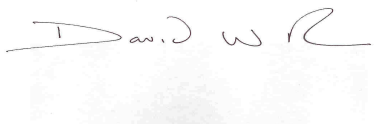
Public Document Pack

Healthy Halton Policy and Performance Board

Tuesday, 11 March 2008 6.30 p.m.
Civic Suite, Town Hall, Runcorn



Chief Executive

BOARD MEMBERSHIP

Councillor Ellen Cargill (Chairman)	Labour
Councillor Kath Loftus (Vice-Chairman)	Labour
Councillor Robert Gilligan	Labour
Councillor Trevor Higginson	Liberal Democrat
Councillor Margaret Horabin	Labour
Councillor Christopher Inch	Liberal Democrat
Councillor Martha Lloyd Jones	Labour
Councillor Joan Lowe	Labour
Councillor Kelly Marlow	Liberal Democrat
Councillor Geoffrey Swift	Conservative
Councillor Pamela Wallace	Labour

Please contact Caroline Halpin on 0151 471 7394 or e-mail caroline.halpin@halton.gov.uk for further information.
The next meeting of the Board is on Tuesday, 10 June 2008

ITEMS TO BE DEALT WITH
IN THE PRESENCE OF THE PRESS AND PUBLIC

Part I

6. PERFORMANCE MONITORING

(A) QUARTERLY MONITORING REPORTS **228 - 295**

In accordance with the Health and Safety at Work Act the Council is required to notify those attending meetings of the fire evacuation procedures. A copy has previously been circulated to Members and instructions are located in all rooms within the Civic block.

Agenda Item 3

REPORT TO: Healthy Halton Policy & Performance Board

DATE: 11 September 2007

REPORTING OFFICER: Strategic Director, Corporate and Policy

SUBJECT: Public Question Time

WARD(s): Borough-wide

1.0 PURPOSE OF REPORT

1.1 To consider any questions submitted by the Public in accordance with Standing Order 33(5).

1.2 Details of any questions received will be circulated at the meeting.

2.0 RECOMMENDED: That any questions received be dealt with.

3.0 SUPPORTING INFORMATION

3.1 Standing Order 34(11) states that Public Questions shall be dealt with as follows:-

(i) A total of 30 minutes will be allocated for members of the public who are residents of the Borough, to ask questions at meetings of the Policy and Performance Boards.

(ii) Members of the public can ask questions on any matter relating to the agenda.

(iii) Members of the public can ask questions. Written notice of questions must be submitted by 4.00 pm on the day prior to the meeting. At any meeting no person/organisation may submit more than one question.

(iv) One supplementary question (relating to the original question) may be asked by the questioner, which may or may not be answered at the meeting.

(v) The Chair or proper officer may reject a question if it:-

- Is not about a matter for which the local authority has a responsibility or which affects the Borough;
- Is defamatory, frivolous, offensive, abusive or racist;
- Is substantially the same as a question which has been put at a meeting of the Council in the past six months; or
- Requires the disclosure of confidential or exempt information.

(vi) In the interests of natural justice, public questions cannot relate to a planning or licensing application or to any matter, which is not dealt with in the public part of a meeting.

(vii) The Chairperson will ask for people to indicate that they wish to ask a question.

(viii) **PLEASE NOTE** that the maximum amount of time each questioner will be allowed is 3 minutes.

(ix) If you do not receive a response at the meeting, a Council Officer will ask for your name and address and make sure that you receive a written response.

Please bear in mind that public question time lasts for a maximum of 30 minutes. To help in making the most of this opportunity to speak:-

- Please keep questions as concise as possible.
- Please do not repeat or make statements on earlier questions as this reduces the time available for other issues to be raised.
- Please note that public question time is not intended for debate – issues raised will be responded to either at the meeting or in writing at a later date.

4.0 POLICY IMPLICATIONS

None.

5.0 OTHER IMPLICATIONS

None.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 **Children and Young People in Halton**

None

6.2 **Employment, Learning and Skills in Halton**

None

6.3 **A Healthy Halton**

None

6.4 **A Safer Halton**

None

6.5 **Halton's Urban Renewal**

None

7.0 EQUALITY AND DIVERSITY ISSUES

7.1 None.

8.0 LIST OF BACKGROUND PAPERS UNDER SECTION 100D OF THE LOCAL GOVERNMENT ACT 1972

8.1 There are no background papers under the meaning of the Act.

REPORT TO: Healthy Halton Policy and Performance Board

DATE: 11 March 2008

REPORTING OFFICER: Strategic Director, Corporate and Policy

SUBJECT: Executive Board Minutes

WARD(s): Boroughwide

1.0 PURPOSE OF REPORT

1.1 The Minutes relating to the Health Portfolio which have been considered by the Executive Board and Executive Board Sub are attached at Appendix 1 for information.

1.2 The Minutes are submitted to inform the Policy and Performance Board of decisions taken in their area.

2.0 RECOMMENDATION: That the Minutes be noted.

3.0 POLICY IMPLICATIONS

None.

4.0 OTHER IMPLICATIONS

None.

5.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

5.1 **Children and Young People in Halton**

None

5.2 **Employment, Learning and Skills in Halton**

None

5.3 **A Healthy Halton**

None

5.4 **A Safer Halton**

None

5.5 **Halton's Urban Renewal**

None

6.0 RISK ANALYSIS

6.1 None.

7.0 EQUALITY AND DIVERSITY ISSUES

7.1 None.

8.0 LIST OF BACKGROUND PAPERS UNDER SECTION 100D OF THE LOCAL GOVERNMENT ACT 1972

8.1 There are no background papers under the meaning of the Act.

APPENDIX 1

Extract of Executive Board and Executive Board Sub Committee Minutes Relevant to the Healthy Halton Policy and Performance Board

EXECUTIVE BOARD MEETING HELD ON 10 JANUARY 2008

EXB73 CARE STANDARDS COMMISSION PERFORMANCE RATING

The Board considered a report of the Strategic Director - Health and Community advising of the increase in the performance rating of the Health and Community Directorate

It was noted that the Directorate had its performance rated annually by the Care Standards Commission Inspectorate (CSCI), which linked to how well the Directorate provided Social Care services to both adults and older people. The rating fed into the Comprehensive Performance Assessment for Halton Borough Council. A copy of the Annual Performance Assessment (APA) was attached at Appendix 1 to the report.

Outcomes and domains that the Directorate was judged against were outlined for the Board's consideration and it was noted that performance in 2006/07 had been rated by CSCI as being 3 star. The actual performance judgement was:

- Delivering outcomes: Good; and
- Capacity for Improvement: Excellent.

Key strengths identified by CSCI were outlined in the report. In addition, an e-mail had been received from Ms Debbie Westhead of CSCI complimenting the Authority on its performance.

The Board congratulated all those that had been involved in this process.

RESOLVED: That the Annual Performance Assessment of Adults and Older People undertaken by CSCI be received.

EXECUTIVE BOARD MEETING HELD ON 7 FEBRUARY 2008

EXB85 PROMOTING MENTAL HEALTH STRATEGY

The Board considered a report of the Strategic Director - Health and Community, and the Director of Public Health, presenting the 'Promoting Mental Health' Strategy developed by the Primary Care Trust, which covered Halton and St Helens Local Authorities.

It was noted that the development of a 'Promoting Mental Health'

Strategy was one of the requirements within the performance framework for mental health services and was monitored annually via a national self-assessment process, reported to the Strategic Health Authority. There was a high prevalence of mental illness in Halton and the strategy was a key component of the prevention agenda.

The consultation process undertaken was outlined for Members' consideration and it was noted that the strategy provided a framework for action to:

- co-ordinate mental health promotion and social inclusion activities across the Boroughs of Halton and St Helens;

- raise public awareness of how to look after our own and other people's mental health; and

- involve communities and organisations, across all sectors, in taking positive steps to promote and protect mental wellbeing.

Champions were identified for each setting and the action plan within the strategy would be implemented over a four-year period. Progress would be monitored on a quarterly basis and reported to the Strategic Health Authority via the annual self-assessment process. Reports would also be presented to the Healthy Halton Policy and Performance Board to chart progress.

In considering the strategy, Members requested an update report on mental health developments following the changes introduced in the service in 2007.

RESOLVED: That the Strategy be endorsed.

EXECUTIVE BOARD SUB COMMITTEE MEETING HELD ON 7 FEBRUARY 2008

ESC77 DISABLED FACILITIES GRANT

This item was deferred to a future meeting.

REPORT TO: Healthy Halton Policy and Performance Board

DATE: 11 March 2008

REPORTING OFFICER: Strategic Director, Health and Community

SUBJECT: Foundation Trust Status for North Cheshire Hospitals NHS Trust

WARDS: Boroughwide

1.0 PURPOSE OF THE REPORT

1.1 The Board will receive a presentation from Catherine Beardshaw, Chief Executive of North Cheshire Hospitals NHS Trust (NCHT) on the consultation currently being undertaken on the Foundation Trust Status for NCHT.

2.0 RECOMMENDATION: That

(1) the presentation be noted; and

(2) Members comment on the consultation document 'together we can do it', attached as Appendix 1.

3.0 SUPPORTING INFORMATION

3.1 The NCHT is currently undertaking a consultation exercise on its Foundation Trust Status. The consultation document 'together we can do it' is attached as Appendix 1 for Members consideration. The consultation ends on Friday 11 April 2008.

4.0 POLICY IMPLICATIONS

4.1 None applicable

5.0 OTHER IMPLICATIONS

5.1 None applicable

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 **Children and Young People in Halton**

6.2 **Employment, Learning and Skills in Halton**

6.3 **A Healthy Halton**

6.4 **A Safer Halton**

6.5 **Halton's Urban Renewal**

7.0 RISK ANALYSIS

7.1 None applicable

8.0 EQUALITY AND DIVERSITY ISSUES

8.1 None applicable

9.0 LIST OF BACKGROUND PAPERS UNDER SECTION 100D OF THE LOCAL GOVERNMENT ACT 1972

9.1 There are no background documents under the meaning of this Act.

North Cheshire Hospitals NHS
NHS Trust

together we can do it!

back 2 back

NHS Foundation Trust consultation document

Seeking your views on our application to become an NHS Foundation Trust.

oduction to our

Foundation Trust campa

NHS
eficial to you

e local community –
ow local people to
can have your say.
we want to keep you
rington and Halton
chance to share your

le to represent your
Trusts allow you to elect
he there will be public and
y you and working
help develop services

faster – NHS Foundation
freedom. This includes
y within set limits to break
ild new facilities and
e need locally

- **We will be able to invest in local services** – NHS Foundation Trusts can reinvest any surpluses they make from running efficient and effective services back into the hospitals rather then return it to the Government

- **We can further improve care for you and your family** – By using freedoms as an NHS Foundation Trust to invest and develop services quickly we can react to local needs and make improvements faster

- **We can help secure the long term future of our hospitals** - Being an NHS Foundation Trust would mean that we can compete with the best hospitals, look at providing new services and be in a stronger position in the future

- **We retain the high quality and access you expect from the NHS** – Whilst allowing us to work in new ways, NHS Foundation Trusts still provide free access to care for everyone that needs it and to the high national standards you expect.

What do we want you to do?

1. Read this consultation document and learn about your hospitals and our vision for the future at Warrington and Halton hospitals
2. Look at our plans for involving the community through Foundation Trust membership and the Governors Council
3. Give your comments on the ideas and how we can make Foundation Trust status work. We need your comments by 11th April 2008 and the back pages of this document explain how you can get your comments to us
4. Become a Member and show your support for your local hospitals. As part of the consultation process we are recruiting prospective Members now.

What happens nex

- Every comment made process will be noted a plans
- Monitor - the Foundation T review at the if we are able nd wil ls on
- If successful, we hope become an NHS Found
- From then, the membe will come into full be begin working in ne community and inv

it

About this consultation

You may have heard of NHS Foundation Trusts. They are a new type of NHS organisation established to run NHS hospitals. They are still part of the NHS and maintain all the values and standards you expect from your health service but, importantly, they make hospitals accountable to local people rather than to central government.

The time is right for North Cheshire Hospitals to become an NHS Foundation Trust. As an NHS Foundation Trust we will have more freedom to work together with local people to better understand what you want and need from your hospitals. Local patients, public and staff can become Members of the trust and also stand for election as hospital Governors for the first time under these proposals.

NHS Foundation Trusts also have other freedoms such as the ability to use financial surpluses and borrow money to quickly develop new hospital buildings and services that will benefit their local communities.

It is important to know t
about changing the pati
Warrington and Halton. I
well and we are investing i
for the future. This consult
way the hospitals will be ru
want to be involved with yo
sure they provide the serv
need them.

All NHS trusts are expecte
Foundation Trus n
progress over th ew
right for North C Ho
now. We unders w
hospitals mean Thi
more involved w yo
have your say by becomin
Foundation Trust. We are
and would like to hear you
this document.

Catherine Beardshaw
Chief Executive

Key questions we want your views on

About your hospitals

s our two hospitals to provide the care that you need. We
nised our services to provide dedicated specialist facilities on
e majority of our emergency care and complex surgical care
n Hospital whilst Halton General Hospital is a centre of
e surgery. These changes were difficult to achieve but they
n that we have two hospitals that between them provide the
local people need.

Warrington Hospital

Halton General Hospital

Hospital

r general hospital which
HS services. It focuses on
nd has all the back up
ents with a range of
conditions. The hospital
velopment work over the
a full range of expert
ces.

o the North Cheshire
and emergency
aternity services.
require extra support or
it is likely to be carried

Services provided at Warrington Hospital include:

Accident and emergency, surgical services, general medicine, children's services, cardiac care, stroke care, elderly care, obstetrics (maternity), gynaecology, orthopaedic, critical care, genito-urinary medicine and ophthalmology.

Support services include:

Radiology, pathology, physiotherapy, dietetics, diagnostic services, speech therapy, occupational therapy plus a wide range of specialist nursing services.

Halton General Hospital

Halton General Hospital, located in Runcorn, is home to a wide range of NHS services and focuses on planned specialist surgery. A range of care for medical and surgical conditions is provided from the hospital and it provides a mix of inpatient and outpatient services. It provides a comfortable environment for expert surgical care.

If your surgery is non-complex and does not require a long hospital stay it is likely to be carried out at Halton General Hospital. There are low operation cancellation rates at the hospital as routine surgery is not as threatened by emergency work which can take priority. The hospital is home to a minor injuries unit which provides a range of minor emergency care services.

Services pr d Halton Gen Ho

General surgery, urology, and emergency), endosco down care and genito-urin

Support services i

Occupational therapy, phy outpatient services, diagn a range of specialist nursi

Did you know

- There are 600 beds across our hospitals
- MRSA infection rates a rates have almost halv

Moving in the right directio

on reconfiguration

th the public on how to deliver services in the future and how best to use Warrington tter Care Sustainable Services consultation saw the move to focus routine surgical y medical care at Warrington. The consultation was difficult and the local community of their hospitals. However, over a year on from the changes we believe that they us to secure the future of both hospitals and move forwards.

clude:

s around waiting and
s so you are seen quickly
vironment

uality of services we
Commission

v services across both
efiting local patients

roved trust in the annual
2006 – and in the top forty

- Being on course to reach financial balance at the end of this financial year (2007/2008)
- Reducing rates of infection with cases of MRSA and Clostridium Difficile amongst the lowest in the North West region for non-specialist hospitals.

Amongst the key changes we have seen:

- **Extra operations**
  An extra operating theatre in place at Halton Hospital and an average of over 200 extra operations taking place each month at the hospital
- **Emergency care**
  Investment in new emergency care wards at Warrington Hospital
- **Less Infection**
  An infection free environment for surgery with no cases of MRSA or Clostridium Difficile infections at Halton Hospital in 2007
- **Fewer cancellations**
  A near 50 percent red
  operations that are ca
  pressure
- **New services planne**
  Plans for a n cal
  cancer servic ılto
  at both sites ıpe

We are continui ves
hospitals and pr erv
modern NHS ar ıve
receive. Moving to NHS F
next step in our work.

What's in a name?

If we become an NHS Foundation Trust, the name of the hospital will change from NH
Trust. However, we also have an opportunity to change the name of the hospital to re
We believe that North Cheshire Hospitals does not give people a true sense of identity
hospitals are based and is confusing for people coming for their care from outside the
to NHS Foundation Trust status we are proposing to change the name of our trust to a
– Warrington and Halton Hospitals NHS Foundation Trust. We'd like your views on thi

Key questions we want your views on

What are NHS Foundation Trus

Key points about NHS Foundation Trusts:

- More involvement from you
- A chance to have your say
- Elected hospital Governors
- More financial freedom to improve services
- Less national control over your local NHS.

NHS Foundation Trusts are a key part of the reform programme in the NHS. They are organisations, free from central Government control. They decide how to improve the any surpluses they generate or borrow money to support these investments. They est with their local communities; local people can become Members and Governors.

These freedoms mean NHS Foundation Trusts can better shape their healthcare services around local needs and priorities. NHS Foundation Trusts remain providers of healthcare according to core NHS principles: free care, based on need and not ability to pay.

They reflect the move from a centrally managed service towards one that is managed locally and more responsive to patients. We have strong local communities in Warrington, Runcorn and Widnes so the aim of working more closely with public and patients is one that is important to us.

NHS Foundation Trusts are still part of the NHS and still work to national targets around key areas of healthcare performance such as waiting times, waiting lists and quick access to services. Foundation Trusts are authorised and monitored by Monitor – the Independent Regulator of NHS Foundation Trusts.

How other hospital Foundation Trust s

There are over 4 Fo country and are nei benefit the deve t o their communitie np new services in se innovative progr th people to work in the hosp

For further information on existing NHS Foundation document published by t Foundation Trust Networ Trusts – The Story So Fa copy on the internet at w

Key questions we want your views on

ng an NHS Foundation Trust is right for

you and your hospitals

te benefits of
oundation Trust

For patients and the public

- **Get involved** - The chance to become a Member or even Governor of the trust with more involvement in having a say in how we run the organisation and deciding the types of services we provide
- **Improved local services** - Closer working with partners in health, social care and the voluntary sector to improve care for patients. Services will be better coordinated between hospitals, councils and NHS community services
- **More impact on the economy** - Stronger links with partners in local authorities and other organisations that will allow us to contribute to prosperity and employment in the local area
- **More money for your services** - Greater control over finances so we can invest any surpluses we make into improving services and improving the experience of patients
- **Supporting your hospitals** - You can learn more about your services and how we can improve them.

For the hospital

- Taking on new ways of working which allow important partners to have more influence and work in partnership with us
- More freedom to respond to local needs and priorities, not just those set by central government
- Opportunities to build on our growing local and national reputation and fully utilise our strengths to improve, enhance and develop our services.
- Greater financial freedom with:
  - freedom to borrow money within clear limits if we require it for new developments.
  - freedom to retain any cash surplus made from treating more patients, which will be invested back into developing services.

For our services

- The ability to quickly in
  local people want and
- Allowing more people f
  choose to co
  their care in
- Continued im
  shorter waiti
- To use the fre
  Trust to build new build
  greater speed so w

Key questions we want your views on

r vision for the future

Seven key ways will improve yo

We have begun work on our long term plan for services across Warrington and Halton hospitals. Seven key themes from this strategy that will improve care for you and your family are:

1. **Investing in your services to bring down waits** - We will ensure the quality of our services continues to improve by investing in new buildings, facilities and equipment across our clinical specialties. This will include investing in our outpatient and diagnostic services so that we can continue to bring down waiting times.

2. **Reducing lengths of stay and cancelled operations** - Where it is appropriate for your care, we will reduce the time you have to spend in hospital (known as 'length of stay'). If you need to come to the hospitals for an operation, we will provide more day case surgery where you do not have to stay overnight. This will be a key focus of Halton General Hospital. We will also work in new ways to reduce the time you spend in hospital before surgery by carrying out all the assessment you need in advance.

3. **Improving provision of emergency care & intensive care services** - We are investing over £6 million in a major redevelopment of intensive care services that will provide us with more critical care and higher dependency care beds by the end of 2008. Emergency care is an essential part of the NHS and we will continue to improve access to our emergency services in the future using Warrington Hospital as our key site for emergency work.

4. **Developing minimally invasive surgery services** -We will invest in state of the art surgical equipment that will allow further development of what we call 'minimally invasive' surgical techniques such as keyhole surgery where it is possible. This means that patients will have a faster recovery time and can be in and out of hospital faster and that you are able to have the latest surgical techniques to benefit your care.

5. **Improving our Diagnostic services** - We will invest in and improve our diagnostic services such as radiology and cardiology across both hospital sites, both in terms of speed of access and convenience. We want you to be able to have diagnostic assessment and outpatient treatment in one visit on the same d needing repeat hospita

6. **Expanding Cardiolog** We will treat more War closer to their home by facilities like our cardia example, in the next tw provide a pacemaker fi to travel to L a services at th en access to ou ent more patient ave

7. **Maintaining ve satisfaction** - At the he be a clear focus on qua with our patients, staff Members and Governo feedback and experien improvements and a gr customer service for yo

Key questions we want your views on

etting involved in your hosp

lation Trust means that local people, patients and staff can North Cheshire Hospitals. Foundation Trusts are ations. Membership is completely free of charge to anyone ent with our hospital or who lives locally. You simply need to

you're involved -

be valuable to both trust. We know your and we have a strong hip with patients and the and Widnes have strong a clear identity and we n these communities in on and Warrington ship is a clear way of

nors -

Council - at least half of the local population and resent our staff and local ongside). Governors then ping guide the hospitals our management team ber is eligible to stand for

Our proposals -

It is important to us at North Cheshire Hospitals NHS Trust that our membership is strong and vibrant and can influence how the hospitals are run. As well as the role in standing for and electing Governors, as part of our membership proposals we want to consult with our Members directly on issues and gain your views so we can shape the hospitals around your needs. At the same time, we want local people to have a better understanding of their NHS and the decisions we have to make.

We think this is a great way of involving local people in the hospitals and ensuring that we are accountable to the local community. It is a key reason as to why we want North Cheshire Hospitals to become an NHS Foundation Trust.

As a Member we propose that you will receive:

- **The opportunity** to vote in the elections for the hospital Governors – and even stand for election yourself if you want.
- **A chance to have your say** by taking part in surveys and consultations about the hospital or letting the hospital Governors who represent Members know your views.
- **A quarterly Member's newsletter**. This will help us bring the hospitals to your home and build your understanding of what's going on in your NHS. We want the newsletter to include health tips and advice direct from our expert staff as well as valuable information on the hospitals and future plans so you are kept informed and can get involved.
- **Invites to exclusive Member's events**. These might range from health fairs where you can come and get your blood pressure checked and meet our staff to open days and informative lectures on key topics.

It's up to you how involved you want to be. We value any of your input. We're proud of our hospitals but know they can be even better with your help. We need as many people as possible to take the step of joining us a Member.

You can indicate h want to be from th

- Informed Member - You developments and info hospitals through a qua to Member only events
- Involved Member - You participate in a number surveys; focus groups
- Active Memb hospital grou meetings an specific area

We are proposing that me people aged 12 years and be available to all resident Borough Council areas, as patients of our hospitals. staff employed by us will a Members of the Foundatio to opt-out of membership.

Key questions we want your views on

elping shape local service

ernors are a key part of the stronger governance arrangements that ensure greater tion Trusts to the local community. The Public Governors will join Governors from ff Governors to form the Governors Council. At least half of the council will be any Member over the age of 16 can stand to be a Governor.

rth Cheshire Hospitals will help shape and endorse the future strategy of the trust, ween the hospital and the different areas and people it serves. Governors give up e a major contribution to the way the hospital relates to its patients and the wider o not 'run' the hospital, the board of directors and the Trust Board does that. with them to hold the hospital to account to the local population and, crucially, into decisions and plans for the hospitals.

ublic Governor Ward Groupings

g each of the following:

- wall
- , Hatton, Stretton
- at Sankey North,
- oft, Poulton North
- West, Poulton South
- airfield & Howley
- olston
- Whittle Hall, Westbrook

Halton

5 Governors, one representing each of the following:

1. Daresbury, Windmill Hill, Norton North, Castlefields
2. Beechwood, Mersey, Heath, Grange
3. Norton South, Halton Brook, Halton Lea
4. Appleton, Farnworth, Hough Green, Halton View
5. Broadheath, Ditton, Hale, Kingsway, Riverside

Other areas, one Governor:

One additional place for patients/and or carers from outside the Warrington and Halton areas.

Our proposal for the Governors Cou

In order to obtain a representative Governors Council that appropriately gains the vie partner organisations, we are proposing the following composition for our Governors:

Total Make-up of the Governors Council

Constituency	Number of Governors
Public	
Warrington residents	9
Halton residents	5
Former patients or carers who live outside Warrington and Halton	1
Total Public Governors	**15**
Staff Governors	5
Partner Organisation Governors	9
Total Governors Council	**29**

Under this composition Me would always be the grou of representatives. The Pu organised around local ele appropriate balance of rep Using this system, Public Governor from t :or in. This has bee d the residents in ea Governors from f g

Partner organis ill organisations we work clo

- One representative fro Trust (PCT) and one fr
- One representative fro Commissioning Conso PBCs representing Ru
- One representative fro Council and one from H
- Three representatives commercial and volunt

Key questions we want your views on

teps

to read through our proposals in
hree steps you can take to show
nts on these plans. Remember that
h April 2008.

u to:

Member

how that the local public are keen
that is more accountable to them
ved. Fill out the membership form
tation document now.

ne at our website
hs.uk Members need to fill in an
ore than one person in your
us then you will need to return a

MOIST HERE

us for more copies using the details on the back cover of this brochure, o

Your Contact Details

Title: Mr / Mrs / Ms / Other First Name:

Surname:

Address:

Post Code:

Home Tel: Mobile Tel:

E-Mail:

How would you prefer to be sent information about the hospitals and membership?

Making the Most of your Membership

Knowing how involved you want to be will help us develop the membership and ensur
amount of information. There are three levels of membership. All levels can vote in ele
Governors and you can change your level of involvement at any time:

☐ **Informed Member**
You will be kept abreast of new developments and information regar
newsletter and invites to Member only events and meetings.

☐ **Involved Member**
You will also be asked to participate in a number of activities such as
special interest events.

☐ **Active Member**
You might also be invited to join hospital groups, help us in service development
your knowledge/skill in specific areas of interest.

Are you potentially interested in standing to be a hospital Governor in the Governor el

About You

The data you give will help us see if our Membership is representative of our local com

Sex: ☐ Male ☐ Female Date of Birth ☐☐ /

What is your ethnic group? Please tick one of these boxes as appropriate.

White:	Mixed:	Black:	Asian:
☐ British	☐ White & Black Caribbean	☐ Caribbean	☐ Indian
☐ Irish	☐ White & Black African	☐ African	☐ Pakista
	☐ White & Asian		☐ Bangla
Other: ☐	Other: ☐	Other: ☐	Other: ☐

Declaration

e Hospitals Foundation Trust
ces
spital

N

Hospitals, then please let us know by the closing date of Friday 11th April 2008.

The questions at the bottom of the key sections may give you an indication of areas you may wish to comment on. However, we welcome your ideas on any aspect of the hospitals and how we can involve you.

Step 3 : Attend one of our public meetings

We have organised a series of pubic meetings where you can come and meet staff from the hospital and find out more about the plans we have.

We are also hosting open days at the hospital during the consultation period where you can come along, learn more about our plans, sign up as a Member and also see displays from some of our teams and departments. You can even benefit from a free blood pressure check whilst you are with us.

If you represent a local group or society (such as a residents, patient or voluntary group or a charity) we would be delighted to arrange come and talk about our plans in more detail at your meetings. Please email us at foundation@nch.nhs.uk or call us on 01925 662296 to arrange.

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What happens next?

If you would like more information about any of the details in this brochure, or if you would like information about becoming a Member of the Foundation Trust, contact:

Foundation Trust Consultation
North Cheshire Hospitals NHS Trust
Executive Offices
Warrington Hospital
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This document can be made available in other languages and formats if requested.
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We are committed to valuing people's differences, no matter what their age, race, ethnic or cultural background, disability, gender, sexuality, religion and beliefs.

We are Smoke Free! To protect our patients and staff, smoking is not permitted in our buildings, at the entrances to any of our buildings or in our car parks.

 Published January 2008 Written by North Cheshire Hospitals NHS Trust
Designed and produced by Cube Creative Ltd 0161 920 0011

REPORT TO: Healthy Halton Policy and Performance Board

DATE: 11 March 2008

REPORTING OFFICER: Strategic Director, Health and Community

SUBJECT: Future Options for Current Provider Services at Halton and St. Helens Primary Care Trust

WARDS: Boroughwide

1.0 PURPOSE OF THE REPORT

1.1 The Board will receive a presentation from Christine Samosa, Director of Workforce and Provider Development, Halton and St. Helens Primary Care Trust (PCT) on the provider arm of the PCT.

2.0 RECOMMENDATION: That

(1) the presentation be noted; and

(2) Members consider whether it would be relevant and/or necessary to establish a Joint Scrutiny Committee to investigate the issue further.

3.0 SUPPORTING INFORMATION

3.1 At its meeting held on 14 January 2008 the St Helen's Adult Social Care and Health Overview and Scrutiny Panel considered the issues surrounding the provider arm of the PCT.

3.2 The Panel concluded from its discussion on the matter that the Healthy Halton PPB and the PCT be requested to consider the matter, particularly whether it was felt relevant and/or necessary to establish a Joint Scrutiny Committee to investigate the issue further.

3.3 A copy of the presentation is attached as Appendix 1.

4.0 POLICY IMPLICATIONS

4.1 None applicable

5.0 OTHER IMPLICATIONS

5.1 None applicable

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 **Children and Young People in Halton**

6.2 **Employment, Learning and Skills in Halton**

6.3 **A Healthy Halton**

6.4 **A Safer Halton**

6.5 **Halton's Urban Renewal**

7.0 RISK ANALYSIS

7.1 None applicable

8.0 EQUALITY AND DIVERSITY ISSUES

8.1 None applicable

9.0 LIST OF BACKGROUND PAPERS UNDER SECTION 100D OF THE LOCAL GOVERNMENT ACT 1972

9.1 There are no background documents under the meaning of this Act.

REPORT TO: Healthy Halton Policy and Performance Board

DATE: 11 March 2008

REPORTING OFFICER: Strategic Director, Health and Community

SUBJECT: The Healthcare Commission Annual Health Check

WARDS: Boroughwide

1.0 PURPOSE OF THE REPORT

1.1 To update the Policy and Performance Board of progress made in 5 Borough's self assessment against The Standards for Better Health during the period April 2007-March 2008.

2.0 RECOMMENDATION: That the Board make a 3rd party commentary from the Policy and Performance to accompany the submission of the Annual Health Check declaration to the 5 Borough's Partnership NHS Trust Board and to be made public on the Trust's website from April 2008

3.0 SUPPORTING INFORMATION

3.1 The annual health check in 2007/2008 assesses how well NHS trusts perform during the financial year from 1st April 2007 to 31st March 2008.

The Healthcare Commission published "The annual health check 2007/2008: assessing and rating the NHS" on 21st June 2007. The guidance sets out:

- the key changes between the 2006/2007 and 2007/2008 annual health check
- how the annual health check focuses on the issues that are most important to patients
- how the annual health check will be better tailored to different types of trust

3.2 The Commission have also published the revised criteria for assessing performance against the 24 core standards. This year they have produced four sets of criteria, one for each type of trust: acute services, mental health services and learning disabaility services, ambulance services and primary care trusts

A copy of the criteria document for mental health services can be found as Appendix 1.

3.3 There is a need to feed in the views of patients and the public into the annual health check cross checking process. The Commission have produced guidance for third party organisations who will be commenting on trust performance as part of the 2007/2008 annual health check. By third parties the commission mean patient and public involvement forums, overview and scrutiny committees and representatives from foundation trust boards of governors.

A copy of the guidance document for third parties is attached as Appendix 2.

4.0 POLICY IMPLICATIONS

4.1 None applicable

5.0 OTHER IMPLICATIONS

5.1 None applicable

6.0 RISK ANALYSIS

6.1 A Key opportunity is provided to demonstrate to the Board compliance with the nominated Standards for Better Health and the evidence base that can be provided as assurance to the Board.

6.2 It is also proposed that further ongoing opportunities be made available to the partners to be able to review progress at regular intervals throughout 2007/2008 cycle of meetings.

7.0 EQUALITY AND DIVERSITY ISSUES

7.1 The selected Standards for self assessment focus upon Equality and Diversity issues

8.0 LIST OF BACKGROUND PAPERS UNDER SECTION 100D OF THE LOCAL GOVERNMENT ACT 1972

8.1 There are no background documents under the meaning of this Act.

Inspecting Informing Improving

Healthcare Commission

Criteria for assessing core standards in 2007/2008

Mental health and learning disability trusts

November 2007

Contents

Overview

These are the 2007/2008 criteria for assessing core standards for trusts that provide mental health and/or learning disability services. As in previous years, we have set out our criteria as "elements" for each of the core standards.

What has changed?

One main change is that this year we have produced separate criteria documents, one for each type of trust (i.e. acute and specialist services, mental health and learning disability services, ambulance services, and primary care trusts). Each trust will need to consider the sets of criteria relevant to the services they provide.

The other main change is that, as we detailed in our publication *The annual health check in 2007/2008: Assessing and rating the NHS*, we have rationalised the elements further, and where possible, reduced the number that apply to each trust.

In particular, we have:

- focused on the outcomes of the standards. We have revised some of the elements to set out more clearly the outcomes required for each standard – particularly those that affect service users. We expect trusts' boards to consider these outcomes when reviewing their compliance.

  For example, in standard C14c (learning from complaints), the second element now states "demonstrable improvements are made to service delivery as a result of concerns and complaints from service users, relatives and carers". So trusts' boards will wish to be assured that service improvements have occurred

- simplified the wording of the elements. We have done this by reducing the number of the references to guidance and removing all references that we had previously asked trusts to "take into account". These are now listed in appendix two as background information but they will not be the basis on which the Healthcare Commission makes judgments in inspection

- reduced the number of elements for some standards, particularly where trusts have told us that there was duplication, for example, in the evidence needed for a number of different elements

- increased our reliance on the findings of others. For trusts that are taking part in the NHS Litigation Authority's pilot assessments for the new risk management standards for mental health trusts, their boards can rely on this information at level 2 and above for the relevant standards. Once the NHS Litigation Authority has rolled out its revised standards to all mental health trusts we will rely on this information for the 2008/2009 assessment for the relevant core standards

We have detailed all of the changes to the elements for 2007/2008 in a separate document, available on the Healthcare Commission's website www.healthcarecommission.org.uk.

How should trusts consider the elements?

Trusts' boards should consider the level of compliance required by the elements when considering the extent to which they meet a core standard. In keeping with previous years, boards should determine whether they are compliant with a standard by assessing whether they have "reasonable assurance" that they have been meeting it, without "significant lapses", in the period 1 April 2007 to 31 March 2008.

Reasonable assurance
Reasonable assurance, by definition, is not absolute assurance. Reasonable assurance must be based on documentary evidence that can stand up to internal and external challenge.

The core standards are not optional and describe a level of service which is acceptable and which must be universal. We expect each trust's objectives to include compliance with the core standards, and that the organisation will use its routine processes for establishing assurance.

Trusts' boards should consider **all** aspects of their services when judging whether they have reasonable assurance that they are meeting the elements.

Where healthcare organisations provide services directly, they have the main responsibility for ensuring that they meet the core standards. However, their responsibility also extends to those services that they provide via partnerships or other forms of contractual arrangement (e.g. where human resource functions are provided through a shared service). When such arrangements are in place, each organisation should have reasonable assurance that those services meet the standards.

Significant lapse
Trusts' boards should decide whether a given lapse is significant or not by considering the extent of risk to service users, staff and the public, and the duration and impact of any lapse. There is no simple formula to determine whether a lapse is significant. A simple quantification of risk, such as the death of a service user or the loss of more than £1 million, cannot provide a complete answer.

Determining whether a lapse is significant depends on the standard under consideration, the circumstances in which a trust operates (such as the services they provide, their functions or the population they serve), and the extent of the lapse (e.g. the level of risk to service users, the duration of the lapse and the range of services affected).

Equality, diversity and human rights

One of the Healthcare Commission's strategic goals is to encourage respect within services for people's human rights and for their diversity, and to promote action to reduce inequalities in people's health and experiences of healthcare. In line with the intention of Standards for better health, we expect that healthcare organisations will interpret and implement the standards in ways which challenge discrimination, promote equity of access and quality of services, reduce inequalities in health, and respect and protect human rights.

More specifically, core standard C7e asks trusts to challenge discrimination, promote equality and respect human rights. The second element of the standard focuses on how the trust is promoting equality, including by publishing information specified by statute in relation to race, disability and gender. We have run two audits of trusts' websites, looking for this information, and we are concerned that many trusts are still not complying with the legislation, particularly in relation to race equality. In 2007/2008, therefore, if we discover that a trust has not published the information required under the Race Relations Act 1976 (as amended) or the Disability Discrimination Act 2005, we will be minded to qualify its declaration of compliance with standard C7e.

Using the findings of others

Our intention is to increase our use of the findings of others in the core standards assessment for mental health services and learning disability services. We will use information from our Concordat partners, and from other bodies, in three particular ways: as adequate assurance that an element or a standard has been met for the year, secondly, to answer specific lines of enquiry in inspection and thirdly, we will continue to use information in our cross checking process to target trusts for inspection.

The NHS Litigation Authority's standards for mental health and learning disability services are being piloted in 2007/2008, and therefore we will not be able to rely on this information for all mental health trusts until 2008/2009. However, for those trusts taking part as pilot sites in 2007/2008, the trust's board may wish to rely on the NHS Litigation Authority's findings at level 2 and above, as adequate assurance for specific standards when making its declaration. We have set out, as part of appendix one, the standards for which information from the NHS Litigation Authority, at level 2 and above, provides an appropriate level of assurance.

We have marked with an asterisk* those standards and elements where information from Patient Environment Action Teams' assessments 2008 provides an appropriate level of assurance. Trusts' boards may wish to rely on this information when making their declarations.

We will continue, where relevant, to use information from the Audit Commission's Auditor's Local Evaluation (ALE) to answer specific lines of enquiry in inspection.

In appendix one, we have set out further details of the findings of others that we are using in the core standards assessment 2007/2008.

First domain: Safety

Domain outcome: Patient safety is enhanced by the use of healthcare processes, working practices and systemic activities that prevent or reduce the risk of harm to patients.

Core standard C1	Elements
Healthcare organisations protect patients through systems that:	
a) identify and learn from all patient safety incidents and other reportable incidents, and make improvements in practice based on local and national experience and information derived from the analysis of incidents	**1** Incidents are reported locally and to the National Patient Safety Agency (NPSA) via the National Reporting and Learning System
	2 Reported incidents are analysed to seek to identify root causes, relevant trends and likelihood of repetition
	3 Demonstrable improvements in practice are made to prevent reoccurrence of incidents as a result of information arising from the analysis of local incidents and from the NPSA's national analysis of incidents
b) ensure that patient safety notices, alerts and other communications concerning patient safety, which require action, are acted upon within required timescales	**1** All communications, including drug alerts, issued by the Safety Alert Broadcast System (SABS) are implemented within the defined timescales, in accordance with *Chief executive's bulletin article* (Gateway 2326)

Core standard C2	Elements
Healthcare organisations protect children by following national child protection guidelines within their own activities and in their dealings with other organisations	**1** Effective processes are in place for identifying, reporting and taking action on child protection issues in accordance with *Working together to safeguard children* (HM Government, 2006) **2** The healthcare organisation works with partners to protect children as set out in *Working together to safeguard children* (HM Government, 2006) **3** Criminal Records Bureau (CRB) checks are conducted for all staff and students with access to children in the normal course of their duties, in accordance with *CRB disclosures in the NHS* (NHS Employers, 2004)
Core standard C3	
Healthcare organisations protect patients by following National Institute for Health and Clinical Excellence (NICE) interventional procedures guidance	This standard will not be assessed for mental health services and learning disability services for 2007/2008

Core standard C4	Elements
Healthcare organisations keep patients, staff and visitors safe by having systems to ensure that:	
a) the risk of healthcare acquired infection to patients is reduced, with particular emphasis on high standards of hygiene and cleanliness, achieving year on year reductions in Methicillin-Resistant Staphylococcus Aureus (MRSA)	**1** The healthcare organisation has systems to ensure the risk of healthcare associated infection is reduced in accordance with *The Health Act 2006 Code of Practice for the Prevention and Control of Health Care Associated Infections* (Department of Health, 2006)
b) all risks associated with the acquisition and use of medical devices are minimised	**1** The healthcare organisation has systems in place to minimise the risks associated with the acquisition and use of medical devices in accordance with guidance issued by the MHRA
c) all reusable medical devices are properly decontaminated prior to use and that the risks associated with decontamination facilities and processes are well managed	This standard will not be assessed for mental health and learning disability services for 2007/2008. Decontamination of environments (cleaning and disinfection) is covered under standard C21
d) medicines are handled safely and securely	**1** Medicines are safely and securely procured, prescribed, dispensed, prepared, administered and monitored, including in accordance with the statutory requirements of the Medicines Act 1968 **2** Controlled drugs are handled safely and securely in accordance with the Misuse of Drugs Act 1971, the Misuse of Drugs Act 1971 *(Modification) Order 2001 and Safer management of controlled drugs: Guidance on strengthened governance arrangements* (Department of Health, 2006)

e) the prevention, segregation, handling, transport and disposal of waste is properly managed so as to minimise the risks to the health and safety of staff, patients, the public and the safety of the environment

1 The prevention, segregation, handling, transport and disposal of waste is properly managed to minimise the risks to service users, staff, the public and the environment in accordance with *Environment and sustainability Health Technical Memorandum 07-01: Safe management of healthcare waste* (Department of Health, November 2006)

Second domain: Clinical and cost effectiveness

Domain outcome: patients achieve healthcare benefits that meet their individual needs through healthcare decisions and services, based on what assessed research evidence has shown provides effective clinical outcomes.

Core standard C5	Elements
Healthcare organisations ensure that:	
a) they conform to National Institute for Health and Clinical Excellence (NICE) technology appraisals and, where it is available, take into account nationally agreed guidance when planning and delivering treatment and care	**1** The healthcare organisation conforms to NICE technology appraisals where relevant to its services
	2 The healthcare organisation can demonstrate how it takes into account nationally agreed best practice as defined in national service frameworks (NSFs), NICE clinical guidelines, national plans and nationally agreed guidance, when delivering services, care and treatment
b) clinical care and treatment are carried out under supervision and leadership	**1** Appropriate supervision and clinical leadership is provided to staff involved in delivering clinical care and treatment in accordance with guidance from relevant professional bodies
c) clinicians[1] continuously update skills and techniques relevant to their clinical work	**1** Clinicians from all disciplines participate in activities to update the skills and techniques relevant to their clinical work
d) clinicians participate in regular clinical audit and reviews of clinical services	**1** Clinicians are involved in prioritising, conducting, reporting and acting on clinical audits
	2 Clinicians participate in reviewing the effectiveness of clinical services through evaluation, audit or research

1 Professionally qualified staff providing care to patients

Core standard C6	Elements
Healthcare organisations cooperate with each other and social care organisations to ensure that patients' individual needs are properly managed and met	**1** Staff work in partnership with colleagues in other health and social care organisations to meet the individual needs of service users including in accordance with the *National Service Framework for Mental Health* (Department of Health, 1999)

Third domain: Governance

Domain outcome: managerial and clinical leadership and accountability, as well as the organisation's culture, systems and working practices, ensure that probity, quality assurance, quality improvement and patient safety are central components of all activities of the healthcare organisation.

Core standard C7	Elements
Healthcare organisations:	
a) apply the principles of sound clinical and corporate governance c) undertake systematic risk assessment and risk management	1 The healthcare organisation has effective arrangements in place for clinical governance 2 There are effective corporate governance arrangements in place that accord with *Governing the NHS: A guide for NHS boards* (Department of Health and NHS Appointments Commission, 2003), and the *Corporate governance framework manual for NHS trusts* (Department of Health, April 2003) 3 The healthcare organisation systematically assesses and manages its risks
b) actively support all employees to promote openness, honesty, probity, accountability, and the economic, efficient and effective use of resources	1 The healthcare organisation actively promotes openness, honesty, probity and accountability to its staff and ensures that resources are protected from fraud and corruption in accordance with the *Code of conduct for NHS Managers* (Department of Health, 2002) and *NHS Counter Fraud and Corruption Manual third edition* (NHS Counter Fraud Service, 2006).

d) ensure financial management achieves economy, effectiveness, efficiency, probity and accountability in the use of resources	This standard will be measured through the use of resources assessment
e) challenge discrimination, promote equality and respect human rights	1 The healthcare organisation challenges discrimination and respects human rights in accordance with the Human Rights Act 1998, *No Secrets: Guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse* (Department of Health, 2000), The Sex Discrimination (Gender Reassignment) Regulations 1999, The Employment Equality (Religion or Belief) Regulations 2003, The Employment Equality (Sexual Orientation) Regulations 2003, and The Employment Equality (Age) Regulations 2006 **2** The healthcare organisation promotes equality, including by publishing information specified by statute, in accordance with the general and specific duties of the Race Relations Act 1976 (as amended), the Code of practice on the duty to promote race equality (Commission for Racial Equality 2002), the Disability Discrimination Act 1995, the Disability Discrimination Act 2005, the Code of practice on the duty to promote disability equality (Disability Rights Commission, 2005), the Equality Act 2006, Gender Equality Duty Code of Practice (Equal Opportunities Commission, November 2006) and *Delivering Race Equality in Mental Health Care (Department of Health, 2005)*
f) meet the existing performance requirements	This standard will be measured through the existing national targets assessment

Core standard C8	Elements
Healthcare organisations support their staff through:	
a) having access to processes which permit them to raise, in confidence and without prejudicing their position, concerns over any aspect of service delivery, treatment or management that they consider to have a detrimental effect on patient care or on the delivery of services	**1** Staff are supported, and know how, to raise concerns about services confidentially and without prejudicing their position, including in accordance with *The Public Disclosure Act 1998: Whistle blowing in the NHS* (HSC 1999/198)
b) organisational and personal development programmes which recognise the contribution and value of staff, and address, where appropriate, under-representation of minority groups	**1** The healthcare organisation supports and involves staff in organisational and personal development programmes as defined by the relevant areas of the Improving Working Lives standard at Practice Plus level **2** Staff from minority groups are offered opportunities for personal development to address under-representation in senior roles

Core standard C9	Elements
Healthcare organisations have a systematic and planned approach to the management of records to ensure that, from the moment a record is created until its ultimate disposal, the organisation maintains information so that it serves the purpose it was collected for and disposes of the information appropriately when no longer required	**1** The healthcare organisation has effective systems for managing clinical records in accordance with *Records management: NHS code of practice* (Department of Health, April 2006)

Core standard C10	Elements
Healthcare organisations:	
a) undertake all appropriate employment checks and ensure that all employed or contracted professionally qualified staff are registered with the appropriate bodies	1 The necessary employment checks are undertaken for all staff in accordance with *Safer recruitment – A guide for NHS employers* (NHS Employers, 2006) and *CRB disclosures in the NHS* (NHS Employers, 2004)
b) require that all employed professionals abide by relevant published codes of professional practice	1 The healthcare organisation explicitly requires staff to abide by relevant codes of professional conduct and takes action when codes of conduct are breached

Core standard C11	Elements
Healthcare organisations ensure that staff concerned with all aspects of the provision of healthcare:	
a) are appropriately recruited, trained and qualified for the work they undertake	1 The healthcare organisation recruits staff in accordance with relevant legislation and with particular regard to the Sex Discrimination (Gender Reassignment) Regulations 1999, The Employment Equality (Religion or Belief) Regulations 2003, The Employment Equality (Sexual Orientation) Regulations 2003, The Employment Equality (Age) Regulations 2006, Race Relations Act 1976 (as amended), the Disability Discrimination Act 2005 and the Equality Act 2006
	2 The healthcare organisation undertakes workforce planning which aligns workforce requirements to its service needs

b) participate in mandatory training programmes	**1** Staff participate in relevant mandatory training programmes **2** Staff and students participate in relevant induction programmes
c) participate in further professional and occupational development commensurate with their work throughout their working lives	**1** Staff have opportunities to participate in professional and occupational development at all points in their career in accordance with *Working together – learning together: a framework for lifelong learning for the NHS* (Department of Health, 2001)

Core standard C12	**Elements**
Healthcare organisations which either lead or participate in research have systems in place to ensure that the principles and requirements of the research governance framework are consistently applied	**1** The healthcare organisation has an effective research governance framework in place which complies with the requirements of the *Research governance framework for health and social care, second edition* (Department of Health, 2005)

Fourth domain: Patient focus

Domain outcome: healthcare is provided in partnership with patients, their carers and relatives, respecting their diverse needs, preferences and choices, and in partnership with other organisations (especially social care organisations) whose services impact on patient wellbeing.

Core standard C13	Elements
Healthcare organisations have systems in place to ensure that:	
a) staff treat patients, their relatives and carers with dignity and respect	**1** The healthcare organisation ensures that staff treat service users, carers and relatives with dignity and respect at every stage of their care and treatment and takes action where dignity and respect has been compromised
	2 The healthcare organisation meets the needs and rights of different service user groups with regard to dignity including by meeting the relevant requirements of the Human Rights Act 1998, the Race Relations Act 1976 (as amended), the Disability Discrimination Act 1995, the Disability Discrimination Act 2005 and the Equality Act 2006
b) appropriate consent is obtained when required, for all contacts with patients and for the use of any confidential patient information	**1** Valid consent, including from those who have communication or language support needs, is obtained by suitably qualified staff for all decisions, treatments, procedures (including post-mortem) and investigations in accordance with the *Reference guide to consent for examination or treatment* (Department of Health, 2001), *Families and post mortems: a code of practice* (Department of Health, 2003), *Code of*

	Practice to the Mental Health Act 1983 (Department of Health, 1999) and *Code of Practice to the Mental Capacity Act 2005* (Department of Constitutional Affairs, 2007)
	2 Service users, including those with language and/or communication support needs, are provided with information on the use and disclosure of confidential information held about them in accordance with *Confidentiality: NHS code of practice* (Department of Health, 2003)
c) staff treat patient information confidentially, except where authorised by legislation to the contrary	**1** Staff act in accordance with *Confidentiality: NHS code of practice* (Department of Health, 2003), the Data Protection Act 1998, *Protecting and using patient information: a manual for Caldicott guardians* (Department of Health, 1999), the Human Rights Act 1998 and the Freedom of Information Act 2000 when using and disclosing service users' personal information

Core standard C14	**Elements**
Healthcare organisations have systems in place to ensure that patients, their relatives and carers:	
a) have suitable and accessible information about, and clear access to, procedures to register formal complaints and feedback on the quality of services	**1** Service users, relatives and carers are given suitable and accessible information about, and can easily access, a formal complaints system
	2 Service users, relatives and carers are provided with opportunities to give feedback on the quality of services
b) are not discriminated against when complaints are made	**1** The healthcare organisation has systems in place to ensure that service users, carers and relatives are not treated adversely as a result of having complained

c) are assured that the organisation acts appropriately on any concerns and where appropriate, make changes to ensure improvements in service delivery	**1** The healthcare organisation acts on, and responds to, complaints appropriately and in a timely manner **2** Demonstrable improvements are made to service delivery as a result of concerns and complaints from service users, relatives and carers

Core standard C15	**Elements**
Where food is provided healthcare organisations have systems in place to ensure that:	
a) patients are provided with a choice and that it is prepared safely and provides a balanced diet	**1*** Service users are offered a choice of food in line with the requirements of a balanced diet, reflecting the needs and preferences and rights (including faith and cultural needs) of its service user population **2** The preparation, distribution, handling and serving of food is carried out in accordance with food safety legislation and national guidance (including the Food Safety Act 1990, the Food Safety (General Food Hygiene) Regulations 1995 and EC regulation 852/2004 * Adequate levels of assurance can be provided by an outcome of "excellent" for "food" for each relevant site from Patient Environment Action Teams' assessments 2008
b) patients' individual nutritional, personal and clinical dietary requirements are met, including where necessary help with feeding and access to food 24 hours a day	**1*** Service users have access to food and drink 24 hours a day **2*** The nutritional, personal and clinical dietary requirements of individual service users are assessed and met, including the right to have religious dietary requirements met

3* Service users requiring assistance with eating and drinking are provided with appropriate support

* Adequate levels of assurance can be provided by an outcome of "excellent" for "food" for each relevant site from Patient Environment Action Teams' assessments 2008

Core standard C16

Healthcare organisations make information available to patients and the public on their services, provide patients with suitable and accessible information on the care and treatment they receive and, where appropriate, inform patients on what to expect during treatment, care and after care

Elements

1 The healthcare organisation provides suitable and accessible information on the services it provides and in languages and formats relevant to its service population which accords with the Disability Discrimination Act 1995, the Disability Discrimination Act 2005 and the Race Relations Act 1976 (as amended)

2 Service users and, where appropriate, carers (including those with communication or language support needs) are provided with sufficient and accessible information on their care, treatment and after care, including a copy of their care plan under the care programme approach, in accordance with the *National Service Framework for Mental Health (Department of Health 1999), the Code of Practice to the Mental Capacity Act 2005* (Department of Constitutional Affairs 2007) and, if detained, about their rights under the Mental Health Act 1983

Fifth domain: Accessible and responsive care

Domain outcome: patients receive services as promptly as possible, have choice in access to services and treatments, and do not experience unnecessary delay at any stage of service delivery or the care pathway.

Core standard C17	Elements
The views of patients, their carers and others are sought and taken into account in designing, planning, delivering and improving healthcare services	**1** The healthcare organisation seeks the views of service users, carers and the local community, including those from disadvantaged and marginalised groups, when planning, delivering and improving services in accordance with *Strengthening Accountability, patient and public involvement policy guidance – Section 11 of the Health and Social Care Act 2001* (Department of Health, 2003) **2** The healthcare organisation demonstrates to service users, carers and the local community how it has taken their views into account when planning, delivering and improving services for service users in accordance with *Strengthening Accountability, patient and public involvement policy guidance – Section 11 of the Health and Social Care Act 2001* (Department of Health, 2003)

Core standard C18	Elements
Healthcare organisations enable all members of the population to access services equally and offer choice in access to services and treatment equitably	**1** The healthcare organisation ensures that all members of the population it serves are able to access its services on an equitable basis including acting in accordance with the Sex Discrimination Act 1975, the Disability Discrimination Act 1995, the Disability Discrimination Act 2005, the Race Relations Act 1976 (as amended) and the Equality Act 2006 **2** The healthcare organisation offers service users choice in access to services and treatment, where appropriate, and ensures that this is offered equitably
Core standard C19	
Healthcare organisations ensure that patients with emergency health needs are able to access care promptly and within nationally agreed timescales, and all patients are able to access services within national expectations on access to services	This standard will be measured under the existing national targets and new national targets assessment

Sixth domain: Care environment and amenities

Domain outcome: care is provided in environments that promote patient and staff wellbeing and respect for patients' needs and preferences in that they are designed for the effective and safe delivery of treatment, care or a specific function, provide as much privacy as possible, are well maintained and are cleaned to optimise health outcomes for patients.

Core standard C20	Elements
Healthcare services are provided in environments which promote effective care and optimise health outcomes by being:	
a) a safe and secure environment which protects patients, staff, visitors and their property, and the physical assets of the organisation	**1** The healthcare organisation effectively manages the health, safety and environmental risks to service users, staff and visitors, including by meeting the relevant health and safety at work and fire legislation, *The Management of Health, Safety and Welfare Issues for NHS staff* (NHS Employers, 2005) and the Disability Discrimination Act 1995
	2 The healthcare organisation provides a secure environment which protects service users, staff, visitors and their property, and the physical assets of the organisation
b) supportive of patient privacy and confidentiality	**1*** The healthcare organisation provides services in environments that are supportive of service user privacy and confidentiality (including the provision of single sex facilities and accommodation), in accordance with *Safety, privacy and dignity in mental health units: guidance on mixed sex accommodation for mental health services* (NHS Executive 1999)

* Adequate levels of assurance can be provided by an outcome of "excellent" for "privacy and dignity" for each relevant site from Patient Environment Action Teams' assessments 2008

Core standard C21	Elements
Healthcare services are provided in environments, which promote effective care and optimise health outcomes by being well designed and well maintained, with cleanliness levels in clinical and non-clinical areas that meet the national specification for clean NHS premises	**1** The healthcare organisation has taken steps to provide care in well designed and well maintained environments including in accordance with *Building Notes and Health Technical Memorandum,* the Disability Discrimination Act 1995, the Disability Discrimination Act 2005 and associated code of practice **2*** Care is provided in clean environments, in accordance with the *National specification for cleanliness in the NHS* (National Patient Safety Agency 2007) and the relevant requirements of The Health Act 2006 Code of Practice for the Prevention and Control of Health Care Associated Infections (Department of Health, 2006) * Adequate levels of assurance can be provided by an outcome of "excellent" for "environment" for each relevant site from Patient Environment Action Teams' assessments 2008, where there is no contradictory evidence from the Healthcare Commission's inspections of *The Health Act 2006 Code of Practice for the Prevention and Control of Health Care Associated Infections*

Seventh domain: Public health

Domain outcome: programmes and services are designed and delivered in collaboration with all relevant organisations and communities to promote, protect and improve the health of the population served and reduce health inequalities between different population groups and areas.

Core standard C22	Elements
Healthcare organisations promote, protect and demonstrably improve the health of the community served, and narrow health inequalities by:	
a) cooperating with each other and with local authorities and other organisations **c) making an appropriate and effective contribution to local partnership arrangements including local strategic partnerships and crime and disorder reduction partnerships**	**1** The healthcare organisation works with local partners to deliver the health and well being agenda, such as by working to improve health and social care pathways for service users across the health community and participating in equity audits to identify population health needs
b) ensuring that the local Director of Public Health's annual report informs their policies and practices	This standard will not be assessed for mental health services and learning disability services for 2007/2008

Core standard C23	Elements
Healthcare organisations have systematic and managed disease prevention and health promotion programmes which meet the requirements of the national service frameworks (NSFs) and national plans with particular regard to reducing obesity through action on nutrition and exercise, smoking, substance misuse and sexually transmitted infections **The elements are driven by the health improvement and health promotion requirements set out in NSFs and national plans with a particular focus on the following priority areas:** • **encouraging sensible drinking of alcohol** • **encouraging people to stop smoking and providing a smokefree environment** • **promoting opportunities for healthy eating** • **increasing physical activity** • **reducing drug misuse** • **improving mental health and well-being** • **promoting sexual health** • **preventing unintentional injuries**	**1** The healthcare organisation collects, analyses and shares data about its service users and services, including with its commissioners, to influence health needs assessments and strategic planning to improve the health of the community served **2** The healthcare organisation provides assessment, advice and support to service users in relation to public health priority areas and their physical health needs, including referral to primary health care and ensuring access to health checks and screening programmes **3** The healthcare organisation provides support and advice for service users to improve their mental health and well being, including support in retaining or accessing employment, training or volunteering opportunities **4** The healthcare organisation implements policies and practices to improve the health and well being of its workforce

Core standard C24	Elements
Healthcare organisations protect the public by having a planned, prepared and, where possible, practised response to incidents and emergency situations, which could affect the provision of normal services	**1** The healthcare organisation has a planned, prepared and, where possible, practised response to incidents and emergency situations (including control of communicable diseases), which includes arrangements for business continuity management, in accordance with *The NHS Emergency Planning Guidance* (Department of Health, 2005) and *UK influenza pandemic contingency plan* (Department of Health, 2005)

Appendix one: Healthcare Commission's use of other Concordat bodies findings in the core standards assessment 2007/2008

The findings of others are integral to the Healthcare Commission's core standards assessment, and have informed which trusts have been targeted for inspection. For 2007/2008, we have increased our reliance on the findings of others, particularly with regard to the NHS Litigation Authority (please see below for further details). We will use the findings of others in the assessment in three particular ways:

- relying on the information as adequate assurance that a trust is 'compliant' for a standard
- using the information to answer specific 'lines of enquiry' in inspection, to reduce the number of questions asked of a trust
- using the information in cross checking to target our inspections

1. Adequate sources of assurance

NHS Litigation Authority's risk management standards for mental health trusts (pilots)
Below we have listed the core standards for which attainment of level 2 or higher in the NHS Litigation Authority's risk management standards for mental health trusts pilots will provide a trust's board with appropriate assurance. Achievement of levels 2 or 3 of the NHS Litigation Authority standards is not, however, required by the Commission for a trust's board to make a declaration of 'compliant' for the listed standards. Instead, alternative sources of assurance may inform the board that the standard has been met for the year. The NHSLA will provide the Healthcare Commission with information that relates to the trusts that have achieved level 2 or higher from the pilot assessments in 2007/2008.

The Healthcare Commission will not have access to results relating to trusts that have not achieved compliance with the NHSLA's pilot assessment.

C1a
C9
C10a
C11b
C14a
C14c
C20a

Patient Environment Action Teams assessment 2008
A trust board may wish to use achievement of "excellent" as assurance for the standards listed below. Achievement of "excellent" is not, however, required by the Healthcare Commission for a trust board to make a declaration of "compliant" for the listed standards, as alternative sources of assurance may inform the board that there has not been a significant lapse for the standard during the year.

C15a
C15b
C20b
C21

The Healthcare Commission reserves the right to act on additional information that indicates there may be a potential issue with compliance with the above standards.

2. Information to inform inspections

NHS Litigation Authority's risk management standards for mental health trusts (pilots)
In addition to the list of standards provided in 1 above, we will also use information from the NHS Litigation Authority's risk management standards for mental health trusts (pilots) to inform our inspections. In the event that a trust is selected for an inspection for one of the standards listed below, we will rely upon information from the NHS Litigation Authority to answer particular lines of enquiry, and reduce the number of questions we need to ask in inspection.

The Healthcare Commission will not have access to results relating to trusts that have not achieved compliance with the NHSLA's pilot assessment.

C4a
C4d
C5a
C6
C14b
C16

Audit Commission's Auditor's Local Evaluation (ALE)
In the 2006/2007 core standards assessment, we used information from the Audit Commission's ALE assessments in our inspections for standards C7a&c, C7b and C21. We did this by relying on information from the ALE where this provided positive assurance that one or more relevant lines of enquiry for a standard were met, rather than requesting additional information from the trust at inspection.

In 2007/2008 we will again use positive assurance from the ALE to reduce the number of questions that we need to ask a trust in the event that they are selected for inspection for a particular standard. We recognise that there are additional standards to the three considered in 2006/2007 where there is overlap between the core standards assessment and ALE. We are working closely with the Audit Commission to identify additional standards where we can rely on information from ALE to reduce the questions we need to ask at inspection.

3. Information from other bodies used in cross checking

We will continue to use information from regulatory bodies and other organisations to inform our cross checking process, in order to target our inspection activity following declaration. We will refresh and add to the information we hold on every NHS trust throughout the year, so that we use the most up to date information possible when cross checking trusts' declarations.

We aim to use as a wide a range of data sources as possible, to build up a profile of information for every NHS trust, mapped to standards. The profiles are based on data sets that have national coverage – including some from our own assessments and work programmes (for example, information from service reviews, from hygiene code visits). We currently use information from 110 different datastreams to check trusts' declarations.

Appendix two: Reference documents

For the 2005/2006 and 2006/2007 assessments of core standards, we published a number of elements that included references to guidance that we asked trusts to "take into account". Our intention had been that this guidance would, in many cases, provide a starting point for trusts to consider, when reviewing their compliance with a standard. However, as this guidance is not sufficient or necessary for trusts to use to determine whether they have met a particular standard, we have taken the decision to remove these references.

We have provided the references below as some trusts may still find them helpful when considering their compliance. The list is not an exhaustive list of references for each standard, but instead may be useful to trusts as a starting point.

Standard	Guidance
C01a	*Building a safer NHS for patients: implementing an organisation with a memory* (Department of Health, 2001)
C02	*Safeguarding children in whom illness is induced or fabricated by carers with parenting responsibilities* (Department of Health, July 2001).
C04a	*Winning ways* (Department of Health, 2003) *A matron's charter: an action plan for cleaner hospitals* (Department of Health, 2004) *Revised guidance on contracting for cleaning* (Department of Health, 2004) *Audit Tools for Monitoring Infection Control Standards* (Infection Control Nurses Association, 2004) *Essential steps to safe, clean care: introduction and guidance* (Department of Health, 2006)
C04d	*Building a safer NHS: improving medication safety* (Department of Health, 2004)
C05a	*How to put NICE guidance into practice* (NICE, December 2005)

Standard	Guidance
C06	*Guidance on the Health Act Section 31 partnership arrangements* (Department of Health 1999)
C07ac	*Clinical governance in the new NHS* (HSC 1999/065). *Assurance: the board agenda* (Department of Health, 2002) *Building the assurance framework: a practical guide for NHS boards* (Department of Health, 2003)
C07b	*Directions to NHS bodies on counter fraud measures* (Department of Health, 2004)
C08b	*Leadership and Race Equality in the NHS Action Plan* (Department of Health, 2004)
C11a	*Code of practice for the international recruitment of healthcare professionals* (Department of Health, 2004)
C11c	*Continuing professional development: quality in the new NHS* (HSC 1999/154)
C13a	*Relevant benchmarks from the Essence of Care toolkit* *NHS Chaplaincy Meeting the religious and spiritual needs of patients and staff* (Department of Health, 2003)
C13b	*Good practice in consent: achieving the NHS plan commitment to patient centred consent practice* (HSC 2001/023) *Seeking Consent: working with children* (Department of Health, 2001)
C16	Toolkit for producing patient information (Department of Health, 2003) Information for patients (NICE) *Guidance On Developing Local Communication Support Services And Strategies* (Department of Health, 2004) and other nationally agreed guidance where available

Standard	Guidance
C17	*Key principles of effective patient and public involvement (PPI)* (The National Centre for Involvement, 2007)
C18	*Building on the best: Choice, responsiveness and equity in the NHS* (Department of Health, 2003)
C20a	*A professional approach to managing security in the NHS* (Counter Fraud and Security Management Service, 2003) and other relevant national guidance
C20b	*Privacy and dignity – a report by the CNO into mixed sex accommodation in hospitals* (Department of Health, 2007)
C21	*Developing an estate's strategy* (1999) *Estatecode: essential guidance on estates and facilities management* (NHS Estates, 2003) *A risk based methodology for establishing and managing backlog* (NHS Estates, 2004) *NHS Environmental assessment tool* (NHS Estates, 2002) *Revised guidance on contracting for cleaning* (Department of Health, 2004) *A matron's charter: an action plan for cleaner hospitals* (Department of Health, 2004)
C22ac	*Choosing health: making healthier choices easier* (Department of Health, 2004) *Tackling health inequalities: a programme for action* (Department of Health, 2003) *Making partnerships work for patients, carers and service users* (Department of Health, 2004)
C23	*Choosing health: making healthy choices easier* (Department of Health, 2004) *Delivering Choosing health: making healthier choices easier* (Department of Health, 2005) *Tackling Health Inequalities: A programme for action* (Department of Health, 2003)
C24	*Beyond a major incident* (Department of Health, 2004) *Getting Ahead of the Curve* (Department of Health, 2002)

This information is available in other formats and languages on request. Please telephone 0845 601 3012.

ENGLISH

આ માહિતી વિનંતી કરવાથી અન્ય રૂપે અને ભાષાઓમાં મળી શકે છે. મહેરબાની કરી ટેલિફોન નંબર 0845 601 3012 પર ફોન કરો.

GUJARATI

ਇਹ ਜਾਣਕਾਰੀ ਬੇਨਤੀ ਕਰਨ 'ਤੇ ਹੋਰਨਾਂ ਰੂਪ 'ਚ ਅਤੇ ਜ਼ਬਾਨਾਂ 'ਚ ਮਿਲ ਸਕਦੀ ਹੈ। ਕ੍ਰਿਪਾ ਕਰਕੇ ਟੈਲਿਫ਼ੋਨ ਨੰਬਰ 0845 601 3012 'ਤੇ ਫ਼ੋਨ ਕਰੋ।

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यह जानकारी बिनती करने पर अन्य रूप में और भाषाओं में मिल सकती है। कृपया टैलिफ़ोन नम्बर 0845 601 3012 पर फ़ोन करें।

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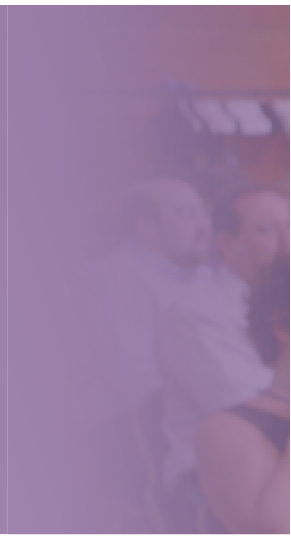
Healthcare Commission

Your part in the annual health check 2007/2008

A step-by-step guide for patient and public involvement forums, overview and scrutiny committees and foundation trusts' boards of governors



From April 2008, trusts will again be gearing up for the declaration part of the annual health check. We need your comments to make sure that we get the full picture about their performance in 2007/2008.

The Healthcare Commmission keeps a check on local healthcare organisations and provides information that is of interest to patients and the public about their local health services – safety and cleanliness, dignity and respect, standards of care, keeping people healthy, waiting to be seen, and good management.

By checking trusts' performance and providing information, we aim to help trusts to improve their services.

We want you to tell us how you think your local trust is performing against the standards set by Government, and to give us the views and experiences of people in your community. We are determined to put the interests of patients and the public at the heart of our work, so your feedback is very important to us. Trusts must include your comments – word for word – in the declarations they submit to us. But if you are invited to comment and say no, neither you nor the trust will be penalised.

We invited patient and public involvement forums, overview and scrutiny committees and foundation trusts' boards of governors to comment last year and they responded well. We really appreciate the hard work that went into providing commentaries that produced so much useful intelligence.

1. Getting ready

Every trust must submit a declaration to us by midday on 30 April 2008. As part of this process, trusts are responsible for inviting 'third parties' to comment on their performance. Third parties include patient and public involvement forums, overview and scrutiny committees and foundation trusts' board of governors.

Your local trust should contact you in early 2008 to agree a timetable for including your comments in their declaration. You may also want to start discussing what you might say, so you are prepared.

If you agree to comment, you may want to set up regular meetings with your members as soon as possible, so that you have enough time to seek the views of others in your community. You may also want to contact the other third parties in your area, so that you can discuss your respective roles, exchange views about local trusts and coordinate your efforts.

You may find it useful to share your draft comments with your trust or with a regional assessment manager from the Healthcare Commission. You don't have to take their feedback into account, but working together may benefit everyone involved.

2. What's new in 2007/2008

The Government published *Standards for Better Health* in July 2004, which set out 24 core standards. These core standards describe a minimum level of service, which patients have the right to expect. We are again asking trusts to tell us how they have performed against the core standards this year. You can comment on your trust's performance in relation to any of these standards. You do not have to comment on all of them.

If you provided comments to your trust for the annual health check in 2006/2007, you may remember that we also asked some of you to comment on their performance in relation to developmental standards. This was a pilot assessment for trusts and we are not asking them to report their progress in relation to these standards again this year. You therefore will not be asked to submit comments in relation to the developmental standards this year.

You are not expected to sign off or comment directly on the declaration by your local trust. Your comments should relate to the period from 1 April 2007 to 31 March 2008.

Given that patient and public involvement forums are in a period of transition, they may wish to submit their comments to trusts at an earlier stage this year. In the key dates section below, we have set out some suggestions to enable this.

3. How will your comments make a difference?

Your comments, once submitted to the Healthcare Commission, will be made publicly available. You could make a difference to your local health services just by putting your views on record.

Your comments will be taken into account when we make our final assessments of how trusts have performed in 2007/2008.

They are more likely to influence our assessments if they are supported by facts.

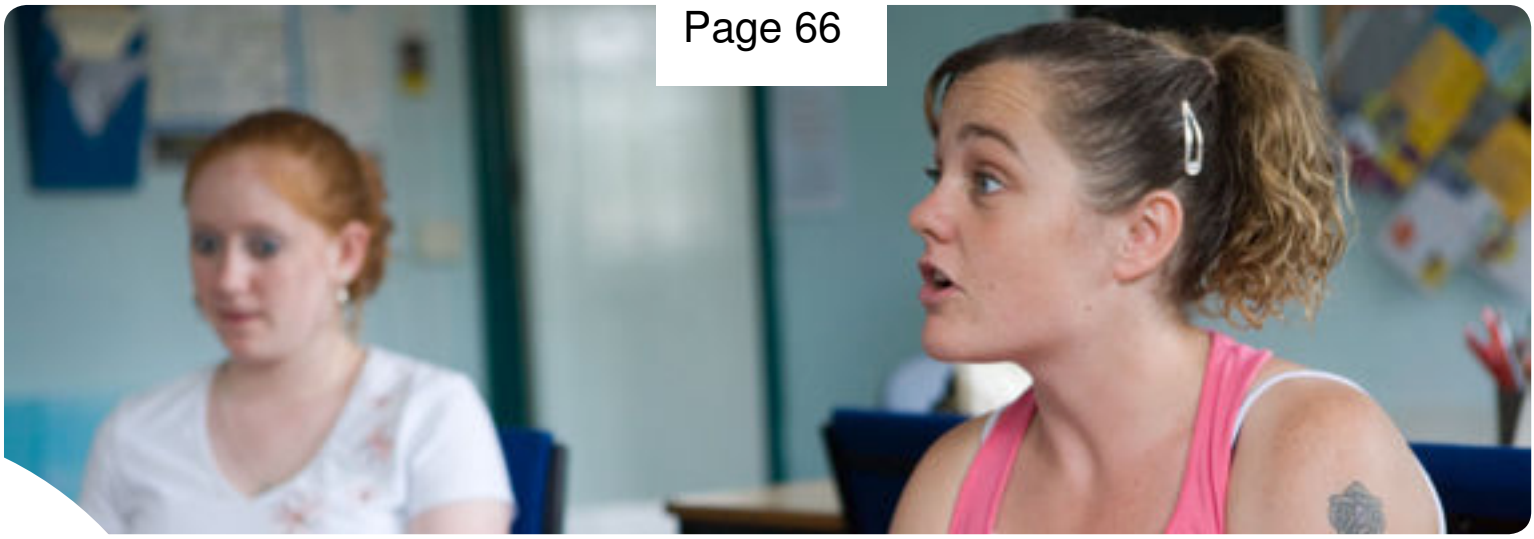
4. Submitting your comments

There is no standard template for giving your comments to trusts – use a format that works best for you. Consider allowing the chair of your group to 'sign off' your comments. This could help you to finalise them more quickly.

It is important that trusts have enough time to include your comments in their declarations before the deadline. They must send us their declaration no later than midday on 30 April 2008 and we will check that they have included your comments.

They should also send you a copy of their declaration once they have submitted it to us so that you can check your comments.

They do not have to share the content of their declaration with you before it is submitted.



Tips to help ensure your comments make a difference

- Think about what matters most to you and the people in your community – what are the most important points you want to get across?
- Think about examples of good practice as well as problems and areas for improvement
- Familiarise yourself with the 24 core standards and guidance relating to them. Aim to match the standards with the points you want to make
- Try to find facts and examples to back up your comments. These may include notes of a meeting or visit to a trust, the results of a local survey, or personal stories from individuals with supporting dates and documents
- Do not submit the supporting information with your comments, but be prepared in case we need to clarify some aspect of your comment

5. Cross checking and follow up

Your comments will be one of the many sources of information that will be used to check the trust's declaration. This helps to ensure our assessments are as fair and accurate as possible. We will also carry out follow up inspections with approximately 20% of trusts – some of these trusts will be chosen at random and some will have been identified as being most at risk of not meeting the core standards.

If your local trust gets a follow up inspection, you may be contacted by one of our regional assessment managers to discuss your comments. We will want to see your supporting information at this point.

Key dates

- **Early 2008**
  Establish the deadlines for submitting comments to your trust

  Because we recognise that patient and public involvement forums are in a state of transition during this period, we accept they may need to submit their commentaries early, and therefore that their commentaries may cover less than twelve months. Forums may negotiate with their trusts to submit their commentaries any time, which we suggest may be from 1 January 2008. They will need to make clear in their commentary the period of time it covers

  If you do not wish to submit any comments for the 2007/2008 annual health check, it would be helpful if you could write formally to your trust advising them of this
- **21 April 2008**
  Trusts can begin to submit their declaration to us
- **Midday 30 April 2008**
  Deadline for trusts to submit their declaration to us
- **16 May 2008**
  Trust declarations made public
- **October 2008**
  Results of the annual health check published

Learning from last year's annual health check

When writing your commentaries for this year's annual health check, try to plan and word your comments so that they include 'items of intelligence' (by that we mean pieces of information) that can be extracted from the commentary and 'coded' against one or more standard, for a particular trust.

In 2007, we received 1,469 comments from third parties. From these comments, 8,196 items of intelligence were extracted and coded because they related to one or more of the standards. Each coded item was weighted 'high', 'medium' or 'low':

- 'high' meant the item had strong association with a particular standard, was closely aligned to the criteria in our inspection guides and provided clear information to support the opinions expressed
- 'low' meant the item related to a small aspect of a standard, or was about one department rather than a whole trust, or had little back-up information
- in total, 492 (6%) of the items were weighted as 'high', 4,180 (51%) as 'low' and 3,524 (43%) as 'medium' weighting.

Find out more

The following publication offers further information about the annual health check:

The annual health check in 2007/2008: assessing and rating the NHS

This can be downloaded directly from the Healthcare Commission website at **www.healthcarecommission.org.uk**

We will shortly be publishing sets of criteria for NHS trusts to give them more information about the assessment of core standards for this year's annual health check. These will also be available to download from the Commission website once they are published.

Healthcare Commission

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REPORT TO: Healthy Halton Policy and Performance Board

DATE: 11 March 2008

REPORTING OFFICER: Strategic Director, Health and Community

SUBJECT: The Healthcare Commission Annual Health Check

WARDS: Boroughwide

1.0 PURPOSE OF THE REPORT

1.1 To update the Policy and Performance Board of progress made in Halton and St Helens Primary Care Trust self assessment against The Standards for Better Health during the period April 2007-March 2008.

2.0 RECOMMENDATION: That the Board make a 3rd party commentary from the Policy and Performance to accompany the submission of the Annual Health Check declaration to the Halton and St Helens Primary Care Trust Board and to be made public on the Trust's website from April 2008

3.0 SUPPORTING INFORMATION

3.1 The annual health check in 2007/2008 assesses how well NHS trusts perform during the financial year from 1st April 2007 to 31st March 2008.

The Healthcare Commission published "The annual health check 2007/2008: assessing and rating the NHS" on 21st June 2007. The guidance sets out:

- the key changes between the 2006/2007 and 2007/2008 annual health check
- how the annual health check focuses on the issues that are most important to patients
- how the annual health check will be better tailored to different types of trust

3.2 The Commission have also published the revised criteria for assessing performance against the 24 core standards. This year they have produced four sets of criteria, one for each type of trust: acute services, mental health services and learning disabaility services, ambulance services and primary care trusts

A copy of the criteria document for PCTs services can be found as Appendix 1.

3.3 There is a need to feed in the views of patients and the public into the annual health check cross checking process. The Commission have produced guidance for third party organisations who will be commenting on trust performance as part of the 2007/2008 annual health check. By third parties the commission mean patient and public involvement forums, overview and scrutiny committees and representatives from foundation trust boards of governors.

A copy of the guidance document for third parties is attached as Appendix 2 to Agenda Item 5(c).

4.0 POLICY IMPLICATIONS

4.1 None applicable

5.0 OTHER IMPLICATIONS

5.1 None applicable

6.0 RISK ANALYSIS

6.1 A Key opportunity is provided to demonstrate to the Board compliance with the nominated Standards for Better Health and the evidence base that can be provided as assurance to the Board.

6.2 It is also proposed that further ongoing opportunities be made available to the partners to be able to review progress at regular intervals throughout 2007/2008 cycle of meetings.

7.0 EQUALITY AND DIVERSITY ISSUES

7.1 The selected Standards for self assessment focus upon Equality and Diversity issues

8.0 LIST OF BACKGROUND PAPERS UNDER SECTION 100D OF THE LOCAL GOVERNMENT ACT 1972

8.1 There are no background documents under the meaning of this Act.

Inspecting Informing Improving

Healthcare Commission

Criteria for assessing core standards in 2007/2008

Primary care trusts

November 2007

Contents

Overview

These are the 2007/2008 criteria for assessing core standards for primary care trusts (PCTs). As in previous years, we have set out our criteria as "elements" for each of the core standards.

What has changed?

One main change is that this year we have produced separate criteria documents, one for each type of trust (i.e. acute and specialist services, mental health and learning disability services, ambulance services, and primary care trusts). Each trust will need to consider the sets of criteria relevant to the services they provide. For example, if your organisation also provides specialist mental health services you will also need to consider the criteria that apply to mental health and learning disability trusts.

The other main change is that, as we detailed in our publication *The annual health check in 2007/2008: Assessing and rating the NHS*, we have rationalised the elements further, and where possible, reduced the number that apply to each trust.

In particular, we have:

- focused on the outcomes of the standards. We have revised some of the elements to set out more clearly the outcomes required for each standard – particularly those that affect service users. We expect trusts' boards to consider these outcomes when reviewing their compliance.

  For example, in standard C14c (learning from complaints), the second element now states "demonstrable improvements are made to service delivery as a result of concerns and complaints from service users, relatives and carers". So trusts' boards will wish to be assured that service improvements have occurred

- simplified the wording of the elements. We have done this by reducing the number of the references to guidance and removing all references that we had previously asked trusts to "take into account". These are now listed in appendix two as background information but they will not be the basis on which the Healthcare Commission makes judgments in inspection

- reduced the number of elements for some standards, particularly where trusts have told us that there was duplication, for example, in the evidence needed for a number of different elements

- increased our reliance on the findings of others. For trusts that are taking part in the NHS Litigation Authority's pilot assessments for the new risk management standards for PCTs, trusts' boards can rely on this information at level 2 and above for the relevant standards. Once the NHS Litigation Authority has rolled out its revised standards to all PCTs we will rely on this information for the 2008/2009 assessment for the relevant core standards

We have detailed all of the changes to the elements for 2007/2008 in a separate document, available on the Healthcare Commission's website www.healthcarecommission.org.uk.

How should trusts consider the elements?

Trusts' boards should consider the level of compliance required by the elements when considering the extent to which they meet a core standard. In keeping with previous years, boards should determine whether they are compliant with a standard by assessing whether they have "reasonable assurance" that they have been meeting it, without "significant lapses", in the period 1 April 2007 to 31 March 2008.

Reasonable assurance

Reasonable assurance, by definition, is not absolute assurance. Reasonable assurance must be based on documentary evidence that can stand up to internal and external challenge.

The core standards are not optional and describe a level of service which is acceptable and which must be universal. We expect each trust's objectives to include compliance with the core standards, and that the organisation will use its routine processes for establishing assurance.

Trusts' boards should consider **all** aspects of their services when judging whether they have reasonable assurance that they are meeting the elements.

Where healthcare organisations provide services directly, they have the main responsibility for ensuring that they meet the core standards. However, their responsibility also extends to those services that they provide via partnerships or other forms of contractual arrangement (e.g. where human resource functions are provided through a shared service). When such arrangements are in place, each organisation should have reasonable assurance that those services meet the standards.

Significant lapse

Trusts' boards should decide whether a given lapse is significant or not by considering the extent of risk to service users, staff and the public, and the duration and impact of any lapse. There is no simple formula to determine whether a lapse is significant. A simple quantification

of risk, such as the death of a service user or the loss of more than £1 million, cannot provide a complete answer.

Determining whether a lapse is significant depends on the standard under consideration, the circumstances in which a trust operates (such as the services they provide, their functions or the population they serve), and the extent of the lapse (e.g. the level of risk to service users, the duration of the lapse and the range of services affected).

Equality, diversity and human rights

One of the Healthcare Commission's strategic goals is to encourage respect within services for people's human rights and for their diversity, and to promote action to reduce inequalities in people's health and experiences of healthcare. In line with the intention of *Standards for better health*, we expect that healthcare organisations will interpret and implement the standards in ways which challenge discrimination, promote equity of access and quality of services, reduce health inequalities, and respect and protect human rights.

More specifically, core standard C7e asks trusts to challenge discrimination, promote equality and respect human rights. The second element of the standard focuses on how the trust is promoting equality, including by publishing information specified by statute in relation to race, disability and gender. We have run two audits of trusts' websites, looking for this information, and we are concerned that many trusts are still not complying with the legislation, particularly in relation to race equality. In 2007/2008, therefore, if we discover that a trust has not published the information required under the Race Relations Act 1976 (as amended) or the Disability Discrimination Act 2005, we will be minded to qualify its declaration of compliance with standard C7e.

Application of the elements to PCTs

As in previous years, the 2007/2008 assessment of a PCT's compliance with core standards includes reference to their arrangements with independent contractors and their arrangements for commissioning. The Commission will not base its assessment of a PCT's compliance with core standards on the level of compliance achieved by its independent contractors or commissioned services. Instead, we ask PCTs to consider the services provided by independent contractors and the services they have commissioned from other providers, in the following ways:

- **independent contractors** – the PCT should have taken reasonable steps to ensure that the services provided by independent contractors (general practitioners, dentists, community pharmacists and optometrists) are compliant with the core standards. We have set out in

appendix three which standards and elements we expect PCTs to consider for their declaration for their independent contractors

- **commissioned services** – the PCT should consider whether it has appropriate mechanisms in place for identifying and, where appropriate, responding to any significant concerns that arise from the services that they have commissioned.

The Commission recognises that PCTs will differ in the mechanisms used in relation to quality and safety in its commissioned services. Some PCTs may have formalised their requirements and monitoring arrangements, through detailed contractual clauses and service level agreements. Others may rely on more general mechanisms to monitor quality and safety in commissioned services, e.g. considering feedback from patients, reviewing performance monitoring information, risk assessing commissioned services, holding regular meetings with their commissioned services or with the lead PCT commissioning that service.

Using the findings of others

Our intention is to increase our use of the findings of others in the core standards assessment for PCTs. We will use information from our Concordat partners, and from other bodies, in three particular ways: as adequate assurance that an element or a standard has been met for the year, secondly, to answer specific lines of enquiry in inspection and thirdly, we will continue to use information in our cross checking process to target trusts for inspection.

The NHS Litigation Authority's standards for PCTs are being piloted in 2007/2008, and therefore we will not be able to rely on this information for all primary care trusts until 2008/2009. However, for those trusts taking part as pilot sites in 2007/2008, the trust's board may wish to rely on the NHS Litigation Authority's findings at level 2 and above, as adequate assurance for specific standards when making its declaration. We have set out, as part of appendix one, the standards for which information from the NHS Litigation Authority, at level 2 and above, provides an appropriate level of assurance.

We have marked with an asterisk* those standards and elements where information from Patient Environment Action Teams' assessments 2008 provides an appropriate level of assurance. Trusts' boards may wish to rely on this information when making their declarations.

We will continue, where relevant, to use information from the Audit Commission's Auditor's Local Evaluation (ALE) to answer specific lines of enquiry in inspection.

In appendix one, we have set out further details of the findings of others that we are using in the core standards assessment 2007/2008.

First domain: Safety

Domain outcome: Patient safety is enhanced by the use of healthcare processes, working practices and systemic activities that prevent or reduce the risk of harm to patients.

Core standard C1	Elements
Healthcare organisations protect patients through systems that:	
a) identify and learn from all patient safety incidents and other reportable incidents, and make improvements in practice based on local and national experience and information derived from the analysis of incidents	**1** Incidents are reported locally and to the National Patient Safety Agency (NPSA) via the National Reporting and Learning System
	2 Reported incidents are analysed to seek to identify root causes, relevant trends and likelihood of repetition
	3 Demonstrable improvements in practice are made to prevent reoccurrence of incidents as a result of information arising from the analysis of local incidents and from the NPSA's national analysis of incidents
b) ensure that patient safety notices, alerts and other communications concerning patient safety, which require action, are acted upon within required timescales	**1** All communications, including drug alerts, issued by the Safety Alert Broadcast System (SABS) are implemented within the defined timescales, in accordance with *Chief executive's bulletin article* (Gateway 2326)

Core standard C2	Elements
Healthcare organisations protect children by following national child protection guidelines within their own activities and in their dealings with other organisations	**1** Effective processes are in place for identifying, reporting and taking action on child protection issues in accordance with *Working together to safeguard children* (HM Government, 2006) **2** The PCT works with partners to protect children as set out in *Working together to safeguard children* (HM Government, 2006) **3** Criminal Records Bureau (CRB) checks are conducted for all staff and students with access to children in the normal course of their duties, in accordance with *CRB disclosures in the NHS* (NHS Employers, 2004)

Core standard C3	Elements
Healthcare organisations protect patients by following National Institute for Health and Clinical Excellence (NICE) interventional procedures guidance	This standard will not be assessed for PCTs for 2007/2008

Core standard C4	Elements
Healthcare organisations keep patients, staff and visitors safe by having systems to ensure that:	
a) the risk of healthcare acquired infection to patients is reduced, with particular emphasis on high standards of hygiene and cleanliness, achieving year on year reductions in Methicillin-Resistant Staphylococcus Aureus (MRSA)	**1** The PCT has systems to ensure the risk of healthcare associated infection is reduced in accordance with *The Health Act 2006 Code of Practice for the Prevention and Control of Health Care Associated Infections* (Department of Health, 2006)

b) all risks associated with the acquisition and use of medical devices are minimised	**1**	The PCT has systems in place to minimise the risks associated with the acquisition and use of medical devices in accordance with guidance issued by the MHRA
c) all reusable medical devices are properly decontaminated prior to use and that the risks associated with decontamination facilities and processes are well managed	**1**	Reusable medical devices are properly decontaminated in appropriate facilities, in accordance with the relevant requirements of *The Health Act 2006 Code of Practice for the Prevention and Control of Health Care Associated Infections* (Department of Health, 2006)
d) medicines are handled safely and securely	**1**	Medicines are safely and securely procured, prescribed, dispensed, prepared, administered and monitored, including in accordance with the statutory requirements of the Medicines Act 1968
	2	Controlled drugs are handled safely and securely in accordance with the Misuse of Drugs Act 1971, the Misuse of Drugs Act 1971 *(Modification) Order 2001* and *Safer management of controlled drugs: Guidance on strengthened governance arrangements* (Department of Health, 2006)
e) the prevention, segregation, handling, transport and disposal of waste is properly managed so as to minimise the risks to the health and safety of staff, patients, the public and the safety of the environment	**1**	The prevention, segregation, handling, transport and disposal of waste is properly managed to minimise the risks to patients, staff, the public and the environment in accordance with *Environment and sustainability Health Technical Memorandum 07-01: Safe management of healthcare waste* (Department of Health, November 2006)

Second domain: Clinical and cost effectiveness

Domain outcome: patients achieve healthcare benefits that meet their individual needs through healthcare decisions and services, based on what assessed research evidence has shown provides effective clinical outcomes.

Core standard C5	Elements
Healthcare organisations ensure that:	
a) they conform to National Institute for Health and Clinical Excellence (NICE) technology appraisals and, where it is available, take into account nationally agreed guidance when planning and delivering treatment and care	**1** The PCT conforms to NICE technology appraisals where relevant to its services
	2 The PCT can demonstrate how it takes into account nationally agreed best practice as defined in national service frameworks (NSFs), NICE clinical guidelines, national plans and nationally agreed guidance, when commissioning and when planning and delivering services, care and treatment
b) clinical care and treatment are carried out under supervision and leadership	**1** Appropriate supervision and clinical leadership is provided to staff involved in delivering clinical care and treatment in accordance with guidance from relevant professional bodies
c) clinicians[1] continuously update skills and techniques relevant to their clinical work	**1** Clinicians from all disciplines participate in activities to update the skills and techniques relevant to their clinical work
d) clinicians participate in regular clinical audit and reviews of clinical services	**1** Clinicians are involved in prioritising, conducting, reporting and acting on clinical audits
	2 Clinicians participate in reviewing the effectiveness of clinical services through evaluation, audit or research

1 Professionally qualified staff providing care to patients

Core standard C6	Elements
Healthcare organisations cooperate with each other and social care organisations to ensure that patients' individual needs are properly managed and met	1 Staff work in partnership with colleagues in other health and social care organisations to meet the individual needs of patients, including, where appropriate, in accordance with *Guidance on the Health Act Section 31 partnership arrangements* (Department Of Health, 1999)

Third domain: Governance

Domain outcome: managerial and clinical leadership and accountability, as well as the organisation's culture, systems and working practices, ensure that probity, quality assurance, quality improvement and patient safety are central components of all activities of the healthcare organisation.

Core standard C7	Elements
Healthcare organisations:	
a) apply the principles of sound clinical and corporate governance **c) undertake systematic risk assessment and risk management**	**1** The PCT has effective arrangements in place for clinical governance **2** There are effective corporate governance arrangements in place that accord with *Governing the NHS: A guide for NHS boards* (Department of Health and NHS Appointments Commission, 2003), *Corporate governance framework manual for PCTs* (Department of Health, April 2003) **3** The PCT systematically assesses and manages its risks
b) actively support all employees to promote openness, honesty, probity, accountability, and the economic, efficient and effective use of resources	**1** The PCT actively promotes openness, honesty, probity and accountability to its staff and ensures that resources are protected from fraud and corruption in accordance with the *Code of conduct for NHS Managers* (Department of Health, 2002) and *NHS Counter Fraud and Corruption Manual, third edition* (NHS Counter Fraud Service, 2006).
d) ensure financial management achieves economy, effectiveness, efficiency, probity and accountability in the use of resources	This standard will be measured through the use of resources assessment

e) challenge discrimination, promote equality and respect human rights

1 The PCT challenges discrimination and respects human rights in accordance with the Human Rights Act 1998, *No Secrets: Guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse (Department of Health, 2000)*, The Sex Discrimination (Gender Reassignment) Regulations 1999, The Employment Equality (Religion or Belief) Regulations 2003, The Employment Equality (Sexual Orientation) Regulations 2003, and The Employment Equality (Age) Regulations 2006

2 The PCT promotes equality, including by publishing information specified by statute, in accordance with the general and specific duties of the Race Relations Act 1976 (as amended), the Code of practice on the duty to promote race equality (Commission for Racial Equality 2002), the Disability Discrimination Act 1995, the Disability Discrimination Act 2005, the Code of practice on the duty to promote disability equality (Disability Rights Commission, 2005), the Equality Act 2006, Gender Equality Duty Code of Practice (Equal Opportunities Commission, November 2006) and *Delivering Race Equality in Mental Health Care* (Department of Health, 2005)

f) meet the existing performance requirements

This standard will be measured through the existing national targets assessment

Core standard C8	Elements
Healthcare organisations support their staff through:	
a) having access to processes which permit them to raise, in confidence and without prejudicing their position, concerns over any aspect of service delivery, treatment or management that they consider to have a detrimental effect on patient care or on the delivery of services	**1** Staff are supported, and know how, to raise concerns about services confidentially and without prejudicing their position, including in accordance with *The Public Disclosure Act 1998: Whistle blowing in the NHS* (HSC 1999/198)
b) organisational and personal development programmes which recognise the contribution and value of staff, and address, where appropriate, under-representation of minority groups	**1** The PCT supports and involves staff in organisational and personal development programmes as defined by the relevant areas of the Improving Working Lives standard at Practice Plus level **2** Staff from minority groups are offered opportunities for personal development to address under-representation in senior roles

Core standard C9	Elements
Healthcare organisations have a systematic and planned approach to the management of records to ensure that, from the moment a record is created until its ultimate disposal, the organisation maintains information so that it serves the purpose it was collected for and disposes of the information appropriately when no longer required	**1** The PCT has effective systems for managing clinical records in accordance with *Records management: NHS code of practice* (Department of Health, April 2006)

Core standard C10	Elements
Healthcare organisations:	
a) undertake all appropriate employment checks and ensure that all employed or contracted professionally qualified staff are registered with the appropriate bodies	1 The necessary employment checks are undertaken for all staff in accordance with *Safer recruitment – A guide for NHS employers* (NHS Employers, 2006) and *CRB disclosures in the NHS* (NHS Employers, 2004)
b) require that all employed professionals abide by relevant published codes of professional practice	1 The PCT explicitly requires staff to abide by relevant codes of professional conduct and takes action when codes of conduct are breached

Core standard C11	Elements
Healthcare organisations ensure that staff concerned with all aspects of the provision of healthcare:	
a) are appropriately recruited, trained and qualified for the work they undertake	1 The PCT recruits staff in accordance with relevant legislation and with particular regard to the Sex Discrimination (Gender Reassignment) Regulations 1999, The Employment Equality (Religion or Belief) Regulations 2003, The Employment Equality (Sexual Orientation) Regulations 2003, The Employment Equality (Age) Regulations 2006, Race Relations Act 1976 (as amended), the Disability Discrimination Act 2005 and the Equality Act 2006
	2 The PCT undertakes workforce planning which aligns workforce requirements to its service needs

b) participate in mandatory training programmes	**1** Staff participate in relevant mandatory training programmes
	2 Staff and students participate in relevant induction programmes
c) participate in further professional and occupational development commensurate with their work throughout their working lives	**1** Staff have opportunities to participate in professional and occupational development at all points in their career in accordance with *Working together – learning together: a framework for lifelong learning for the NHS* (Department of Health, 2001)

Core standard C12	**Elements**
Healthcare organisations which either lead or participate in research have systems in place to ensure that the principles and requirements of the research governance framework are consistently applied	**1** The PCT has an effective research governance framework in place which complies with the requirements of the *Research governance framework for health and social care, second edition* (Department of Health, 2005)

Fourth domain: Patient focus

Domain outcome: healthcare is provided in partnership with patients, their carers and relatives, respecting their diverse needs, preferences and choices, and in partnership with other organisations (especially social care organisations) whose services impact on patient wellbeing.

Core standard C13	Elements
Healthcare organisations have systems in place to ensure that:	
a) staff treat patients, their relatives and carers with dignity and respect	**1** The PCT ensures that staff treat patients, carers and relatives with dignity and respect at every stage of their care and treatment and takes action where dignity and respect has been compromised
	2 The PCT meets the needs and rights of different patient groups with regard to dignity including by meeting the relevant requirements of the Human Rights Act 1998, the Race Relations Act 1976 (as amended), the Disability Discrimination Act 1995, the Disability Discrimination Act 2005, and the Equality Act 2006
b) appropriate consent is obtained when required, for all contacts with patients and for the use of any confidential patient information	**1** Valid consent, including from those who have communication or language support needs, is obtained by suitably qualified staff for all treatments, procedures (including post-mortem) and investigations in accordance with the *Reference guide to consent for examination or treatment* (Department of Health, 2001), *Families and post mortems: a code of practice* (Department of Health, 2003) and Code of Practice to the Mental Capacity Act 2005 (Department of Constitutional Affairs, 2007)

	2 Patients, including those with language and/or communication support needs, are provided with information on the use and disclosure of confidential information held about them in accordance with *Confidentiality: NHS code of practice* (Department of Health, 2003)
c) staff treat patient information confidentially, except where authorised by legislation to the contrary	**1** Staff act in accordance with *Confidentiality: NHS code of practice* (Department of Health, 2003), the Data Protection Act 1998, *Protecting and using patient information: a manual for Caldicott guardians* (Department of Health, 1999), the Human Rights Act 1998 and the Freedom of Information Act 2000 when using and disclosing patients' personal information

Core standard C14	**Elements**
Healthcare organisations have systems in place to ensure that patients, their relatives and carers:	
a) have suitable and accessible information about, and clear access to, procedures to register formal complaints and feedback on the quality of services	**1** Patients, relatives and carers are given suitable and accessible information about, and can easily access, a formal complaints system
	2 Patients, relatives and carers are provided with opportunities to give feedback on the quality of services
b) are not discriminated against when complaints are made	**1** The PCT has systems in place to ensure that patients, carers and relatives are not treated adversely as a result of having complained

c) are assured that the organisation acts appropriately on any concerns and where appropriate, make changes to ensure improvements in service delivery	**1** The PCT acts on, and responds to, complaints appropriately and in a timely manner **2** Demonstrable improvements are made to service delivery as a result of concerns and complaints from patients, relatives and carers

Core standard C15	**Elements**
Where food is provided healthcare organisations have systems in place to ensure that:	
a) patients are provided with a choice and that it is prepared safely and provides a balanced diet	**1*** Patients are offered a choice of food in line with the requirements of a balanced diet, reflecting the needs and preferences and rights (including faith and cultural needs) of its service user population **2*** The preparation, distribution, handling and serving of food is carried out in accordance with food safety legislation and national guidance (including the Food Safety Act 1990, the Food Safety (General Food Hygiene) Regulations 1995 and EC regulation 852/2004 * Adequate levels of assurance can be provided by an outcome of "excellent" for "food" for each relevant site from Patient Environment Action Teams' assessments 2008.

b) patients' individual nutritional, personal and clinical dietary requirements are met, including where necessary help with feeding and access to food 24 hours a day	**1*** Patients have access to food and drink 24 hours a day **2*** The nutritional, personal and clinical dietary requirements of individual patients are assessed and met, including the right to have religious dietary requirements met **3*** Patients requiring assistance with eating and drinking are provided with appropriate support * Adequate levels of assurance can be provided by an outcome of "excellent" for "food" for each relevant site from Patient Environment Action Teams' assessments 2008.

Core standard C16	Elements
Healthcare organisations make information available to patients and the public on their services, provide patients with suitable and accessible information on the care and treatment they receive and, where appropriate, inform patients on what to expect during treatment, care and after care	**1** The PCT provides suitable and accessible information on the services it provides and in languages and formats relevant to its service population which accords with the Disability Discrimination Act 1995, the Disability Discrimination Act 2005 and the Race Relations Act 1976 (as amended) **2** Patients and, where appropriate, carers (including those with communication or language support needs) are provided with sufficient and accessible information on their care, treatment and after care

Fifth domain: Accessible and responsive care

Domain outcome: patients receive services as promptly as possible, have choice in access to services and treatments, and do not experience unnecessary delay at any stage of service delivery or the care pathway.

Core standard C17	Elements
The views of patients, their carers and others are sought and taken into account in designing, planning, delivering and improving healthcare services	**1** The PCT seeks the views of patients, carers and the local community, including those from disadvantaged and marginalised groups, when planning, commissioning, delivering and improving services in accordance with *Strengthening Accountability, patient and public involvement policy guidance – Section 11 of the Health and Social Care Act 2001* (Department of Health, 2003) **2** The PCT demonstrates to patients, carers and the local community how it has taken their views into account when planning, commissioning, delivering and improving services for patients in accordance with *Strengthening Accountability, patient and public involvement policy guidance – Section 11 of the Health and Social Care Act 2001* (Department of Health, 2003)

Core standard C18	Elements
Healthcare organisations enable all members of the population to access services equally and offer choice in access to services and treatment equitably	1 The PCT ensures that all members of the population it serves are able to access its services on an equitable basis including acting in accordance with the Sex Discrimination Act 1975, the Disability Discrimination Act 1995, the Disability Discrimination Act 2005, the Race Relations Act 1976 (as amended) and the Equality Act 2006 2 The PCT offers patients choice in access to services and treatment, where appropriate, and ensures that this is offered equitably

Core standard C19	Elements
Healthcare organisations ensure that patients with emergency health needs are able to access care promptly and within nationally agreed timescales, and all patients are able to access services within national expectations on access to services	This standard will be measured under the existing national targets and new national targets assessment

Sixth domain: Care environment and amenities

Domain outcome: care is provided in environments that promote patient and staff wellbeing and respect for patients' needs and preferences in that they are designed for the effective and safe delivery of treatment, care or a specific function, provide as much privacy as possible, are well maintained and are cleaned to optimise health outcomes for patients.

Core standard C20	Elements
Healthcare services are provided in environments which promote effective care and optimise health outcomes by being:	
a) a safe and secure environment which protects patients, staff, visitors and their property, and the physical assets of the organisation	**1** The PCT effectively manages the health, safety and environmental risks to patients, staff and visitors, including by meeting the relevant health and safety at work and fire legislation, *The Management of Health, Safety and Welfare Issues for NHS staff* (NHS Employers, 2005) and the Disability Discrimination Act 1995
	2 The PCT provides a secure environment which protects patients, staff, visitors and their property, and the physical assets of the organisation
b) supportive of patient privacy and confidentiality	**1** The PCT provides services in environments that are supportive of patient privacy and confidentiality, including the provision of single sex facilities and accommodation

Core standard C21	Elements
Healthcare services are provided in environments, which promote effective care and optimise health outcomes by being well designed and well maintained, with cleanliness levels in clinical and non-clinical areas that meet the national specification for clean NHS premises	**1** The PCT has taken steps to provide care in well designed and well maintained environments including in accordance with *Building Notes and Health Technical Memorandum,* the Disability Discrimination Act 1995, the Disability Discrimination Act 2005 and associated code of practice **2** Care is provided in clean environments, in accordance with the *National specification for cleanliness in the NHS* (National Patient Safety Agency 2007) and the relevant requirements of *The Health Act 2006 Code of Practice for the Prevention and Control of Health Care Associated Infections* (Department of Health, 2006)

Seventh domain: Public health

Domain outcome: programmes and services are designed and delivered in collaboration with all relevant organisations and communities to promote, protect and improve the health of the population served and reduce health inequalities between different population groups and areas.

Core standard C22	Elements
Healthcare organisations promote, protect and demonstrably improve the health of the community served, and narrow health inequalities by:	
a) cooperating with each other and with local authorities and other organisations **c) making an appropriate and effective contribution to local partnership arrangements including local strategic partnerships and crime and disorder reduction partnerships**	**1** The PCT actively works with partners (commissioners and providers) to improve health and tackle health inequalities, through the local strategic partnership(s), and other statutory partnerships, such as the Crime and Disorder Reduction Partnership(s) and operational partnerships, such as Youth Offending Teams **2** Commissioning decisions are taken in consultation with clinicians, local authorities and other partners, including patients, the public and their representatives
b) ensuring that the local Director of Public Health's annual report informs their policies and practices	**1** The PCT's policies and practice to improve health and reduce health inequalities are informed by the local Director of Public Health's annual public health report (APHR)

Core standard C23

Healthcare organisations have systematic and managed disease prevention and health promotion programmes which meet the requirements of the national service frameworks (NSFs) and national plans with particular regard to reducing obesity through action on nutrition and exercise, smoking, substance misuse and sexually transmitted infections

The elements are driven by the health improvement and health promotion requirements set out in NSFs and national plans with a particular focus on the following priority areas:

- **tackling health inequalities**
- **encouraging sensible drinking of alcohol**
- **encouraging people to stop smoking and providing a smokefree environment**
- **promoting opportunities for healthy eating**
- **increasing physical activity**
- **reducing drug misuse**
- **improving mental health and well-being**
- **promoting sexual health**
- **preventing unintentional injuries**

Elements

1 The PCT assesses the health needs of its local population, including analysis of its demography, health status, health and social care use and patient and public views

2 The PCT's commissioning decisions and local target setting are informed by intelligence from its assessment of health needs, the Director of Public Health's Annual Public Health Report, information from equity audits, evidence of effectiveness and national priorities

3 The PCT commissions or provides targeted programmes and services to protect and improve health, based on the needs of its local population

4 The PCT monitors and reviews its commissioning decisions in relation to improving health and tackling health inequalities and, where appropriate, makes changes

5 The PCT implements policies and practices to improve the health and wellbeing of its workforce

Core standard C24	Elements
Healthcare organisations protect the public by having a planned, prepared and, where possible, practised response to incidents and emergency situations, which could affect the provision of normal services	**1** The PCT has a planned, prepared and, where possible, practised response to incidents and emergency situations (including control of communicable diseases), which includes arrangements for business continuity management, in accordance with *The NHS Emergency Planning Guidance* (Department of Health, 2005) and *UK influenza pandemic contingency plan* (Department of Health, 2005) **2** The PCT works with key partner organisations, including through Local Resilience Forums, in the preparation of, training for and annual testing of emergency preparedness plans, in accordance with the Civil Contingencies Act 2004, *The NHS Emergency Planning Guidance 2005* and *UK influenza pandemic contingency plan* (Department of Health, 2005)

Appendix one: Healthcare Commission's use of other Concordat bodies' findings in the core standards assessment 2007/2008

The findings of others are integral to the Healthcare Commission's core standards assessment, and have informed which trusts have been targeted for inspection. For 2007/2008, we have increased our reliance on the findings of others, particularly with regard to the NHS Litigation Authority (please see below for further details). We will use the findings of others in the assessment in three particular ways:

- relying on the information as adequate assurance that a trust is 'compliant' for a standard
- using the information to answer specific 'lines of enquiry' in inspection, to reduce the number of questions asked of a trust
- using the information in cross checking to target our inspections

1. Adequate sources of assurance

NHS Litigation Authority's risk management standards for PCTs (pilots)
Below we have listed the core standards for which attainment of level 2 or higher in the NHS Litigation Authority's risk management standards for PCTs (pilots) will provide a trust's board with appropriate assurance. Achievement of levels 2 or 3 of the NHS Litigation Authority standards is not, however, required by the Commission for a board to make a declaration of 'compliant' for the listed standards. Instead, alternative sources of assurance may inform the board that the standard has been met for the year. The NHSLA will provide the Healthcare Commission with information that relates to the trusts that have achieved level 2 or higher from the pilot assessment in 2007/2008.

The Healthcare Commission will not have access to NHSLA's results relating to trusts that have not achieved compliance with the NHSLA's pilot assessment.

C1a
C9
C10a
C11b
C14a
C14c
C20a

Patient Environment Action Teams' assessments 2008

A trust board may wish to use achievement of 'excellent' as assurance for the standards listed below. Achievement of 'excellent' is not, however, required by the Commission for a trust board to make a declaration of 'compliant' for the listed standards, as alternative sources of assurance may inform the board that there has not been a significant lapse for the standard during the year.

C15a
C15b

The Healthcare Commission reserves the right to act on additional information that indicates there may be a potential issue with compliance with the above standards.

2. Information to inform inspections

NHS Litigation Authority's risk management standards for PCTs (pilots)

In addition to the list of standards provided in 1 above, we will also use information from the NHS Litigation Authority's risk management standards for PCTs (pilots) to inform our inspections. In the event that a trust is selected for an inspection for one of the standards listed below, we will rely upon information from the NHS Litigation Authority to answer particular lines of enquiry, and reduce the number of questions we need to ask in inspection.

The Healthcare Commission will not have access to NHSLA's results relating to trusts that have not achieved compliance with the NHSLA's pilot assessment.

C4a
C4b
C4d
C5a
C13b
C14b
C16

Audit Commission's Auditor's Local Evaluation (ALE)

In the 2006/2007 core standards assessment, we used information from the Audit Commission's ALE assessments in our inspections for standards C7a&c, C7b and C21. We did this by relying on information from the ALE where this provided positive assurance that one or more relevant lines of enquiry for a standard were met, rather than requesting additional information from the trust at inspection.

In 2007/2008 we will again use positive assurance from the ALE to reduce the number of questions that we need to ask a trust in the event that they are selected for inspection for a

particular standard. We recognise that there are additional standards to the three considered in 2006/2007 where there is overlap between the core standards assessment and ALE. We are working closely with the Audit Commission to identify additional standards where we can rely on information from ALE to reduce the questions we need to ask at inspection.

3. Information from other bodies used in cross checking

We will continue to use information from regulatory bodies and other organisations to inform our cross checking process, in order to target our inspection activity following declaration. We will refresh and add to the information we hold on every NHS trust throughout the year, so that we use the most up to date information possible when cross checking trusts' declarations.

We aim to use as wide a range of data sources as possible, to build up a profile of information for every NHS trust, mapped to standards. The profiles are based on data sets that have national coverage – including some from our own assessments and work programmes (for example, information from service reviews, from hygiene code visits). We currently use information from 110 different datastreams to check trusts' declarations.

Appendix two: Reference documents

For the 2005/2006 and 2006/2007 assessment of core standards, we published a number of elements that included references to guidance that we asked trusts to "take into account". Our intention had been that this guidance would in many cases provide a starting point for trusts to consider when reviewing their compliance with a standard. However, as this guidance is not sufficient or necessary for trusts to use to determine whether they have met a particular standard, we have taken the decision to remove these references.

We have provided the references below as some trusts may still find them helpful when considering their compliance. The list is not an exhaustive list of references for each standard, but instead may be useful to trusts as a starting point.

Standard	Guidance
C01a	*Building a safer NHS for patients: implementing an organisation with a memory* (Department of Health, 2001)
C02	*Safeguarding children in whom illness is induced or fabricated by carers with parenting responsibilities* (Department of Health, July 2001)
C04a	*Winning ways* (Department of Health, 2003) *A matron's charter: an action plan for cleaner hospitals* (Department of Health, 2004) *Revised guidance on contracting for cleaning* (Department of Health, 2004) *Audit Tools for Monitoring Infection Control Standards* (Infection Control Nurses Association, 2004) *Essential steps to safe, clean care: introduction and guidance* (Department of Health, 2006)
C04c	Guidance issued by the MHRA and Medical Devices Directive (MDD) 93/42 EEC
C04d	*Building a safer NHS: improving medication safety* (Department of Health, 2004)
C05a	*How to put NICE guidance into practice* (NICE, December 2005)

Standard	Guidance
C07ac	*Clinical governance in the new* NHS (HSC 1999/065) *Assurance: the board agenda* (Department of Health, 2002) *Building the assurance framework: a practical guide for NHS boards* (Department of Health 2003)
C07b	*Directions to NHS bodies on counter fraud measures* (Department of Health, 2004)
C08b	*Leadership and Race Equality in the NHS Action Plan* (Department of Health 2004)
C11a	*Code of practice for the international recruitment of healthcare professionals* (Department of Health, 2004)
C11c	*Continuing professional development: quality in the new NHS* (HSC 1999/154)
C13a	Relevant benchmarks from the Essence of Care toolkit *NHS Chaplaincy Meeting the religious and spiritual needs of patients and staff* (Department of Health, 2003)
C13b	*Good practice in consent: achieving the NHS plan commitment to patient centred consent practice* (HSC 2001/023) *Seeking Consent: working with children* (Department of Health, 2001) *Code of Practice to the Mental Health Act 1983* (Department of Health, 1999)

Standard	Guidance
C16	*Toolkit for producing patient information* (Department of Health, 2003) Information for patients (NICE) *Guidance On Developing Local Communication Support Services And Strategies* (Department of Health 2004) and other nationally agreed guidance where available *National Service Framework for Mental Health* (Department of Health, 1999)
C17	*Key principles of effective patient and public involvement (PPI)* (The National Centre for Involvement, 2007)
C18	*Building on the best: Choice, responsiveness and equity in the NHS* (Department of Health, 2003)
C20a	*A professional approach to managing security in the NHS* (Counter Fraud and Security Management Service, 2003) and other relevant national guidance
C20b	*Privacy and dignity – a report by the CNO into mixed sex accommodation in hospitals* (Department of Health, 2007)
C21	*Developing an estate's strategy* (1999) *Estatecode: essential guidance on estates and facilities management* (NHS Estates, 2003) *A risk based methodology for establishing and managing backlog* (NHS Estates, 2004) *NHS Environmental assessment tool* (NHS Estates, 2002) *Revised guidance on contracting for cleaning* (Department of Health, 2004) *A matron's charter: an action plan for cleaner hospitals* (Department of Health, 2004)
C22ac	*Choosing health: making healthier choices easier* (Department of Health, 2004) *Tackling health inequalities: a programme for action* (Department of Health, 2003) *Making partnerships work for patients, carers and service users* (Department of Health, 2004)
C23	*Choosing health: making healthy choices easier* (Department of Health, 2004) *Delivering Choosing health: making healthier choices easier* (Department of Health, 2005) *Tackling Health Inequalities: A programme for action* (Department of Health, 2003)
C24	*Beyond a major incident* (Department of Health, 2004) *Getting Ahead of the Curve* (Department of Health, 2002) *Tuberculosis prevention and treatment: a toolkit for planning, commissioning and delivering high-quality services in England* (Department of Health, 2007)

Appendix three: Standards and elements applicable to independent contractors

When making its declaration, each PCT should consider whether it has taken reasonable steps to ensure that its independent contractors are meeting the standards. The Healthcare Commission recognises that each PCT will have different arrangements in place through which they do this, and that the arrangements will be different for the each of the independent contractor groups.

In the table below we have set out the relevant standards that the Healthcare Commission will apply the 'reasonable steps' assessment in the 2007/2008 assessment. For the standards where we will not apply the reasonable steps, for a particular independent contractor group, this is marked with an N/A. The standards identified as N/A are generally where the assessment focuses on the role of the PCT (such as C22a&c – public health partnerships), or where the standards are not relevant to the services provided by the contractor (such as C15 – food).

Standard	General practitioner	General dental practitioners	Community pharmacists	Community optometrists
C01a	√	√	√	√
C01b	√	√	√	√
C02	√	√	√	√
C03	N/A	N/A	N/A	N/A
C04a	√	√	N/A	√
C04b	√	√	√	√
C04c	√	√	√	√
C04d	√	√	√	√
C04e	√	√	√	X
C05a	√	√	√	√
C05b	√ (element one for GP registrars and medical students)	N/A	N/A	N/A
C05c	√	√	√	√
C05d	√	√	√	√
C06	√	√	√	√
C07ac	√	√	√	√
C07b	√	√	√	√

Standard	General practitioner	General dental practitioners	Community pharmacists	Community optometrists
C07e	√ (element one)	√ (element one)	√ (element one))	√ (element one)
C08a	√	√	√	√
C08b	√	√	√	√
C09	√	√	√	√
C10a	√	√	√	√
C10b	√	√	√	√
C11a	√ (element one)	√ (element one)	√ (element one)	√ (element one)
C11b	√	√	√	√
C11c	√	√	√	√
C12	√	√	√	√
C13a	√	√	√	√
C13b	√	√	√	√
C13c	√	√	√	√
C14a	√	√	√	√
C14b	√	√	√	√
C14c	√	√	√	√
C15a	N/A	N/A	N/A	N/A
C15b	N/A	N/A	N/A	N/A
C16	√	√	√	√
C17	√	√	√	√
C18	√	√	√	√
C20a	√	√	√	√
C20b	√	√	√	√
C21	√	√	√ (element one)	√ (element one)
C22ac	N/A	N/A	N/A	N/A
C22b	N/A	N/A	N/A	N/A
C23	√	√	√	√
C24	√ (communicable disease control)	N/A	√ (communicable disease control)	N/A

This information is available in other formats and languages on request. Please telephone 0845 601 3012.

ENGLISH

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REPORT TO: Healthy Halton Policy and Performance Board

DATE: 11 March 2008

REPORTING OFFICER: Strategic Director, Health and Community

SUBJECT: The Healthcare Commission Annual Health Check

WARDS: Boroughwide

1.0 PURPOSE OF THE REPORT

1.1 To update the Policy and Performance Board of progress made in North Cheshire Hospitals NHS Trust self assessment against The Standards for Better Health during the period April 2007-March 2008.

2.0 RECOMMENDATION: That the Board make a 3rd party commentary from the Policy and Performance to accompany the submission of the Annual Health Check declaration to the North Cheshire Hospitals NHS Trust Board and to be made public on the Trust's website from April 2008

3.0 SUPPORTING INFORMATION

3.1 The annual health check in 2007/2008 assesses how well NHS trusts perform during the financial year from 1st April 2007 to 31st March 2008.

The Healthcare Commission published "The annual health check 2007/2008: assessing and rating the NHS" on 21st June 2007. The guidance sets out:

- the key changes between the 2006/2007 and 2007/2008 annual health check
- how the annual health check focuses on the issues that are most important to patients
- how the annual health check will be better tailored to different types of trust

3.2 The Commission have also published the revised criteria for assessing performance against the 24 core standards. This year they have produced four sets of criteria, one for each type of trust: acute services, mental health services and learning disabaility services, ambulance services and primary care trusts

A copy of the criteria document for Acute Trust services can be found as Appendix 1.

3.3 There is a need to feed in the views of patients and the public into the annual health check cross checking process. The Commission have produced guidance for third party organisations who will be commenting on trust performance as part of the 2007/2008 annual health check. By third parties the commission mean patient and public involvement forums, overview and scrutiny committees and representatives from foundation trust boards of governors.

A copy of the guidance document for third parties is attached as Appendix 2 to Agenda Item 5(c).

4.0 POLICY IMPLICATIONS

4.1 None applicable

5.0 OTHER IMPLICATIONS

5.1 None applicable

6.0 RISK ANALYSIS

6.1 A Key opportunity is provided to demonstrate to the Board compliance with the nominated Standards for Better Health and the evidence base that can be provided as assurance to the Board.

6.2 It is also proposed that further ongoing opportunities be made available to the partners to be able to review progress at regular intervals throughout 2007/2008 cycle of meetings.

7.0 EQUALITY AND DIVERSITY ISSUES

7.1 The selected Standards for self assessment focus upon Equality and Diversity issues

8.0 LIST OF BACKGROUND PAPERS UNDER SECTION 100D OF THE LOCAL GOVERNMENT ACT 1972

8.1 There are no background documents under the meaning of this Act.

Inspecting Informing Improving

Healthcare Commission

Criteria for assessing core standards in 2007/2008

Acute trusts

November 2007

Contents

Overview

These are the 2007/2008 criteria for assessing core standards for trusts that provide acute and specialist services. As in previous years, we have set out our criteria as "elements" for each of the core standards.

What has changed?

One main change is that this year we have produced separate criteria documents, one for each type of trust (i.e. acute and specialist services, mental health and learning disability services, ambulance services, and primary care trusts). Each trust will need to consider the sets of criteria relevant to the services they provide. For example, if your organisation also provides specialist mental health services you will also need to consider the criteria that apply to mental health and learning disability trusts.

The other main change is that, as we detailed in our publication *The annual health check in 2007/2008: Assessing and rating the NHS*, we have rationalised the elements further, and where possible, reduced the number that apply to each trust.

In particular, we have:

- focused on the outcomes of the standards. We have revised some of the elements to set out more clearly the outcomes required for each standard – particularly those that affect patients. We expect trusts' boards to consider these outcomes when reviewing their compliance.

  For example, in standard C14c (learning from complaints), the second element now states "demonstrable improvements are made to service delivery as a result of concerns and complaints from patients, relatives and carers". So trusts' boards will wish to be assured that service improvements have occurred

- simplified the wording of the elements. We have done this by reducing the number of the references to guidance and removing all references that we had previously asked trusts to "take into account". These are now listed in appendix two as background information but they will not be the basis on which the Healthcare Commission makes judgments in inspection

- reduced the number of elements for some standards, particularly where trusts have told us that there was duplication, for example, in the evidence needed for a number of different elements

- increased our reliance on the findings of others, in particular we will rely on findings from the NHS Litigation Authority's risk management scheme for acute trusts at level 2 and above for identified standards. We will rely on this information, unless we have serious concerns from another source that a trust is not meeting a particular standard. Further, trusts' boards can use this information to provide them with an appropriate level of assurance when considering their compliance.

We have detailed all of the changes to the elements for 2007/2008 in a separate document, available on the Healthcare Commission's website www.healthcarecommission.org.uk.

How should trusts consider the elements?

Trusts' boards should consider the level of compliance required by the elements when considering the extent to which they meet a core standard. In keeping with previous years, boards should determine whether they are compliant with a standard by assessing whether they have "reasonable assurance" that they have been meeting it, without "significant lapses", in the period 1 April 2007 to 31 March 2008.

Reasonable assurance
Reasonable assurance, by definition, is not absolute assurance. Reasonable assurance must be based on documentary evidence that can stand up to internal and external challenge.

The core standards are not optional and describe a level of service which is acceptable and which must be universal. We expect each trust's objectives to include compliance with the core standards, and that the organisation will use its routine processes for establishing assurance.

Trusts' boards should consider **all** aspects of their services when judging whether they have reasonable assurance that they are meeting the elements.

Where healthcare organisations provide services directly, they have the main responsibility for ensuring that they meet the core standards. However, their responsibility also extends to those services that they provide via partnerships or other forms of contractual arrangement (e.g. where human resource functions are provided through a shared service). When such arrangements are in place, each organisation should have reasonable assurance that those services meet the standards.

Significant lapse

Trusts' boards should decide whether a given lapse is significant or not by considering the extent of risk to patients, staff and the public, and the duration and impact of any lapse. There is no simple formula to determine whether a lapse is significant. A simple quantification of risk, such as the death of a patient or the loss of more than £1 million, cannot provide a complete answer.

Determining whether a lapse is significant depends on the standard under consideration, the circumstances in which a trust operates (such as the services they provide, their functions or the population they serve), and the extent of the lapse (e.g. the level of risk to patients, the duration of the lapse and the range of services affected).

Equality, diversity and human rights

One of the Healthcare Commission's strategic goals is to encourage respect within services for people's human rights and for their diversity, and to promote action to reduce inequalities in people's health and experiences of healthcare. In line with the intention of *Standards for better health*, we expect that healthcare organisations will interpret and implement the standards in ways which challenge discrimination, promote equity of access and quality of services, reduce inequalities in health, and respect and protect human rights.

More specifically, core standard C7e asks trusts to challenge discrimination, promote equality and respect human rights. The second element of the standard focuses on how the trust is promoting equality, including by publishing information specified by statute in relation to race, disability and gender. We have run two audits of trusts' websites, looking for this information, and we are concerned that many trusts are still not complying with the legislation, particularly in relation to race equality. In 2007/2008, therefore, if we discover that a trust has not published the information required under the Race Relations Act 1976 (as amended) or the Disability Discrimination Act 2005, we will be minded to qualify its declaration of compliance with standard C7e.

Using the findings of others

We have significantly increased our use of the findings of others in the core standards assessment. In 2007/2008 we will use information from our Concordat partners, and from other bodies, in three particular ways: as adequate assurance that an element or a standard has been met for the year, secondly, to answer specific lines of enquiry in inspection and thirdly, we will continue to use information in our cross checking process to target trusts for inspection.

For acute and specialist trusts, we will rely on the findings of the NHS Litigation Authority at level 2 and above, where this provides a level of assurance that particular elements or standards have been met. We expect that trusts' boards will also wish to rely on this information when making their declarations. We have marked with an asterisk* those standards and elements where information from the NHS Litigation Authority, at level 2 and above, provides this level of assurance.

We have marked with an asterisk* those standards and elements where information from Patient Environment Action Teams' assessments for 2008 provides an appropriate level of assurance. Trusts' boards may wish to rely on this information when making their declarations.

We will continue, where relevant, to use information from the Audit Commission's Auditor's Local Evaluation (ALE) to answer specific lines of enquiry in inspection.

Appendix one sets out in further detail how we are using the findings of others in 2007/2008.

First domain: Safety

Domain outcome: Patient safety is enhanced by the use of healthcare processes, working practices and systemic activities that prevent or reduce the risk of harm to patients.

Core standard C1	Elements
Healthcare organisations protect patients through systems that:	
a) identify and learn from all patient safety incidents and other reportable incidents, and make improvements in practice based on local and national experience and information derived from the analysis of incidents	**1*** Incidents are reported locally and to the National Patient Safety Agency (NPSA) via the National Reporting and Learning System **2*** Reported incidents are analysed to seek to identify root causes, relevant trends and likelihood of repetition **3*** Demonstrable improvements in practice are made to prevent reoccurrence of incidents as a result of information arising from the analysis of local incidents and from the NPSA's national analysis of incidents * Adequate levels of assurance can be provided by level 2 and above of the NHSLA's Risk Management Standards for acute trusts.
b) ensure that patient safety notices, alerts and other communications concerning patient safety, which require action, are acted upon within required timescales	**1** All communications, including drug alerts, issued by the Safety Alert Broadcast System (SABS) are implemented within the defined timescales, in accordance with *Chief executive's bulletin article* (Gateway 2326)

Core standard C2	Elements
Healthcare organisations protect children by following national child protection guidelines within their own activities and in their dealings with other organisations	**1** Effective processes are in place for identifying, reporting and taking action on child protection issues in accordance with *Working together to safeguard children* (HM Government, 2006) **2** The healthcare organisation works with partners to protect children as set out in *Working together to safeguard children* (HM Government, 2006) **3** Criminal Records Bureau (CRB) checks are conducted for all staff and students with access to children in the normal course of their duties, in accordance with *CRB disclosures in the NHS* (NHS Employers, 2004)

Core standard C3	Elements
Healthcare organisations protect patients by following National Institute for Health and Clinical Excellence (NICE) interventional procedures guidance	**1** The healthcare organisation follows NICE interventional procedures guidance in accordance with *The interventional procedures programme* (Health Service Circular 2003/011)

Core standard C4	Elements
Healthcare organisations keep patients, staff and visitors safe by having systems to ensure that:	
a) the risk of healthcare acquired infection to patients is reduced, with particular emphasis on high standards of hygiene and cleanliness, achieving year on year reductions in Methicillin-Resistant Staphylococcus Aureus (MRSA)	**1** The healthcare organisation has systems to ensure the risk of healthcare associated infection is reduced in accordance with *The Health Act 2006 Code of Practice for the Prevention and Control of Health Care Associated Infections* (Department of Health, 2006) To note: the measurement of the MRSA target is undertaken through the 'national targets' component of the annual health check.
b) all risks associated with the acquisition and use of medical devices are minimised	**1** The healthcare organisation has systems in place to minimise the risks associated with the acquisition and use of medical devices in accordance with guidance issued by the MHRA **2** The healthcare organisation has systems in place to meet the requirements of the *Ionising Radiation (Medical Exposure) Regulations 2000* [IR(ME)R]
c) all reusable medical devices are properly decontaminated prior to use and that the risks associated with decontamination facilities and processes are well managed	**1** Reusable medical devices are properly decontaminated in appropriate facilities, in accordance with the relevant requirements of *The Health Act 2006 Code of Practice for the Prevention and Control of Health Care Associated Infections* (Department of Health, 2006)

d) medicines are handled safely and securely	1 Medicines are safely and securely procured, prescribed, dispensed, prepared, administered and monitored, including in accordance with the statutory requirements of the Medicines Act 1968
	2 Controlled drugs are handled safely and securely in accordance with the Misuse of Drugs Act 1971, the Misuse of Drugs Act 1971 (Modification) Order 2001 and *Safer management of controlled drugs: Guidance on strengthened governance arrangements* (Department of Health, 2006)
e) the prevention, segregation, handling, transport and disposal of waste is properly managed so as to minimise the risks to the health and safety of staff, patients, the public and the safety of the environment	1 The prevention, segregation, handling, transport and disposal of waste is properly managed to minimise the risks to patients, staff, the public and the environment in accordance with *Environment and sustainability Health Technical Memorandum 07-01: Safe management of healthcare waste* (Department of Health, November 2006)

Second domain: Clinical and cost effectiveness

Domain outcome: patients achieve healthcare benefits that meet their individual needs through healthcare decisions and services, based on what assessed research evidence has shown provides effective clinical outcomes.

Core standard C5	Elements
Healthcare organisations ensure that:	
a) they conform to National Institute for Health and Clinical Excellence (NICE) technology appraisals and, where it is available, take into account nationally agreed guidance when planning and delivering treatment and care	**1** The healthcare organisation conforms to NICE technology appraisals where relevant to its services
	2 The healthcare organisation can demonstrate how it takes into account nationally agreed best practice as defined in national service frameworks (NSFs), NICE clinical guidelines, national plans and nationally agreed guidance, when delivering services, care and treatment
b) clinical care and treatment are carried out under supervision and leadership	**1** Appropriate supervision and clinical leadership is provided to staff involved in delivering clinical care and treatment in accordance with guidance from relevant professional bodies
c) clinicians[1] continuously update skills and techniques relevant to their clinical work	**1** Clinicians from all disciplines participate in activities to update the skills and techniques relevant to their clinical work
d) clinicians participate in regular clinical audit and reviews of clinical services	**1** Clinicians are involved in prioritising, conducting, reporting and acting on clinical audits
	2 Clinicians participate in reviewing the effectiveness of clinical services through evaluation, audit or research

1 Professionally qualified staff providing care to patients

Core standard C6	Elements
Healthcare organisations cooperate with each other and social care organisations to ensure that patients' individual needs are properly managed and met	1 Staff work in partnership with colleagues in other health and social care organisations to meet the individual needs of patients

Third domain: Governance

Domain outcome: managerial and clinical leadership and accountability, as well as the organisation's culture, systems and working practices, ensure that probity, quality assurance, quality improvement and patient safety are central components of all activities of the healthcare organisation.

Core standard C7	Elements
Healthcare organisations:	
a) apply the principles of sound clinical and corporate governance **c) undertake systematic risk assessment and risk management**	**1** The healthcare organisation has effective arrangements in place for clinical governance **2** There are effective corporate governance arrangements in place that accord with *Governing the NHS: A guide for NHS boards* (Department of Health and NHS Appointments Commission, 2003), and the *Corporate governance framework manual for NHS trusts* (Department of Health, April 2003) **3** The healthcare organisation systematically assesses and manages its risks
b) actively support all employees to promote openness, honesty, probity, accountability, and the economic, efficient and effective use of resources	**1** The healthcare organisation actively promotes openness, honesty, probity and accountability to its staff and ensures that resources are protected from fraud and corruption in accordance with the *Code of conduct for NHS Managers* (Department of Health, 2002) and *NHS Counter Fraud and Corruption Manual third edition* (NHS Counter Fraud Service, 2006).

d) ensure financial management achieves economy, effectiveness, efficiency, probity and accountability in the use of resources	This standard will be measured through the use of resources assessment
e) challenge discrimination, promote equality and respect human rights	**1** The healthcare organisation challenges discrimination and respects human rights in accordance with the Human Rights Act 1998, *No Secrets: Guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse* (Department of Health, 2000), The Sex Discrimination (Gender Reassignment) Regulations 1999, The Employment Equality (Religion or Belief) Regulations 2003, The Employment Equality (Sexual Orientation) Regulations 2003 and The Employment Equality (Age) Regulations 2006 **2** The healthcare organisation promotes equality, including by publishing information required by statute, in accordance with the general and specific duties of the Race Relations Act 1976 (as amended), the Code of practice on the duty to promote race equality (Commission for Racial Equality 2002), the Disability Discrimination Act 1995, the Disability Discrimination Act 2005, the code of practice on the duty to promote disability equality (Disability Rights Commission, 2005), the Equality Act 2006 and the Gender Equality Duty Code of Practice (Equal Opportunities Commission, November 2006)
f) meet the existing performance requirements	This standard will be measured through the existing national targets assessment

Core standard C8	Elements
Healthcare organisations support their staff through:	
a) having access to processes which permit them to raise, in confidence and without prejudicing their position, concerns over any aspect of service delivery, treatment or management that they consider to have a detrimental effect on patient care or on the delivery of services	**1** Staff are supported, and know how, to raise concerns about services confidentially and without prejudicing their position, including in accordance with *The Public Disclosure Act 1998: Whistle blowing in the NHS* (HSC 1999/198)
b) organisational and personal development programmes which recognise the contribution and value of staff, and address, where appropriate, under-representation of minority groups	**1** The healthcare organisation supports and involves staff in organisational and personal development programmes as defined by the relevant areas of the Improving Working Lives standard at Practice Plus level **2** Staff from minority groups are offered opportunities for personal development to address under-representation in senior roles

Core standard C9	Elements
Healthcare organisations have a systematic and planned approach to the management of records to ensure that, from the moment a record is created until its ultimate disposal, the organisation maintains information so that it serves the purpose it was collected for and disposes of the information appropriately when no longer required	**1*** The healthcare organisation has effective systems for managing clinical records in accordance with *Records management: NHS code of practice* (Department of Health, April 2006) * Adequate levels of assurance can be provided by level 2 and above of the NHSLA's Risk Management Standards for acute trusts.

Core standard C10	Elements
Healthcare organisations:	
a) undertake all appropriate employment checks and ensure that all employed or contracted professionally qualified staff are registered with the appropriate bodies	**1*** The necessary employment checks are undertaken for all staff in accordance with *Safer recruitment – A guide for NHS employers* (NHS Employers, 2006) and *CRB disclosures in the NHS* (NHS Employers, 2004) * Adequate levels of assurance can be provided by level 2 and above of the NHSLA's Risk Management Standards for acute trusts.
b) require that all employed professionals abide by relevant published codes of professional practice	**1** The healthcare organisation explicitly requires staff to abide by relevant codes of professional conduct and takes action when codes of conduct are breached

Core standard C11	Elements
Healthcare organisations ensure that staff concerned with all aspects of the provision of healthcare:	
a) are appropriately recruited, trained and qualified for the work they undertake	**1** The healthcare organisation recruits staff in accordance with relevant legislation and with particular regard to the Sex Discrimination (Gender Reassignment) Regulations 1999, The Employment Equality (Religion or Belief) Regulations 2003, The Employment Equality (Sexual Orientation) Regulations 2003, The Employment Equality (Age) Regulations 2006, Race Relations Act 1976 (as amended), the Disability Discrimination Act 2005 and the Equality Act 2006 **2** The healthcare organisation undertakes workforce planning which aligns workforce requirements to its service needs

b) participate in mandatory training programmes	**1*** Staff participate in relevant mandatory training programmes as defined by the NHSLA's risk management standards for acute trusts **2*** Staff and students participate in relevant induction programmes * Adequate levels of assurance can be provided by level 2 or above of the NHSLA's Risk Management Standards for acute trusts.
c) participate in further professional and occupational development commensurate with their work throughout their working lives	**1** Staff have opportunities to participate in professional and occupational development at all points in their career in accordance with *Working together – learning together: a framework for lifelong learning for the NHS* (Department of Health, 2001)

Core standard C12	Elements
Healthcare organisations which either lead or participate in research have systems in place to ensure that the principles and requirements of the research governance framework are consistently applied	**1** The healthcare organisation has an effective research governance framework in place which complies with the requirements of the *Research governance framework for health and social care, second edition* (Department of Health, 2005)

Fourth domain: Patient focus

Domain outcome: healthcare is provided in partnership with patients, their carers and relatives, respecting their diverse needs, preferences and choices, and in partnership with other organisations (especially social care organisations) whose services impact on patient wellbeing.

Core standard C13	Elements
Healthcare organisations have systems in place to ensure that:	
a) staff treat patients, their relatives and carers with dignity and respect	**1** The healthcare organisation ensures that staff treat patients, carers and relatives with dignity and respect at every stage of their care and treatment, and, where relevant, takes action where dignity and respect have been compromised
	2 The healthcare organisation meets the needs and rights of different patient groups with regard to dignity including by meeting the relevant requirements of the Human Rights Act 1998, the Race Relations Act 1976 (as amended), the Disability Discrimination Act 1995, the Disability Discrimination Act 2005 and the Equality Act 2006
b) appropriate consent is obtained when required, for all contacts with patients and for the use of any confidential patient information	**1** Valid consent, including from those who have communication or language support needs, is obtained by suitably qualified staff for all treatments, procedures (including post-mortem) and investigations in accordance with the *Reference guide to consent for examination or treatment* (Department of Health 2001), *Families and post mortems: a code of practice* (Department

	of Health 2003), and Code of Practice to the Mental Capacity Act 2005 (Department of Constitutional Affairs, 2007
	2 Patients, including those with language and/or communication support needs, are provided with information on the use and disclosure of confidential information held about them in accordance with *Confidentiality: NHS code of practice* (Department of Health, 2003)
c) staff treat patient information confidentially, except where authorised by legislation to the contrary	**1** Staff act in accordance with *Confidentiality: NHS code of practice* (Department of Health, 2003), the Data Protection Act 1998, *Protecting and using patient information: a manual for Caldicott guardians* (Department of Health, 1999), the Human Rights Act 1998 and the Freedom of Information Act 2000 when using and disclosing patients' personal information

Core standard C14	Elements
Healthcare organisations have systems in place to ensure that patients, their relatives and carers:	
a) have suitable and accessible information about, and clear access to, procedures to register formal complaints and feedback on the quality of services	**1*** Patients, relatives and carers are given suitable and accessible information about, and can easily access, a formal complaints system **2*** Patients, relatives and carers are provided with opportunities to give feedback on the quality of services * Adequate levels of assurance can be provided by level 2 and above of the NHSLA's Risk Management Standards for acute trusts.
b) are not discriminated against when complaints are made	**1** The healthcare organisation has systems in place to ensure that patients, carers and relatives are not treated adversely as a result of having complained
c) are assured that the organisation acts appropriately on any concerns and where appropriate, make changes to ensure improvements in service delivery	**1*** The healthcare organisation acts on, and responds to, complaints appropriately and in a timely manner **2*** Demonstrable improvements are made to service delivery as a result of concerns and complaints from patients, relatives and carers * Adequate levels of assurance can be provided by level 2 and above of the NHSLA's Risk Management Standards for acute trusts.

Core standard C15	Elements
Where food is provided healthcare organisations have systems in place to ensure that:	
a) patients are provided with a choice and that it is prepared safely and provides a balanced diet	**1*** Patients are offered a choice of food in line with the requirements of a balanced diet, reflecting the needs and preferences and rights (including faith and cultural needs) of its service user population **2** The preparation, distribution, handling and serving of food is carried out in accordance with food safety legislation and national guidance (including the Food Safety Act 1990, the Food Safety (General Food Hygiene) Regulations 1995 and EC regulation 852/2004. * Adequate levels of assurance can be provided by an outcome of "excellent" for "food" for each relevant site from Patient Environment Action Teams' assessments 2008.
b) patients' individual nutritional, personal and clinical dietary requirements are met, including where necessary help with feeding and access to food 24 hours a day	**1*** Patients have access to food and drink 24 hours a day **2*** The nutritional, personal and clinical dietary requirements of individual patients are assessed and met, including the right to have religious dietary requirements met **3*** Patients requiring assistance with eating and drinking are provided with appropriate support * Adequate levels of assurance can be provided by an outcome of "excellent" for "food" for each relevant site from Patient Environment Action Teams' assessments for 2008.

Core standard C16	Elements
Healthcare organisations make information available to patients and the public on their services, provide patients with suitable and accessible information on the care and treatment they receive and, where appropriate, inform patients on what to expect during treatment, care and after care	1 The healthcare organisation provides suitable and accessible information on the services it provides and in languages and formats relevant to its service population which accords with the Disability Discrimination Act 1995, the Disability Discrimination Act 2005 and the Race Relations Act 1976 (as amended) 2 Patients and, where appropriate, carers (including those with communication or language support needs) are provided with sufficient and accessible information on their care, treatment and after care and, where appropriate, in accordance with the Code of Practice to the Mental Capacity Act 2005 (Department of Constitutional Affairs, 2007)

Fifth domain: Accessible and responsive care

Domain outcome: patients receive services as promptly as possible, have choice in access to services and treatments, and do not experience unnecessary delay at any stage of service delivery or the care pathway.

Core standard C17	Elements
The views of patients, their carers and others are sought and taken into account in designing, planning, delivering and improving healthcare services	1 The healthcare organisation seeks the views of patients, carers and the local community, including those from disadvantaged and marginalised groups, when planning, delivering and improving services in accordance with *Strengthening Accountability, patient and public involvement policy guidance – Section 11 of the Health and Social Care Act 2001* (Department of Health, 2003) 2 The healthcare organisation demonstrates to patients, carers and the local community how it has taken their views into account when planning, delivering and improving services for patients in accordance with *Strengthening Accountability, patient and public involvement policy guidance – Section 11 of the Health and Social Care Act 2001* (Department of Health, 2003)

Core standard C18	Elements
Healthcare organisations enable all members of the population to access services equally and offer choice in access to services and treatment equitably	1 The healthcare organisation ensures that all members of the population it serves are able to access its services on an equitable basis including acting in accordance with the Sex Discrimination Act 1975, the Disability Discrimination Act 1995, the Disability Discrimination Act 2005, the Race Relations Act 1976 (as amended) and the Equality Act 2006 2 The healthcare organisation offers patients choice in access to services and treatment, where appropriate, and ensures that this is offered equitably

Core standard C19	
Healthcare organisations ensure that patients with emergency health needs are able to access care promptly and within nationally agreed timescales, and all patients are able to access services within national expectations on access to services	This standard will be measured under the existing national targets and new national targets assessment

Sixth domain: Care environment and amenities

Domain outcome: care is provided in environments that promote patient and staff wellbeing and respect for patients' needs and preferences in that they are designed for the effective and safe delivery of treatment, care or a specific function, provide as much privacy as possible, are well maintained and are cleaned to optimise health outcomes for patients.

Core standard C20	Elements
Healthcare services are provided in environments which promote effective care and optimise health outcomes by being:	
a) a safe and secure environment which protects patients, staff, visitors and their property, and the physical assets of the organisation	**1*** The healthcare organisation effectively manages the health, safety and environmental risks to patients, staff and visitors, including by meeting the relevant health and safety at work and fire legislation, *The Management of Health, Safety and Welfare Issues for NHS staff* (NHS Employers, 2005) and the Disability Discrimination Act 1995 **2*** The healthcare organisation provides a secure environment which protects patients, staff, visitors and their property, and the physical assets of the organisation * Adequate levels of assurance for this standard can be provided by level 2 and above of the NHSLA's Risk Management Standards for acute trusts.
b) supportive of patient privacy and confidentiality*	**1*** The healthcare organisation provides services in environments that are supportive of patient privacy and confidentiality, including the provision of single sex facilities and accommodation * Adequate levels of assurance can be provided by an outcome of "excellent" for "privacy and dignity" for each relevant site from Patient Environment Action Teams' assessments 2008.

Core standard C21	Elements
Healthcare services are provided in environments, which promote effective care and optimise health outcomes by being well designed and well maintained, with cleanliness levels in clinical and non-clinical areas that meet the national specification for clean NHS premises	**1** The healthcare organisation has taken steps to provide care in well designed and well maintained environments including in accordance with *Building Notes and Health Technical Memorandum*, the Disability Discrimination Act 1995 and the Disability Discrimination Act 2005 and associated code of practice **2*** Care is provided in clean environments, in accordance with the *National specification for cleanliness in the NHS* (National Patient Safety Agency 2007) and the relevant requirements of *The Health Act 2006 Code of Practice for the Prevention and Control of Health Care Associated Infections* (Department of Health, 2006) * Adequate levels of assurance can be provided by an outcome of "excellent" for "environment" for each relevant site from Patient Environment Action Teams' assessments 2008, where there is no contradictory evidence from the Healthcare Commission's inspections of *The Health Act 2006 Code of Practice for the Prevention and Control of Health Care Associated Infections*

Seventh domain: Public health

Domain outcome: programmes and services are designed and delivered in collaboration with all relevant organisations and communities to promote, protect and improve the health of the population served and reduce health inequalities between different population groups and areas.

Core standard C22	Elements
Healthcare organisations promote, protect and demonstrably improve the health of the community served, and narrow health inequalities by:	
a) cooperating with each other and with local authorities and other organisations **c) making an appropriate and effective contribution to local partnership arrangements including local strategic partnerships and crime and disorder reduction partnerships**	1 The healthcare organisation works with local partners to deliver the health and well being agenda, such as by working to improve care pathways for patients across the health community and participating in equity audits to identify population health needs
b) ensuring that the local Director of Public Health's annual report informs their policies and practices	This standard will not be assessed for acute/specialist trusts for 2007/2008

Core standard C23	Elements
Healthcare organisations have systematic and managed disease prevention and health promotion programmes which meet the requirements of the national service frameworks (NSFs) and national plans with particular regard to reducing obesity through action on nutrition and exercise, smoking, substance misuse and sexually transmitted infections **The elements are driven by the health improvement and health promotion requirements set out in NSFs and national plans with a particular focus on the following priority areas:** • **encouraging sensible drinking of alcohol** • **encouraging people to stop smoking and providing a smokefree environment** • **promoting opportunities for healthy eating** • **increasing physical activity** • **reducing drug misuse** • **improving mental health and well-being** • **promoting sexual health** • **preventing unintentional injuries**	**1** The healthcare organisation collects, analyses and shares data about its patients and services, including with its commissioners, to influence health needs assessments and strategic planning to improve the health of the community served **2** Patients are provided with advice and support along their care pathway in relation to public health priority areas, including through referral to specialist advice and services **3** The healthcare organisation implements policies and practices to improve the health and well being of its workforce

Core standard C24	Elements
Healthcare organisations protect the public by having a planned, prepared and, where possible, practised response to incidents and emergency situations, which could affect the provision of normal services	1 The healthcare organisation has a planned, prepared and, where possible, practised response to incidents and emergency situations (including control of communicable diseases), which includes arrangements for business continuity management, in accordance with *The NHS Emergency Planning Guidance* (Department of Health, 2005) and *UK influenza pandemic contingency plan* (Department of Health, 2005) 2 The healthcare organisation works with key partner organisations, including through Local Resilience Forums, in the preparation of, training for and annual testing of emergency preparedness plans, in accordance with the Civil Contingencies Act 2004, The NHS Emergency Planning Guidance 2005, and *UK influenza pandemic contingency plan* (Department of Health, 2005)

Appendix one: Healthcare Commission's use of other Concordat bodies' findings in the core standards assessment 2007/2008

The findings of others are integral to the Healthcare Commission's core standards assessment, and have informed which trusts have been targeted for inspection. For 2007/2008, we have increased our reliance on the findings of others, particularly with regard to the NHS Litigation Authority (please see below for further details). We will use the findings of others in the assessment in three particular ways:

- relying on the information as adequate assurance that a trust is 'compliant' for a standard
- using the information to answer specific 'lines of enquiry' in inspection, to reduce the number of questions asked of a trust
- using the information in cross checking to target our inspections

1. Adequate sources of assurance

NHS Litigation Authority's risk management standards for acute trusts
Below we have listed the core standards for which attainment of level 2 or higher in the NHSLA's risk management standards for acute trusts will provide adequate assurance without the need for inspection by the Healthcare Commission. Similarly, a trust's board can use the achievement of a minimum of level 2 as assurance for the standards listed below. Achievement of levels 2 or 3 of the NHSLA standards is not, however, required by the Commission for a board to make a declaration of 'compliant' for the listed standards. Instead alternative sources of assurance may inform the board that the standard has been met for the year.

C1a
C9
C10a
C11b
C14a
C14c
C20a

Patient Environment Action Teams' assessments 2008
A trust board may wish to use achievement of "excellent" for each relevant site as assurance for the standards listed below. Achievement of "excellent" is not, however, required by the Commission for a trust board to make a declaration of "compliant" for the listed standards, as alternative sources of assurance may inform the board that there has not been a significant lapse for the standard during the year.

C15a
C15b
C20b
C21

The Healthcare Commission reserves the right to act on additional information that indicates there may be a potential issue with compliance with the above standards.

2. Information to inform inspections

NHS Litigation Authority's Risk management scheme for acute trusts
In addition to the list of standards provided in 1 above, we will also use information from the NHSLA's risk management standards for acute trusts to inform our inspections. In the event that a trust is selected for an inspection for one of the standards listed below, we will rely upon information from the NHSLA to answer particular lines of enquiry, and reduce the number of questions we need to ask in inspection.

C4a
C4b
C4d
C5a
C6
C13b
C14b
C16

Audit Commission's Auditor's Local Evaluation (ALE)
In the 2006/2007 core standards assessment, we used information from the Audit Commission's ALE assessments in our inspections for standards C7a&c, C7b and C21. We did this by relying on information from the ALE where this provided positive assurance that one or more relevant lines of enquiry for a standard were met, rather than requesting additional information from the trust at inspection.

In 2007/2008 we will again use positive assurance from the ALE to reduce the number of questions that we need to ask a trust in the event that they are selected for inspection for a particular standard. We recognise that there are additional standards to the three considered in 2006/2007 where there is overlap between the core standards assessment and ALE. We are working closely with the Audit Commission to identify additional standards where we can rely on information from ALE to reduce the questions we need to ask at inspection.

3. Information from other bodies used in cross checking

We will continue to use information from regulatory bodies and other organisations to inform our cross checking process, in order to target our inspection activity following declaration. We will refresh and add to the information we hold on every NHS trust throughout the year, so that we use the most up to date information possible when cross checking trusts' declarations.

We aim to use as wide a range of data sources as possible, to build up a profile of information for every NHS trust, mapped to standards. The profiles are based on data sets that have national coverage – including some from our own assessments and work programmes (for example, information from service reviews or from hygiene code visits). We currently use information from 110 different data streams to check trusts' declarations.

Appendix two: Reference documents

For the 2005/2006 and 2006/2007 assessment of core standards, we published a number of elements that included references to guidance that we asked trusts to "take into account". Our intention had been that this guidance would, in many cases, provide a starting point for trusts to consider, when reviewing their compliance with a standard. However, as this guidance is not sufficient or necessary for trusts to use to determine whether they have met a particular standard, we have taken the decision to remove these references.

We have provided the references below as some trusts may still find them helpful when considering their compliance. The list is not an exhaustive list of references for each standard, but instead may be useful to trusts as a starting point.

Standard	Guidance
C01a	*Building a safer NHS for patients: implementing an organisation with a memory* (Department of Health, 2001)
C02	*Safeguarding children in whom illness is induced or fabricated by carers with parenting responsibilities* (Department of Health, July 2001)
C04a	*Winning ways* (Department of Health, 2003), *A matron's charter: an action plan for cleaner hospitals* (Department of Health, 2004) *Revised guidance on contracting for cleaning* (Department of Health, 2004), *Audit Tools for Monitoring Infection Control Standards* (Infection Control Nurses Association, 2004) *Saving lives: A delivery programme to reduce healthcare associated infection (HCAI) including MRSA* (Department of Health, 2005)
C04c	Guidance issued by the MHRA and Medical Devices Directive (MDD) 93/42 EEC
C04d	*Building a safer NHS: improving medication safety* (Department of Health, 2004)

Standard	Guidance
C05a	*How to put NICE guidance into practice* (NICE, December 2005)
C06	*Guidance on the Health Act Section 31 partnership arrangements* (Department Of Health, 1999)
C07ac	*Clinical governance in the new NHS* (HSC 1999/065). *Assurance: the board agenda* (Department of Health, 2002) *Building the assurance framework: a practical guide for NHS boards* (Department of Health, 2003)
C07b	*Directions to NHS bodies on counter fraud measures* (Department of Health, 2004)
C08b	*Leadership and Race Equality in the NHS Action Plan* (Department of Health, 2004)
C11a	*Code of practice for the international recruitment of healthcare professionals* (Department of Health, 2004)
C11c	*Continuing professional development: quality in the new NHS* (HSC 1999/154)
C13a	Relevant benchmarks from the Essence of Care toolkit. *NHS Chaplaincy Meeting the religious and spiritual needs of patients and staff* (Department of Health, 2003)
C13b	*Good practice in consent: achieving the NHS plan commitment to patient centred consent practice* (HSC 2001/023) *Seeking Consent: working with children* (Department of Health, 2001)
C16	Toolkit for producing patient information (Department of Health, 2003) *Information for patients* (NICE) *Guidance On Developing Local Communication Support Services And Strategies* (Department of Health, 2004) and other nationally agreed guidance where available

Standard	Guidance
C17	*Key Principles of Effective Patient and Public Involvement* (PPI) (The National Centre for Involvement, 2007)
C18	*Building on the best: Choice, responsiveness and equity in the NHS* (Department of Health, 2003)
C20a	*A professional approach to managing security in the NHS* (Counter Fraud and Security Management Service, 2003) and other relevant national guidance
C20b	*Privacy and dignity – a report by the CNO into mixed sex accommodation in hospitals* (Department of Health, 2007)
C21	*Developing an estate's strategy* (1999) *Estatecode: essential guidance on estates and facilities management* (NHS Estates, 2003) *A risk based methodology for establishing and managing backlog* (NHS Estates, 2004) NHS Environmental assessment tool (NHS Estates, 2002) *Revised guidance on contracting for cleaning* (Department of Health, 2004) *A matron's charter: an action plan for cleaner hospitals* (Department of Health, 2004)
C22ac	*Choosing health: making healthier choices easier* (Department of Health, 2004) and associated implementation guidance *Tackling health inequalities: a programme for action* (Department of Health, 2003) *Making partnerships work for patients, carers and service users* (Department of Health, 2004)
C23	*Choosing health: making healthy choices easier* (Department of Health, 2004) *Delivering Choosing health: making healthier choices easier* (Department of Health, 2005) *Tackling Health Inequalities: A programme for action* (Department of Health, 2003)
C24	*Beyond a major incident* (Department of Health, 2004) *Getting Ahead of the Curve* (Department of Health, 2002) *UK influenza pandemic contingency plan* (Department of Health, 2005) Health Technical Memorandum 00 Policies and Principles

This information is available in other formats and languages on request. Please telephone 0845 601 3012.

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REPORT TO:	Healthy Halton Policy and Performance Board
DATE:	11th March 2008
REPORTING OFFICER:	Strategic Director, Health and Community
SUBJECT:	Employment Strategy for Disabled Adults and Carers 2008-2011
WARDS:	Boroughwide

1.0 PURPOSE OF THE REPORT

1.1 To present to Policy and Performance Board the draft strategy (Appendix 1) to support people with disabilities and carers into employment.

2.0 RECOMMENDED: That the Policy and Performance Board note and comment on the strategy.

3.0 SUPPORTING INFORMATION

3.1 This strategy has been developed in Partnership between the Health and Community - Adults of Working Age and Economic Regeneration - Enterprise and Employment Directorates

3.2 It sets out the approach for the Council's social care services and employment service, in collaboration with partner organisations, to establish real pathways into employment and move away from creating dependability to enabling people to maintain or develop employability skills and move into work or self-employment.

3.3 The strategy covers a three-year period and through the action plan will promote best practice in providing an employment routeway for all disabled people and carers in Halton helping them to progress into work or self-employment. It is aimed at disabled people, those with mental illness and carers of working aged from 16+ years. There is a particular focus on service users that are known to social care including adults of working age 18-64 with physical, sensory or learning disabilities or mental illness plus carers, young people aged 16+ in transition from Children to Adult services and young carers.

3.4 This document has been produced by external Consultants chosen for their knowledge/experience in relation to employment and employability of disabled people. The work has been overseen by a steering group consisting of the OD for Adults of Working Age, DM for Enterprise and Employment and Commissioning Manager for Adults with Disabilities.

3.5 Interviews have been undertaken with over 30 stakeholders in the delivery of health, social care and employment support services. Three focus groups have also been held to bring together representatives of key employment support agencies, local carers organisations and disabled people who have accessed employment support in Halton over recent years. An action planning event was also held.

3.6 The accompanying action plan sets outcomes that support delivery of the Adult Social Care Outcomes framework and the targets for moving people into employment.

3.7 A newly established Disability Employment Forum will oversee implementation of the strategy through the development of a performance framework to monitor effectiveness. This framework will include specific targets relating to Adults with Learning Disabilities supported into sustainable employment that the Directorate is required to report annually to CSCI.

4.0 POLICY IMPLICATIONS

4.1 As major employers in the Borough, the Council needs to consider how it can lead the way by offering more support and employment opportunities to disabled people and carers.

5.0 FINANCIAL IMPLICATIONS

5.1 The strategy outlines all the organisations and statutory agencies that can support employment opportunities in the Borough and through working in partnership, available limited resources can be targeted at addressing the priorities in the action plan.

5.2 To date, some staff have been funded within the Enterprise and Employment Division have been funded through NRF which ends 31/03/08. It will be essential to the delivery of this strategy that funding for these posts continues but given the importance of this Strategy the criteria for the Working Neighbourhoods Fund should be met.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 Children and Young People In Halton
Planning for transition to adulthood with disabled young people will include a work focussed development plan where appropriate and through a multi-agency approach will aim to offer the same opportunities for learning and employment as their peers.

6.2 Employment, Learning & Skills in Halton
The strategy aims to bring about a cultural change in both disabled people and employers by concentrating on the individuals ability to work rather than their disability. It promotes rights and independence in retaining employment, available employment, and training and education options.

6.3 A Healthy Halton
Evidence exists that someone who is out of work is more likely to be in poor health and use services more frequently. People out of work for longer periods are at greater risk of losing their sense of well-being and confidence. Establishing pathways for disabled people and carers into employment will alleviate this and avoid longer-term Mental Health conditions.

6.4 A Safer Halton
None

6.5 Halton's Urban Renewal
None

7.0 RISK ANALYSIS

7.1 None identified.

8.1 EQUALITY AND DIVERSITY ISSUES

The strategy addresses Equality and Diversity and there are no particular implications arising as a result of the proposed actions. An Equality Impact Assessment (EIA) will need to accompany this strategy and be subject to review by the Directorate Equalities Group.

9.0 LIST OF BACKGROUND PAPERS UNDER SECTION 100D OF THE LOCAL GOVERNMENT ACT 1972

9.1 There are no background papers under the meaning of the Act.

Halton Disability and Carers Employment Strategy, 2008-2011

EXECUTIVE SUMMARY

HALTON BOROUGH COUNCIL

EXECUTIVE SUMMARY

In December 2007, Inner City Solutions was appointed by Halton Borough Council to develop, in consultation with key partners, a three-year employment strategy for people with disabilities and carers across the Borough. The Halton Disability and Carers Employment Strategy for 2008-2011 sets out a framework and action plan that will promote best practice in providing an employment route way for all people with disabilities and carers in Halton that want to and can work, and help them to progress into work or self-employment. For the purpose of this strategy, the definition of a disabled person is adopted from the Disability Discrimination Act of 1995, as a person who '…. has an impairment which has a substantial and long-term adverse effect on his (her) ability to carry out normal day-to-day activities'. The key purpose of the strategy is to support more Halton residents that have a disability, and those with care responsibilities to have access to and participate in all forms of employment and/or training provision, including voluntary work, which will help them to develop employability skills and move into paid sustainable work.

The strategy is based upon the twin pillars of modernisation of social care services in Halton, together with a drive towards full economic inclusion for all working age residents in the borough.

Modernisation Agenda

This strategy is underpinned by the four principles of the Valuing People White Paper based upon:

Individual rights

Halton Borough Council and its key partners believe that people with a disability and carers have the same rights to access work opportunities as other residents

Independence

Promoting employment as a sustainable career option will deliver greater independence for those people with disabilities and carers in the borough who want to and can work

Choice

People with disabilities and carers in Halton should have the choice to work if that is what they want to and can do

Inclusion

Developing sustainable employment route-ways for people with disabilities and carers will promote the social and economic inclusion of all people of working age in Halton

The Economic Case

Recent welfare and work reforms emphasise the need to fully engage with excluded groups in the labour market. Proposals set out in recent documents such as 'Ready for Work; Full Employment in our Generation' sets a national aspiration to raise employment rates to 80% by 2010, from its current levels of around 74%. As part of this goal, a number of measures will be introduced from April 2008 that will seek to engage people with health conditions and disabilities in accessing sustainable employment. Thus, the Ready for Work document sets out a number of principles that will influence the drive for improvement of specialist disability employment services in Halton over the lifetime of this strategy:

- Increased flexibility in employment support, to meet the needs of people with disabilities and their employers
- Greater integration of service provision, to deliver better transitions into work
- More focus on helping people with disabilities realise their potential, helping more individuals maintain employment independently

Key Aims of the Strategy

This strategy has three key aims in supporting people with disabilities and carers in Halton into employment opportunities:

- To support and develop routes for people with disabilities and carers into employment for those who want to work and are able to work
- To assist these people to ensure that they remain in sustainable employment (6 months and over)
- To help people with disabilities and carers move closer to the labour market through a variety of progression routes, that are appropriate to their individual circumstances

Why is the Strategy Needed?

Despite a number of interventions through employment and social care programmes over recent years, the number of people with disabilities in Halton progressing into sustainable employment is significantly lower than borough wide averages. This disparity becomes significantly marked when assessing the employment levels of people with disabilities known to the Council's social care services.

A greater focus on a person centred planning includes consideration of individuals' vocational needs. The challenge for delivery and commissioning partners across Halton is how to respond most effectively to these needs.

Employment is acknowledged as an important means of achieving social inclusion, economic independence, improving health and promoting a better quality of life. This strategy will link into other initiatives that impact on the employment agenda for people with disabilities and carers and will require a higher profile within the activities of the Halton Partnership.

Development of the Strategy

This strategy has been developed through a number or research methods including:

Research and Analysis

This has included a desk based research programme that has analysed the main policy documents that set the strategic context for the development of this employment strategy. The findings of this research are summarised in Chapter 2 of the main report.

The research element has been further augmented by consideration of a number of best practice case studies from across the U.K. These case studies highlight a number of employment and social care-related projects that offer relevant lessons for Halton, in making progress on its employment agenda for people with disabilities and carers. Five case studies are highlighted in Appendix 1 of the main report.

Consultation Programme

The development of this strategy has been driven by an extensive consultation programme that has incorporated the range of views held by the main stakeholders involved in the employment agenda for people with disabilities and carers in Halton. This consultation programme has included:

- Interviews with over 30 stakeholders involved in the delivery and support of social care and/or employment support services for people with disabilities and carers in Halton.
- Three focus group events held across Halton, attended by social care practitioners, local carer groups, employment support agencies, and people with disabilities and carers across the borough. These focus groups culminated in an action planning event held at the Heath Business Park on January 15th 2008 that established Halton's strategic priorities and accompanying action plan up to 2011. This action plan is described in more detail in Appendix 1 of the main report.

Key Recommendations

The strategy outlines a series of recommendations for partners in Halton to take forward, in improving the employment rates of people with disabilities and carers. The main recommendations are as follows:

Recommendation 1: Establishment of a Disability Employment Network

An immediate priority is to establish a Disability Employment Network within the overall reporting framework of the Halton Partnership.

The Network would engage all public, private and third sector agencies who deliver employment and related support services for people with disabilities and carers in Halton. In effect, the Network would act as the implementation group to deliver the key outcomes contained within the three-year action plan as described in Chapter 6. The establishment of such a network would help to raise the employment agenda for people with disabilities and carers and assist in the future planning and commissioning of employment support services in the borough.

Over time, the key benefits of such a Network in Halton would be:

- More regular communication between delivery partners
- Greater collaboration, and sharing of performance data
- A focal point for the dissemination of information relating to employment of people with disabilities and carers
- Agreement on target setting for improving employment levels for these priority groups

A Draft Terms of Reference for the Group is attached as Appendix 3 of the main report.

Recommendation 2: Improved Service Mapping

Allied to the establishment of a Disability Employment Network is the need for better centralised intelligence on available support services for people with disabilities and carers in Halton. This agenda cuts across a number of policy fields including health, social care, and economic development.

Inevitably, this has led to a degree of overlap and 'working in silos' among delivery agencies, a fact that needs to be addressed given the limited resources available to deliver this strategy in full.

Research as part of the development of this strategy has highlighted some of the current service gaps in employment support services in Halton. The establishment of the Disability Employment Network, once fully established, can begin to develop a commonly agreed framework of milestones and outputs that will measure and monitor the progress made in implementing the key actions of this strategy.

Recommendation 3: Better Promotion of Existing Support Services

Nationally, the employment agenda is in the middle of a sustained period of change that will ultimately impact upon the employment options available for people with disabilities and carers seeking work. In Halton, there is currently a limited take up of many of the programmes specifically set up to support these target groups into work. Obvious examples include the limited take-up and knowledge of Return to Work Credit and negligible use of the 104 Hour Week Rule as outlined in Section 4.2.5 of this report.

This strategy must thus ensure that appropriate mechanisms are put in place by partners such as JobCentre Plus, that link on-the-ground advisors with the knowledge of and practical skills to access such support for their eligible customers in Halton. This will ensure a greater take-up of many of these and other employment support programmes, that would enable far greater numbers of people with disabilities and carers in Halton to access sustainable employment opportunities.

Recommendation 4: Key Focus on People with Mental Illness

The strategy recognises that there are a significant number of people in Halton that have a physical, sensory or learning disability or mental illness. The Council's supported employment service has helped more people with a physical or sensory disability to move into sustainable work than those with a learning disability or mental illness. However it would seem that an increasing number of people with mental illness are actively seeking and securing work. The Jobcentre Plus Pathways to Work programme has helped 83 Incapacity Benefit customers to progress into work and of those 58 (70%) have cited mental illness as their primary health condition.

Mental health and employment is a key employment challenge for Halton, with mental health conditions a major cause of people claiming incapacity benefits. A National Strategy on Mental Health and Work is currently under development and partners in Halton must respond to its main recommendations in due course.

Recommendation 5: Co-ordination of Benefits Advice

Recent welfare to work reforms will have a significant impact on issues such as tax credits, housing benefit entitlement, and personal benefits rights. In order that people with disabilities and carers remain fully informed of the impact of such changes, better signposting to appropriate benefits advice services in Halton must be developed.

JobCentre Plus is best placed to deliver on key areas of welfare advice. However other organisations, including Halton Council and local advocacy groups offer additional expertise that must be fully utilised. There are existing projects in the borough, such as the Halton Benefits Bus, that offer a valuable route to promoting joint working between such agencies, while ensuring that the full financial benefits of taking up a job opportunity are made available to eligible clients locally.

This is another area that can be addressed through the work of the Disability Employment Network, with an appropriate referral mechanism fully established, to ensure that Halton residents receive accurate and timely welfare benefits advice.

Recommendation 6: Greater Employer Engagement

There are a number of local employers who currently actively engage with partners, in supporting people with disabilities and carers into a range of employment opportunities. Nevertheless, there is significant scope to expand the levels of employer engagement locally based upon a strong business case that focuses upon individuals' ability to work, irrespective of their disability or care responsibilities. In order to support real employer engagement, it will be necessary for key delivery partners on the Disability Employment Network to identify adequate resources to provide a programme of in-work support. This will be critical both in retaining individuals in employment, and supporting local employers to adopt more flexible HR practices where necessary.

Delivery and funding of the strategy

Full implementation of this strategy will require a mix of mainstream and external funding to be accessed over the next three years. Key funding sources available to support this agenda over the period 2008-2011 will include:

- Extra mainstream support to expand projects such as Bridge Building, as part of the Council's overall modernising agenda
- Jobcentre Plus commissioning specific disability employment interventions from projects such as Halton People into Jobs, and other third sector and private sector providers
- Support from the Halton and St. Helens Primary Care Trust for particular excluded groups, such as people with mental illness
- Support on the transitioning agenda from Halton Connexions, with potential funding available from the Learning and Skills Council
- From 2008/9, the introduction of the Working Neighbourhoods Fund (WNF) as the successor to the Neighbourhood Renewal Fund currently administered by the Halton Partnership. The WNF will provide resources to the Halton Partnership to tackle worklessness on a community wide basis, with a funding allocation of approximately £17m over the next three years. It is anticipated that a significant element of this funding will be assigned to the Employment Learning and Skills

Specialist Strategic Partnership, who will commission a range of employment support programmes across Halton

- The 2007-2013 European Operational Programme administered by North West Development Agency may be a potential source of finding to support employment provision for disadvantaged groups including people with disabilities and carers.

Ownership of the Strategy

This strategy will only be delivered through an integrated approach that makes full use of the different skills and resources of a number of local delivery agencies within this agenda. In effect the proposed Disability Employment Network would act as the implementation body that would deliver the key recommendations of this strategy.

The proposed strategy for Halton must make full use of the skills and resources of a number of stakeholder agencies responsible for the delivery of employment and vocational support services across Halton. The Disability Employment Network will act as the forum through which these services can be best co-ordinated to maximise their impact in supporting people with disabilities and carers in Halton into sustainable employment opportunities. Over time, this would be strengthened by a commonly agreed framework of outcomes that fully reflects the scale of support services available to people with disabilities and carers in the borough.

REPORT TO: Healthy Halton Policy and Performance Board

DATE: 11 March 2008

REPORTING OFFICER: Strategic Director, Health and Community

SUBJECT: 'Our NHS, Our Future' Lord Darzi's Interim report

WARDS: Boroughwide

1.0 PURPOSE OF THE REPORT

1.1 To provide the Policy and Performance Board with Lord Darzi's Interim report 'Our NHS, Our Future'.

2.0 RECOMMENDATION: That Lord Darzi's Interim Report 'Our Future, Our NHS' be noted.

3.0 SUPPORTING INFORMATION

3.1 The full report was published in October 2007 and is attached as Appendix 1. A copy of the Executive Summary is also attached as Appendix 2.

4.0 POLICY IMPLICATIONS

4.1 None applicable

5.0 OTHER IMPLICATIONS

5.1 None applicable

6.0 RISK ANALYSIS

6.1 None applicable.

7.0 EQUALITY AND DIVERSITY ISSUES

7.1 None applicable.

8.0 LIST OF BACKGROUND PAPERS UNDER SECTION 100D OF THE LOCAL GOVERNMENT ACT 1972

8.1 There are no background documents under the meaning of this Act.

NHS

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NHS NEXT STAGE REVIEW

Interim report

October 2007

DH Department of Health

DH INFORMATION READER BOX

Policy HR/Workforce Management Planning/ Clinical	Estates Commissioning IM & T Finance Social Care/Partnership Working
Document purpose	Gathering INFORMATION
ROCR ref:	**Gateway ref: 8857**
Title	NHS Next Stage Review Interim Report
Author	Professor Lord Darzi
Publication date	04 Oct 2007
Target audience	PCT CEs, NHS Trust CEs, SHA CEs, Care Trust CEs, Foundation Trust CEs, Medical Directors, Directors of PH, Directors of Nursing, PCT PEC Chairs, NHS Trust Board Chairs, Special HA CEs, Directors of HR, Directors of Finance, Allied Health Professionals, GPs, Communications Leads, Emergency Care Leads, Local Authority CEs, Directors of Adult SSs, Directors of Children's SSs, Voluntary and Independent Sector Organisations
Circulation list	(See above)
Description	Interim report by Lord Darzi on the NHS Next Stage Review
Cross reference	N/A
Superseded documents	N/A
Action required	N/A
Timing	N/A
Contact details	NHS Next Stage Review Team Room 524A, Richmond House, 79 Whitehall, London SW1A 2NS 020 7210 3000 Email: ournhs@dh.gsi.gov.uk http://www.nhs.uk/ournhs
For recipient's use	

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Summary letter

Dear Prime Minister, Chancellor of the Exchequer, and Secretary of State for Health,

As you know, I'm a doctor not a politician. That's why you asked me to take on this task – and it's why I agreed. With my colleagues, I have spent my career committed to doing my best to provide patients with high quality NHS care. And I am continuing to work as an NHS surgeon.

But the reason I accepted your invitation to lead this Review is because I believe that it is an important opportunity to take stock of the progress of recent years in improving the quality of care and up the pace of improvement going forward.

I want to make the most of this opportunity to listen to the views of patients, staff and public on how to do this. I have already heard from thousands of people in the weeks since the Review began – and their views have helped shape this interim report. I want to continue to give everyone the chance to contribute during the second stage of the Review.

My aim is to convince and inspire everyone working in the NHS, and in partner organisations, to embrace and lead change. I have met with some scepticism, including from clinical colleagues. I was expecting it. I told them I would not have agreed to get involved if this was a means of avoiding awkward decisions. I believe however that this is a chance to shape the future of the NHS in a new way.

My assessment is that the NHS is perhaps two thirds of the way through its reform programme set out in 2000 and 2002. In my visits across the NHS I have detected little enthusiasm for doing something completely different; instead the majority opinion is that the current set of reforms should be seen through to its conclusion. I agree.

Making the improvements that people expect us to achieve will not be easy. Improving the quality of care means accepting that fundamental change will have to happen. No-one should see this Review as a way of slowing down or diluting what we need to do. If anything we should be seeking to respond to the rising aspirations of patients and the public and be more ambitious, to help all members of our diverse population live longer, healthier lives, especially those least able to help themselves.

I believe passionately that, through this Review, we all have an opportunity to shape the NHS for the 21st century. Our ambition should be nothing less than the creation of a world class NHS that prevents ill health, saves lives and improves the quality of people's lives.

Summary letter

Some aspects are already world class. The challenge is to ensure that every aspect matches the best – to take our health service from good to great.

This interim report is the start of developing this vision for the next ten years. It has two purposes. It describes the key elements of a vision – an NHS that is fair, personal, effective and safe – and sets out the immediate actions that should now be taken to make progress towards it.

I have spent the last three months visiting different NHS organisations and hearing the views of staff. I have participated in lively debates with patients and the public about how they feel the NHS and its partners should respond to their needs.

This report is based on those views, visits and discussions. It acknowledges the progress that NHS and other staff have already made towards achieving that vision, challenges them to be ambitious in striving towards it, and sets out the scope for improvement and the challenges we need to meet over the second stage of the Review.

I believe that this vision for the future should not be just mine – or the Government's – but a vision for the future of health and healthcare in England that is developed and owned by patients, staff and public together.

THE JOURNEY SO FAR

We are not starting from scratch in achieving this vision.

Back in 1997, the NHS was in relatively poor health. Investment levels had varied considerably over previous decades, hampering proper planning. Although many patients enjoyed good care, many more experienced the trauma of poor access to primary care, long waiting times, old buildings and a winter crisis that was as predictable as the season itself.

Since then, the NHS has vastly improved. I only have to look at my own experience to see the progress that has been made. There are more staff in my team; our patients do not wait as long for operations; and their care is of a higher quality and is more personalised.

Those experiences are echoed across the country. The sustained investment since the NHS Plan (2000) has allowed the NHS to grow. As a result, there are tens of thousands more doctors, nurses and other NHS staff, hundreds of new or refurbished facilities and thousands of new pieces of equipment. Together with the reforms that have been put in place this has helped reduce waiting times, raise standards and improve the quality of care the NHS provides – care that is still provided according to clinical need and not ability to pay.

But in spite of this improvement, the views I have heard from patients, staff and the public do not always fit with the description above.

Patients have told me that they still sometimes feel like a number rather than a person. They do not know how to access the services they need to help them stay well and independent. They cannot always see a GP or practice nurse when they need to.

In short, patients lack 'clout' inside our health care system.

The public say they are sometimes confused about which NHS service they should use. They hear a lot about changes but do not know why they are being made.

Some staff tell me that they haven't been listened to and trusted. They do not feel that their values – including wanting to improve the quality of care – have been fully recognised. Nor do they feel that they have always been given the credit for the improvements that have been made.

The NHS could therefore continue to make incremental improvements.

This would not resolve the frustrations I have identified. It would mean accepting that services stay broadly as they are now. It would mean accepting steady progress rather than a step-change in reducing mortality rates. It would mean the NHS facing mounting pressure from rising public expectations and from major public health challenges.

A WORLD CLASS NHS

Alternatively we can choose to be ambitious and set out a clear vision for a world class NHS focused relentlessly on improving the quality of care.

Based on what I have heard and seen, I believe that only this approach allows us fully to respond to the aspirations of patients, staff and the public. Only this approach enables us to deliver the kind of personalised care we all expect.

Our vision should be an NHS that is:

- **Fair** – equally available to all, taking full account of personal circumstances and diversity

- **Personalised** – tailored to the needs and wants of each individual, especially the most vulnerable and those in greatest need, providing access to services at the time and place of their choice

- **Effective** – focused on delivering outcomes for patients that are among the best in the world

- **Safe** – as safe as it possibly can be, giving patients and the public the confidence they need in the care they receive.

Summary letter

This is not about changing the way NHS is funded or structured. Successive reports have shown not only that our system is fair, but also that other comparable systems are, in key respects, less efficient. We now need to:

- move beyond just expanding the capacity of the NHS and focus relentlessly on improving the quality of care patients receive
- be ambitious – respond to the aspirations of patients and the public for a more personalised service by challenging and empowering NHS staff and others locally
- change the way we lead change – effective change needs to be animated by the needs and preferences of patients, empowered to make their decisions count within the NHS; with the response to patient needs and choices being led by clinicians, taking account of the best available evidence
- support local change from the centre rather than instructing it – providing that the right reformed systems and incentives are in place
- make best use of resources to provide the most effective care, efficiently.

IMMEDIATE STEPS

Some immediate steps should be taken ahead of my final report:

1. To help make care **fairer** the Secretary of State has announced a comprehensive strategy for reducing health inequalities, challenging the NHS, as a key player, to live up to its founding and enduring values.

2. To help make care more **personal**, patient choice should be embedded within the full spectrum of NHS funded care, going beyond elective surgery into new areas such as primary care and long term conditions:

   - New resources should be invested to bring new GP practices – whether they are organised on the traditional independent contractor model or by new private providers – to local communities where they are most needed, starting with the 25% of PCTs with the poorest provision
   - Newly procured health centres in easily accessible locations should be offering all members of the local population a range of convenient services, even if they choose not to be directly registered with GPs in these centres
   - PCTs should introduce new measures to develop greater flexibility in GP opening hours,

including the introduction of new providers. Our aim is that, over time, the majority of GP practices will offer patients much greater choice of when to see a GP, extending hours into the evenings or weekend.

3. To support the delivery of more **effective** care, we should establish a Health Innovation Council to be the guardians of innovation, from discovery to adoption.

4. To help make care **safer**, we should support the National Patient Safety Agency (NPSA) in establishing a single point of access for frontline workers to report incidents: Patient Safety Direct. And to reduce rates of healthcare associated infections still further we should:

   - legislate to create a new health and adult social care regulator with tough powers, backed by fines, to inspect, investigate and intervene where hospitals are failing to meet hygiene and infection control standards

   - give matrons further powers to report any concerns they have on hygiene direct to the new regulator

   - introduce MRSA screening for all elective admissions next year, and for all emergency admissions as soon as practicable within the next three years.

5. We should ensure that any major change in the pattern of local NHS hospital services is clinically led and **locally accountable** by publishing new guidelines to make clear that:

   - change should only be initiated when there is a clear and strong clinical basis for doing so (as they often may well be)

   - that consultation should proceed only where there is effective and early engagement with the public and

   - resources are made available to open new facilities alongside old ones closing.

Any proposals to change services will also be subject to independent clinical and managerial assessment prior to consultation through the Office of Government Commerce's Gateway review process.

THE SECOND STAGE OF THE REVIEW

Building on these immediate actions, the second stage of the Review will set out how we can deliver the vision for a world class health service through a locally accountable NHS in which health and social care staff are empowered to lead change, supported by the right reformed systems and incentives.

Summary letter

Groups of health and social care staff – over 1,000 people in total – will be established in every region of the country to discuss how best to achieve this vision across eight areas of care:

- Maternity and newborn care
- Children's health
- Planned care
- Mental health
- Staying healthy
- Long-term conditions
- Acute care
- End-of-life care

I want each group to listen to patients, the public and others to identify what it would take over the next decade to commission and provide world class care, using the best available evidence, and set out their plans to deliver on our vision of a fair, personal, effective, safe and locally accountable NHS.

I also have come to the view that the NHS could benefit from greater distance from the day to day thrust of the political process, and believe there is merit in exploring the introduction of an NHS Constitution. I have therefore asked NHS Chief Executive, David Nicholson, to chair a national working group of experts to consider the scope, form and content that such a Constitution might take.

These steps – local and national – will form the basis for a vision for a world class NHS, to be published in June 2008 in time for the 60th anniversary of the NHS.

Best wishes

Professor the Lord Darzi of Denham FREng, KBE, FMedSci
Parliamentary Under Secretary of State, Paul Hamlyn Chair of Surgery Imperial College London, Honorary Consultant Surgeon, St Mary's Hospital and the Royal Marsden Hospitals NHS Foundation Trust

Introduction

The NHS has cared for us all for nearly 60 years. As an NHS surgeon, working in partnership with professional colleagues across the NHS, I am proud to have learnt my skills in the NHS and to have given back to the NHS as part of a professional team. I know we cannot take the services that the NHS and its partners provide for granted.

That is why I believe the NHS Next Stage Review is so important. It is a chance to take stock of progress made in recent years towards the vision of a patient-centred NHS set out in the NHS Plan (2000). It challenges us to look ahead for the next decade and consider what more we could and should be doing to respond to people's rising aspirations. Everyone deserves the best possible health and healthcare and we should challenge people and communities to raise their aspirations to achieve it.

The terms of reference for the Review set out a number of challenges:

- Working with NHS staff to ensure that clinical decision-making is at the heart of the future of the NHS and the pattern of service delivery
- Improving patient care, including high-quality, joined-up services for those with long-term or life-threatening conditions, and ensuring patients are treated with dignity in safe, clean environments
- Delivering more accessible and more convenient, integrated care reflecting best value for money and offering services in the most appropriate settings for patients
- In time for the 60th anniversary of the founding of the NHS, establishing a vision for the next decade of the health service which is based less on central direction and more on patient control, choice and local accountability and which ensures services are responsive to patients and local communities, whatever the circumstances

To help me understand how best to meet these challenges I have spent the last three months visiting local health communities and hearing the views of staff. I have participated in lively debates with patients and the public about the priorities they feel the NHS and its partners need to adopt to respond to their needs. Specifically I have:

- visited and spoken to 1,500 NHS staff in 17 NHS organisations across the country

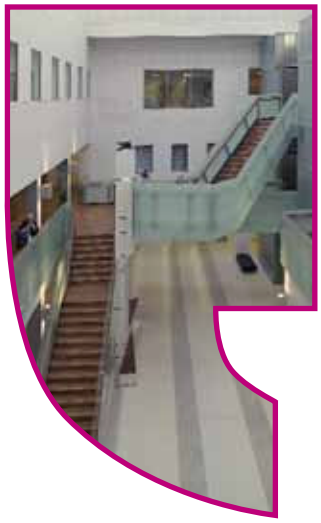
Introduction

- taken part in a nationwide day of detailed discussions on the priorities for the NHS with 1,000 patients, public and health and social care staff in nine different towns and cities
- met with representatives of 250 stakeholder groups representing the full diversity of our population and staff
- read more than 1,400 letters and emails from people up and down the country
- in preparation for the second stage of the Review, brought together over 1,000 doctors, nurses and other health and social care staff in groups in every part of the country to focus on discussing how best to plan and provide care for patients
- reviewed the evidence available for what matters to patients, staff and the public, drawing on research from the NHS Leadership team this year.

The views that I have heard and the NHS organisations that I have visited are the basis for this report. It is the start of developing the vision that I believe we need to renew for the NHS – a world class NHS that prevents ill health, saves lives, improves the quality of people's lives and treats people with dignity and respect. It acknowledges the progress that NHS and other staff have already made in achieving that vision, describes the scope for improvement that remains, and sets out the immediate steps we should take and the challenges we need to meet over the second stage of the Review.

This vision for the future should not be just mine – or the Government's – but a vision for the future of health and healthcare in England that is developed and owned by patients, staff and public together.

The journey so far



We are not starting from scratch in achieving this vision. The NHS has made clear progress over the last decade.

Back in 1997, the NHS was in relatively poor health. Investment levels had varied considerably over previous decades, hampering proper planning. Although many patients enjoyed good care, many more experienced the trauma of poor access to primary care, long waiting times, old buildings and a winter crisis that was as predictable as the season itself. The NHS simply was not big enough or capable enough to meet patients' expectations.

Since then the NHS has vastly improved. I only have to look at my own experience to see the progress that has been made. Compared with 10 years ago:

- we have more staff – I used to be the only colorectal surgeon in my hospital. Now I am one of a team of four surgeons working with colleagues in a network that reaches out into primary care
- we can detect disease earlier and treat more patients more quickly from the moment they see their GP. My patients sometimes used to wait over a year for treatment. Now they are likely to have waited a few weeks, and even less when they are suspected of suffering from cancer and require urgent surgery
- we have made systematic changes to improve the quality of care – I used to have corridor conversations with colleagues about cases. We now discuss each cancer case in a weekly meeting as a multidisciplinary team of clinicians to agree the best recommendation for each patient's care
- we are providing more personal care with greater dignity for patients – we used to have one part-time stoma nurse, now we have two full-time stoma nurses, two specialist nurses and a nurse consultant, working to help local people and practitioners improve the quality of people's care. We have a colorectal patient user group which meets every three months with staff in my team, helping to personalise people's care

I only have to look at my own experience to see the progress that has been made

The journey so far

- the operations we carried out used to be highly invasive – most of what we do now is keyhole surgery developed with the help of NHS investment in technology and training.

This progress is replicated right across the country.

The *NHS Plan* (2000) diagnosed the problems and wrote the prescription that provided sustained, unprecedented investment to increase capacity. Since then this investment has allowed the NHS to grow. As a result, there are tens of thousands more doctors, nurses and other NHS staff, hundreds of new or refurbished facilities and thousands of new pieces of equipment.

The NHS now sees and treats more patients than ever before. Last year, on average every day, we saw over 50,000 people in accident and emergency (A&E), held nearly 900,000 GP consultations and took over 16,000 calls to NHS Direct.

The NHS continues to provide care based on clinical need and not ability to pay and remains one of the fairest health systems in the world.

Care is more personalised than it was. New primary care services, such as walk-in centres and NHS Direct, enable patients to access and receive care more conveniently. People should wait no longer than four hours in A&E and, if they really need to, can usually see a GP within 48 hours. More people with serious mental health problems are now supported in their own homes, without the interruption to daily life that hospital admissions would bring.

The genuinely impressive reductions in maximum hospital waiting times, unthinkable even a few years ago, will be complete by December 2008. Consequently, patients will be able to expect treatment, including operations, within a maximum of 18 weeks of referral by their GP – and much sooner if the GP suspects cancer. The average waiting time should be closer to nine weeks.

Better care now results in better outcomes for patients. For example, we have now substantially reduced cardiovascular disease mortality rates meeting the target four years early, and cancer mortality has also fallen significantly. These outcomes will continue to improve – saving many more thousands of lives each year.

Better care now results in better outcomes for patients

Care is more safety focused. We now have systems in place to report and learn from safety incidents, and we are using this to prevent errors occurring in the first place. A much stronger focus on cleanliness and infection control is enabling the NHS to make real progress against MRSA.

These improvements are down to the hard work of all staff involved, and are improvements to be proud of. A number of existing reforms support these improvements and help make care fairer, more personal, more effective, and safer. Independent bodies like the National Institute for Health and Clinical Excellence (NICE), the Healthcare Commission (HCC) and the Commission for Social Care Inspection (CSCI) have been created to set standards and hold organisations to account for meeting them.

Reforms such as payment by results (making it easier for money to follow the patient) and, in some places, effective practice-based commissioning are beginning to make it easier for patients to choose where they are treated – and to get care more locally. The commissioning process itself is starting to drive improvements in the quality of care provided to patients – although there remains significant work to do to improve commisioning to fully support the delivery of our vision.

NHS hospitals, in many cases as NHS foundation trusts, are now more clearly accountable to local communities and are better placed to

The journey so far

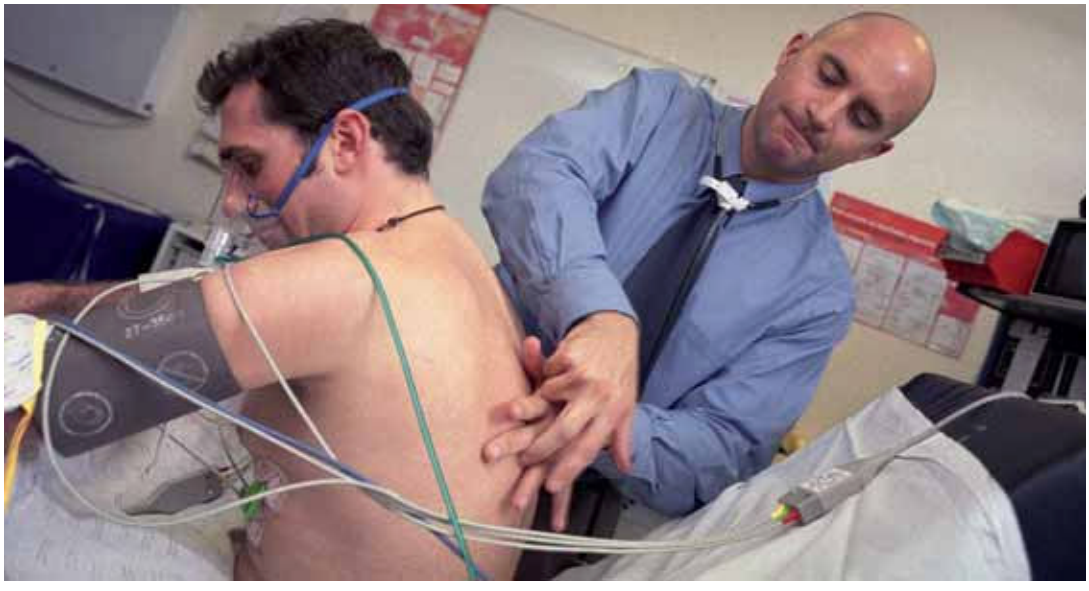
innovate to improve the quality of the services they provide.

Independent sector providers have also helped extend choice, add capacity and spur innovation. They have increasingly become a fixture of NHS provision, with three-quarters of a million NHS patient care episodes performed by the independent sector to date.

This evidence of progress is confirmed by external evaluation. A study earlier this year by the Commonwealth Fund, an independent health research group, found that our improvements have made this country the top healthcare system among five comparator countries, rating the UK better overall than Australia, Canada, Germany, New Zealand and the United States – an improvement since the previous report from the same group.[1]

So, if the NHS is objectively in such good health, why – subjectively – do the views I have heard from patients, the public and staff not always fit with the description above?

Patients have told me that they still sometimes feel like a number rather than a person. The research shows they want to be treated as people, not as sets of symptoms or conditions. They want care to fit into their lives, not have to fit their lives around the care they receive. And of course they want us to get the basics right – they expect competent staff, to be treated with dignity and respect, their notes to



1 Commonwealth Fund: Mirror, Mirror on the Wall: An international update on the comparative performance of American healthcare, May 15, 2007 (Updated May 16, 2007) Volume 59

be available and for buildings to be clean. Research shows us that while 80% of patients are satisfied with their last hospital inpatient visit, 56% of hospital patients told us they did not have an opportunity to talk to a doctor.

The public say they are sometimes confused about which NHS service they should use. They want us to treat all patients fairly – based on need, not ability to pay, or ability to 'work' the system – and they want the NHS to be there for them when they need it most. They hear a lot about the reforms that are being made, but do not know the reasons why the changes are being made and how it will deliver higher quality than before. We need to respond to these concerns by being much clearer about the case for change where it is necessary, and showing how it will improve quality.

Staff often feel left out of the changes that are happening. It is true that in some cases that is because greater power for patients is challenging old ways of doing things, but in other cases staff can see that changes need to be made. They now need the space to act on this.

In part, that means changing the conceptualisation but not the necessity of reform. I recognise this from my own experiences. I don't discuss the merits of payment by results with my colleagues in the scrub room or the nurses' station. There is a time and a place for that – but what we talk and care about are the cases we have done, the techniques we are using and the outcomes we are getting for our patients.

I've seen that targets can be effective – and I have seen the difference they make for patients in terms of driving progress on reducing waiting times – but they are not always the answer and sometimes they can seem perverse.

I have considered all of these points as I have put together this interim report. We should acknowledge the undoubted progress made over the last decade – the NHS is not only back on its feet, it is world class in some areas. It could continue to move forward on this basis. That would mean incremental improvements in care but it would not resolve the frustrations and shortcomings I have identified. The challenge is to move from world class in some aspects to world class in all – to take the NHS from 'good' to 'great'.

I do not believe we should change the way the NHS is funded or structured.

The journey so far

Successive reports, including the *NHS Plan* and the reports from Derek Wanless[2], have shown not only that our system is fair, but also that other comparable systems are, in some important respects, less efficient. The last few years have demonstrated that, through investment in primary, community, hospital and social care, the current model can deliver significant improvements and gives us a meaningful chance of meeting the challenges of the future.

But I do believe that we can only achieve our vision – and genuinely live up to the founding principles of the NHS – by doing things differently. This means:

- moving beyond expanding the capacity of the NHS and renewing our focus on improving the quality of care patients receive
- being ambitious – responding to the expectations of patients and the public of a more personalised service by challenging and empowering NHS staff and others locally to deliver on them
- changing the way we lead change – effective change needs to be animated by the needs and preferences of patients, empowered to make their decisions count within the NHS; with the response to those patient needs and choices led by clinicians, taking account of the best available evidence.
- supporting local change from the centre rather than instructing it – ensuring that the right reformed systems and incentives are in place
- making best use of NHS resources to provide the most effective care, efficiently.

2 Securing Our Future Health: Taking a long term view, 2002 and securing good health for the whole population: Final Report, February 2004

A world-class NHS – our vision

Over the last three months, I have spoken to patients, the public and NHS staff about what makes a world-class NHS. I know that there is real enthusiasm to be ambitious and renew our vision for an NHS fit for the 21st century.

I am convinced we should lift our sights. Our aim should be nothing short of creating a world-class NHS that strives relentlessly to improve the quality and personalised nature of the services and care patients receive.

Achieving this means responding to the things that matter most to people. I have heard repeatedly that care should be:

- **fair**
- **personalised**
- **effective**
- **safe**

As a doctor working in the NHS, I agree. We should judge success by these criteria. I believe our vision should be of an NHS that provides care that is:

- equally available to all, taking full account of personal circumstances and diversity
- personalised to the needs and wants of each individual, especially the most vulnerable and those in greatest need, providing access to services at the time and place of their choice
- focused on delivering quality outcomes for patients that are among the best in the world
- as safe as it possibly can be, giving patients and the public the confidence they need in the care they receive

The next four chapters set out a vision for the future in each case: why these four aspects of quality matter; what we need to change; and the steps – immediate and over the second stage of this Review – I believe we must now take. I then set out how we can deliver on them – through a locally accountable NHS in which health and social care staff are empowered to lead change, supported by the right systems and processes.

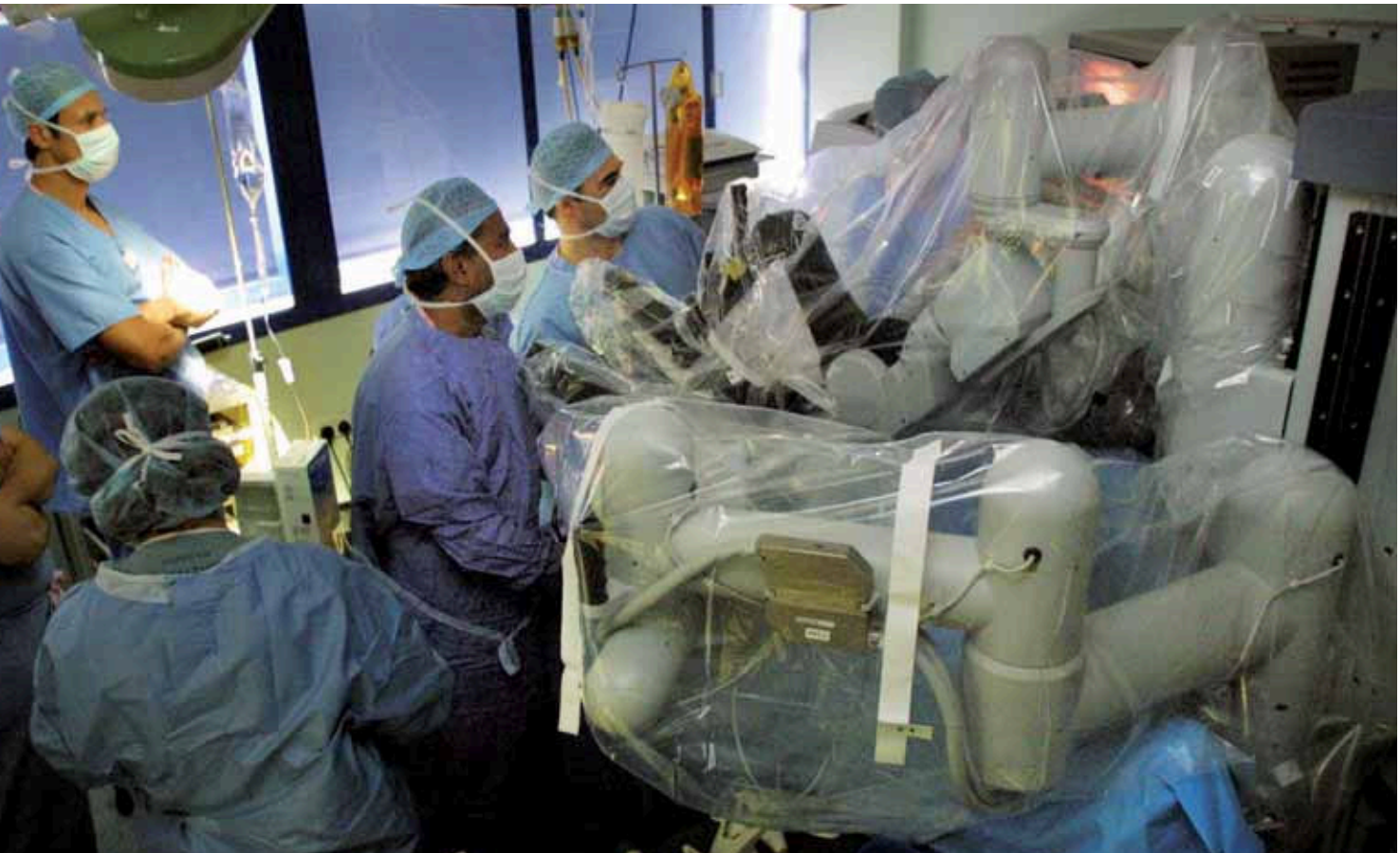
During the second stage of the Review, groups of NHS and social care staff will be established in every region of the country to discuss how best to achieve this vision for each of eight areas of care:

- Maternity and newborn care
- Staying healthy
- Children's health

A world-class NHS – our vision

- Planned care
- Acute care
- Mental health
- Long-term conditions
- End-of-life care

I want each group to listen to patients, staff and the public and identify what it would take over the next decade to provide world-class care, using the best available evidence and help to reduce health inequalities. They will consider the priorities identified by patients, public, staff and partners and set out their plans to deliver on our vision.



A fair NHS

VISION

A fair NHS must continue to be equally available to all, taking full account of personal circumstances and diversity.

A FAIR NHS MATTERS

Our evidence shows that the public and staff care deeply about the NHS and that one of the things that matters to them is that patients are treated fairly – based on need, not ability to pay.

One of the great triumphs of the NHS, largely tax-funded, universal and free at the point of need, is that it is fair and equitable. The public are rightly proud of this and throughout the last few months I have been struck by their fundamental support for this principle. When we asked participants at the consultative event whether they agreed that the NHS should continue like this into the 21st century, an overwhelming 92% of people said yes.

The majority of the public believe that they have a responsibility to fund the NHS, that the NHS has enough money, but that it is not always well used.

WHERE WE ARE NOW

Although major improvements in care have been made over the last decade – as I described in chapter 2 – these improvements have not been universal. The breadth and scale of inequalities within England are still striking. Major inequalities exist in life expectancy, infant mortality and cancer mortality. Too many of the poorest communities experience the worst health outcomes. Although the nation's health has improved over the years, including the health of those born with fewer socioeconomic advantages, a boy born in the City of Manchester today is now likely to die almost ten years earlier than a boy born in the Royal Borough of Kensington and Chelsea.

The gap in life expectancy between the most deprived and least deprived areas has widened, despite improvements in life expectancy in the most deprived areas. Someone's social status or where they live should not affect when they die.

A fair NHS

There is also evidence that the opportunity to access healthcare is actually worse in areas of greater need. The maps below show how areas where life expectancy is lowest for men (red, map 1) – concentrated in London, the Midlands, Yorkshire, North West and North East – broadly match the areas with fewer GPs per head (red, map 2). The picture is the same for women.

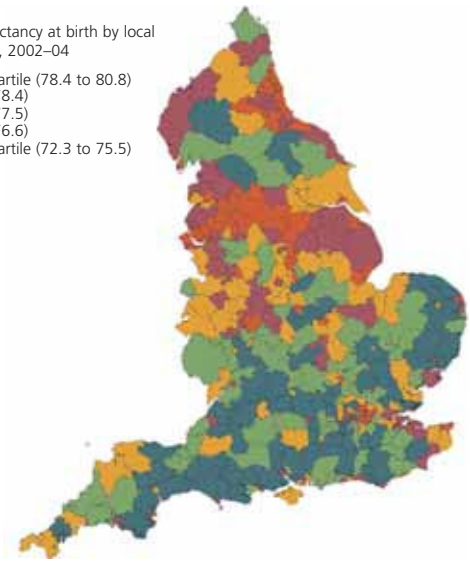
Mid Devon PCT, for example, has over twice as many GPs per head of weighted population as Oldham PCT.

And sadly it turns out that our current GP system has actually led to a *larger* inequality in the distribution of GPs across the country over the past two decades even as the overall number of GPs has increased. We therefore need to open up the supplying of GP services in deprived communities to a wider range of providers – be they GP practices or new private GP providers – so as to seek to improve equity in the availability of GP services.

I also believe we should ensure that taxpayers' money is used well. When compared with other countries, the NHS should achieve high levels of productivity because of the way we fund care and our primary care system in particular.

Map 1
Male life expectancy at birth by local authority area, 2002–04

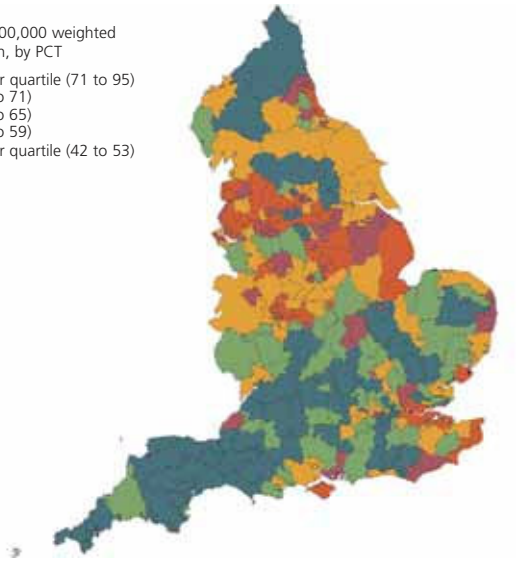
- Upper quartile (78.4 to 80.8)
- (77.5 to 78.4)
- (76.6 to 77.5)
- (75.5 to 76.6)
- Lower quartile (72.3 to 75.5)



Source: Office for National Statistics, Life Expectancy 2002–2004

Map 2
GPs per 100,000 weighted population, by PCT

- Upper quartile (71 to 95)
- (65 to 71)
- (59 to 65)
- (53 to 59)
- Lower quartile (42 to 53)



Source: Information Centre – Workforce Census 2006

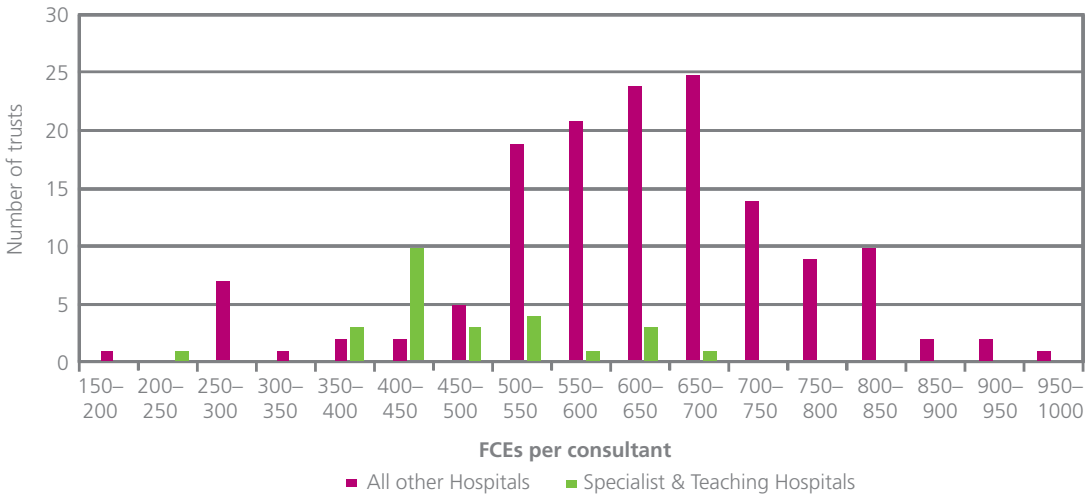
However, there are still areas in which significant variations in productivity exist – and in which we could do more to improve the way we measure productivity. For example, the graph below shows how numbers of 'finished consultant episodes' per consultant vary across NHS trusts on a typical index of productivity.

SCOPE TO IMPROVE

To create a fairer NHS, we have to focus on improving access to health and social care services for people in disadvantaged and hard-to-reach groups and those living in deprived areas. This also means making services more personal: designing and delivering services that fit with people's lives will help to reduce inequalities in health and social care outcomes.

I know from what I have seen around the country that, while the NHS has a big part to play, the NHS cannot do this on its own. Nationally, cross-government action needs to focus on the wider social determinants of health, such as early child development, poverty, lifestyle, housing etc. And locally the most successful action happens when different agencies work together. PCTs have a key role in working with local authorities, Local Strategic Partnerships, communities, industry, the voluntary and private sector and individuals to ensure a broader approach and focused action.

Finished consultant episodes per whole time equivalent consultant, 2004/05



Source: Hospital Episode Statistics 2005/06 and Information Centre: Workforce Census Sept. 2005

A fair NHS

NEXT STEPS

Locally, the eight clinical pathway groups in each region, described in chapter 3, will consider as part of their work how to improve fairness in each pathway.

Nationally, the Secretary of State has recently announced a comprehensive strategy for reducing health inequalities, challenging the NHS, as a key player, to live up to its founding and enduring values of universality and fairness. This will aim to ensure that the NHS and other services:

- close unjustified gaps in health status between individuals, whatever their background
- ensure fair access to NHS services for everyone
- treat all patients fairly, with high quality and good outcomes of care for all.

A personalised NHS

VISION

A personalised NHS must be tailored to the needs and wants of each individual, especially the most vulnerable and those in greatest need, providing access to services at the time and place of their choice.

WHY IT MATTERS

People have told me consistently that personalised care matters. But we all know – as professionals, friends, family, carers and users of the NHS ourselves – that patients sometimes feel treated as numbers, are made to wait too long, do not have their condition or treatment explained sufficiently, feel lost in the system, receive poor 'customer service', are denied choice, and experience basic lapses in care. Care may be personal, but too often it is experienced as impersonal. And with patients coming into contact with dozens of different staff along a typical care 'pathway' it may only take one person to undermine a good patient experience.

Based on what I have heard, I have so far identified four broad factors on which we could improve:

- access
- dignity and the patient as a person
- integrating care/partnership
- choice and personal control

IMPROVING ACCESS TO PRIMARY AND COMMUNITY CARE

As I set out in chapter 2, NHS staff have helped deliver major improvements in access to care over the last decade.

There have genuinely been tremendous improvements in access to care in the past decade, particularly for planned specialist care. When the '18 weeks' target is finally met in 2008, all patients referred by their GP for medical or surgical consultant-led care will be entitled to choose to receive clinically appropriate treatment quicker or as quickly as patients in any comparable country. This was scarcely imaginable 10 years ago. Already, patients should not need to spend more than 4 hours in A&E (unless

NHS staff have **helped deliver major improvements** in access to care over the last decade

A personalised NHS

there is a clinical need) and the great majority of patients can see their GP within 48 hours. What I have learned from talking to people up and down the country is that what matters is that patients really feel the difference – and that we avoid reducing it to a form-filling exercise for staff. A key measure of success ought to be listening to what our patients tell us about their experience.

The issue that has been raised with me most frequently during the first part of this Review is how difficult some people still find it to access primary care.

More than 80% of NHS patient contact takes place in primary care. Most secondary and tertiary care is accessed through primary care, and millions of people receive community-based care, for example for long term conditions. In my visits around the country, I have witnessed for myself the strength of our primary care and community services. Our registered GP list system is renowned internationally. Our primary care system co-ordinates care for patients in a way few other countries match. There are strong bonds of trust between staff and their patients, families and carers.

But primary care faces a number of pressing challenges in terms of people's experience of access. A number of steps have already been taken. I believe we need to take further action now to meet these challenges.

It's when my GP refers me onwards to a specialist clinic that the problems start – the left hand doesn't know what the right hand is doing.

[Consultative event – Maidstone]

EQUITABLE ACCESS TO PRIMARY MEDICAL CARE

As I described in chapter 4, there is a correlation between areas with lowest life expectancy and fewer GPs per head of population.

This is clearly unacceptable and so **the Government should invest new resources to bring at least 100 new GP practices, including up to 900 GPs, nurses and healthcare assistants into the 25% of PCTs with the poorest provision**, ie fewest primary care clinicians, lowest patient satisfaction with access and poorest health outcomes. These new practices will increase capacity and offer an innovative range of services, including extended opening hours. They will improve health outcomes in these areas, with more targeted and preventive interventions that identify and tackle illness at an earlier stage.

The vast majority of patients who see GPs and other professionals in primary care are highly satisfied with the care they receive,[3] but the consultative event in September showed that many people are seeking the opportunity to access routine primary care from a GP in the evenings or at weekends. And a quarter of patients still report that they cannot book advance appointments at their GP practice. It is also significant that young working males and black and ethnic minority communities are more likely to report difficulties in accessing GP services.

The following further action should therefore now be taken:

- **We should invest new resources to enable PCTs to develop 150 GP-led health centres, situated in easily accessible locations and offering a range of services to all members of the local population (whether or not they choose to be registered with these centres), including pre-bookable appointments, walk-in services and other services.** The guiding principle will be to ensure that any member of the public can access GP services at any time between 8am and 8pm, seven days a week. These centres will reflect local need and circumstance and maximise the scope for co-location with other community-based services such as diagnostic, therapeutic (eg physiotherapy),

3 2006/07 GP Patient Survey: http://www.dh.gov.uk/en/Publicationsandstatistics/PublishedSurvey/GPpatientsurvey2007/index.htm

A personalised NHS

pharmacy and social care services. PCTs will be expected to commission these new health centres on a level playing field from existing GP groups or other providers.

- PCTs will work with all new and existing GP practices in their areas to develop greater flexibility in opening hours – our aim is that at least half of all GP practices will open each weekend or on one or more evenings each week. Where existing GPs do not start to offer these extended services, PCTs will be able to use the funding we make available for this to commission new services from other GPs, GP federations or other providers.

- **We will ensure that an increasing proportion of the NHS payments made to GP practices are linked to their success in attracting patients, and the views of their patients, including the ability to book advance appointments and the ability to see a GP within 48 hours**.

- **Later this month key information about all GP practices – including the results of the patient survey, practice opening times and performance against key quality indicators – will be made available on a single website, NHS Choices, via www.nhs.uk.** This service will provide people with reliable and accessible information on GP practices to help them choose which one is likely to best meet their needs, and – if they are not satisfied – how to change their practice.

I will also be considering whether more convenient hours should apply to services provided in secondary care settings. Providers should certainly be considering whether to make bookable slots available in the evenings and at weekends for patients requiring outpatient appointments.

OUT-OF-HOURS SERVICES

During the first part of this Review, I have heard many people say that they find it confusing to know which NHS service to access for routine or urgent care when their GP practice is not open. This matters especially for people with long term conditions who are usually cared for by staff at the local GP practice, but whose condition deteriorates at a time when the practice is shut. Should they go to A&E? Ring NHS Direct? Find a walk-in centre? Phone the local out-of-hours number if they can find it? Try the pharmacist? Wait until the morning?

Our aim is that **at least half of all GP practices will open** each weekend or on one or more evenings each week

I believe that commissioners and providers need to understand how people are accessing services and use this information to ensure they are planning and providing the right mix of services to meet people's needs.

We need to find a way of enabling people with different lifestyles to access care in ways that suit them, while ensuring that everyone knows how best to access care, particularly urgent care, when they need it. And we need to find ways to engage people so that minor symptoms or lifestyle risks are not ignored until they have become established diseases. In particular, we need to do this for those people less equipped to engage with traditional general practice, who frequently lead, busy lives and find it hardest to find time to see their GP.

As I said in my London Review[4], we should consider options to improve and simplify access for the public to urgent healthcare by exploring the introduction of a single three-digit number in addition to the emergency services number 999. We will also identify how pharmacies can best support seamless urgent care for patients. We know that people continue to have concerns about prompt and easy access to medicines, including access to urgent repeat medicines.

FUTURE STRATEGY ON PRIMARY AND COMMUNITY CARE

I believe we need to go further still to meet the challenges of the next decade. In part two of the Review, we will develop a vision for primary and community care services and a strategy that brings together these access issues with the other main factors determining personalisation, effectiveness, fairness and safety.

To help me, I will be drawing together an advisory board that includes GPs, community nurses and other health and care professionals.

4 NHS London: Healthcare for London: A Framework for Action, 2007

A personalised NHS

Advisory Board

Dr Sam Everington (GP from East London and Member of BMA Council)

Dr Michael Dixon (GP from Devon and Chair of NHS Alliance)

Prof Mayur Lakhani (GP from Leicestershire and Chair of Council of Royal College of GPs)

Sir John Oldham (GP from Glossop and former-Head of Improvement Foundation)

Ursula Gallagher (Community Nurse and Director of Quality, Ealing PCT)

Andrew Burnell (Community Nurse and Director of Provider Services and Nursing, Hull PCT)

Paul Farmer (Chief Executive of MIND)

Anne Williams (President of ADASS)

Alwen Williams (CE, Tower Hamlets PCT)

Dr David Colin-Thomé (National Clinical Director for Primary Care)

The review will need to include:

- the development of a vision of world-class primary and community services, capable of tackling existing challenges of access and inequality and promoting choice and control, as well as focusing ever more strongly on promoting health, preventing illness and managing long term conditions, not least in response to the ageing of the population and lifestyle risk factors such as obesity. This is likely to mean reaching out to the harder-to-reach groups among our diverse population rather than waiting for them to present at the GP surgery

- a genuine understanding of what the barriers and enablers are to achieving this vision, in every local area

- proposals for new models of care – and linked proposals for changes to estates, workforce, training and accountability

The review will also need to identify how the contractual and commissioning arrangements for primary medical care can continue to evolve to reflect these trends and challenges, including:

- how to reshape incentives to provide a stronger focus on health outcomes and continuous quality improvements; whether there should be an independent process for setting and reviewing outcome measures in the framework; and whether there should be greater flexibility for PCTs in setting outcomes that reflect local needs and priorities

- how to provide a more equitable link between the funding that a GP practice receives and the number of patients for whom it provides care, and the relative needs of its local population, based on the principles that practices should be fairly rewarded for taking on new patients and that 'money follows the patient' if he or she chooses to switch practices

- how to expand patient choice in primary care, including exploring new models that enable patients to switch GPs more easily and register with GP practices near their workplace, and how to make it easier for the new entrants to start providing primary care on contract to the NHS as of right in underdoctored areas without a slow and bureaucractic procurement process

- how to involve the fullest possible range of service providers, including existing GP practices, voluntary sector organisations and independent sector providers in developing innovative solutions to tackling inequalities, improving patient access, developing more responsive services and increasing patient choice.

A personalised NHS

The introduction of nationally procured independent sector providers in planned care has been successful in introducing innovation and changing the culture of surgery. As we move from expanding capacity to focus on creating a more personalised service, so the focus of the independent sector should shift to helping services locally to respond quickly to patients' needs. This means a shift from national procurement to locally procured services and a greater role for the private and voluntary sectors in primary and out-of-hospital care. I believe that the innovative practice that independent sector providers can bring will help realise dramatic improvements for patients and challenge the established ways of working among NHS organisations.

DIGNITY AND A FOCUS ON THE PATIENT AS A PERSON

I know from my own patients how much they value being treated with dignity and respect. I hear it most from older people, when treated in hospital, that they who are concerned about:

- feeling neglected or ignored while receiving care
- being treated more as an object than a person
- feeling their privacy was not respected during intimate care
- needing to eat with fingers rather than being helped with a knife and fork
- generally being rushed and not listened to

I believe that the innovative practice that independent sector providers can bring will help realise dramatic improvements for patients and challenge the established ways of working among NHS organisations

- beds not being cleaned
- not being helped to wash
- mixed-sex wards.

At the nationwide consultative event in September, more than 50% of patients, public and staff said there needs to be a lot or a fair amount of improvement in the dignity and respect with which patients are treated. Information and communication were also cited as important and requiring improvement. And when things do go wrong, we also need to improve the way complaints are treated.

This is a key challenge for all clinicians. Nurses have a key role to play here, but we should all be constantly challenging ourselves to find ways of improving the patient experience. For example, when I am conducting a lengthy operation and I know that the parent, spouse or carer of the patient will be anxiously waiting for news, I will often arrange for them to receive a call to keep them informed. Similarly, we should ask ourselves, does this patient really need to travel in to get test results or to hear how successful my surgical intervention has been? For example, patients who are terminally ill, or dying, may find the bustle, limited privacy and noise of a busy ward a stressful and inappropriate environment, or that they are subject to clinical tests and interventions which may be of limited real value.

INTEGRATING CARE

There is evidence that one-stop care – for example by carrying out a number of diagnostic tests together, by co-locating care under one roof, or by

A personalised NHS

making better use of information and information technology – helps improve the effectiveness and safety of care.[5] Basing that care where it is most needed also increases its connection to local communities, eg locating children's health services on extended school sites.

Integrating care is also a key driver of personalisation because, for example, there are likely to be fewer appointments on a typical pathway, greater familiarity between patient and staff, better information for the patient, and a more 'seamless' experience for the patient. Designing services in terms of care pathways is the best way to ensure that the quality of care and the patient's perspective are foremost, with organisational boundaries a secondary consideration. This pathway approach will be taken locally for part two of the Review. At the heart of this will be the relationship between local government and the local NHS. In effect, we need a single health and wellbeing service in every local community, shaped around the user, not the organisation.

In my experience, the best care is provided when there is collective accountability for the outcomes at each point along the pathway. Based on this and on what I have heard from NHS staff on my visits, we could do more to ensure that current processes, including the NHS tariff, support this approach.

Not all of the conclusions of my review of London's health services will apply nationally, but one which I believe does is the principle of 'localise where possible, centralise where necessary'. As we know from the consultation for the *Our Health, Our Care, Our Say* White Paper (2006), patients, families and carers prefer where possible to be treated close to home, and medical advances make this increasingly possible. For instance, modern surgery allows more day cases, outside major hospital settings. The US health system has its challenges but the shift in outpatient appointments from hospital to community settings (90% in hospital in 1981; 50% in 2003)[6] shows the scope for care to become more personalised in this respect. In England, it is estimated that over 90% of outpatient appointments still take place in hospital.

CHOICE AND PERSONAL CONTROL

Patients increasingly aspire to greater control and choice over the services they receive. I have seen how greater control can be offered to patients by ensuring that they have excellent information about the care options available to them and then by sharing decisions between patient and

5 Making the shift: Key Sucesss Factors, July 2006, University of Birmingham Health Services Management Centre.
6 Amercian Hospital Statistics; CSF; AHA Trendwatch Chatbook; CMS; Office of the Actuary

clinician, leading to a personalised care plan tailored to the patient and agreed with them and their carers.

So far, the drive towards greater choice in the NHS has been focused largely on those patients referred for one-off elective treatments. Surely equally important is offering more choice to those patients who have to live for many years with an enduring medical condition. National patient groups are keen that the NHS should increasingly offer such patients greater choice and control, through the care planning process and supported with better information and help.

I have also been impressed by what I have heard about the introduction of individual budgets in social care linked to direct payments and individual budget pilots, which have clearly transformed the care of some social care users. From this, we need to learn how to support and allow eligible service users increasingly to design their own tailored care and support packages. This could include personal budgets that include NHS resources. As a first step, we will encourage practice-based commissioners to use NHS funds much more flexibly to secure alternatives to traditional NHS provision where this would provide a better response to an individual's needs, eg through respite care or support, installing grab rails to help maintain independence, self-monitoring equipment for people with long term conditions, supporting carers of terminally ill patients, and so on.

NEXT STEPS

This chapter has set out my view of the difference personalised care can make – and some of the steps we should take now to act on this. In the next stage of the Review, the eight clinical pathway groups in each SHA region, described in chapter 3, will consider how to improve personalisation in each pathway. They will do this in partnership with patients, carers and their advocates.

An effective NHS

VISION

An effective NHS must therefore focus on delivering outcomes for patients that are among the best in the world.

Providing effective treatment and care is what saves lives, improves the quality of people's lives and prevents them getting ill. In my experience it is also the reason that most staff join the NHS in the first place.

At the consultative events, we asked people what the top priority for improvement was. 'Getting the right treatment and drugs' came out top.

Preventive care matters because if the NHS can support people to make healthier choices, they can avoid ill health. The alternative is that smoking and unhealthy eating, for example, can lead to long term conditions such as heart disease, diabetes, asthma and respiratory problems such as chronic obstructive pulmonary disease.

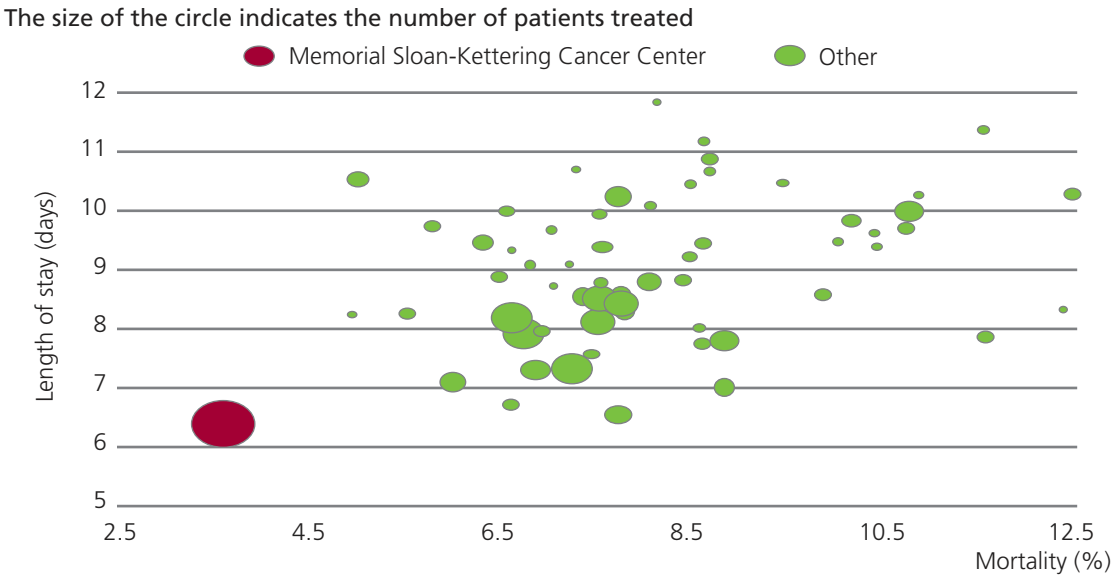
There are currently over 15 million people in England with a long term condition and who are proportionately far higher users of health services. They account for 55% of GP appointments, 68% of outpatient and A&E attendances and 77% of inpatient bed days.[7]

It also matters because it can provide better value for money. This was an argument Derek Wanless made in his 2004 report *Securing Good Health for the Whole Population*. He made the case for engaging the public in making healthier choices to save a potential £30 billion by 2022/23.

Effective care matters of course because patients should get the best outcomes. The evidence also shows that the most effective treatment is very often the most efficient treatment.

7 2005 General Household Survey

Risk-adjusted mortality from cancer against length of stay for institutions in New York State



Source: BMJ 2005: 330; 530-533 "What can the UK and US health systems learn from each other: Lois Quam and Richard Smith

The Memorial Sloan-Kettering Cancer Center in New York provides an excellent illustration of this point. Here, it is possible to see how volume and specialisation can be linked to clinical excellence.

WHERE WE ARE NOW

There have been clear improvements in life expectancy over recent years. Male life expectancy at birth in England is at its highest recorded level: 76.9 years in 2003/05 compared with 74.8 years in 1996/98. The same is true for women, with average life expectancy at birth standing at 81.2 years in 2003/05 compared with 79.8 in 1996/98.

These improvements in life expectancy can, in large part, be attributed to tackling the major diseases – cancer and cardiovascular disease in particular. Reductions in the last decade in mortality from these two diseases have saved 50,000 and 150,000 lives respectively through a combination of better prevention, earlier detection and better treatment.

SCOPE TO IMPROVE

Despite these improvements, there remains much more we can do – in terms of both effective prevention and effective treatment. The scope for improvement and the challenges facing us can be illustrated by looking at how we compare with other countries, the variations in the effectiveness of care that exist within England, and how we are responding to the emergence of new treatments and technologies.

An effective NHS

Female life expectancy at birth

England, EU countries and selected averages, latest data (2004*)

- EU weighted averages
- EU-15
- EU-12
- England

*Denmark, Italy 2001; Belgium – 1997

Source: England – Government Actuary's Department. Web link www.gad.gov.uk/,
All other countries – WHO, Health For All Database, June 2007. Web link www.euro.who.int/hfadb

Although we have seen significant increases in life expectancy over the last decade, average life expectancy in England is still not as high as in some other countries. This is particularly true of life expectancy for women.

Healthy life expectancy is not increasing at the same rate as overall life expectancy. For men in England in 2003, the difference between overall life expectancy at birth and the expected number of years lived in good health was 8.7 years. For women the difference was 10.7 years.

74% of the public at the September consultative event agreed that the NHS should focus more on preventing people becoming ill than on further reducing waiting times.

Although we have seen significant increases in life expectancy over the last decade, average life expectancy in England is still not as high as in some other countries

The September consultative event illustrated the growing appetite among the public for the NHS to provide greater support and advice to help them stay healthy. And with unhealthy behaviours currently forecast to rise, the economic viability of the NHS demands this.

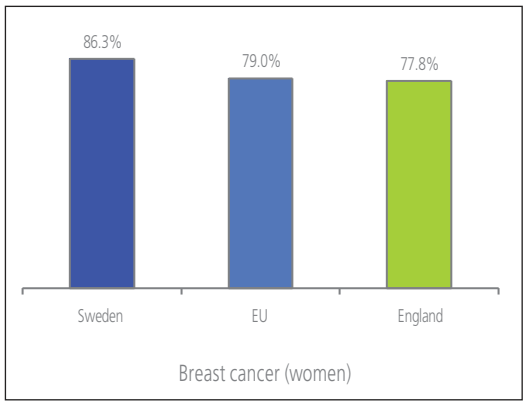
We therefore need to pursue evidence-based interventions that support people to make healthy choices and prevent ill health. For example, we need to do more to tackle the problem of obesity, especially in childhood.

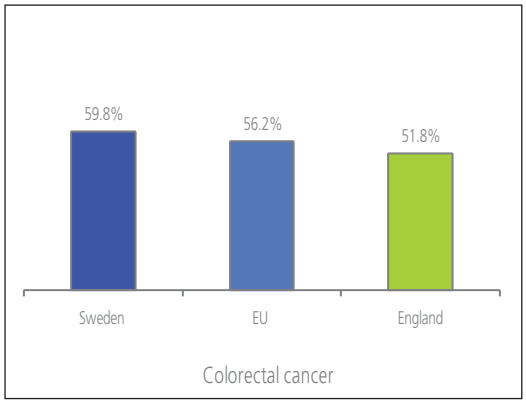
And as the NHS moves from being a sickness service to a wellbeing service, we need services that engage members of the public much sooner, which help them understand their risk factors and which equip them to take better control of their health and the lifestyle factors that affect it, such as exercise, obesity, smoking. In the next stage of the Review, I will continue to look at the case for shaping services which provide this kind of life and health checkup and at other routes that encourage individuals to take greater responsibility and control over their own health.

The focus on prevention and on early intervention means the Government must ensure that the NHS is rapidly able to adopt new vaccines or new approaches to screening which are recommended by the Joint Committee on Vaccination and Immunisation and the UK National Screening Committee.

And while the mortality rate for cancer has fallen, there is still scope to improve outcomes. For people diagnosed with cancer in 2000/01, before the NHS Cancer Plan took effect, the proportion who were alive five years later is significantly lower in England compared with the best

Cancer survival – percentage alive five years after diagnosis[8]





8 *Recent cancer survival in Europe: a 2000–02 period analysis of Eurocare* – 4 data, Verdecchia et al (published 21 August 2007)

An effective NHS

performing countries. This is largely because people in England were diagnosed with more advanced stage disease. To improve survival rates we need to focus on getting people to come forward earlier when they have symptoms and on ensuring they are diagnosed quickly.

Even within England there are significant variations in the quality and effectiveness of care that people receive.

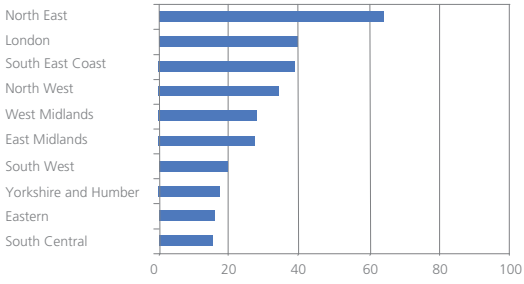
Taking stroke as an example, the graph below shows that in the North East of England patients were more likely to be treated in stroke units with the six key features associated with high quality stroke care, namely:

- continuous physiological monitoring (ECG, oximetry, blood pressure)
- access to scanning within three hours of admission
- access to brain imaging within 24 hours
- policy for direct admission from A&E
- specialist ward rounds at least five times a week
- acute stroke protocols/guidelines.

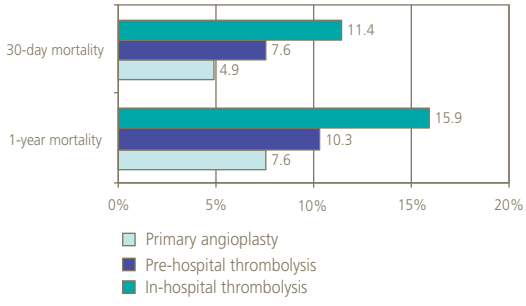
The statistics in the graph are far from impressive. And recently, many countries, including Australia, Canada and Germany, have taken advantage of new developments in stroke care and now give some patients a type of clot-busting treatment that has been shown to improve outcomes. Here, this treatment is available in only a handful of specialist centres.

We are also beginning to lag behind other countries in treating heart attack patients with primary angioplasty (a technique for unblocking arteries carrying blood to the heart muscle as the main or first treatment for patients

Proportion of sites with acute stroke units with five or six key features[9]



Outcomes from angioplasty vs thrombolysis[10]



9 National Sentinel Stroke Audit 2006

10 Long-term outcome of primary percutaneous coronary interventions in prehospital and in-hospital thrombolysis for patients with ST-Elevation Myocardial Infarction. Journal of the American Medical Association. 2006 296:174a-1756

suffering a heart attack). For some patients, the effectiveness of this new treatment compared with the more conventional treatment of administering thrombolysis is stark. I am pleased that the Department of Health is running a feasibility study, looking at the extent to which primary angioplasty can be rolled out as the main treatment for heart attack in England. But we need to accelerate this to get it in place much faster.

We need to build an NHS that is able to harness the tremendous benefits that can flow from new treatments and technologies such as these as swiftly as possible.

But effectiveness is not just about making use of the very latest treatments and technologies. It is also about ensuring that patients receive well co-ordinated and integrated care.

For example, we know that the care of patients with long term conditions is not as good as it could be and does not always meet recommended guidelines. Taking diabetes as an example, the National Service Framework recommends that patients with diabetes should agree to a care plan to manage their conditions, as the best results are achieved by:

- patients engaged in their own care and empowered to manage it themselves or with the help of carers
- organised diabetes teams that actively seek out people to ensure that they get the best care
- partnerships between people with diabetes and health and social care professionals to solve problems and plan care.

However, despite this guidance we know from a 2006 Healthcare Commission survey of people with diabetes that nationally less than 50% of people actually have an agreed care plan to manage their diabetes.

In terms of people with serious mental health problems, 2007 Healthcare Commission survey reported that 25%

are still not involved in drawing up their care plan.

And looking across a range of long term conditions – cardiovascular disease, diabetes, dementia, COPD – some initial analysis by the Department of Public Health and Epidemiology at the University of Birmingham suggests that less than 50% of patients eligible for treatment were receiving optimal treatment for their condition.[11]

NEXT STEPS

I believe the emerging picture is clear. Although some progress has been made, we can do much better in delivering the most effective care and outcomes for patients.

Locally, the eight clinical pathway groups in each SHA region, described in chapter 3, will consider how to improve effectiveness in each pathway in the second part of this Review.

Nationally, I believe we should focus on facilitating innovation and on creating a clear quality framework for healthcare.

Innovation

Since the creation of the NHS, innovations in pharmaceuticals, medical devices and clinical care have improved the quality of patients' lives.

But the NHS does not always make best use of innovation. While there have been increases in research and development funding, including the recent commitment to invest £15 billion over the next decade for medical research, and good progress in the uptake of clinically and cost-effective innovative technologies appraised by NICE, more needs to be done.

Despite some excellent work taking place locally, there remains some reluctance within the NHS to adopt new products and procedures. For example, my team and I performed the first colorectal keyhole bowel operation in the early 1990s in London. But across the NHS we are still well behind other European countries in the uptake of this technique. The NHS needs to move away from cost containment and seek to harness innovation. To encourage this change in culture, there needs to be better demonstration of the benefits of innovation in terms of improved safety, effectiveness, personalisation, fairness and value.

A new Health Innovation Council (HIC) will be established to act as the overarching guardian for innovation from discovery through to adoption, holding the Department of Health and the NHS to account for taking up innovation and helping overcome

11 Harrison W, Marshall T, Singh D and Tennant R, *The Effectiveness of healthcare systems in the UK – scoping study*, Department of Public Health and Epidemiology and HSMC University of Birmingham, July 2006.

barriers to doing so. Organisations including NICE, the National Institute for Health Research and the NHS Institute for Innovation and Improvement will have key roles to play and will be members of the HIC.

Linked to this, we need to think about how we can best bring together world-class research, teaching and patient care to encourage innovation and deliver exemplary care for patients. The concept of Academic Health Sciences Centres (AHSCs), which do just this, will be rolled out in major teaching centres across the country.

A clear quality framework

A key part of providing more effective care is being able to assess what clinicians do so we can compare our performance with others. And patients should be able to see this information before choosing where to be treated.

There is a wealth of information already available but it is not normally directly comparable and not benchmarked in a systematic way. For example, while I record the clinical outcomes of the surgery I undertake, the data is not regularly benchmarked against that of other surgeons carrying out similar work. There are individual examples of excellent practice, such as some clinical audits, but these are isolated examples.This is a significant hindrance to progress.

Establishing a clear framework and standard ways to measure results will allow us to demonstrate the high quality of what we do, and identify what is needed to sustain and improve that high quality. Any framework will need to be comprehensive, rooted firmly in the recurring questions about their care that people tell us are at the forefront of their minds, but also scientifically valid and clinically relevant. It could be useful to build on recent advances in measuring outcomes as assessed by patients themselves, and make these patient-reported outcome measures a stronger part of our approach to clinical quality.

I have asked the Government's Chief Medical Officer, Professor Sir Liam Donaldson, to develop a standard quality framework and proposals for systematic measurement against this framework. I have asked Professor Sir Bruce Keogh, the NHS Medical Director, to advise on how best to implement it within the NHS.

Despite some **excellent work taking place** locally, there remains some **reluctance** within the NHS to adopt **new products** and **procedures**

A safe NHS

VISION

A safe NHS must be as safe as it possibly can be, giving patients and the public the confidence they need in the care they receive.

A SAFE NHS MATTERS TO PEOPLE

Safety should be the first priority of every NHS organisation. People rightly expect to receive the safest possible care and to be confident that this will be the case.

At the consultative event I attended in September, I heard patients and the public voice their concerns about safety. They wanted the places where they go for care to be clean, safe environments where the risks of infection are minimised. They felt there should be rigorous attention to cleanliness in particular. In a study by the NPSA in 2007, 71% of patients wanted to be involved with daily hand hygiene practice in hospital. Some 82% of those at the consultative events wanted information on infection rates when choosing which hospital to go to.

And staff agree that it is important.

WHERE WE ARE NOW

Significant progress has been made towards improving safety in the NHS. The report *An Organisation with a Memory* (2000) brought the problem of unsafe care to national attention for the first time in the UK.

Since then, the NPSA has been established, along with independent regulation underpinned by improved clinical governance. When errors occur they are investigated, lessons learned and systems changed. We are about to embark on a new chapter of this journey. The recent report *Safety First* (2006) set out a national blueprint for patient safety and has led to a fresh approach by the NPSA.

The National Reporting and Learning System has shown that healthcare professionals will report adverse events – there have been rapidly increasing numbers of incidents reported in the last three years. The objective is to capture and report patient safety incidents and promote learning and awareness in order to reduce harm to patients.

We also need to extend local accountability for all aspects of safe care. Local patient safety action teams will be responsible for encouraging reporting of errors, investigation of incidents and ensuring local learning.

One area of safety practice of particular concern to patients is the control of HCAI. International data shows that this is a shared problem.

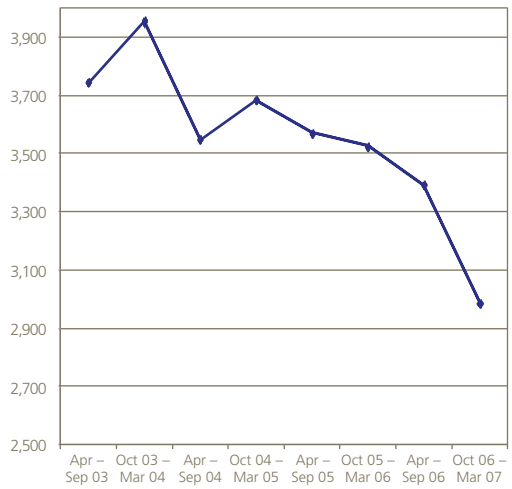
Tackling MRSA has therefore been a priority for patients, the public and NHS staff. Action has been taken over

recent years, as a result of which MRSA infection rates are coming down (although there is variation in progress between localities).

Prevalence of HCAI		Incidence of MRSA bacteraemias per 100,000 patient days	
USA	5–10%	Netherlands	0.35
Australia	6%	Germany	3.29
Norway	7%	Spain	6.00
England	8.3%	Italy	6.44
Denmark	8%	Greece	7.36
France	6–10%	UK	9.56
Netherlands	7%	France	11.79
Spain	8%	Portugal	17.58

These tables are based on international surveillance data and other available evidence

MRSA bloodstream infections by six-month period (April 2003 – March 2007)[12]



During this time, there has been an increasing focus on *C. difficile*. Mandatory surveillance of *C. difficile* was introduced in 2004 and specific interventions to combat *C. difficile* have been added to the widely used *Saving Lives* delivery programme.

SCOPE TO IMPROVE

Tackling safety issues, cleanliness and infection control is the responsibility of everyone who comes into contact with the NHS – from visitors to managers to nurses to surgeons. I believe we must do more to develop a culture of safety, and in some cases staff have told me that they need more powers and greater authority to tackle these issues. A local focus is crucial – the problem cannot be addressed by central direction.

In the last few months, more action has been announced to tackle HCAI. These actions are designed both to improve patients confidence in the safety of their care and also to tackle the root causes of infection. The Government has:

- introduced a 'bare below the elbows' dress code to improve the quality of hand washing
- released new guidance on isolating infected patients

A safe NHS

- extended the NPSA's *clean**your**hands* campaign to care settings outside hospitals
- announced that the forthcoming Bill will introduce a new legal requirement on chief executives, backed by fines, to report MRSA bloodstream infections and *C. difficile* infections to the Health Protection Agency
- set out plans for a deep clean of all hospital wards as part of the drive for a culture of cleanliness.
- made £50 million available for SHA Directors of Nursing to spend on tackling HCAI
- doubled the size of the expert improvement team
- announced quarterly reporting to trust boards by matrons and clinical directors on infection control and cleanliness

NEXT STEPS

There will now be further action to build on this. We will:

- use the Bill to give a new health and adult social care regulator tough powers, backed by fines, to inspect, investigate and intervene where hospitals are failing to meet hygiene and infection control standards

Cleanliness isn't just about infection. It also gives an impression to patients so that they can be confident about the standard of care they are going to receive.

(South East Coast – consultative event)

We should **build on the action** we have taken already to tackle HCAI **by going even further**

- introduce annual infection control inspections of all acute trusts using teams of specialist inspectors

- introduce MRSA screening for all elective admissions next year, and for all emergency admissions as soon as practicable within the next 3 years.

- look into ways of building financial penalties or rewards into the commissioning process linked to providers' performance in terms of HCAIs and cleanliness.

And we must empower staff, particularly nurses. For this reason, I have asked the Chief Nursing Officer, Professor Christine Beasley, to take forward work as part of the Review to develop a clear plan and guidance for the NHS which increases the powers of local staff. This means empowering matrons to:

- report any concerns they have on hygiene direct to the new regulator

- order additional cleaning

I also believe we should build on the National Reporting and Learning System, responding to feedback from the service, and support the NPSA in establishing a single point of access for frontline workers to report safety incidents: Patient Safety Direct. This would use email, telephone and letters to streamline the reporting process, providing a quicker and more systematic service 24 hours a day.

A locally accountable NHS

LOCAL CHANGE

Realising our vision for a world class NHS means working differently. If we are genuinely to make the most of the talents of staff and respond to patients' expectations, we need to empower patients and give health and social care staff greater flexibility to respond and lead.

NEW STANDARDS FOR LOCAL CHANGE

At the same time, I have heard during the first part of the Review that where change does go ahead, it does not always happen as transparently as it should. We need to reassure patients and the public that change is necessary and that it will improve the care they receive. I believe we can and should do more now to improve this process.

We should be clear from the outset that no major service change should happen except on the basis of need and sound clinical evidence. Specifically we will:

- raise the standard of evidence we expect before change takes place – we will publish by the end of this year a set of guidelines for how local areas should undertake changes to NHS services. These will be founded on the principles and recommendations set out in the Carruthers Review (February 2007). They will make clear that change should only be initiated when there is a clear and strong clinical basis for doing so; and that consultation should proceed only where there is effective and early engagement with the public, clear evidence of improved outcomes for patients, and resources available to enable new facilities to open alongside old ones closing

- ensure that local decision-making processes are subject to greater public and clinical scrutiny including by ensuring that the local case for change is led by clinicians, and is subjected to independent clinical assessment prior to consultation – through the Office of Government Commerce's Gateway review process whose main findings and recommendations will be published. The public should be reassured that the NHS will not pursue changes that have not been verified as safer and of a higher quality

If we are genuinely to make the most of the talents of NHS staff and respond to patients' expectations, we need to empower health and social care staff locally

- streamline the process – I have observed that the process of consultation is often too protracted, delaying decisions unnecessarily. There are currently few timescales for any part of the reconfiguration process other than the formal public consultation stage (minimum 12 weeks). We will therefore publish for consultation options for streamlining the reconfiguration process, including introducing clear timescales for all key stages

- improve the evidence base – a national clinical evidence base will be created, housing what local, national and international clinicians believe to be the best available evidence about clinical practice, pathways and models of care and innovations. This will be available to commissioners, practitioners, patients and the public alike. We will work with the relevant bodies, such as NICE, the National Library for Health the new Health Innovation Council and the Independent Reconfiguration Panel (IRP) to take this forward.

SUPPORTING ACTION

The second stage of my Review will also focus on supporting the frontline NHS in responding to these challenges. To understand what is required to do this, I have held discussions during the first part of this Review with a wide range of stakeholders – including professional bodies, trade unions and voluntary sector organisations – and

A locally accountable NHS

identified a number of areas on which action is needed. Those areas include:

- workforce planning, education and training
- leadership
- information to support excellence
- enabling systems and processes
- the case for an NHS Constitution.

I will be using the second part of this review to work with the senior NHS leadership team – clinicians and managers – to bring together experts from this country and abroad to discuss the key issues in more detail and identify the best way in each case to support change to happen locally. I want this work to involve professional bodies, trade unions, voluntary sector organisations and other partners.

To ensure that the NHS benefits from the best available advice, I will also be commissioning research, analysis and contributions from a range of organisations, in this country and abroad.

Workforce planning, education and training

The NHS currently employs over 1.3 million people – 70% of its costs are linked to staffing. The NHS spends over £4 billion annually on training and developing its staff so they can provide the best quality care. Yet despite an increasing NHS budget, education and training expenditure has not increased as much as planned in the last year. This has often affected those who needed it most – the staff who have benefited least from development opportunities. We also know that commissioning of training places has not always matched commissioning of services. We therefore need to do more to grasp the potential of education as a lever for service improvement.

Despite the highly publicised problems with the Medical Training Application Service (MTAS) recruitment system, I believe that the principles of the Modernising Medical Careers (MMC) programme developed with the

professional bodies and regulators are sound. It is the implementation that has fallen so far short.

But overall, our approach to workforce planning and the commissioning of education and training needs an overhaul, so that we can avoid any repetition of the problem where many NHS-trained physiotherapists who graduated last year were not able to find posts in the NHS despite rehabilitation after illness (such as stroke) being vital to the recovery of hundreds of thousands of NHS patients.

And we need to look at the content of curricula to ensure that they are aligned with the care our vision is intended to deliver.

Workforce planning needs to be more evidently and consistently linked with new models of care and with financial and service planning at all levels in the system. Education and training providers also need to be more involved and forward looking.

We need to strengthen education and training commissioning so that training for all staff delivers the skills and competencies required to meet staff and patient expectations. We should develop robust quality-assessment tools to ensure we are getting the right quality of education, not just the right quantity.

Leadership

The essence of clinical leadership is to motivate, to inspire, to promote the values of the NHS, to empower and to create a consistent focus on the needs of the patients being served. Leadership is necessary not just to maintain high standards of care but to transform services to achieve even higher levels of excellence.

I often hear clinicians say that they feel constrained and undervalued by managers, and this also applies between different clinical groups. But it is also true that managers sometimes see clinicians as stubborn and slow to change. Most importantly, however, recent research (*What Matters to Staff*, 2007) has demonstrated just how much clinicians, managers and other staff want to collaborate on improving local services. There is evidence that where this is already happening, patient and staff satisfaction is higher.

The challenge now is to accelerate our progress. I will ask the NHS Chief Executive, David Nicholson, to convene a national working group to identify actions we can take. Included in this

Our approach to workforce planning and the commissioning of education and training needs an overhaul

A locally accountable NHS

group will be professional and representative bodies. It will draw on best NHS and international practices. I will ask them to consider how to put the business of care at the heart of what local NHS boards do and, specifically to:

- define what excellent leadership looks like, including collaborative leadership
- develop a strategy for health leadership development, including research
- examine how leadership development can be built into formal and informal education and training for all professional groups, and role models identified, building on existing work
- consider how to identify and encourage healthcare professionals to take up leadership roles as part of normal career paths.

Information to support excellence

All modern organisations serving consumers rely on high quality information to provide consumers with choice, to assess progress, to cement accountability and to evaluate the input of new policies or programmes.

The NHS has a great deal of data, but a paucity of information. Much of the information we do have is available to limited numbers of people, is often inconsistent with that held elsewhere, and is frequently not available at the point of need.

The NHS's recent investment in technology has created the opportunity to make a step-change. The national infrastructure established by the National Programme for Information Technology has connected every hospital and GP surgery to a common secure network. Clinicians should benefit from the implementation of digital access to X-rays and scans – Picture Archiving and Communications System (PACS). But I believe more work is now needed to ensure that the Connecting for Health programme delivers real clinical benefits, and I will be considering in the second stage of my Review how best to achieve this.

Enabling systems and processes

The NHS is perhaps two-thirds of the way through its reform programme set out in 2000 and 2002. In my visits

across the NHS I have detected little enthusiasm for doing something completely different; instead the majority opinion is that the current reforms should be seen through to their conclusion. I agree. A more personalised NHS requires services that are locally designed and can adapt quickly to patients' needs. In turn that means that if we are to have world class services across the board, then we need world class commissioning. PCTs working with practice-based commissioners and local authorities will need to commission services based on the models of care that the local clinical pathway groups devise.

Commissioners need to look at best practice across the globe and ensure that a range of independent and commercial skills are adopted or brought in, where they can improve population health and healthcare. Given the variation in NHS commissioning skills currently on offer, in my view – and that of the Government – that needs to mean extensive use within every SHA of the new Framework for procuring External Support for Commissioners (FESC).

The case for an NHS Constitution

The way the NHS is run has evolved to meet today's challenges. There is already much less top-down intervention, with NHS foundation trusts much more free to innovate locally, and PCTs able to decide on service priorities to a greater degree than before.

While there is a consensus that the shape and delivery of local services should be determined locally, where this is not possible, people want a clear and transparent process for arbitration and decision making. They feel that without this clarity people cannot be held to account properly for the decisions they do take.

In my terms of reference, the Prime Minister and the Secretary of State said that, at the end of the Review, a decision will be taken on whether there is a case for an NHS Constitution, as part of a new and enduring settlement for the NHS as it approaches its 60th birthday. The objective would be to enshrine the values of the NHS and increase local accountability to patients and public.

A locally accountable NHS

The Secretary of State and I have asked the NHS Chief Executive to establish and chair a national working group of experts to consider the scope, form and contents of an NHS Constitution or settlement, in particular how it might:

- help secure the enduring principles and fundamental values of the NHS, based on evidence of what matters to our patients, the public and staff
- establish a stronger framework of responsibility, accountability and legitimacy for decision making within the service, both nationally and locally including in PCTs and NHS foundation trusts
- establish the responsibilities of all organisations who work for NHS patients
- include an open and accountable process for arbitration and decision making where decisions on the shape and delivery of local services cannot be resolved locally
- embed a stronger focus on rights and responsibilities for patients, the public and staff, based on evidence of what matters

A stronger focus on rights and responsibilities for patients, the public and staff, based on evidence of what matters

- set out a right of engagement for patients and staff covering consultation, independent assurance and rights of redress

- strengthen the opportunity to work in partnership with other agencies to improve access and the integration of care

- review the process for NHS appointments, in line with the Governance of Britain green paper.

This work will be underpinned by what our patients, staff and the public tell us over the coming months. I have been delighted by the enthusiasm that people have shown for the Review so far – and it is clear that there is an appetite for more engagement as this work progresses. Whether we devise an NHS Constitution or not, part of my responsibility is to ensure that everyone who wants to can feed into that process and have a real opportunity to influence the shape of our NHS for the next decade.

How to get involved

I want people across the country – patients, the public and staff wherever they are working in the health and social care system – to discuss this report and to get involved in shaping a world class NHS. I encourage you to discuss, deliberate and examine the proposals and let me know your comments.

Engagement will be locally led; I envisage many more discussions taking place up and down the country, similar to the events we held nationwide in September.

The Review website, www.nhs.uk/ournhs, contains information about the Review and updates about what is happening in your area. It will shortly contain an online resource pack to support your discussions locally; the material includes tailored agendas for a full-day and half-day event, standardised feedback forms to record the outputs from your discussions and supporting documents.

An online questionnaire will be made available soon, downloadable from the site, and I encourage you to share it among your friends, family, carers, neighbours, colleagues and peers. Hard copies of the questionnaire are available on demand from:

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email: dh@prolog.uk.com
Tel: 08701 555455
Fax: 01623 724524

I have also arranged for a number of new forums and groups to be created to enable people to contribute their views. The many organisations involved in health and social care will be continuing their normal processes for dialogue with stakeholders as well.

If you are unable to hold or attend a local event, or cannot contribute to the questionnaire, I still want to hear your views. You can email ournhs@dh.gsi.gov.uk or write to me at the Department of Health, and I will ensure that your views are taken into account.

I want people across the country – **patients, the public and staff** wherever they are working in the health and social care system – to discuss this report and to get involved in **shaping a world class NHS**

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NHS NEXT STAGE REVIEW

Interim report: Summary

October 2007

DH Department of Health

Summary

Dear Prime Minister, Chancellor of the Exchequer, and Secretary of State for Health,

As you know, I'm a doctor not a politician. That's why you asked me to take on this task – and it's why I agreed. With my colleagues, I have spent my career committed to doing my best to provide patients with high quality NHS care. And I am continuing to work as an NHS surgeon.

But the reason I accepted your invitation to lead this Review is because I believe that it is an important opportunity to take stock of the progress of recent years in improving the quality of care and up the pace of improvement going forward.

I want to make the most of this opportunity to listen to the views of patients, staff and public on how to do this. I have already heard from thousands of people in the weeks since the Review began – and their views have helped shape this interim report. I want to continue to give everyone the chance to contribute during the second stage of the Review.

My aim is to convince and inspire everyone working in the NHS, and in partner organisations, to embrace and lead change. I have met with some scepticism, including from clinical colleagues. I was expecting it. I told them I would not have agreed to get involved if this was a means of avoiding awkward decisions. I believe however that this is a chance to shape the future of the NHS in a new way.

My assessment is that the NHS is perhaps two thirds of the way through its reform programme set out in 2000 and 2002. In my visits across the NHS I have detected little enthusiasm for doing something completely different; instead the majority opinion is that the current set of reforms should be seen through to its conclusion. I agree.

Making the improvements that people expect us to achieve will not be easy. Improving the quality of care means accepting that fundamental change will have to happen. No-one should see this Review as a way of slowing down or diluting what we need to do. If anything we should be seeking to respond to the rising aspirations of patients and the public and be more ambitious, to help all members of our diverse population live longer, healthier lives, especially those least able to help themselves.

I believe passionately that, through this Review, we all have an opportunity to shape the NHS for the 21st century. Our ambition should be nothing less than the creation of a world class NHS that prevents ill health, saves lives and improves the quality of people's lives.

Some aspects are already world class. The challenge is to ensure that every aspect matches the best – to take our health service from good to great.

This interim report is the start of developing this vision for the next ten years. It has two purposes. It describes the key elements of a vision – an NHS that is fair, personal, effective and safe – and sets out the immediate actions that should now be taken to make progress towards it.

I have spent the last three months visiting different NHS organisations and hearing the views of staff. I have participated in lively debates with patients and the public about how they feel the NHS and its partners should respond to their needs.

This report is based on those views, visits and discussions. It acknowledges the progress that NHS and other staff have already made towards achieving that vision, challenges them to be ambitious in striving towards it, and sets out the scope for improvement and the challenges we need to meet over the second stage of the Review.

I believe that this vision for the future should not be just mine – or the Government's – but a vision for the future of health and healthcare in England that is developed and owned by patients, staff and public together.

THE JOURNEY SO FAR

We are not starting from scratch in achieving this vision.

Back in 1997, the NHS was in relatively poor health. Investment levels had varied considerably over previous decades, hampering proper planning. Although many patients enjoyed good care, many more experienced the trauma of poor access to primary care, long waiting times, old buildings and a winter crisis that was as predictable as the season itself.

Since then, the NHS has vastly improved. I only have to look at my own experience to see the progress that has been made. There are more staff in my team; our patients do not wait as long for operations; and their care is of a higher quality and is more personalised.

Those experiences are echoed across the country. The sustained investment since the NHS Plan (2000) has allowed the NHS to grow. As a result, there are tens of thousands more doctors, nurses and other NHS staff, hundreds of new or refurbished facilities and thousands of new pieces of equipment. Together with the reforms that have been put in place this has helped reduce waiting times, raise standards and improve the quality of care the NHS provides – care that is still provided according to clinical need and not ability to pay.

Summary

But in spite of this improvement, the views I have heard from patients, staff and the public do not always fit with the description above.

Patients have told me that they still sometimes feel like a number rather than a person. They do not know how to access the services they need to help them stay well and independent. They cannot always see a GP or practice nurse when they need to.

In short, patients lack 'clout' inside our health care system.

The public say they are sometimes confused about which NHS service they should use. They hear a lot about changes but do not know why they are being made.

Some staff tell me that they haven't been listened to and trusted. They do not feel that their values – including wanting to improve the quality of care – have been fully recognised. Nor do they feel that they have always been given the credit for the improvements that have been made.

The NHS could therefore continue to make incremental improvements.

This would not resolve the frustrations I have identified. It would mean accepting that services stay broadly as they are now. It would mean accepting steady progress rather than a step-change in reducing mortality rates. It would mean the NHS facing mounting pressure from rising public expectations and from major public health challenges.

A WORLD CLASS NHS

Alternatively we can choose to be ambitious and set out a clear vision for a world class NHS focused relentlessly on improving the quality of care.

Based on what I have heard and seen, I believe that only this approach allows us fully to respond to the aspirations of patients, staff and the public. Only this approach enables us to deliver the kind of personalised care we all expect.

Our vision should be an NHS that is:

- **Fair** – equally available to all, taking full account of personal circumstances and diversity
- **Personalised** – tailored to the needs and wants of each individual, especially the most vulnerable and those in greatest need, providing access to services at the time and place of their choice
- **Effective** – focused on delivering outcomes for patients that are among the best in the world
- **Safe** – as safe as it possibly can be, giving patients and the public the confidence they need in the care they receive.

This is not about changing the way NHS is funded or structured. Successive reports have shown not only that our system is fair, but also that other comparable systems are, in key respects, less efficient. We now need to:

- move beyond just expanding the capacity of the NHS and focus relentlessly on improving the quality of care patients receive
- be ambitious – respond to the aspirations of patients and the public for a more personalised service by challenging and empowering NHS staff and others locally
- change the way we lead change – effective change needs to be animated by the needs and preferences of patients, empowered to make their decisions count within the NHS; with the response to patient needs and choices being led by clinicians, taking account of the best available evidence
- support local change from the centre rather than instructing it – providing that the right reformed systems and incentives are in place
- make best use of resources to provide the most effective care, efficiently.

IMMEDIATE STEPS

Some immediate steps should be taken ahead of my final report:

1. To help make care **fairer** the Secretary of State has announced a comprehensive strategy for reducing health inequalities, challenging the NHS, as a key player, to live up to its founding and enduring values.

2. To help make care more **personal**, patient choice should be embedded within the full spectrum of NHS funded care, going beyond elective surgery into new areas such as primary care and long term conditions:

   - New resources should be invested to bring new GP practices – whether they are organised on the traditional independent contractor model or by new private providers – to local communities where they are most needed, starting with the 25% of PCTs with the poorest provision
   - Newly procured health centres in easily accessible locations should be offering all members of the local population a range of convenient services, even if they choose not to be directly registered with GPs in these centres
   - PCTs should introduce new measures to develop greater flexibility in GP opening hours,

Summary

including the introduction of new providers. Our aim is that, over time, the majority of GP practices will offer patients much greater choice of when to see a GP, extending hours into the evenings or weekend.

3. To support the delivery of more **effective** care, we should establish a Health Innovation Council to be the guardians of innovation, from discovery to adoption.

4. To help make care **safer**, we should support the National Patient Safety Agency (NPSA) in establishing a single point of access for frontline workers to report incidents: Patient Safety Direct. And to reduce rates of healthcare associated infections still further we should:

   - legislate to create a new health and adult social care regulator with tough powers, backed by fines, to inspect, investigate and intervene where hospitals are failing to meet hygiene and infection control standards

   - give matrons further powers to report any concerns they have on hygiene direct to the new regulator

   - introduce MRSA screening for all elective admissions next year, and for all emergency admissions as soon as practicable within the next three years.

5. We should ensure that any major change in the pattern of local NHS hospital services is clinically led and **locally accountable** by publishing new guidelines to make clear that:

   - change should only be initiated when there is a clear and strong clinical basis for doing so (as they often may well be)

   - that consultation should proceed only where there is effective and early engagement with the public and

   - resources are made available to open new facilities alongside old ones closing.

Any proposals to change services will also be subject to independent clinical and managerial assessment prior to consultation through the Office of Government Commerce's Gateway review process.

THE SECOND STAGE OF THE REVIEW

Building on these immediate actions, the second stage of the Review will set out how we can deliver the vision for a world class health service through a locally accountable NHS in which health and social care staff are empowered to lead change, supported by the right reformed systems and incentives.

Groups of health and social care staff – over 1,000 people in total – will be established in every region of the country to discuss how best to achieve this vision across eight areas of care:

- Maternity and newborn care
- Children's health
- Planned care
- Mental health
- Staying healthy
- Long-term conditions
- Acute care
- End-of-life care

I want each group to listen to patients, the public and others to identify what it would take over the next decade to commission and provide world class care, using the best available evidence, and set out their plans to deliver on our vision of a fair, personal, effective, safe and locally accountable NHS.

I also have come to the view that the NHS could benefit from greater distance from the day to day thrust of the political process, and believe there is merit in exploring the introduction of an NHS Constitution. I have therefore asked NHS Chief Executive, David Nicholson, to chair a national working group of experts to consider the scope, form and content that such a Constitution might take.

These steps – local and national – will form the basis for a vision for a world class NHS, to be published in June 2008 in time for the 60th anniversary of the NHS.

Best wishes

Professor the Lord Darzi of Denham FREng, KBE, FMedSci
Parliamentary Under Secretary of State, Paul Hamlyn Chair of Surgery Imperial College London, Honorary Consultant Surgeon, St Mary's Hospital and the Royal Marsden Hospitals NHS Foundation Trust

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REPORT TO: Healthy Halton Policy and Performance Board

DATE: 11th March 2008

REPORTING OFFICER: Chief Executive

SUBJECT: Performance Management Reports
Quarter 3 to 31st December 2007

WARDS: Boroughwide

1. PURPOSE OF REPORT

1.1 To consider and raise any questions or points of clarification in respect of the 3rd quarter performance management reports on progress against service plan objectives and performance targets, performance trends/comparisons, factors affecting the services etc. for:

- Older People's Services
- Adults of Working Age
- Health & Partnerships

2. RECOMMENDED: That the Policy and Performance Board

1) Receive the 3rd quarter performance management reports;

2) Consider the progress and performance information and raise any questions or points for clarification; and

3) Highlight any areas of interest and/or concern where further information is to be reported at a future meeting of the Policy and Performance Board.

3. SUPPORTING INFORMATION

3.1 The departmental service plans provide a clear statement on what the services are planning to achieve and to show how they contribute to the Council's strategic priorities. The service plans are central to the Council's performance management arrangements and the Policy and Performance Board has a key role in monitoring performance and strengthening accountability.

3.2 The quarterly reports are on the Information Bulletin to reduce the amount of paperwork sent out with the agendas and to allow Members access to the reports as soon as they have become available.
It also provides Members with an opportunity to give advance notice of any questions, points or requests for further information that will be

raised to ensure the appropriate Officers are available at the PPB meeting.

4. POLICY AND OTHER IMPLICATIONS

4.1 There are no policy implications associated with this report.

5. RISK ANALYSIS

5.1 Not applicable.

6. EQUALITY AND DIVERSITY ISSUES

6.1 Not applicable.

7. LIST OF BACKGROUND PAPERS UNDER SECTIONS 100D OF THE LOCAL GOVERNMENT ACT 1972

7.1 There are no background documents under the meaning of the Act.

QUARTERLY MONITORING REPORT

DIRECTORATE: **Health & Community**

SERVICE: **Adults of Working Age**

PERIOD: **Quarter 3 to period-end 31 December 2007.**

1.0 INTRODUCTION

This quarterly monitoring report covers the Adults of Working Age Department second quarter period up to 31 December 2007. It describes key developments and progress against key objectives and performance indicators for the service.

The way in which traffic lights symbols have been used to reflect progress to date is explained within Appendix 4.

2.0 KEY DEVELOPMENTS

A project has been undertaken and its first phase completed to develop a pilot In Control/Individualised budgets for learning disabilities and physical and sensory disability services. An analysis of this early work will be undertaken and an action plan to take forward a second phase developed. An event has taken place involving managers across services to look at how the In Control/Individualised budgets agenda and how this is progressed in Halton.

There is a project in learning disability services that is being taken forward with the NWTDT and supported by CSCI to develop person centred reviews with people with PMLD. This will be a tripartite project with neighbouring authorities and will focus on PCP Review training and development for Care Managers this commenced in October 2007 and will continue in to February 2008.

A key development in physical and sensory disability services is an agreement to begin a work topic with members to review the voluntary sector contracts, this work has began with the project work commenced in October 2007 and will run to March 2008.

A new sub group to support the achievement of the LPSA target on PSD carers has been established, this will identify targets and developments with the carers grant and other carers issues. An action plan is to be developed.

The Mental Health Improvement Review continues to be monitored through both the Mental Health LIT and the Partnership Board. The

project manager is in place and is focusing on delivering key aspects of the Action Plan, particularly those relating to service delivery. A Transition Group in mental health services is looking at the pathways for young people with mental health problems as they reach adulthood. It is expected that all actions in the Action Plan will be completed by March 2008.

The part-time social work posts in the Crisis Resolution/Home Treatment Team and the Primary Care Support Team have been advertised and are expected to be appointed in early 2008.

The implementation of the Mental Capacity Act 2007 continues through the multidisciplinary Steering Group. The Deprivation of Liberty Safeguards are now due to be implemented in April 2009 and a process is in place to deliver the training, systems and procedures and publicity for this. Specialist training is being set up for specific areas of the Mental Capacity Act and flowcharts have been developed. Agreement has been reached between Halton and St Helens Borough Councils and the PCT to pool resources to establish a Mental Capacity Act project lead role; this post will be based within St Helens Council but serve both communities.

"Change for the Better" – the redesign of 5Boroughs services is now largely complete although there are still some areas of detail to consider. Progress against objectives continues to be scrutinised on a monthly basis by the Mental Health LIT and the Partnership Board.

The Mental Health Partnership Board meets every month. The full partnership was implemented as from 1st November 2007 and all health and social care mental health services provided by the council and the 5Boroughs are fully accountable to the Partnership Board. In particular, the line management of the community mental health teams is now through the Borough Council.

Emergency Duty Team (EDT): this service continues to operate successfully. A second phase IT solution for the transfer of information is in development and an operational group has been set up to manage interface issues between the team and daytime services. The EDT Steering Group has now been re-formed as a Partnership Board.

Carers assessments: these continue to be the subject of considerable attention, with monthly meetings of all operational services to ensure that systems and procedures for assessing carers needs are working smoothly. 2007/08 is the "dry run" for the LPSA target of 600 carers receiving a service as a result of an assessment; at this stage the target is already likely to be exceeded. In addition a national performance target relating to carers assessments has also been exceeded.

Bridge Building: it has now been agreed that this service will be mainstreamed and extended in 2008, following its successful evaluation.

3.0 EMERGING ISSUES

We are looking to improve the way we develop our joint working arrangements and integrated services in the learning disability specialist community team, and a reconfiguration of services has been formally agreed by the council and PCT. Work has progressed an action plan has been developed, re-modelling will take the form of a hub and spoke approach and reported in future Quarterly Monitoring Reports.

A Joint Commissioning Strategy for People with Physical and/or Sensory Disability Services has been developed and now formally agreed. This is now being implemented through the Physical and Sensory Disability Local Implementation Team

The Mental Health Act 2007 is due to be implemented in April 2008. This will require changes to policies and procedure, changes to role definitions, training that is both awareness-raising and detailed for those people who need it, and publicity and information to be developed. Some of this can be developed across a wider footprint than the Borough Council, and a process is starting to pool resources and effort across the Boroughs of Halton, Warrington, St Helens and Knowsley, and involving the 5BoroughsPartnership, to share some of this work.

The departure of the Principal and Practice Managers from the Community Mental Health Team (CMHT) in Widnes has provided an opportunity to review the management structure of the CMHTs in both Widens and Runcorn. This review is taking place through the Mental Health Partnership Board and will be reported in future Quarterly Monitoring Reports

The extension of the period for the introduction of the Deprivation of Liberty Safeguards has given the opportunity to develop a more structured approach over a period of time for the implementation. A multidisciplinary scoping meeting took place in December 2007 which identified the processes which will need to take place and these will be developed into a more formal action plan in early 2008.

4.0 PROGRESS AGAINST KEY OBJECTIVES / MILESTONES

Total	**6**		**6**		**0**	 **0**

Progress towards all six key milestones for the service is good. For further details please refer to Appendix 1.

4.1 PROGRESS AGAINST OTHER OBJECTIVES / MILESTONES

There are no other objectives for the service. Eleven milestones within the key objectives are designated 'non-key'. Those milestones are routinely reported in quarters 2 and 4. No non-key milestones are reported by exception this quarter.

5.0 SERVICE REVIEW

In learning disability services there has been a review of respite services and we are developing services to offer a menu of short breaks services. We have recruited a temporary project manager from September '07 to March '08 to accelerate this. An action plan has been developed to progress this agenda.

In learning disability services we have commissioned a Consultant Behaviour Analyst on a "behavioural solutions project" to continue to help us review the way services are delivered for people with complex needs, whose behaviour is experienced as difficult or challenging. We have a project brief, which will start incrementally by working with selected providers for two of the 24 hour supported living schemes for people with complex needs; the schedule of training and interventions commenced in October 07 and continues into April 08. This work continues to progress.

In physical and sensory disability services the Progress in Sight benchmarking exercise is being completed and action plan will be implemented. A champion has been identified to take this work forward.

Although both CSCI and the Healthcare Commission have agreed that they are satisfied with the progress in mental health services through the Action Plan for the Improvement Review of 2007, progress continues to be monitored by CSCI, and is subject to monthly review in both the Mental Health LIT and the Partnership Board. The Project Manager for the Action Plan remains in place and is focusing on specific and achievable tasks, particularly in terms of developing service user/carer involvement, transition arrangements for young people with mental health problems into adulthood, and interface relationships with other services.

6.0 PROGRESS AGAINST KEY PERFORMANCE INDICATORS

Total	**6**		**4**		**1**		**0**

Progress towards all other Key indicators is generally good. One indicator relating to ethnicity is rated amber. Key indicator PAF B17, cost of home care, will be reported after closure of accounts in June/July 2008. For further details please refer to Appendix 2.

6.1 PROGRESS AGAINST OTHER PERFORMANCE INDICATORS

Total	**18**		**13**		**3**		**0**

Progress against all 'Other indicators' is satisfactory. None are being reported by exception this quarter.

7.0 PROGRESS AGAINST LPSA TARGETS

There are no LPSA targets for this service. The service contributes towards an LPSA around providing services to carers, which is in the Older People's Services service plan, and is reported in the Older People's Services quarterly monitoring report.

8.0 RISK CONTROL MEASURES

During the production of the 2007-08 Service Plan, the service was required to undertake a risk assessment of all Key Service Objectives.

Where a Key Service Objective has been assessed and found to have associated 'High' risk, progress against the application of risk treatment measures is to be monitored, and reported in the quarterly monitoring report in quarters 2 and 4.

9.0 PROGRESS AGAINST HIGH PRIORITY EQUALITY ACTIONS

During 2006/07 the service was required to undertake an Equality Impact Assessment. Progress against actions identified through that assessment, with associated High priority are to be reported in the quarterly monitoring report in quarters 2 and 4.

10.0 APPENDICES

Appendix 1- Progress against Key Objectives/ Milestones
Appendix 2- Progress against Key Performance Indicators
Appendix 3- Financial Statement
Appendix 4- Explanation of traffic light symbols

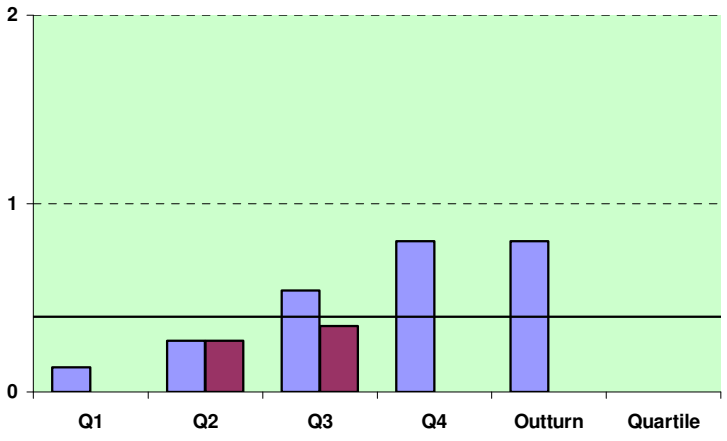
Service Plan Ref.	Objective	2007/08 Key Milestone *Italic = Q2 & Q4 only*	Progress to date	Commentary
AWA1	To work in partnership across traditional boundaries, always keeping service users and carers at the centre of the service, to strengthen service delivery to hard to reach groups, including those from the BME community, and to ensure that services are needs-led and outcome focussed.	Consult the BME community with the assistance of the Cheshire Halton & Warrington Racial Equality Council (CHAWREC) to ascertain whether services are meeting the needs of this community by April 2007		Completed. Audit of work is currently being undertaken by specialist worker who will report in March 2008
		Continue to implement ALD's financial recovery plan to ensure that the service becomes increasingly efficient and effective by March 2008		A project team continues to carry out this work in agreed timescales and will be reviewed March 2008.

Service Plan Ref.	Objective	2007/08 Key Milestone *Italic = Q2 & Q4 only*	Progress to date	Commentary
AWA2	To continue to modernise mainstream socially inclusive opportunities by implementing meaningful daytime activities and maximising employment opportunities for all vulnerable people to promote independence and community inclusion	Monitor implementation of Community Bridge Building Service as part of the Day Services Strategy and evaluate by March 2008		Phase two of the referral to the community bridge building team is in process. Day services management team are currently identifying further people to refer to the service. Community bridge builders are holding drop in sessions in all day services venues to profile the service to an extended audience. The day services community bridge builders link person is working in collaboration with the B.E.M. worker in establishing the need of service users from ethnic minority groups. There has been one referral for day services from the care management team after initial referral to the community bridge building team. People on the waiting list are having their referrals processed.
		Implement “In Control” model pilot for people with learning disabilities and physical/sensory disabilities by Sept 2007		The first phase of the project has been undertaken and a half-day event was held in November 2007 with senior managers to agree how to take the next phase forward.

Service Plan Ref.	Objective	2007/08 Key Milestone *Italic = Q2 & Q4 only*	Progress to date	Commentary
AWA3	To develop and improve a range of services and support for carers in accordance with the Carers Strategy to ensure carers needs are met and to support the delivery of the Carers LPSA Target	Meet the Carers LPSA target to ensure carers receive the help, support and services they need by March 2008		LPSA target will be met in Older Peoples services.
		Develop new model to increase access to new funding for Carers Centres by March 2008		New model has been developed and is due to be presented to Health Halton Policy & performance Board on 15.1.08 for comment

AWAPAF C73

Admissions of Supported Residents aged 18-64 into residential/nursing care



Key

2006/7
2007/8
Target
Top 25%
Middle 50%
Bottom 25%

No quartile data available

PAF Assessment

Better

Band	5	4	3	2	1
Target	X				
Current	X				

Likely to hit PAF target

Trend

Better than this time last year

Green

Should hit target for the year

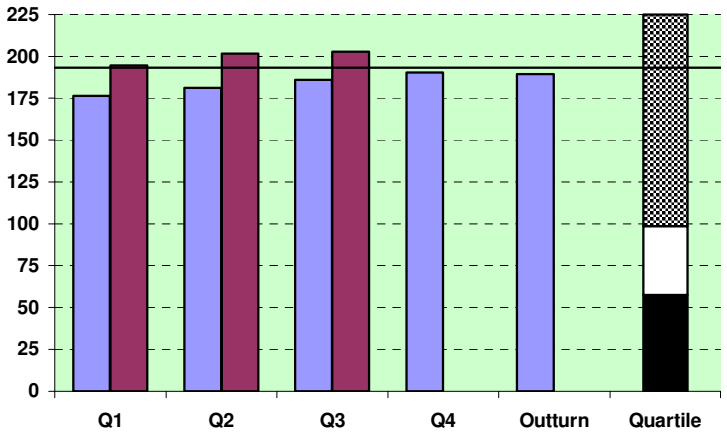
Commentary

Current performance of 0.35 admissions per 10,000 population is in line with the target and maximum PAF Band 5.

BVPI 201

Number of adults and older people receiving direct payments

Higher figures represent better performance



Key

2006/7
2007/8
Target
Top 25%
Middle 50%
Bottom 25%

PAF Assessment

Better

Band	5	4	3	2	1
Target	X				
Current	X				

Likely to hit PAF target

Trend

Better than this time last year

Green

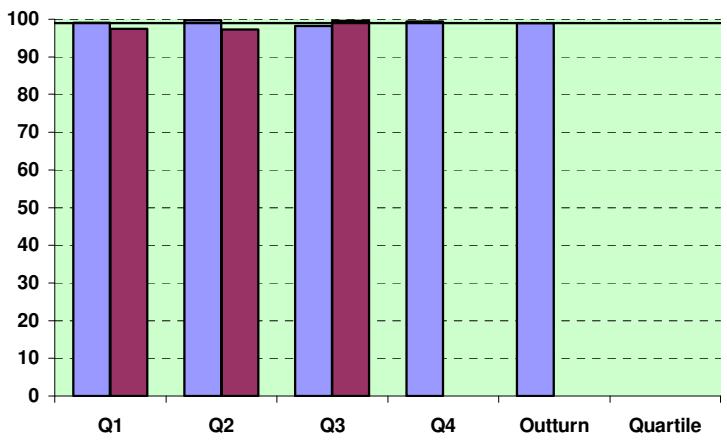
Should hit target for the year

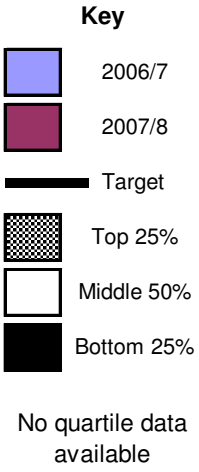
Commentary

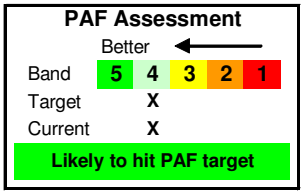
The number of adults and older people in receipt of direct payments per 100,000 population is 202.77. This indicator is in relation to client users only. Direct payments used to benefit the carer (I.e respite or carers break) is reported in a separate performance indicator to measure carers services. Current performance would be awarded a PAF Band 5. Target exceeded.

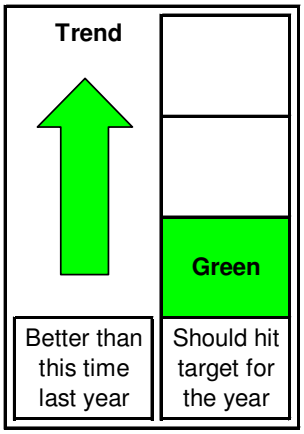
AWAPAF D39

Percentage of people receiving a statement of their needs and how they will be met.







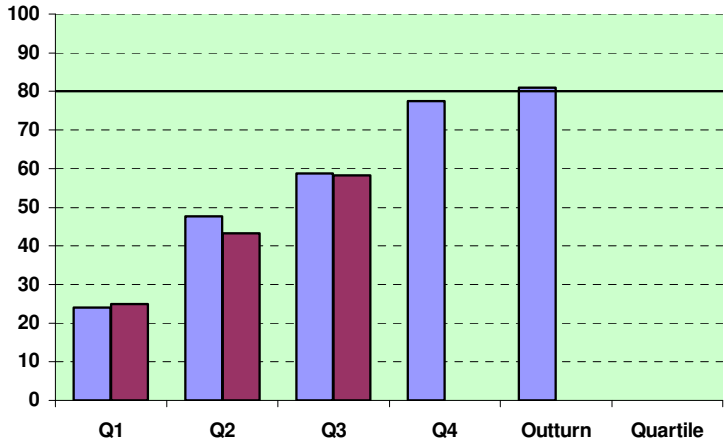


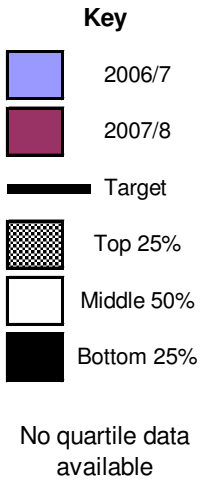
Commentary

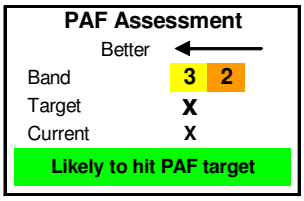
Currently, 99.50% of clients receiving services during the year to date have received a copy of their care plan. This area of performance is still subject to continual monitoring and all operational teams are informed on a monthly basis of those clients not in receipt of a copy of their care plan. Current performance would be awarded a PAF Band 4, movement to Band 5 requires performance of 100%.

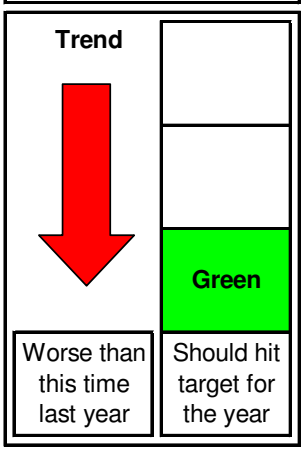
AWAPAF D40

Clients receiving a review as a % of adult clients receiv)ng a service (cost effectiveness PSA Target)







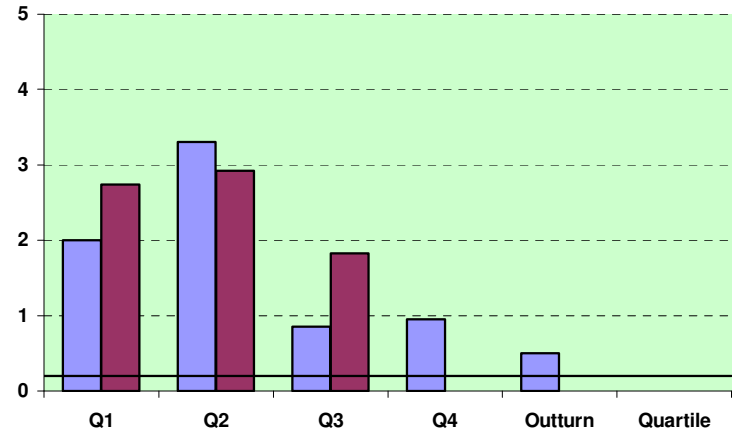


Commentary

Currently 58.30% of clients have received a review of their needs. The production of monthly reports listing all clients yet to be reviewed by each team will ensure the target figure of 80% will be met.

AWAKTI 1

Percentage of adults assessed in year where ethnicity is not stated



Key

2006/7

2007/8

Target

Top 25%

Middle 50%

Bottom 25%

No quartile data available

Trend

Amber

No data for same Qtr last year

May hit target for the year

Commentary

Current performance is 1.83% unknown ethnicity. The production of monthly reports listing all clients whose ethnicity is unknown by each team should ensure the target figure will be met.

HEALTH & COMMUNITY – ADULTS OF WORKING AGE (ALD, MH, PSD)

Revenue Budget as at 31st December 2007

	Annual Revised Budget £000	Budget To Date £000	Actual To Date £000	Variance To Date (overspend) £000	Actual Including Committed Items £000
Expenditure					
Staffing	2,867	2,150	2,091	59	2,149
Premises	139	0	0	0	0
Other Premises	59	45	46	(1)	46
Joint Equipment Service	110	0	0	0	0
Other Supplies & Services	366	150	153	(3)	214
Food Provisions	10	8	9	(1)	10
Aid & Adaptations	124	92	73	19	152
Transport of Clients	559	223	356	(133)	459
Other Transport	18	14	15	(1)	15
Departmental Support Services	840	0	0	0	0
Central Support Services	183	0	0	0	0
Contract & SLAs	808	557	546	11	582
Emergency Duty Team	117	46	48	(2)	48
Community Care:					
Residential Care	1,348	933	832	101	832
Nursing Care	53	37	27	10	27
Home Care	360	249	409	(160)	409
Direct Payments	491	340	512	(172)	512
Supported Living	164	114	50	64	50
Day Care	26	18	12	6	12
Meals	3	2	2	0	12
Specific Grants	327	42	0	42	0
Asset Charges	191	0	0	0	0
Contribution to ALD Pooled Budget	6,063	3,343	4,049	(706)	4,098
Total Expenditure	**15,226**	**8,363**	**9,230**	**(867)**	**9,627**
Income					
Residential Fees	-205	-142	-80	(62)	-80
Fees & Charges	-93	-64	-76	12	-76
Preserved Rights Grant	-113	-113	-113	0	-113
Supporting People Grant	-519	-172	-171	(1)	-171
Mental Health Grant	-513	-420	-421	1	-421
Carer Grant	-518	-490	-489	(1)	-489
Mental Capacity IMCA Grant	-55	-55	-55	0	-55
Aids Support Grant	-5	-4	-8	4	-8
Nursing Fees – PCT	-53	-25	-24	(1)	-24
PCT Reimbursement	-319	-239	-294	55	-294

Other Income	-158	-100	-16	(84)	-16
Total Income	**-2,551**	**-1,824**	**-1,747**	**(77)**	**-1,747**
Net Expenditure	**12,675**	**6,539**	**7,483**	**(944)**	**7,880**

Comments on the above figures:

In overall terms spending at the end of quarter 3 (excluding the ALD pool budget) is £238k over budget profile however the ALD Pool is over budget profile by £706k, therefore Adults services is actually over budget profile by £944k at this stage of the financial year. This is due in the main to the community care budget and underachievement of income, in particular residential fees and inter-authority income. However this will be contained within the overall Health & Community Directorate budget.

The staffing budget is expected to be slightly under budget profile at year end after the achievement of all staff savings targets.

All expenditure relating to the joint equipment service is incurred by Halton & St Helens PCT and in accordance with the Partnership Agreement, the PCT invoice Halton BC for 50% of the costs. To date no invoices have yet been received from the PCT despite requests from Halton BC however, this will continue to be progressed as a matter of urgency to ensure all costs are met before year end.

The community care budget as a whole continues to be closely monitored, as it is a fairly volatile budget known to fluctuate throughout the year dependant on client demand. To the end of the third quarter the net budget is £201k over budget profile for mental health and PSD service users. Whilst residential care is currently under budget profile, which is reflected in reduced residential fees income, homecare for clients with mental health needs & physical & sensory disabilities is significantly over budget profile. The direct payments budget is also under pressure and it is expected to be over budget profile at year end. Further work is currently being undertaken to realign the community care budget so it reflects activity within the service more accurately. Applications for joint funding for s117 service users and PSD service users using the new continuing care criteria could help to mitigate these pressures.

The transport budget is anticipated to be over budget at year end as the day centre modernisation has increased transport costs.

Although reimbursements from the PCT are overachieving current budget to date, this is not a long term expectation and will not continue next year.

Other income includes a budget of £147k for income from other authorities, which is no longer achieved, and this budget is anticipating a shortfall at year-end.

Note: A summary of the H.B.C. Contribution to ALD Pooled Budget can be found on the following page:

HEALTH & COMMUNITY – ADULTS WITH LEARNING DISABILITIES

Contribution to ALD Pooled Budget

Revenue Budget as at 31st December 2007

	Annual Revised Budget £000	Budget To Date £000	Actual To Date £000	Variance To Date (overspend) £000	Actual Including Committed Items £000
Expenditure					
Nursing Care	47	32	33	(1)	33
Residential Care	952	647	734	(87)	734
Supported Living	1,875	1,385	1,397	(12)	1,402
Home Care	1,684	911	1,095	(184)	1,095
Direct Payments	387	304	550	(246)	550
Day Services	1,905	1,278	1,158	120	1,178
Specialist LD Team	451	335	324	11	332
Management Costs	1,046	95	100	(5)	114
Respite	461	256	191	65	193
Total Expenditure	**8,808**	**5,243**	**5,582**	**(339)**	**5,631**
Income					
Rents & Service Charges	-66	-49	-6	(43)	-6
Community Care Fees	-98	-68	-59	(9)	-59
Residential Fees	-100	-75	-54	(21)	-54
Direct Payments	0	0	-28	28	-28
Preserved Rights Grant	-489	-360	-359	(1)	-359
Supporting People Grant	-1,671	-1,196	-972	(224)	-972
CITC – Astmoor	-52	-38	0	(38)	0
CITC – Special Needs	-6	-4	0	(4)	0
Other Client Income	-61	0	0	0	0
Nursing Care – PCT Reimbursement	-47	-35	-33	(2)	-33
Other Fees & Charges	-155	-75	-22	(53)	-22
Total Income	**-2,745**	**-1,900**	**-1,533**	**(367)**	**-1,533**
Net Expenditure	**6,063**	**3,343**	**4,049**	**(706)**	**4,098**

HEALTH & COMMUNITY – LOCAL STRATEGIC PARTNERSHIP BUDGET

Budget as at 31st December 2007

	Annual Budget £'000	Budget To Date £'000	Actual To Date £'000	Variance To Date (Overspend) £'000	Actual Including Committed Items £'000
Priority 1 Healthy Halton					
Health Awareness	40	30	0	30	0
Recipe For Health	29	22	14	8	14
Five A Day Programme	3	2	0	2	0
Vulnerable Adults Task Force	592	444	328	116	328
Vol. Sector Counselling Proj.	39	29	19	10	19
Info. Outreach Services	34	26	17	9	17
Reach for the Stars	34	26	16	10	16
Carer Support Development	49	37	25	12	25
Healthy Living Programme	98	73	47	26	47
Advocacy	63	48	41	7	41
Priority 2 Urban Renewal					
Landlord Accreditation Programme	28	21	28	(7)	28
Priority 5 Safer Halton					
Good Neighbour Pilot	27	20	13	7	13
Grassroots	18	14	5	9	5
Development	43	32	0	32	0
Alcohol Harm Reduction					
Domestic Violence	77	58	18	40	18
Total Expenditure	**1,174**	**882**	**571**	**311**	**571**

HEALTH & COMMUNITY

Capital Budget as at 31st December2007

	2007/08 Capital Allocation £000	Allocation To Date £000	Actual Spend To Date £000	Allocation Remaining £000
1.0 *Social Care & Health*				
DDA	24	2	0	24
LDDF	7	7	0	7
Women's Centre & Other Projects	178	100	102	76
PODS (Utilising DFG)	40	0	0	40
Bredon Improvements	24	24	32	(8)
Improvement of Care Homes	150	100	141	9
Bridgewater Capital Improvements	1	1	0	1
Refurbishments to John Briggs House	90	30	6	84
Door Entry System – John Briggs	2	2	2	0
IT for Mobile Working	12	12	0	12
Total Spending	528	278	283	245

It is anticipated the capital budget will be fully committed by the end of the year.

The traffic light symbols are used in the following manner:

		Objective	Performance Indicator
Green		Indicates that the objective is on course to be achieved within the appropriate timeframe.	Indicates that the target is on course to be achieved.
Amber		Indicates that it is unclear at this stage, due to a lack of information or a key milestone date being missed, whether the objective will be achieved within the appropriate timeframe.	Indicates that it is either unclear at this stage or too early to state whether the target is on course to be achieved.
Red		Indicates that it is highly likely or certain that the objective will not be achieved within the appropriate timeframe.	Indicates that the target will not be achieved unless there is an intervention or remedial action taken.

QUARTERLY MONITORING REPORT

DIRECTORATE: **Health & Community**

SERVICE: **Health & Partnerships**

PERIOD: **Quarter 3 to period-end 31 December 2007.**

1.0 INTRODUCTION

This quarterly monitoring report covers the Health & Partnerships Department third quarter period up to 31 December 2007. It describes key developments and progress against key objectives and performance indicators for the service.

The way in which traffic lights symbols have been used to reflect progress to date is explained within Appendix 5

It should be noted that this report is presented to a number of Policy and Performance Boards. Those objectives and indicators that are not directly relevant to this Board have been shaded grey.

2.0 KEY DEVELOPMENTS

Information Technology

Corporate IT will be working with Health & Community (H&C) and Children' & Young People's Directorate (CYPD) to implement Carefirst 6. The Project Board is due to meet in January and start to progress the implementation of the system.

In addition to implementing Carefirst 6, H&C will commence work on a comprehensive Business Process Review with Corporate IT so that a 3 and 5 year Information Technology Strategy is produced for the Directorate.

Finance

A Croft Divisional Group has been established in line with the CSED (Care Services Efficiency Group) initiative for financial assessments. Work has commenced this quarter with progress made in a number of areas e.g. to improve the management of bad debts, increase methods of payment and recovery through the use of direct debits and a review of the charging policy and the fee rates for Direct Payments. A number of suggestions have been/will be put forward to members to ensure consistent application with neighbouring authorities across the North West in particular for charging policy and direct payment rates.

Direct Payments
The number of service users in receipt of Direct Payments continues to increase and in total has exceeded this years target. At the 31st December there were 190 ongoing service users and 338 carers receiving a carers break using a Direct Payment.

Performance Management
The Directorate has noted which of the 198 National Indicators it will be required to contribute to. Additionally H&C will be working with Health to determine how the 40 indicators outlined in the new Health & Social Care Outcomes Performance Accountability Framework will be supplied. An announcement is expected from CSCI in February 2008 about the way they will measure performance for social care services in 08/09 following their recent merger with the Department of Health and the setting up of the new Care Quality Commission.

Consumer Protection
The financial aspects of the joint Halton/Warrington project aimed at developing a single Trading Standards Service to serve both Boroughs are to be examined by the management consultants KPMG, as one element of their work programme for the Council.

A customised, shared online diary system has been installed for use by the Registration Service, the Contact Centre and the staff at HDL offices. It is envisaged that funeral directors and Halton Hospital will be allowed to make appointments on the system at the end of 2008. The system will also generate certain performance data, which is presently recorded and collated manually.

Contracts and Supporting People
Work has commenced on the development of a Domiciliary Care Strategy. The strategy will take into account long term demand forecasts, the local and regional market and best practise models/innovation in the field of domiciliary care. Service users, carers, providers and wider stakeholders will be consulted to inform the development of the strategy.

Housing
Following the announcement in the Housing Green Paper (July07) of opportunities to bid for housing Growth Point status, a joint expression of interest has been submitted for the Mersey sub region by Halton/St Helens and Liverpool/Wirral. For Halton, Growth Point Status will require the development of 600 units per annum to 2016 (i.e. Draft RSS figure of 500pa + 20% over 8 years).

The refurbishment of Riverview Traveller site has been successfully completed, and the temporary site at Johnsons Lane has now been decommissioned.

3.0 EMERGING ISSUES

Housing

The initial bidding round for Housing Corporation funding to support Housing Association developments in the Borough over the next 3 years has now closed and the outcome is expected in March 08. Key proposals include:

- the continued regeneration of the Castlefields neighbourhood
- the development of extra care housing in Halton View, Widnes

4.0 PROGRESS AGAINST KEY OBJECTIVES / MILESTONES

Total	**6**		**3**		**3**		**0**

Os the six key milestones, three are progressing satisfactorily and three have been rated amber. For further details, please see Appendix 1.

4.1 PROGRESS AGAINST OTHER OBJECTIVES / MILESTONES

There are no other objectives for the service. Nine milestones within the key objectives are designated 'non-key'. Those milestones are routinely reported in quarters 2 and 4. No non-key milestones have been reported by exception this quarter.

5.0 SERVICE REVIEW

Housing
Halton Housing Trust (HHT) completed a review of contracted services carried out by HHT on behalf of HBC. A project team in Health and Community have been reviewing the implications for HBC with a view to presenting options to members on the future of the services by February 2008.

Adults with Learning Disabilities Financial Recovery Plan
The Directorate Management Accounts Team is continuing to provide support to critically review all areas of spend and services provided to identify ways of reducing the current ALD overspend of care services and transport.

6.0 PROGRESS AGAINST KEY PERFORMANCE INDICATORS

Total	**6**		**6**		**0**		**0**

Progress towards targets for all Key indicators is good. For further details refer to Appendix 2

6.1 PROGRESS AGAINST OTHER PERFORMANCE INDICATORS

Total	**22**		**13**		**6**		**3**

Of the other indicators for the service, 13 are progressing satisfactorily. 6 are uncertain and have been rated amber and 3 are causing cause for concern and have been rated red. For further details, please refer to Appendix 3.

7.0 PROGRESS AGAINST LPSA TARGETS

There are no LPSA targets for this service.

8.0 RISK CONTROL MEASURES

During the production of the 2007-08 Service Plan, the service was required to undertake a risk assessment of all Key Service Objectives.

Where a Key Service Objective has been assessed and found to have associated 'High' risk, progress against the application of risk treatment measures is to be monitored, and reported in the quarterly monitoring report in quarters 2 and 4.

9.0 PROGRESS AGAINST HIGH PRIORITY EQUALITY ACTIONS

During 2006/07 the service was required to undertake an Equality Impact Assessment. Progress against actions identified through that assessment, with associated High priority are to be reported in the quarterly monitoring report in quarters 2 and 4.

10.0 APPENDICES

Appendix 1- Progress against Key Objectives/ Milestones
Appendix 2- Progress against Key Performance Indicators
Appendix 3- Progress against Other Performance Indicators
Appendix 4- Financial Statement
Appendix 5- Explanation of traffic light symbols

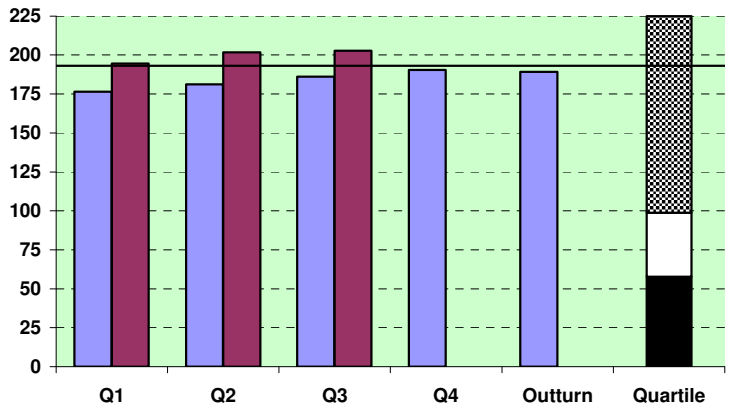
Service Plan Ref.	Objective	2007/08 Key Milestone *Italic = Q2 & Q4 only*	Progress to date*	Commentary
HP1	Ensure that high level strategies are in place, and working to deliver service improvements, and support frontline services to deliver improved outcomes to the residents of Halton	Update the Housing and Homelessness Strategy's to reflect findings of 2006 needs assessment and revised strategy and action plan by March 2008		The first draft of the Housing Strategy has now been completed. Consultation will take place January and February 08, before being submitted to Board for adoption. Development of the Homelessness Strategy has been delayed due to the ongoing review into the future delivery of the service. Production of the strategy will likely slip into 2008/09.
		Review 5 year Supporting People Strategy to ensure diverse and flexible housing support services are in place to support people to live at home by July 2007		Targets met - work ongoing to reconfigure ALD supported living services - good progress to date.
HP2	Work with operational managers to design a performance management framework that will provide high quality performance monitoring and management information,	Develop a performance monitoring framework to meet the requirements of changing National priorities including outcomes and non care managed services by June 2007		A Performance and IT Management Strategy is produced on an annual basis and approved by SMT.

Service Plan Ref.	Objective	2007/08 Key Milestone *Italic = Q2 & Q4 only*	Progress to date*	Commentary
	to help improve service delivery and assist services to continuously improve	Establish an IT strategy in conjunction with Corporate IT so that Carefirst6, Carestore and CareAssess are implemented in accordance with agreed timescales so that Carefirst users have access to more effective data input systems – October 2007		A Performance and IT Management Strategy is produced on an annual basis and approved by SMT.
HP3	To deliver high quality Bereavement, Consumer and Registration Services, that are fit-for-purpose and meet the needs, dignity and safety of the Halton community	Ensure that sufficient longer-term cemetery provision exists to meet the needs of the Halton people, by initially completing an options appraisal and securing member decision by 31 March 2008		The completed options appraisal has been considered by the Safer Halton P & P Board and the Chief Officer's Management Team. Detailed cost benefit analysis work is ongoing to inform the final member decision.
HP4	Ensure that effective financial strategies and services are in place to enable the directorate to procure and deliver high quality value for money services that meet people's needs	Develop, by April 2007, a 3-year financial strategy, to ensure that funding is matched to changing service requirements		Completed. Gross and savings proposals submitted to Corporate Services as part of 2008/09 budget setting round including details details of all future proposed grant spend to be rolled into the base budget. This includes staff in temporary and permanent grant funded posts. Decision awaited by members once all grant announcements are known with strategy to be then amended accordingly.

BVPI 201

Number of adults and older people receiving direct payments

Higher figures represent better performance



Key

- 2006/7
- 2007/8
- Target
- Top 25%
- Middle 50%
- Bottom 25%

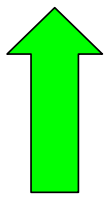
PAF Assessment

Better

Band	5	4	3	2	1
Target	X				
Current	X				

Likely to hit PAF target

Trend



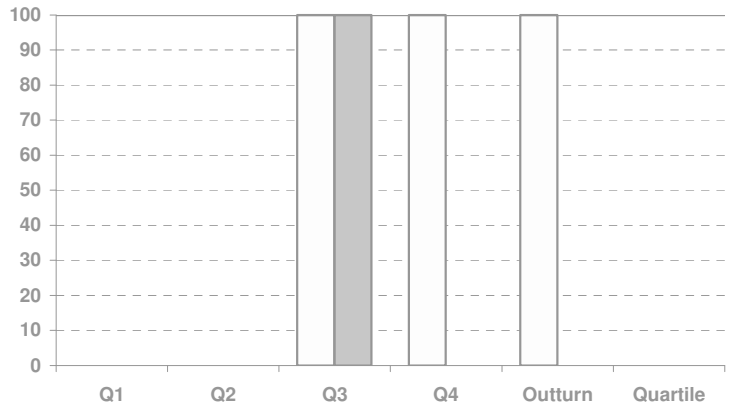
Better than this time last year	Should hit target for the year
	Green

Commentary

The number of adults and older people in receipt of direct payments per 100,000 population is 202.77. This indicator is in relation to client users only. Direct payments used to benefit the carer (I.e respite or carers break) is reported in a separate p

HPLI 4

Percentage of schools (incl. Yr 11 and Sixth pupils) offered a Validate card.

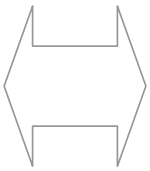


Key

- 2006/7
- 2007/8
- Target
- Top 25%
- Middle 50%
- Bottom 25%

No quartile data available

Trend



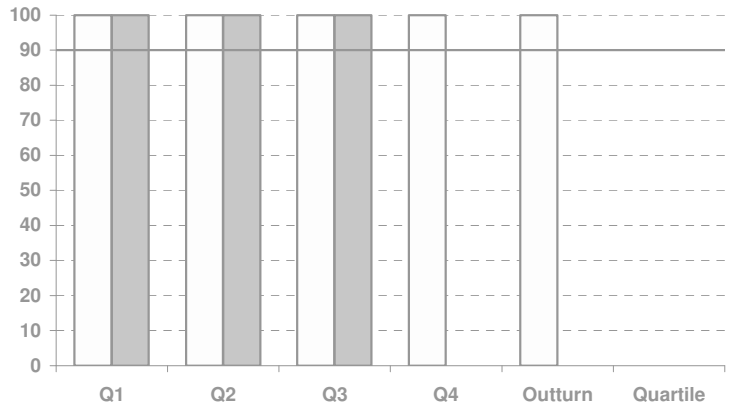
Same as this time last year	Should hit target for the year
	Green

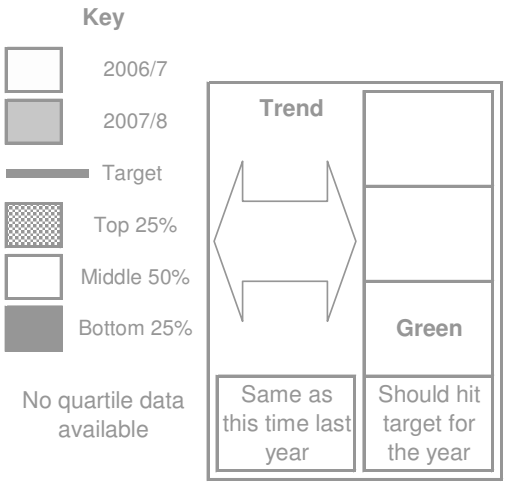
Commentary

All schools have now been offered the Validate proof of age card. However, it should be noted that five secondary schools remain to take-up the offer and without such take-up, the effective roll-out of this proof of age card cannot guaranteed.

HPLI 9

% of times service has offered 2 burial appointments within 9 working days (Dec to Feb inclusive) or within 7 working days at other times



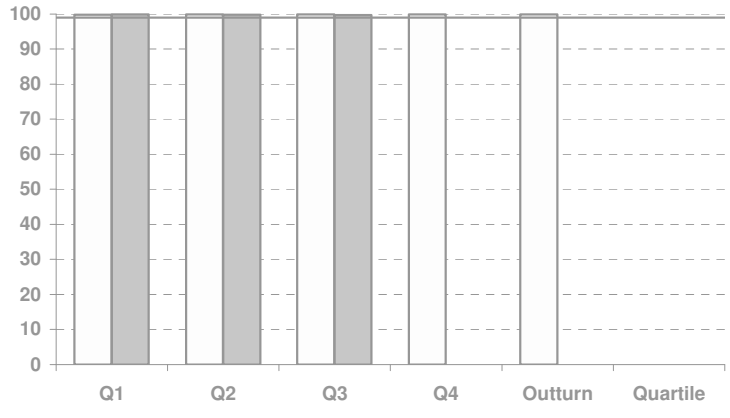


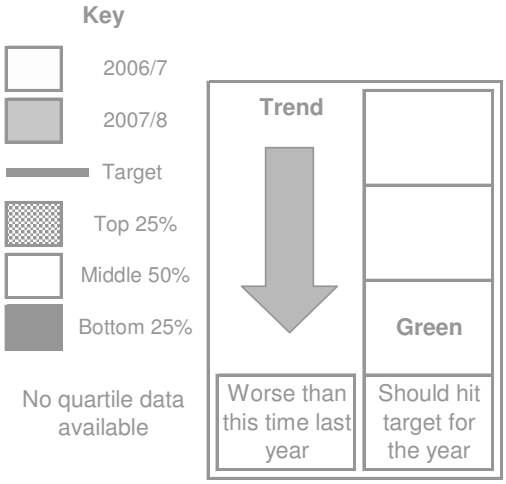
Commentary

This performance relates to 256 burials in the Council's cemetries during the first three quarters of the year.

HPLI 12

Percentage of clients attended to within 10 minutes of their appointment time.



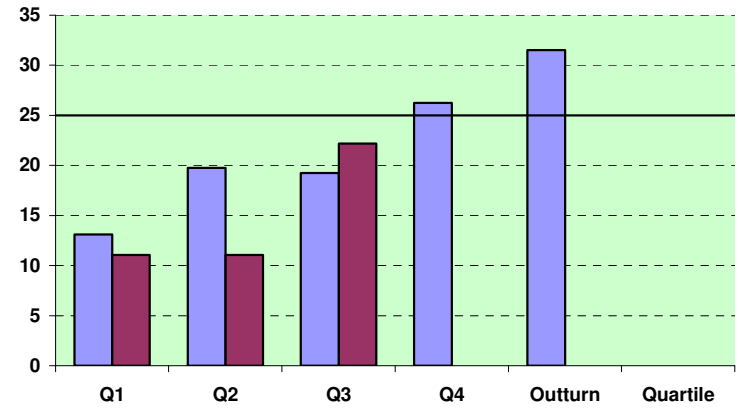


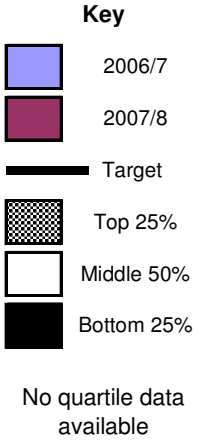
Commentary

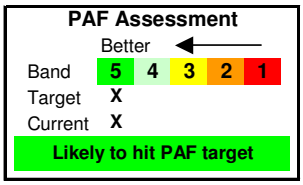
During the period 2537 people were seen with an appointment. Of these, 8 people had to wait longer than the 10 minute standard.

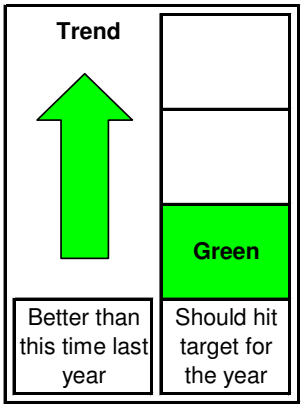
HPPAF 59

No. of assessed social work practice learning days per whole time equivalent social worker







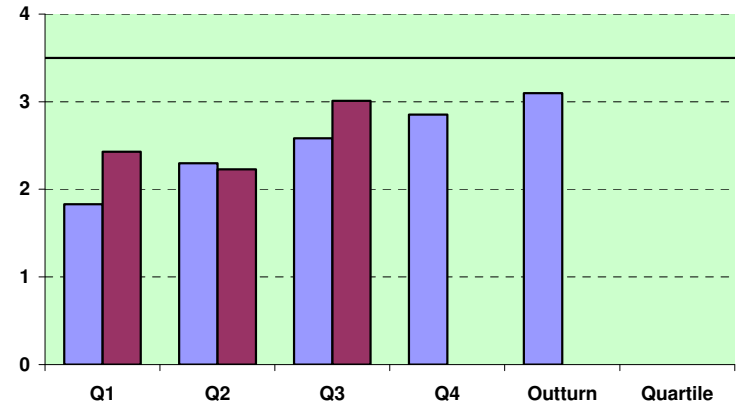


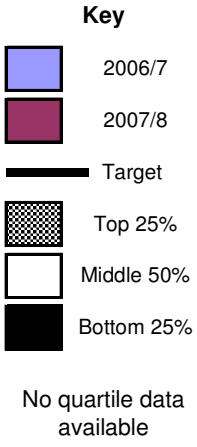
Commentary

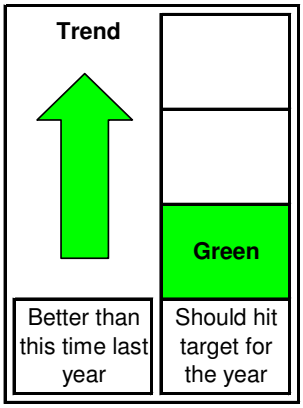
This PI is calculated by dividing the number of placement days; directly provided by HBC and placements provided in the vol sector, by the no of WTE social workers. Last year we were awarded 1080 vols placement days and we can confidently anticipate at le

HPLI 16

% of SSD gross current expenditure on staffing which was spent on training the Council's directly employed staff during the financial year







Commentary

Training budget spend in 3rd quarter, including Post Entry Training costs, against cost centres 6060, 6000, 6200 & 6220, divided by the social care staffing for the 3rd quarter, not including Children Services. T&D Spend £331,409 divided by £10,984,573 mu

Ref	Indicator	Actual 06 / 07	Target 07 / 08	Quarter 3	Progress*	Commentary
	Service Delivery Indicators.					
BVPI 64	Number of private sector dwellings returned into occupation or demolished as a direct result of action by the local authority.	2	2	1		Outputs against this BVPI have always been reliant on Council grants for Landlords to refurbish and let out previously empty dwellings that they acquired. Under current grants policy only accredited landlords can access assistance, and no such applications are in the pipeline. There is therefore a risk of not meeting even the low target that has been set.
BVPI 183a	The average length of stay in B&B accommodation of homeless households that are unintentionally homeless and in priority need (weeks)	5.33	3.0	3.45		The average period has reduced throughout 2007/08 from the 5.33 weeks reported for 2006/07, and should continue to decline due to the introduction of a number of homelessness prevention initiatives, However quarter 4 is traditionally a period of high homelessness presentations and meeting the 3 week overall target may be difficult to achieve.
BVPI 202	Number of Rough Sleepers	0	0	N/K		A consultation with stakeholder organisations will be undertaken at year-end to inform the year-end BVPI

Ref	Indicator	Actual 06 / 07	Target 07 / 08	Quarter 3	Progress*	Commentary
BVPI 203	The % change in the average number of families placed in temporary accomodation	18.75%	-15%	-10.3%		This BVPI is calculated by averaging the numbers of household (accepted as homeless and in priority need) with children or an expectant mother, in temporary accommodation at the end of each quarter in 2007/08, and then comparing that figure with the same calculation for the previous year. A complete picture will not therefore be available until year-end but a snapshot comparison of Q1-3 this year to Q1-3 last year shows a 10.3% decrease, which is a move in the right direction compared to the +18.75% in 2006/07.
BVPI 213	The number of households who considered themselves as homeless, who approached the LA housing advice service, and for whom housing advice casework intervention resolved their situation (expressed as the number divided by the number of thousand households in the Borough)	0.42	1.42	0		The Directorate established a Homelessness Welfare/Prevention Team earlier this year to assist in the prevention of homelessness. Although the service can evidence 118 successful interventions (equivalent to a BVPI indicator of 2.46), these outcomes cannot be included for BVPI purposes due to the way in which the service is funded.
HP/ LPI 2	Percentage of Social Services working days/shifts lost to sickness absence during the financial year.	9.21%	8%	9.11		This figure is for April – November 07. Figures for the full period April – December 07 will be available from approximately 16th January 08
HP/ LPI 1	Percentage of SSD directly employed staff that left during the year.	7.69%	8%	9.32		Figure updated using actual leavers for September 2007

Ref	Indicator	Actual 06 / 07	Target 07 / 08	Quarter 3	Progress*	Commentary
	Cost & Efficiency Indicators.					
HP/ LPI 15	% of SSD directly employed posts vacant on 30 September	11.78%	9.5%	14.89%		The above % figure relates to vacancies as at 30th September 2007 within Adults, Health and Partnerships and Older People, and is based on the number of posts within all service areas. As Part of the continued drive to improve retention in the Health and Community Directorate, a new Recruitment and Retention Strategy is currently being produced.
HP/LPI 6	% of HR Development Strategy Grant spent on Council staff	73%	73%	42%		Due to the revised allocation of the HRD Grant on the independent sector (£35k), the soend on Council staff is on track for 64.5% by 31st March 2008.

HEALTH & COMMUNITY - HEALTH AND PARTNERSHIPS

Revenue Budget as at 31st December 2007

	Annual Revised Budget £'000	Budget To Date £'000	Actual To Date £'000	Variance To Date (overspend) £'000	Actual Including Committed Items £'000
Expenditure					
Employees	3,312	2,442	2,300	142	2,311
Premises Support	164	0	0	0	0
Other Premises	77	40	32	8	32
Supplies & Services	579	371	373	(2)	438
Training	79	31	24	7	33
Transport	24	18	16	2	16
Departmental Support Services	132	0	0	0	0
Central Support Services	1,052	0	0	0	0
Agency Related	106	85	77	8	146
Supporting People Payments to Providers	9,233	6,021	6,017	4	6,017
Asset Charges	905	0	0	0	0
Total Expenditure	**15,663**	**9,008**	**8,839**	**169**	**8,993**
Income					
Sales	-13	-10	-10	0	-10
Receivership	-18	-13	-47	34	-47
Rents	-64	-61	-118	57	-118
HR Development Grant	-99	-99	-99	0	-99
National Training Strategy Grant	-159	-159	-159	0	-159
Information Management Grant	-103	-10	-8	(2)	-8
Supporting People Main Grant	-9,233	-6,740	-6,736	(4)	-6,736
Supporting People Grant	-132	-90	-91	1	-91
Disabled Facilities Grant	-40	-30	-39	9	-39
Departmental Support Services	-3,990	0	0	0	0
Other Grants	-218	-135	-239	104	-239
Re-imbursements	-91	-91	-147	56	-147
Other Income	-84	0	0	0	0
Total Income	**-14,244**	**-7,438**	**-7,693**	**255**	**-7,693**
Net Expenditure	**1,419**	**1,570**	**1,146**	**424**	**1,300**

Comments on the above figures:

In overall terms the revenue spending (including commitments) at the end of quarter 3 is £270k below budget profile. This, in the main, is due to expenditure on employees being less than anticipated at this stage of the year and also to the overachievement of income.

Salary costs are below budget by £131k (including commitments), which is due to a number of posts being vacant at the start of the financial year. Several of these posts are now filled therefore the staffing budget is not expected to be significantly under budget profile at year-end. The pay award for 2007/08 has now been agreed and was paid to employees in December, therefore is included within the actual to date figure.

The commitment figure for supplies & services relates to further IT costs. It is anticipated this area will be over budget profile at year-end.

Commitments for agency & related expenditure refer to bed & breakfast invoices not yet received. This area is also expected to be over budget profile at year-end.

Receivership income has increased following a review of the service user needs, changing their status from appointee to a receivership service in line with the Mental Capacity Act. This has lead to the recovery of higher charges this year.

Rents received during the period are currently overachieving budget profile especially for the Riverview site, where rents are higher than anticipated at budget setting time. Included within the £118k rents received to date is a one off payment of £17k in respect of rent recovered relating to two prosecutions for non payment of rent from previous years.

The Disabled Facilities Grant has also overachieved against the current budget profile. This represents the client contributions made for adaptations and it is anticipated this will continue throughout quarter 4.

Other grants include Community Rollout grant £100k for the Roy Castle appeal & other projects & Supporting People grant for both the ALD reconfiguration project £41k and £19k for the rent deposit scheme.

Reimbursement income has also overachieved against budget profile. This includes £34k for practice placements, of which £22k was carried forward from 2006/07 and also £10k for Local Involvement Network.

Health And Partnerships

Capital Projects as at 31st December 2007

	2007/8 Capital Allocation £'000	Allocation To Date £'000	Actual Spend To Date £'000	Allocation Remaining £'000
Private Sector Housing				
Renovation/Modernisation Grants	586	300	125	461
Disabled Facilities Grants	942	700	251	691
Home Link	10	4	0	10
Energy Promotion	75	50	21	54
Castlefield Equity Release Loans	565	65	78	487
West Bank Neighbourhood Renewal Assessment	4	4	4	0
Riverview Refurbishment	1,272	1,267	1,187	85
Belvedere Repairs	28	28	0	28
Adaptations Initiative	92	30	0	92
Uncommitted	122	0	0	122
Total Expenditure	**3,696**	**2,448**	**1,666**	**2,030**

HEALTH & COMMUNITY – LOCAL STRATEGIC PARTNERSHIP BUDGET

Budget as at 31st December 2007

	Annual Budget £'000	Budget To Date £'000	Actual To Date £'000	Variance To Date (Overspend) £'000	Actual Including Committed Items £'000
Priority 1 Healthy Halton					
Health Awareness	40	30	0	30	0
Recipe For Health	29	22	14	8	14
Five A Day Programme	3	2	0	2	0
Vulnerable Adults Task Force	592	444	328	116	328
Vol. Sector Counselling Proj.	39	29	19	10	19
Info. Outreach Services	34	26	17	9	17
Reach for the Stars	34	26	16	10	16
Carer Support Development	49	37	25	12	25
Healthy Living Programme	98	73	47	26	47
Advocacy	63	48	41	7	41
Priority 2 Urban Renewal					
Landlord Accreditation Programme	28	21	28	(7)	28
Priority 5 Safer Halton					
Good Neighbour Pilot	27	20	13	7	13
Grassroots	18	14	5	9	5
Development	43	32	0	32	0
Alcohol Harm Reduction					
Domestic Violence	77	58	18	40	18
Total Expenditure	**1,174**	**882**	**571**	**311**	**571**

HEALTH & COMMUNITY

Capital Budget as at 31st December2007

	2007/08 Capital Allocation £000	Allocation To Date £000	Actual Spend To Date £000	Allocation Remaining £000
Social Care & Health				
DDA	24	2	0	24
LDDF	7	7	0	7
Women's Centre & Other Projects	178	100	102	76
PODS (Utilising DFG)	40	0	0	40
Bredon Improvements	24	24	32	(8)
Improvement of Care Homes	150	100	141	9
Bridgewater Capital Improvements	1	1	0	1
Refurbishments to John Briggs House	90	30	6	84
Door Entry System – John Briggs	2	2	2	0
IT for Mobile Working	12	12	0	12
Total Spending	528	278	283	245

It is anticipated the capital budget will be fully committed by the end of the year.

FAIR TRADING & LIFE EVENTS

Revenue Budget as at 31st December 2007

	Annual Revised Budget £'000	Budget To Date £'000	Actual To Date £'000	**Variance To Date** (overspend) £'000	Actual Including Committed Items £'000
Expenditure					
Employees	796	600	590	10	594
Premises Support	145	0	0	0	0
Other Premises	252	84	88	(4)	101
Hired & Contracted Services	52	35	32	3	51
Supplies & Services	95	73	68	5	75
Transport	19	14	15	(1)	15
Support Services	575	0	0	0	0
Asset Charges	54	0	0	0	0
Total Expenditure	1,988	**806**	**793**	**13**	**836**
Income					
Sales	-86	-59	-60	1	-60
Fees & Charges	-630	-442	-437	(5)	-437
Grants	-1	-1	-12	11	-12
Rents	-4	-3	-3	0	-3
Support Recharge	-202	0	0	0	0
Total Income	-923	**-505**	**-512**	**7**	**-512**
Net Expenditure	1,065	**301**	**281**	**20**	**324**

Comments on the above figures:

In overall terms the revenue spending to the end of quarter 3 is below the budget profile.

Expenditure on employees is likely to be slightly underspent. The 2007/08 Budget originally included a £75,000 saving item relating to the proposed outsourcing of the Consumer Protection Service. However, we now know that even if this proposal materialises, no savings will be made within the current financial year. As a consequence, the £75,000 savings target has been removed from the 2007/08 budget, and the savings will be met from elsewhere within the Health and Community Directorate. However, the savings target remains built into the Consumer Protection 2008/09 base budget, so measures will need to be implemented to ensure that this target is met.

A vacant post was kept unfilled in the current financial year with a view towards contributing to the original savings item, and the current net underspend on employee costs for the first three quarters is in the region of £10,000.

Income budgets are running broadly to target at this stage in the year, and Cemeteries and Crematoria income are currently running at the anticipated income target for the first three quarters. However the previous two quarters income for Cemeteries and Crematoria were marginally above target, so the third quarter's income has not achieved the same level of performance against estimate. Due to the nature of the service it is difficult to estimate whether income targets will be fully realised.

The over-achievement of grants income relates to a payment received from the Home Office for copyright enforcement. This grant is fully committed to be spent during the year.

Capital Projects as at 31st December 2007

	2007-08 Capital Allocation £'000	Allocation To Date £'000	Actual Spend To Date £'000	Allocation Remaining £'000
Cemeteries	50	50	52	-2
Headstone Safety Programme	50	36	24	26

Bereavement Services Capital Programmes
Phase 3 of the western strip works cost slightly more than the £50,000 capital allocation but this small overspend will be offset by a corresponding underspend in the headstone safety programme.

Commitments in the system for the headstone safety programme plus anticipated Quarter 4 spend will ensure that this budget is fully spent by year-end.

LSP, External or Grant Funded Items as at 31st December 2007

	Annual Revised Budget £'000	Budget To Date £'000	Actual To Date £'000	**Variance To Date** (overspend) £'000	Actual Including Committed Items £'000
Bill Payment Service	33	16	17	(1)	17
Budgeting Skills Project	33	24	15	10	15

The traffic light symbols are used in the following manner:

		Objective	Performance Indicator
Green		Indicates that the objective is on course to be achieved within the appropriate timeframe.	Indicates that the target is on course to be achieved.
Amber		Indicates that it is unclear at this stage, due to a lack of information or a key milestone date being missed, whether the objective will be achieved within the appropriate timeframe.	Indicates that it is either unclear at this stage or too early to state whether the target is on course to be achieved.
Red		Indicates that it is highly likely or certain that the objective will not be achieved within the appropriate timeframe.	Indicates that the target will not be achieved unless there is an intervention or remedial action taken.

QUARTERLY MONITORING REPORT

DIRECTORATE: **Health & Community**

SERVICE: **Older People's Services**

PERIOD: **Quarter 3 to period-end 31 December 2007.**

1.0 INTRODUCTION

This quarterly monitoring report covers the Older People's Services Department third quarter period up to 31 December 2007. It describes key developments and progress against key objectives and performance indicators for the service.

The way in which traffic lights symbols have been used to reflect progress to date is explained within Appendix 6

2.0 KEY DEVELOPMENTS

Single Point Of Access pilot continues, end date still envisaged for March 2008. Following evaluation the PCT will consider options for further development.

SMT report for review of day services completed. Oak meadow day centre will be reviewed as part of the review of Oak meadow, linking to the overall review and redesign of day services across Halton- SMT report will be completed March 2008. Sure start is now operational, and self-assessment and self-referrals are available.

The implementation of the Mental Capacity Act 2007 continues through the multidisciplinary Steering Group. The Deprivation of Liberty Safeguards are now due to be implemented in April 2009 and a process is in place to deliver the training, systems and procedures and publicity for this. Specialist training is being set up for specific areas of the Mental Capacity Act and flowcharts have been developed. Agreement has been reached between Halton and St Helens Borough Councils and the PCT to pool resources to establish a Mental Capacity Act project lead role; this post will be based within St Helens Council but serve both communities.

Emergency Duty Team (EDT): this service continues to operate successfully. A second phase IT solution for the transfer of information is in development and an operational group has been set up to manage interface issues between the team and daytime services. The EDT Steering Group has now been re-formed as a Partnership Board.

Carers assessments: these continue to be the subject of considerable attention, with monthly meetings of all operational services to ensure that systems and procedures for assessing carers needs are working smoothly. 2007/08 is the "dry run" for the LPSA target of 600 carers receiving a service as a result of an assessment; at this stage the target is already likely to be exceeded. In addition a national performance target relating to carers assessments has also been exceeded.

Bridge Building: it has now been agreed that this service will be mainstreamed and extended in 2008, following its successful evaluation.

Four newly qualified Occupational Therapists have now taken up posts within the Independent Living Team. Three of these posts are permanent and one is temporary.

The proposal for the evaluation of the self-assessment scheme for equipment was delayed due to complexities experienced by Personal Social Services Research Unit in analysing the national pilot schemes. The proposal is now expected in January and the evaluation will benefit from the learning from the national evaluation.

3.0 EMERGING ISSUES

Work has commenced on the development of a Domiciliary Care Strategy. The strategy will take into account long term demand forecasts, the local and regional market and best practise models/innovation in the field of domiciliary care. Service users, carers, providers and wider stakeholders will be consulted to inform the development of the strategy.

The Continuing Health Care National Guidance has been in place since 1st October. A joint PCT/LA strategy group has been established to review existing local pathways in light of the new guidance. Joint training for staff across the whole system is being delivered.

Winter pressures beds have been opened on the Halton hospital site to enable transfer of patients prior to decisions about longer-term care needs; this will address the reduction in acute beds and prevent hospital delays.

A business plan for the development of an Intermediate Care Unit on the Halton Hospital site is currently being completed, jointly with the PCT. Dependant on decisions at PCT board, the unit is planned to be operational from April 2008.

The extension of the period for the introduction of the Deprivation of Liberty Safeguards has given the opportunity to develop a more structured approach over a period of time for the implementation. A multidisciplinary scoping meeting took place in December 2007, which

identified the processes which will need to take place and these will be developed into a more formal action plan in early 2008.

The option of a local retailer piloting an outlet at the Independent Living Centre is being explored. The Care Services Efficiency Development (CSED) team have identified two possible retailers and have agreed to make initial contacts as part of the national Transforming Community Equipment Services initiative.

A growth bid to maintain and expand the Adult placement Service has been submitted.

4.0 PROGRESS AGAINST KEY OBJECTIVES / MILESTONES

Total	**19**		**18**		**1**		**0**

Of the 19 key milestones for the service, 18 are progressing satisfactorily and one is rated amber. For further details, please refer to Appendix 1.

4.1 PROGRESS AGAINST OTHER OBJECTIVES / MILESTONES

There are no other objectives for the service. 21 milestones within the key objectives are designated 'non-key'. Those milestones are routinely reported in quarters 2 and 4. 10 of the 21 non-key milestones are being reported by exception this quarter and appear in Appendix 1. They are re designated by the use of *italic* text.

5.0 SERVICE REVIEW

Interim report to SMT was presented in October, including the project plan. A further report will be presented in January outlining the dependencies across council areas, which will require SMT decisions (i.e. IT). The final report on potential long-term efficiencies will be presented to SMT April 2008.

Review of Oak meadow on target for completion in April 2008.

Gold Standard for Intermediate Care, including a performance management framework completed. Initial mapping of existing services completed

The impact upon the Adult Hospital Team, of reductions in acute beds shift from North Cheshire Hospital Trust to Whiston Hospital and the implementation of the new continuing care guidance, has presented

significant capacity issues for the team. 2 new social work posts will be established by April 2008, to work across both sites and in the community on Continuing Health Care (CHC) assessments, to resolve this issue. Review of Home Care Pathways continues to be progressed.

6.0 PROGRESS AGAINST KEY PERFORMANCE INDICATORS

Total	**9**		**7**		**1**		**0**

Progress towards targets for Key indicators is generally good. One indicator has been rated amber – PAF E82, and quarter 3 data for BVPI 56 is not currently available, this indicator will be reported in quarter 4. For further details please refer to Appendix 2.

6.1 PROGRESS AGAINST OTHER PERFORMANCE INDICATORS

Total	**14**		**7**		**1**		**1**

Of the 14 Other indicators, 7 are progressing satisfactorily. Data is unavailable for 5 of these PI's at the current time, and 2 are being reported by exception as data was unavailable in quarter 2. For further details, please see Appendix 3.

7.0 PROGRESS AGAINST LPSA TARGETS

Progress against the LPSA targets for emergency bed days and support for carers is detailed in this monitoring report. For information and commentary, please refer to Appendix 4.

8.0 RISK CONTROL MEASURES

During the production of the 2007-08 Service Plan, the service was required to undertake a risk assessment of all Key Service Objectives.

Where a Key Service Objective has been assessed and found to have associated 'High' risk, progress against the application of risk treatment measures is to be monitored, and reported in the quarterly monitoring report in quarters 2 and 4.

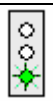
9.0 PROGRESS AGAINST HIGH PRIORITY EQUALITY ACTIONS

During 2006/07 the service was required to undertake an Equality Impact Assessment. Progress against actions identified through that assessment, with associated High priority are to be reported in the quarterly monitoring report in quarters 2 and 4.

10.0 APPENDICES

Appendix 1- Progress against Key Objectives/ Milestones
Appendix 2- Progress against Key Performance Indicators
Appendix 3- Progress against Other Performance Indicators
Appendix 4- Progress against LPSA targets
Appendix 5- Financial Statement
Appendix 6- Explanation of traffic light symbols

Service Plan Ref.	Objective	2007/08 Key Milestone *Italic = Q2 & Q4 only*	Progress to date*	Commentary
OPS1	Plan and commission / redesign services to meet the needs of the local population	Monitor implementation of Community Bridge Building Service as part of the Day Services Strategy and evaluate by March 2008		A total of 20 referrals to the Bridge Building Service have been made by Bridgewater Day Centre.
		Future role of Bridgewater & Oakmeadow identified within overall Day Services Review by July 2007 to ensure that we make best of all the community facilities available to the Council.		Thirty-five reviews have been undertaken. Those people who need ongoing day care services and those who can link to community services have been identified and work is underway to link users to appropriate services. Consideration will be given to the future role of Bridgewater and Oakmeadow as part of the wider review of all day services.
		Priorities identified for improved accessibility by physically disabled people to community centres and other buildings by June 2007.		Identified and report sent to Culture, Leisure and Sport Division for further action.
		Tender completed and contract awarded for one EMI respite bed by June 2007 to ensure that EMI respite is available in Halton.		Tender completed. Two tenders received. Neither tender met requirements. The Commissioning Manager to reconsider future need.

Service Plan Ref.	Objective	2007/08 Key Milestone *Italic = Q2 & Q4 only*	Progress to date*	Commentary
OPS1 Continued		Increase capacity for Adult Placement Service to 24 carers by September 2007 to ensure that this service option is available as an option to those who could benefit from it.		There are now 20 approved Adult Placement Carers and a further 3 will be considered for approval at the next Panel meeting to be held in February 2008.
		Accessible Homes Register established by September 2007 to ensure adapted homes are able to be managed across the borough and can be matched quickly against individuals.		A spreadsheet to register available adapted properties and people who require adapted properties has been developed. Work is being carried out in partnership with the relevant Registered Social Landlords to ensure the principles of the Accessible Homes Register are included in the Choice Based Lettings Scheme being developed for Halton.
		Report back on learning for Halton from CSED improving care management efficiency project by October 2007, report to identify opportunities to learn from best practice.		Report presented to SMT in October, project plan in place. Further reports to SMT in January and April 2008.

Service Plan Ref.	Objective	2007/08 Key Milestone *Italic = Q2 & Q4 only*	Progress to date*	Commentary
OPS1 Continued		Implement the Payments and Expenses Policy and Procedure for service users and carers to encourage and recognise their participation in service development initiatives by June 2007		Implemented. Payments continue to be made to 4 Adult Placement Service panel members for each attendance at the approval panel.
OPS2	To work in partnership and strengthen governance and joint working arrangements	*Draw up delivery plan for Local Area Agreement by May 2007*	Refer to comment	*Events have moved on since the 2007 LAA was finalised, and currently we are working to a new LAA that will supersede the 2007 one. The work for that is progressing well and outcome areas have been agreed which are more far reaching than the previous ones and more aligned to the modernisation that older peoples services are keen to achieve.*
		Agree delivery plan for Local Area Agreement with partners by July 2007	Refer to comment	*As above*
		Contribute to the implementation of the development of 'Change for the Better', the 5BP's new model of care for older peoples mental health services, which aims to reduce reliance on in-patient beds and develop services based on recovery and social inclusion, by March 2008.		OP MH project manager in post.

Service Plan Ref.	Objective	2007/08 Key Milestone *Italic = Q2 & Q4 only*	Progress to date*	Commentary
OPS2 Continued		*Agree a process for the review of therapy provision across Halton with PCT by March 2008 to ensure that the level of need for therapy input can be met.*		Halton and St Helens PCT has prioritised a review of therapy services in its 08/09 commissioning business plan. Work will commence before March 08 to establish the review process. This joint piece of work will feed into 2009/10's service plan.
		Launch directory of services for older people by June 2008 to provide single easily accessible source of information on service is available to older people and staff.		Draft paper based Directory of Services has been completed, amendments and additions due for completion in early January.
		Launch ageing well strategy by June 2008 to ensure that Halton has a single approach to aging within a consistent framework and intentions.		Members agreed the Strategy in November 2007 and the strategy will be printed and launched in Early 2008.
		Redesign RARS and IC pathways and processes to take into account the new PCT and commissioning priorities i.e. more focus on preventing hosp admission, by December 2007.		Gold standard and initial mapping completed. Report to PCT board to be completed by April 2008.
		Representation of Practice Based Commissioning (PBC) Bodies identified and agreed by June 2007		P Barron current representative on PBC Boards. Positive investment already achieved by Runcorn PBC investing in additional social care staff to support primary care.

Service Plan Ref.	Objective	2007/08 Key Milestone *Italic = Q2 & Q4 only*	Progress to date*	Commentary
OPS2 Continued		Joint policy, Pathway and training for Moving and Handling in place to improve coordination of services that support moving and handling by August 2007.		The Moving and Handling Policy is in draft format awaiting ratification by the partner agencies. An analysis of the use of external moving and handling advisers is being carried out. Due to personnel changes in Halton and St Helens PCT the option to recruit a joint specialist moving and handling adviser is being considered.
		Identify options for future HICES/Equipment with other local authorities and PCTs. By November 2007 to improve efficiency and reduce duplication.		Exploring options with other local authorities and PCTs is ongoing. Meeting with Warrington Council has taken place and further meeting with Halton and St Helens PCT planned for January. Options being considered need to take account of Government's Transforming Community Equipment Services initiative that is proposing the introduction of a retail model.

Service Plan Ref.	Objective	2007/08 Key Milestone *Italic = Q2 & Q4 only*	Progress to date*	Commentary
OPS2 Continued		*SAP rolled out to older peoples community social work teams by October 2007 in line with government policy.*		*Unforeseeable delays with the procurement process for the paper based system, resulted in a delay in delivery (previously expected for October, now confirmed for December 07). Official launch event organised for 30th January, with implementation of the folders and EASYCare documentation to commence from 4th February 2008. Currently involved in discussions with Primary Care Trust, St Helens Council and Health Informatics to progress issues related to the implementation of an electronic system for SAP within Halton, which includes future IT implications, hosting, etc. decisions expected by the end of December 2007. Agreement obtained from Health to fund 50% towards the costs for E-SAP.*
		Agree and implement Joint Medication Policy with PCT by December 2007.		Medication Policies have recently been agreed with Oakmeadow and Domiciliary Carer Services and are currently in the process of being drawn up for Bridgewater and the Adult Placement Service. Following which the development of a Joint Medication policy with the PCT will be progressed.

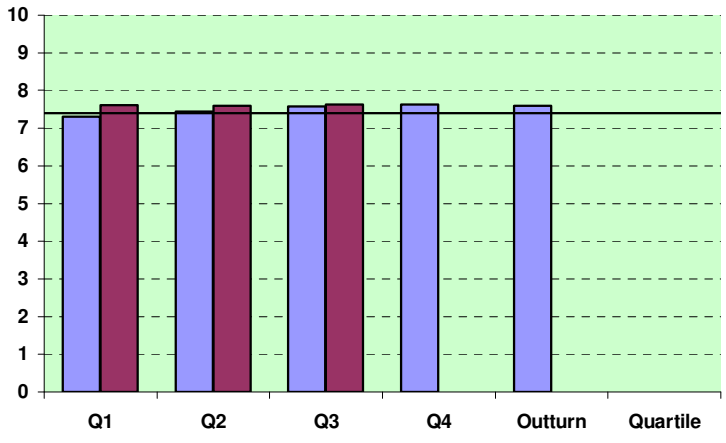
Service Plan Ref.	Objective	2007/08 Key Milestone *Italic = Q2 & Q4 only*	Progress to date*	Commentary
OPS2 Continued		Complete Adaptations Review by October 2007 to ensure improved system and processes for adaptations.		Completed. To date thirteen changes to the a daptation process have been agreed and some of these have already been implemented. The staff structure for the service has been agreed and will be implemented in April 2008. The refurbished accommodation is due to be available in March and plans are being developed for the staff to be relocated**.**
		Review social work provision within OPMH Team by January 2008 (dependent on future arrangements with 5BP).		New Project Manager is reviewing case mix and skill mix of the OP MH Community Team. Funding has been consolidated for the Team Manager post. Review will yield information to be used to inform future re-design options by March 08
		Participate in the Urgent Care Pathway redesign work due to complete end of May 2007 to ensure social care perspective on how that journey can be improved and resourced.		Single point pilot in progress. Urgent Care Pathway redesign on target for completion in March 2008.
OPS3	Ensure services are needs-led and outcome focussed and keep service users and carers, and those from hard to reach groups (including the black and minority ethnic community), at the centre of	Meet the Carers LPSA target to ensure carers receive the help, support and services they need by March 2008.		LPSA target will be met in Older Peoples services.

Service Plan Ref.	Objective	2007/08 Key Milestone *Italic = Q2 & Q4 only*	Progress to date*	Commentary
	services	Create new sub-group of older people LIT and delegate carers grant to that group to manage by April 2007 to ensure better co-ordination and range of services for older carers and carers of older people.		Sub Group continues to ensure carers grant allocation is used effectively to support the needs of older peoples carers.
OPS3 Continued		*A new services/initiative developed with Halton & St Helen's PCT to identify carers via GP practices, hospitals and clinics, by December 2007 and ensure that older carers and carers of older people are identified.* *Work with Halton & St Helen's PCT to improve the physical health of carers by Sept*		Proposals still to be agreed by the Local Medical Committee. PCT have agreed to fund an information officer for GP practices to cover both Halton and St helens The PCT have now agreed 3 year funding for Carers Services

Service Plan Ref.	Objective	2007/08 Key Milestone *Italic = Q2 & Q4 only*	Progress to date*	Commentary
OPS3 Continued		Increase the number of carers provided with assessments leading to provision of service to ensure Carers needs are met by March 2008		A detailed process has been established to ensure an improvement in the number of carers who are assessed who carry on to receive a service. This has involved redesigning posts to ensure that there are specialist carers assessors in each service area, setting individual targets for staff within teams (particularly OP services) and ensuring that data collection is accurate. This has resulted in a significant improvement in reported services for carers and the 2009 LPSA target remains on line for achievement.
		Work with Cheshire Halton & Warrington Racial Equality Council (CHWREC) to increase carers services to the Black & Minority Ethnic (BME) community by June 2007		Work continues with CHWREC regarding the promotion of carer services delivered by the Carers Centres etc to the BME community
		Implement new model for carers Centres to increase access to additional funding by March 2009		New model has been developed and is due to be presented to Health Halton Policy & performance Board on 15.1.08 for comment

OPPSIPAF C29

Adults with physical disabilities helped to live at home



Key

- 2006/7
- 2007/8
- Target
- Top 25%
- Middle 50%
- Bottom 25%

No quartile data available

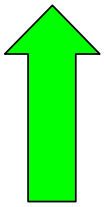
PAF Assessment

Better ←

Band	5	4	3	2	1
Target	X				
Current	X				

Likely to hit PAF target

Trend



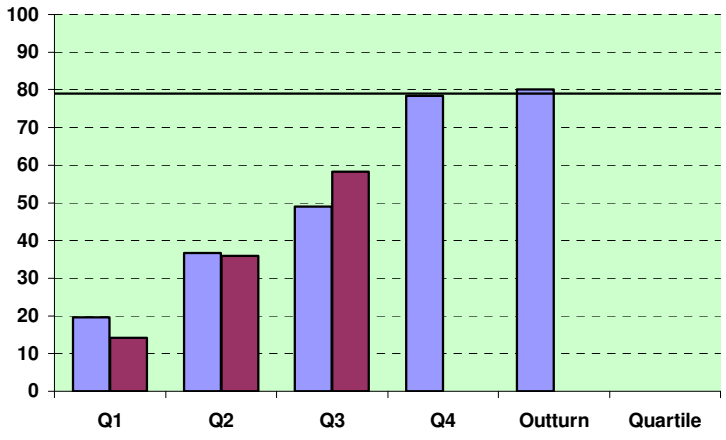
Better than this time last year	Should hit target for the year
	Green

Commentary

Currently, 7.63 adults with physical disabilities are helped to live at home per 1000 population. Target has already been exceeded. This performance will be awarded a PAF Band 5.

OPPSIPAF C72

Admissions of supported residents aged 65+ to permanent residential/nursing care (per 10,000 population)



Key

- 2006/7
- 2007/8
- Target
- Top 25%
- Middle 50%
- Bottom 25%

No quartile data available

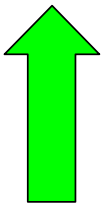
PAF Assessment

Better ←

Band	5	4	3	2	1
Target	X				
Current	X				

Likely to hit PAF target

Trend



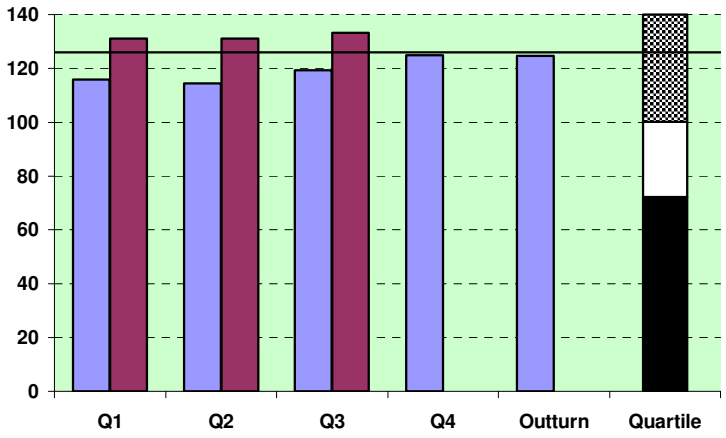
Better than this time last year	Should hit target for the year
	Green

Commentary

Current performance of 58.37 admissions per 10,000 population is in line with the target and maximum PAF Band 5.

BVPI 54

Over 65s helped to live at home per 1000 population



Higher figures represent better performance

Key

2006/7
2007/8
Target
Top 25%
Middle 50%
Bottom 25%

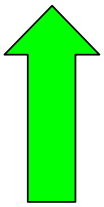
PAF Assessment

Better

Band	5	4	3	2	1
Target	X				
Current	X				

Likely to hit PAF target

Trend



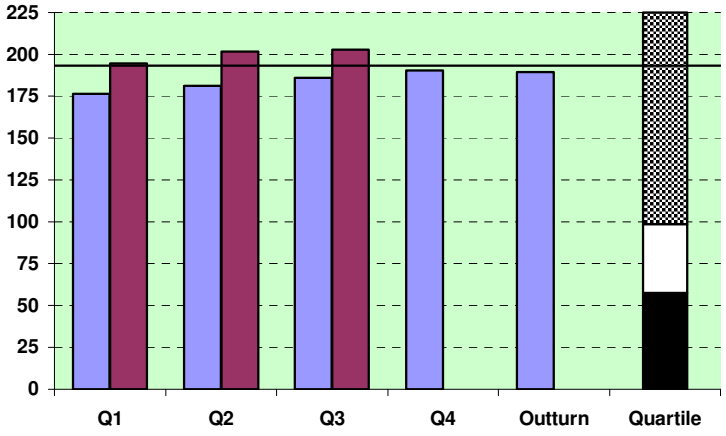
Better than this time last year	Should hit target for the year
	Green

Commentary

Currently, 133.07 older people are helped to live at home per 1000 population. Target has already been exceeded. Current performance will be awarded a PAF Band 5.

BVPI 201

Number of adults and older people receiving direct payments



Higher figures represent better performance

Key

2006/7
2007/8
Target
Top 25%
Middle 50%
Bottom 25%

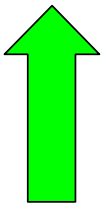
PAF Assessment

Better

Band	5	4	3	2	1
Target	X				
Current	X				

Likely to hit PAF target

Trend



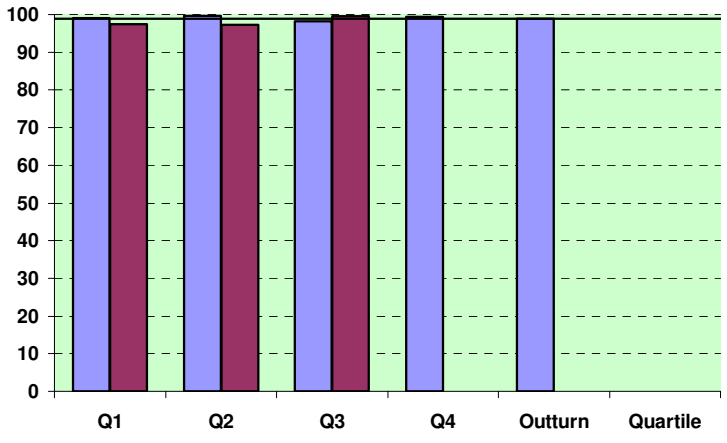
Better than this time last year	Should hit target for the year
	Green

Commentary

The number of adults and older people in receipt of direct payments per 100,000 population is 202.77. This indicator is in relation to client users only. Direct payments used to benefit the carer (I.e respite or carers break) is reported in a separate performance indicator to measure carers services. Current performance would be awarded a PAF Band 5. Target exceeded.

OPPSIPAF D39

Percentage of people receiving a statement of their needs and how they will be met.



Key

2006/7

2007/8

Target

Top 25%

Middle 50%

Bottom 25%

No quartile data available

PAF Assessment

Better

Band	5	4	3	2	1
Target		X			
Current		X			

Likely to hit PAF target

Trend

Better than this time last year

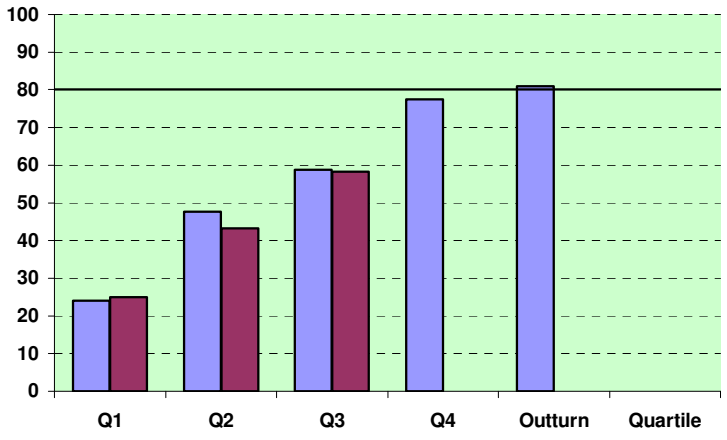
Should hit target for the year — **Green**

Commentary

Currently, 99.50% of clients receiving services during the year to date have received a copy of their care plan. This area of performance is still subject to continual monitoring and all operational teams are informed on a monthly basis of those clients not in receipt of a copy of their care plan. Current performance would be awarded a PAF Band 4, movement to Band 5 requires performance of 100%.

OPPSIPAF D40

Clients receiving a review as a %age of adult clients receiving a service



Key

2006/7

2007/8

Target

Top 25%

Middle 50%

Bottom 25%

No quartile data available

PAF Assessment

Better

Band	3	2
Target		X
Current	X	

Likely to hit PAF target

Trend

Worse than this time last year

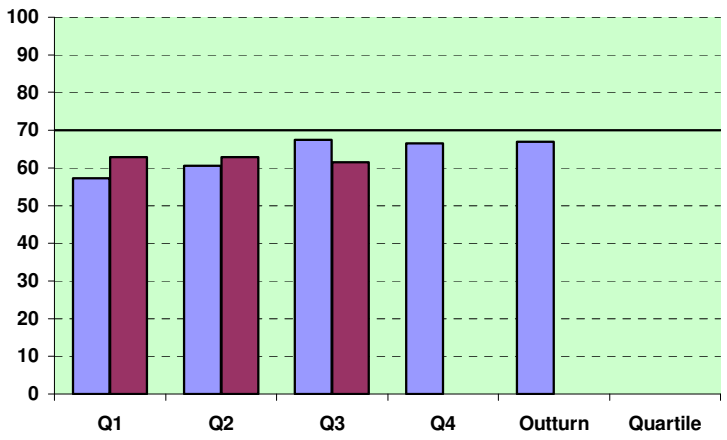
Should hit target for the year — **Green**

Commentary

Currently 58.30% of clients have received a review of their needs. The production of monthly reports listing all clients yet to be reviewed by each team will ensure the target figure of 80% will be met.

OPPSIPAF E82

Assessments of adults and older people leading to provision of a service



Key

- 2006/7
- 2007/8
- Target
- Top 25%
- Middle 50%
- Bottom 25%

No quartile data available

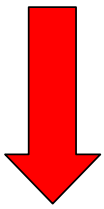
PAF Assessment

Better ←

Band	5	4	3	2
Target	X			
Current			X	

May hit PAF target

Trend



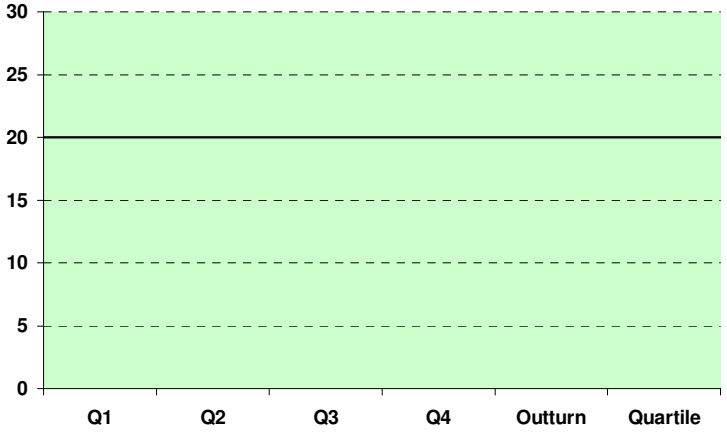
Worse than this time last year	May hit target for the year
	Amber

Commentary

Currently, 61.44% of assessments led to services being provided. Current performance would be awarded a PAF Band 3.

OPPSIPLI 4

No. of days reimbursement as a result of delayed discharge of older people

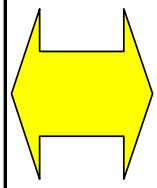


Key

- 2006/7
- 2007/8
- Target
- Top 25%
- Middle 50%
- Bottom 25%

No quartile data available

Trend



Same as this time last year	Should hit target for the year
	Green

Commentary

There have been no re-imbursable delays during Quarter 3.

Quarter 3 data for key Indicator BVPI 56, ‘Percentage of Items of equipment delivered within 7 working days’ is not available at the time of publishing. A graph has not been included. This indicator will be reported in quarter 4.

Ref	Indicator	Actual 06 / 07	Target 07 / 08	Quarter 3	Progress *	*PAF band Target*	*PAF band Actual*	*PAF Progress* *	Commentary
	Service Delivery Indicators								
PAF C28/ BVPI 53/	Households (all adults) receiving intensive homecare (per 1000 population aged 65 or over) *Key Threshold >8*	11.14	12	11.43		4	3		This figure is based on a sample week of service users receiving homecare in September, therefore it cannot be improved by actions taken each month. Although the target figure of 12 was not met this year, progress has been made to achieve this. Despite not reaching the target the success of other services do contribute to this. For example, Direct Payments and Supporting People cannot be counted towards this indicator and a very successful intermediate care service means residents in Halton do not need to receive intensive levels of Homecare over a long period of time.
	Cost & Efficiency Indicators								
PAF B11/ SA3	Intensive home care as a percentage of intensive home care and residential care	28	28	28.14E		5	5		The estimated figure is 28.14. Part of this calculation is based on the sample week of service users receiving homecare in September and therefore, this part of the calculation cannot be improved. However, the number of weeks spent in residential and nursing care will be updated at year end and therefore an updated figure will be provided in Q4.

LPSA Ref.	Indicator	Baseline	Target	Perform 06/07	Perform 07/08 Q3	Traffic light	Commentary
8	**Improved care for long term conditions and support for carers.** **1.** Number of unplanned emergency bed days (Halton PCT registered population)	**58,649** (04/05)	**-6% to 55,130** (31/03/09)	**51,977**	**39470** Projected for 2007/8		Actual data available shown as admissions between April 2007 and November 2007. The emergency bed days number includes bed days within incomplete spells (i.e. this figure could increase over the year once the patients are discharged). December 2007 is estimated using the April to November available data. The Projected figure for the year includes some estimation, i.e. December – March 2008. The projected 07-08 year end estimated figure of emergency bed days for the over 65's is 39,470, 24% down on the same period in 2006_07.

LPSA Ref.	Indicator	Baseline	Target	Perform 06/07	Perform 07/08 Q3	Traffic light	Commentary
	2. Number of carers receiving a specific carer service from Halton Borough Council and its partners, after receiving a carer's assessment or review	**195** (last six months of 04/05)	**600** (31/03/09)	**419**	**534**		Numbers of carers of older people increasing. Detailed work continues with assessment teams within the directorate to ensure that increased numbers of carers receive an assessment which leads to the provision of a service. Monthly meetings take place with the services, which are attended by the carers assessors, and performance and recording agendas are consider in detail at each meeting. Carers assessors have been appointed to all social work teams. The directorate has achieved it's 2007/8 PAF target for this area and is working to achieve the carers LPSA target by 2009.

HEALTH & COMMUNITY - OLDER PEOPLE

Revenue Budget as at 31st December 2007

	Annual Revised Budget £000	Budget To Date £000	Actual To Date £000	Variance To Date (overspend) £000	Actual Including Committed Items £000
Expenditure					
Employees	5,076	3,807	3,761	46	3,771
Premises Support	241	0	0	0	0
Other Premises	40	30	35	(5)	35
Food Provisions	47	35	36	(1)	44
Supplies & Services	391	169	179	(10)	243
Transport	200	137	118	19	121
Departmental Support Services	1,506	0	0	0	0
Central Support Services	400	0	0	0	0
Community Care:					
Residential Care	7,506	4,964	4,692	272	4,692
Nursing Care	555	380	377	3	377
Home Care	1,907	1,426	1,417	9	1,424
Supported Living	389	266	236	30	236
Day Care	40	27	41	(14)	41
Meals	120	82	88	(6)	117
Direct Payments	260	233	228	5	228
Other Agency	636	88	41	47	41
Specific Grants	150	0	0	0	0
Access & Systems Cap. Grant	292	0	0	0	0
Asset Charges	50	0	0	0	0
Total Expenditure	**19,806**	**11,644**	**11,249**	**395**	**11,370**
Income					
Residential Fees	-2,438	-1,688	-1,891	203	-1,891
Pump Priming Grant	-50	0	0	0	0
Fees & Charges	-1,101	-762	-681	(81)	-681
Preserved Rights Grant	-106	-40	-34	(6)	-34
Supporting People Grant	-891	-575	-549	(26)	-549
Access & Systems Cap. Grant	-1,636	-1,636	-1,636	0	-1,636
Delayed Discharges Grant	-243	-243	-243	0	-243
Preventative Technology Grant	-132	100	-103	3	-103
Nursing Fees - PCT	-555	-350	-337	(13)	-337
PCT Reimbursement	-20	-15	-15	0	-15

Joint Finance - PCT	-31	-23	-24	1	-24
Other Reimbursements	-311	-310	-397	87	-397
Total Income	**-7,514**	**-5,742**	**-5,910**	**168**	**-5,910**
Net Expenditure	**12,292**	**5,902**	**5,339**	**563**	**5,460**

Comments on the above figures:

In overall terms revenue spending (including commitments) on Older People's services is currently £442k below budget profile. This is due, in the main, to expenditure on salaries and community care being less than anticipated at this stage of the year and also to the overachievement if income

Although there are a number of vacancies within the department the use of agency staff for Social Worker posts is being strictly monitored to ensure costs are managed within the salary budget. The pay award for 2007/8 has still now been agreed and was paid to employees in December. This budget is expected to be slightly below budget profile at year-end after the achievement of all staff savings targets.

The Community Care net budget is currently under budget profile by £421k however it is expected that an increase in invoices in January & February for winter pressures, will result in this underspend reducing. An additional week of community care net expenditure, approximately £124k, will also be built into the forecast projection to align the four weekly billing cycle with year end to ensure all income & expenditure to 31st March 2007 is correctly accounted for.

Residential fees are currently over budget profile as the proportion of service users paying higher contributions, or even the full cost of their care has increased, particularly within Runcorn area.

Additional income has also been received in the form of reimbursements from the PCT to fund increased capacity in Intermediate care in line with the principle of 50% Health & Social Care funding.

HEALTH & COMMUNITY – LOCAL STRATEGIC PARTNERSHIP BUDGET

Budget as at 31st December 2007

	Annual Budget £'000	Budget To Date £'000	Actual To Date £'000	Variance To Date (Overspend) £'000	Actual Including Committed Items £'000
Priority 1 Healthy Halton					
Health Awareness	40	30	0	30	0
Recipe For Health	29	22	14	8	14
Five A Day Programme	3	2	0	2	0
Vulnerable Adults Task Force	592	444	328	116	328
Vol. Sector Counselling Proj.	39	29	19	10	19
Info. Outreach Services	34	26	17	9	17
Reach for the Stars	34	26	16	10	16
Carer Support Development	49	37	25	12	25
Healthy Living Programme	98	73	47	26	47
Advocacy	63	48	41	7	41
Priority 2 Urban Renewal					
Landlord Accreditation Programme	28	21	28	(7)	28
Priority 5 Safer Halton					
Good Neighbour Pilot	27	20	13	7	13
Grassroots	18	14	5	9	5
Development	43	32	0	32	0
Alcohol Harm Reduction					
Domestic Violence	77	58	18	40	18
Total Expenditure	**1,174**	**882**	**571**	**311**	**571**

HEALTH & COMMUNITY

Capital Budget as at 31st December2007

	2007/08 Capital Allocation £000	Allocation To Date £000	Actual Spend To Date £000	Allocation Remaining £000
Social Care & Health				
DDA	24	2	0	24
LDDF	7	7	0	7
Women's Centre & Other Projects	178	100	102	76
PODS (Utilising DFG)	40	0	0	40
Bredon Improvements	24	24	32	(8)
Improvement of Care Homes	150	100	141	9
Bridgewater Capital Improvements	1	1	0	1
Refurbishments to John Briggs House	90	30	6	84
Door Entry System – John Briggs	2	2	2	0
IT for Mobile Working	12	12	0	12
Total Spending	528	278	283	245

It is anticipated the capital budget will be fully committed by the end of the year.

The traffic light symbols are used in the following manner:

		Objective	Performance Indicator
Green		Indicates that the objective is on course to be achieved within the appropriate timeframe.	Indicates that the target is on course to be achieved.
Amber		Indicates that it is unclear at this stage, due to a lack of information or a key milestone date being missed, whether the objective will be achieved within the appropriate timeframe.	Indicates that it is either unclear at this stage or too early to state whether the target is on course to be achieved.
Red		Indicates that it is highly likely or certain that the objective will not be achieved within the appropriate timeframe.	Indicates that the target will not be achieved unless there is an intervention or remedial action taken.