A meeting of the **OVERVIEW AND SCRUTINY PANEL (SOCIAL WELL-BEING)** will be held in **CIVIC SUITE 0.1A, PATHFINDER HOUSE, ST MARY'S STREET, HUNTINGDON, PE29 3TN** on **TUESDAY, 4 FEBRUARY 2014** at **7:00 PM** and you are requested to attend for the transaction of the following business:-

Contact (01480)

APOLOGIES

1. MINUTES (Pages 1 - 6)

To approve as a correct record the Minutes of the meeting of the Panel held on 7th January 2014. **Miss H Ali 388006**

2 Minutes.

2. MEMBERS' INTERESTS

To receive from Members declarations as to disclosable pecuniary or other interests in relation to any Agenda Item. Please see Notes below.

2 Minutes.

3. NOTICE OF EXECUTIVE DECISIONS (Pages 7 - 12)

A copy of the current Notice of Key Executive Decisions, which was published on 15th January 2014 is attached. Members are invited to note the decisions and to comment as appropriate on any items contained therein. **Mrs H Taylor 388008**

5 Minutes.

4. CLINICAL COMMISSIONING GROUP: FINANCE AND PERFORMANCE COMMITTEE REPORT (Pages 13 - 98)

To receive Finance and Performance Reports from Cambridgeshire and Peterborough Clinical Commissioning Group in relation to Hinchingbrooke Hospital.

Mr R Murphy, Interim Local Chief Officer (Huntingdonshire System) and Mr K Poyntz, Assistant Director of Commissioning and Contracting (Huntingdonshire System), Cambridgeshire and Peterborough Clinical Commissioning Group, will be in attendance for this item.

Members of the Overview and Scrutiny Panels (Economic Well-Being) and (Environmental Well-Being) have been invited to attend for this item.

30 Minutes.

5. CORPORATE PLAN

To receive the Corporate Plan – **TO FOLLOW**. **H Thackray 388035**

20 Minutes.

6. CAMBRIDGESHIRE ADULTS, WELL-BEING AND HEALTH OVERVIEW AND SCRUTINY (Pages 99 - 114)

To receive an update from Councillor J W G Pethard on the outcome of recent meetings of the Cambridgeshire Adults, Well-Being and Health Overview and Scrutiny Committee.

5 Minutes.

7. WORK PLAN STUDIES (Pages 115 - 116)

To consider, with the aid of a report by the Head of Legal and Democratic Services, the current programme of Overview and Scrutiny studies. **Miss H Ali 388006**

10 Minutes.

8. OVERVIEW AND SCRUTINY PANEL (SOCIAL WELL-BEING) - PROGRESS (Pages 117 - 124)

To consider a report by the Head of Legal and Democratic Services on the Panel's programme of studies. **Miss H Ali 388006**

15 Minutes.

9. SCRUTINY

To scrutinise decisions as set in the Decision Digest **(TO FOLLOW)** and to raise any other matters for scrutiny that fall within the remit of the Panel.

5 Minutes.

Dated this 27 day of January 2014

Head of Paid Service

Notes

1. Disclosable Pecuniary Interests

(1) Members are required to declare any disclosable pecuniary interests and unless you have obtained dispensation, cannot discuss or vote on the matter at the meeting and must also leave the room whilst the matter is being debated or voted on.

(2) A Member has a disclosable pecuniary interest if it -

(a) relates to you, or
(b) is an interest of -

(i) your spouse or civil partner; or
(ii) a person with whom you are living as husband and wife; or
(iii) a person with whom you are living as if you were civil partners

and you are aware that the other person has the interest.

(3) Disclosable pecuniary interests includes -

(a) any employment or profession carried out for profit or gain;
(b) any financial benefit received by the Member in respect of expenses incurred carrying out his or her duties as a Member (except from the Council);
(c) any current contracts with the Council;
(d) any beneficial interest in land/property within the Council's area;
(e) any licence for a month or longer to occupy land in the Council's area;
(f) any tenancy where the Council is landlord and the Member (or person in (2)(b) above) has a beneficial interest; or
(g) a beneficial interest (above the specified level) in the shares of any body which has a place of business or land in the Council's area.

Other Interests

(4) If a Member has a non-disclosable pecuniary interest or a non-pecuniary interest then you are required to declare that interest, but may remain to discuss and vote.

(5) A Member has a non-disclosable pecuniary interest or a non-pecuniary interest where -

(a) a decision in relation to the business being considered might reasonably be regarded as affecting the well-being or financial standing of you or a member of your family or a person with whom you have a close association to a greater extent than it would affect the majority of the council tax payers, rate payers or inhabitants of the ward or electoral area for which you have been elected or otherwise of the authority's administrative area, or
(b) it relates to or is likely to affect any of the descriptions referred to above, but in respect of a member of your family (other than specified in (2)(b) above) or a person with whom you have a close association

and that interest is not a disclosable pecuniary interest.

2. Filming, Photography and Recording at Council Meetings

The District Council supports the principles of openness and transparency in its decision making and permits filming, recording and the taking of photographs at its meetings that are open to the public. It also welcomes the use of social networking and micro-blogging websites (such as Twitter and Facebook) to communicate with people about what is happening at meetings. Arrangements for these activities should operate in accordance with guidelines agreed by the Council and available via the following link - filming,photography-and-recording-at-council-meetings.pdf or on request from the Democratic Services Team. The Council understands that some members of the public attending its meetings may not wish to be filmed. The Chairman of the meeting will facilitate this preference by ensuring that any such request not to be recorded is respected.

Please contact Miss H Ali, Democratic Services Officer, Tel No: (01480) 388006 / email: Habbiba.Ali@huntingdonshire.gov.uk if you have a general query on any Agenda Item, wish to tender your apologies for absence from the meeting, or would like information on any decision taken by the Panel.

Specific enquiries with regard to items on the Agenda should be directed towards the Contact Officer.

Members of the public are welcome to attend this meeting as observers except during consideration of confidential or exempt items of business.

Agenda and enclosures can be viewed on the District Council's website – www.huntingdonshire.gov.uk *(under Councils and Democracy).*

If you would like a translation of Agenda/Minutes/Reports or would like a large text version or an audio version please contact the Democratic Services Manager and we will try to accommodate your needs.

Emergency Procedure

In the event of the fire alarm being sounded and on the instruction of the Meeting Administrator, all attendees are requested to vacate the building via the closest emergency exit.

HUNTINGDONSHIRE DISTRICT COUNCIL

MINUTES of the meeting of the OVERVIEW AND SCRUTINY PANEL (SOCIAL WELL-BEING) held in Civic Suite 0.1A, Pathfinder House, St Mary's Street, Huntingdon, PE29 3TN on Tuesday, 7 January 2014.

PRESENT: Councillor S J Criswell – Chairman.

Councillors K M Baker, R C Carter, I J Curtis, Mrs P A Jordan, S M Van De Kerkhove, M C Oliver and J W G Pethard.

APOLOGIES: Apologies for absence from the meeting were submitted on behalf of Councillors D B Dew, R Fuller, C R Hyams and Mrs M Nicholas.

72. MINUTES

The Minutes of the meetings of the Panel held on 3rd and 11th December 2013 were approved as a correct record and signed by the Chairman.

73. MEMBERS' INTERESTS

Councillor Mrs P A Jordan declared a non-disclosable pecuniary interest in Minute Nos 13/75 and 13/76 by virtue of her employment with the NHS.

74. NOTICE OF KEY EXECUTIVE DECISIONS

The Panel considered and noted the current Notice of Key Executive Decisions (a copy of which is appended in the Minute Book) which had been prepared by the Executive Leader of the Council for the period 1st January to 30th April 2014.

75. REDESIGN OF MENTAL HEALTH SERVICES

(Mr J Ellis, Commissioning and Contract Lead for Mental Health, Mrs C Hodgson, Mental Health Commissioning and Contract Manager, Cambridgeshire and Peterborough Clinical Commissioning Group, Dr D Irwin, GP Mental Health Lead for Hunts Care Partnership, and Mr A Thomas, Chief Executive of Cambridgeshire and Peterborough NHS Foundation Trust, were in attendance for consideration of this item).

Pursuant to Minute No. 13/57, and with the aid of a presentation by Mr J Ellis, Commissioning and Contract Lead for Mental Health, the Panel received an update on local mental health services in Huntingdonshire following the redesign of services across Cambridgeshire and Peterborough. As part of the presentation, Members were reminded of the objectives of the public consultation which had taken place in 2011/12, and received details of the adopted new service model. The Panel then received information on the Advice and Referral Centre which had been launched locally in May

2013. Finally, data on the number of patients in Huntingdonshire accessing mental health services was provided.

Having concluded the presentation, Mr Ellis proceeded to respond to questions, which had been raised by the Panel in advance of the meeting. With regard to the number of Huntingdonshire patients who were accessing acute services in Peterborough or Fulbourn in comparison to two years ago when Acer Ward was operational, it was stated that demand for acute services had remained the same, though there had been a notable increase in the number of times the Huntingdonshire Crisis Team was contacted.

On the question of the support and care services that were available to mental health patients who have been discharged into the community, Mr A Thomas, Chief Executive of Cambridgeshire and Peterborough NHS Foundation Trust, explained that overall there had been a decrease in the number of Hospital admissions and that attempts were made to utilise primary care mental health services wherever possible.

In response to the question on the Hospital's transportation arrangements and the accessibility of acute wards, Mrs C Hodgson, Mental Health Commissioning and Contract Manager, explained that £15,000 had been invested into the Cambridgeshire Community Car Scheme. No negative comments had been received from service users to date and Mr Thomas advised that, since he had come into post in September 2013, the Trust had not received any complaints in this respect. In noting that regular contact with the service user group was maintained, Mrs Hodgson undertook to forward their details on to the Panel outside of the meeting.

Other matters that were discussed included the extent to which the Clinical Commissioning Group commissioned services from the voluntary sector. The Panel would be provided with details of the various voluntary organisations commissioned by the service. The functions performed by the Advice and Referral Centre included the transfer of patients to and from acute and community services. Members were then acquainted with the challenges faced by the service to meet growing levels of demand whilst being mindful of increasing budgetary pressures, the number of Huntingdonshire patients currently admitted to acute facilities, the types of referrals made by GPs to the Advice and Referral Centre and performance statistics for the Centre in its first few months of operation within Huntingdonshire.

At the conclusion of the Panel's discussions, the Chairman thanked all those present for their attendance at the meeting. Mr Ellis indicated that he and his colleagues would be happy to return to provide a further update to Members at a future meeting.

76. PROCUREMENT OF OLDER PEOPLES PROGRAMME

(Mr R Murphy, Interim Local Chief Officer (Huntingdonshire System), and Mr I Weller, Strategic Programme Lead, Cambridgeshire and Peterborough Clinical Commissioning Group, and Dr D Irwin, GP Mental Health Lead, Hunts Care Partnership, were in attendance for consideration of this item).

Mr I Weller, Strategic Programme Lead for Cambridgeshire and Peterborough Clinical Commissioning Group (CCG), delivered an update on the procurement exercise currently being undertaken in relation to the Older Peoples Programme. He reported that an open competitive tendering process for a range of acute hospital unplanned care, community services, primary care, voluntary sector grants, older people's mental health services and end of life care had been launched in July 2013. Ten providers had been invited to submit outline solutions in August 2013, and five now were taking part in the current stage of the procurement process. Bids had been invited for the whole contract and for smaller defined geographical areas.

A process of evaluation was currently taking place to review the outline submissions received with a view to short listing the bidders down to three providers. These would be invited to submit final solutions, which would be assessed to determine who would be awarded the contract. It was hoped that an announcement would be made in April/May 2014. A twelve week public consultation would then be launched, with the mobilisation phase commencing in late summer/early autumn. The contract would last for five years, with an option to extend it to seven years. Representatives of the CCG acknowledged that the timescales were tight, particularly given that staff would have to transfer across to the new provider.

In response to a question by the Chairman whether any elected Members would be involved in the procurement process, Mr I Weller reported that such provision had not been made but that local authority Officers from both the County and District Councils were assisting with the evaluation phase of the procurement process. Nevertheless, the view was expressed that Members acted as advocates for the public and their involvement would instil in them trust and confidence in the process. Given that bids could be submitted for various combinations of areas, it was suggested that there should be some local Member involvement, especially if the process resulted in arrangements for the Huntingdonshire area that were different from the others.

Following a question about the quality of the services to be provided, Mr I Weller confirmed that the outcomes framework contained a number of quality indicators, which had been based on NHS quality standards. He also advised that the Prospectus for the procurement would shortly be released for publication, with quality appearing as key criteria in determining who would be awarded the contract. Having been advised that the outcomes framework had been tested by a number of interested stakeholders, which included patient user groups, comment was made on the absence of these groups during the evaluation phase of the procurement process. The view was expressed that these individuals would be able to contribute to the evaluation of service delivery.

The Panel echoed the concerns of the Cambridgeshire Adults, Well-Being and Health Overview and Scrutiny Committee over the timetable for the mobilisation of the contract. In response, it was reported that it was likely that the current timescales would change.

Other matters that were discussed included the need to ensure that

the successful bidder would meet local needs, the opportunity that existed to transform primary care services and the added social value that the procurement would bring to the community whilst being mindful of the voluntary sector's role in the tendering process.

At the conclusion of discussions, the Chairman thanked the representatives of the Clinical Commissioning Group for their attendance at the meeting.

77. RECONNECTIONS POLICY FOR HOMELESS PEOPLE WITH NO LOCAL CONNECTION

With the aid of a report by the Head of Customer Services (a copy of which is appended in the Minute Book) the Panel gave consideration to a draft policy which aimed to assist with the prevention of homelessness by reconnecting homeless people with the area with which they had a local connection. By way of background, Mr J Collen, the Council's Housing Needs and Resource Manager, explained that all housing authorities within the Cambridge sub-region were now adopting similar policies with a view to preventing rough sleeping within their areas. It was further explained that the policy formalised practices already employed by the Council through its homeless prevention work. Members were advised that a recent audit had established that there were between 0 and 3 rough sleepers within Huntingdonshire at any one time.

A Member asked whether individuals could be reconnected against their interests. In response, Mr Collen stated that alternative mechanisms were in place for certain cases, for example those who had been subjected to domestic violence, but that the justification for being treated this way was verified with the appropriate authorities.

RESOLVED

> that the Cabinet be recommended to endorse the content of the Reconnections Policy for Homeless People with No Local Connection as appended to the report now submitted.

78. DISCHARGING A HOMELESSNESS DUTY THROUGH THE PRIVATE RENTED SECTOR

Consideration was given to a report by the Head of Customer Services (a copy of which is appended in the Minute Book), which sought endorsement for a policy that would allow the Council to fulfil its duty to a household accepted as homeless by making an offer of suitable private rented sector accommodation. In introducing the report Mr J Collen, Housing Needs and Resource Manager, explained that the Localism Act 2011 had given the Council the power to introduce such a policy but that it was unlikely that the policy would be regularly utilised. Having been advised that Regulations contained criteria that required accommodation to be suitable, safe and reasonable, it was

RESOLVED

> that the Cabinet be recommended to endorse the content of the Policy to Discharge the Council's Homelessness Duties

Through the Private Rented Sector.

79. FACING THE FUTURE

Pursuant to Minute Nos 13/59, 62, 67 and 71, the Chairman delivered an update on the Facing the Future process. The Overview and Scrutiny Chairmen and Vice-Chairmen had met on 18th December 2013 to review the complete list of potential savings suggestions and the priorities that they had been accorded. Further meetings would be held on 9th and 16th January 2014. The latter would involve the Council's Chief Officers Management Team. In addition it was noted that an informal Cabinet away-day had been arranged for late January 2014 to enable Executive Councillors to consider the outcome of the Panels' deliberations and their own priorities. Reports on progress would then be submitted to Overview and Scrutiny and to the Cabinet in February 2014.

80. CAMBRIDGESHIRE ADULTS, WELL-BEING AND HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Councillor J W G Pethard reported on matters currently being considered by the Cambridgeshire Adults, Wellbeing and Health Overview and Scrutiny Committee. These included the Adult Social Care, Older People and Mental Health Services Business Plans, the Commissioning of Older People's Services and Sheltered Housing at Langley Court and Langley Close, St Ives. Having been advised that the County Council would be changing its governance arrangements to the Committee system in the new Municipal Year, Members were informed that the Adults, Well-Being and Health Overview and Scrutiny Committee would continue to exist because the authority still had a duty to scrutinise health matters.

(At this point during the meeting (8.40pm) Councillor S M Van De Kerkhove left the meeting).

81. WORK PLAN STUDIES

The Panel received and noted a report by the Head of Legal and Democratic Services (a copy of which is appended in the Minute Book) which contained details of studies being undertaken by the Overview and Scrutiny Panels for Economic Well-Being and Environmental Well-Being.

82. OVERVIEW AND SCRUTINY PANEL (SOCIAL WELL-BEING) - PROGRESS

The Panel received and noted a report by the Head of Legal and Democratic Services (a copy of which is appended in the Minute Book) which contained details of actions taken in response to recent discussions and decisions. It was reported that a meeting of the Hinchingbrooke Hospital Joint Working Group would be held on 23rd January 2014. Brief updates were also received on the Corporate Plan, Voluntary Sector, Consultation Processes and Social Value Working Groups. A meeting of the Elderly Patient Care Working Group would be arranged to consider the End of Life Pathway.

Pursuant to Minute No. 13/75, the Panel agreed that representatives

of the mental health service user group should be invited to a future Panel meeting with a view to gaining an understanding of local residents' experience of the service. A suggestion was made and accepted that the invitation should be extended to Hunts Mind and various other relevant voluntary groups within the District.

Further to the earlier discussions on the procurement of the Older People's Programme (Minute No. 13/76 refers) the Panel reiterated its concerns over the tight timescales proposed for and the absence of any Elected Member representation from the procurement process. In noting that Dr S Lammin, Head of Environmental and Community Health Services, was the District Council's lead Officer in this area, it was agreed that her views should be sought on the best way for the Panel to obtain feedback on the procurement process.

83. SCRUTINY

The 140th Edition of the Decision Digest was received and noted.

Chairman

Huntingdonshire
DISTRICT COUNCIL

NOTICE OF EXECUTIVE KEY DECISIONS INCLUDING THOSE TO BE CONSIDERED IN PRIVATE

Prepared by **Councillor J D Ablewhite Miss Effe Chrisostomou**
Date of Publication: **15 January 2014**
For Period: **3 February 2014 to 31 May 2014**

Membership of the Cabinet is as follows:-

Councillor J D Ablewhite	- Leader of the Council, with responsibility for Strategic Economic Development	3 Pettis Road St. Ives Huntingdon PE27 6SR Tel: 01480 466941 E-mail: Jason.Ablewhite@huntingdonshire.gov.uk
Councillor N J Guyatt	- Deputy Leader of the Council with responsibility for Strategic Planning and Housing	6 Church Lane Stibbington Cambs PE8 6LP Tel: 01780 782827 E-mail: Nick.Guyatt@huntingdonshire.gov.uk
Councillor B S Chapman	- Executive Councillor for Customer Services	6 Kipling Place St. Neots Huntingdon PE19 7RG Tel: 01480 212540 E-mail: Barry.Chapman@huntingdonshire.gov.uk
Councillor J A Gray	- Executive Councillor for Resources	Vine Cottage 2 Station Road Catworth PE28 OPE Tel: 01480 861941 E-mail: Jonathan.Gray@huntingdonshire.gov.uk
Councillor R Howe	- Executive Councillor for Healthy and Active Communities	The Old Barn High Street Upwood Huntingdon PE26 2QE Tel: 01487 814393 E-mail: Robin.Howe@huntingdonshire.gov.uk

Councillor T D Sanderson	- Executive Councillor for Healthy and Active Communities	29 Burmoor Close Stukeley Meadows Huntingdon PE29 6GE Tel: 01480 412135 E-mail: Tom.Sanderson@huntingdonshire.gov.uk
Councillor D M Tysoe	- Executive Councillor for Environment	Grove Cottage Maltings Lane Ellington Huntingdon PE28 OAA Tel: 01480 388310 E-mail: Darren.Tysoe@huntingdonshire.gov.uk

Notice is hereby given of:

- Key decisions that will be taken by the Cabinet (or other decision maker)
- Confidential or exempt executive decisions that will be taken in a meeting from which the public will be excluded (for whole or part).

A notice/agenda together with reports and supporting documents for each meeting will be published at least five working days before the date of the meeting. In order to enquire about the availability of documents and subject to any restrictions on their disclosure, copies may be requested by contacting Mrs Helen Taylor, Senior Democratic Services Officer on 01480 388008 or E-mail Helen.Taylor@huntingdonshire.gov.uk.

Agendas may be accessed electronically at www.huntingdonshire.gov.uk.

Formal notice is hereby given under The Local Authorities (Executive Arrangements) (Meetings and Access to Information) (England) Regulations 2012 that, where indicated part of the meetings listed in this notice will be held in private because the agenda and reports for the meeting will contain confidential or exempt information under Part 1 of Schedule 12A to the Local Government (Access to Information) Act 1985 (as amended) and that the public interest in withholding the information outweighs the public interest in disclosing it. See the relevant paragraphs below.

Any person who wishes to make representations to the decision maker about a decision which is to be made or wishes to object to an item being considered in private may do so by emailing Legal&DemServDemocratic@huntingdonshire.gov.uk or by writing to the Senior Democratic Services Officer. If representations are received at least eight working days before the date of the meeting, they will be published with the agenda together with a statement of the District Council's response. Any representations received after this time will be verbally reported and considered at the meeting.

Paragraphs of Part 1 of Schedule 12A to the Local Government (Access to Information) Act 1985 (as amended) (Reason for the report to be considered in private)

1. Information relating to any individual
2. Information which is likely to reveal the identity of an individual
3. Information relating to the Financial and Business Affairs of any particular person (including the Authority holding that information)
4. Information relating to any consultations or negotiations or contemplated consultations or negotiations in connection with any labour relations that are arising between the Authority or a Minister of the Crown and employees of or office holders under the Authority
5. Information in respect of which a claim to legal professional privilege could be maintained in legal proceedings
6. Information which reveals that the Authority proposes:-
   (a) To give under any announcement a notice under or by virtue of which requirements are imposed on a person; or
   (b) To make an Order or Direction under any enactment
7. Information relating to any action taken or to be taken in connection with the prevention, investigation or prosecution of crime.

Colin Meadowcroft
Head of Legal and Democratic Services

Huntingdonshire District Council
Pathfinder House
St Mary's Street
Huntingdon PE29 3TN.

Notes:- (i) Additions changes from the previous Forward Plan are annotated ***
(ii) Part II confidential items which will be considered in private are annotated ## and shown in italic.

Subject/Matter for Decision	Decision/ recommendation to be made by	Date decision to be taken	Documents Available	How relevant Officer can be contacted	Reasons for the report to be considered in private.	Relevant Executive Councillor	Relevant Overview & Scrutiny Panel
Service Delivery Options###	Cabinet	13 Feb 2014		Steve Couper, Assistant Director of Finance and Resources Tel No 01480 388103 or email Steve.Couper@huntingdonshire.gov.uk		J D Ablewhite	Economic Well-Being
Facing the Future - Suggested Priorities	Cabinet	13 Feb 2014		Steve Couper, Assistant Director of Finance and Resources Tel No 01480 388103 or email Steve.Couper@huntingdonshire.gov.uk		J A Gray	All
Budget & MTP	Cabinet	13 Feb 2014		Steve Couper, Assistant Director of Finance and Resources Tel No 01480 388103 or email Steve.Couper@huntingdonshire.gov.uk		J A Gray	Economic Well-Being
Treasury Management Strategy	Cabinet	13 Feb 2014		Steve Couper, Assistant Director of Finance and Resources Tel No 01480 388103 or email Steve.Couper@huntingdonshire.gov.uk		J A Gray	Economic Well-Being

Subject/Matter for Decision	Decision/ recommendation to be made by	Date decision to be taken	Documents Available	How relevant Officer can be contacted	Reasons for the report to be considered in private	Relevant Executive Councillor	Relevant Overview & Scrutiny Panel
Corporate Plan	Cabinet	13 Feb 2014		Howard Thackray, Policy and Strategic Services Manager Tel No 01480 388035 or email Howard.Thackray@huntingdonshire.gov.uk		J D Ablewhite	All
Local Plan to 2036 - Proposed Submission	Cabinet	20 Mar 2014	Submission - Draft Local Plan	Paul Bland, Planning Service Manager (Policy) Tel No. 01480 388430 or email Paul.Bland@huntingdonshire.gov.uk		N J Guyatt	Environmental Well-Being
Carbon Management Plan	Cabinet	20 Mar 2014		Chris Jablonski, Environment Team Leader Tel No. 01480 388368 or email Chris.Jablonski@huntingdonshire.gov.uk		D M Tysoe	Environmental Well-Being
Green Deal	Cabinet	20 Mar 2014		Chris Jablonski, Environment Team Leader Tel No. 01480 388368 or email Chris.Jablonski@huntingdonshire.gov.uk		D M Tysoe	Environmental Well-Being
Huntingdonshire Infrastructure Business Plan	Cabinet	20 Mar 2014		Paul Bland, Planning Service Manager (Policy) Tel No. 01480 388430 or email Paul.Bland@huntingdonshire.gov.uk		N J Guyatt	Environmental Well-Being
Huntingdon West Masterplan	Cabinet	20 Mar 2014	Following consultation. Preferred option.	Paul Bland, Planning Service Manager (Policy) Tel No. 01480 388430 or email Paul.Bland@huntingdonshire.gov.uk		N J Guyatt	Environmental Well-Being
Wind Turbines SPD	Cabinet	20 Mar 2014	Draft SPD	Paul Bland, Planning Service Manager (Policy) Tel No. 01480 388430 or email Paul.Bland@huntingdonshire.gov.uk		N J Guyatt	Environmental Well-Being

Subject/Matter for Decision	Decision/ recommendation to be made by	Date decision to be taken	Documents Available	How relevant Officer can be contacted	Reasons for the report to be considered in private	Relevant Executive Councillor	Relevant Overview & Scrutiny Panel
Consultation and Engagement Strategy	Cabinet	10 Apr 2014		Louise Sboui, Senior Policy Officer Tel No. 01480 388032 or email Louise.Sboui@huntingdonshire.gov.uk		J D Ablewhite	Social Well-Being
Huntingdon and Godmanchester Market Town Transport Strategy	Cabinet	10 Apr 2014	Market Town Transport Strategy	Paul Bland, Planning Service Manager (Policy) Tel No. 01480 388430 or email Paul.Bland@huntingdonshire.gov.uk		N J Guyatt	Environmental Well-Being
A14	Cabinet	10 Apr 2014		Steve Ingram, Assistant Director, Environment, Growth and Planning Tel No. 01480 388400 or email Steve.Ingram@huntingdonshire.gov.uk		N J Guyatt	Environmental Well-Being

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NHS
Cambridgeshire and Peterborough
Clinical Commissioning Group

MEETING: **CCG GOVERNING BODY**

AGENDA ITEM: **3.1**

DATE: **7 JANUARY 2014**

TITLE: **FINANCE AND PERFORMANCE COMMITTEE - SUMMARY**

FROM: **EDWARD LIBBEY, CHAIR OF FINANCE AND PERFORMANCE COMMITTEE**

FOR: **INFORMATION**

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1 ISSUE

1.1 The Finance and Performance Committee is a formal sub-committee of the Cambridgeshire and Peterborough Clinical Commissioning Group (CCG) Governing Body. It meets on a monthly basis to monitor finance and performance on behalf of the Governing Body, consider possible risks to future performance, and engender a high performance culture.

1.2 The latest meeting of the Committee will be held via Telecon on 6 January 2014. A verbal update on any specific issues arising from this meeting will therefore be given by the Chair at the Governing Body meeting.

2 STRATEGIC AIMS/ EQUALITY AND DIVERSITY GOALS AND CCG ASSURANCE FRAMEWORK AND RISK REGISTER REFERENCE

2.1 This report links Strategic Aims 2 (Finance), 4 (Contracts Management & Performance) 6 (Governance). It is also links to a number of CCG Assurance Framework Risks, including F2 – *risks associated with on-going CHC claims process*; F3 – *Achievement of the Financial plan for 2013/14;* CMT1 – *risks to delivery of QIPP and System Reform Plan*; CMP2 – *failure to achieve key performance targets* and G2 – *Risk to on-going development of CCG Governance arrangements.* The report also links to EDS Goal 4 – Inclusive leadership at all levels.

3. RECOMMENDATION

2.1 The Governing Body is asked to note that a verbal update on the last Finance and Performance Committee is to be given at the meeting.

Author ***Name*** ***Simon Barlow***
Title ***Corporate Governance Manager***
Date ***6 December2013***

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NHS
Cambridgeshire and Peterborough
Clinical Commissioning Group

MEETING: CCG GOVERNING BODY IN PUBLIC

AGENDA ITEM: 3.2

DATE: 7 JANUARY 2014

TITLE: FINANCE REPORT – CAMBRIDGESHIRE AND PETERBOROUGH CCG

FROM: TIM WOODS
CHIEF FINANCE OFFICER

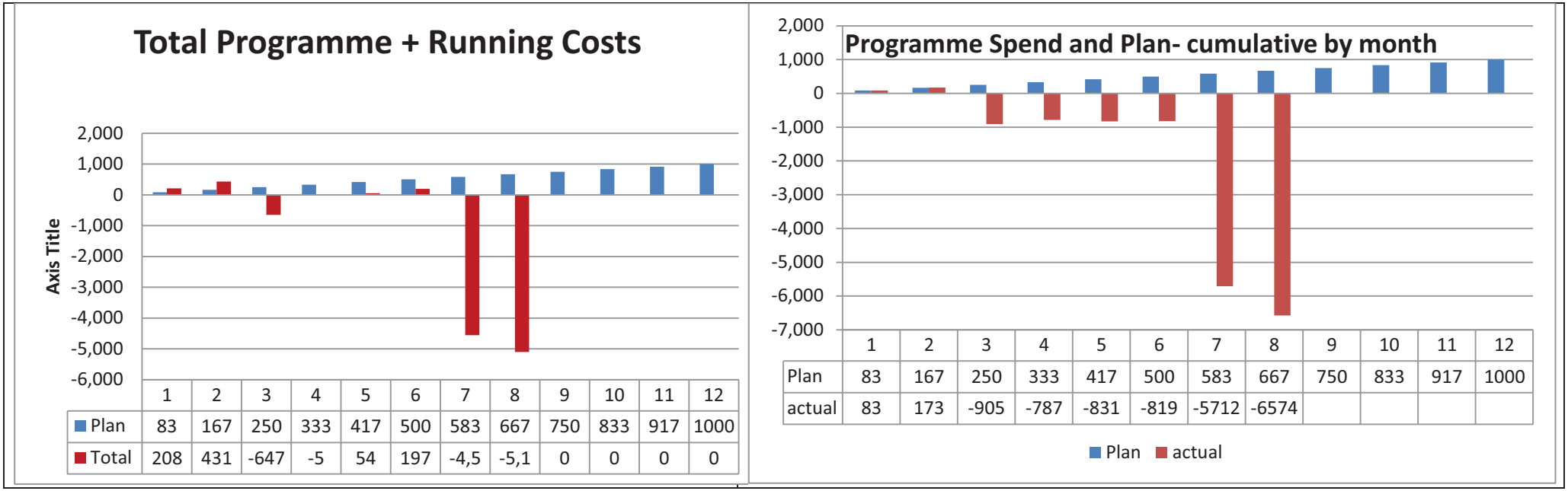
FOR: INFORMATION AND DISCUSSION

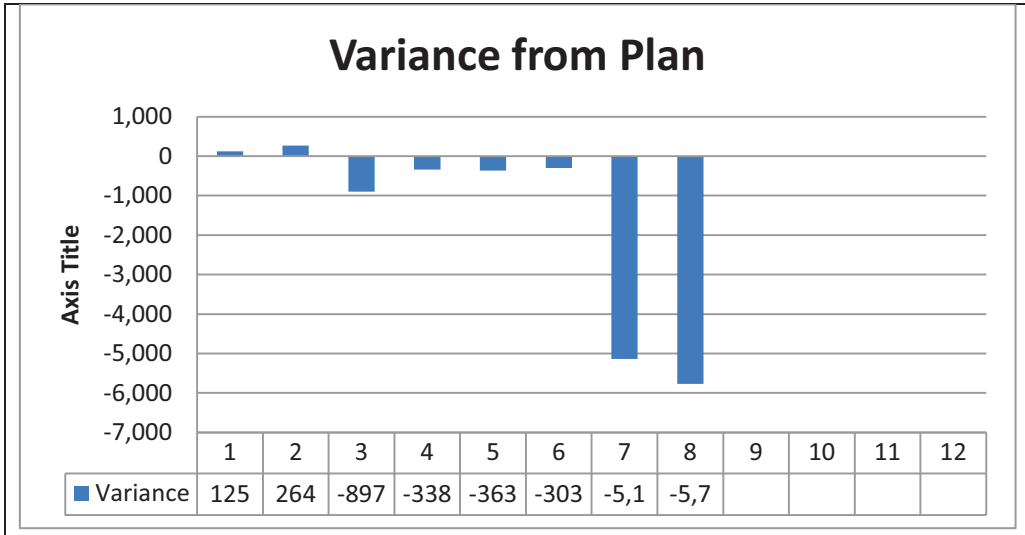
15

1 FINANCIAL OVERVIEW

Year to date summary

	I&E Summary - November 2013 (Month 8)							
	Year to Date				Forecast Position			
	Plan	Actual	Variance Fav / (Adv)		Plan	Actual	Variance Fav / (Adv)	
	£'000	£'000	£'000	%	£'000	£'000	£'000	%
Programme	570,242	576,711	(6,468)	(1.1)%	861,941	871,896	(9,955)	(1.2)%
Running Costs	13,761	12,395	1,366	9.9%	20,800	18,953	1,847	8.9%
Total	**584,003**	**589,106**	**(5,102)**	**(0.9)%**	**882,741**	**890,849**	**(8,108)**	**(0.9)%**





Key Points

- Table 1, above, shows the CCG is reporting a year to date programme deficit of £6,468,000, this is partially offset by the year to date surplus on running costs of £1,366,000 leaving the CCG with a year to date combined deficit of £5,102,000. Based on this, the forecast deficit made in early December was £8.1m, a £0.5m improvement since month 7.

- The CCG had disputed some elements of the specialist rebasing exercise; the result has been a £2.5m return of resource to the CCG, £1.9m less than anticipated at month 7. The impact of this £1.9m reduction in resource has been offset by the impact of £1.3m of financial recovery plan actions and other spending reductions.

- The remaining impact of the Financial Recovery Plan is excluded from this forecast but will be included at month 9; it is anticipated that when this is done and following the work done with the Turnaround team, we should be able to reduce the forecast end of year deficit to circa £5.0m.

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2. STRATEGIC AIMS/EQUALITY AND DIVERSITY GOALS AND CCG GOVERNING BODY ASSURANCE FRAMEWORK & RISK REGISTER REFERENCE

2.1 The paper links to Strategic Aims 2 (Finance) and 3 (Change Management and Transformation) and links specifically to the following risks on the CCG Governing Body Assurance Framework and Risk Register: F2 – Achievement of the Financial plan for 2013/14: F2 – Risks associated with the on-going retrospective NHS CHC claims process; and CMT1 – Risk to delivery of QIPP and the System Reform Plan.

2.2 It also links to EDS Goal 1 – Better health outcomes for all.

3. CCG ASSURANCE – FINANCIAL PERFORMANCE

NHS England has produced a CCG assurance process; the table above covers the financial performance element. The column "CCG Performance" shows our assessment of the CCG against the standards where we have one red indicator.

Financial Performance			Individual indicator RAG Rating Threshold				
No.	Indicator	Primary / supporting indicator	CCG performance	Green	Amber Green	Amber / Red	Red
1	Underlying recurrent surplus	Primary	-0.8%	>= 2%	1% - 1.99%	0% - 0.99%	< 0%
2	Surplus - year to date performance	Primary	-0.9%	>=1%	>= 0.8%	>= 0.5%	< 0.1%
3	Surplus - full year forecast	Primary	-1.0%	>=1%	>= 0.8%	>= 0.5%	< 0.1%
4	Management of 2% NR funds within agreed process	Supporting	Yes	Yes			No
5	QIPP - year to date delivery	Primary	63%	>= 95% of plan	>= 80% of plan	>= 50% of plan	< 50% of plan
6	QIPP - full year forecast	Primary	88%	>= 95% of plan	>= 80% of plan	>= 50% of plan	< 50% of plan
7	Activity trends year to date	Supporting	*	<101% of plan	<102% of plan	<103% of plan	< 104% of plan
8	Activity trends - full year forecast	Supporting	*	<101% of plan	<102% of plan	<103% of plan	< 104% of plan
9	Running costs	Primary	= RCA	<=RCA			> RCA
10	Clear identification of risks against financial delivery and mitigations	Primary		Indicator met in full	Indicator part met - limited uncovered risk	Indicator part met - material uncovered risk	Indicator not met

4. LCG Performance – November (Month 8)

- The tables across and on the next page show the LCG performance at month 8 for programme and running cost budgets.
- The programme LCG budgets are based on the historical spend for each area. Actuals reported against this, where ever possible, are based on usage.
- LCGs need to focus on the devolved line as this is the area of spend over which they have most control and/or influence. As at month 8, all LCGs except Hunts Health have an adverse variance on this line. The most significant in % terms is CamHealth.
- With respect to the CCG central budgets, these have been allocated to LCGs to minimise LCG overspends.

Local Commissioning Group		Year to Date				Forecast Position			
		Plan £'000	Actual £'000	Variance Fav/(Adv) £'000	%	Plan £'000	Actual £'000	Variance Fav/(Adv) £'000	%
Borderline	Programme devolved	71,656	71,970	(314)	(0.4)	108,208	108,836	(628)	(0.6)
	Running Costs	1,688	1,535	153	9	2,551	2,325	226	9
	Total LCG devolved	***73,344***	***73,505***	***(161)***	***(0.2)***	***110,759***	***111,161***	***(402)***	***(0.4)***
	CCG Central	1,023	619	403	39.4	3,013	2,611	402	13.3
	Total	**74,367**	**74,125**	**242**	**0.3**	**113,772**	**113,772**	**0**	**0.0**
Peterborough	Programme devolved	93,968	94,981	(1,013)	(1.1)	142,408	144,714	(2,306)	(1.6)
	Running Costs	2,158	1,983	175	8	3,262	3,003	259	8
	Total LCG devolved	***96,126***	***96,964***	***(838)***	***(0.9)***	***145,670***	***147,717***	***(2,046)***	***(1.4)***
	CCG Central	1,684	840	843	50.1	4,088	2,042	2,046	50.0
	Total	**97,810**	**97,805**	**5**	**0.0**	**149,759**	**149,759**	**(0)**	**(0.0)**
Camhealth	Programme devolved	47,532	50,110	(2,578)	(5.4)	71,194	75,345	(4,151)	(5.8)
	Running Costs	1,347	1,213	134	10	2,037	1,810	227	11
	Total LCG devolved	***48,879***	***51,323***	***(2,444)***	***(5.0)***	***73,231***	***77,154***	***(3,924)***	***(5.4)***
	CCG Central	2,020	441	1,579	78.2	2,145	292	1,854	86.4
	Total	**50,899**	**51,764**	**(865)**	**(1.7)**	**75,376**	**77,446**	**(2,070)**	**(2.7)**
CATCH	Programme devolved	119,194	123,395	(4,202)	(3.5)	180,052	187,421	(7,369)	(4.1)
	Running Costs	3,374	3,019	355	11	5,108	4,614	494	10
	Total LCG devolved	***122,568***	***126,414***	***(3,847)***	***(3.1)***	***185,160***	***192,035***	***(6,875)***	***(3.7)***
	CCG Central	4,124	1,060	3,064	74.3	5,154	1,077	4,078	79.1
	Total	**126,691**	**127,474**	**(783)**	**(0.6)**	**190,314**	**193,112**	**(2,798)**	**(1.5)**

- All LCGs are under spending against running costs and this is mitigating but not eliminating the adverse variances.

Local Commissioning Group		Year to Date				Forecast Position			
		Plan	Actual	Variance Fav/(Adv)		Plan	Actual	Variance Fav/(Adv)	
		£'000	£'000	£'000	%	£'000	£'000	£'000	%
Hunts Care Partners	Programme devolved	78,384	80,899	(2,514)	(3.2)	117,395	120,577	(3,182)	(2.7)
	Running Costs	1,780	1,612	168	9.4	2,690	2,411	279	10.4
	Total LCG devolved	***80,164***	***82,511***	***(2,346)***	***(2.9)***	***120,085***	***122,988***	***(2,903)***	***(2.4)***
	CCG Central	1,522	668	854	56.1	3,251	890	2,361	72.6
	Total	**81,686**	**83,179**	**(1,493)**	**(1.8)**	**123,336**	**123,878**	**(542)**	**(0.4)**
Hunts Health	Programme devolved	49,545	49,584	(39)	(0.1)	74,780	74,451	329	0.4
	Running Costs	1,198	1,046	152	12.7	1,811	1,642	169	9.3
	Total LCG devolved	***50,743***	***50,630***	***113***	***0.2***	***76,591***	***76,093***	***498***	***0.7***
	CCG Central	1,030	426	604	58.6	2,074	2,073	0	0.0
	Total	**51,773**	**51,056**	**717**	**1.4**	**78,665**	**78,166**	**498**	**0.6**
Isle of Ely	Programme devolved	59,853	63,084	(3,231)	(5.4)	89,858	94,403	(4,545)	(5.1)
	Running Costs	1,483	1,307	176	11.9	2,242	2,090	152	6.8
	Total LCG devolved	***61,336***	***64,391***	***(3,055)***	***(5.0)***	***92,100***	***96,493***	***(4,394)***	***(4.8)***
	CCG Central	2,120	520	1,600	75.5	2,531	378	2,153	85.1
	Total	**63,455**	**64,911**	**(1,456)**	**(2.3)**	**94,630**	**96,871**	**(2,241)**	**(2.4)**
Wisbech	Programme devolved	36,322	37,780	(1,458)	(4.0)	54,173	56,463	(2,290)	(4.2)
	Running Costs	731	679	52	7.1	1,106	1,059	47	4.3
	Total LCG devolved	***37,053***	***38,459***	***(1,406)***	***(3.8)***	***55,279***	***57,522***	***(2,243)***	***(4.1)***
	CCG Central	266	332	(66)	(24.7)	1,613	324	1,290	79.9
	Total	**37,319**	**38,791**	**(1,471)**	**(3.9)**	**56,893**	**57,846**	**(954)**	**(1.7)**

5. Programme Spend – November 2013 (Month 8)

- The programme budget is showing a year to date overspend of £6.5m and a forecast overspend of £10.0m, this is partially offset by an underspend on running costs but the CCG is now forecasting a year end deficit of £8.1m The impact of the specialist services rebasing materialised has now been included in the year to date position.
- 8/12ths of all contingencies have been played in to the year to date position.
- The main reasons for the year to date overspend are acute contract over performance shortfalls in some of the QIPP schemes, the wheelchair service within the "other community" line and the shortfall in specialist rebasing.
- As can be seen, the three acute Trusts are over performing. More detail in respect of this can be found in the performance report.
- The CCG total QIPP requirement for the year is £26.8m, £18.2m of which has been built into budgets, leaving £8.5m. The forecast deficit is reliant on an additional savings of £1.9m to be found, mainly from contract penalties and challenges.
- This is a serious position which means the CCG will not be able to meet its statutory financial duty. Hence, a financial recovery plan has been produced and a financial turnaround team appointed.

	Year to Date £'000				Forecast Position £'000			
	Plan	Actual	Variance		Plan	Actual	Variance	
ACUTE SERVICES								
CUHFT	119,380	122,150	(2,770)	(2.3)	178,545	183,242	(4,697)	(2.6)
Peterborough	79,861	83,335	(3,474)	(4.3)	119,792	125,003	(5,211)	(4.3)
Hinchingbrooke	54,907	57,433	(2,526)	(4.6)	82,014	84,919	(2,905)	(3.5)
Kings Lynn & Wisbech	16,477	17,040	(564)	(3.4)	24,715	25,561	(846)	(3.4)
Papworth	8,781	8,781	0	0.0	12,938	12,938	0	0.0
East of England Ambulance	16,655	16,136	520	3.1	24,983	24,383	600	2.4
Other Acute	22,116	24,081	(1,964)	(8.9)	38,124	41,181	(3,057)	(8.0)
Subtotal	**318,178**	**328,956**	**(10,779)**	**(3.4)**	**481,111**	**497,226**	**(16,116)**	**(3.3)**
MENTAL HEALTH SERVICES								
Cambs and Pboro FT	44,565	44,494	71	0.2	66,847	66,741	106	0.2
Other	17,738	18,051	(313)	(1.8)	26,607	26,895	(288)	(1.1)
Subtotal	**62,303**	**62,545**	**(242)**	**(0.4)**	**93,454**	**93,636**	**(181)**	**(0.2)**
COMMUNITY SERVICES								
Cambs Community Services	49,483	49,411	72	0.1	73,854	73,804	50	0.1
CPFT Pboro children's	2,292	2,216	76	3.3	3,438	3,324	114	3.3
Other Community Services	13,434	14,636	(1,202)	(8.9)	20,522	22,575	(2,054)	(10.0)
Individual Placements	30,416	30,857	(440)	(1.4)	45,625	46,736	(1,111)	(2.4)
Subtotal	**95,625**	**97,120**	**(1,495)**	**(1.6)**	**143,438**	**146,439**	**(3,001)**	**(2.1)**
PRIMARY CARE								
GP Prescribing	68,526	70,239	(1,713)	(2.5)	102,789	103,750	(961)	(0.9)
Prescribing Support	2,449	2,452	(3)	(0.1)	3,674	3,652	22	0.6
Other Primary Care (OOHs & PDMA)	10,731	9,578	1,153	10.7	16,522	14,971	1,551	9.4
Subtotal	**81,706**	**82,269**	**(563)**	**(0.7)**	**122,985**	**122,373**	**612**	**0.5**
TRANSFORMATION								
LCG agreed business cases (2%)	913	913	0	0.0	2,534	2,534	0	0.0
LCG QIPP not in budgets / contracts	(2,271)		(2,271)	1.0	(5,451)		(5,451)	
Subtotal	**(1,358)**	**913**	**0**	**0.0**	**(2,917)**	**2,534**	**0**	**0.0**
LCG DEVOLVED BUDGETS	**556,454**	**571,804**	**(15,350)**	**(2.8)**	**838,071**	**862,209**	**(24,138)**	**(2.9)**
CCG CENTRAL BUDGETS								
Contingency	2,847	0	2,847	100.0	4,270	0	4,270	100.0
Innovation fund 2% reserve	10,403	330	10,073	0.0	14,440	2,989	11,451	79.3
QIPP not in budgets / contracts	(3,439)	0	(3,439)	0.0	(3,114)	(1,900)	(1,214)	39.0
Earmarked Reserves	8,836	4,577	4,259	0.0	15,570	8,598	6,972	44.8
Specialist shortfall	(4,858)	0	(4,858)	1.0	(7,296)	0	(7,296)	100.0
TOTAL EXPENDITURE	**570,242**	**576,711**	**(6,468)**	**(1.1)**	**861,941**	**871,896**	**(9,955)**	**(1.2)**

6. Financial Risks not included in the I&E position

- This table shows the current assessment of the CCGs risks, those risks that have been built into the month 8 forecast, the residual risk and the resources available to offset these risks.
- As can be seen, the risks relating to specialist services have been built into the forecast and the CCG does not have sufficient mitigations to offset this and is therefore reporting a deficit.
- The current reported financial position and additional risks identified, confirms that without continued and further action the CCG will miss its financial plan. In addition to the actions below, the CCG has also produced a financial recovery plan a final version of which will be sent to NHSE at the end of November.
  - A strong focus on' Living within our means'. This will include practices, LCG and central CCG actions.
  - Focused contract management, to be led by the LCG contract teams supported by finance and information.
  - Line by line forensic review across all budget areas.
  - Complete the review of all third sector commitments. This is being led initially by finance supported by contracts.
- Due to the extent of the financial problem it is unlikely the CCG will achieve its duty to breakeven even with delivery of the above actions and financial recovery plan. However, minimising this year's deficit will improve the financial position of the CCG in 2014/15.

	Total Risk £'000	Risk assessment %	Assessed Risk £'000	In Forecast £'000	Residual Risk £'000
Current identified risks not included in CCG forecast					
Specialist	(15,641)	81%	(12,691)	(12,691)	0
QIPP non-delivery	(26,700)	32%	(8,567)	(8,567)	0
Contract Over performance	(15,000)	93%	(13,875)	(13,875)	0
CHC in year costs & assessment of provision	(8,000)	50%	(4,000)	(3,000)	(1,000)
Baseline issues emerging at year-end	(4,000)	85%	(3,400)	(1,400)	(2,000)
GP Prescribing	(6,000)	16%	(961)	(961)	
Other budget overspends			(1,806)	(1,806)	
Current assessment of Risk	**(75,341)**		**(45,300)**	**(42,300)**	**(3,000)**
Planned surplus			**2,441**	**2,441**	**0**
Forecast deficit if risks crystallise			**(42,859)**	**(39,859)**	**(3,000)**
Current Mitigations					
Contingency 0.5%			4,240	4,240	0
2% trans uncommitted			11,451	11,451	0
Reserves			6,972	6,972	0
Running costs underspend			1,847	1,847	0
Additional QIPP identified			2,700	2,700	0
Non-recurrent B/fwd PCT surpluses			2,641	2,641	0
Current Mitigations			**29,851**	**29,851**	**0**
Current shortfall in mitigations			**(13,008)**	**(10,008)**	**(3,000)**
Further actions to be implemented					
Actively participate in specialist rebasing	8,800	0%	0	0	0
Continue to drive QIPP (living within or means)	5,867	60%	3,500	200	
Robust contract management not already in FOT	2,600	65%	1,700	1,700	0
Further actions to be implemented	**17,267**		**5,200**	**1,900**	**0**
Potential headroom			**(7,808)**	**(8,108)**	**(3,000)**

6. Conclusions

It is clear that the CCG is facing a significant financial challenge in 13/14 due a combination of factors a) pressure on acute contracts; b) issues with respect to our baseline allocation; c) less than full delivery of planned savings. This is a serious financial position and the organisation is doing its utmost to mitigate this in order for the CCG to meet its statutory financial duty.

This position after eight months informs us that in addition to the current actions and planned savings, we need further savings. As reported previously, we have begun to implement further actions called 'Living within our means'. This has focused on referrals, prescribing; contract challenges, clinical thresholds, individual placement costs in Peterborough; in addition all, other areas of spend have been reviewed on a line by line basis. This has been further strengthened in the last four weeks with weekly task and action meetings plus the appointment of an external Turnaround Team. Based on the early turnaround work, it is forecast that the deficit will be able to be reduced within the range of £3.0 to £5.0m. Nevertheless, all effort will continue to be made to enable further improved assessments to be made as we approach the end of the financial year.

The Governance for this approach is being led by the Chief Clinical Officer with the Chief Operating Officer deputising. Co-ordination of the recovery programme will also be the responsibility of the Director of Director of Delivery and the Chief Finance Officer. The Turnaround Director will be accountable to the Chief Clinical Officer with a reporting line to the Area Team of NHS England.

7. Recommendation

The Finance and Performance Committee is asked to note the financial position at month 8, the risks associated with the year end forecast and the actions being taken to address these and mitigate the adverse financial outlook.

Author: **Wanda Kerr,**
Title: **Deputy Chief Finance Officer**
Date: **31 December 2013**

Reviewed and presented by: **Tim Woods, Chief Financed Officer.**

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2013/14 Integrated delivery report

- January 6 2014

NHS
Cambridgeshire and Peterborough
Clinical Commissioning Group

Contents

Executive summary

Comments |

As previously reported, the CCG Assurance Framework has been published by NHS England (Dec 2013 final version). The CCG has aligned its reporting to the methodology and thresholds included within the CCG assurance framework and the integrated report has been updated to reflect this.

The balanced scorecard is required to be published by each CCG and the latest one is provided below:

Cambridgeshire and Peterborough CCG | Balanced scorecard	
Are local people getting good quality care?	Amber green
Are patient rights under the NHS Constitution being promoted?	Amber red
Are health outcomes for local people improving?	Amber red
Are CCGs commissioning services within their financial allocations?	Red
Are conditions of CCG authorisation being addressed and removed?	Yes

- For the good quality care domain, the CCG self assessment remains at amber green.
- For the NHS Constitution domain, the CCG self assessment is amber red, as A&E and Ambulance performance is still below the required standard.
- For the health outcomes domain, the CCG self assessment is amber red as HCAI is off track for achievement of the quality premium.
- For the Finance domain, the CCG self assessment is red due to the CCG forecasting a year end deficit of £8.6m.

Section one

GOOD QUALITY CARE

Domain scorecard

CCG assurance framework - updated 13/11/2013

Indicator:	CUHFT	HHT	PSHFT	Papworth	CCS	CPFT	QEKL
Has local provider been subject to enforcement action by the CQC?	N	N	N	N	N	N	Y
Has local provider been flagged as a "quality compliance risk" by Monitor and / or are requirements in place around breaches of provider licence conditions?	Y		Y	N		N	Y
Has local provider been subject to enforcement action by the NHS TDA based on quality risk?							
Does feedback from the Friends and Family Test (or any other patient feedback) indicate cause for concern?	Y	N	N	N	N	N	Y
Has the provider been identified as a 'negative outlier' on SHMI or HSMR	N	N	N	N	N	N	N
MRSA cases above zero?	Y	N	N	N	N	N	N
More C diff than trajectory?	Y	N	Y	N	N	N	N
MSA breaches are above zero?	N	N	N	N	N	N	N
Unclosed SUIs?	Y	N	Y	Y	Y	N	N
Has the provider experienced any never events during the last quarter? (July - Sept 2013)	N	N	Y	N	N	N	N
	5	0	4	1	1	0	3

CCG

Does the CCG have any outstanding conditions of authorisation in place on clinical governance?	N
Concerns around quality issues being discussed regularly by the CCG Governing Body	N
Concerns around early warning of failing service?	N
Concerns re arrangements in place for SUIs?	N
Concerns re active participant in Quality Surveillance Group?	N

EPRR*

If there was an event in the last quarter, has CCG self-assessed....	N

Winterbourne

Has the CCG self assessed and identified any risk to progress against its Winterbourne View action plan?	N
	0

Score: 14 out of 63 **22%**

Key

Green | All No responses

Amber / green | One or more Yes responses but action plan in place to successfully mitigate patient risk

Amber / red | One or more Yes responses but action plan not in place, does not successfully mitigate patient risk

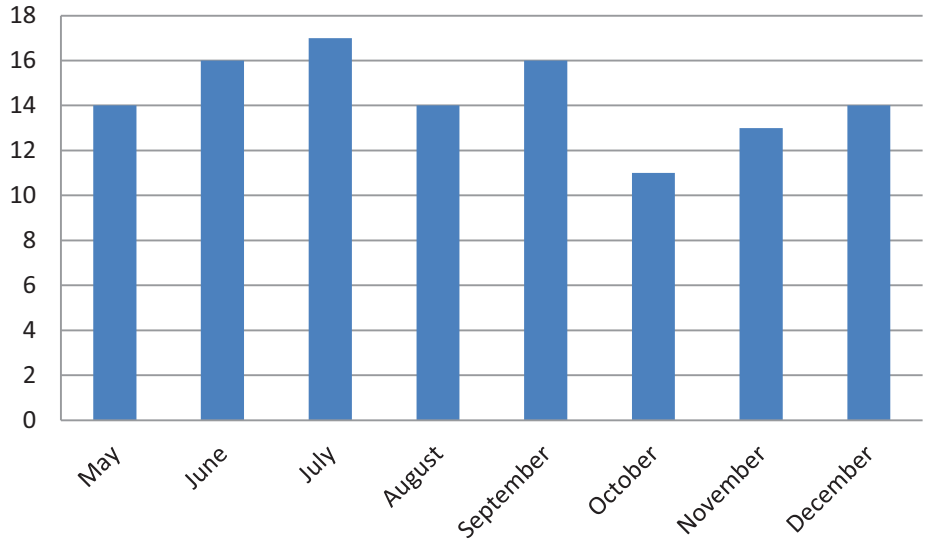
Red | Enforcement action in place and CCG not engaged in proportionate action planning to address patient risk

* Emergency Preparedness Resilience and Response

CCG self assessment of Amber/Green

Domain scorecard

Fig 1. CCG Assurance Framework Performance Year to Date



Comments

14 areas out of 63 have been flagged as Yes by the CCG, showing a small increase from the previous month.

Provider Overview

Quality and Patient Safety Provider Summary

10 – Dec -13

NHS
Cambridgeshire and Peterborough Clinical Commissioning Group

	CUHFT	PSHFT	HHCT	CCS	CPFT	QEH	Papworth
Safety | MRSA – November YTD	2/0	0/0	0/0	-	-	-	0/0
Safety | C Diff – November YTD	35/39	27/26	5/8	-	-	10/19	3/5
Safety | Never Events – November	0	0	0	0	0	0	0
Experience | Friends & Family: A&E – October	57.1	59.9	71.7	-	-	52.1	-
Experience | Friends & Family: Inpatient – October	52.3	72.0	80.6	85.0	-	61.0	82.5

Comments |

There were no cases of MRSA in October, however, provisional data indicates one case at CUHFT in November.

The provisional position for the number of C difficile cases in November is outlined above. CUHFT and PSHFT remain above trajectory with PSHFT exceeding the annual ceiling.

Further details are provided in the HCAI section of this report.

Friends and Family data for October is shown above. Contract and quality leads continue to have discussions with Providers with regard to improving performance.

CUHFT's methodology for collecting F&F data will be changed from January 2014, to bring CUHFT in line with the majority of other trusts and they intend to roll out an electronic system to collect F&F data using iPads on the day of discharge. Further details can be found on page 41.

The test score for A&E across England was 55 for October. All of our providers apart from QEH exceeded this score.

Serious Incidents and Never Events

Organisation	SIs reported during November 2013 (including Never events)	Never events reported during November 2013	Final Investigation reports received during November 2013	SIs closed during November 2013	Open SIs as at 30th November 2013	SIs Overdue closure within timescales excluding 'Stop the Clock'
C&P CCG	0	0	1	3	0	0
CCS	26	0	8	9	38	4
CPFT	7	0	11	7	19	1
CUHFT	5	0	4	4	10	0
EEAS	0	0	0	0	2	0
HHCT	8	0	4	2	14	0
HUC/111	1	0	0	0	1	0
Papworth	0	0	0	1	4	1
PSHFT	5	0	3	4	11	0
QEH	2	0	0	0	15	0
UCC	0	0	0	0	2	0
Total	**54**	**0**	**31**	**30**	**116**	**6**

Comments |

No never events were reported during November. The number of Serious Incidents (SIs) reported during November 2013 are outlined above.

Contract queries (CQ) in relation to SI management have been sent to CCS, CUHFT and PSHFT.

The CCS CQ was in relation to "Harm Free" reporting/performance. A Contract management meeting was held between CCS and the CCG and three actions were agreed for CCS to take forward: 1) RAP in relation to Pressure Ulcers management 2) RAP in relation to Falls 3) agreed improvements in SI reporting

It was acknowledged at a recent CQR that CCS had made good progress in relation to all 3 actions. Specifically the timeliness and process around SI reporting and the CQ is likely to be closed for this area.

CUHFT – There is an action plan in place in response to the contract query. New proforma have been developed to ensure quality issues are addressed. CUHFT has agreed improved methods of communication for SI reporting and there is now a lead coordinator for SIs. There have been some improvements in both timeliness and quality of SI reporting.

PSHFT – As previously reported, the Trust has submitted a remedial action plan to address the management of SIs. A new nurse has been recruited who will be responsible for the fact finding element of SI investigations and all out of date SI reports have now been submitted.

Source: NRLS reporting

Section two

NHS CONSTITUTION

Overall delivery | NHS Constitution

Comments |

This report will focus on those areas still experiencing difficulties as follows:

- RTT - At an aggregated level, the CCG is meeting all national operating standards for October, however there are still some areas not meeting the standard at specialty level.
- Diagnostics – The CCG and all of our providers met the standard for October and the CCG met the standard for November.
- The A&E standard was not met across the CCG for the month of November 2013. CUHFT and QEH also failed to meet the standard for the month, however, HHCT and PSHFT met the standard for November.
- Cancer - The CCG met all cancer standards in October apart from the 31 day wait for subsequent surgery standard which was missed by 0.25%. However, all of our providers met all cancer standards for October.
- Ambulance performance remains challenged and for the month of November, Red1, Red 2 and Category A19 minute performance were below standard.
- The CCG had one Mixed Sex Accommodation breach in November. However, there were 4 breaches at QEH. Two of the breaches at QEH were in the Critical Care Unit due to lack of bed availability. We are awaiting further details of the other 2 breaches.
- There was only one urgent cancelled operations across our providers during November- QEH.

A detailed breakdown by individual indicator is included in the following sections.

NHS Constitution scorecard

Referral to treatment access times	Threshold	Lower Threshold	Current Period	Prior Period	YTD Actual	Movement	Period	Delivered Current Period	Delivered YTD	Below Lower Threshold
Admitted patients	90.0%	85.0%	93.30%	93.87%	93.40%	↓	Oct-13	Yes	Yes	No
Non-admitted patients	95.0%	90.0%	97.21%	98.09%	97.95%	↓	Oct-13	Yes	Yes	No
Incomplete pathways	92.0%	87.0%	96.65%	96.92%	96.65%	↓	Oct-13	Yes	Yes	No
Over 52 week waits - Incomplete Pathway	0	10	1	0		↓	Oct-13	No	No	No
								75%	75%	

Diagnostic waits	Threshold	Lower Threshold	Current Period	Prior Period	YTD Actual	Movement	Period	Delivered Current Period	Delivered YTD	Below Lower Threshold
No patient should wait > 6 weeks	99.0%	87.0%	99.68%	99.91%	99.68%	↓	Nov-13	Yes	Yes	No
								100%	100%	

A&E waits	Threshold	Lower Threshold	Current Period	Prior Period	YTD Actual	Movement	Period	Delivered Current Period	Delivered YTD	Below Lower Threshold
Patients spending four hours or less in all CCG	95.0%	90.0%	94.32%	94.23%	94.66%	↑	Nov-13	No	No	No
Patients spending four hours or less in all CUHFT	95.0%	90.0%	92.32%	93.78%	94.86%	↓	Nov-13	No	No	No
Patients spending four hours or less in all Hinchingbrooke	95.0%	90.0%	98.04%	95.92%	96.47%	↑	Nov-13	Yes	Yes	No
Patients spending four hours or less in all PSHFT	95.0%	90.0%	95.30%	93.67%	93.22%	↑	Nov-13	Yes	No	No
Patients spending four hours or less in all QEH	95.0%	90.0%	94.45%	92.53%	91.44%	↑	Nov-13	No	No	No
Over 12 hr trolley waits	0	0	0	0	0	↔	Nov-13	Yes	Yes	
								50%	33%	

Key

↑	Improved performance as compared to prior period
↓	Deteriorated performance as compared to prior period
↔	No Change

NHS Constitution scorecard – pg.2

Cancer waits	Threshold	Lower Threshold	Current Period	Prior Period	YTD Actual	Movement	Period	Delivered Current Period	Delivered YTD	Below Lower Threshold
2 week wait for urgent cancer referrals	93.0%	88.0%	97.66%	97.55%	97.50%	↑	Oct-13	Yes	Yes	No
2 week wait for breast symptom referrals	93.0%	88.0%	98.47%	97.84%	96.46%	↑	Oct-13	Yes	Yes	No
31 day wait to first definitive treatment for all cancers	96.0%	91.0%	97.98%	98.49%	98.58%	↓	Oct-13	Yes	Yes	No
31 day wait for subsequent surgery	94.0%	89.0%	93.75%	95.89%	96.71%	↓	Oct-13	No	Yes	No
31 day wait for subsequent drug	98.0%	93.0%	100.00%	100.00%	99.76%	↔	Oct-13	Yes	Yes	No
31 day wait for subsequent radiotherapy	94.0%	89.0%	97.76%	94.50%	96.15%	↑	Oct-13	Yes	Yes	No
62 day wait to first definitive treatment for all cancers	85.0%	80.0%	90.08%	91.62%	89.56%	↓	Oct-13	Yes	Yes	No
62 day wait following screening referral	90.0%	85.0%	96.43%	95.65%	95.29%	↑	Oct-13	Yes	Yes	No
62 day wait following consultant upgrade	None	None	87.50%	92.31%	89.61%	↓	Oct-13			
								88%	100%	

Category A ambulance	Threshold	Lower Threshold	Current Period	Prior Period	YTD Actual	Movement	Period	Delivered Current Period	Delivered YTD	Below Lower Threshold
Cat A calls response arriving within 8 minutes - Red 1	75.0%	70.0%	74.52%	75.03%	74.89%	↓	Nov-13	No	No	No
Cat A calls response arriving within 8 minutes - Red 2	75.0%	70.0%	68.47%	68.00%	71.09%	↑	Nov-13	No	No	Check
Cat A calls ambulance arriving within 19 mins	95.0%	90.0%	92.82%	92.48%	93.35%	↑	Nov-13	No	No	No
Ambulance Handover - Arrival to clear - 30 mins	85.0%	None	49.0%	48.0%	50.7%	↓	Nov-13	No	No	
Ambulance Handover - Arrival to clear - 60 mins	0.0%	None	3.3%	3.8%	4.5%	↑	Nov-13	No	No	
								0%	0%	

Mixed sex accommodation	Threshold	Lower Threshold	Current Period	Prior Period	YTD Actual	Movement	Period	Delivered Current Period	Delivered YTD	Below Lower Threshold
Mixed Sex Accommodation Breaches	0	10	1	0	11	↓	Nov-13	No	No	No
								0%	0%	

Key

↑	Improved performance as compared to prior period
↓	Deteriorated performance as compared to prior period
↔	No Change

NHS Constitution scorecard – pg.3

Cancelled operations		Threshold	Lower Threshold	Current Period	Prior Period	YTD Actual	Movement	Period	Delivered Current Period	Delivered YTD	Below Lower Threshold
Cancelled operations not rebooked within 28 days		None	None	25	71	96	↑	July -Sep (Q2)			
Urgent Operations cancelled	CUHFT	None	None	0	11	88	↑	Nov-13			
Urgent Operations cancelled	Hinchingbrooke	None	None	0	0	0	↔	Nov-13			
Urgent Operations cancelled	Papworth	None	None	0	5	30	↑	Nov-13			
Urgent Operations cancelled	PSHFT	None	None	0	0	2	↔	Nov-13			
Urgent Operations cancelled	QEH	None	None	1	0	15	↓	Nov-13			

Care Programme Approach	Threshold	Lower Threshold	Current Period	Prior Period	YTD Actual	Movement	Period	Delivered Current Period	Delivered YTD	Below Lower Threshold
% of people on CPA followed up within 7 days of discharge	95.0%	90.0%	95.1%	96.3%	96.3%	↓	Oct-13	Yes	Yes	No
								100%	100%	

Key

Green | No indicators rated red
Amber green | No indicators rated red but future concerns
Amber red | one indicator rated red
Red | Two or more indicators rated red

Comments |

The following areas will be covered in more detail using Exception Reports (ER):

1. RTT - pg. 15
2. Diagnostics - pg. 16
3. Accident and Emergency - pg. 17
4. Cancer Waits - pg.18
5. Ambulance - pg. 19
6. Mixed Sex Accommodation – pg.20

ER 1 | Referral to treatment

Fig 1. CCG wide RTT performance over time

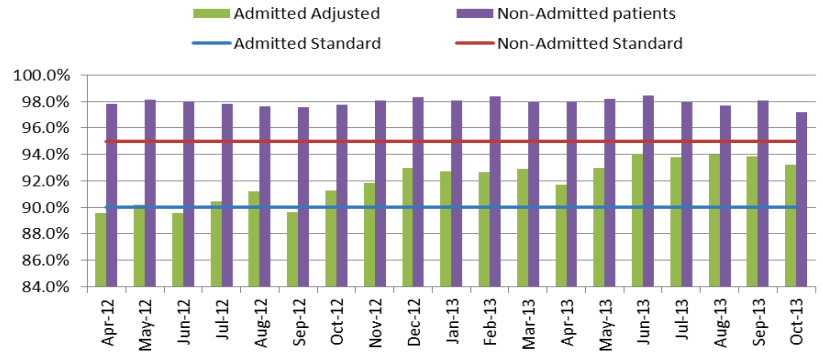


Fig. 2 CCG over 52 week waits reported by providers

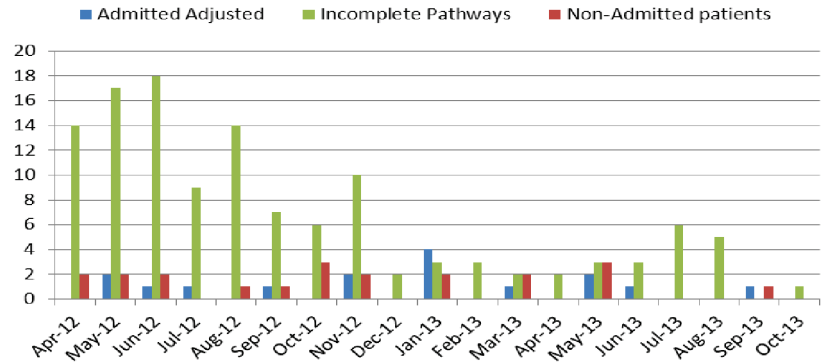


Fig 3. CCG specialty level breakdown

Number of specialties Not meeting national standard

	% 18 wk RTT
Admitted	3
Non Admitted	0
Incomplete	0

Comments |

At an aggregated level, the CCG is meeting all national operating standards for October (admitted pathways, non-admitted pathways and incomplete pathways) as shown in figure 1.

There was one 52 week breach in October at Papworth which was the same patient as reported last month. The patient has now been treated successfully and has returned home.

The CCG are currently reviewing processes to ensure that we monitor, with Providers their PTL and review all patients who have been waiting 26 weeks or more to ensure proactive management.

Provider level information is available in the provider performance section.

Figure 3 shows the speciality level split which indicates that at CCG level, 3 specialties (ENT – 88.3%, General Surgery – 89.0% and T&O 89.3%) are not meeting the national admitted pathway standard.

All of the above are being managed via contractual meetings. Root causes and actions are included in the provider section of the report.

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ER 2 | Diagnostic tests

Fig 1. Table to show breakdown of CCG breaches in October 2013 by provider and specialty

	CUHFT	Oxford	PSHFT	QEH	TOTAL
Cystoscopy	1				1
Dexa Scan	1				1
MRI		1	1		2
Urodynamics	3			1	4
TOTAL	**5**	**1**	**1**	**1**	**8**

Comments |

The CCG met the national standard in October (with 0.09% of patients waiting 6 weeks + for key diagnostic tests) and November (with 0.32% of patients waiting 6 weeks +).

All of our providers also met the standard for October. We are awaiting final provider level data for November.

Across the CCG there were 8 patients waiting more than 6 weeks in October as outlined in Figure 1 which is an improvement on September.

ER 3 | Accident & emergency

Fig 1. CCG wide A&E performance over 2013/14

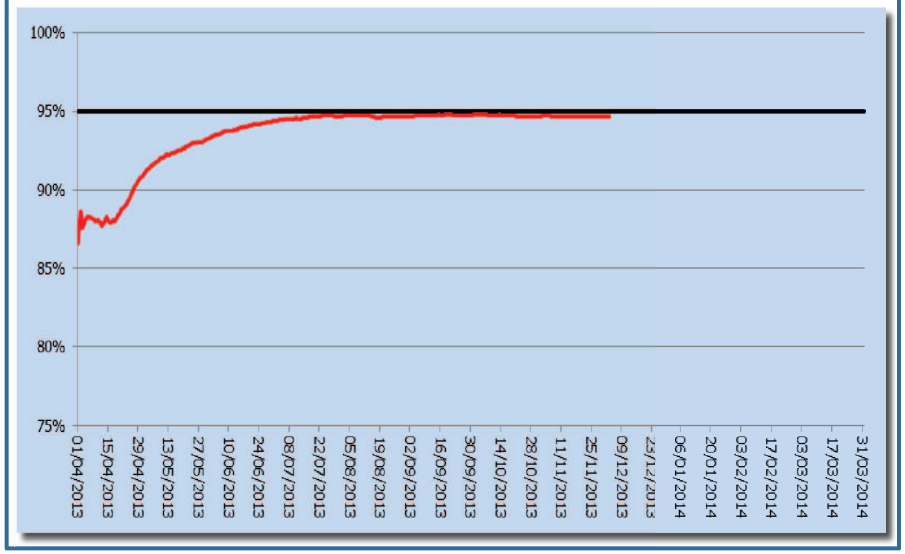
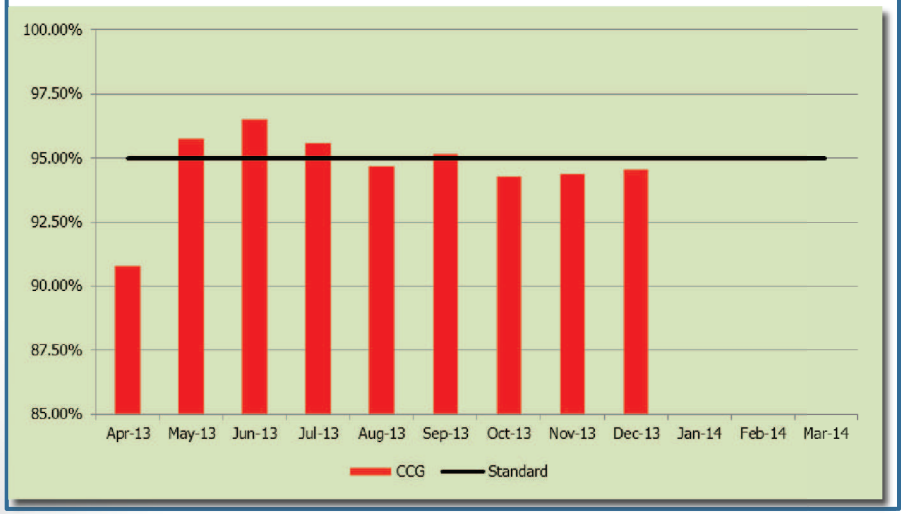


Fig. 2 CCG monthly performance in 13/14



Comments |

The A&E standard was not met across the CCG for the month of November 2013. CUHFT and QEH also failed to meet the standard for the month, however, HHCT and PSHFT met the standard for November

Performance is monitored through the local system urgent care boards which centre around providers. For each provider, A&E remains a key service performance element in the contract and as such contract queries are raised for under performance and remedial action plans submitted to commissioners to address under performance.

Provider level information is available in the provider performance section.

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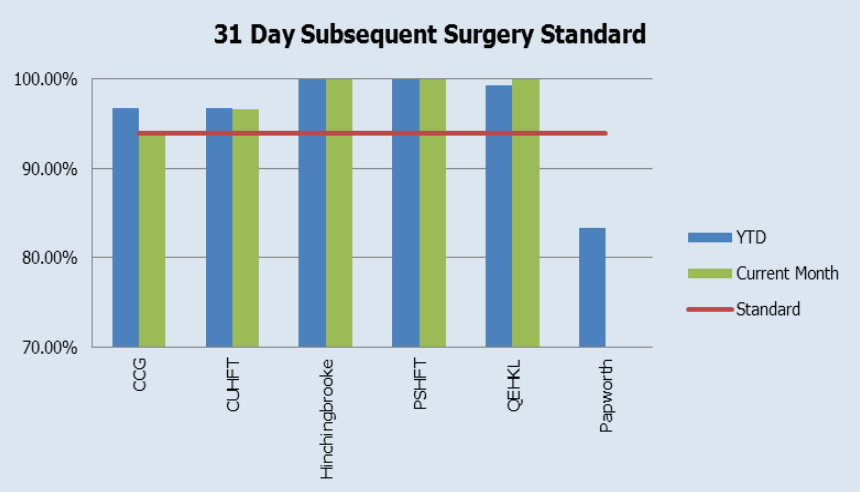
ER 4 | Cancer waits

Fig 1. 31 day subsequent surgery standard



Comments |

The CCG met all cancer standards in October apart from the 31 day wait for subsequent surgery standard which was just missed by 0.25%. However, all of our providers met all cancer standards for October. CUHFT performance for CCG patients for surgery was 83.35% in October and although CUHFT met the target at provider level, the target was not met for CCG patients and as a result the CCG missed the target overall.

With regard to the 62 day standard, CUHFT have advised that the number of late referrals is increasing into Quarter 3. The Chief Executive has written to the Anglia Network Trusts confirming the decision of the Cancer Network forum that there will be automatic reallocation of any patient referred after day 38. It is hoped that this will achieve a benefit for patients by focusing referring Trusts on reducing delays in the early stage of the patient pathway.

CUHFT have also advised that both the 62 day and 31 day first definitive treatment standards are at risk for November. A high volume of potential skin cancer delays are continuing due to patient choice. Capacity pressures on the service may be limiting the number of choices that can be offered to patients. Recruitment is ongoing to meet current demand levels.

ER 5 | Ambulance performance

Fig 1. East of England Ambulance trust Cat A performance

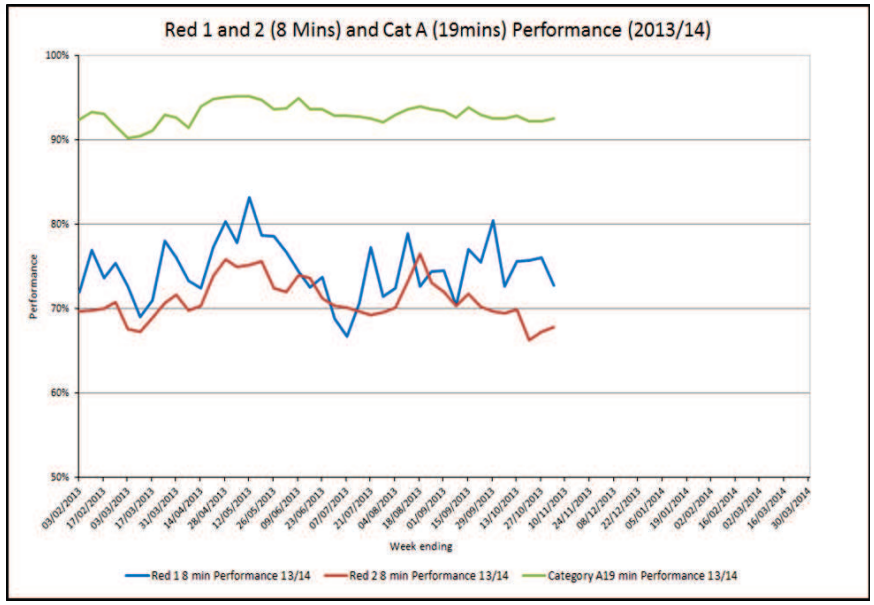
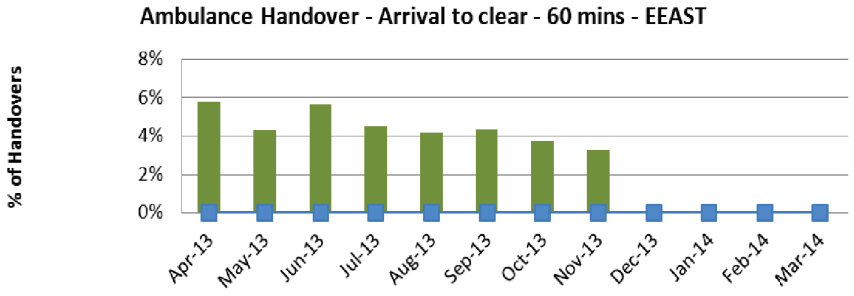


Fig 2. Handover: arrival to clear



	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14
Monthly Actual	5.8%	4.3%	5.7%	4.5%	4.2%	4.3%	3.8%	3.3%	0.0%	0.0%	0.0%	0.0%
Plan	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

Comments |

For the month of November, performance was as follows:

- Red 1 (8 minute) performance was below the 75% standard at 74.52%.
- Red 2 (8 minute) performance was below the 75% standard at 68.47%.
- Category A19 minute performance was below the 95% standard at 92.82%.

Red 1, Red 2 and A19 performance remain challenged. Red activity remains elevated.

A contract query was issued by the Consortium in August and it was agreed that the Co-ordinating Commissioner and EEAST would carry out a joint investigation which was closed on 22nd October on the understanding that EEAST delivered a Remedial Action Plan (RAP) by 31st October. EEAST missed this deadline and the co-ordinating commissioner are using contractual levers to withhold payment for failure to deliver a RAP.

The CCG are proactively working with the consortium to ensure a strong remedial plan is put in place to improve performance. It is recognised that major transformational change is required to sustain performance at the standard as a minimum.

For further details, please refer to the Contract Queries section of the report (page 70).

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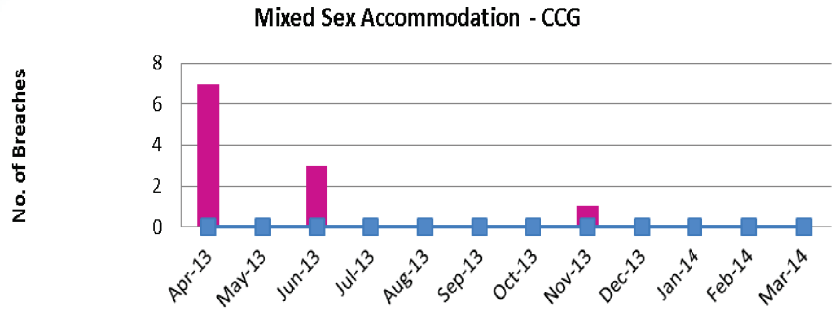
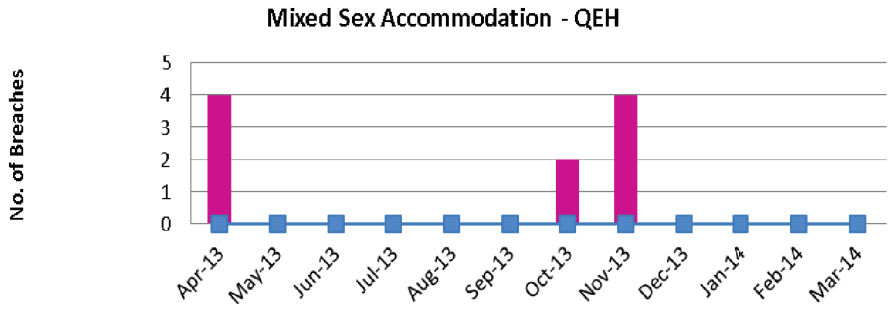
ER 6 | Mixed sex accommodation

Fig 1. CCG Breaches



	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14
Monthly Actual	7	0	3	0	0	0	0	1	0	0	0	0
Plan	0	0	0	0	0	0	0	0	0	0	0	0

Fig 2. QEH Breaches



	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14
Monthly Actual	4	0	0	0	0	0	2	4	0	0	0	0
Plan	0	0	0	0	0	0	0	0	0	0	0	0

Comments |

November data shows that there was 1 breach across the CCG.

There were 4 Mixed Sex Accommodation breaches at QEH.

Two of the MSA breaches at QEH were in the Critical Care Unit, due to lack of bed availability. We are awaiting further information regarding the other 2 breaches.

We have raised this with QEH at the performance meeting and as we had previously agreed they would ensure a robust escalation process is in place.

We will raise at the December Clinical Quality Review Meeting to seek assurance that they now have a robust plan in place.

Section three

THE MANDATE

Overall delivery | The Mandate

Comments |

The five outcome domains that we will be reporting against in 2013/14 are:

Domain one | Preventing people from dying prematurely
Domain two | Enhancing the quality of life for those with long term conditions
Domain three | Helping people to recover from episodes of ill health
Domain four | Ensuring people have a positive experience of care
Domain five | Providing a safe environment

At the present time some indicators are still in development for reporting in 13/14 and some data is not yet available. Therefore this section remains under development until the national data sets are available at CCG level. We will continue to refine this in line with published data availability.

The Mandate scorecard

Preventing people from dying prematurely	Threshold	Current Period	Prior Period	YTD Actual	Movement	Period	Delivered Current Period	Delivered YTD
Emergency admissions for alcohol related liver disease	Reduce	26.1	27.9	54.0	↑	July -Sep (Q2)	Yes	
Antenatal assessment < 13 weeks	93.2%	94.0%	93.8%	93.9%	↑	July -Sep (Q2)	Yes	Yes
Maternal smoking at delivery	13.9%	11.0%	10.0%	10.5%	↓	July -Sep (Q2)	Yes	Yes
Prevalence of breast feeding at 6 - 8 weeks from birth	53.3%	56.8%	53.2%	55.0%	↑	July -Sep (Q2)	Yes	Yes
							100%	100%

Enhancing quality of life for people with LTC	Threshold	Current Period	Prior Period	YTD Actual	Movement	Period	Delivered Current Period	Delivered YTD
Unplanned hospitalisation for chronic ambulatory care sensitive conditions	Reduce	61.3	61.9	414.5	↑	Oct-13	Yes	
Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s	Reduce	29.0	41.1	171.9	↑	Oct-13	Yes	
							67%	0%

Helping people to recover from episodes of ill health	Threshold	Current Period	Prior Period	YTD Actual	Movement	Period	Delivered Current Period	Delivered YTD
Emergency Readmission within 30 days of discharge	Not Available	11.0%	11.5%	11.0%	↑	Oct-13	Yes	Yes
Emergency admissions for acute conditions that should not usually require admis	Reduce	77.6	71.3	554.8	↓	Oct-13	No	
Emergency admissions for children with lower respiratory tract infections	Reduce	21.4	11.0	98.0	↓	Oct-13	No	
							33%	100%

Ensuring people have a positive experience of care		Threshold	Current Period	Prior Period	YTD Actual	Movement	Period	Delivered Current Period	Delivered YTD
Friends and Family net Promoter - Inpatients	CUHFT	75.0	52.3	45.3	50.3	↑	Oct-13	No	No
Friends and Family net Promoter - Inpatients	Hinchingbrooke	75.0	80.6	80.5	81.9	↑	Oct-13	Yes	Yes
Friends and Family net Promoter - Inpatients	Papworth	75.0	82.5	83.9	86.3	↓	Oct-13	Yes	Yes
Friends and Family net Promoter - Inpatients	PSHFT	75.0	72.0	71.5	72.9	↑	Oct-13	No	No
Friends and Family net Promoter - Inpatients	QEH	75.0	61.0	69.2	67.2	↓	Oct-13	No	No
Friends and Family net Promoter - Inpatients	CCS	75.0	85.0	85.0	84.0	↔	Oct-13	Yes	Yes
Friends and Family net Promoter - A&E	CUHFT		57.1	60.8	59.0	↓	Oct-13		
Friends and Family net Promoter - A&E	Hinchingbrooke		71.7	77.5	76.5	↓	Oct-13		
Friends and Family net Promoter - A&E	PSHFT		59.9	70.0	63.3	↓	Oct-13		
Friends and Family net Promoter - A&E	QEH		52.1	49.1	49.5	↑	Oct-13		
								50%	50%

Safe environment	Threshold	Current Period	Prior Period	YTD Actual	Movement	Period	Delivered Current Period	Delivered YTD
Incidence of VTE	90.0%	98.5%		98.6%	↓	July -Sep (Q2)	Yes	Yes
MRSA Infections	0	1	0	3	↓	Nov-13	No	No
C. Diff Infections	134	12	15	113	↑	Nov-13	No	No
							33%	33%

Comments |

The following areas will be covered in more detail, using exception reporting (ER):

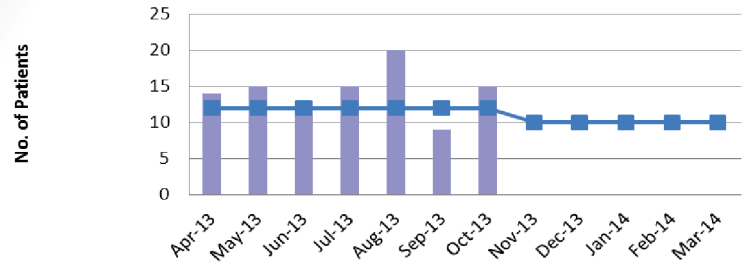
7. MRSA and C.Diff Infections

The FFT results are covered in the provider performance sections of this report.

With regard to Emergency Admissions, LCGs continue to engage with Practices to ensure they are managing patients through disease registers, prescribing reminders, medication reviews etc. in order to reduce admissions. Actual patient numbers are very small.

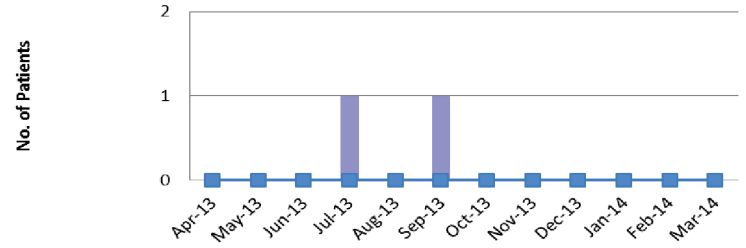
ER 7 | HCAI

Fig 1. CCG wide C diff by month (up to end of October)



	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14
Monthly Actual	14	15	13	15	20	9	15	0	0	0	0	0
Plan	12	12	12	12	12	12	12	10	10	10	10	10

Fig. 2 CCG wide MRSA by month (up to end of October)



	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14
Monthly Actual	0	0	0	1	0	1	0	0	0	0	0	0
Plan	0	0	0	0	0	0	0	0	0	0	0	0

Fig. 3 Trust provisional November C Diff data

Trust	Annual Trajectory	Provisional November data	November Target
CUHFT	39	1	3
HHCT	8	0	1
Papworth	5	0	0
PSHFT	26	5	2

Comments |

MRSA

There were no cases of MRSA in October, however, provisional data indicates a case at CUHFT in November. The RCA has commenced and the Post Infection Review meeting will take place within the next few weeks.

Clostridium Difficile

The final Clostridium Difficile data for October 2013 was worse than expected with 15 cases assigned. One of these is an out-of-area patient at Papworth.

Initial data for November identifies 8 community onset cases with an expected final figure of 12. This will bring the CCG up to 113 cases against an annual trajectory of 134.

No cases have yet been sent to appeal. However, following discussions with the NHS England Infection Prevention and Control lead and other colleagues, the CCG will identify relevant cases for appeal.

The HCAI Strategy Group is working on the development of a strategy with agreement from all Directors of Infection Prevention and Control, and in association with expertise from the Infection Prevention and Control Nurse leads from provider organisations.

The Infection Prevention and Control team have carried out a thematic analysis of CCG Clostridium Difficile cases. There have been 56 community onset cases since 1st April and the team identified the following themes:

- 34% of cases had a hospital admission within the past 30 days
- 21% of cases had a hospital admission in the previous 8-12 weeks
- 34% of cases had no hospital admission during the last 6 months
- 18% of cases had attending out-patient clinics. There was additional prescribing noted in these areas.
- 20% of cases had community service involvement
- 2 cases identified input from dental sources (one abroad)
- 14% of cases had underlying bowel disorder
- 59% of specimens are taken on admission to hospital

Patients receiving primary care treatment at the time of onset include:

- 28.5% - UTI
- 27% - soft tissue injury
- 9% - respiratory
- 9% - other/unknown

The team will use the analysis in understanding the current trends and difficulties associated with this disease.

Provisional data for November 2013 is outlined in figure 3.

QP

Section four

TRANSFORMING SERVICES

2013/14 Efficiency plan

	QIPP Target Value (£)	Prior Month FY Forecast (£)	M7 Tracker Actual (£)	M7 YTD Cumulative Actual (£)	M7 QIPP Forecast (£)	M7 LWOM (Plan B) (£)	M7 Total QIPP/LWOM Forecast (£)	% of Original QIPP Target	FYE QIPP and LWOM Forecast (£)
Borderline and Peterborough System	5,302,000	7,009,000	369,052	3,533,816	5,590,335	1,575,600	7,165,935	135%	1,863,935
CAM H/CATCH System	5,165,000	2,551,000	159,007	793,456	2,006,086	14,534	2,020,620	39%	-3,144,380
Hunts H/HCP System	3,884,000	2,839,000	233,816	1,512,693	2,196,238	491,000	2,687,238	69%	-1,196,762
IoE/Wisbech System	1,412,000	2,538,000	80,870	429,760	1,088,038	654,000	1,742,038	123%	330,038
CCG wide schemes	3,973,000	2,178,000	74,433	522,024	2,284,109	250,000	2,534,109	64%	-1,438,891
Program Scheme Totals (£)	**19,736,000**	**17,115,000**	**917,178**	**6,791,749**	**13,164,807**	**2,985,134**	**16,149,941**	**82%**	**-3,586,059**

Support to Bottom Line Totals (£)	**7,010,000**		**7,010,000**	
Total CCG* (£)	**26,746,000**	**Forecast against Total CCG* (£)**	**23,159,941**	**87%**
Contract Compliance Measures (£)	**7,154,000**			
Total Saving Required (£)	**33,900,000**			

2013/14 Efficiency plan

Comments

As at M7 the LCG has **delivered 87% of its original QIPP** schemes (including LWOM and central CCG schemes) - this is based on forecast savings of **£23.16m**. This is a shortfall of **£3,59m.** Actual delivery to month 7 is £13.8m.

Additional pressures in year have resulted in the CCG forecasting a financial deficit of £8.6m (please see latest finance report - under delivery of QIPP is one of the key factors contributing to the CCGs financial position). Based on this the CCG has rapidly initiated a turnaround process and has appointed a turnaround team from Deloitte to support delivery. The organisation is now working with Deloitte to augment the original QIPP/LWOM schemes with further schemes to support the CCG through its financial Recovery. A financial recovery plan (FRP) was submitted to the Area Team end of November and feedback on this is expected mid December 2013. One key aspect of support is strengthening the CCGs programme management function (PMO) to provide more robust assurance on monitoring and delivery of the financial recovery programme. Future reporting will move to reporting against the FRP which will cover the original QIPP/LWOM schemes.

The CCG remains committed to achieving these targets and continues to work with LCGs and their Boards to ensure this remains our top priority.

Section five

ACTIVITY

CCG Activity scorecard – SS to complete – table updated

Activity lines	Month Plan	Month Actual	Cumulative Plan	Cumulative Actual	Cumulative Variance to Plan	Cumulative YoY growth	Period
GP written referrals to Hospital	12,080	15,749	79,848	101,476	21.3%	9.5%	Oct-13
Other referrals	9,391	11,051	57,778	70,228	17.7%	4.7%	Oct-13
All 1st OP	19,670	20,901	127,855	130,902	2.3%	10.5%	Oct-13
Elective	10,121	10,178	65,788	65,358	-0.7%	9.6%	Oct-13
Ambulance journeys		38,035		259,664		3.6%	Oct-13
A&E attendances	17,346	20,019	121,419	115,849	-4.8%	8.1%	Oct-13
Non Elective	6,481	6,309	42,127	41,129	-2.4%	3.3%	Oct-13

Comments |

No significant change to what was reported last month. One of the key messages from this data is the on going pressure the CCG is seeing in elective care. Our FRP is actively targeting this area to reverse the trend.
Our referral support service (RSS) is now up and running – it started in the Cambs/Hunts systems 2nd Dec and Borderline/Peterborough system 9th Dec. The rapid implementation of the programme is mainly due to strong clinical leadership across the CCG. The majority of GP referrals in specific specialties are going through the RSS and the LCGs are now focussing on how to impact on non GP generated elective activity e.g. clinician to clinician referrals, referrals linked to clinical thresholds already in the system. Providers have been written to making them aware of the RSS and that they must not reduce waiting lists to fill the additional capacity the RSS is likely to generate.

Section six

QUALITY PREMIUM

Quality Premium scorecard

Quality Premium scorecard

National Measure	Weighting	Value	Frequency	Threshold	Baseline	Latest data	Period	Pass / Fail	Funding calculation
Potential years of life lost from causes amenable to healthcare	12.50%	519,928.75	Annual	Reduction of 3.2%					£0.00
Emergency admissions composite measure	25.00%	1,039,857.50	Monthly	Reduction or 0% change	873	877	Oct-13	Fail	£0.00
Friends and family roll out plan	12.50%	519,928.75			Part of Local Providers Contracts		Oct-13	Pass	£519,928.75
Friends and family improvement - IP - CCG		-	Monthly	Improvement	74	73.8	Oct-13	Fail	£0.00
Friends and family improvement - A&E - CCG		-	Monthly	Improvement	60	62.5	Oct-13	Pass	£0.00
HCAI | MRSA - CCG	12.50%	519,928.75	Monthly	0		2	Oct-13	Fail	£0.00
HCAI | C Diff - CCG			Monthly	134		101	Oct-13		£0.00

Local Measure	Weighting	Value	Frequency	Threshold	Baseline	Latest data	Period	Pass / Fail	Funding calculation
Smoking at time of delivery - CCG	12.50%	519,928.75	Quarterly	13.9%		10.5%	July -Sep (Q2)	Pass	£519,928.75
Older People Emergency Bed days rate per person	12.50%	519,928.75	Monthly	1.93		1.86	Oct-13	Pass	£519,928.75
Primary prevention of CHD in deprived areas - CCG	12.50%	519,928.75	Monthly	90.0%		81.4%	Nov-13	Fail	£0.00
Total Value		**4,159,430.00**							**£1,559,786.25**

Pre conditions	Position
Financial breakeven or better	
Significant quality failure	

NHS Constitution measures	Threshold	Basis	Organisation	Latest data	Adjustment to funding	Adjustment	Period	Pass / Fail	Funding calculation
Incomplete RTT pathways	92%	Annual	CCG	96.6%	25%	£389,946.56	Oct-13	Pass	£0.00
A&E waits	95%	Annual	CCG mapped	94.7%	25%	£389,946.56	Nov-13	Fail	-£389,946.56
62 day cancer waits	85%	Annual	CCG	89.6%	25%	£389,946.56	Oct-13	Pass	£0.00
Cat A Red 1 calls	75%	Annual	EEAST	74.52%	25%	£389,946.56	Nov-13	Fail	-£389,946.56
					Adjusted total				**£779,893.13**

QP

Quality Premium scorecard

Comments |

As previously reported, CCG performance in 2013/14 will be measured against 4 national quality measures (reducing potential years of life lost from causes amenable to healthcare – 12.5%, reducing avoidable emergency admissions – 25%, ensuring roll out of the friends and family test – 12.5% and preventing HCAI – 12.5%), and 3 locally agreed measures (reducing the rate of maternal smoking at time of delivery – 12.5%, reducing older people's emergency bed day rates – 12.5% and improving primary prevention of CHD in deprived areas – 12.5%).

The total financial envelope for the quality premium is £5 per head of population. The C&P CCG population is 831,886, and based on these calculations, the CCG would have an opportunity to achieve a maximum quality premium payment of **£4,159,430** in 2014/15 if each of the 7 measures above are fully achieved and assuming the pre-payment criterion (as outlined below) is fully achieved in 2013/14. This is shown as the first figure in the total value row of the table on page 30. Based on the data we currently have, the second figure in this row, **£1,559,786.25**, is the quality premium payment that we think we can realistically achieve.

Defined pre-payment criterion

The total payment will be reduced (by 25% per criterion) if the CCG's providers do not meet the NHS Constitution rights of pledges for patients in relation to:

1. Maximum 18-week waits from RTT – incomplete pathways (25%)
2. Maximum 4 hour waits in A&E departments (25%)
3. Maximum 62 day waits from urgent GP referral to first definitive treatment for cancer (25%)
4. Maximum 8-minute responses for Category A red 1 ambulance calls (25%)

Please note, this would be 25% of the figure achieved (e.g.£1,559,786.25) and NOT 25% of the full amount available (£4,159,430).

Based on our *current* performance, the CCG is predicting that the A&E and the Category A red 1 ambulance calls criterion will not be met. Consequently, we would lose 50% of the £1,599,786.25 figure, resulting in a quality premium payment of £779,893 as outlined in the table below.

Total Quality Premium Payment available (= £5 per head of population of 831,886)	£4,159,430
Predicted funding available based on achievement of national measures	£1,599,786.25
Deduction based on pre-payment criterion:	
A&E (25% of £1,599,786.25)	£389,946.56
Cat A Red 1 Calls	£389,946.56
Predicted Quality Premium Payment	**£779,893**

Furthermore, in order to receive this payment, the CCG is required to manage within its total resources envelope for 2013/14 and to not exceed the agreed level of surplus drawdown – the turnaround work programme is driving to achieve this standard.

This analysis assumes failure of the HCAI measure due to current Clostridium Difficile & MRSA performance (a loss of £519, 928.75).

With regard to Primary prevention of CHD in deprived areas, the CCG is now receiving reports from all 46 Practices on a monthly basis. The first quarter was below target (50% against a target of 90%) however, in quarter 2, the position has improved to 71%. A series of Practice visits has commenced focussed on those practices achieving below 60% with follow up phone calls to any practices achieving between 60-75%. The report for November 2013 has increased overall achievement to 83%. Lessons learned from these Practices will be summarised and shared with all – the common themes emerging are:

- Correctly read coding hypertension (confirm it is not an ongoing issue and code accordingly)
- Local process for completing CVD risk score within 12 weeks of diagnosis – filing correctly in clinical records
- Review of work to do list, to ensure the report has identified the correct patients in the denominator – report any anomalies to Primary care Informatics for further investigation.

The CCG remains confident that 90% can be achieved by the end of the year. If 90% is achieved, our predicted quality premium payment would increase to **£2,079,715.**

Section seven

PROVIDER PROFILES

CUHFT | 1 of 2

Referral to treatment access times	Threshold	Current Period	Prior Period	Movement	YTD	Period	Delivered Current Period	Delivered YTD
Admitted patients	90%	93.74%	93.75%	↓	93.98%	Oct-13	Yes	Yes
No. of failing specialties	*0*	*1*	*3*	↑	*14*	Oct-13	No	No
Non admitted specialties	95%	98.06%	98.09%	↓	98.07%	Oct-13	Yes	Yes
No. of failing specialties	*0*	*0*	*0*	↔	*1*	Oct-13	Yes	No
Incomplete pathways	92%	97.72%	98.15%	↓	97.72%	Oct-13	Yes	Yes
No. of failing specialties	*0*	*0*	*0*	↔	*0*	Oct-13	Yes	Yes
Over 52 week waits	0	0	0	↔	0	Oct-13	Yes	Yes
Over 40 week waits		*3*	*4*	↑	*3*	Oct-13		

Diagnostic waits	Threshold	Current Period	Prior Period	Movement		Period	Delivered Current Period	Delivered YTD
No patient should wait > 6 weeks	99%	99.80%	99.80%	↔		Oct-13	Yes	Yes

A&E waits	Threshold	Current Period	Prior Period	Movement	YTD	Period	Delivered Current Period	Delivered YTD
Within four hours	95%	92.32%	93.78%	↓	94.86%	Nov-13	No	No
12 hour trolley breaches	*0*	*0*	*0*	↔	*0*	Nov-13	Yes	Yes
Ambulance Handover - Arrival to clear - 60 mins	0%	3.1%	3.2%	↑	3.0%	Nov-13	No	No

2 Week Cancer waits	Threshold	Current Period	Prior Period	Movement	YTD	Period	Delivered Current Period	Delivered YTD
2 week wait for urgent cancer referrals	93%	97.57%	96.76%	↑	96.97%	Oct-13	Yes	Yes
2 week wait for breast symptom referrals	93%	97.37%	95.61%	↑	94.74%	Oct-13	Yes	Yes

31 day Cancer waits	Threshold	Current Period	Prior Period	Movement	YTD	Period	Delivered Current Period	Delivered YTD
31 day wait to first definitive treatment for all	96%	97.28%	97.24%	↑	97.62%	Oct-13	Yes	Yes
31 day wait for subsequent surgery	94%	96.63%	94.95%	↑	96.73%	Oct-13	Yes	Yes
31 day wait for subsequent drug	98%	100.00%	100.00%	↔	100.00%	Oct-13	Yes	Yes
31 day wait for subsequent radiotherapy	94%	96.97%	95.55%	↑	95.89%	Oct-13	Yes	Yes

62 day Cancer waits	Threshold	Current Period	Prior Period	Movement	YTD	Period	Delivered Current Period	Delivered YTD
62 day wait to first definitive treatment for all	85%	86.15%	85.00%	↑	85.54%	Oct-13	Yes	Yes
62 day wait following screening referral	90%	90.00%	91.30%	↓	91.59%	Oct-13	Yes	Yes
62 day wait following consultant upgrade	None	100.00%	92.86%	↑	96.34%	Oct-13		

Mixed sex accommodation	Threshold	Current Period	Prior Period	Movement		Period	Delivered Current Period	Delivered YTD
Number of reported breaches	*0*	*0*	*0*	↔		Nov-13	Yes	Yes

Cancelled operations	Threshold	Current Period	Prior Period	Movement	YTD	Period	Delivered Current Period	Delivered YTD
Patients cancelled, not rebooked within 28 days	Not Available	0	6	↑	6	July -Sep (Q2)		
Urgent Operations cancelled	Not Available	0	11	↑	88	Nov-13		

VTE Risk Assessment	Threshold	Current Period	Prior Period	Movement	YTD	Period	Delivered Current Period	Delivered YTD
Incidence of VTE	90%	98.7%	98.9%	↓	98.8%	July -Sep (Q2)	Yes	Yes

Emergency Readmissions	Threshold	Current Period	Prior Period	Movement	YTD	Period	Delivered Current Period	Delivered YTD
Emergency Readmission within 30 days of discharge - (Crude A	Not Available	7.8%	8.8%	↑	8.3%	Oct-13		

Maternity	Threshold	Current Period	Prior Period	Movement	YTD	Period	Delivered Current Period	Delivered YTD
C-Section Rates	25%	30.0%	26.6%	↓	26.3%	Oct-13	No	No
1 to 1 Care in Established Labour	100%	96.4%	93.1%	↑	95.5%	Oct-13	No	No

Dementia	Threshold	Current Period	Prior Period	Movement	YTD	Period	Delivered Current Period	Delivered YTD
Percentage of Dementia cases identified aged 75 and over	90%	91.82%	92.00%	↓	91.91%	July -Sep (Q2)	Yes	Yes
Percentage of Dementia cases diagnosed aged 75 and over	90%	98.24%	98.00%	↑	98.12%	July -Sep (Q2)	Yes	Yes
Percentage of Dementia cases referred aged 75 and over	90%	100.00%	100.00%	↔	100.00%	July -Sep (Q2)	Yes	Yes

CUHFT | 2 of 2

Quality indicators

Mortality information	National Mean	Current Period	Prior Period	Movement	Period	Delivered Current Period	Delivered YTD
SHMI	1	0.84	0.85	↑	Apr-12 - March-13	Yes	Yes

Patient safety	Threshold	Current Period	Prior Period	Movement	Period	Delivered Current Period	Delivered YTD
MRSA cases	0	0	0	↔	Oct-13	Yes	No
C Diff cases	39	2	4	↑	Oct-13	Yes	No
Never Events	0	0	1	↑	Nov-13	Yes	No
SIs reported within timescale	90%	53.0%			Apr - June (Q1)	No	No
Harm free care	95%	96.8%	96.2%	↑	Oct-13	Yes	Yes
Pressure Ulcer Prevalence	0	1.1	1.2	↑	Oct-13		

CQC status	Threshold	Current Period	Prior Period	Movement	Period	Delivered Current Period	Delivered YTD
Major concerns	0	0	0	↔	Oct-13	Yes	Yes
Moderate concerns	0	0	0	↔	Oct-13	Yes	Yes
Minor concerns	0	0	0	↔	Oct-13	Yes	Yes

Patient Experience	Threshold	Current Period	Prior Period	Movement	Period	Delivered Current Period	Delivered YTD
Friends and family test Inpatient	75	52.3	45.3	↑	Oct-13	No	No
Friends and family test A&E		57.1	60.8	↓	Oct-13		

Comments |

Based on the provider profiles created, the following exception reports will be provided:

1. RTT
2. Diagnostics
3. A&E
4. Maternity
5. HCAI
6. Friends and Family test

ER CUHFT 1 | RTT

Fig 1. CUHFT specialities below operating standards in October

Number of specialties Not meeting national standard

	% 18 wk RTT
Admitted	1
Non Admitted	0
Incomplete	0

Comments |

The Trust aggregate position for all RTT standards was maintained in October (93.7% admitted, 98.1% non admitted, 97.7% incomplete). At specialty level, ENT underachieved the admitted RTT standard in the month. There were no over 52 week waiters to report in October.

CUHFT has seen a continued increase in the number of patients exceeding 18 weeks. The growth in backlog has been predominantly in those patients without a decision to admit (non-admitted). In addition to ENT, Orthopaedics and Dermatology, where backlog remains high, the Trust has seen notable increases in Urology, Plastic Surgery, General Surgery and Neurosurgery. Demand has increased for Urology and Neurosurgery, but in addition all these services have been impacted by staffing resources. Plastic surgery has lost consultant manpower and all the services have suffered from gaps in tracking and booking resource to progress pathways. All of this is being managed via the trust weekly operational meetings, additional waiting list tracker administrators are being recruited and the RSS programme by the CCG will also help. Specific actions are set out below.

- ENT – The recovery trajectory is being monitored weekly. Sufficient additional sessions are being organised both in the independent sector and on-site to deliver the backlog reduction. The Trust are having difficulties in encouraging people to be treated before the New Year.
- Orthopaedics – There have been some cancellations both due to bed pressures and patient fitness. This has put increased pressure on the already increased surgical demand. The demand requires a further day in theatre per week. The service will not achieve the admitted target in November. The CCG has identified that the MSK interface service has not been adhering to the surgical threshold guidance when referring on to the Trust and an audit of the internal application of the policies will also be undertaken.
- Dermatology – The admitted target (which relates entirely to MOHs surgery) is at risk again for November.
- Plastic Surgery – Gaps in medical staffing are likely to impact on achievement in future months. PAs are being repatriated from Peterborough from December and a further 2 consultants expected to return to work from January and March. Locum position being extended for 3 months.

Cancelled Operations: November data shows a decrease from 11 in October to 0 in November. As previously reported, CUHFT and the CCG have reviewed the way that CUHFT were reporting their data and have changed their reporting method to bring them in line with the way that other Trusts are reporting on the cancellation of urgent operations. As expected, the impact of this has been reflected in November figures.

ER CUHFT 2 | Diagnostics

Fig 1. Table to show breakdown of CUHFT breaches in October 2013 by specialty

	CUHFT
Cystoscopy	1
Dexa Scan	1
MRI	
Urodynamics	3
TOTAL	**5**

Comments |

The 6 week diagnostic standard was met in October.

The only themes identified were a particular issue with Urodynamics capacity in the month related to staff sickness and an impact on MRI capacity due to equipment failure.

ER CUHFT 3 | A&E

Comments |

CUHFT failed to meet the 95% target in November, achieving 92.3%. As previously reported, a contract query letter was sent on 20th November asking CUHFT to provide a Remedial Action Plan to outline key actions to ensure the Quarter 3 target will be achieved, however, CUHFT are at high risk of not achieving the quarter and they have declared this risk to Monitor.

System wide daily escalation meetings commenced on 7th November chaired by the CCG. The surge ward was available for use from November and has been successfully opened to support patient flow as required. A decision has been taken to recruit some additional locum junior medical staff to support the Emergency Department. CUHFT are preparing to identify further areas to support emergency flow given the announcement that a further £150 million will be made available nationally.

Although there have been bed capacity issues at times, internal processes have been the cause of a significant number of breaches

- An analysis into the cause of problems and potential solutions is being conducted
- CUHFT have invited ECIST to support the Trust in recovering their performance
- Following poor performance at the start of December CUHFT are holding an urgent consultant leadership meeting (9th December) to investigate the cause and improvements
- A winter funding meeting took place on 10th December. Allocation will not be agreed until there is a full understanding of the cause of the problem and therefore how to direct funding to achieve the greatest impact
- The sanctuary scheme became operational w/c 9th December to take people from reablement and therefore improve patient flow
- Validation meetings have taken place to investigate apparent low referrals
- Out of county referrals will be reviewed every two hours to ensure all referrals are picked up
- UCC are providing information on the number of patients seen by GPs, to improve the process to increase numbers
- CUHFT are holding a series of meetings during the day covering all patient areas to expedite release of bed capacity
- Reviewing rota of speciality teams to increase capacity in ED
- EEAT to report conveyance rate for the local area in the last 24 hours and any handover delay issues
- CUHFT and UCC have agreed clinical responsibility for OOH referrals to CCG commissioned Rapid Response Nursing Service
- CCS planning for increased discharge pressure (resulting from high over 85 admissions)
- CCG agreed to premium rate for OOH transport (OOH transport has been the cause of some delays)
- Constant review of community capacity and liaison with CUHFT
- Weekly DTOC meetings in place and action taken to reduce. DPSN staff numbers now back to normal and most social care posts are also covered
- Improved position for community rehabilitation beds
- Meeting with CCG, care providers, CUHFT and CCC to develop actions to increase capacity
- Social care offering enhanced rates to reduce domiciliary care waiting lists (which backs up delays in reablement and in the acute
- Communications to GPs to increase utilization of acute nursing service (equivalent to 10 beds) to reduce pressure on CUHFT
- Capacity at Churchill Nursing Centre has been expanded to 24 beds

Transformation and turnaround projects progressing to improve patient flow and reduce length of stay:

- Addenbrookes at home – expanded the bed pool and inclusion of DTOC patients
- Enhancing psychiatric liaison service in ED and Clinical Decisions Unit (CDU)
- Enhanced near patient testing in the ED

Fig 1. CUHFT Daily A&E Attends up to 15th Dec 2013

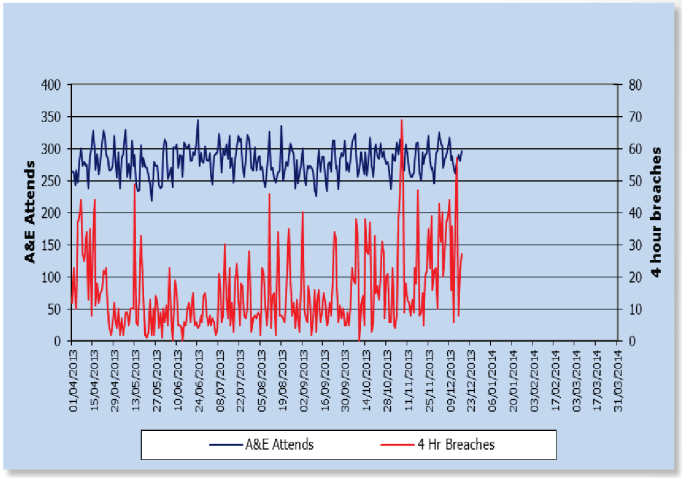
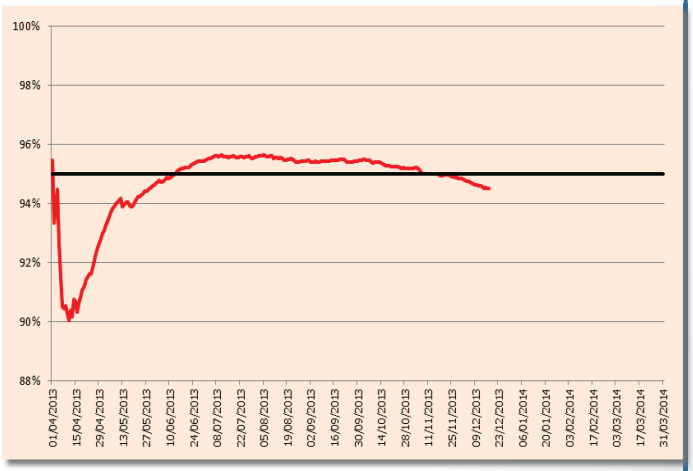


Fig 2. Cumulative A&E performance at CUHFT in 13/14



ER CUHFT 4 | Maternity

Comments |

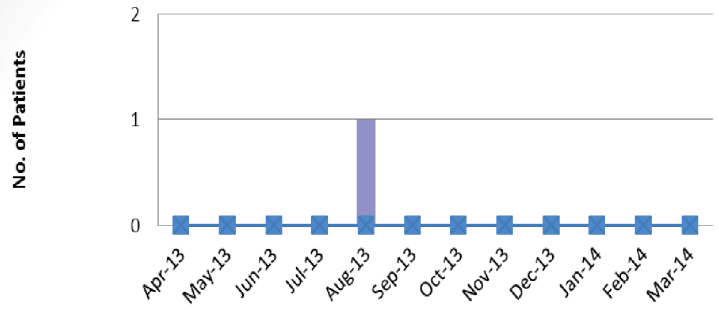
As previously reported, a maternity service peer review at CUHFT took place on 15th October 2013.

CUHFT has reviewed the visit report for factual accuracy and returned this to the CCG. The final report will be sent shortly. CUHFT has started work on the issues raised. The Peer Review team will continue to work with CUHFT on this area of work.

The CCG await the project plan for strategy and workforce development.

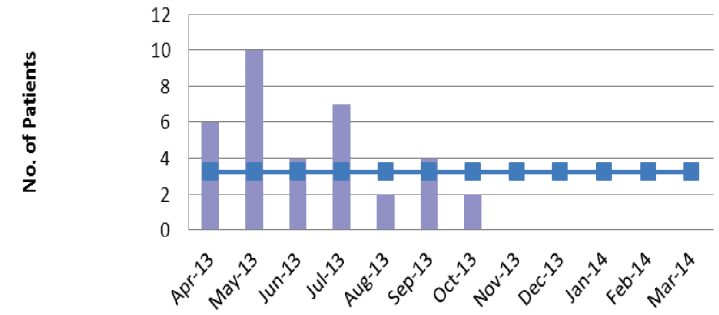
ER CUHFT 5 | HCAI

Fig 1. CUHFT MRSA cases (up to end of October)



	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14
Monthly YTD	0	0	0	0	1	0	0	0	0	0	0	0
Plan YTD	0	0	0	0	0	0	0	0	0	0	0	0

Fig 2. CUHFT C Diff cases (up to end of October)



	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14
Monthly Actual	6	10	4	7	2	4	2	0	0	0	0	0
Plan	3.25	3.25	3.25	3.25	3.25	3.25	3.25	3.25	3.25	3.25	3.25	3.25

Comments |

MRSA

There were no cases of hospital–acquired MRSA bacteraemia at CUHFT in October. Actions in progress include:

- MRSA decolonisation – staff education and audits are in place. There was a slight increase in October compliance figures but further improvement is required. There has been an increase in audits from once to twice monthly with results fed back to individual wards immediately and via the SCN forum and monthly Divisional Infection Prevention and Control Group meetings. A number of elements are audited and education by the Clinical Educator and the Infection Control Nurses, as well as individual ward feedback is focusing on those elements which record the highest non-compliance rates.
- An audit of paediatric blood culture technique and recording has been undertaken and the results are awaited.

CUHFT identified a hospital onset MRSA bacteraemia in November. The RCA has commenced and the Post Infection Review meeting will take place within the next few weeks.

C Diff

A contract query is in place due to continuing concerns in relation to CUHFT's Infection Prevention and Control. There were 2 cases of Clostridium Difficile in the Trust in October, 1 under the trajectory of 3 for the month. Both cases have been submitted for appeal. CUHFT has recorded 35 cases this financial year to date. In total, to the end of October, 16 cases have been submitted for appeal. One case only to date has been successful and this will be removed from the trajectory. Information on all other appeals is still awaited; final decisions regarding the appeals are being actively sought.

The CCG Infection Prevention and Control Matron led an unannounced visit to CUHFT in November to talk to frontline staff about their HCAI knowledge and management at ward level. The visit was very positive with a good level of knowledge noted.

CUHFT's focus remains on ensuring staff are aware of the key measures needed to control Clostridium Difficile – good hand hygiene, prompt segregation of patients with diarrhoea from others, timely testing of samples, environmental cleanliness and good antibiotic stewardship.

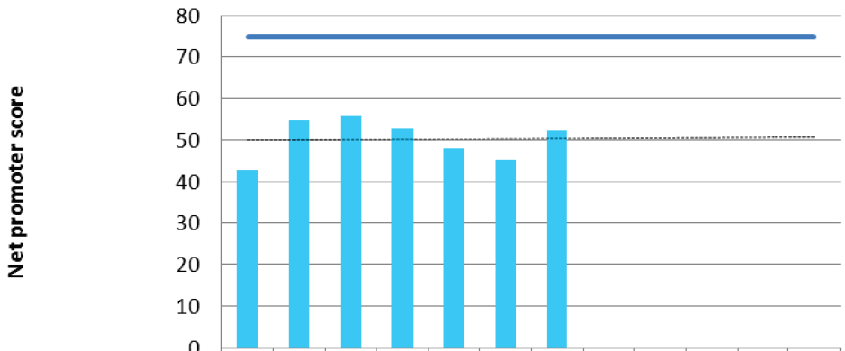
Specific points to note are:

- Infection Control Fortnightly round-up being published
- Weekly feedback of isolation information on patients for whom Clostridium difficile specimens have been sent indicates improving compliance. October average compliance was 87% (September 82%). The importance of isolation of all patients with new onset diarrhoea continues to be emphasised. The monthly audit of compliance with the Trust's isolation policy (a snap shot on one day) showed 100% of 67 eligible patients were isolated appropriately.
- The care plan has been amended to ensure there is greater prominence regarding the need to record the nutritional assessment information (which is an element where failures are occurring). Additional education for all wards where compliance is low is being undertaken by the Infection Control Nurse Clinical Educator.
- The process for extended (hours) deep cleaning using one decant ward in order to deep clean 2 wards each week is working well. A follow up meeting to formally assess its efficacy took place in November.
- The bed exchange programme continues to be under utilised; further communication as to the need to use this is underway.

QP

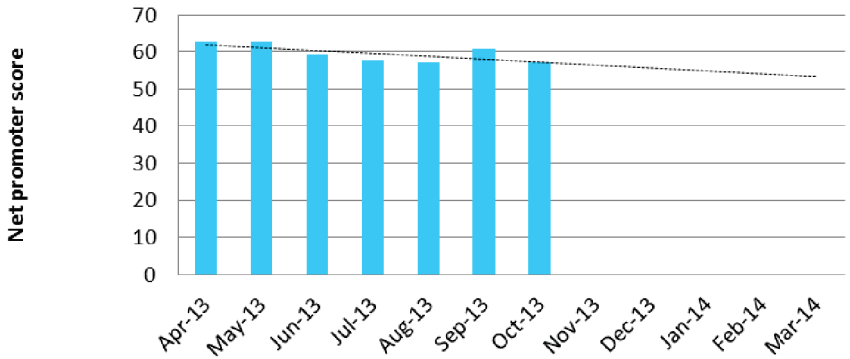
ER CUHFT 6 | Friends and Family

Fig 1. Friends and Family Net Promoter (Inpatients) - CUHFT



	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14
Monthly Actual	43	55	56	53	48	45	52					
Plan	75	75	75	75	75	75	75	75	75	75	75	75

Fig 2. Friends and Family Net Promoter (A&E) - CUHFT



	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14
Monthly Actual	63	63	59	58	57	61	57					

Comments |

CUHFT has an action plan in place looking at F&F and wider patient experience. This will be submitted to the CCG for review and comment.

The Trust's methodology for collecting F&F data will be changed from January 2014, to bring CUHFT in line with the majority of other trusts.

It is CUHFT's intention to roll out an electronic system to collect F&F data using iPads on the day of discharge. This will help to drill down to individual wards where there are issues. CUHFT is piloting this in surgery and will roll out division by division. The target date for full implementation is February 2014.

PSHFT | 1 of 2

Referral to treatment access times	Threshold	Current Period	Prior Period	Movement	YTD	Period	Delivered Current Period	Delivered YTD
Admitted patients	90%	90.90%	90.79%	↑	90.38%	Oct-13	Yes	Yes
No. of failing specialties	*0*	*4*	*2*	↓	*23*	Oct-13	No	No
Non admitted specialties	95%	97.11%	97.12%	↓	97.17%	Oct-13	Yes	Yes
No. of failing specialties	*0*	*3*	*2*	↓	*18*	Oct-13	No	No
Incomplete pathways	92%	97.79%	97.60%	↑	97.79%	Oct-13	Yes	Yes
No. of failing specialties	*0*	*1*	*1*	↔	*1*	Oct-13	No	No
Over 52 week waits	0	0	0	↔	0	Oct-13	Yes	Yes
Over 40 week waits		*2*	*2*	↔	*2*	Oct-13		

Diagnostic waits	Threshold	Current Period	Prior Period	Movement		Period	Delivered Current Period	Delivered YTD
No patient should wait > 6 weeks	99%	99.90%	99.80%	↑		Oct-13	Yes	Yes

A&E waits	Threshold	Current Period	Prior Period	Movement	YTD	Period	Delivered Current Period	Delivered YTD
Within four hours	95%	95.30%	93.67%	↑	93.22%	Nov-13	Yes	No
12 hour trolley breaches	*0*	*0*	*0*	↔	*0*	Nov-13	Yes	Yes
Ambulance Handover - Arrival to clear - 60 mins	0%	2.2%	2.1%	↓	2.0%	Nov-13	No	No

2 Week Cancer waits	Threshold	Current Period	Prior Period	Movement	YTD	Period	Delivered Current Period	Delivered YTD
2 week wait for urgent cancer referrals	93%	96.42%	97.19%	↓	97.40%	Oct-13	Yes	Yes
2 week wait for breast symptom referrals	93%	97.39%	99.08%	↓	97.14%	Oct-13	Yes	Yes

31 day Cancer waits	Threshold	Current Period	Prior Period	Movement	YTD	Period	Delivered Current Period	Delivered YTD
31 day wait to first definitive treatment for all	96%	100.00%	100.00%	↔	99.90%	Oct-13	Yes	Yes
31 day wait for subsequent surgery	94%	100.00%	100.00%	↔	100.00%	Oct-13	Yes	Yes
31 day wait for subsequent drug	98%	100.00%	100.00%	↔	100.00%	Oct-13	Yes	Yes
31 day wait for subsequent radiotherapy	94%	100.00%	100.00%	↔	99.78%	Oct-13	Yes	Yes

62 day Cancer waits	Threshold	Current Period	Prior Period	Movement	YTD	Period	Delivered Current Period	Delivered YTD
62 day wait to first definitive treatment for all	85%	86.11%	91.05%	↓	89.01%	Oct-13	Yes	Yes
62 day wait following screening referral	90%	100.00%	96.30%	↑	93.95%	Oct-13	Yes	Yes
62 day wait following consultant upgrade	None	100.00%	89.47%	↑	95.43%	Oct-13		

Mixed sex accommodation	Threshold	Current Period	Prior Period	Movement		Period	Delivered Current Period	Delivered YTD
Number of reported breaches	*0*	*0*	*0*	↔		Nov-13	Yes	No

Cancelled operations	Threshold	Current Period	Prior Period	Movement	YTD	Period	Delivered Current Period	Delivered YTD
Patients cancelled, not rebooked within 28 days	Not Available	3	40	↑	43	July -Sep (Q2)		
Urgent Operations cancelled	Not Available	0	0	↔	2	Nov-13		

VTE Risk Assessment	Threshold	Current Period	Prior Period	Movement	YTD	Period	Delivered Current Period	Delivered YTD
Incidence of VTE	90%	97.3%	96.8%	↑	97.0%	July -Sep (Q2)	Yes	Yes

Emergency Readmissions	Threshold	Current Period	Prior Period	Movement	YTD	Period	Delivered Current Period	Delivered YTD
Emergency Readmission within 30 days of discharge - (Crude A	Not Available	18.3%	19.3%	↑	18.5%	Oct-13		

Maternity	Threshold	Current Period	Prior Period	Movement	YTD	Period	Delivered Current Period	Delivered YTD
C-Section Rates	Not Available	24.7%	26.0%	↑	23.8%	Oct-13		

Dementia	Threshold	Current Period	Prior Period	Movement	YTD	Period	Delivered Current Period	Delivered YTD
Percentage of Dementia cases identified aged 75 and over	90%	92.52%	90.00%	↑	91.26%	July -Sep (Q2)	Yes	Yes
Percentage of Dementia cases diagnosed aged 75 and over	90%	97.31%	96.00%	↑	96.65%	July -Sep (Q2)	Yes	Yes
Percentage of Dementia cases referred aged 75 and over	90%	92.92%	94.00%	↓	93.46%	July -Sep (Q2)	Yes	Yes

PSHFT | 2 of 2

Quality indicators

Mortality information	National Mean	Current Period	Prior Period	Movement	Period	Delivered Current Period	Delivered YTD
SHMI	1	1.01	1.02	↑	Apr-12 - March-13	No	No

Patient safety	Threshold	Current Period	Prior Period	Movement	Period	Delivered Current Period	Delivered YTD
MRSA cases	0	0	0	↔	Oct-13	Yes	Yes
C Diff cases	26	4	3	↓	Oct-13	No	No
Never Events	0	0	0	↔	Nov-13	Yes	No
SIs reported within timescale	90%	78.0%			Apr - June (Q1)	No	No
Harm free care	95%	91.5%	91.0%	↑	Oct-13	No	No
Pressure Ulcer Prevalence	0	4.2	4.9	↑	Oct-13		

CQC status	Threshold	Current Period	Prior Period	Movement	Period	Delivered Current Period	Delivered YTD
Major concerns	0	0	0	↔	Oct-13	Yes	Yes
Moderate concerns	0	1	1	↔	Oct-13	No	No
Minor concerns	0	4	4	↔	Oct-13	No	No

Patient Experience	Threshold	Current Period	Prior Period	Movement	Period	Delivered Current Period	Delivered YTD
Friends and family test Inpatient	75	72.0	71.5	↑	Oct-13	No	No
Friends and family test A&E		59.9	70.0	↓	Oct-13		

Comments |

Based on the provider profiles created, the following exception reports will be provided:

1. RTT
2. A&E
3. HCAI
4. CQC Status

ER PSHFT 1 | RTT

Fig 1. PSHFT specialities below operating standards in October

	% 18 wk RTT
Admitted	4
Non Admitted	3
Incomplete	1

Comments |

The Trust aggregate position for all RTT standards was achieved in October (90.9% admitted, 97.1% non-admitted, 97.8% incomplete). Specialty level trajectories are reviewed monthly. In October, PSHFT failed to meet the standard for the following specialties:

- General Surgery (77.43%) , T&O (81.88%), Ophthalmology (88.07%) and Rheumatology (88.89%) - admitted
- Gastroenterology (90.65%), Plastic Surgery (90.91%) and T&O (92.82%) - non-admitted
- Neurosurgery (89.47%) – incomplete

The RSS programme operating in Borderline and Peterborough is expected to reduce referrals and support improvements at speciality level.
Detailed internal exception reports have been shared by PSHFT tracking performance at a specialty level with the CCG. In the main, it has been the same specialties that are a risk, the current list is:

- General Surgery (admitted) – The majority of problems in general surgery are linked to one consultant who has a particular specialism in colorectal surgery (40% of the surgery backlog.) The Trust has been redirecting any new referrals to alternative surgeons as a temporary measure since 10th September. This has been widely communicated to commissioners and referring GPs. This specialty represents a long-standing challenge. The plan focusses on the backlog reduction, & remains high risk. Clearing the residual backlog will take 3-4 months, but also requires the bed capacity – which will be a significant challenge during winter. Performance will deteriorate / remain below the 90% standard until the backlog is reduced to a sustainable level. (Note: non-admitted performance has been an issue but the Directorate has taken steps to ensure delays are minimised in this part of the pathway, given the 'admitted' pressures. The 95% standard was achieved in September and October and is on track for November.)
- Orthopaedics (admitted) - This is a high-volume specialty and performance was below 90% in Q1 alongside the Trust position as the backlog was recovered, and performance achieved in July & August, but is now below target (as predicted) in September, and is projected to remain <90% in October & November. Recovering the backlog is dependent upon protecting elective bed capacity. To this end, a 9-month virtual ward pilot commenced on 22nd October. (Note: non-admitted performance was delivered in July & August, missed the standard in September & October but is projected to be back on track for November)
- Ophthalmology (admitted) – This is another high-volume specialty with a number of capacity challenges to overcome throughout the pathway, and a focus for redesign through the Trust's PMO. Increasing pressures on the backlog has meant that the 'tail' is being targeted & reduced with lower performance as a by-product as the backlog is cleared. There are c. 200 clock stops per month, so the backlog needs to be maintained significantly under 20 for sustainable performance. November performance will be under-target, again due to this reduction, but should be more sustainable from December onwards.
- Gastroenterology / General Medicine (non-admitted) – Performance has been below 95% since the start of the year. A number of steps are being taken, including an investment appraisal for an additional consultant, but performance has been slightly above the previously agreed (internal) specialty trajectory, but the improvement fell slightly short of 95% in October (90.7%). A job plan has been agreed for 1 WTE Locum Consultant for Gastroenterology (starting on 1st November) to include morning ward rounds and afternoon outpatient clinics. The ward rounds will free up existing consultants to enable more outpatient clinics to take place with a view to improving performance.
- Neurosurgery (incomplete) - Neurosurgery non-admitted was under the 92% incomplete pathways target at the end of October. (Backlog of 4 patients). This is a very small volume service provided by a visiting consultant from CUHFT. The pathway is reliant on his availability & booking processes from CUHFT. PSHFT are in weekly contact with the Neurosurgery admin team there, to ensure patients are monitored / validated.

Weekly meetings are held where waiting lists are discussed at individual patient level to ensure next steps are booked and in place for all long-wait patients. Risks are then escalated to the COO at a weekly (Friday) Operations meeting which all General Managers attend.

There were no patients waiting over 52 weeks in October.

ER PSHFT 2 | A&E

Comments |

PSHFT met the A&E standard in November achieving 95.3%.

There are twice daily capacity meetings with a third meeting if the system is stretched. An escalation plan for the system has been drafted and has been in use from 1st November. Breach meetings are also held daily to analyse causes and actions taken

The system currently has a number of work streams to review processes as set out in the winter plan and the following actions are being undertaken to improve performance:

- Emergency Short Stay (ESS) pathways
- front door team/admission avoidance
- investment in discharge planning and interim beds to improve Delayed Transfers Of Care (DTOC) and patient flow.
- Invoke DTOC Act to S2s and S5s
- Discharge lounge fully functional from 21/11/13
- Intermediate Care services assessment will be done before PDD, not after.
- New assessment team based in ED goes live and plans to extend to become Single Point Of Access (SPOA) and work at back-end of hospital as well is in place.
- Support therapies internally to do speedy assessment
- Ward sisters & pharmacists to review and improve TTO process
- Streamline referrals process
- CHC reviewed
- "Choice" letters will be issued – in place
- Review of community services acceptance & discharge criteria
- Re-organising A&E internal process to better manage GP referrals – in place
- PSHFT currently reviewing process for speciality assessments within A&E to speed up review

As per the contract Remedial Action Plan, a plan with associated penalties is in place. Financial penalties were applied for October but haven't been applied for November as they have achieved the standard.

Fig 1. PSHFT Daily A&E Attends up to 15th December 2013

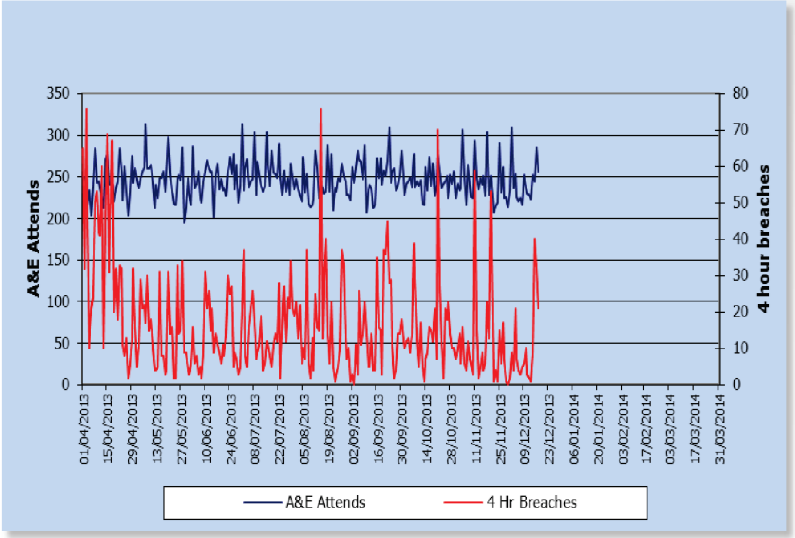
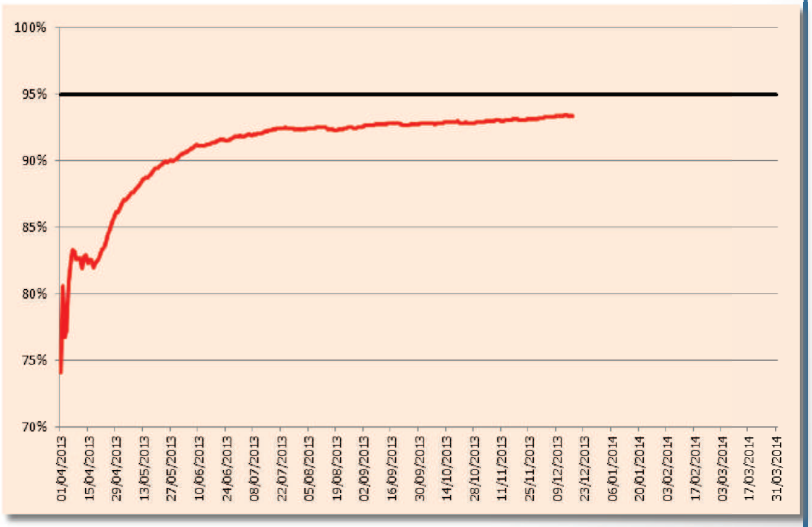
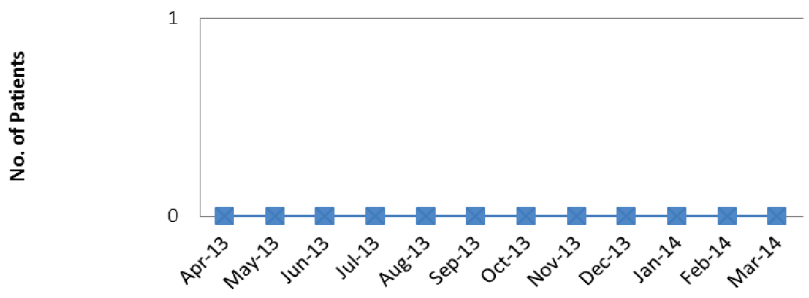


Fig 2. Cumulative A&E performance at PSHFT in 13/14



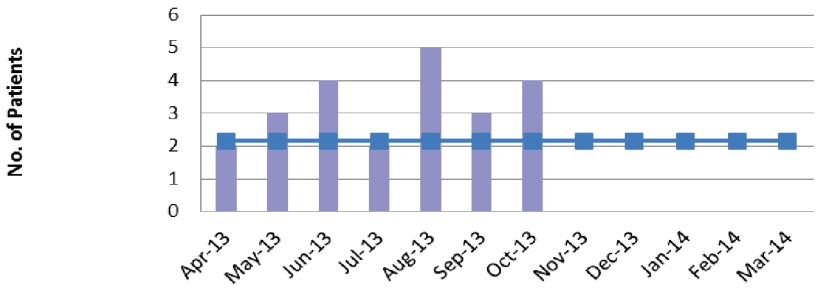
ER PSHFT 3 | HCAI

Fig 1. PSHFT MRSA cases (up to end of October)



	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14
Monthly Actual	0	0	0	0	0	0	0	0	0	0	0	0
Plan	0	0	0	0	0	0	0	0	0	0	0	0

Fig 2. PSHFT C Diff cases (up to end of October)



	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14
Monthly Actual	2	3	4	2	5	3	4	0	0	0	0	0
Plan	2.17	2.17	2.17	2.17	2.17	2.17	2.17	2.17	2.17	2.17	2.17	2.17

Comments |

MRSA

PSHFT had no cases of MRSA in October.
There have been 2 colonisations on one ward for MRSA.
Two members of staff tested positive.

PSHFT has returned to weekly audits in relation to MRSA colonisation.

C Diff

There were four cases of hospital acquired *Clostridium difficile* infection reported in October 2013. 23 cases YTD against an annual threshold of 26. A recent stakeholder meeting (held on 30th October) concluded that there may be issues in relation to cleaning. The CCG have not yet received minutes and actions from this meeting.

PSHFT has increased the scrutiny on their cleaning and are working on the issues of nurses helping with the cleaning in A&E. The Trust is piloting a new method of cleaning on two wards.

One case of C Difficile was deemed to be unavoidable by the NHS England Area Team scrutiny panel.

Provisional data show PSHFT reporting 5 C Difficile cases in November 2013 and therefore the Trust has breached its annual trajectory.

Nine cases sent for appeal have been declined by NHS England until transferred onto the correct forms. Early feedback has indicated concern over the contracted cleaning standards and audit results in place within the Trust. Further work is in progress to resolve these issues. Two wards have been deep cleaned using an ultra violet method.

QP

ER PSHFT 4 | CQC Status

Comments |

PSHFT has 1 moderate and 4 minor CQC concerns.

The CQC made a visit to John Van Geest Unit In Stamford in May 2013, and there was a follow up visit in August 2013. Three minor concerns were noted in relation to 4: Care and welfare of people who use services, 13: Staffing and 16: Assessing and monitoring the quality of service provision

The CQC inspected the Peterborough City Hospital in February 2013. This resulted in a moderate concern for outcome 4: Care and welfare of people who use services and a minor concern for outcome 16: Assessing and monitoring the quality of service provision.

PSHFT has two CQC action plans. All actions are completed in relation to the Peterborough City Hospital concern. There was one action outstanding on the Stamford Hospital plan, and this was completed in November 2013.

The CQC concerns will remain in place until the CQC carry out a follow-up review or inspection which is planned for 4th March 2014.

Outcome	Level of concern
4: Care and welfare of people who use services and outcome	Moderate - City Hospital, Minor - Stamford
13: Staffing	Minor - Stamford
16: Assessing and monitoring the quality of service provision	Minor – City Hospital, Minor - Stamford

Hinchingbrooke 1 of 2

Referral to treatment access times	Threshold	Current Period	Prior Period	Movement	YTD	Period	Delivered Current Period	Delivered YTD
Admitted patients	90%	93.82%	95.10%	↓	94.95%	Oct-13	Yes	Yes
No. of failing specialties	*0*	*0*	*0*	↔	*1*	Oct-13	Yes	No
Non admitted specialties	95%	98.40%	98.97%	↓	98.65%	Oct-13	Yes	Yes
No. of failing specialties	*0*	*0*	*0*	↔	*0*	Oct-13	Yes	Yes
Incomplete pathways	92%	93.99%	93.55%	↑	93.99%	Oct-13	Yes	Yes
No. of failing specialties	*0*	*0*	*0*	↔	*0*	Oct-13	Yes	Yes
Over 52 week waits	0	0	0	↔	0	Oct-13	Yes	Yes
Over 40 week waits		*2*	*8*	↑	*2*	Oct-13		

Diagnostic waits	Threshold	Current Period	Prior Period	Movement		Period	Delivered Current Period	Delivered YTD
No patient should wait > 6 weeks	99%	100.00%	99.90%	↑		Oct-13	Yes	Yes

A&E waits	Threshold	Current Period	Prior Period	Movement	YTD	Period	Delivered Current Period	Delivered YTD
Within four hours	95%	98.04%	95.92%	↑	96.47%	Nov-13	Yes	Yes
12 hour trolley breaches	*0*	*0*	*0*	↔	*0*	Nov-13	Yes	Yes
Ambulance Handover - Arrival to clear - 60 mins	0%	0.9%	1.9%	↑	2.0%	Nov-13	No	No

2 Week Cancer waits	Threshold	Current Period	Prior Period	Movement	YTD	Period	Delivered Current Period	Delivered YTD
2 week wait for urgent cancer referrals	93%	98.95%	98.41%	↑	98.55%	Oct-13	Yes	Yes
2 week wait for breast symptom referrals	93%	100.00%	98.04%	↑	98.51%	Oct-13	Yes	Yes

31 day Cancer waits	Threshold	Current Period	Prior Period	Movement	YTD	Period	Delivered Current Period	Delivered YTD
31 day wait to first definitive treatment for all	96%	98.28%	100.00%	↓	97.87%	Oct-13	Yes	Yes
31 day wait for subsequent surgery	94%	100.00%	100.00%	↔	100.00%	Oct-13	Yes	Yes
31 day wait for subsequent drug	98%	100.00%	100.00%	↔	100.00%	Oct-13	Yes	Yes
31 day wait for subsequent radiotherapy	94%	-	100.00%	↑	100.00%	Oct-13	Yes	Yes

62 day Cancer waits	Threshold	Current Period	Prior Period	Movement	YTD	Period	Delivered Current Period	Delivered YTD
62 day wait to first definitive treatment for all	85%	90.11%	94.57%	↓	90.44%	Oct-13	Yes	Yes
62 day wait following screening referral	90%	-	100.00%	↑	90.48%	Oct-13	Yes	Yes
62 day wait following consultant upgrade	None	0.00%	100.00%	↓	50.00%	Oct-13		

Mixed sex accommodation	Threshold	Current Period	Prior Period	Movement		Period	Delivered Current Period	Delivered YTD
Number of reported breaches	*0*	*0*	*0*	↔		Nov-13	Yes	Yes

Cancelled operations	Threshold	Current Period	Prior Period	Movement	YTD	Period	Delivered Current Period	Delivered YTD
Patients cancelled, not rebooked within 28 days	Not Available	0	1	↑	1	July -Sep (Q2)		
Urgent Operations cancelled	Not Available	0	0	↔	0	Nov-13		

VTE Risk Assessment	Threshold	Current Period	Prior Period	Movement	YTD	Period	Delivered Current Period	Delivered YTD
Incidence of VTE	90%	98.2%	98.7%	↓	98.5%	July -Sep (Q2)	Yes	Yes

Emergency Readmissions	Threshold	Current Period	Prior Period	Movement	YTD	Period	Delivered Current Period	Delivered YTD
Emergency Readmission within 30 days of discharge - (Crude A	Not Available	14.8%	14.1%	↓	13.9%	Oct-13		

Maternity	Threshold	Current Period	Prior Period	Movement	YTD	Period	Delivered Current Period	Delivered YTD
C-Section Rates	20%	19.2%	23.4%	↑	23.7%	Oct-13	Yes	No

Dementia	Threshold	Current Period	Prior Period	Movement	YTD	Period	Delivered Current Period	Delivered YTD
Percentage of Dementia cases identified aged 75 and over	90%	41.51%	5.00%	↑	23.25%	July -Sep (Q2)	No	No
Percentage of Dementia cases diagnosed aged 75 and over	90%	70.45%	100.00%	↓	85.23%	July -Sep (Q2)	No	No
Percentage of Dementia cases referred aged 75 and over	90%	55.68%	100.00%	↓	77.84%	July -Sep (Q2)	No	No

Hinchingbrooke 2 of 2

Quality indicators

Mortality information	National Mean	Current Period	Prior Period	Movement	Period	Delivered Current Period	Delivered YTD
SHMI	1	0.97	0.97	↓	Apr-12 - March-13	Yes	Yes

Patient safety	Threshold	Current Period	Prior Period	Movement	Period	Delivered Current Period	Delivered YTD
MRSA cases	0	0	0	↔	Oct-13	Yes	Yes
C Diff cases	8	0	0	↔	Oct-13	Yes	No
Never Events	0	0	0	↔	Nov-13	Yes	Yes
SIs reported within timescale	90%	79.0%			Apr - June (Q1)	No	No
Harm free care	95%	89.2%	89.2%	↑	Oct-13	No	No
Pressure Ulcer Prevalence	0	6.9	4.6	↓	Oct-13		

CQC status	Threshold	Current Period	Prior Period	Movement	Period	Delivered Current Period	Delivered YTD
Major concerns	0	0	0	↔	Oct-13	Yes	Yes
Moderate concerns	0	0	0	↔	Oct-13	Yes	Yes
Minor concerns	0	0	0	↔	Oct-13	Yes	Yes

Patient Experience	Threshold	Current Period	Prior Period	Movement	Period	Delivered Current Period	Delivered YTD
Friends and family test Inpatient	75	80.6	80.5	↑	Oct-13	Yes	Yes
Friends and family test A&E		71.7	77.5	↓	Oct-13		

Comments |

Based on the provider profiles created, the following exception reports will be provided:

1. A&E
2. HCAI

Please note that with regard to the Dementia figures, HHCT have advised that the way UNIFY records this information does not match the language in the CQUIN and therefore what is actually recorded and reported by HHCT. At a meeting with the Trust on 12th December they confirmed that they were at 100% for the percentage of patients identified that have been assessed and then referred. They also have made good progress and are now at 94.3% in November for patients identified. The Trust raised this issue with the Department of Health in October and as the figures had been released as 'public' it wasn't possible to amend them at the time. Recent uploads have now had the error corrected.

ER HHCT 1 | A&E

Comments |

HHCT met the A&E Target for November (98.04%).

The Hunts system is coordinating daily, multiagency, teleconferences.

At each Urgent Care Board (UCB) call the following information is discussed:

- Reasons for each breach of 4 hours and actions to prevent in the future.
- Number and reasons for each DTOC (delayed transfer of care) and mitigating actions
- Planned admissions and discharges, to assure of Trust "net" bed state.

Commissioners and partners have agreed an operational shift of beds in Residential Care to Nursing Interim beds in order to support patient flow from Acute to Community to own/residential home.

HHCT has sustained good performance to date. Pressure is building as winter hits and noro-virus etc. puts pressure on beds. The allocation of winter funds will allow the system to expand capacity in community beds and services and this should enable the system to continue to deliver the 95% standard.

Fig 1. HHCT Daily A&E Attends up to 15th December 2013

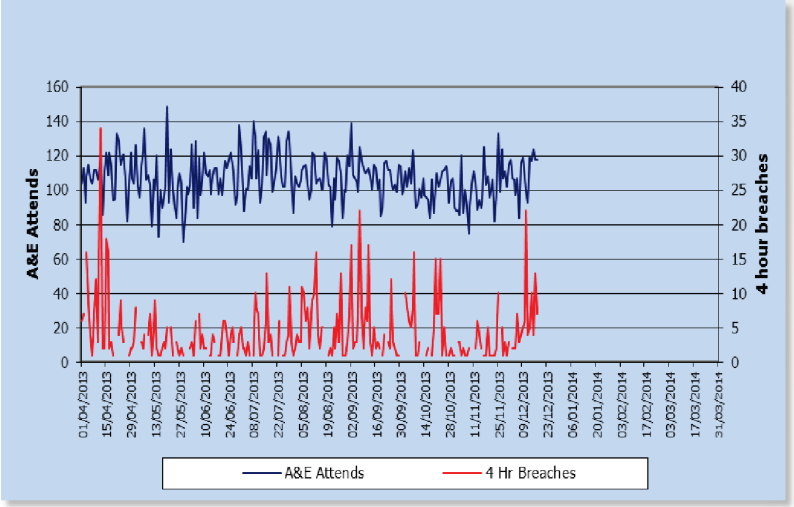
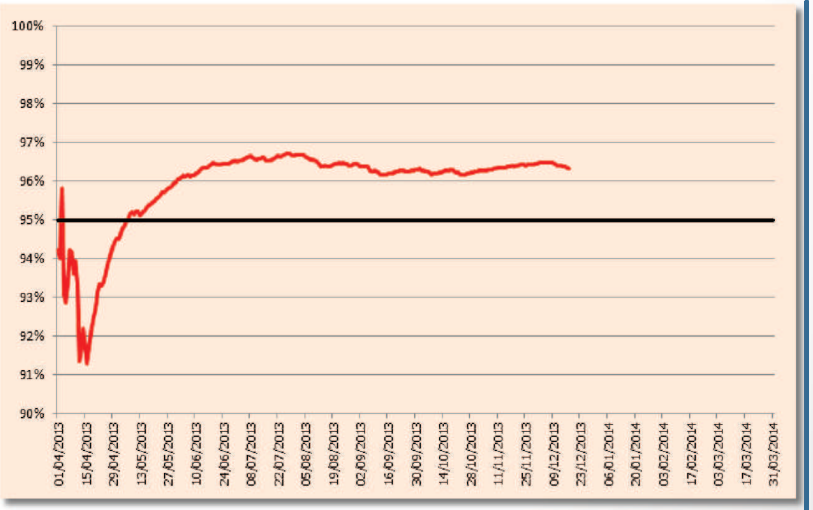
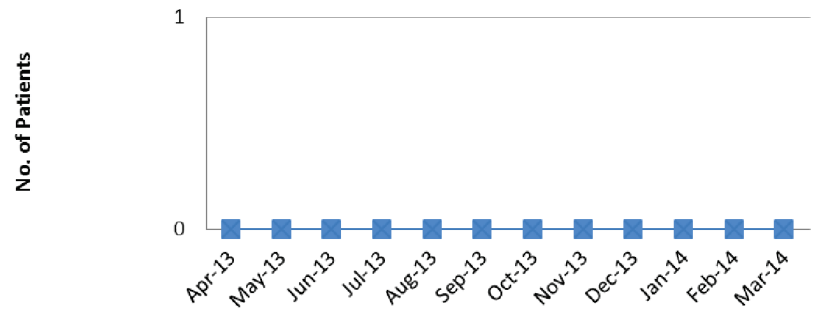


Fig 2. Cumulative A&E performance at HHCT in 13/14



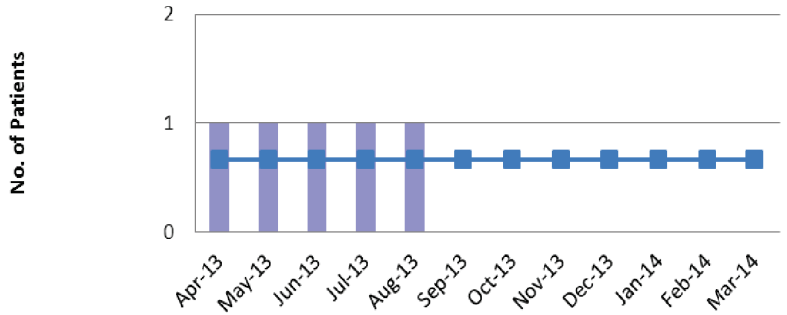
ER HHCT 2 | HCAI

Fig 1. HHCT MRSA cases (up to end of October)



	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14
Monthly Actual	0	0	0	0	0	0	0	0	0	0	0	0
Plan	0	0	0	0	0	0	0	0	0	0	0	0

Fig 2. HHCT C Diff cases (up to end of October)



	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14
Monthly Actual	1	1	1	1	1	0	0	0	0	0	0	0
Plan	0.67	0.67	0.67	0.67	0.67	0.67	0.67	0.67	0.67	0.67	0.67	0.67

Comments |

MRSA

HHCT had no cases of MRSA in October.

- There are monthly hand hygiene audits in clinical areas and non-compliant areas are audited on a weekly basis until compliance is sustained.
- All non compliant screens are investigated.
- Current issues with laboratory/IT interface means that some specimen results are not transferring over. This is being investigated by the Trust.
- Blood culture contamination and the preparation of skin prior to cannulation is reinforced at mandatory update and induction training.

C Diff

No cases of C Difficile have been reported in October.

- Changes to the treatment regime (in line with the most up to date guidelines from PHE) have been made to the Procedure document.
- As with MRSA, there are monthly hand hygiene audits monthly in clinical areas with non-compliant areas being audited on a weekly basis until compliance is sustained.
- ICNs monitor single room occupancy and provide advice.
- ICNs are now conducting environmental audits and training ward managers to undertake the audits.
- As reported last month, the Trust Development Authority have visited and an action plan to address the issues highlighted is in progress.

A peer-review of IP&C took place on 5th November 2013 and some infection control issues were identified. An Action Plan is being developed and a further peer-review visit will take place on 16th December. HHCT are still within their Clostridium Difficile ceiling.

QP

CCS |

Referral to treatment access times	Threshold	Current Period	Prior Period	Movement	YTD	Period	Delivered Current Period	Delivered YTD
Non admitted specialties	95%	99.48%	99.77%	↓	99.53%	Oct-13	Yes	Yes
No. of failing specialties	*0*	*0*	*0*	↔	*0*	Oct-13	Yes	Yes
Incomplete pathways	92%	99.60%	99.84%	↓	99.60%	Oct-13	Yes	Yes
No. of failing specialties	*0*	*0*	*0*	↔	*0*	Oct-13	Yes	Yes
Over 52 week waits	0	0	0	↔	0	Oct-13	Yes	Yes
Over 40 week waits		*0*	*0*	↔	*0*	Oct-13		

Diagnostic waits	Threshold	Current Period	Prior Period	Movement	Period	Delivered Current Period	Delivered YTD
No patient should wait > 6 weeks	99%	100.00%	100.00%	↔	Oct-13	Yes	Yes

Mixed sex accommodation	Threshold	Current Period	Prior Period	Movement	Period	Delivered Current Period	Delivered YTD
Number of reported breaches	*0*	*0*	*0*	↔	Nov-13	Yes	Yes

Cancelled operations	Threshold	Current Period	Prior Period	Movement	YTD	Period	Delivered Current Period	Delivered YTD
Urgent Operations cancelled	Not Available	0	0	↔	0	Nov-13		

VTE Risk Assessment	Threshold	Current Period	Prior Period	Movement	YTD	Period	Delivered Current Period	Delivered YTD
Incidence of VTE	90%	100.0%	99.7%	↑	99.9%	July -Sep (Q2)	Yes	Yes

Quality indicators

Patient safety	Threshold	Current Period	Prior Period	Movement	Period	Delivered Current Period	Delivered YTD
MRSA cases	0	0	0	↔	Oct-13	Yes	Yes
C Diff cases	1	0	0	↔	Oct-13	Yes	Yes
Never Events	0	0	0	↔	Nov-13	Yes	Yes
SIs reported within timescale	90%	73.0%			Apr - June (Q1)	No	No
Harm free care	95%	93.2%	91.4%	↑	Oct-13	No	No
Pressure Ulcer Prevalence	0	5.1	5.9	↑	Oct-13		

CQC status	Threshold	Current Period	Prior Period	Movement	Period	Delivered Current Period	Delivered YTD
Major concerns	0	2	0	↓	Oct-13	No	No
Moderate concerns	0	0	1	↑	Oct-13	Yes	No
Minor concerns	0	2	4	↑	Oct-13	No	No

Patient Experience	Threshold	Current Period	Prior Period	Movement	Period	Delivered Current Period	Delivered YTD
Friends and family test Inpatient	75	85.0	85.0	↔	Oct-13	Yes	Yes

Comments |

Based on the provider profiles created, the following exception reports will be provided:

1. Harm Free Care
2. CQC Concerns

ER CCS 1 | Harm Free Care

Comments |

Harm free care has been Amber or Red for each month of 2013 - a contract query has been issued.

CCS has taken action to reduce pressure ulcers and falls, and CCS pressure ulcer numbers are falling. Falls have reduced significantly which may be relating to ExtraCare going from CCS to Cambridgeshire County Council as this was an area where many falls occurred.

VTEs are a concern because when patients develop a VTE at home and this is diagnosed by CCS, this contributes towards the CCS 'new harms' figure.

CCS has had a small increase in catheter-acquired UTIs (CAUTIs). The Trust is looking at being part of a joint approach to CAUTI management that involves PSHFT, CCS, Primary Care and PCC. This could then be extended to other areas of the CCG.

Please see the Contract Queries section of this report for further details (page 73).

ER CCS 2 | CQC Status

Comments |

CCS has two major and two minor CQC concerns. There is a minor concern relating to district nurse staffing (outcome 13: Staffing) and another relating to CCS governance (outcome 16: Assessing and monitoring the quality of services).

In September 2013 the CQC followed up their February visit to the paediatrics Holly Ward and the final report increased the concerns for outcome 4: Care and welfare of people who use services and outcome 13: Staffing from minor to major. The ward was found to be compliant with outcome 10: Safety and suitability of premises.

Outcome	Level of concern
4: Care and welfare of people who use services and outcome	Major – Holly ward
13: Staffing	Minor – Headquarters, Major – Holly ward
16: Assessing and monitoring the quality of service provision	Minor – Headquarters

The CCG Quality team visited Holly Ward in September 2013. A contract query has been issued to CCS. A Remedial Action Plan is in place encompassing CQC and CCG actions. This is being monitored through the CQR process and is progressing to timescale.

NOTE: CCS has declared non-compliance for the CQC outcome 13: Staffing. The CQC visited the Trust on 9th December 2013.

CPFT |

Care Programme Approach	Threshold	Lower Threshold	Current Period	Prior Period	YTD Actual	Movement	Period	Delivered Current Period	Delivered YTD	Below Lower Threshold
% of people on CPA followed up within 7 days of discharge	95.0%	90.0%	95.1%	96.3%	96.3%	↓	Oct-13	Yes	Yes	No
								100%	100%	

Mixed sex accommodation	Threshold	Current Period	Prior Period	Movement	Period	Delivered Current Period	Delivered YTD
Number of reported breaches	*0*	*0*	*0*	↔	Nov-13	Yes	Yes

VTE Risk Assessment	Threshold	Current Period	Prior Period	Movement	YTD	Period	Delivered Current Period	Delivered YTD
Incidence of VTE								

Quality indicators

Patient safety	Threshold	Current Period	Prior Period	Movement	Period	Delivered Current Period	Delivered YTD
Never Events	0	0	0	↔	Nov-13	Yes	Yes
Harm free care	95%	100.0%	96.8%	↑	Oct-13	Yes	Yes

CQC status	Threshold	Current Period	Prior Period	Movement	Period	Delivered Current Period	Delivered YTD
Major concerns	0	0	0	↔	Oct-13	Yes	Yes
Moderate concerns	0	0	0	↔	Oct-13	Yes	Yes
Minor concerns	0	1	0	↓	Oct-13	No	No

Comments |

Based on the provider profiles created and additional information, the following exception reports will be provided:

1. IAPT - People who completed treatment and are moving to recovery
2. CQC Status

ER CPFT 1 | IAPT

Comments |

CCG Performance for 2013/14 so far is outlined in the table below:

KPI	Target	Actual Performance	Reason for Poor performance	How target will be delivered
% of patients who have entered treatment for Psychological Therapy	60%	April – 88.5% May – 55.5% June – 72.5% July – 70% August – 65% September – 73% October – 68%	N/A as well above target for every month apart from May.	N/A
% of patients who have completed **therapy and are moving to recovery**	50%	April – 40% May – 62% June – 43% July – 45% August – 49% September – 46% October – 46%	The IAPT programme has very restricted criteria for a patient to qualify as "recovered". Their measured levels of typical anxiety or depression must fall between narrow bands both before they enter and after they have completed treatment. These bands have been set arbitrarily and have no clinical validity. The practical effect is to encourage providers to exclude patients who would benefit from the service, but whose measured levels of anxiety or depression fall (mostly) above or below the criteria set. Patients may also improve their measured well-being by more than that specified to qualify as "recovered", but for the purposes of this target not count as "recovered". This measure also in practice reduces the numbers accessing therapy at all, contrary to the aim of the other key IAPT target to increase overall access rates amongst the local population. The recovery rate of the local IAPT service is actually significantly above the national average. The clinical steer of local GPs has been to promote overall access, not to restrict access in order to meet this artificial target.	In order to raise the reported recovery rate, we would need to reduce the numbers actually accessing therapy at all. As explained, this would be clinically inappropriate, especially in the way that access to effective treatment for the more severely ill would in practice be closed. We would then fail to meet our key access targets. The LAT (Local Area Team) have been briefed by all local services about this contradiction between their targets. Local access rates are approximately 6% of the local population. With further productivity initiatives, the maximum access rate that can be achieved within the current service capacity is 8%. Therefore the CCG has a shortfall from the expected target of 15% by 7%. It is going to be extremely challenging to achieve 15% by March 2015 because of the constraints around who can deliver IAPT-compliant services, the need for staff recruitment and training. This will also require almost a doubling of the capacity of the current local service. CMET are aware and have been briefed as to the financial implications of this requirement.

ER CPFT 2 | CQC Status

Comments |

The CQC visited Fulbourn Hospital in September 2013, focusing on Mulberry 3 and Springbank wards. A minor concern was reported for outcome 7: Safeguarding people who use services from abuse.

There have been six Serious Incidents (SIs) relating to Safeguarding Adults since April 2013.

A contract query is in place in relation to the Safeguarding Adults SIs. The CCG are monitoring the Trusts' Safeguarding Adults Action Plan via the CQR process. The Action plan includes CQC concerns and the SIs.

Outcome	Level of Concern
7: Safeguarding people who use services from abuse.	Minor

There is a moderate concern for outcome 7: Safeguarding people who use services from abuse and a minor concern for outcome 13: Staffing in relation to the Specialist Commissioned Service at CUHFT.

Papworth | 1 of 2

Referral to treatment access times	Threshold	Current Period	Prior Period	Movement	YTD	Period	Delivered Current Period	Delivered YTD
Admitted patients	90%	90.32%	95.10%	↓	92.24%	Oct-13	Yes	Yes
No. of failing specialties	*0*	*1*	*1*	↔	*7*	Oct-13	No	No
Non admitted specialties	95%	98.57%	97.44%	↑	98.48%	Oct-13	Yes	Yes
No. of failing specialties	*0*	*0*	*0*	↔	*0*	Oct-13	Yes	Yes
Incomplete pathways	92%	93.82%	94.41%	↓	93.82%	Oct-13	Yes	Yes
No. of failing specialties	*0*	*1*	*1*	↔	*1*	Oct-13	No	No
Over 52 week waits	0	2	1	↓	2	Oct-13	No	No
Over 40 week waits		*10*	*9*	↓	*10*	Oct-13		

Diagnostic waits	Threshold	Current Period	Prior Period	Movement		Period	Delivered Current Period	Delivered YTD
No patient should wait > 6 weeks	99%	99.60%	99.30%	↑		Oct-13	Yes	Yes

31 day Cancer waits	Threshold	Current Period	Prior Period	Movement	YTD	Period	Delivered Current Period	Delivered YTD
31 day wait to first definitive treatment for all	96%	100.00%	100.00%	↔	97.52%	Oct-13	Yes	Yes

62 day Cancer waits	Threshold	Current Period	Prior Period	Movement	YTD	Period	Delivered Current Period	Delivered YTD
62 day wait to first definitive treatment for all	85%	60.00%	85.71%	↓	68.75%	Oct-13	No	No

Mixed sex accommodation	Threshold	Current Period	Prior Period	Movement		Period	Delivered Current Period	Delivered YTD
Number of reported breaches	*0*	*0*	*1*	↑		Nov-13	Yes	No

Cancelled operations	Threshold	Current Period	Prior Period	Movement	YTD	Period	Delivered Current Period	Delivered YTD
Patients cancelled, not rebooked within 28 days	Not Available	13	5	↔	18	July -Sep (Q2)		
Urgent Operations cancelled	Not Available	0	5	↑	30	Nov-13		

VTE Risk Assessment	Threshold	Current Period	Prior Period	Movement	YTD	Period	Delivered Current Period	Delivered YTD
Incidence of VTE	90%	99.3%	99.6%	↓	99.5%	July -Sep (Q2)	Yes	Yes

Emergency Readmissions	Threshold	Current Period	Prior Period	Movement	YTD	Period	Delivered Current Period	Delivered YTD
Emergency Readmission within 30 days of discharge - (Crude A	Not Available	2.1%	3.0%	↑	1.8%	Oct-13		

Dementia	Threshold	Current Period	Prior Period	Movement	YTD	Period	Delivered Current Period	Delivered YTD
Percentage of Dementia cases identified aged 75 and over	90%	100.00%	95.00%	↑	97.50%	July -Sep (Q2)	Yes	Yes
Percentage of Dementia cases diagnosed aged 75 and over	90%	100.00%	100.00%	↔	100.00%	July -Sep (Q2)	Yes	Yes

Papworth | 2 of 2

Quality indicators

Patient safety	Threshold	Current Period	Prior Period	Movement	Period	Delivered Current Period	Delivered YTD
MRSA cases	0	0	0	↔	Oct-13	Yes	Yes
C Diff cases	5	1	0	↓	Oct-13	No	No
No. of post infection reviews for MRSA	0	0			Apr-13	Yes	Yes
Never Events	0	0	0	↔	Nov-13	Yes	Yes
Harm free care	95%	99.0%	97.5%	↑	Oct-13	Yes	Yes
Pressure Ulcer Prevalence	0	0.5	0.5	↑	Oct-13		

CQC status	Threshold	Current Period	Prior Period	Movement	Period	Delivered Current Period	Delivered YTD
Major concerns	0	0	0	↔	Oct-13	Yes	Yes
Moderate concerns	0	0	0	↔	Oct-13	Yes	Yes
Minor concerns	0	0	0	↔	Oct-13	Yes	Yes

Patient Experience	Threshold	Current Period	Prior Period	Movement	Period	Delivered Current Period	Delivered YTD
Friends and family test Inpatient	75	82.5	83.9	↓	Oct-13	Yes	Yes

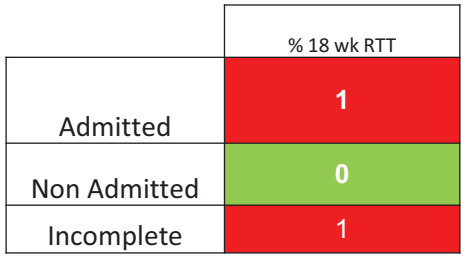
Comments |

Based on the provider profiles created, the following exception reports will be provided:

1. RTT
2. HCAI

ER Papworth 1 | RTT

Fig 1. PSHFT specialities below operating standards



Comments |

The Trust aggregate position for all RTT standards was achieved in October (90.32% admitted, 98.57% non-admitted, 93.82% incomplete).

Cardiothoracic Surgery underachieved both the admitted (82.8%) and incomplete (85.8%) RTT standard in October.

This is due to increased referrals and increased cancellations leading to inefficiency in the use of the existing capacity.

A Recovery Plan has been received and the following actions are being taken to improve performance:

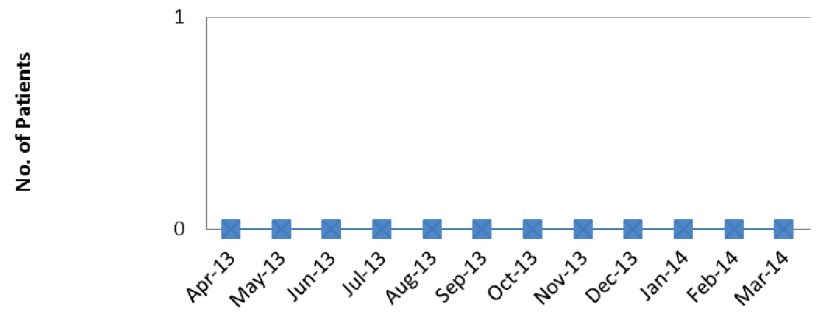
- The waiting list is being reviewed weekly by the Clinical Director of Cardiac Surgery and the service manager.
- The weekly meeting is to risk assess all cases and ensure as far as possible that urgent cases are kept to no more than 32. Urgent cases are typically short waiters and the Trust needs to ensure that it targets the long waiters while balancing the need of the urgent cases.
- The remaining capacity is taken up with in house urgent i.e. emergency activity.
- An additional theatre has been opened to run on a Saturday for two sessions (commenced mid July 2013).
- Glenfield Hospital, Leicester have agreed to undertake ten cases per month on Papworth's behalf, commencing from October for one year.
- The Trust is currently undertaking a pilot with The Spire Lee Hospital in Cambridge for Thoracic surgery. The pilot is expected to result in a longer term arrangement for Thoracic surgery which will release theatre capacity on the Papworth site as activity is transferred to the Spire Lee.
- The current new management of IHU activity has seen a reduction in IHU theatre slots required due to the reduction in cancellations of operations. This is expected to release one theatre slot a week.
- There are future plans to undertake cardiac surgery at CUHFT from Spring 2013.

The Trust plan envisages to meeting the standard for this specialty by May 2014 and we are working with NHS England to monitor implementation of the RAP.

There were 2 patients waiting over 52 week waits in October, one of which was a C&P CCG patient. The patient has now been seen and treated. The other patient is on a specialist pathway and is being followed up by NHS England.

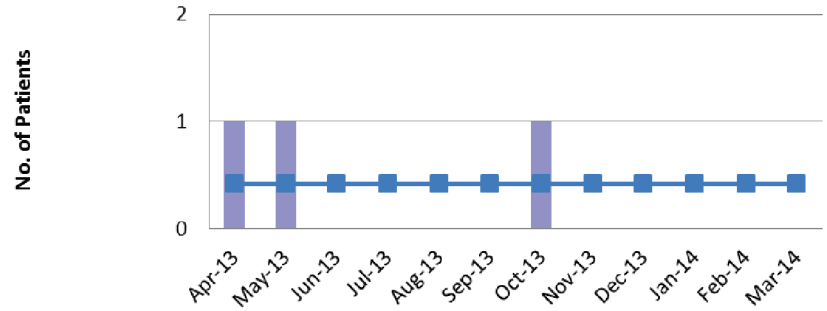
ER Papworth 2 | HCAI

Fig 1. Papworth MRSA cases (up to end of October)



	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14
Monthly Actual	0	0	0	0	0	0	0	0	0	0	0	0
Plan	0	0	0	0	0	0	0	0	0	0	0	0

Fig 2. Papworth C Diff cases (up to end of October)



	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14
Monthly Actual	1	1	0	0	0	0	1	0	0	0	0	0
Plan	0.42	0.42	0.42	0.42	0.42	0.42	0.42	0.42	0.42	0.42	0.42	0.42

Comments |

MRSA

There have been no cases of MRSA at Papworth.

C Diff

There were no C Difficile cases reported by Papworth in November. There was one case in October and a review meeting took place on 5th December and the case is being prepared for appeal.

QP

QEH | 1 of 2

Referral to treatment access times	Threshold	Current Period	Prior Period	Movement	YTD	Period	Delivered Current Period	Delivered YTD
Admitted patients	90%	89.54%	90.39%	↓	91.10%	Oct-13	No	Yes
No. of failing specialties	*0*	*4*	*4*	↔	*31*	Oct-13	No	No
Non admitted specialties	95%	98.28%	99.44%	↓	98.53%	Oct-13	Yes	Yes
No. of failing specialties	*0*	*1*	*0*	↓	*3*	Oct-13	No	No
Incomplete pathways	92%	95.63%	95.76%	↓	95.63%	Oct-13	Yes	Yes
No. of failing specialties	*0*	*2*	*2*	↔	*2*	Oct-13	No	No
Over 52 week waits	0	0	0	↔	0	Oct-13	Yes	Yes
Over 40 week waits		*5*	*1*	↓	*5*	Oct-13		

Diagnostic waits	Threshold	Current Period	Prior Period	Movement		Period	Delivered Current Period	Delivered YTD
No patient should wait > 6 weeks	99%	99.90%	99.80%	↑		Oct-13	Yes	Yes

A&E waits	Threshold	Current Period	Prior Period	Movement	YTD	Period	Delivered Current Period	Delivered YTD
Within four hours	95%	94.45%	92.53%	↑	91.44%	Nov-13	No	No
12 hour trolley breaches	*0*	*0*	*0*	↔	*0*	Nov-13	Yes	Yes
Ambulance Handover - Arrival to clear - 60 mins	0%	1.0%	5.6%	↑	5.6%	Nov-13	No	No

2 Week Cancer waits	Threshold	Current Period	Prior Period	Movement	YTD	Period	Delivered Current Period	Delivered YTD
2 week wait for urgent cancer referrals	93%	96.64%	97.98%	↓	97.70%	Oct-13	Yes	Yes
2 week wait for breast symptom referrals	93%	100.00%	100.00%	↔	98.79%	Oct-13	Yes	Yes

31 day Cancer waits	Threshold	Current Period	Prior Period	Movement	YTD	Period	Delivered Current Period	Delivered YTD
31 day wait to first definitive treatment for all	96%	98.25%	97.00%	↑	98.59%	Oct-13	Yes	Yes
31 day wait for subsequent surgery	94%	100.00%	96.43%	↑	99.35%	Oct-13	Yes	Yes
31 day wait for subsequent drug	98%	98.08%	100.00%	↓	99.21%	Oct-13	Yes	Yes

62 day Cancer waits	Threshold	Current Period	Prior Period	Movement	YTD	Period	Delivered Current Period	Delivered YTD
62 day wait to first definitive treatment for all	85%	89.92%	82.20%	↑	88.05%	Oct-13	Yes	Yes

Mixed sex accommodation	Threshold	Current Period	Prior Period	Movement		Period	Delivered Current Period	Delivered YTD
Number of reported breaches	*0*	*4*	*2*	↓		Nov-13	No	No

Cancelled operations	Threshold	Current Period	Prior Period	Movement	YTD	Period	Delivered Current Period	Delivered YTD
Patients cancelled, not rebooked within 28 days	Not Available	9	19	↑	28	July -Sep (Q2)		
Urgent Operations cancelled	Not Available	1	0	↓	15	Nov-13		

VTE Risk Assessment	Threshold	Current Period	Prior Period	Movement	YTD	Period	Delivered Current Period	Delivered YTD
Incidence of VTE	90%	97.5%	97.9%	↓	97.7%	July -Sep (Q2)	Yes	Yes

Emergency Readmissions	Threshold	Current Period	Prior Period	Movement	YTD	Period	Delivered Current Period	Delivered YTD
Emergency Readmission within 30 days of discharge - (Crude A	Not Available	24.8%	22.3%	↓	23.3%	Oct-13		

Maternity	Threshold	Current Period	Prior Period	Movement	YTD	Period	Delivered Current Period	Delivered YTD
C-Section Rates	22%	21.6%	27.7%	↑	24.8%	Oct-13	Yes	No

Dementia	Threshold	Current Period	Prior Period	Movement	YTD	Period	Delivered Current Period	Delivered YTD
Percentage of Dementia cases identified aged 75 and over	90%	94.79%	93.00%	↑	93.89%	July -Sep (Q2)	Yes	Yes
Percentage of Dementia cases diagnosed aged 75 and over	90%	100.00%	100.00%	↔	100.00%	July -Sep (Q2)	Yes	Yes
Percentage of Dementia cases referred aged 75 and over	90%	100.00%	100.00%	↔	100.00%	July -Sep (Q2)	Yes	Yes

QEH | 2 of 2

Quality indicators

Mortality information	National Mean	Current Period	Prior Period	Movement	Period	Delivered Current Period	Delivered YTD
SHMI	1	1.02	0.99	↓	Apr-12 - March-13	No	No

Patient safety	Threshold	Current Period	Prior Period	Movement	Period	Delivered Current Period	Delivered YTD
MRSA cases	0	0	0	↔	Oct-13	Yes	Yes
C Diff cases	19	0	2	↑	Oct-13	Yes	Yes
Never Events	0	0	0	↔	Nov-13	Yes	Yes
Harm free care	95%	93.9%	91.7%	↑	Oct-13	No	No
Pressure Ulcer Prevalence	0	4.9	6.6	↑	Oct-13		

CQC status	Threshold	Current Period	Prior Period	Movement	Period	Delivered Current Period	Delivered YTD
Major concerns	0	3	3	↔	Oct-13	No	No
Moderate concerns	0	2	2	↔	Oct-13	No	No
Minor concerns	0	4	4	↔	Oct-13	No	No

Patient Experience	Threshold	Current Period	Prior Period	Movement	Period	Delivered Current Period	Delivered YTD
Friends and family test Inpatient	75	61.0	69.2	↓	Oct-13	No	No
Friends and family test A&E		52.1	49.1	↑	Oct-13		

Comments |

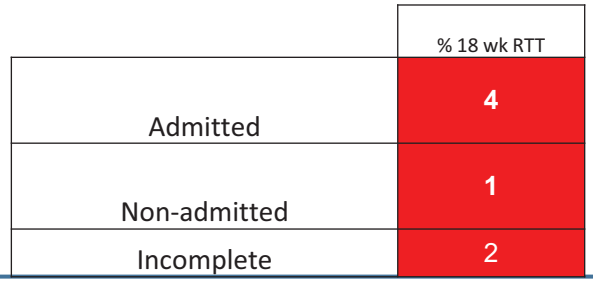
Based on the provider profiles created, the following exception reports will be provided:

1. RTT
2. A&E
3. CQC Status
4. Friends and Family

Please note, West Norfolk CCG are co-ordinating commissioner for QEH.

ER QEH 1 | RTT

Fig 1. QEH specialities below operating standards



Comments |

The Trust aggregate position for non-admitted and incomplete RTT standards was achieved in October (98.28% non-admitted, 95.63% incomplete), however the Trust did not meet the admitted standard (89.54%).

ENT (71.1%), Gynaecology (77%), Plastic Surgery (75%) and T&O (66.9%) underachieved the admitted standard in October.

Urology (83.3%) underachieved the non admitted standard and Geriatric medicine (89.7%) and T&O (91.5%) underachieved the incomplete standard.

The CCG had previously agreed with QEH that they would achieve 18 week waiting targets at specialty level by the end of October except for T&O (end of December). Fines are being levied for 18 week + waiters in line with contractual requirements. We are awaiting a further update from the Trust.

ER QEH 2 | A&E

Comments |

QEH failed to meet the A&E 4 hour performance standard in November (94.45%).

There has been a forensic focus on A&E performance at QEH following the poor performance in the first few months of the year. This has included weekly Urgent Care Network meetings and a daily teleconference led / attended by NHS England. A Remedial Action Plan was drawn up and more recently a plan to utilise the additional winter pressures funding allocated to the system. Wisbech LCG has played a full part in this work. As a result A&E performance has improved markedly with the last four weeks up until week commencing 16th December seeing performance above 95%. Performance has dropped in the week commencing 16th December and the system wide focus on achieving this target remains.

Fig 1. QEH Daily A&E Attends up to 15th December 2013

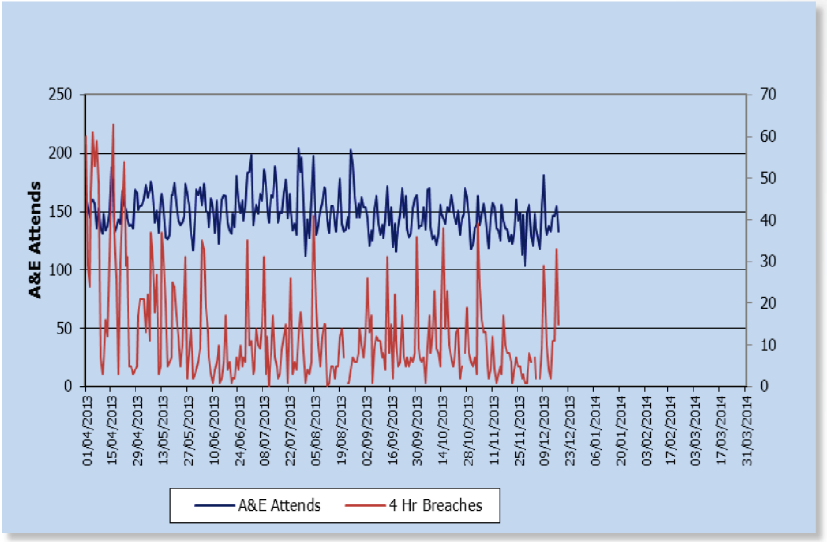
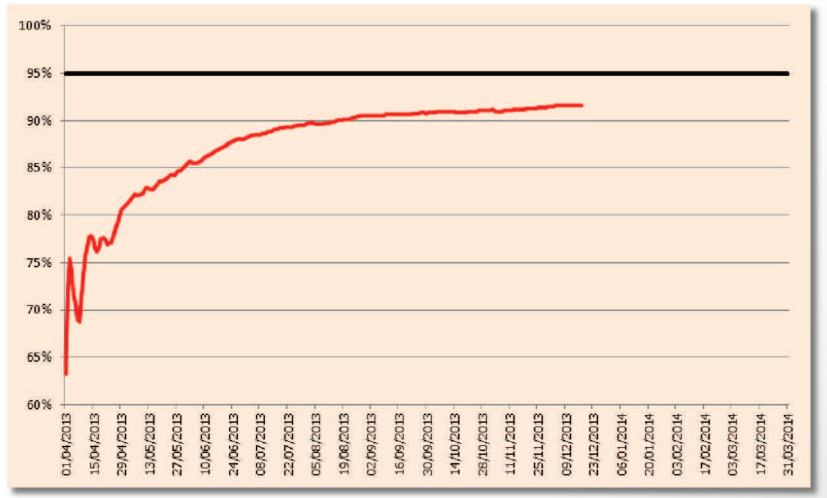


Fig 2. Cumulative A&E performance at QEH in 13/14



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QP

ER QEH 3 | CQC Status

Comments |

The CQC warning notices for outcomes 7: Safeguarding, 13: Staffing, 14: Supporting workers and 16: Assessing and monitoring the quality of service provision remain in place. These notices need to be met by 31st December 2013.

The CCG continue to work with West Norfolk CCG to drive improvements at QEH.

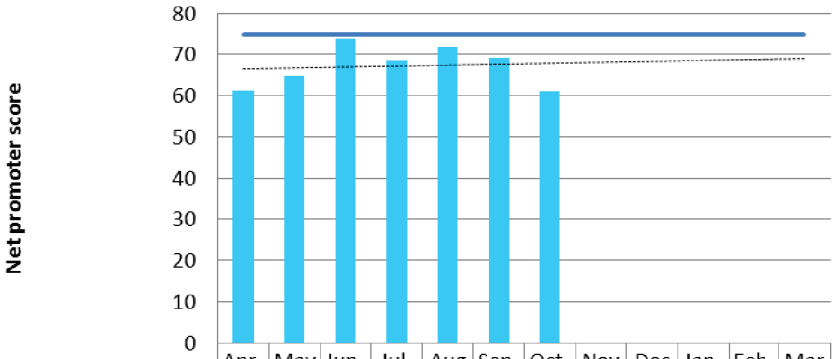
An external interim Director of Nursing has been appointed from Ipswich Hospital and this post will hold the executive lead for quality.

Activity around improving the workforce continues to ensure the right resources are in place.

Outcome	Level of concern
2: Consent to care and treatment	Major
7: Safeguarding people who use services from abuse	Warning Notice
13: Staffing	Warning Notice
14. Supporting workers	Warning Notice
16: Assessing and monitoring the quality of service provision	Warning Notice
5. Meeting nutritional needs	Moderate
6: Cooperating with other providers	
21: Records	
1: Respecting and involving people who use services	Minor
4: Care and welfare of people who use services	
9: Management of medicines	
17: Complaints	

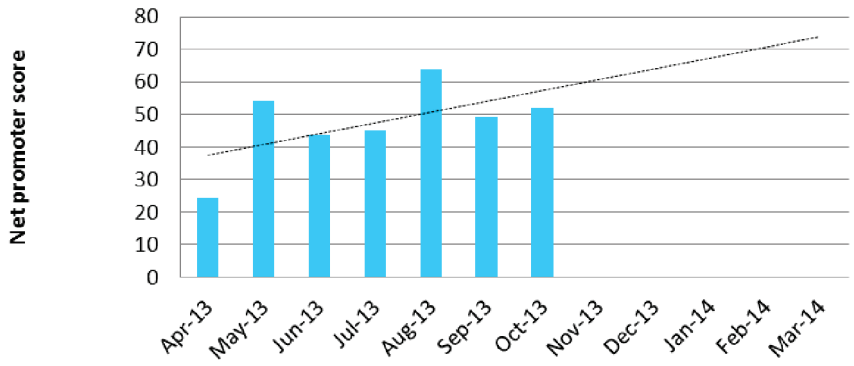
ER QEH 4 | Friends and Family

Fig 1. Friends and Family Net Promoter (Inpatients) - QEH



	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14
Monthly Actual	61	65	74	69	72	69	61					
Plan	75	75	75	75	75	75	75	75	75	75	75	75

Fig 2. Friends and Family Net Promoter (A&E) - QEH



	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14
Monthly Actual	24	54	43	45	64	49	52					

Comments |

QEH's scores for both A&E and the Wards are relatively low compared to other Trusts. Both the individual scores and free text comments are shared with Matrons and Ward Charge Nurses / Sisters, discussed with the team and issues identified are addressed. It is felt that as the Trust improves its staffing levels they will see an improvement in the F&F scores.

Section eight

CONTRACTUAL LEVERS SUMMARY

1. Contract Queries in Line with General Condition 9

Standard / Quality requirement	CUHFT	PSHFT	HHCT	Other Contracts (eg UCC, QEH, Papworth)
RTT	Contract query raised 30.09.13. Meeting held 14.10.13 and action plan received. One new consultant in place - a second joint post with Peterborough will commence at their host Trust on 18.11.13 A weekly trajectory for this backlog clearance is now being sent. A remedial action plan has been sent by the Trust. CCG to write to the Trust to confirm agreement to the plan as it stands.	PSHFT failed the aggregate admitted standard for the first time in May. Contract Query issued 11.07.13. Specialty level trajectories are reviewed monthly. Contract query raised for individual speciality level and for 1 x 52 week wait in August. RTT action plan received and agreed. PSHFT holding weekly meetings to review and expedite patients at risk of breaching target.	Contract query issued in 2012/13 regarding 18 week RTT Rules. As of 24 October Trust advise that the Deloitte Audit has been deferred for the next 6 months as the Trust COO advised that they are undertaking a review of their validation process and a detailed Action Plan of the work the Trust are doing around 18 Week RTT will be shared with the CCG and they will confirm the audit dates with the Contracts Team once they have been finalised to take place early March. CQ CLOSED	Papworth- Contract Query raised 24th June regarding Cardiothoracic surgery. NHSE is the dominant commissioner for this activity. Trust have an action plan in place and recovery is anticipated May 2014. QEH - Contract Query issued by Co-ordinating Commissioner (West Norfolk CCG) on 8th July 2013 in relation to four specialities not achieving target in April. Remedial action plan produced by QEH and agreed. Performance monitored monthly. Fines being levied as per contract.
Diagnostics			Contract query issued 29.05.13 HHCT provided RAP 7.6.13. Not agreed by CCG. Revised trajectory requested to bring performance back into standard earlier than previously reported. Letter sent to Trust 16.7.13 notifying them that the CCG will be withholding payment for failure to agree RAP and if no RAP is agreed by 30.7.13 2% monthly payables will be withheld. Trust COO to provide overall trajectory and TCI dates for the backlog of patients being treated by 2.8.13. Agreed to withhold money from 5.8.13 until overall trajectory received including patient TCI dates. 9.8.13 revised trajectory received and shows that the Trust will meet the 99% standard by end of August 2013. This is being closely monitored. 24.10.13 CQ CLOSED	
A&E	A & E Update Contract query meeting held on 04.12.13 and further review 10.12.13. Remedial Action Plan not yet agreed.	Performance continues to be below standard, achieving only 1 month since April. £5 million has been secured to assist implementation of the urgent care winter plan. Release of additional funding is conditional on a commitment to achieve the 95% standard . Contract Query on A&E performance on the 19th of April. Various iterations of the RAP have been discussed. The final version the RAP including a trajectory has been submitted to show delivery of the 95% standard by the Trust from October including the application of financial consequences for failure to achieve any milestones. Any financial penalties applied for the performance in October and November will be reinvested to support the deliver of the standard in subsequent months. From December the application of penalties will be in line with the standard contract clauses set out in General condition 9. Failed to achieve target in October so 2% withheld on Nov 1st. Achieved 95.2% in November so 2% repaid to PSHFT in December	Contract Query raised 20.09.13 due to increase in the percentage of admissions from A&E and need to understand the reasons for this. CQ CLOSED Trust A&E Consultant left HHCT and Trust did not notify CCG until the day the consultant was leaving . CQ CLOSED	QEH - Contract Query issued by Co-ordinating Commissioner (West Norfolk CCG) in April 2013 following poor performance on A&E target. .The 95% target was not achieved in either Q1 or Q2. The original RAP has been superseded as a result of the CQC and Monitor actions. As a result of Area Team action progress on achieving A&E target now forms part of wider action plan being managed and monitored through weekly Urgent Care Board meetings and daily teleconferences, both of which attended by IOE / Wisbech LCG representatives. QEH has achieved 95% in last four weeks although looks likely to fail to do so in most recent week (w/b 8 Dec)

1. Contract Queries in Line with General Condition 9 (cont)

Standard / Quality requirement	CUHFT	PSHFT	HHCT	Other Contracts (eg UCC, QEH, Papworth)
Cancelled Operations		The number of cancelled operations continues to be above trajectory.		
HCAI	Contract query raised 27.08.13. Meeting held 06.09.13 to discuss action plan. Action plan now agreed and in place and monitored by Lynn Rodriguez.	CQN was issued on 24.09.13 to seek assurance of actions to mitigate performance in year to meet annual ceiling. Investigation demonstrated the cases were non-avoidable cases CQ not closed until improvement seen next quarter. MRSA – contract query raised for failure to meet the 100% screening threshold. New national guidance is being published soon and indications are a change back to risk assessed screening. Awaiting the guidance before proceeding, but CQ remains open. CQ's remain open. Unannounced inspection to PSHFT happening on 11.12.13 to assess infection control.	Contract Query raised 04.07.13 re CDiff cases x1 for 3 consecutive months. Contract Management Meeting held with Trust 23rd July with agreed actions. Contract Query will be held open and revisited once Qtr. 2 data is available, by then the Trust will have established whether the proposed review process is effective. HHCT have had 5 C.Diff cases YTD which is within their profile. A peer-review of IP&C took place 05.11.13 and some infection control issues were identified. An Action Plan is being developed and a further peer-review visit will take place on 16.12.13. HHCT are still within their C.Difficile ceiling.	
Ambulance Handover			Ambulance Handover Issues. Trust COO arranging Tripartite Meeting with EEAST, HHCT, CCS and CCG to update on actions from audit undertaken by EEAST. Tri partite Meeting scheduled for end of September to jointly agree and sign off Handover Protocol. A meeting with HHCT and EEAST was arranged for 22.11.13. but EEAST did not turn up so meeting cancelled. This has been escalated within the CCG and needs to be resolved by EEAST in the next 2 weeks.	EEAST – Urgent and Emergency Ambulance contract A contract query was issued by the consortium on 14.08.13 on the failure of EEAST to deliver against the Red 1, Red 2, and Cat A19 targets in the contract year to date. There has been no improvement in performance and EEAST have failed to produce a RAP which clearly demonstrates their ability to rectify this under performance Therefore, with effect from December 2013, 2% of the monthly contract sum is to be withheld until such time as EEAST provide satisfactory RAP The actual and potential implications of this under performance on clinical quality and safety, is currently being reviewed by the Consortiums Clinical Quality and Governance group. The Clinical Quality Commission commenced a follow up inspection w/c 09.12.13
Stroke / TIA		In July and August failed to meet the >80% threshold for patients being on stroke unit 90% of time. CQ not raised as met target in Sept	High risk TIA contract query raised Contract Query raised 2012/13. CCG met with Trust on 16.5.13. It was agreed at this meeting that referrals from within the Hunts system should go along the stroke pathways and be referred to either Peterborough or CUHFT. CUHFT requested a further meeting with CCG and HHCT to establish an agreed process. Meeting currently being re scheduled as soon as possible We have expedited the delay in Trust leads getting back to us to their Commercial Lead and hopefully we will get a date scheduled soon. Teleconference took place on 28th August with HHCT, CUHFT, EEAST and CCG.. Following this CUHFT now want to discuss internally before providing CCG with a "formal" view on whether they can take the small number of HHCT patients. CUHFT CCG Contract Lead has advised that the current pathway must not be changed until agreement is reached.	

1. Contract Queries in Line with General Condition 9 (cont)

Standard / Quality requirement	CUHFT	PSHFT	HHCT	CPFT	CCS	Other Contracts (eg UCC, QEH, Papworth)
C & B	Contract Query raised 05.11.13 regarding poor response times for Advice and Guidance through choose and book. Meeting held on 5 November. Action plan now in place. Administration staff have been identified to lead and follow up requests that are not responded to within 5 working days. Ops managers to be trained and granted access to CAB. Reinforced awareness amongst the clinical team of the importance of providing responses in a timely manner and the Trust Lead Manager and Lead Clinical will review the performance monthly. No further action to be taken. Ongoing monitoring on response times by C&B manager.		Contract Query issued 29th May 2013. RAP not agreed. Revised RAP with trajectory received within deadline 9th August 2013. Trust advise performance will be brought back into standard by December (Urology and GI Liver) and November for other specialties excluding Urology and GI Liver. CCG advised Trust on 22.08.13 that we require all specialties to be brought back into standard by end of November at the latest. Choose & Book Slot Issues have improved on last month and stand at 0.07 for Month 6. HHCT are committed to reaching 0.03 target by end of November. On week commencing 24.11.13 Trust ASI issues reported at 0.11. It is unlikely that performance will be brought back into standard. This is being closely monitored. The CCG are preparing to send a first exception notice.			
Failure to report SI	CQ raised 18.10.13. Meeting held 22.10.13 to discuss action plan. As of 08.11.13 waiting for CUHFT to confirm agreement to action plan. Action plan and revised reporting templates are in place. A designated email address has been identified for liaison and reporting purposes and a further review meeting has been arranged on 24.01.14	CQ raised on 01/10 for failure to report in time. Meeting to be held on 09.10.13 to discuss action plan. Action plan agreed and CQ remains open until action plan completed and improvement seen				
Other			C- Section: Contract Query Raised failure to deliver Caesarean Section Rate performance indicator month 1 and 2. Trust responded 14.06.13 and COO reported that each case had been reviewed and all cases were undertaken for medical reasons with the exception of 5 cases. HHCT Gynaecologist is trying to reduce the rate of patients who previously had a C-Section having subsequent births by C-section. Discussed further at SQEG Meeting 25.07.13 and was agreed clinically appropriate.CQ remains open until further discussion with GP Leads takes place as to whether further action required. Discussed at SQEG 22.08.13 and Trust Consultant Gynaecologist to send through a more detailed report of cases reviewed for CCG feedback. Report and audit reviewed by GP leads. CQ CLOSED	CAMH Waiting lists: 17.7.13 - Request to receive accurate performance data that reflects the current position regarding CAMH waiting lists and confirmation that this error is not replicated in any other area within the Providers performance data. 14.08.13 – RAPs received for both parts of the Contract query that are being monitored through the normal performance meeting route. Both are on target. CQ CLOSED	Community Beds – Brookfields (Lord Byron) and POW (Welney Ward) - Original contract query issued in January 2013 following closure of Welney Ward (POW). Welney Ward opened in May 2013 but Lord Byron Ward (Brookfields) closed at the same time. Therefore kept original CQ open but agreeing with CCS new remedial action plan and financial consequences of closure. Contract management meetings held and agreement reached on RAP and "rebate" during period of closure. CCS running project with active involvement of local LCGs. Performance will be monitored through SQPR and local project meeting led by Catch / Cam Health LCGs Update: 04/11/13 - CQ remains open. Weekly CCS/LCG meetings continue. Lord Byron scheduled for a phased re-opening, commencing 11th November. In addition to agreed rebate during closure of ward, will be further rebate as per contract until CCS 90% occupancy of 20 F11beds. CV under negotiation for 6 beds to become step-up beds. Welney Ward has remained opened despite serious staffing issues. Update: 11/12/13 - L.Byron has 14 step-down beds. Opening of step-up delayed until January 2014, due to recruitment issues. Welney ward beds open. CQ remains open.	QEH - Following adverse CQC reports and Monitor assessment QEH has been placed in special measures. They are required to produce a single action plan that incorporates addressing the CQC concerns and key performance and financial issues

1. Contract Queries in Line with General Condition 9 (cont)

Standard / Quality requirement	HHCT	CPFT	CCS
Other	Colorectal Cancer: Contract Query raised regarding Colorectal Cancer Reporting 24.07.1. Discussed at CQR Meeting 25.07.13. Agreed Trust evidence to be sent through to CCG by 02.08.13. Trust commercial Lead will address issue of Trust staff on leave which created a single point of failure for submitting the evidence required. CQ CLOSED	Serious Incidents: Contract Query issued due to the large number and nature of Serious Incidents from February to June 2013. Action: A contract query meeting was held 09.09.13 A RAP has been agreed although a final version is awaited and is being monitored through the performance meetings (next meeting 09.12.13)	Integrated Respiratory Service Concerns raised about whether the additional funding given in 2012/13 has resulted in the achievement of an integrated service between CCS and Addenbrookes. Also indications of issues with clinical staff raised by the clinical leads. As CCS are lead provider for this service CQ raised with them. Contract query issued 15/07/13. Contract management meeting held on 23rd July. CCS actions agreed at the meeting (RAP) with timetable. CCS report on actions received and performance will be monitored through SQPR and local meeting led by Cam Health LCG. Update: 04/11/13 Awaiting response from CCS to one query, intention will then be to close CQ. Update: 11/12/13 Steering Group meeting scheduled 12th Dec. Will then be reviewed with a view to CQ being closed.
Other	Mandatory staff training: Contract Query raised 08.08.13 regarding low % of Trust Staff who have received Mandatory Training. This issue had been raised in the June CQR Meeting but no improvement had been made by the following meeting. RAP received 22.08.13 in the CQR Meeting on this date. RAP agreed however, Trust need to include equality and diversity training. RAP to be monitored through CQR and have requested improvement in % of training figures by next meeting 3rd October. The Trust does not currently offer Equality and Diversity training, mandatory training figures are improving, and Basic Life Support percentages are now shown. HHCT has recruited someone to take forward Equality and Diversity training. All new staff receive E&D training at induction. E&D roll-out to complete by end December.	SI Management: This Contract Query was issued in accordance with the Quality Dashboard contained within Schedule 6C of the Contract Particulars and which states as follows: "If a monthly indicator remains amber for 3 months or more, with no progress made towards the green threshold, the rating will be revised to Red. If a quarterly indicator remains amber for 2 quarters or more, with no progress made towards the green threshold, the rating will be revised to Red." This applies to the following area below which is now Amber and has been rated Amber for preceding 5 month period SI Management (15a) Actions: SLG of CPFT agreed to provide a RAP by 26 September detailing all remedial Action to be taken including that discussed in the CQR on 9 September 2013. Draft RAP provided and comments made. Waiting for final version to be sent through and to be monitored through the performance meetings (next meeting 09.12.13)	Specialist Nursing: Lengthy dialogue between CCG and CCS following questions about clinical governance arrangements for specialist nurses. Has culminated in CQ issued on 15th July to seek clear answers to specific questions about these arrangements. Contract management meeting held on 23rd July. CCS actions agreed at the meeting (RAP) with timetable. CCS initial response received and will be assessed by CCG Quality team to determine if satisfactory. Final response due on 6th September and will also be assessed. Performance will be monitored through CQR and SQPR. Update: 04/11/13 CQ CLOSED
Other	Cardia rehab: Contract Query raised re Cardiac Rehab 2012/13. Joint work currently being undertaken with Public Health to gain feedback from all Trusts to ensure standard reporting from Trusts is achieved. Letter to be sent out to all Cambs and Peterborough hospitals 15.08.13. Letter on hold till further notice from Public Health. Public Health and CCG Contract Leads Teleconference/Meeting scheduled for 20.09.13 regarding cardiac rehab. This will cover areas of Commissioning Intentions, Older People Procurement and implications for CR, moving forward audit/benchmarking activity (review letter and process) and Agree next steps. CQ CLOSED following submission of audit.		District Nursing – Following three unannounced visits to services In Cambridge, Peterborough, and Wisbech some concerns identified that previous assurances that action plan had been completed and arrangements in place were not borne out in the visits in some cases. CQ issued on 15th July. Contract management meeting held on 23rd July. CCS actions agreed at the meeting (RAP) with timetable. Modified action plan (RAP) to be produced by CCS by 12th September and will be assessed by Quality team. Performance will be monitored through CQR and SQEG. Update: 11/12/13 Paper had been submitted to CMET 20th Nov, with recommendation series of reg. mtg's planned with LCG's & CCS. CCS have sent CGC submission stating they are now non-compliant with reg 22, but didn't notify CCG. But have given assurance will be compliant 1st Dec. Will be further discussed at CQR/SQEG 12th Dec CQ remains open

1. Contract Queries in Line with General Condition 9 (cont)

Standard / Quality requirement	CCS
Other	Harm Free Care CQ issued 22nd August to seek a RAP and associated trajectory for lifting performance to above 95%. CCS have provided a response / several RAPs covering key areas but questioning 95% target. CCG will consider this response but has provisionally arranged a Contract management meeting for when key people are back from annual leave later in September. Update: 04/11/13 CQ Meeting took place 7th Oct, and action plan agreed. Monitoring continues Update: 11/12/13 Oct 2013 report shows achievement of 93.18%, (Sept 93.35%). Will be reviewed at SQEG, and decision taken to continue to monitor or close CQ
Other	Holly Ward: Continued concerns, mainly re: staffing levels CQ issued 4th Nov. CCS have issued RAP. Meeting arranged 7th Nov with CCS to review. Update: 11/12/13 Following meeting CCS issued updated RAP. CQ remains open. City Care Centre Community Beds: Following concerns raised that there were a number of empty beds at City Care Centre which CCS had not informed the LCGs / CCG about a contract query has been raised to identify what happened and appropriate action to prevent any re-occurrence. Update: 11/12/13 CCS issued excusing notice 19th Nov. In response CCG has scheduled meeting s18th Dec. Following meeting and agreed RAP, decision will be taken if CQ to be closed.
Other	City Care Centre Community Beds: Following concerns raised that there were a number of empty beds at City Care Centre which CCS had not informed the LCGs / CCG about a contract query has been raised to identify what happened and appropriate action to prevent any re-occurrence. Update: 11/12/13 CCS issued excusing notice 19th Nov. In response CCG has scheduled meeting s18th Dec. Following meeting and agreed RAP, decision will be taken if CQ to be closed.

2. Activity Query Notices in line with Service Condition 29

Area of Query by treatment function or service	HHCT	Other Contracts (eg UCC, QEH, Papworth)
Over Performance	Activity Query Notice issued 14th June 2013. Joint Activity Review Meeting took place on 9th July with agreed actions. Next meeting currently being schedule 17th September. CCG and Trust Strategic Escalation Meeting held on 13th August. Activity Review Meetings continue -joint investigation and actions agreed following last meeting. AMP discussions on-going with Trust	
Outpatients		Papworth - Activity Query raised 5 July on outpatients over performance. Recent analysis of activity by clinic has pinpointed change of attendance type in Respiratory Medicine. The Trust is due to respond as to the reason for this. Trust has also admitted a coding change in Oncology clinics from single professional to multiprofessional.

3. Information Breaches in Line with Service Condition 28

Information Breach	HHCT
Direct Access Radiology	Information Requirements Activity Notice Query issued 9th June 2013. Rectified within 5 op days. CQ CLOSED

Overview and Scrutiny Committee

ADULTS, WELLBEING AND HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Cambridgeshire County Council

5th December 2013

Action

24. DECLARATIONS OF INTEREST

Councillor van de Kerkhove declared an interest in agenda item 5b (minute 28b refers) as a trustee for Dhiverse. Councillor Bailey declared an interest in agenda item 6 (minute 29 refers) as the County Council's representative on the Council of Governors of Cambridgeshire and Peterborough Foundation Trust (CPFT).

25. MINUTES OF LAST MEETING

The minutes of the meeting held on 12th September 2013 were confirmed as a correct record and signed by the Chairman.

26. FORWARD WORK PROGRAMME

a) Committee priorities and work programme 2013/14

The Committee reviewed its priorities and work programme for the remainder of the municipal year. Members noted that the Committee was scheduled to meet twice more, on 4th February and 13th March, before the Council implemented the change to the committee system of governance on 13th May 2014.

The Chairman offered to lead a member-led review on housing and support for people with acquired brain injury; through his work as a local member, he had become aware of problems that could arise in such cases. The Committee supported this proposal, and it was agreed that Councillor Bridget Smith would serve on the review group with Councillor Bourke. **KB, BS**

Members noted the work that had already been undertaken by Councillors Hickford and Scutt to examine the level of support given to families who experience a miscarriage, stillbirth or neonatal death. Councillor Hickford advised that he was unable to continue with this work himself, but would support the formation of a working group. It was decided to ask Councillor Scutt and the Scrutiny and Improvement Officer to continue to look at this important topic. **JB, JS**

Examining the table of priorities and the outline timetable, the Committee

- agreed that each organisation should be asked to submit, for the March meeting, a one-page update on its work to implement the recommendations of the member-led review of delayed discharge and discharge planning
- agreed that the topic of Adult Social Care IT was too substantial for the Committee to embark on at this stage

- agreed that an item on the East of England Ambulance Trust should be added to the agenda for the February or March meeting
- agreed that Councillors Bourke, Frost and van de Ven would meet the Director of Public Health to explore where Overview and Scrutiny could add value to work on tackling health inequalities
- noted that the regional Joint Overview and Scrutiny Committee on liver metastases surgery proposals was making good progress. It was anticipated that an information report could be brought to Committee on 4th February
- commented that insufficient priority had perhaps been given to Mental Health, as there was a mental health aspect to every area of the Committee's work.

b) Cabinet agenda plan

The Committee noted that the Long Term Transport Strategy for Cambridgeshire was on the Cabinet agenda plan for the meeting on 28th January. It was agreed that, while there was insufficient time for the Committee to make any fresh observations on transport issues, Councillors Reynolds and van de Ven would follow up previous comments by the Committee on transport matters.

27. MEMBER LIAISON ARRANGEMENTS

The Committee reviewed its liaison arrangements with lead County Council officers, with NHS organisations used by people in Cambridgeshire, and with Healthwatch Cambridgeshire. The following changes and additions were agreed:

- CPFT – Councillor K Reynolds to join Councillors Bourke, van de Ven and B Smith on the liaison group
- Hinchingbrooke Hospital – Councillor Bourke (not Councillor Bailey) to join Councillors Criswell, Downes and K Reynolds on the liaison group
- Cambridge University Hospitals NHS Foundation Trust (CUHFT, Addenbrooke's) – liaison to be undertaken by Councillor Hickford, the Council's partner organisation governor on the CUHFT Council of Governors
- Papworth Hospital NHS Foundation Trust – Councillor Loynes to join Councillor M Smith, with Councillor Bourke if available
- Queen Elizabeth Hospital King's Lynn NHS Trust – Councillor Bourke to liaise should liaison be required
- Peterborough and Stamford Hospitals NHS Foundation Trust – no named member to be identified at this stage, as Peterborough City Council's Scrutiny Commission for Health Issues was taking the lead on liaison with the Trust.

It was reported that design images had recently been published for the new Papworth Hospital, to be built on the Addenbrooke's site. Members were reminded that the Papworth Joint Overview and Scrutiny Committee had examined the proposal to relocate some years ago; it remained to be seen whether that committee's recommendations would be reflected in the design of the new hospital.

A member asked that members be notified of the dates of liaison meetings with Adult Social Care, to give other members the opportunity to attend with the Chairman and Vice-Chairman

28. COUNTY COUNCIL BUSINESS PLAN 2014/15

a) Adult Social Care, Older People and Mental Health Services

The Committee considered a report setting out the Council's draft Business Plan proposals for Adult Social Care (ASC), Older People (OP) and Mental Health (MH) services. The report also provided an update on performance in 2013/14.

In attendance to present the report and respond to members' questions and comments were

- Councillor Fred Yeulett, Cabinet Member for Adult Services
- Adrian Loades, Executive Director: Children, Families and Adults (CFA)
- Charlotte Black, Service Director: Older People's Services, CFA
- Claire Bruin, Service Director: Adult Social Care, CFA
- Meredith Teasdale, Service Director: Strategy and Commissioning, CFA.

The Cabinet Member introduced the report. He reminded members that ASC was the largest budget area within the Council, and that its services were demand-led. With the exception of Older People's services, the 2013/14 budget was being delivered. In response to a £7.1m overspend reported by Cambridgeshire Community Services NHS Trust (CCS) in OP care management budgets at October 2013, new budget management arrangements had been put in place, under which the care management teams had taken control of the budgets. Reablement was delivering savings, but it was proving increasingly difficult to deliver savings at a time when increased numbers of people were using the services; service users were living longer and had higher levels of need than in the past.

For the future, the Cabinet Member said that it was necessary to re-think how to use the budget, because the level of savings required meant that the current pattern of services for adults (aged 18 – 64) and older people (aged 65+) was unsustainable. He stressed the importance of early intervention where it would reduce longer-term costs, and of working closely with carers, voluntary sector partners, and local communities. It would be necessary to take risks and to make difficult decisions together with partners, in particular the Health Service. An Adult Social Care bill was being published, and the Government would be looking at social care criteria.

The Cabinet Member told members that it was important that the Integrated Transformation Funding – which was not all new money – be used to deliver services differently. The Health and Wellbeing Board would have an important part to play in this. The way ahead for the delivery of Adult Social Care, Older People's, and Mental Health services would be difficult and challenging.

The Executive Director reinforced the Cabinet Member's message, saying that there was an enormous challenge, in respect of both Council funding as a whole and how the funding related to individual services. Given the level of demand and the resources available, the current approach to service delivery could not be sustained. It was necessary to make a reality of the rhetoric of prevention, to provide a safety net, and to give staff the discretion occasionally to provide services for somebody below the qualifying threshold where it made long-term sense to so. He was aware that the reductions in service provision would have a negative impact on recipients, but the necessary savings could not be made without reducing direct care costs.

The Committee examined the budget proposals for ASC, OP and MH as a whole and in detail, identifying a number of concerns in the course of a wide-ranging discussion. The points noted by members in answer to their questions and comments included that

- the authority would not be changing its eligibility criteria because the Care and Support Bill was due to set national criteria. These might be different from the authority's current criteria, though the Executive Director believed that current criteria were in line with those anticipated; he did not expect that the current number of recipients would be reduced
- the figures for inflation, demography and demand had been arrived at in conjunction with the Council's Research Group; those for demography and demand were as robust as they could be, but the Executive Director was less sure of the sensitivity of the inflation analysis
- the authority had joined with others in the Local Government Association's lobbying of Government for better funding. The Cabinet Member did not disagree with a member's suggestion that a detailed direct letter be sent to Government – this approach had already been tried in relation to the level of funding for education
- in response to the question whether it was realistic to embed and action 37 specific bullet-pointed savings [report paragraph 8.12], the Executive Director said that the Committee would have been more critical had the report lacked such detail. These actions were at the heart of the strategy because it was essential to make savings and manage demand
- the Service Director: Older People's Services had met all staff transferring in from CCS and sought their views on what could be done to make savings; many of the components of the action plan had come from the staff. The bullet-pointed savings needed now to be transferred into a prioritised action programme
- care providers would be receiving an uplift of 1.5%, following one year of a 3% reduction and two years of zero uplift. The Committee's member-led review on home care had concluded that it was necessary to spend more in order to give a decent level of pay and attract staff. The most recent tendering had been done in November 2013; inspection visits were carried out on a regular basis, and any organisation inflating its rates above the market would not be used in future. When providers had been told to make savings in the years of negative and zero uplift, they had delivered the savings
- 'robust' had been used frequently [para. 8.12] to mean that the various actions required needed to achieve value for money. The Service Director: Older People's Services had heard from staff that thinking about the impact of actions on the budget had not been explicit, in that individual staff had not given due weight to value for money when for example conducting assessments. It was necessary to tighten up procedures, and if a cheaper course of action could produce outcomes for the service user as good as those from a more expensive course, then the cheaper course should be preferred.
- CCS budgets had been held centrally, but ASC had devolved budgets (except for block purchase) to team managers, and ensured that team managers were aware of unit costs. The budgets had been devolved on the basis of the current spend, but work was under way to develop a fairer way to allocate funds from April 2014 onwards, to avoid uneven spending in different areas of the county

- clearer guidance was being supplied to the panel established to consider packages above a certain figure, and agreement had been reached with CPFT about the level of scrutiny it would apply to decisions it made when arranging mental health care packages
- in response to a question whether some people were receiving services that they no longer required because their cases were not being reviewed, it was acknowledged that review performance could be better. The Executive Director offered to supply the figure for reviews conducted, which was around 60% to 70% over the past 18 months **AL**
- asked whether there was a business case for employing extra staff to conduct reviews, officers said that this had been done to some extent in Learning Disability in the previous year, and could be considered for OP services. A peripatetic team was being deployed on an invest-to-save basis to go and trouble-shoot on e.g. assessments and delayed reviews
- what was meant by 'a maximum limit for different types of care packages'[para. 8.12d] was that if the cost of supporting somebody in their own home exceeded the benchmark cost of residential care, the question would be asked whether it was reasonable to keep them in their own home. The onus on the authority was to meet the assessed need, but there was no obligation to pay the higher figure
- the risks associated with measures to manage packages for people with learning disabilities, with physical disabilities, and with sensory needs [para. 8.13] included as a major element the need to manage demand from the cohort already receiving services at a time when more people were starting to receive services than were no longer requiring them and budgets were shrinking. Reducing direct payments would have an impact on the activities that they could afford to undertake; this could be subject to judicial review if a family said that the funding allocated was insufficient to meet assessed needs
- in response to a question about investing in voluntary and community sector support to mitigate the effects of reduced funding, such as increased isolation, members were advised that housing associations were looking at infrastructure support to smaller associations, and it might be possible for the Council to work through them
- savings of about 20% were required in the Adult Mental Health Services budget [para. 8.16]. Work on how to achieve this was being undertaken with CPFT; individual care packages were the largest area of spending. The CPFT post of Director of Service Integration was jointly funded by the Council and CPFT as part of efforts to achieve better joining-up of health and social care services.

  The Service Director: Older People's Services offered to supply detail of the percentage figure; the Chairman asked for budget reports in future to have that type of information within the narrative **ChB**
- in response to the point that conventional transport was not always the right form of transport, and questions on how far officers in the Council's Environment, Transport and Economy directorate had been pressed to protect the community transport budget [budget line 6.105], and what was being done about the government grant for community transport that was about to end, members were advised that community transport was used if there was no need for special transport. The Chairman said that community transport would be followed up outside the meeting

- the use of assistive technology to replace waking night staff [line 6.109] had already been started; a six-week monitoring period was used to establish what equipment would be needed and what reduction in staff could be made
- the rationalisation of housing support contracts [line 6.122] covered support at a level below that of social care, and included e.g. regular payment of bills and relationships with neighbours; contracts were being retendered and aligned with core County Council business, and could well be delivered by housing associations
- a joint approach was being developed with the CCG to negotiating residential and nursing home placements and supporting self-funders to secure placements [line 6.202]
- the Executive Director undertook to supply members with the information missing from the budget table which corresponded to the community impact assessment on services for single homeless people in the review of voluntary and community organisations [line 6.205]. **AL**

Members pointed out that they had a responsibility to share information with their residents and asked how the urgency of the budget situation was being communicated to the general public. At a recent parish conference, a member had said that it would be helpful to know the unit costs of activities that parish councils might fund. The Executive Director assured members that Adult and Older People's services did link up with the Council's communications team, and also had their own communications strategy for service users.

In reply to the comment that it was difficult to get an overall sense of where the big risks were and how they would be managed, the Executive Director said that the largest and most controversial savings would be run as projects, using project management techniques including risk monitoring.

At the Committee's request, officers provided an update on actions to address the continuing problem of delayed discharge from hospital, which had been the subject of a recent member-led review. Measures at Addenbrooke's included a brokerage scheme for care provision, increased domiciliary care capacity, additional capacity for reablement, and adoption of 'discharge to assess', under which patients were discharged and then assessed at home, where their needs could be judged better than in hospital. It had been agreed with Addenbrooke's that, rather than paying delay fees, the authority would put funding into the provision of alternative care. Similar discussions were being held with other local hospitals. The Chairman asked that a further report be brought to a future meeting of the Committee if necessary, in accordance with the Committee's work programme agreed earlier.

The Chairman summarised the Committee's conclusions, including that

- the plan was theoretically coherent, and already achieving results, though the demand-led nature of the service and the history of overspends in previous years gave cause for concern; the Committee had little confidence that the plan would be met
- there were enormous risks in the proposed reductions in funding, as acknowledged by the Executive Director
- although the overspend was a relatively low percentage of the overall budget, and less than in 2012/13, the overspend in OP services continued a trend

- although performance was good in some areas, notably reablement, there was still significant room for improvement in Adult and Older People's service; the Adult element of CFA still had work to do to match the Children's element
- much of the transformation and preventative work could have been started some time ago (this was not intended as a criticism of those present); it was now necessary to race to catch up with the demographic curve
- the fundamental review of social work was particularly impressive; members were encouraged that the findings had emerged from discussions with former CCS staff
- previous Business Plans had been underpinned by large "unidentified savings" and reference to "thematic reviews", neither of which had offered much reassurance, but a strategic plan for meeting the challenges facing the service was now taking shape
- the transfer of staff from CCS gave the authority more control over service delivery
- the integrated transformation fund should give the authority more resource to enable transformative change; it was important that it be used for transformation wherever possible, even when plugging gaps in service budgets
- the CCG's Older People's Programme represented both an opportunity and a significant challenge for the Council, and contained a risk of increased demand for the authority's services..

The Chairman listed additional points which had been identified by members in the course of discussion, including

- the Business Plan was perhaps taking an over-optimistic view of inflation, and could perhaps benefit from a more prudent approach, as inflation was outside the Council's control
- there was perhaps scope for making savings by investing more resource into addressing the backlog of assessments
- the relatively low level of reserves was potentially problematic, given the scale of challenge involved in delivering the Business Plan
- it would have been helpful had more information been included about the savings to be made from proposed changes to contracts with voluntary and community organisations for Homeless People Support in Cambridge City
- in relation to the CCG's Older People's Programme, it was important that the Council engage early with potential service providers, in order to ensure that any risk to the Council was minimised and that the benefits of better integration were realised quickly
- the management team was trying to achieve a great deal very quickly and was perhaps rather a small team to achieve such a large change programme; there was the question of prioritising areas where results could be delivered quickly

The Executive Director pointed out that the pressures on the Adult and the Children's services were different, so they were not directly comparable; one member commented that the demographics of aging meant that the speed of change was greater in the Adult world. The Cabinet Member reminded members that the budget would not be finalised until February, and invited any suggestions for how to achieve further savings.

b) Public Health

The Committee considered a report updating it on the delivery of the public health business plan for 2013/14 and detailing proposals for the business plan for 2014/15. The report was presented by Councillor Tony Orgee, Cabinet Member for Health and Wellbeing, and Dr Liz Robin, Director of Public Health.

The Cabinet Member explained that, at the Chairman's request, the report included considerable background information because the Council had only recently, from April 2013, been given responsibility for public health. He drew attention to the public health ring-fenced grant allocation for 2014/15 and the use which would be made of it, and stressed the importance of providing mental health training for front line staff across a wide range of agencies in order to give them the skills and confidence needed to support and refer service users with mental health needs.

The Director of Public Health explained that public health represented good value for money for the public sector, because it would deliver long-term savings through preventative work to influence lifestyle factors which, if not addressed, would give rise to greater costs to society. In the process of transferring public health to the Council, it had been necessary to extract parts of services from existing Primary Care Trust (PCT) contracts. The Government had ring-fenced the public health grant allocation.

Members queried whether, perhaps because of this ring-fencing, the public health budget had not been subject to the same efficiency pressures as the authority's other budgets. The Chairman commented that some councils seemed to have widened the boundaries of what could be regarded as public health work; the Cabinet Member said that there was a requirement to account to Government for the use that had been made of the ring-fenced funding.

The Director went on to say that the Cambridgeshire public health service was underfunded as a consequence of the low level of funding received by the PCT in previous years, and was not doing all that it should to provide preventative services. The service had however received some growth funding in 2013/14 and further growth funding for 2014/15; the aim was to secure adequate public health services across the whole county.

In answer to members' questions, the Director advised the Committee that

- because childhood vision screening services were offered out of school for children aged under three years, the assumption had been made that these should not be included in the return made to the Department of Health (DoH), but they did in fact form part of the school entry programme, so should have been included. In recognition that such mistakes had occurred, all councils had received an uplift of at least 8%
- it would be possible to go back to the DoH to seek correction of the vision screening mistake, as another council in the region was doing, but this would not necessarily have the desired result
- the lack of clarity in relation to funding responsibilities for HIV services had arisen when mixed messages had been received from NHS England. It had now been established that HIV services should be funded by NHS England rather than by the local authority, and sexual health services were currently out to tender in a joint exercise between the local authority and NHS England.

Asked about the scope for using public health commissioning efficiencies to offset other cuts, such as those to children's centres, the Executive Director: Children, Families and Adults said that the public health budget was very strictly ring-fenced. However, it would be possible – and was necessary – to ensure that maximum benefit was obtained from the funding available, and that adult social care services and public health services did not duplicate provision, or lack of provision. More work was needed to get the best impact from public health being included in the local authority's services. The Chairman said that the Committee would welcome work of this kind; the present report was a good report, but not a programme for transformation.

The Director of Public Health said that she would be happy to take this approach, though it was difficult to be transformational given the current levels of uncertainty. The financial position would only be known at year end, but she would welcome the opportunity to look across budgets at getting the best out of public health. At present, public health carried out its own commissioning (rather than going through the Service Director: Strategy and Commissioning), but could and should learn from the work of the Council's other directorates.

The Chairman urged caution in signing long-term contracts relating to service areas that were being reviewed. The Director said that it would however be necessary to sign the sexual health contract; this was a large, transformative contract that would be bringing different areas of work together.

29. COMMISSIONING OF OLDER PEOPLE'S SERVICES

a) Commissioning of Older People's Services: Older People's Programme Update

The Committee received a report summarising the approach being taken by the Older People's Programme of the Cambridgeshire and Peterborough Clinical Commissioning Group (CCG) and outlining progress to date. Attending from the CCG to present the report and respond to members' questions and comments were

- Jessica Bawden, Director of Corporate Affairs
- Dr Arnold Fertig, Clinical Lead, Older People
- Matthew Smith, Assistant Director Improving Outcomes

A member of the public, Miss Jean Simpson, asked a question under the Council's scheme for public speaking at Overview and Scrutiny Committees. Her question raised concerns about whether the CCG had followed due process with regard to its proposals, in particular with regard to the level of public involvement in their development, and given that the CCG was a new and untried organisation and the contract currently the largest out to tender in England. She asked whether, in the Committee's view, patients and public had been sufficiently involved in the decision to put the service out to competitive tender, the adoption of the 'lead provider' model, and the decision to use an 'outcome achievement' model (with criteria developed with the successful bidder) to monitor the success of the contract. She pointed out that the CCG was planning to give patients and public an opportunity to feed into the process only after the successful bidder had been chosen, which meant that much of the service design and monitoring would already have been decided, and asked why the public was not being allowed to discuss the shape of the future service before it had been decided.

In response to a question of clarification, the speaker said that it was not for her to determine the mechanics of a process to allow public input; the CCG had a duty to make arrangements for public consultation.

Presenting the report, the Clinical Lead explained that, as a GP, he was keen to improve services for frail elderly people for a number of reasons, including that

- the increasing fragmentation of services made it difficult to provide for people with complex needs
- the needs of those aged over 85 were seven times greater than the average
- the lack of join-up between health and care led to a reactive rather than a proactive service
- the majority of people wanted to stay in their own homes
- some of the patients whose discharge from hospital had been delayed need not have been admitted in the first place, but no alternative had been available (e.g. a GP on a Friday afternoon had been unable to put care services in place to enable an older person to stay at home).

Because hospitals were paid to admit patients, they had no incentive not to admit them. It was however necessary to move resources out of hospitals and in to the community.

The Assistant Director drew attention to the CCG's work to create the conditions for transformation. The draft Outcomes Framework was based on seven domains and included a total of 33 outcomes with indicators. The CCG was inviting bidders to submit outline solutions, which would be refined in the course of dialogue with the bidders. The purpose of the dialogue process was to ensure that each bidder understood the nature of the proposals.

Members raised a number of questions and concerns about the proposals, including

- the reason for and the conduct of the dialogue process

  The Committee was advised that the two-way dialogue process, lasting ten weeks to 6th January 2014, was intended to help bidders to come up with the best solutions and to inform the final design of the contract. The proposals were not set in stone and could be modified in the light of bidders' responses; the dialogue process was being conducted without favouring any one organisation.

  All the outcomes that were wanted had been set out in detail, including where dialogue was sought; all bidders would be responding to the same specification, though they might have different solutions to how to achieve the outcomes. The CCG was seeking practical, not over-onerous, measures for outcomes, and wanted to hear bidders' views.

  The process was commercially sensitive, with different bidders asking different questions in the course of their dialogue. The initial questions posed by the CCG had been the same, and all bidders were given the CCG's answers to each bidder's questions. The next round of the bidding process would start with a fresh set of CCG questions, with all bidders being asked the same questions.

  It was not possible, for reasons of commercial confidentiality, to tell the Committee why four out of ten bidders had dropped out; the decision whether or not to proceed had been made by the bidders. The CCG was working to statutory guidance on procurement, which included the question of commercial sensitivity. Bidders took a decision about whether to participate, and it was not unexpected that some dropped out as the dialogue developed.

Members noted that the CCG had taken legal advice on the procurement process and that other CCGs and Primary Care Trusts had conducted competitive dialogues.

- the conduct and timing of current public consultation

  The Committee was advised that since January 2013, the CCG had already gone to around 90 organisations about the principles of the Older People's Programme, and 108 general practices were having dialogue with patient groups. It had looked at the patient experience outcome with patient groups and had talked to Healthwatch, as part of work to identify issues that patients wished to see addressed. The 90 organisations had not been consulted on the same questions as those in the dialogue process with bidders, because of the commercially sensitive nature of the iterative dialogue process.

- the timetable for the mobilisation of the contract

  Members noted that on current plans, the successful bidder would be awarded the contract in May 2014 and the target date for the start of the new service was 1st July 2014, though one of the questions to bidders was round the mobilisation timetable, and it might become necessary to adjust the start date. They noted that the CCG continued to work closely with current service providers, and that current arrangements for service delivery would continue if the 1st July start date could not be met.

  Members expressed concern about the speed of transition implied by the timetable for implementing the new contract. They queried whether it would be achievable, especially given the need for public consultation on any service changes that were proposed. Based on comparisons with the time taken to implement other significant changes in the local health and social care environment, such as the transfer of CCS staff to the County Council and the transfer of Hinchingbrooke Hospital's management function to Circle, members suggested that the current mobilisation timetable was unrealistic, even impossible, to achieve. Members were advised that the nature of the contract was such that the successful bidder would not necessarily implement all the planned changes at once, but would take over the service and implement the changes gradually.

  The committee resolved to express its concerns to the CCG about the shortness of the mobilisation period, which was felt to be unrealistic and potentially disruptive to service delivery, if the transition were rushed.

- the adequacy of future public consultation and the implementation timetable

  The Committee was advised that the CCG would proceed to public consultation on the specific proposals for service change once these were clear. All bidders were aware that the successful bidder's proposals would be put out to public consultation, and might be subject to change as a result of that consultation. The preferred bidder was due to be identified in May 2014, after which the 12-week period of public consultation would start.

  Asked what scope there would be for the public to influence the service design at formal consultation stage, the Director of Corporate Affairs said that because this was not a usual service specification, there was no standard model for the consultation. She offered to bring the draft public consultation document to the Overview and Scrutiny Committee before the consultation started. **JsB**

Members asked whether the public would be able to know about all the ideas and innovations proposed in the course of the dialogue process as part of the consultation. CCG officers advised that as much information as possible would be published at this stage and further information published at the end of the whole process, but some would still be excluded as commercially sensitive.

The Committee recommended that the timetable be adjusted to allow time for the consultation findings and the Overview and Scrutiny Committee's findings to be fully taken into account.

The Director and Assistant Director acknowledged the Committee's concerns about the timetable for consultation and mobilisation, and undertook to reflect upon the points raised.

- elements for inclusion in the final contract

  Asked about the importance of information-sharing, the Clinical Lead said that, if it was a question about sharing clinical information, the key to the successful bid would be how the contractor would ensure that summary key clinical information was available at any time of any day or night. He went on to say that it was critical to the successful bid that all parties included in a contract – not just the lead in an alliance – be at the table sharing and giving information.

  The Chairman proposed and the Committee agreed that it would like to see the contractor obliged to demonstrate a strong commitment to share information with sub-contractors, the CCG and Public Health. This should be firmly incorporated into the contract, and would help to ensure that as much could be learned from the new service as possible.

The Chairman said that it was clear that, from a technical point of view, due process had been followed. However, due process was the minimum required, and there was nothing to stop the CCG going beyond this to involve the public in consultation on the higher-level aims of the programme at an earlier stage. In reply to CCG officers' comments that the CCG had undertaken consultation beyond the minimum statutory requirement, he acknowledged that the CCG had indeed done more than the minimum, and thanked the CCG for allowing the Committee's working group to be involved in the detail of the process; other local authorities round the country were watching the process and outcome with interest. However, it remained the case that more could have been done to consult the public on the high-level aims of the programme.

The Committee resolved to recommend to the CCG and the Health and Wellbeing Board that in future there should be public consultation from the outset on the high-level aims of any major commissioning programme.

The Director of Corporate Affairs noted the request for higher-level consultation as a point to bear in mind for the future, but suggested that it might be difficult to frame it in such a way that the consultation did not simply seek views on the merits of platitudinous aims with which it was impossible to disagree.

Summary of the Committee's recommendations

The Committee identified four particular concerns as described above. Its recommendations are repeated below for clarity:

- The committee resolved to express its concerns to the CCG about the shortness of the mobilisation period, which was felt to be unrealistic and potentially disruptive to service delivery, if the transition were rushed.
- The Committee recommended that the timetable be adjusted to allow time for the consultation findings and the Overview and Scrutiny Committee's findings to be fully taken into account.
- The Chairman proposed and the Committee agreed that it would like to see the contractor obliged to demonstrate a strong commitment to share information with sub-contractors, the CCG and Public Health.
- The Committee resolved to recommend to the CCG and the Health and Wellbeing Board that in future there should be public consultation from the outset on the high-level aims of any major commissioning programme.

b) Future Commissioning of Older People's Services: Working Group Terms of Reference, Membership and Activities

The Committee considered a report on the proposed membership and terms of reference for the working group to examine and comment on plans for the future commissioning of Older People's Services, which it had decided to establish at its previous meeting. The Vice-Chairman expressed the Committee's thanks to the Clinical Commissioning Group for finding ways in which to enable the Committee's involvement in the commissioning process and allowing it access to commercially confidential information.

Members noted that the group had already met with the CCG to discuss the procurement process and how Overview and Scrutiny could contribute to the quest for the best outcomes for service users. All members of the working group, including observers from other local authorities, would be bound by the same need to respect commercial confidentiality.

The Committee agreed to the proposed terms of reference (attached to the minutes as Appendix 1) for the working group, and agreed that its members would be County Councillors Bourke, Reeve, K Reynolds, Scutt and van de Kerkhove, and Cambridge City Councillor Brierley, with Councillor Sylvester of Peterborough City Council and Councillor Hughes of Northamptonshire Borough Council attending as observers and the scrutiny officer at Hertfordshire County Council being kept informed of the group's work.

30. SHELTERED HOUSING AT LANGLEY COURT AND LANGLEY CLOSE, ST IVES

The Committee received a report updating it on the redevelopment by the Luminus Group of the Langley Court and Langley Close sheltered housing scheme in St Ives. At its meeting in September, the Committee had agreed to delegate to the Chairman and Vice-Chairman the task of working out, in conjunction with Local Members, how to proceed in response to the Luminus decision to redevelop; the Chairman and Vice-Chairman's report of their findings and recommendations was also presented to the Committee for endorsement.

In attendance were Councillor Paul Bullen, one of the two local members for St Ives, Councillor Fred Yeulett, Cabinet Member for Adult Services, and Claire Bruin, the Service Director: Adult Social Care.

Speaking at the Chairman's invitation, Councillor Bullen told members that he had nothing to add to what he had said at County Council on 15th October 2013, and asked the Committee not to endorse the report.

The Committee resolved by a majority to endorse the members' report, Councillor Ashcroft dissenting and Councillor van de Kerkhove abstaining.

The Service Director updated the Committee on recent developments

- the Cabinet of Huntingdonshire District Council had now approved the provision of a loan to Luminus to fund the new extra care home
- the plans for the development were due to be shared with St Ives Town Council on 11th December and District Council colleagues were investigating whether they could also be shared with the local County members
- it was expected that the planning application would be submitted to the District Council in mid-December
- asked to clarify whether the home removal package being offered to residents transferring to other Luminus accommodation (which included redecoration of the new property and help with moving and settling in) would also be offered to those moving elsewhere, Nigel Finney, Luminus's Executive Director (Operations) had confirmed that the same services would be provided, subject to the other landlord's agreement.

In answer to members' questions, the Service Director said that only those residents who received a social care package were in direct contact with social care staff, but the majority of residents did not have such a package. Asked whether, in his experience, all residents were receiving the level of support described by Luminus, Councillor Bullen said that they were not. He agreed to supply examples of those not receiving support to the Service Director for her to convey to the interagency Local Implementation Group, which included officers from Luminus, the County Council and the District Council.

Members' comments included that the whole experience was an unhappy and unsettling one for residents, that those who did not qualify for social care needed an independent advocate, and that Luminus must be made aware that their actions would continue to be the subject of scrutiny. Ways of identifying those residents who had spent money on making improvements to their accommodation from November 2012 were explored; the Service Director said that only Luminus, not the Implementation Group, would hold that information. The Chairman and Councillor Bullen agreed that they would look into the question of communicating with residents further.

Councillor Bullen thanked the Committee for the expediency with which it had dealt with looking into the redevelopment of Langley Court and Langley Close.

31. CALLED IN DECISIONS

There were no called in decisions.

32. DATE OF NEXT MEETING

The Committee noted that its next meeting was due to be held at 2.30pm on Tuesday 4th February 2014.

Members of the Committee in attendance:
County Councillors K Bourke (Chairman), P Ashcroft, A Bailey (Vice-Chairman), P Downes, S Frost, R Hickford, M Loynes, K Reynolds, M Smith, M Tew, S van de Kerkhove and S van de Ven; District Councillors J Pethard (Huntingdonshire)and B Smith (South Cambridgeshire)

Apologies: County Councillor J Scutt; District Councillors M Archer, Z Moghadas and W Sutton

Also in attendance: County Councillors P Bullen, T Orgee and F Yeulett

Time: 1.05pm – 5.10pm
Place: Shire Hall, Cambridge

Chairman

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ONGOING STUDIES

STUDY	OBJECTIVES	PANEL	STATUS	TYPE
Great Fen	To monitor the latest developments in respect of the Great Fen.	Environmental Well-Being	The Project Collaboration Agreement has been renewed for a further 5 year period. Further updates will continue to be provided in due course.	Whole Panel.
Economic Development	To be determined.	Economic Well-Being	The Huntingdonshire Economic Growth Plan 2013 to 2023 was considered by the Panel in July 2013. The Economic Development Manager will attend a future meeting to provide an update on the marketing and implementation plans.	Whole Panel.
Communications & Marketing	To be determined.	Economic Well-Being	This review has been put on hold pending the outcome of the Cabinet's deliberations on the 'Facing the Future' programme.	Working Group
Shared Services	To be determined.	Economic Well-Being	This review has been put on hold pending the outcome of the Cabinet's deliberations on the 'Facing the Future' programme.	Working Group
Estates	To be determined.	Economic Well-Being	This review has been put on hold pending the outcome of the Cabinet's deliberations on the 'Facing the Future' programme.	To be confirmed.

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Panel Date	Decision	Action	Response	Date for Future Action
	Hinchingbrooke Hospital **(a) Management of the Hospital**			
5/04/11/ 2/10/12/ 5/03/13	With effect from 1st February 2012, Circle took over the management of Hinchingbrooke Hospital and representatives of Circle and the Hospital have since attended the Panel's meeting on an annual basis. Agreed to come back in a year's time to provide a further update.	Invitation to be extended to the Hospital and Circle to attend the Panel's March 2014 meeting.	Invite all O&S Members and Ruth Rogers, Chair of Healthwatch Cambridgeshire when discussion on Hinchingbrooke Hospital takes place.	**4/03/14**
	(b) Hinchingbrooke Hospital Joint Working Group			
6/11/12	A meeting between relevant County Members and the Panel was held on 5th November 2012 to share information and issues relating to services at Hinchingbrooke Hospital.			
4/12/12	A Joint Working Group with the County Council's Cambridgeshire Adults Wellbeing and Health Overview and Scrutiny Committee was established comprising Councillors S J Criswell, C R Hyams, P Kadewere and M C Oliver. The Working Group will receive regular updates on the Hospital.	**Working Group met on 23rd January 2014.**	**A brief update on the outcome will be reported at the meeting.**	
	(c) Financial and Operational Performance			
4/12/12 & 5/02/13 & 02/07/13	Presentation received from Mrs S Shuttlewood, representative of Cambridgeshire and Peterborough Clinical Commissioning Group on the Group's role in monitoring the financial and operational performance	Reports on the financial and operational performance of	Next update to be received in February 2014. **This item appears elsewhere on the Agenda.**	**4/02/14**

Panel Date	Decision	Action	Response	Date for Future Action
	of the Hospital.	Hinchingbrooke Hospital to be presented to the Panel every six months.		
4/12/12	**<u>Delivery of Advisory Services Within the District</u>** New voluntary sector funding arrangements came into effect on 1st April 2013. Voluntary Sector Working Group, comprising Councillor R C Carter, Mrs P A Jordan and Mrs M Nicholas, to meet with the voluntary organisations in October and April each year to review the grant agreements established under the new arrangements. An annual performance report will also be submitted to the Panel in June 2014.	Working Group has met with 5 out of the 6 voluntary organisations to monitor their progress against acceptance agreements.	Outcome to be reported to the Panel in due course.	**TBC**
15/05/13 **7/06/11**	**<u>Corporate Plan</u>** Councillors S J Criswell and R C Carter appointed to Corporate Plan Working Group. The Panel expressed their wish for continued involvement by overview and scrutiny in monitoring the performance of the new Corporate Plan.	Number of meetings of the Corporate Plan Working Group held to develop the Delivery Plan.	Corporate Plan to be launched on 1st April 2014. Working Group met on 18th December 2013 to discuss further the content of the Plan. **This item appears elsewhere on the Agenda.**	**4/02/14**

Panel Date	Decision	Action	Response	Date for Future Action
12/06/12 & 2/07/13	**<u>Consultation Processes</u>** Councillors Mrs P A Jordan, P Kadewere and J W G Pethard appointed on to the Consultation Processes Working Group. Councillor R C Carter subsequently appointed on to the Working Group at the Panel's July 2013 meeting.	Meeting of the Working Group held on 5th September 2012.	Strategy and Guidance reviewed by the Working Group. Chief Officers Management Team have since had sight of the Strategy and requested for changes to be made. **Meeting of the Working Group to be held mid-late March 2014 – details to be confirmed.**	**1/04/14**
03/01/12 **03/07/12**	**<u>Social Value</u>** This study emerged following completion of a joint study with the Economic Well-Being Panel on One Leisure. Working Group tasked with the development of a methodology for the quantification of Social Value. Councillor S J Criswell appointed to the Social Value Sub-Group. Meetings held on 2nd August and 23rd November 2012 and 2nd April 2013.	Working Group has agreed to focus on three key areas; namely the social, health and financial benefits of social value.	Officers have been tasked with attaching financial values to these benefits and to report back thereon to the Working Group. The next step will be to produce a detailed account of the methodology used to undertake this work. Anticipated that the final report will be submitted to a future Panel meeting shortly.	**TBC**

Panel Date	Decision	Action	Response	Date for Future Action
12/06/12 / 4/06/13	**Equality Framework for Local Government – Peer Assessment** Noted the recent accreditation achieved by the Council as an "Achieving" authority under the Equality Framework for Local Government. Councillors Mrs P A Jordan, P Kadewere and J W G Pethard together with former Panel Member Councillor R J West, were appointed on to a Working Group to review the action plan arising from the assessment.	Meetings of the Working Group held on 29th August 2012 and 23rd January 2013.	Annual Equality Progress Report presented to Panel in February. The Working Group will continue to meet to monitor progress against the Action Plan on an ad hoc basis.	
7/06/11 **8/10/13**	**Housing Benefit Changes and the Potential Impact on Huntingdonshire** Requested a background report to be provided on the emerging issue of homelessness arising as a result of changes to the Housing Benefit system. Quarterly reports have since been considered by the Panel. Agreed to receive the report on a six monthly basis.	Request submitted to the Head of Customer Services.	Members of the Economic Well-Being Panel will be invited to attend for this item. Next report expected June 2014 – will include a full year's data.	**10/06/14**

Panel Date	Decision	Action	Response	Date for Future Action
7/01/14	**<u>Redesign of Mental Health Services</u>** **Representatives of Cambridgeshire and Peterborough Clinical Commissioning Group (C&P CCG) updated Panel on redesign of mental health services. The following information was requested:-** • **Details of the service user engagement network (SUN);** • **List of voluntary organisations commissioned by the CCG;** • **Information from the Advice and Referral Centre in respect of Huntingdonshire during its first few months of operation;** • **The number of Huntingdonshire patients admitted within acute facilities; and** • **The types of referrals made by GPs to the Advice and Referral Centre.** **Suggestion made to invite representatives of the service user group to a future meeting together with other relevant groups such as Hunts Mind.**	**Information circulated to Members electronically on 13th January 2014 however further details are awaited on the latter two points.** **Invitation to be extended in due course.**		
3/09/13	**<u>Shape Your Place</u>** Panel received the annual report detailing the performance statistics for Shape Your Place since its first year of operation. Panel has welcomed the performance levels achieved.		Further performance report to be submitted in a year's time. Report expected September 2014.	**2/09/14**

Panel Date	Decision	Action	Response	Date for Future Action
	<u>Review of Elderly Patient Care at Hinchingbrooke Hospital</u>			
4/06/13	Working Group appointed comprising Councillors S J Criswell, I C Curtis, C R Hyams, Mrs P A Jordan, P Kadewere and J W G Pethard to undertake a review of elderly patient care at Hinchingbrooke Hospital. The study will be undertaken in conjunction with the Hospital.	Meeting held on 18th July and 11th November 2013.	**A further meeting is being arranged to consider the End of Life Pathway – details to be confirmed.**	
	<u>Procurement of Older Peoples Programme</u>			
4/06/13	Since the Working Group's initial meeting, the Chairman has met with Mr I Weller from the Cambridgeshire and Peterborough Clinical Commissioning Group (C&P CCG) to be briefed on the procurement exercise being undertaken on the Older People's Programme which forms part of the Future of Cambridgeshire Community Services Project. This meeting was held on 30th July 2013. On behalf of the Panel, the Chairman expressed his wish to be involved as part of the procurement process in relation to the evaluation of bids received for the Huntingdonshire area.		Further performance report to be submitted in a year's time. Report expected September 2014.	**2/09/14**
7/01/14	**Representatives of C&P CCG delivered a presentation on the current procurement process. Concerns remain over the absence of elected Member involvement from the process and the tight timetable for the mobilisation of the contract. Agreed to seek the views of the Head of**			

Panel Date	Decision	Action	Response	Date for Future Action
	Environmental and Community Health Services on ways of providing feedback to the Panel on the procurement exercise.			
7/01/14	**<u>Facing the Future</u>** **Panel received a brief update on the Facing the Future process following the various strategic service reviews undertaken by the Overview and Scrutiny Panels in November and December 2013. A joint report from the Overview and Scrutiny Panels will be submitted to the Environmental Well-Being Panel and the Cabinet at their February 2014 meetings outlining the complete list of potential savings and the priorities accorded.**	**All Panel Members are encouraged to attend the Environmental Well-Being Panel's meeting on 11th February.**		
03/04/11/ 6/11/12 / 3/09/13	**<u>Huntingdonshire Strategic Partnership (HSP)</u>** The Panel has a legal duty to scrutinise the work of the HSP, with three thematic groups of the HSP falling within its remit. **Huntingdonshire Community Safety Partnership** Annual review of the work of the Partnership undertaken. Members have expressed their satisfaction that appropriate accountability and reporting mechanisms are in place.		Next review expected July 2014.	**1/07/14**

Panel Date	Decision	Action	Response	Date for Future Action
05/10/10	**Children and Young People** Details of the thematic group's outcomes and objectives have been received together with the latest report of the group, outlining its terms of reference, membership and current matters being discussed.	Invitation extended to the Lead Officer of the thematic group.	Item due for consideration at the Panel's **March/April 2014** meeting.	**4/03/14 / 1/04/14**
7/02/12 / 3/09/13	**Health and Well-Being** Background information received on the thematic group's outcomes, terms of reference, membership and Action Plan.		Next review expected July 2014.	**1/07/14**

ACTION LOG
(Requests for information/other actions other than those covered within the Progress Report)

Date of Request	Description	Response
	None identified at present.	