability of AEDs and response times in cases of sudden cardiac arrest.

This would then increase the availability of AEDs.[26]

Legal liability on resuscitation

Concerns of legal liability and the unintentional injury of a cardiac arrest victim are believed to also act as a deterrent to bystander intervention and the use of AEDs.[27] As such, several areas in the US and Canada have introduced Good Samaritan laws – legislation designed to protect those who choose to tend to others who are injured or ill.[28,29,30,31] They are intended to reduce bystanders' hesitation to assist, for fear of being sued or prosecuted for unintentional injury or wrongful death.[32] In the case of some European countries this is framed in the context of a 'Duty to Rescue' law, legislation which penalises bystanders who fail to act in an emergency.[33] For the purposes of this statement we will focus on Good Samaritan laws.

A survey commissioned by the BHF in 2011 suggested that a fear of legal action may present a barrier to coming to the aid of someone who has suffered a cardiac arrest. The

[23] The Scottish Government, 2011, Defibrillator partnership, 10/10/2011, last visited: 24/3/13 http://www.scotland.gov.uk/News/Releases/2011/10/10141042
[24] Schober, P. *et al* (2011) 'Public access defibrillation: time to access the public." Ann Emerg Med. 58(3):240-7 http://www.annemergmed.com/article/S0196-0644(10)01868-8/fulltext
[25] Ibid.
[26] Netherlands Heart Foundation, Netherlands, 2013, 6-Minute Zones, http://www.6minutenzone.nl/Home/Default.aspx
[27] Jeffrey Lubin et al, 2004, An assessment of public attitudes toward automated external defibrillators, Resuscitation, Volume 62, Issue 1, July 2004, Pages 43–47 http://www.sciencedirect.com/science/article/pii/S030095720400084X
[28] Hannah England, BA; Paul S. Weinberg, JD; N. A. Mark Estes, MD, The Automated External DefibrillatorClinical Benefits and Legal Liability, The *Journal of the American Medical Association.* 2006;295(6):687-690. http://jama.jamanetwork.com/article.aspx?articleid=202311
[29] Reiner, J.S et al, Shock and Law, Circulation. 2011; 124: 1391-1394 http://circ.ahajournals.org/content/124/12/1391.full
[30] British Columbia Laws, Good Samaritan Act [RSBC 1996] CHAPTER 17, Available at: http://www.bclaws.ca/EPLibraries/bclaws_new/document/ID/freeside/00_96172_01
[31] Service Ontario e-laws , Good Samaritan Act, 2001, Available at: http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_01g02_e.htm
[32] Hannah England, BA; Paul S. Weinberg, JD; N. A. Mark Estes, MD, The Automated External DefibrillatorClinical Benefits and Legal Liability, The *Journal of the American Medical Association.* 2006;295(6):687-690. http://jama.jamanetwork.com/article.aspx?articleid=202311
[33] Smits, J. (2000) The Good Samaritan in European Private Law; On the Perils of Principles without a Programme and a Programme for the Future, Inaugural lecture, Maastricht University http://arno.unimaas.nl/show.cgi?fid=3773

survey found that 40 per cent of respondents would be put off helping someone that had collapsed and wasn't breathing due to 'the thought of being sued if they did something wrong'.[34]

According to the Resuscitation Council UK, there are no known examples of anyone in the UK being successfully sued for any injury (e.g. broken ribs) resulting from someone performing CPR or using a defibrillator – and this would be very unlikely in the future. However, a lack of a specific protection for bystanders in a medical emergency may act as a deterrent. At present, there are no statutory duties relating to the field of resuscitation, but potential liability can arise at common law.[35]

Domestic legislation in relation to public access AEDs

In the UK there is no statutory requirement regarding the placement of AEDs in public places and at present there is no specific legal requirement for employers to provide AEDs in the work place. First aid at Work (FAW) courses do not include the use of AEDs.[36] However, FAW guidance states that if 'a workplace decides to provide a defibrillator in the workplace, those who may use it should be appropriately trained.'[37] [38]

All UK ambulances are equipped with defibrillators for professional use, i.e. fixed defibrillators which are not automated, but some trusts also have AEDs on ambulances. For example, the London Ambulance Service has AEDs on all ambulances and response vehicles (e.g. rapid response cars). AEDs are not equipped on all emergency service vehicles in the UK, such as police and fire engines, however, in some instances there may be reasons for this. For example, a fire engine might only leave the station when it is on call and therefore it is not the best place to have an AED.

Responses to out-of-hospital cardiac arrest

The Department of Health has set a target for ambulance services to respond to at least 75% of category A (immediately life-threatening) calls within eight minutes. Research has shown that an individual's chance of survival following a sudden cardiac arrest decreases by 7% to 10% for every minute following onset.[39] Whilst it would be ideal for an ambulance to be on the scene within five minutes of an out-of-hospital cardiac arrest, this is just not practically possible, therefore Ambulance Trusts have developed groups of Community First Responders (CFRs) to help augment the ambulance service's response.

CFRs are typically members of the public who receive basic medical training from their ambulance service, or a charitable organisation specialising in life-saving skills (e.g. St John Ambulance). They have traditionally been dispatched in rural areas as a way of improving ambulance response times in cases of cardiac arrest, and are managed by ambulance services and trained to begin CPR and use an AED while waiting for the arrival of an ambulance crew.[40] In 2007, there were 10,158 CFRs across 1,331 CFR schemes in

[34] One Poll, 2,000 respondents, UK-wide, November 2011. Full results available upon request
[35] Resuscitation Council UK (2010) The Legal Status of those who attempt resuscitation, Resuscitation Council UK: London http://www.resus.org.uk/pages/legal.pdf
[36] Health and Safety Executive (2013) Frequently Asked Questions on First Aid: Automated external defibrillators http://www.hse.gov.uk/firstaid/faqs.htm
[37] Ibid.
[38] Health and Safety Executive Northern Ireland, (2011) First-aid at work The Health and Safety (First-Aid) Regulations (Northern Ireland) 1982 http://www.hseni.gov.uk/first_aid_at_work_approved_code_of_practice_2011.pdf
[39] Commission for Healthcare Audit and Inspection, 2007 The role and management of community first responders: Findings from a national survey of NHS ambulance services in England, London: Commission for Healthcare Audit and Inspection
[40] Ibid.

England. In 2006/2007 CFRs in England responded to 92,928 (1.8%) of all emergency calls.[41]

In line with Resuscitation Council UK & American Heart Association guidelines, the British Heart Foundation advocates prompt CPR and AED intervention in a short space of time (a response time of approximately 4-5 minutes) to maximise the benefit of care to cardiac arrest victims.[42] In light of the high proportion of out-of-hospital cardiac arrests that occur within the home, action to improve medical response times to all out-of-hospital cardiac arrests and maintain existing Community First Responder Groups, is recommended.

To encourage greater levels of bystander intervention in cases of out-of-hospital cardiac arrests, and improve response times, the British Heart Foundation established the Heartstart training programme. The Heartstart scheme operates in schools across the UK, and teaches children life-saving skills, including CPR. The BHF believes that all young people in the UK should leave school with the knowledge of how to save a life, equipping them with vital skills needed in their communities. As part of our campaigns work, we have been calling on Government to create a new generation of lifesavers, by making life-saving skills a mandatory part of the National Curriculum.[43]

Four nations overview

Scotland

In accordance with the Better Heart Disease and Stroke Action plan in 2009, NHS Boards in Scotland should have previously sought advice from their Cardiac Managed Clinical Networks to consider whether the introduction of static public access defibrillation schemes in busy public places would be beneficial.[44] Where advised that they would be appropriate, NHS Boards should have introduced schemes by the end of March 2010, however, the process for this has been delayed and at present it is unclear how many NHS Boards have done this.

Northern Ireland

In January 2013, the Northern Ireland Executive announced the development of a regional community resuscitation strategy for Northern Ireland.[45] The Chief Medical Officer for Northern Ireland will be arranging for a working group to be established to develop a community resuscitation strategy for Northern Ireland, aimed at coordinating existing resources to maximise the number of individuals trained in life-saving skills, including defibrillation.[46] The document is set to be drafted for consultation in autumn 2013 (October).

Wales

The Welsh Assembly recently published the Heart Disease Delivery Plan for Wales. The document outlines plans to review the provision of AEDs in public places – alongside investment in community first responders trained in CPR and ambulance response times – to significantly increase the chance of survival and recovery for out-of-hospital cardiac

[41] Ibid.
[42] Resuscitation Council UK, Resuscitation Guidelines 2010, Resuscitation Council UK: London http://www.resus.org.uk/pages/guide.htm
[43] For more information, visit bhf.org.uk/els
[44] The Scottish Government, 2009, Better Heart Disease and Stroke Care Action Plan, Defibrilators in public places (4.20-4.24), available at: http://www.scotland.gov.uk/Publications/2009/06/29102453/6
[45] Northern Ireland Executive, 2013, Health Minister Edwin Poots today announced the development of a regional community resuscitation strategy for Northern Ireland.
Wednesday, 9 January 2013 http://www.northernireland.gov.uk/news-dhssps-090113-minister-announces-the
[46] Ibid.

arrests. According to the plan the review will be conducted within Local Health Board areas, in liaison with the Welsh Ambulance Service Trust and the British Heart Foundation.[47]

England

In March 2013, a debate was held in Parliament regarding AEDs in public places. The debate, led by Steve Rotherham MP, was the result of an e-petition which received over 100,000 signatures, which illustrates the broad level of public support for the issue. The debate forms part of a campaign that has been led by the Oliver King Foundation and a coalition of community organisations, which is being supported by the Labour Party.

During the debate, Shadow Health Minister Andy Burnham and other MPs called for legislation to require the placement of defibrillators in public places to ensure that they are available where they are most needed. However, Health Minister Anna Soubry disagreed with this proposal – commenting that she wasn't convinced of the need for legislation and that Ambulance Trusts were the best people to ensure the delivery of AEDs and training in communities.[48]

International comparison on the placement of AEDs

Canada

Under regulations contained within The Defibrillator Public Access Act, the Government in the Canadian Province of Manitoba will require AEDs to be installed in high-traffic public places such as gyms, arenas, community centres, golf courses, schools and airports by January 31, 2014.[49]

The public places designated under the Act were selected based on expert advice and public feedback. An expert advisory group, including paramedics and charitable organisations, identified several types of high traffic public places where cardiac arrest is more likely to occur, public capacity thresholds, as well as the types of activities that occur, e.g. physical activity.

The Act and Regulation outline the following requirements:

- **Access and installation:** Owners of premises must install AEDs to ensure that a member of the public witnessing a victim of cardiac arrest at any public location on the premises is able to access a defibrillator and return to the victim in less than three minutes to maximize the benefit offered by AEDs.

- **Registration:** Once installed, AEDs must be registered with the Heart and Stroke Foundation in Manitoba, which acts as the registrar. This registry is shared with 911 dispatchers so they can assist a caller in an emergency with locating the nearest AED.

- **Maintenance:** owners of designated premises maintain their AEDs in accordance with the Regulation and can make their own arrangements as to who inspects it.

[47] Welsh Government (2013) Together for Health – a Heart Disease Delivery Plan
A Delivery Plan up to 2016 for NHS Wales and its Partners http://wales.gov.uk/docs/dhss/publications/130503hearten.pdf
[48] Hansard (2013) Westminster Hall, Back Bench Debate, Sudden Adult Death Syndrome, Monday 25 March 2013
http://www.publications.parliament.uk/pa/cm201213/cmhansrd/cm130325/halltext/130325h0001.htm#13032523000001
[49] Manitoba Law, 2011 The Defibrillator Public Access Act, http://web2.gov.mb.ca/laws/statutes/2011/c01011e.php

USA

Over the past decade, legislators in some US States have introduced a broad range of laws to introduce the availability of AEDs.

The following areas have introduced legislation requiring or supporting AED placement in:

- **Schools:** California, Colorado, Florida, Georgia, Illinois, Iowa, Maryland, Michigan, Nevada, New Jersey New York, Ohio, Pennsylvania, South Carolina, Tennessee, Virginia, Wisconsin.

- **Health Clubs:** California, Illinois, Indiana, Massachusetts, Michigan, New Jersey, New York, Pennsylvania, Rhode Island, and the District of Columbia.[50]

- **Public places:**

    - **Oregon**: In the state of Oregon, all places of public assembly that have 50,000 ft^2 or more and where at least 25 persons congregate on a normal business day will be required to possess at least one AED and therefore must comply with this policy where noted.[51]

    - **New York State**: New York State requires all public buildings, stadia, arenas and convention centres in cities with a population of over one million to be equipped with AEDs and that employees are trained in their use.[52] The state also requires every assisted living facility to have at least one AED on the premises and have at least one individual trained in its use in attendance at all times.[53]

Taiwan

In December 2012, the Taiwanese Government introduced legislation requiring the installation of AEDs in public venues.[54] However, the emphasis appears to be on the use of defibrillators by individuals with prior training and the Department of Health is currently in the process of determining the order of priority for venues where AEDs will be installed. The amended law also exempts people who try but fail to save a life with the device from criminal and civil liabilities. Off-duty medical professionals are included in this immunity.[55]

Japan

The Japanese government has not legislated any requirement of the placement of AEDs in public places. However, its authorisation of the use of AEDs by laypersons in 2004 has led to rapid dissemination of AEDs.[56] This has been primarily guided by voluntary involvement of individual organisations and business owners rather than government action. Unique concepts are being employed to expand public use but keep costs to a minimum – for

[50] National Conference of State Legislatures (2013) State Laws on Cardiac Arrest & Defibrillators. http://www.ncsl.org/issues-research/health/laws-on-cardiac-arrest-and-defibrillators-aeds.aspx
[51] 75th Oregon Legislative Assembly--2009 Regular Session Senate Bill 556 http://www.statesurge.com/bills/sb556-oregon-552404
[52] State of New York,2009, Bill 1246 http://www.statescape.com/TextArchive/BillTextArchive/SSBillText2010/NY20092010/NY_20092010_AB_001246_Current_2026.htm
[53] State of New York, 2009, Bill 5611 http://www.statescape.com/TextArchive/BillTextArchive/SSBillText2010/NY20092010/NY_20092010_AB_005611_Current_4498.htm
[54] Taiwan Today, 2012, ROC lawmakers OK AEDs in public places , 12/26/2012 http://taiwantoday.tw/ct.asp?xItem=200153&CtNode=413
[55] Ibid.
[56] Hideo Mitamura, Public access defibrillation: advances from Japan, *Nature Clinical Practice Cardiovascular Medicine* (2008) 5, 690-692 http://www.nature.com/nrcardio/journal/v5/n11/full/ncpcardio1330.html

example, AEDs have been placed in vending machines where costs are covered by food and drink purchases and advertising panels have been placed above the AED to create revenue.

Switzerland

Since July 2008 all buses in Davos have been equipped with AEDs and bus drivers are trained to use them. This project is controlled and supported by Hospital Davos.[57]

Portugal

AEDs are located in public places but use is limited to laypersons who are trained and certified. In 2011, there were 145 AEDs licensed for use in Portugal – 2/3 of which are placed in public spaces e.g. shopping centres and airports, however, according to media reports, the Government has recently introduced a requirement that all sports, leisure and entertainment venues with a capacity of 5,000 people will also have to have the equipment installed.[58] [59]

BHF activity

AED deployment by the BHF has been in existence since the early 1990s and has helped to improve the range of these lifesaving pieces of equipment by donating AEDs to GPs initially, then offering supportive funding for AEDs in the wider community. In 1999 the BHF and Department of Health (DH) worked together to bring 700 AEDs to static sites across the UK in areas of high footfall under the Defibrillators in Public Places Initiative (DIPPI), this was built upon by the National Defibrillator Programme from 2004-2006 which saw a further 2300 units placed within the community in England with support from the Big Lottery Fund. This fulfilled the criteria set out by the DH of having a network of 3000 public access defibrillators within the UK. These developments have run concurrently with the BHF funded initiatives and have helped to build a network of AEDs across the UK.

In recent years the BHF AED programme has passed the landmark figure of 9500 AEDs deployed into the community. The range of the AED programme has been far reaching and the BHF knows of at least 230 lives saved since inception; with potentially many more that have gone unreported or that attempted to save a life without success. Between 2000-2013 the BHF spent approximately £10.8 million on AEDs.

In March 2013, BHF launched a partnership with The Football Association (FA) to place defibrillators in lower league football clubs in England. The £1.2million project, which includes teaching Hands-only CPR skills, will place at least 900 defibrillators in National League System clubs, below Npower League Two, and the Women's Super League. The BHF will match fund an initial donation of £400,000 from The FA towards the cost of the defibrillators, with clubs contributing the rest of the money.

At present, the BHF and Resuscitation Council UK are currently funding a project to create a national cardiac arrest registry whereby OHCA data can be collated and easily compared (at the moment ambulance services collect data in different ways).

[57] Davos Klosters (2013) Heart Safe Davos, Available at: http://www.davos.ch/en/stay/health-spa-town/heart-safe-in-davos.html
[58] Portugal News (2011) Portugal making progress in heart attack intervention http://www.theportugalnews.com/news/view/1100-13
[59] Portugal News (2012) Defibrillators compulsory in shopping centres http://theportugalnews.com/news/defibrillators-compulsory-in-shopping-centres/26412

BHF's activity in relation to AEDs forms part of a wider Community Resuscitation programme, which seeks to strengthen the Chain of Survival. The programme is formed of three key strands: Heartstart (which teaches life-saving skills within schools & communities across the UK), AEDs and Community Resuscitation funded posts (such as Community Resuscitation Development Officers, Community Resuscitation Training Officers and Community Defibrillation Officers). The BHF's Community Resuscitation programme is currently being reviewed and at present we cannot guarantee the content of it going forwards.

For more information, please contact policy@bhf.org.uk

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SCRUTINY COMMISSION FOR RURAL COMMUNITIES	Agenda Item No. 4
15 JULY 2013	Public Report

Report of the Cambridgeshire and Peterborough Clinical Commissioning Group

Contact Officer(s) – Jessica Bawden,
Cambridgeshire and Peterborough Clinical Commissioning Group
Contact Details - 01223 725584.

NHS 111 SERVICE

1. PURPOSE

1.1 Information requested by the Commission on NHS 111 service.

2. RECOMMENDATIONS

2.1 To note the report.

3 BACKGROUND

3.1 **Introduction**

NHS 111 is a new telephone service being introduced to make it easier for the public to access local health services, when they need medical help fast, but it isn't a 999 emergency. This will replace the current NHS Direct service, nationally from 1 April 2013, and across Cambridgeshire and Peterborough from 22 October 2013.

The NHS 111 service will ultimately form part of an integrated 24/7 urgent care service, incorporating GP out-of-hours services and provide urgent medical care for people registered with a GP elsewhere.

Cambridgeshire and Peterborough will be piloting the NHS 111 service from 22 October 2013, with the intention of tendering the service in 2014/15.

3.2 **Background**

Research with the public has made clear for some time that the public find it difficult to access NHS services when they develop unplanned, unexpected healthcare needs. Changes in the way in which services are delivered, in particular the introduction of new services like NHS Walk-in Centres or Urgent Care Centres, have added to the complexity of the urgent healthcare system. The result is that many people are unclear which services are available to meet their urgent, unplanned needs and how they should be accessed, especially outside normal working hours when GP practices are closed or when they are away from home.

NHS reviews have also found that patients want better information and more help to understand how to access the best care, especially urgent care, when they need it. Consultations with the public and clinicians carried out by Strategic Health Authorities resulted in them calling for the introduction of a single number to improve access to urgent healthcare services.

The Department of Health started work in 2008 on scoping the introduction of a single number to access NHS urgent healthcare services. This included carrying out research with the public that found there was overwhelming support for such a service in particular with a '999 style' memorable number. Research was also conducted to identify which of the available three-digit numbers the public preferred, 111 was by far the most popular.

This work also identified that the introduction of a three-digit number could provide significant

benefits, not only to the public, but to the NHS as well. The data the service will collect will enable the commissioning of more effective and productive healthcare services that are better tuned to meet patient needs.

3.3 **How does it work?**

111 will get you through to a team of fully trained call advisers, who are supported by experienced nurses. They will ask you questions to assess your symptoms, and give you the healthcare advice you need or direct you to the right local service.

The NHS 111 team will where possible book you an appointment or transfer you directly to the people you need to speak to. If they think you need an ambulance, they will send on immediately – just as if you had originally dialled 999.

3.4 **When do you use it?**

You should use the NHS 111 service if you need medical help or advice urgently but it's not a life-threatening situation.
You should call 111 if:

- It's not a 999 emergency
- you think you need to go to A&E or another NHS urgent care service;
- you don't think it can wait for an appointment with your GP; or
- you don't know who to call for medical help.
- For less urgent health needs, you should still contact your GP in the usual way.
- For immediate, life-threatening emergencies, you should continue to call 999.

3.5 **Why should you use it?**

NHS 111 is a fast and easy way to get the right help – whatever your need, wherever you are, and whatever the time.

NHS 111 can help us take the pressure off the 999 service and local A&E departments, so that they can focus on emergency cases.

4 KEY ISSUES

4.1 Due to delays with the launch of our local 111 service, on 5 March the Governing Body of Cambridgeshire and Peterborough Clinical Commissioning Group (CCG) made the decision to appoint an alternative provider to run the local NHS 111 service.

The CCG Governing Body made this decision on the basis of patient safety. It did not believe that, even with further delay, the implementation issues could be resolved sufficiently to provide a safe service for the residents of Cambridgeshire and Peterborough.

This decision was communicated to UCC and unfortunately they immediately commenced legal action against the CCG, which has made it difficult to communicate openly with our members.

As a clinically led organisation, our Governing Body GPs made a clear decision that the interests of patients must come first. Experience elsewhere in the country has shown that this must be the overriding consideration when making decisions of this kind.

5 NEXT STEPS

5.1 The CCG have now appointed Herts Urgent Care (HUC) to provide the pilot for the NHS 111 service across Cambridgeshire and Peterborough, with a planned public launch date of 22 October 2013 (soft launch with GPs late September), subject to a series of tests, both by the Cambridgeshire and Peterborough Clinical Commissioning Group as well as Department of Health, to ensure it is clinically safe before launch.

HUC are a social enterprise company that started life as a GP out of hours cooperative. They have successfully grown and provide a range of services including a very successful NHS 111

service in Hertfordshire.

Herts Urgent Care will be working closely with NHS Cambridgeshire and NHS Peterborough, local clinicians, community services and hospitals, and the current GP Out of Hours services (provided by Urgent Care Cambridgeshire in Cambridgeshire and Cambridge Community Services in Peterborough).

In the meantime, patients requiring advice and urgent healthcare services in the Cambridgeshire and Peterborough area will continue to be able to access the NHS Direct service

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SCRUTINY COMMISSION FOR RURAL COMMUNITIES	Agenda Item No. 5
15 JULY 2013	Public Report

Report of the Head of Neighbourhood Services

Contact Officer(s) – Cate Harding
Contact Details – 01733 317497

SUPPORT FOR THE DEVELOPMENT OF COMMUNITY CENTRES AND VILLAGE HALLS IN RURAL AREAS

1. PURPOSE

1.1 This report explores the support available for the development of community centres and village halls in rural areas, and sets out an overall direction of travel for further work throughout the year.

2. RECOMMENDATIONS

2.1 The Commission is asked:

- To agree to further, focussed work being carried out over the next few months, as set out in section 4, to ensure that the specific issues and opportunities relating to rural community assets are fully explored, and that a report is brought back to the Commission at a future date during the municipal year

- To ask the Parish Liaison Committee to include a session on community assets in rural areas at this year's Parish Conference event.

3. LINKS TO THE SUSTAINABLE COMMUNITY STRATEGY

3.1 Community based assets, including village halls, community centres and public open space, add value to a neighbourhood and often act as a catalyst for community involvement and participation. When managed well, they act as a focal point for bringing communities together and have huge potential to act as a base for services to be delivered from.

3.2 Given this, well managed, vibrant and sustainable community assets contribute to priorities across the entire Sustainable Community Strategy, but especially to the priority to create strong and supportive communities.

4. BACKGROUND

4.1 Peterborough benefits from a rich, varied and diverse mix of community based assets, including village halls, community centres and public parks. Many are in public ownership, whilst others are owned by parish councils or by private sector organisations. One common theme though, regardless of ownership, is that they rely on active citizenship to help them to thrive.

4.2 In Peterborough, community centres and village halls in public ownership are managed by volunteers who give their time generously and freely to provide a local facility.

4.3 The importance of community assets such as this is significant. They often help to define a community and bring people together helping to build pride and a sense of place. The notion of asset-based community development is well tested elsewhere in the world, and is emerging more and more as a UK method of empowering, developing and sometime regenerating a community. Assets in this context include physical buildings as well as the collective skills and experiences of residents.

4.4 A programme of work is underway which sets out to ensure the city's community assets are supported, developed and sustainable. This programme includes:

- reviewing the Council's approach to asset management to ensure that it is fully aligned across the organisation
- exploring all aspects of the Localism Act to ensure that opportunities created from it are maximised
- working closely with the Peterborough Council for Voluntary Service who have been externally funded to support community associations and community centres to thrive and become sustainable
- working with the Parish Liaison Committee to ensure the role of parish councils is fully understood and all opportunities for diversification and growth are taken

4.5 This overarching work programme is already closely aligned, although its various components are being taken forward separately. It is recommended that those aspects of the programme that relate to the development of village halls and community centres in rural areas be combined and a resultant report and recommendations be prepared for presentation back to the Scrutiny Commission later in this municipal year.

5. KEY ISSUES

5.1 Despite the work programme being taken forward, it is still helpful for the Commission to understand the broader context within which we operate, and some of the emerging and existing pressures we face. This will help to shape our collective thinking when considering how best to support the development and sustainability of village halls and community centres.

5.2 The Council is working closely with parish councils, through our relationship with the Peterborough Association of Local Councils and the refocused Parish Liaison Committee, to support parish councils in both rural and urban communities. This support is being developed in full recognition of the important role that parish councils play in helping to resolve local issues, to inform and engage with local people, and to represent communities in important processes.

5.3 The policy context within which our collaboration with parish councils is being taken forward includes the Localism Act. As a principle, Localism is a way of ensuring that services are designed, investments made and decisions taken that best fit local need, whether local is defined as Peterborough as a whole or a specific street or community. The Localism Act in turn sets out legislative rights to enable this way of working to be realised.

5.4 In autumn 2012 the Council and parish councils in Peterborough came together at an inaugural Parish Conference to begin the exploration of Localism in the context of parish councils. The conference looked at ways of using Localism to support and sustain the role of parish councils, including how services could be delivered locally, how community assets could be used more creatively, and how parish councils could reduce overheads through collaborative working with other parish councils.

5.5 A second conference is now being planned for later this year, and we are currently seeking input from parish councils about the subject matters that they would find most interesting and beneficial. It is suggested that the Scrutiny Commission may wish to ask the Parish Liaison Committee, who are organising the conference, to include a more in-depth look at how community assets in rural areas can be best supported and developed.

5.6 Alongside this collaboration with parish councils, we are facing unprecedented levels of budget reductions and need to be innovative and forward thinking in our approach to delivering these savings. It is widely recognised that an approach which seeks to prevent issues from arising, as opposed to dealing with them once they have happened, is often better value for money in the longer term. It is also widely recognised that an approach that works in full partnership with other agencies and organisations, and that engages effectively with residents, is far more likely to deliver the most appropriate savings and have the least impact.

5.7 Our developing relationship with parish councils will help to innovate and identify new ideas to achieve efficiencies whilst maintaining, or even improving, services. One of these ideas is to examine the ways in which community assets might be developed and utilised to help deliver the more preventative focus of service delivery, in turn making longer term improvements that last. For example, alongside the Localism principles providing opportunities for parish councils to deliver services, village halls could become host to a range of service providers keen to reach local people and to address the issues that really affect them.

5.8 We're also currently working hard to identify, manage and mitigate the risks and unintended consequences of the reform of the welfare benefits system. We recognise the value that accredited, quality debt advice brings to help people better manage their finances before debt itself becomes a way of life. We are working with a range of voluntary sector providers to understand the issues that people face and offer practical solutions to deal with crisis situations and prevent there reoccurrence. However, we are already seeing a significant increase in the number of people trying to access debt and other financial advice through agencies in Peterborough, who, at the moment, are finding it more and more difficult to meet demand. To address this, we are working with the Citizens Advice Bureau to increase the provision of accredited, quality debt advice not only in the city centre, but within neighbourhoods and rural locations.

5.9 This would see the availability of debt advice and other advice and information services delivered from village halls and community centres. This will provide an opportunity for people to access help in a more familiar environment at a time which is convenient for them. In turn, it will help further develop the role of parish councils, village halls and community centres leading to further options for diversification and development. This work forms a key strand of our preventative agenda.

5.10 Although some general themes to support the development of village halls and community centres in rural areas have been referenced in this report, the work being carried out to deliver a Localism-focussed approach, our growing collaboration with parish councils through the Parish Liaison Committee, and the driver for us to deliver even more efficient service delivery will lead to a more defined identity and role for community assets across Peterborough.

6. IMPLICATIONS

6.1 At this stage, direct financial, legal or other implications are not known.

7. CONSULTATION

7.1 The programmes of work identified in section 4 draw together relevant stakeholders as necessary.

8. NEXT STEPS

8.1 If the approach set out in this report is endorsed by the Commission, officers will ensure that there is proper recognition of the role and needs of village halls and community centres in rural areas in the various programmes of work, and will draw together the various outcomes of those programmes relating to rural community assets for discussion and debate at a future Commission meeting.

9. BACKGROUND DOCUMENTS

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

9.1 None

10. APPENDICES

10.1 None

SCRUTINY COMMISSION FOR RURAL COMMUNITIES	Agenda Item No. 6
15 JULY 2013	Public Report

Report of the Head of Legal Services

Contact Officer(s) – Adrian Chapman, Head of Neighbourhood Services
Paulina Ford, Senior Governance Officer
Contact Details – Tel: 01733 863887

SCRUTINY IN A DAY: A FOCUS ON WELFARE REFORM

1. PURPOSE

1.1 This report sets out proposals to hold an intensive, cross-scrutiny committee event focussing on the impacts of welfare reform in order to understand and mitigate against the breadth of impact on individuals, families, communities and businesses.

2. RECOMMENDATIONS

2.1 That a one-day Welfare Reform Scrutiny Summit be held in late autumn or early winter 2013 to understand the impact of Welfare Reform across all scrutiny agendas, and make recommendations to mitigate those impacts.

2.2 That a cross-scrutiny committee working group be formed to work with officers to plan the event and to oversee the implementation of recommendations from the event after it is held.

3. LINKS TO THE SUSTAINABLE COMMUNITY STRATEGY

3.1 The welfare reform programme will present both opportunities and risks for many aspects of our work, and each of the priorities set out in the Sustainable Community Strategy could be impacted upon by these changes.

4. BACKGROUND

4.1 The 2012 Welfare Reform Act is making the biggest change to the welfare benefits system since the 1940's. These changes will have a direct impact for most benefit claimants, which for some will be significant. There may also be a number of indirect and unintended consequences, some negative (such as overcrowding) and some positive (such as greater innovation leading to new employment schemes).

4.2 Between 2012 and 2017, a number of important changes will come into effect on a range of welfare benefits such as housing benefit, council tax benefit, tax credits, disability living allowance and incapacity benefit amongst others. Welfare Reform will affect people both in and out of work.

4.3 The Act will also see the introduction of Universal Credit, which aims to simplify the current benefits system by bringing together a range of separate benefit payments into one single streamlined payment process. A key feature of Universal Credit is that it aims to provide greater support to people looking for work and will ensure that people are better off by being in work.

4.4 Welfare Reform will have an impact in how the council and its partners deliver support, advice and services to the public. The council will need to work even closer with local partners across the public and civil society sectors, and with businesses in delivering the changes that Welfare

Reform brings. Key to the successful implementation of Welfare Reform will be ensuring that the council and local partners have an agreed strategy and understanding of the issues and how they can be addressed.

5. KEY ISSUES

5.1 Given the scale and impact that changes will bring each of the council's scrutiny committees / commissions will have a strong interest in understanding these impacts on their areas of work and in making recommendations to manage these impacts.

5.2 It is therefore proposed that a one-day Welfare Reform Scrutiny Summit be held in late autumn/early winter 2013 to allow all committees / commissions the chance to understand in-depth and scrutinise responses on this cross-cutting agenda. The summit would provide a chance to understand the Government's strategy on Welfare Reform, and how it affects Peterborough. It will also allow the committees to understand how Welfare Reform will impact individuals, families and communities from a range of different perspectives.

5.3 It is proposed that the event is organised in a similar way to a conference – a number of speakers presenting on the key aspects of the reform agenda and how it is impacting or may impact on residents and businesses, followed by more in-depth work focussing in on the issues pertinent to each committee / commission. The event would be supported by robust evidence as well as case studies.

5.4 To ensure this important event is as relevant and meaningful as possible, it is further proposed that representatives from each scrutiny committee / commission form a working group to plan the event and to oversee delivery of the recommendations that emerge from it.

6. IMPLICATIONS

6.1 Focussing on a single cross-cutting theme in this way will ensure that the council's response to the opportunities and challenges presented by welfare reform is completely joined-up and has the highest possible impact.

7. CONSULTATION

7.1 These proposals are being presented to each scrutiny committee / commission for discussion and debate.

8. NEXT STEPS

8.1 If the committees agree with the recommendations set out in this report, a small cross-committee working group will be established to work with officers to plan for the event.

9. BACKGROUND DOCUMENTS

9.1 None

10. APPENDICES

10.1 None

SCRUTINY COMMISSION FOR RURAL COMMUNITIES	Agenda Item No. 7
15 JULY 2013	Public Report

Report of the Head of Legal Services

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

NOTICE OF INTENTION TO TAKE KEY DECISIONS

1. PURPOSE

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

2. RECOMMENDATIONS

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

3. BACKGROUND

3.1 The latest version of the Notice of Intention to Take Key Decisions is attached at Appendix 1. The Notice contains those key decisions, which the Leader of the Council believes that the Cabinet or individual Cabinet Member(s) can take and any new key decisions to be taken after 25 July 2013.

3.2 The information in the Notice of Intention to Take Key Decisions provides the Commission with the opportunity of considering whether it wishes to seek to influence any of these key decisions, or to request further information.

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

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

4. CONSULTATION

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

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

None

6. APPENDICES

Appendix 1 – Notice of Intention to Take Key Decisions

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

PUBLISHED: 28 JUNE 2013

NOTICE OF INTENTION TO TAKE KEY DECISIONS

In the period commencing 28 days after the date of publication of this notice, Peterborough City Council's Executive intends to take 'key decisions' on the issues set out below. Key decisions relate to those executive decisions which are likely to result in the Council spending or saving money in excess of £500,000 and/or have a significant impact on two or more wards in Peterborough.

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

This Notice should be seen as an outline of the proposed decisions for the forthcoming month and it will be updated on a fortnightly basis. Each new notice supersedes the previous notice and items may be carried over into forthcoming notices. Any questions on specific issues included on the Notice should be included on the form which appears at the back of the Notice and submitted to Alex Daynes, Senior Governance Officer, Chief Executive's Department, Town Hall, Bridge Street, PE1 1HG (fax 01733 452483). Alternatively, you can submit your views via e-mail to alexander.daynes@peterborough.gov.uk or by telephone on 01733 452447.

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

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

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

All decisions will be posted on the Council's website: www.peterborough.gov.uk/executivedecisions. If you wish to make comments or representations regarding the 'key decisions' outlined in this Notice, please submit them to the Governance Support Officer using the form attached. For your information, the

contact details for the Council's various service departments are incorporated within this notice.

KEY DECISIONS FROM 25 JULY 2013

KEY DECISION REQUIRED	DECISION MAKER	MEETING OPEN TO PUBLIC	RELEVANT SCRUTINY COMMITTEE	CONSULTATION	CONTACT DETAILS / REPORT AUTHORS	DOCUMENTS RELEVANT TO THE DECISION SUBMITTED TO THE DECISION MAKER (IF ANY OTHER THAN PUBLIC REPORT)
A1260 Longthorpe Bridge Works - KEY/25JUL13/01 To award the contract for the works, via the Eastern Highways Alliance Framework; to carry out essential strengthening and improvement works to Longthorpe Bridge.	**Councillor Gr. Uff. Marco Cereste Leader of the Council and Cabinet Member for Growth, Strategic Planning, Housing, Economic Development and Business Engagement**	**N/A**	Sustainable Growth and Environment Capital	Ward councillors and relevant internal stakeholders.	Simon Machen Head of Planning, Transport and Engineering Services Tel: 01733 453475 simon.machen@peterborough.gov.uk	It is not anticipated that there will be any further documents.
The Expansion of Fulbridge Academy to four forms of entry - KEY/25JUL13/02 Award of Contract for the Expansion of Fulbridge Academy, including the approval of property, legal and	**Councillor John Holdich OBE Cabinet Member for Education, Skills and University, Cabinet Member for Resources**	**N/A**	Creating Opportunities and Tackling Inequalities	Relevant internal and external stakeholders.	Brian Howard Programme Manager - Secondary Schools Development Tel: 01733 863976 brian.howard@peterborough.gov.uk	It is not anticipated that there will be any further documents.

financial arrangements for various enabling agreements with third parties.						

Fletton Parkway Widening Jn17-2 - KEY/25JUL13/03 To award the contract for Site Supervision and Contract Administration.	**Councillor Gr. Uff. Marco Cereste Leader of the Council and Cabinet Member for Growth, Strategic Planning, Housing, Economic Development and Business Engagement**	**N/A**	Sustainable Growth and Environment Capital	Relevant internal and external stakeholders.	Simon Machen Head of Planning, Transport and Engineering Services Tel: 01733 453475 simon.machen@peterborough.gov.uk	It is not anticipated that there will be any further documents
PREVIOUSLY ADVERTISED DECISIONS						
Moy's End Stand Demolition and Reconstruction - KEY/03APR/12 Award of Contract for the Demolition of the Moy's End Stand and Reconstruction	**Councillor David Seaton Cabinet Member for Resources**	**N/A**	Sustainable Growth and Environment Capital	Internal and External Stakeholders as appropriate.	Richard Hodgson Head of Strategic Projects Tel: 01733 384535 richard.hodgson@peterborough.gov.uk	It is not anticipated that there will be any further documents.
Delivery of the Council's Capital Receipt Programme through the Sale of Dickens Street Car Park - KEY/03JUL/11 To authorise the Chief Executive, in consultation with the Solicitor to the Council, Executive Director – Strategic Resources, the Corporate Property Officer and the	**Councillor David Seaton Cabinet Member for Resources**	**N/A**	Sustainable Growth and Environment Capital	Consultation will take place with the Cabinet Member, Ward councillors, relevant internal departments & external stakeholders as appropriate.	Richard Hodgson Head of Strategic Projects Tel: 01733 384535 richard.hodgson@peterborough.gov.uk	It is not anticipated that there will be any further documents.

Cabinet Member Resources, to negotiate and conclude the sale of Dickens Street Car Park.						
Rolling Select List - Independent Fostering Agencies - KEY/01JUL/12 To approve the list for independent fostering agencies.	**Councillor Sheila Scott OBE Cabinet Member for Children's Services**	**N/A**	Creating Opportunities and Tackling Inequalities	Internal and external stakeholders as appropriate.	Oliver Hayward Commissioning Officer - Aiming High Tel: 01733 863910 oliver.hayward@peterborough.gov.uk	It is not anticipated that there will be any further documents.
Clare Lodge Service Review Outcome - KEY/13NOV12/06 To approve the outcome of the service review of Clare Lodge Secure Unit.	**Councillor Sheila Scott OBE Cabinet Member for Children's Services**	**N/A**	Creating Opportunities and Tackling Inequalities	Internal and External Stakeholders as appropriate.	Oliver Hayward Commissioning Officer - Aiming High Tel: 01733 863910 oliver.hayward@peterborough.gov.uk	It is not anticipated that there will be any further documents.
Residential Approved Provider List - KEY/13NOV12/08 Create a compliant Approved Provider List for Residential units for children and young people.	**Councillor Sheila Scott OBE Cabinet Member for Children's Services**	**N/A**	Creating Opportunities and Tackling Inequalities	Internal and external stakeholders as appropriate.	Oliver Hayward Commissioning Officer - Aiming High Tel: 01733 863910 oliver.hayward@peterborough.gov.uk	It is not anticipated that there will be any further documents.
Future of Children's Play Services - KEY/13NOV12/09 To determine the future of Play Services in the city	**Councillor Sheila Scott OBE Cabinet Member for Children's Services**	**N/A**	Creating Opportunities and Tackling Inequalities.	To be undertaken with key stakeholders.	Oliver Hayward Commissioning Officer - Aiming High Tel: 01733 863910 oliver.hayward@peterborough.gov.uk	It is not anticipated that there will be any further documents.
Care and Repair Framework Agreement - KEY/18DEC12/01 To approve a framework agreement and schedule of	**Councillor Nigel North Cabinet Member for Environment Capital and**	**N/A**	Strong and Supportive Communities	Relevant Internal Departments.	Russ Carr Care & Repair Manager Tel: 01733 863864 russ.carr@peterborough.gov.uk	It is not anticipated that there will be any further documents.

rates to deliver disabled facility grant work. specifically providing disabled access to toilet and washing facilities and associated work in domestic properties.	**Neighbourhoods**					
Award of Contract for the 413 Bus Service - KEY/27DEC12/01 Award of Contract for Route 413 (Maxey to City Centre) from 1 April 2013.	**Councillor Gr. Uff. Marco Cereste Leader of the Council and Cabinet Member for Growth, Strategic Planning, Housing, Economic Development and Business Engagement**	**N/A**	Sustainable Growth and Environment Capital	Relevant internal departments and external stakeholders.	Mark Speed Transport Planning Team Manager Tel: 317471 mark.speed@peterborough.gov.uk	It is not anticipated that there will be any further documents.
Environment Capital Action Plan - KEY/24JAN13/02 Approve the Plan for public consultation.	**Cabinet**	**YES**	Sustainable Growth and Environment Capital	Four week public consultation.	Charlotte Palmer Climate Change Team Manager charlotte.palmer@peterborough.gov.uk	It is not anticipated that there will be any further documents.
Fletton Parkway Junction 17 to 2 improvement scheme - KEY/24JAN13/07 To agree funding is brought forward between 2012 and 2015 in Medium Term Financial Strategy and the	**Councillor Gr. Uff. Marco Cereste Leader of the Council and Cabinet Member for Growth, Strategic Planning,**	**N/A**	Sustainable Growth and Environment Capital	Relevant internal and external stakeholders.	Mark Speed Transport Planning Team Manager Tel: 317471 mark.speed@peterborough.gov.uk	It is not anticipated that there will be any further documents.

contract awarded for the works.	**Housing, Economic Development and Business Engagement**					

Sale of Craig Street Car Park - KEY/25MAR13/01 To approve the sale of land known as Craig Street Car Park.	**Councillor David Seaton Cabinet Member for Resources**	**N/A**	Sustainable Growth and Environment Capital	Relevant Internal and External Stakeholders and ward councillors.	David Gray Capital Projects Officer Tel: 01733 384531 david.gray@peterborough.gov.uk	It is not anticipated that there will be any further documents.
Short Breaks Service - KEY/08APR13/01 Approval to award a contract for the provision of short break services for families with children and young people with disabilities.	**Councillor Sheila Scott OBE Cabinet Member for Children's Services**	**N/A**	Creating Opportunities and Tackling Inequalities	Relevant internal departments.	Oliver Hayward Commissioning Officer - Aiming High Tel: 01733 863910 oliver.hayward@peterborough.gov.uk	It is not anticipated that there will be any further documents.
Peterborough Highway Services 2013-2023 - KEY/18APR13/01 To approve the preferred bidder and award the contract for Peterborough Highway Services.	**Councillor Gr. Uff. Marco Cereste Leader of the Council and Cabinet Member for Growth, Strategic Planning, Housing, Economic Development and Business Engagement**	**N/A**	Sustainable Growth and Environment Capital	Relevant Internal and External Stakeholders.	Andy Tatt Transport and Engineering Group Manager Tel: 01733 453469 andy.tatt@peterborough.gov.uk	It is not anticipated that there will be any further documents.
The Expansion of Gladstone Primary School onto the site of the Gladstone Community Centre - KEY/18APR13/02 Award of Contract for the Expansion of Gladstone	**Councillor John Holdich OBE, Cabinet Member for Education, Skills and University**	**N/A**	Creating Opportunities and Tackling Inequalities	Relevant internal and external stakeholders, ward councillors and public.	Brian Howard Programme Manager - Secondary Schools Development Tel: 01733 863976 brian.howard@peterborough.gov.uk	It is not anticipated that there will be any further documents.

Primary School on the site of the Gladstone Community Centre.						
Passenger Transport - Subsidised Service Provision - KEY/30MAY13/02 To decide on the level of subsidised services to be provided by Peterborough City Council from the 1st of October 2013 in line with the revised budget allocation.	**Cabinet**	**Yes**	Sustainable Growth and Environment Capital	Cross-group advisory group.	Mark Speed Transport Planning Team Manager Tel: 317471 mark.speed@peterborough.gov.uk	It is not anticipated that there will be any further documents.
Future Cities Demonstrator - KEY/11JUL13/01 To re-affirm the council's commitment to delivering the 'Peterborough DNA' programme as set out in the submission to the Technology Strategy Board (TSB) which attracted the award of £3M to Peterborough City Council on the 31 March 2013.	**Councillor Gr. Uff. Marco Cereste Leader of the Council and Cabinet Member for Growth, Strategic Planning, Housing, Economic Development and Business Engagement**	**N/A**	Sustainable Growth and Environment Capital	Consultation has taken place with the Leader of the Council, the Chief Executive, Cabinet Member for Environment Capital and Neighbourhoods, the Peterborough DNA Delivery Team and approximately fifty partnership representatives at a workshop on 14th May 2013.	Charlotte Palmer Climate Change Team Manager charlotte.palmer@peterborough.gov.uk	It is not anticipated that there will be any further documents

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

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

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

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

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

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

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

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

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

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

Compliance)

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

APPENDIX 2

SCRUTINY COMMISSION FOR RURAL COMMUNITIES **Updated: 4 JULY 2013**
WORK PROGRAMME 2013/14

Meeting Date	Item	Progress
17 June 2013 *Draft report 30 May* *Final report 6 June*	**Review of 2012/13 and Future Work Programme** To review the work undertaken during 2011/12 and to consider the future work programme of the Committee **Contact Officer: Paulina Ford**	
	Update on Superfast Broadband **Contact Officer: Richard Godfrey**	
	Use of the Homecare Monitoring System – Update **Contact Officer: Nick Blake**	
	Impact of the Welfare Reform on Rural Areas **Contact Officer: Leonie McCarthy**	
15 July 2013 *Draft report 27 June* *Final report 4 July*		
	First Response Groups in Rural Areas To receive and comment on a report which informs the Commission on the development of First Response Groups in Rural Areas. **Contact Officer: East of England Ambulance Service**	
	NHS 111 To receive and comment on a report which informs the Commission on the	

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Meeting Date	Item	Progress
	new NHS 111 telephone service. **Contact Officer, Jessica Bawden,**	
	Support for the Development of Community Centres and Village Halls in Rural Areas To receive and comment on a report which explores the support available for the development of community centres and village halls in rural areas. **Contact Officer: Cate Harding**	
	Scrutiny In A Day: A Focus on Welfare Reform To receive a report on a proposal for a Scrutiny in a Day review into the Impact of Welfare Reform. **Contact Officer: Paulina Ford / Adrian Chapman**	
16 September 2013 *Draft report 29 Aug* *Final report 5 Sept*	**Local Flood Risk Management Draft Strategy** **Contact Officer: Julia Chatterton**	
	Parish Plans – Progress **Contact Officer: Cate Harding**	Requested at June 2013 meeting.
	Solar and Wind Farms **Contact Officer: John Harrison**	Requested at March 2013 meeting.
	Impact of Welfare Reform in Rural Areas – Progress Report	Requested at June 2013 meeting.

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Meeting Date	Item	Progress
	Use of Homecare Monitoring System - Data **Contact Officer: Nick Blake**	Requested at June 2013 meeting.
18 November 2013 *Draft report 31 Oct* *Final report 7 Nov*	**Educational Attainment in Rural Areas** **Contact Officer: Jonathan Lewis**	
	Disability Issues in Rural Areas – Update **Contact Officer: Jawaid Khan/Ian Phillips**	
13 January 2014 Draft report 24 Dec Final report 2 Jan	**British Transport Police** **Contact Officer:**	
	Crime and Disorder in Rural Areas **Contact Officer: Gary Goose**	Requested at June 2013 meeting.
8 or 20 January	**Budget 2013/14 and Medium Term Financial Plan**	

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Meeting Date	Item	Progress
2014 (Joint Meeting of the Scrutiny Committees and Commissions)	To scrutinise the Executive's proposals for the Budget 2014/15 and Medium Term Financial Plan. **Contact Officer: John Harrison/Steven Pilsworth**	
1 April 2014 *Draft report 14 March* *Final report 21 March*		

Items to be programmed in: