# Board of Directors – Public Session

Meeting to be held on Thursday 25\textsuperscript{th} June 2015 from 09:30 at The Elisabeth Room, Endeavour House, 8 Russell Road, Ipswich IP1 2BX

Please note that at lunchtime there will a presentation of staff long-service awards

## AGENDA

<table>
<thead>
<tr>
<th>Time</th>
<th>Item No</th>
<th>Description</th>
<th>Attachment</th>
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<tbody>
<tr>
<td>09:30</td>
<td>15.105</td>
<td>Chair’s welcome, apologies for absence and notification of any urgent business</td>
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<td></td>
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<td>Apologies: Stuart Smith</td>
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<tr>
<td>09:35</td>
<td>15.106</td>
<td><strong>Standing Item:</strong> Declarations of Interest</td>
<td>Attachment A</td>
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<tr>
<td>09:40</td>
<td>15.107</td>
<td>To approve the minutes of the previous meeting in public, held on 28\textsuperscript{th} May 2015</td>
<td>Attachment A</td>
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<tr>
<td></td>
<td></td>
<td>\textit{i. To approve the release of the minutes under the Freedom of Information Act}</td>
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<tr>
<td>09:45</td>
<td>15.108</td>
<td>Matters arising from the meeting in public held on 28\textsuperscript{th} May 2015</td>
<td>Attachment B</td>
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<tr>
<td>09:50</td>
<td>15.109</td>
<td>Chair’s Report (Gary Page)</td>
<td>Attachment C</td>
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<td>10:00</td>
<td>15.110</td>
<td>CEO’s Report (Michael Scott)</td>
<td>Attachment D</td>
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<td>15.111</td>
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<td><strong>Items for Approval</strong></td>
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<td>10:15</td>
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<td>\textit{i. Quality Improvement Plan Progress Report including Buddy Trust arrangements (Michael Scott)}</td>
<td>Attachment E</td>
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<td>10:35</td>
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<td>\textit{ii Monitor Compliance Statements (Robert Nesbitt)}</td>
<td>Attachment F</td>
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<td>10:45</td>
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<td>\textit{iii Finance Report M02 (Andrew Hopkins)}</td>
<td>Attachment G</td>
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<td>11:00</td>
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<td>\textit{iv Business Performance Report M02 (Andrew Hopkins)}</td>
<td>Attachment X</td>
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<td>11:15</td>
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<td>\textit{v Fire Policy (Leigh Howlett)}</td>
<td>Attachment H</td>
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<td>11:20</td>
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<td>\textit{vi Finance Committee Chair’s report 16\textsuperscript{th} June 2015 (Stuart Smith)}</td>
<td>Attachment Z</td>
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To follow
Time    Item No
11:25    BREAK

11:40    15.112 Items for Debate
   i.  None

15.113 Items for Assurance
11:40    i.  Quality Improvement Plan assurance (Michael Scott)  Presentation
11:50    ii.  Organisational Development & Workforce Committee Chair’s report 29th May 2015 (Brian Parrott)  Attachment I
11:55    iii. Audit & Risk Committee Chair’s Report 15th June 2015 (John Brierley)  Attachment J
12:00    iv.  Quality Governance Committee Chair’s report 3rd June 2015 (Gary Page)  Attachment K
12:05    v.  Medical Education Report (Bohdan Solomka)  Attachment L

12:10    15.114 Any other urgent business, previously notified to the Chair

12:15    15.115 Date, time and location of next meeting
The next meeting of the Board of Directors will be held in public on Thursday 23rd July 2015 at the at King Centre, 63-75 King Street, Norwich, Norfolk NR1 1PH

12:20    15.116 Motion to exclude public and press from confidential part of the meeting

12:25    CLOSE

Long Service Awards & Lunch

LUNCH 12:30 – 13:15

Robert Nesbitt
Trust Secretary
5th June 2015
Unconfirmed

Minutes of the
Board of Directors – Public Session
Held on Thursday 28th May 2015 at 9am at King Centre, 63-75 King Street,
Norwich, Norfolk NR1 1PH

Present:
Gary Page (Chair)
Michael Scott: CEO
Dr Bohdan Solomka: Medical Director
Leigh Howlett: Director of Strategy & Resources
Andrew Hopkins: Director of Finance & Performance (from 9.12am)
Jane Sayer: Director of Nursing, Quality and Patient Safety
Debbie White: Director of Operations – Norfolk

John Brierley: Non-Executive Director
Brian Parrott: Non-Executive Director
Stuart Smith: Non-Executive Director
Adrian Stott: Non-Executive Director
Marion Saunders: Non-Executive Director
Tim Newcomb: Non-Executive Director

In attendance:
Robert Nesbitt: Trust Secretary
Kate Hope: Assistant Trust Secretary (minutes)
Alan Yates: Improvement Director

There were six Governors and seven members of the public present.

Meeting commenced at: 9am

15.85 Chair’s welcome, notification of any urgent business and apologies for absence
The Chair (Gary Page) welcomed the Board of Directors, Governors, staff and public.

Apologies were received from Alison Armstrong.

The Chair informed those present that questions from the public gallery would be taken at the end of the agenda. Members of the Campaign to Save Mental Health Services were in attendance and were given the opportunity to address the meeting to express their concerns at this decision. It was explained that other Trusts conduct their Board meetings in a similar manner.

15.86 **Standing Item: Declarations of Interest**

There were no additional declarations of interest reported.

15.87 **To approve the minutes of the previous meeting in public, held on 23rd April 2015**

It was agreed that the word ‘undertaken’ was replaced with the word ‘supported’ in the second paragraph of 15.68.

The minutes were otherwise approved by the Board as an accurate record of the meeting.

i The Board approved the release of the minutes under the Freedom of Information Act.

15.88 **Matters arising from the meeting in public held on 23rd April 2015**

It was agreed that action 15.69i would be left as open. Updates would be circulated as soon as possible.

Action 15.69v was confirmed as on track.

Action 15.69vii Monitor Compliance Framework Quarterly Declarations –the Governance of these will be made at the next Board meeting.

Action 15.69viii will be left as outstanding and will be carried forward.

15.89 **Chair’s Report**

The Board noted the report.

15.90 **CEO’s Report**

Michael Scott reported that following the monthly assurance meeting with Monitor there is still some work to be done to demonstrate the Trust has a
proper grip on the issues it is facing and a robust assurance process to
demonstrate performance against the Quality Improvement Plan (QIP).

The recent visit by Nottinghamshire Trust went extremely well and was a
positive experience for all involved.

Michael Scott gave an overview of this month’s ward and team visits to the
Board as outlined in his report.

The IG Toolkit Submission was discussed. Whilst this showed a small
improvement on the previous year, we still failed to be classed as
satisfactory. It was agreed that this was a disappointment especially as this
one was one of five policies which is still under review post-merger and has
taken two years to have approved. A policy is in place now which has been
approved by the commissioners and this will need embedding. The
introduction of Lorenzo will assist the Trust with this issue. The Board
agreed that it was confident that the Trust will not be in the same position this
year. The Quality Governance Committee has asked for dates when these
five policies will be merged.

Michael Scott extended the Board’s thanks to Leigh Howlett and her team for
the work they had put in to implementing Lorenzo. He reported that he had
visited a team this week who are working through the system and who can
already see the benefits of it. Many staff throughout the Trust have done an
amazing job and have put in all the extra hard work necessary to support the
new system during the initial implementation period.

15.91 Items for Approval

i  Patient Safety and Quality Report

Jane Sayer presented the report (attachments E and Ei).

There are two issues to highlight:-

1. Increasing admissions of under eighteens out of area.
2. The ongoing availability of under eighteen beds.

It was confirmed that the Trust has written to NHS England and local
Commissioners about the bed shortage. The Trust continues to press this
issue but the Board is not optimistic about the response.

The Board agreed that as it was totally unacceptable to have under
eighteens admitted to adult wards, the Trust will lobby harder to get this issue
addressed.
The Board were informed that staffing levels continued to be a challenge for the Trust. National Health Service Professionals (NHSP) are working hard with NSFT to address this but the Trust’s demand outstrips supply.

Michael Scott reported that the Executives were focused on this issue and it needed forensic examination. Staffing and recruitment has been worked into the PMO structure for management and control. The Senior Management Forum (SMF) meeting on 2nd June 2015 has a three hour slot devoted to the issues of temporary staffing and recruitment drives.

Leigh Howlett confirmed that the Trust is proactively targeting potential staff by visiting universities, colleges and conferences to make sure that students and delegates are aware that the Trust is an attractive employer to work for.

Debbie White reported that there are areas in the trust where staffing levels are quite fragile. This is partly due to the increase in staffing required for safer staffing. In addition the Trust has lost experienced staff. However staff who remain continue to do a remarkable job. Where there is pressure they cover this with overtime. The issue to be concerned with as a result is a tired workforce and this is a risk to delivery of the QIP.

The Board requested that for future reports, a more extensive executive summary was added.

**Action 15.91i**
Chair and CEO to write to MPs for Norfolk and Suffolk to highlight issue of CAMHS inpatient beds. *(Michael Scott)*

**ii Quality Improvement Plan Progress Report including Buddy Trust arrangements**

Michael Scott reported that the Quality Improvement Plan (QIP) delivery tracker was now in place and showed that twenty of the thirty five plans were now signed off and in delivery. If any of the projects fall behind in the future and delivery targets are in danger of being missed, the Board will receive an exception report to consider. The same process applies to the Cost Improvement Plan (CIP) and the CIP projects are all going through the same development and delivery process.

Gary Page reported that he would be organising a meeting over the next two weeks with the Governors and the Non-Executive Directors to go over how the architecture around assurance works and he would encourage everyone to attend this session as he is aware that there has been some confusion, particularly amongst the Governors, as to how the structure works.
It was noted that the figure in 3.1 of the report should be £8.1m and not £8.9m and for future meetings the reports for this should be reproduced in colour.

**Action 15.91ii**

a. A meeting for Non-Executive Directors and Governors to be organised within two weeks to set out how the assurance process works for the QIP/CIP Plans (Robert Nesbitt)

b. Board Report to be printed in colour from next month (Kate Hope)

c. Include in report actual progress against outcomes and information about risks (to be prepared in time for the NED/Governor meeting above). (Robert Nesbitt)

### iii Trust Operating Model

Michael Scott presented this report to the Board.

As part of the simplified operating model of locality and service management the Central Norfolk locality will be broken down into three localities:

- Norfolk South
- Norwich
- Norfolk North

Each locality will have a locality manager, modern matron and a lead clinician. This approach has been simplified and adopted to optimise performance management to improve delivery. In addition it would provide an opportunity for each locality to have a real sense of belonging and ownership.

It was noted that learning disabilities did not feature in this report. It was agreed that this would be added to the model as a service line.

The Board discussed the issue of reporting lines and it was clarified that there would be clear reporting lines with the modern matron and lead clinician all reporting to their locality manager. It was requested that the reporting lines were to be made clear and were to be known and acknowledged by the lead clinicians.

The Board approved the Operating Model and acknowledged that it provides greater consistency and clarity and also addressed one of the key issues highlighted by the Foresight Report.

**Action 15.91iii**
iv Board Assurance Framework including risk register

The report was taken as read.

Robert Nesbitt reported that the Board Assurance Framework (BAF) presented to the Board was displayed in a new format and outlined how to read and interpret the framework.

The next step in developing the framework was for the Executive Team to go through the Datix risks and the BAF will be mapped against the QIP/CIP to provide a comprehensive narrative for assurance purposes.

Recruitment was highlighted as the most significant challenge facing the Trust. Governors had specifically asked for an update on this. It was agreed to prepare an agenda item for the next Board of Governors meeting.

The BAF will be presented to the Board on a quarterly basis.

The Board noted the report.

Action 15.91iv

a. Map the risks onto the committee structure. (Robert Nesbitt)

b. The BAF is to be printed in colour for next meeting. (Kate Hope)

c. Include an item on the Board of Governors’ July agenda for Leigh Howlett on recruitment actions. (Robert Nesbitt)

v Finance Report M01

Andrew Hopkins informed the Board that this report identifies significant over performance against budget. The Trust is currently well within the expected £1m deficit at £0.67m. However the Board should consider that temporary staffing issues are loaded more heavily in the second part of the year and consequently this picture will change.

Capital expenditure is currently ahead of plan. In addition the sale of the site at St Clements should proceed next month

Another further variable to consider was the income settlement with the Clinical Commissioning Groups (CCGs) in relation to out of area placements and safe staffing levels. The Board is currently waiting for CCGs to make their final offer. If this is not satisfactory the matter will go to arbitration. If this does take place then there will be no middle ground. A binary decision will be made either agreeing with the Trust’s position or with the CCG.
The Board noted the report.

vi Finance Committee Report

Stuart Smith confirmed that there was nothing to present to the Board on this occasion as the report was presented to the Board on 23rd April 2015.

vii Business Performance Report M01

It was reported that the CRHT Gatekeeping Target breach had been investigated and in April 2015 there was a change in pattern of service users coming into beds. Steps are currently being taken to ensure that reporting of these incidents is correct in the first place as this is a key governance target with Monitor.

The seven day follow up target had also breached but it was reported that in reality this breach was in relation to two patients, one of which had declined to have the contact. This was not from lack of effort on the part of the staff involved and was also down to slightly unusual circumstances in these cases.

It was noted that subject to the continuing implementation of Lorenzo, the Board was confident that the performance standards would be met.

In addition it was noted that the Trust has been successful in reducing delays in discharges. These figures were the lowest reported for some time.

The meeting took a break from the agenda to take questions at 10.50am.

The following questions were put to the Board:-

1. Are consultation fees being reduced to tackle the issue of staffing costs?

   It is acknowledged by Monitor that there is a cost involved with getting out of special measures. No money is being diverted from front line services. There is a provision of £1.5m set aside to address what needs to be done in connection with the Care Quality Commission (CQC) Report. This is a figure which has been acknowledged and accepted by Monitor.

2. Are the reported deaths in Wellbeing due to cuts in funding and services? It appears there have been twenty five unexplained deaths in a two month period. Why was this not included on the agenda today?

   There has been an enormous increase in service users accessing wellbeing services. The cause of death in each case has not been determined at the current time. They are under review and therefore it would not be appropriate to include them on the agenda. However these serious
incidents are constantly under review and are addressed in Board and Quality Governance Committees.

3. Once the ward is closed at Carlton Court, what is happening regarding the loss of those beds?

There will be a net loss of eight beds in total. This was the clear result of a public consultation in Great Yarmouth and Waveney. They have twenty beds remaining and the plan is to reinvest in community services to avoid service users going into crisis. It is felt that twenty beds is adequate for patients from the Yarmouth and Waveney locality.

4. There is a multi-agency suicide group in existence. Why is it not well publicised by the Trust?

Dr Jane Sayer confirmed that the group referred to was new. She welcomed receiving the contact details for anyone who may wish to join the group as she was keen to expand membership and extend invitations to individuals and groups who can really make a difference.

5. How many service users have up to date crisis plans and how many of these plans advise the patient to contact the Mind Support Line? How qualified are the staff at Mind to triage these calls and are the incidents recorded in the service user’s crisis plans?

It was confirmed that staff working on the Mind Support Line are trained and their role is to refer people to CRHT if appropriate. However the continued funding for the Mind Support Line is now in doubt. The staff at Mind do not have access to crisis plans.

The crisis plan figure was not known by the Board and would be provided at a later date.

The meeting took a break from 11.10am to 11.25am

viii Trust learning from incidents – current arrangements and future plans

The Board noted the report, recognising that implementing this was an important component in addressing one of the major findings from Foresight.

ix Monitor Self-Certification Declarations

Robert Nesbitt outlined the declarations which need to be made by the end of May 2015.

The Trust is in a different position this year due to special measures.
The Trust will confirm that it is able to provide a safe and effective service but is in breach of the licence.

Robert Nesbitt proposed some specific wording for the declarations as follows:-

For declaration 1 – not confirmed

‘The Trust entered special measures on 18th February 2015 following the publication of the CQC report on its inspection (which took place in October 2014). The Trust has given Monitor enforcement undertakings to address the quality and governance shortcomings. Progress on the Quality Improvement Plan is monitored by the Board of Directors and updates are provided to a monthly Stakeholder Assurance Meeting.’

For declaration 2 - confirmed

‘The Board of Directors recognises that this declaration is in the context of the Trust entering special measures on 18th February 2015 and the Quality Improvement Plan that is now in place.’

The wording proposed was approved by the Board.

Consultant Psychiatrist Appointments

The report was taken as read.

Bohdan Solomka reported that Dr Vivek Agarwal has been interviewed for the Consultant Psychiatrist vacancy for PICU in-patient services at Rollesby Ward, Hellesdon Hospital and was considered a suitable appointment.

It was noted that no Royal College representative was present on the consultant panel. This was not through lack of trying to secure one for the panel. It has been the Trust's experience that whilst a representative has been applied for, the Royal College has not provided one. To wait for one would mean a long delay in the recruitment process.

It was agreed that the Trust should write to the Royal College confirming that since November we have not had a representative from the Royal College present for any of our appointments.

It was agreed that the Trust should write formally to the Royal College, expressing disappointment but also stressing that we do not wish to delay panels.

Action 15.91x

Write to the Royall College of Psychiatrists highlighting the difficulty in getting an RCP representative on consultation appointment panels. (Bohdan Solomka)

15.92 Items for Debate
There were no items for debate.

15.93 Items for Assurance

i Freedom to speak up - update

Jane Sayer reported that from a staff survey it was noted that members of staff have expressed reservations about raising concerns. The main observation arising from this report was the possible appointment of a Freedom Guardian. Other Trusts have done this and have seen the benefits of such a role. The Board agreed this course of action in principal and further work is to be done around the role and how this is to be undertaken.

The Trust has a clear policy of zero-tolerance in relation to bullying and harassment and it was agreed that this should be reinforced with a Board Bulletin which Michael Scott will put together with the Communications Team.

<table>
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<th>Action 15.93i</th>
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<tr>
<td>Check what approach other Trusts are adopting, particularly in relation to the appointment of a Freedom Guardian (Jane Sayer)</td>
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ii Item removed

iii Quality Governance Committee (28th April 2015/26th May 2015) Chair’s Report

Gary Page reported that there had been a few minor changes around membership in the terms of reference.

The Board noted the report and approved the revised terms of reference.

15.94 Any other business, previously notified to the Chair

There had been no notifications of urgent business.

The Board took further questions from the public as follows:-

1. The lack in morale often causes staff sickness. In such cases the service user is not necessarily informed who has taken over their treatment. Service users should be provided something in writing so they know which members of staff are responsible for their treatment.

Debbie White confirmed that this had already been picked up as part of the CQC Report.

2. The public minutes for this meeting were not put online early enough.
It was explained this was due to a technical error, meaning that the minutes were uploaded on the Tuesday before the meeting.

3. There had not been any updates on stories from staff and service users for some time. It was confirmed that these were shared on an individual basis regularly within the Trust. There were six junior doctors attending after the meeting today to give the Board a presentation on their workloads and their experiences of working with the Trust. In addition, Debbie White confirmed that she recently met with a service user who had attended a previous Board meeting to share her experiences of the Trust. She found this was a positive experience and has now trained as a nurse.

15.95 Date, time and location of next meeting

The next meeting of the Board of Directors will be held in public on Thursday 25th June 2015 at the Elisabeth Room, Endeavour House, Russell Road, Ipswich, IP1 2BX

15.96 Motion to exclude public and press from confidential part of the meeting

The meeting closed at 12.15
Matters arising from board of directors’ meeting - public 28th May 2015

Carried forward from April 2015

<table>
<thead>
<tr>
<th>Min 15.69i (a) and (b) PMO Terms of Reference</th>
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<tr>
<td>Ensure that the PMO ToR are updated to include the diagram and then circulated to the BoD. (Robert Nesbitt)</td>
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<tr>
<th>Min 15.69viii LD declaration narrative letter</th>
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<tr>
<td>Circulate the narrative letter that will accompany the Monitor learning disability declaration to the BoD. (Andrew Hopkins)</td>
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<tr>
<th>Min 15.69 viii Board Committee ToR standardisation</th>
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<td>Finalise remaining issues and circulate to BoD. (Robert Nesbitt)</td>
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From May 2015

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<tr>
<th>Min 15.91i Patient safety and quality report</th>
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<td>c. Include in report actual progress against outcomes and information about risks (this to be ready for NED / Governor meeting) (Michael Scott)</td>
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<tr>
<td>Include a structure diagram in the operating model document that makes explicit that the Lead Clinician reports to the Locality Manager. (Michael Scott).</td>
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c. Include an item on the BoG July agenda for Leigh Howlett on recruitment actions. (Robert Nesbitt)  

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Executive Summary:

This report highlights some themes following the meetings that have taken place over the last month. I also include at the end of report a list of the key meetings that I have had.

1.0 Key observations from the month:

1.1 This month I have visited all five Trust localities, Wellbeing Services and Secure Services. As always I see incredibly dedicated staff and some common challenges but a very variable picture in terms of morale and pressure on services. I saw some some areas in the trust under very real pressure – the DIST team in Kings Lynn West Norfolk, Coastal IDT in Suffolk and Assertive Outreach in Yarmouth - yet others like Foxhall House in Suffolk where recruitment is complete, Lorenzo working well and morale very positive. I visited two teams undergoing significant change – the Wellbeing Service in Yarmouth and Chilton Houses in Suffolk where staff were excited about the changes and welcoming the opportunity to shape the service they worked for. Recruitment remains in my opinion our biggest challenge because so many issues are dependent on it – both in terms of the quality of our service, our financial position and the morale and wellbeing of our staff.

1.2 The financial pressure the Trust is under is becoming increasingly evident. Across all providers 2014/15 saw a net deficit of £822 million with 47% of trusts in deficit. There are 16 mental health trusts including ourselves also in the red. For 2015/16 the planned net deficit increases to £2.1 bln with 62% of trusts recording a loss and that is after cumulative planned CIP of £3.1bln. There is a significant cost associated with getting out of special measures
and there is a Financial Recovery Plan in place but the long term sustainability of the Sector requires much more attention to managing demand for services and I see very little attention being given to that at a national level. Prevention and early Intervention are key factors in driving this forward.

1.3 The architecture around the PMO and the QIP is badly needed to drive delivery and provide assurance but this is not going to fix issues around quality and governance. That will happen because of new behaviours and ways of doing things on the ground. I’ve heard some great things happening in CRHT, Safe wards, Memory assessment because people are getting on and doing it. I’m also seeing in Quality Governance a new collaborative approach emerging between governance teams and localities/services which is dedicated to understanding where we have challenges and what we need to do to fix it.

2.0 Key Meetings

2.1 Staff and Services:

- I met with Staff Governor Howard Tidman.

- Together with Jane Millar, Governor, I visited Foxhall and Chilton House in Suffolk and I returned to Chilton House later in the month to attend a team meeting as part of the programme of Board Member visits.

- I attended the Carers Lead Advisory Group meeting.

- I spent the day in West Norfolk as the new Locality NED and visited Children’s services, the Fermoy Inpatient unit and Community Teams (including attending the DIST Team Meeting as part of the programme of Board member visits).

- I met with the Lead Governor.

- I sat on a Hospital managers Hearing at the Norvic

- I chaired a disciplinary hearing

- I attended a team meeting with the Wellbeing service in Yarmouth and Waveney as part of the programme of Board Member visits.

- I met with Simon Millard, in Great Yarmouth to discuss concerns around the resourcing of Early Intervention services in the locality.

- I met with Michael Lozano, to discuss how we can improve the reports coming into Quality Governance by providing detailed Locality Input into the reports.
• I chaired two meetings of Board Directors and Governors from the IPC group to ensure a collective understanding and sign off of the assurance process around the QIP.

• I met with Lynsey Dunne from HR to discuss the planned event to present awards to Long Serving members of staff.

• I met with Ben Askew from HR to begin the process around the recruitment of two new Non Executive Directors

• I attended the Hospital managers Committee

• I met with Ruth Mills, Psychologist to discuss the Memory Assessment Service in East Suffolk

• I met with Margaret Little Locality manager East Suffolk for an update

• I attended the Locality Quality Governance Meeting in West Suffolk

• I met with Catherine Wells, Governor to discuss Ideas on recruitment of Nursing staff

• I Chaired the Quality Governance Meeting

2.2 **Service Users:**

• I had at meeting with Lyn Skipper and Sharon Picken to discuss the role out of the Service User and Carer involvement Strategy

• I met with Stephen Fletcher, a Service user and Public Governor

• I met with parents of a young Suffolk service user to discuss the difficulties they had accessing services.

2.3 **External Organisations:**

• I attended the Sweet Arts, Mad Hatters Art Auction in Norwich.

• I met with Dennis Bacon, and Stephen Becsi and Sue Jauncey from Pulse UK to hear about an innovative approach to improving staff engagement which has been pioneered very successfully in Australia.

• Together with Michael Scott, I had a teleconference with the Chair and CEO of our buddy Trust Nottingham NHS.

• I also discussed how the Buddy Trust can help us with our programme of Board Development with Julian Eve the Lead at Nottinghamshire Trust for the Buddying arrangements

• I met with Alan Yates, the Improvement Director
I attended the NSFT/Board Meeting followed by the External stakeholder Assurance meeting

3.0 Recommendations

3.1 The Board is asked to note the report.

Gary Page
Chair
Executive Summary:

This report provides an update on the main issues, insights, observations and activities undertaken by the Chief Executive over the past month.

1.0 Monitor

1.1 The Trust’s monthly assurance meeting with Monitor is due to be held on 24th June. A verbal update will be given at the meeting.

2.0 Buddy Trust

2.1 Buddy Trust arrangements are fully underway with an executive visit to Nottinghamshire Healthcare NHS Foundation Trust planned for 18th June. Arrangements are also being made for Board members to visit Nottingham on 27th August.

2.0 Programme Management Office (PMO)

3.1 The in-house PMO office is now fully functional after the departure of PwC and continues to oversee the implementation of both the transformation programme and the QIP.

3.0 Meetings and visits

3.1 I opened the Suffolk Nursing Academy Launch on 15th June. The academy will provide training and support to newly qualified nurses as they make the transition from university life to the workplace. The scheme has been running successfully in Norfolk since November 2014 and the Trust has received positive feedback and was featured in a very positive article in the Nursing Standard.
3.2 I was invited to run a workshop on ‘Delivering Mental Health by Reverse Commissioning’ at the NHS BME Network annual conference on 12th June. I was accompanied by service users and staff who have been involved in the project locally. The workshop was very well received.

3.3 The Quarterly SMF meeting took place on 2nd June. The focus was on workforce, in particular, how reliance on temporary staffing can be reduced across the Trust.

3.4 We held an executive development day on 1st June where the focus was very much on the development of strategy and implementation of the Quality Improvement Plan.

3.5 I spoke at a ‘Headucate’ event on 28th May on the history of mental health and management. Headucate is a UEA student run group set up to tackle stigma and raise awareness of mental health issues in local schools. Encouragingly, it is one of the best attended interest groups in the medical school.

4.0 Risks / mitigation in relation to the Trust objectives

4.1 None.

5.0 Recommendations

5.1 The Board is asked to note the content of this report.

Michael Scott
Chief Executive
Executive Summary:

The Trust Board has asked for regular reports on progress with delivering the Trust’s Quality Improvement Plan (QIP) and Cost Improvement Plan (CIP), as oversee by the Programme Management Office (PMO).

The PMO team has been in place since late May, and has taken over from PWC the responsibility of overseeing the Programme Trackers and liaising with each project’s Executive Sponsor and project lead to ensure that the objectives are delivered. Overall, both the QIP and CIP programmes are graded as ‘amber’, with good progress made to date but further work to be done on key risks and challenges.

Each Executive Sponsor has been assigned a member of the PMO staff to work with on active projects, as well as new ideas for the pipeline.

PMO reports to weekly meetings of the Transformation Programme Board (TPB), and TPB will prepare regular reports for the Board, as well as advising the Assurance Committees of Finance, Audit & Risk and Quality Governance, when one of their ‘twinned’ projects submits an Exception Report to the TPB. (An Exception Report is produced when a project is rated by its lead, or by PMO, as either ‘amber’ or ‘red’ for delivery.) This enables the project’s Executive Sponsor to set out the necessary next steps to be taken.

Further progress reports will be made to the next meeting.

1.0 Introduction

1.1 The Transformation Programme Board (TPB), meeting weekly, is devoting alternate weeks to assuring ‘delivery’ of the active programmes and reviewing ‘pipeline/development’ of new ideas for CIP and QIP.

Recent weeks have focused on ensuring that all ‘Quality Transactional’ tasks in
the four workstreams have been actioned, and, where necessary, assigned to current projects; reviewing the delivery of CIP and specific new proposals on cost-reduction – for instance, taking local action to address current overspends on temporary staffing. The Board will be aware that the Secretary of State and NHS England’s Chief Executive have both referred to this latter point as a specific national priority for the NHS. The TPB has also focused on preparation for Monitor of Highlight Progress Reports on all QIP projects.

1.2 The Transformation Programme Board has asked for Exception Reports to be raised when a project is rated by its lead, or by PMO, as either ‘amber’ or ‘red’ for delivery. This enables the project’s Executive Sponsor to set out the necessary next steps to be taken. Exception Reports will also be brought to the appropriate sub-committee of the Board.

2.0 Current Progress

2.1 QIP - TPB received a report at its meeting on 17 June showing 4 of the current 29 QIP projects as ‘amber’ and with Exception Reports; the remainder as ‘green’.

Following the meeting on 17 June further review of the QIPs took place by executive sponsors and the status of some projects was amended. This reflects the fact that the PMO process is a dynamic one and as there are a large number of complex projects the position changes on an almost daily basis. The current position at the time of writing is shown in appendix 1. Where projects have moved from green to amber or red, exception reports are required (although project leads have not had time to complete these new exception reports in time to be included with this paper).

The 4 amber projects reported on 17 June were as follows:

<table>
<thead>
<tr>
<th>Project ID</th>
<th>Project Name</th>
<th>Project Description</th>
<th>Executive Sponsor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q13</td>
<td>CCG DIST model of care</td>
<td>To establish 24/7 crisis / emergency response provision for people with dementia or complexity in later life (DCLL) which includes frail elderly with co-morbid mental illness.</td>
<td>Debbie White, Director of Operations (Norfolk)</td>
</tr>
<tr>
<td>Q16</td>
<td>Safe Staffing</td>
<td>The Trust will ensure that there are sufficient community staff at all times to provide care to meet patients’ needs, and ensure that community patients are supported to remain in their own home environment.</td>
<td>Debbie White, Director of Operations (Norfolk)</td>
</tr>
</tbody>
</table>
The aim of the project is to coproduce with staff, service users and stakeholders a clinical strategy that practitioners use to support their practice, and that is used as a framework for clinical quality governance processes.

Bohdan Solomka, Medical Director

Implement the Flexible assertive community treatment (FACT) model to locality level to provide more intensive support that is responsive to risk.

Debbie White, Director of Operations (Norfolk)

The exception reports are in appendix 2.

2.2 Work is underway with all projects to check that milestones, Key Performance Indicators and risks are realistic, with corrective action highlighted to TPB as necessary.

2.3 CIP – TPB reviewed 4 Exception Reports, out of the 34 active projects –

<table>
<thead>
<tr>
<th>Project ID</th>
<th>Project Name</th>
<th>Target (£K)</th>
<th>Executive Sponsor</th>
</tr>
</thead>
<tbody>
<tr>
<td>CIP021</td>
<td>ICT Restructure</td>
<td>283</td>
<td>Leigh Howlett, Director of Strategy &amp; Resources</td>
</tr>
<tr>
<td>CIP023</td>
<td>Management Costs</td>
<td>500</td>
<td>Leigh Howlett, Director of Strategy &amp; Resources</td>
</tr>
<tr>
<td>CIP032</td>
<td>External Specialist Placements</td>
<td>100</td>
<td>Debbie White, Director of Operations (Norfolk)</td>
</tr>
<tr>
<td>CIP035</td>
<td>Printing &amp; Photocopying Costs</td>
<td>100</td>
<td>Leigh Howlett, Director of Strategy &amp; Resources</td>
</tr>
</tbody>
</table>

Current progress with CIP delivery is as follows. The Trust has set an Annual Plan Target of £8.9m of which 83% (£7.4m) has been identified to date. However, the Trust has set an internal target of £11m, of which:

- £2.795m (25%) has been actioned and removed from budgets
- £0.958m (8%) is deemed low risk but not yet removed from budgets
- £2.830m (26%) is deemed medium risk
- £0.833m (8%) is deemed high risk; and
- £3.584m (33%) is unidentified.
£5.933m (80% of the £7.4m identified) are recurrent savings, whilst £1.484m are non-recurrent. As at 31 May 2015 £0.782m delivered against the year to date target of £0.702m.

2.4 The Exception Reports presented to the Transformation Programme Board on 17 June are attached at appendix 1. The overall QIP and CIP Delivery Trackers are attached at appendix 2.

3.0 Risks / mitigation in relation to the Trust objectives

3.1 The Transformation Programme Board reviews the principal risks, and appropriate mitigating actions, for the Cost and Quality Improvement Programmes at each meeting. Mitigating actions on specific projects can also be triggered by discussion of the Exception Reports. Project risks, where graded at 15 or above, are escalated to the Programme Risk Log, and (where appropriate) TPB will escalate key risks to the Trust’s own Risk Register.

3.2 The PMO Risk Log, reviewed at the Transformation Programme Board on 17 June, is attached at appendix 3.

3.3 Some risks remain to the delivery of key milestones, and avoidance of identified risks, for the Quality Improvement Plan. Further risks exist to the identification of as yet unidentified savings, and delivery of the Trust’s identified programme. The PMO team will be actively working with project leads and Executive Sponsors to mitigate and minimise these risks. The risk log is in appendix 3.

4.0 Recommendations

4.1 The Board is asked to note this report.

Michael Scott
Chief Executive

Background Papers / Information

Appendix 1 – Delivery Tracker
Appendix 2 – Exception Reports
Appendix 3 – Programme Risks Log
## QIP Delivery Tracker (as at 18 June 2015)

<table>
<thead>
<tr>
<th>Project ID</th>
<th>Project Name</th>
<th>Project Description</th>
<th>Overall RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>QO001</td>
<td>Ward Managers</td>
<td>Identify and removal of Ligature Risks, Environmental quality including fixtures and fittings, decor and furnishings, availability of Personal Alarms to staff and all who need them, Medical Equipment is in a state of readiness for emergencies, Drug administration policy is fully compliant.</td>
<td>Amber</td>
</tr>
<tr>
<td>QO002</td>
<td>Ligature Audit Action Plan</td>
<td>To reduce ligatures in the ward environment. In line with Safe Environment identified ligatures should be removed or mitigated.</td>
<td>Amber</td>
</tr>
<tr>
<td>QO003</td>
<td>Line of sight Action Plan</td>
<td>To reduce risks where there are poor lines of sight. To have a robust ligature policy for which the Trust has a measurable way of demonstrating its ongoing application in a systematic and defendable way.</td>
<td>Amber</td>
</tr>
<tr>
<td>QO004</td>
<td>Norvic Clinic</td>
<td>Reconfiguration of Drayton &amp; Thorpe wards to address the concerns raised in the CQC report.</td>
<td>Green</td>
</tr>
<tr>
<td>QO005</td>
<td>Mixed Sex Accommodation</td>
<td>To reduce the number of mixed sex accommodation areas across the Trust</td>
<td>Red</td>
</tr>
<tr>
<td>QO006</td>
<td>Poppy and Avocet Female Only Plan</td>
<td>Addressing concerns that are no quiet facility at Woodlands on Poppy and Avocet Wards for female patients.</td>
<td>Amber</td>
</tr>
<tr>
<td>QO007</td>
<td>Seclusion</td>
<td>To address areas of particular concern, lack of CCTV outside seclusion rooms, not all seclusion suites have en-suite facilities and there were also instances where male and female service users shared an area.</td>
<td>Green</td>
</tr>
<tr>
<td>QO008</td>
<td>Seclusion data and governance review</td>
<td>Review of the data and governance review around Seclusion</td>
<td>Green</td>
</tr>
<tr>
<td>QO010</td>
<td>Reducing restrictive interventions</td>
<td>To reduce the number of restrictive interventions that occur across the Trust</td>
<td>Green</td>
</tr>
<tr>
<td>QO012</td>
<td>Community care</td>
<td>To ensure that there are robust policies and procedures that keep staff and patients safe in the community, with particular regard to management of community based appointments.</td>
<td>Green</td>
</tr>
<tr>
<td>QO013</td>
<td>CCG DIST model of care</td>
<td>To establish 24/7 crises / emergency response provision for people with dementia or complexity in later life (DCLL) which includes frail elderly with co-morbid mental illness.</td>
<td>Amber</td>
</tr>
<tr>
<td>QO014</td>
<td>Safety Incidents - Learning Lessons</td>
<td>The Trust will strengthen the current systems to provide feedback and learning from incidents and complaints by implementing an improved system of cascading and embedding learning.</td>
<td>Green</td>
</tr>
<tr>
<td>QO015</td>
<td>Locality Governance</td>
<td>Embed and monitor delivery of quality standards within locality based governance arrangements to achieve parity across the organisation.</td>
<td>Green</td>
</tr>
<tr>
<td>QO016</td>
<td>Safe Staffing</td>
<td>The Trust will ensure that there are sufficient community staff at all times to provide care to meet patients' needs, and ensure that community patients are supported to remain in their own home environment.</td>
<td>Amber</td>
</tr>
<tr>
<td>QO017</td>
<td>Service User and Carer Strategy</td>
<td>Service User Carer Strategy was agreed by the Board March 2015. The project will produce an implementation plan for the delivery of the 6 objectives laid out in the strategy.</td>
<td>Red</td>
</tr>
<tr>
<td>QO018</td>
<td>Staff supervision and appraisals</td>
<td>To ensure that all staff receive regular supervision and annual appraisals, and ensure all nursing staff will be revalidated.</td>
<td>Green</td>
</tr>
<tr>
<td>-------</td>
<td>---------------------------------</td>
<td>-----------------------------------------------------------------------------------------------------------------</td>
<td>-------</td>
</tr>
<tr>
<td>QO019</td>
<td>Lorenzo implementation</td>
<td>Implementation of the Lorenzo system across the Trust</td>
<td>Green</td>
</tr>
<tr>
<td>QO022</td>
<td>Practitioner quality framework - Clinical Strategy</td>
<td>The aim of the project is to coproduce with staff, service users and stakeholders a clinical strategy that practitioners use to support their practice, and that is used as a framework for clinical quality governance processes.</td>
<td>Amber</td>
</tr>
<tr>
<td>QO023</td>
<td>Physical healthcare form completion</td>
<td>Redesign and implementation of the physical healthcare forms and ensure completion of forms</td>
<td>Green</td>
</tr>
<tr>
<td>QO024</td>
<td>Physical healthcare monitoring</td>
<td>To ensure that every service user has a physical health assessment and appropriate interventions (organised or conducted) annually, but in addition on admission and consistently as directed through their care plan.</td>
<td>Green</td>
</tr>
<tr>
<td>QO029</td>
<td>CYP out of area placement review</td>
<td>This project focusses on reviewing the accessibility of NHSE commissioned CAMHs Tier 4 beds for children and young people in Suffolk and Norfolk.</td>
<td>Green</td>
</tr>
<tr>
<td>QO030</td>
<td>Additional 5 beds at Carlton Court</td>
<td>Expansion of Carlton Court capacity to include an additional 5 beds</td>
<td>Green</td>
</tr>
<tr>
<td>QO031</td>
<td>Provision of inpatient beds</td>
<td>Provision of inpatient beds for secured services to ensure that there is sufficient capacity across the Trust.</td>
<td>Green</td>
</tr>
<tr>
<td>QO032</td>
<td>Medicines Management</td>
<td>The Trust will ensure that medicines prescribed to patients who use the service are stored, administered, recorded and disposed of safely.</td>
<td>Green</td>
</tr>
<tr>
<td>QO033</td>
<td>Post-consultation of inpatient bed implementation</td>
<td>15 beds currently provided for acute adults at Waveney Acute Services, Carlton Court are expected to close in October 2015.</td>
<td>Green</td>
</tr>
<tr>
<td>QO034</td>
<td>Provision of single bedded safety units</td>
<td>Review of the evaluation findings and recommend how many place of safety units are needed based upon evidence regarding the impact of the pilot projects &amp; consider how to resource extensions of the pilot project work.</td>
<td>Green</td>
</tr>
<tr>
<td>QO035</td>
<td>Secured services improvement plan</td>
<td>To coordinate within a single plan the existing and future initiatives to improve the quality of secure services across NSFT.</td>
<td>Green</td>
</tr>
<tr>
<td>QO036</td>
<td>Community service - allocated care</td>
<td>Implement the Flexible assertive community treatment (FACT) model to locality to provide more intensive support that is responsive to risk.</td>
<td>Amber</td>
</tr>
<tr>
<td>QO037</td>
<td>CYP out of hours arrangements</td>
<td>Joint project with other providers to improve out of hours arrangements</td>
<td>0</td>
</tr>
<tr>
<td>QO038</td>
<td>Youth Councils</td>
<td>Developing Youth Councils in order to engage CYP</td>
<td>Green</td>
</tr>
<tr>
<td>QO039</td>
<td>Multi-agency suicide prevention</td>
<td>Establish a multi-agency working group to improve suicide prevention across Norfolk and Suffolk</td>
<td>Green</td>
</tr>
<tr>
<td>QO040</td>
<td>BME community response</td>
<td>To better understand of the diversity of Suffolk communities (beyond the top level census data) with insights into how under-represented groups conceptualise mental health and perceive NSFT. To identify and address barriers to access through practical changes which can be evaluated.</td>
<td>Green</td>
</tr>
<tr>
<td>QO041</td>
<td>Learning disability and autism strategy</td>
<td>0</td>
<td>Amber (approved for entry to QIP Programme on 17 June; Exception Report to follow at next meeting)</td>
</tr>
</tbody>
</table>
## CIP Delivery Tracker (as at 18 June 2015)

<table>
<thead>
<tr>
<th>Project ID</th>
<th>Project Name</th>
<th>Project Description</th>
<th>Budgeted CIP £K</th>
<th>Cost Improve £K</th>
<th>Overall RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>CIP001</td>
<td>Estates Rationalisation</td>
<td>Capturing the revenue savings from the implementation of the 5 year estates strategy.</td>
<td>470</td>
<td>364</td>
<td>Green</td>
</tr>
<tr>
<td>CIP003</td>
<td>Curtail demand to services</td>
<td>Undertaking a review of all services across NSFT, to understand demand for and income from each service</td>
<td>250</td>
<td>250</td>
<td>Delivery Plan under review</td>
</tr>
<tr>
<td>CIP004</td>
<td>Procurement</td>
<td>Improving volume of orders through the e-procure system, to ensure best value is achieved.</td>
<td>200</td>
<td>200</td>
<td>Delivery Plan under review</td>
</tr>
<tr>
<td>CIP005</td>
<td>Lorenzo - Patient Administration System</td>
<td>The implementation of Lorenzo as an electronic patient record system across all NSFT secondary mental health services</td>
<td>70</td>
<td>70</td>
<td>Green</td>
</tr>
<tr>
<td>CIP006</td>
<td>GY&amp;W after CCG consultation</td>
<td>Reduction in adult acute beds in GY&amp;W following public consultation in 2014</td>
<td>450</td>
<td>450</td>
<td>Green</td>
</tr>
<tr>
<td>CIP007</td>
<td>Extension of Non-Medical Staff review</td>
<td>Review of difficult to recruit to medical posts, to identify areas in which non-medical responsible can be utilised to reduce staffing costs.</td>
<td>100</td>
<td>-</td>
<td>Delivery Plan under review</td>
</tr>
<tr>
<td>Code</td>
<td>Project Type</td>
<td>Description</td>
<td>Value 1</td>
<td>Value 2</td>
<td>Status</td>
</tr>
<tr>
<td>--------</td>
<td>----------------------------------</td>
<td>-----------------------------------------------------------------------------</td>
<td>---------</td>
<td>---------</td>
<td>-------------------------------</td>
</tr>
<tr>
<td>CIP008</td>
<td>Domestic Service Tender</td>
<td>Outsourcing of Norfolk &amp; Suffolk domestic services.</td>
<td>200</td>
<td>200</td>
<td>Green</td>
</tr>
<tr>
<td>CIP009</td>
<td>Corporate Savings: Service Governance &amp; Training</td>
<td>Restructure of service governance and training department</td>
<td>58</td>
<td>58</td>
<td>Green</td>
</tr>
<tr>
<td>CIP010</td>
<td>Corporate Savings: Service Governance &amp; Training</td>
<td>Identification of non-recurrent savings</td>
<td>291</td>
<td>-</td>
<td>Delivery Plan under review</td>
</tr>
<tr>
<td>CIP011</td>
<td>Corporate Savings: Medical Director &amp; Pharmacy</td>
<td>Restructure of pharmacy department</td>
<td>106</td>
<td>106</td>
<td>Green</td>
</tr>
<tr>
<td>CIP012</td>
<td>Corporate Savings: Medical Director &amp; Pharmacy</td>
<td>Identification of non-recurrent savings</td>
<td>451</td>
<td>-</td>
<td>Delivery Plan under review</td>
</tr>
<tr>
<td>CIP013</td>
<td>Corporate Savings: Chief Executive</td>
<td>Reduction in chaplaincy posts, CNST savings and exec costs</td>
<td>232</td>
<td>232</td>
<td>Green</td>
</tr>
<tr>
<td>CIP014</td>
<td>Corporate Savings: Chief Executive</td>
<td>Identification of non-recurrent savings</td>
<td>131</td>
<td>-</td>
<td>Green</td>
</tr>
<tr>
<td>CIP015</td>
<td>Corporate Savings: Commercial Directorate</td>
<td>Restructure of commercial management and communications team</td>
<td>680</td>
<td>680</td>
<td>Green</td>
</tr>
<tr>
<td>CIP016</td>
<td>Corporate Savings: Estates Maintenance</td>
<td>Restructure of estates and facilities management team and facilities team</td>
<td>325</td>
<td>325</td>
<td>Green</td>
</tr>
<tr>
<td>CIP017</td>
<td>Corporate Savings: Estates Maintenance</td>
<td>Identification of non-recurrent savings</td>
<td>402</td>
<td>-</td>
<td>Delivery Plan under review</td>
</tr>
<tr>
<td>Code</td>
<td>Category</td>
<td>Description</td>
<td>Amount</td>
<td>Revised Amount</td>
<td>Status</td>
</tr>
<tr>
<td>--------</td>
<td>-----------------------------------</td>
<td>-----------------------------------------------------------------------------</td>
<td>--------</td>
<td>----------------</td>
<td>--------</td>
</tr>
<tr>
<td>CIP018a</td>
<td>Corporate Savings: Finance</td>
<td>Restructure of finance team</td>
<td>85</td>
<td>85</td>
<td>Green</td>
</tr>
<tr>
<td>CIP018b</td>
<td>Corporate Savings: Finance Commercial Development</td>
<td>Identification of non-recurrent savings</td>
<td>125</td>
<td>125</td>
<td>Green</td>
</tr>
<tr>
<td>CIP019</td>
<td>Corporate Savings: HR</td>
<td>Restructure of HR team</td>
<td>169</td>
<td>169</td>
<td>Green</td>
</tr>
<tr>
<td>CIP020</td>
<td>Corporate Savings: HR</td>
<td>Identification of non-recurrent savings</td>
<td>28</td>
<td>-</td>
<td>Green</td>
</tr>
<tr>
<td>CIP021</td>
<td>Corporate Savings: ICT</td>
<td>Identification of non-recurrent savings</td>
<td>283</td>
<td>-</td>
<td>Red</td>
</tr>
<tr>
<td>CIP022</td>
<td>Corporate Savings: ICT Mobile</td>
<td>Restructure of ICT department</td>
<td>100</td>
<td>100</td>
<td>Green</td>
</tr>
<tr>
<td>CIP023</td>
<td>Corporate Savings: Management Costs</td>
<td>Identification of further management cost savings</td>
<td>500</td>
<td>-</td>
<td>Red</td>
</tr>
<tr>
<td>CIP024</td>
<td>Corporate Savings: Direct Clinical Services Senior Operational Team (SOT) savings</td>
<td>Restructure of senior operational team</td>
<td>133</td>
<td>126</td>
<td>Green</td>
</tr>
<tr>
<td>CIP026</td>
<td>Norfolk Central UEA Post</td>
<td>Removal of vacant band 9 post</td>
<td>110</td>
<td>110</td>
<td>Green</td>
</tr>
<tr>
<td>CIP027</td>
<td>Norfolk Central Older People Acute</td>
<td>Review of users in external private placements</td>
<td>40</td>
<td>40</td>
<td>Green</td>
</tr>
<tr>
<td>CIP Code</td>
<td>Description</td>
<td>Details</td>
<td>Target Cost</td>
<td>Achieved Cost</td>
<td>Status</td>
</tr>
<tr>
<td>---------</td>
<td>------------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------</td>
<td>-------------</td>
<td>---------------</td>
<td>----------</td>
</tr>
<tr>
<td>CIP029</td>
<td>GYW Band 8a post</td>
<td>Removal of Band 8a post in GYW</td>
<td>50</td>
<td>50</td>
<td>Green</td>
</tr>
<tr>
<td>CIP030</td>
<td>GYW Band 8b post</td>
<td>Removal of Band 8b post in GYW</td>
<td>70</td>
<td>70</td>
<td>Green</td>
</tr>
<tr>
<td>CIP032</td>
<td>External Specialist Placements (Norfolk)</td>
<td>Review of all external specialist placements to consider what level is most appropriate and if any cost savings can be achieved.</td>
<td>100</td>
<td>-</td>
<td>Amber</td>
</tr>
<tr>
<td>CIP033</td>
<td>External Specialist Placements (Suffolk)</td>
<td>0</td>
<td>-</td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>CIP034</td>
<td>E-Rostering &amp; Recruitment</td>
<td>Implementation of e-rostering system</td>
<td>420</td>
<td>-</td>
<td>Green</td>
</tr>
<tr>
<td>CIP035</td>
<td>Photocopying &amp; printing wastage</td>
<td>Reduction in the usage of photocopying and printing, resulting in a subsequent cost saving.</td>
<td>100</td>
<td>100</td>
<td>Red</td>
</tr>
<tr>
<td>CIP037</td>
<td>Shorter Handover Periods &amp; Use of Band 2s</td>
<td>Review of handover periods, and implementation of standardisation, that will result in a cost saving from staff costs.</td>
<td>900</td>
<td>-</td>
<td>Green</td>
</tr>
<tr>
<td>CIP038</td>
<td>West Norfolk Band 8a Savings</td>
<td>Removal of Band 8a post in West Norfolk</td>
<td>77</td>
<td>77</td>
<td>Green</td>
</tr>
</tbody>
</table>

**TOTALS**

7,705  4,038
Appendix 2 – Exception Reports

TO BE COMPLETED BY THE PROJECT LEAD FOR EACH PROJECT THAT IS RAG RATED RED & AMBER BY THE PMO, AND PRESENTED BY THE EXECUTIVE SPONSOR AT THE TRANSFORMATION PROGRAMME BOARD

Project @ Risk

12/06/2015

Rating - Amber

QO013 – CCG DIST Dementia Intensive Support Team

Project Lead & Executive Sponsor
Debbie White, Marcus Hayward

Where slipped?
Mapping of current out of hours services for older people was supposed to happen by 01/06.

Why slipped?
There has been a delay getting feedback from DIST teams so have revised due date to 22nd June - This may impact on next milestone (Creation of draft guidance)

Actions to fix?
MH to chase

Time to green
22 June 2015
Project Lead & Executive Sponsor
Debbie White, Veno Sunghuttee

Where slipped?
1 milestone missed (Identify Caseload by Locality and CTLs in line with New Structure)

Why slipped?
Informatics problems preventing identification of caseload

Actions to fix?
Project lead on leave - will meet when back

Time to green
Unsure as dependent on informatics. Will have better idea when project lead returns from leave
Project Lead & Executive Sponsor

Bodhan Solomka

Where slipped?

Following a meeting with Lead Clinicians and Consultants, it was agreed to move forward with this project

Why slipped?

Engagement with Lead Clinicians

Actions to fix?

PID and Workbook have been completed and need to be finalised. PID and QIA need to be prepared for signature by Jane Sayer

Time to green

26 June 2015
QO036 – Allocated care community services

Project Lead & Executive Sponsor
Debbie White, Del Mitchell

Where slipped?
Following project meeting on 08/06 a milestone has been pushed back (Identify third sector provider) until 06/07 which pushes 2 dependent milestones back

Why slipped?
Has not been possible to formally identify third sector provider

Actions to fix?
Project lead to confirm provider

Time to green
06 July 2015
CIP 021 - ICT Restructure

Project Lead & Executive Sponsor
Darren Adams
Leigh Howlett

Where slipped?
Finance tracker has a total of £291.3k with £31.9k due in April and £23.6k in May and June. It is not clear whether these sums have yet been banked.

Why slipped?
Project Lead is uncertain where the savings have been identified and feels that savings calculations cannot be committed to until the restructure has been modelled, which cannot happen until the end of June 2015.

Actions to fix?
Further discussion required between Finance, ICT Project Lead and Director of Strategy to decide ways forward

Time to green
01 July 2015
CIP 023 Management Costs

Project Lead & Executive Sponsor
Leigh Howlett

Where slipped?
Outstanding finance has been identified but no milestones, KPIs or Risks have been set in place

Why slipped?
Projects not yet identified with specific savings attached

Actions to fix?
Further discussion required between Finance and Director of Strategy to decide ways forward. Draft benchmarking report has arrived, but is awaiting checking and confirmation from participating Trusts.

Time to green
01 July 2015
CIP032 – External specialist placements

Project Lead & Executive Sponsor
Debbie White, Micki Munro

Where slipped?
Milestones on track. However 23k overspend in month 1 and 31k overspend in month 2 therefore rated as amber.

Why slipped?
Milestones have not slipped but overspend rates this as amber.

Actions to fix?
Careful monitoring with finance and project lead.

Time to green
Client reviews due to start week commencing 22 June but may slip because of staff absence.
CIP 035 Photocopying & Printing Costs

Project Lead & Executive Sponsor
Jane Parris, Leigh Howlett

Where slipped?
Design of protocols for use of Photocopiers and Printers milestone has been missed - due in May

Why slipped?
Further clarification needed.

Actions to fix?
Jane Parris will update the PMO 17 June 2015

Time to green
01 July 2015
### PMO Programme Progress Report - Appendix 3

**Norfolk and Suffolk**

**NHS Foundation Trust**

**Last updated: 18 June 2015**

<table>
<thead>
<tr>
<th># Risk Identifed</th>
<th>Date Identified</th>
<th>Risk Owner</th>
<th>Probability</th>
<th>Impact</th>
<th>Score</th>
<th>Probability</th>
<th>Impact</th>
<th>Score</th>
<th>Status</th>
<th>Mitigating Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>31-Mar-15</td>
<td>Michael Scott</td>
<td>4</td>
<td>5</td>
<td>16</td>
<td>4</td>
<td>4</td>
<td>2</td>
<td>Open</td>
<td>Detailed review initiated of staff and workforce development needs. Recruitment and retention strategies in place (although these will take time to bear fruit).</td>
</tr>
<tr>
<td>4</td>
<td>01-Jun-15</td>
<td>Leigh Howlett</td>
<td>4</td>
<td>4</td>
<td>16</td>
<td>2</td>
<td>4</td>
<td>8</td>
<td>Open</td>
<td>Active and regular monitoring by PMO and TPB, with regular review by the Board</td>
</tr>
<tr>
<td>5</td>
<td>15-Jun-15</td>
<td>Michael Scott</td>
<td>4</td>
<td>4</td>
<td>16</td>
<td>4</td>
<td>4</td>
<td>16</td>
<td>Open</td>
<td>Out to advert for Head of Strategy and Transformation and Head of Organisational Development. Executive fast-track development process under consideration</td>
</tr>
<tr>
<td>6</td>
<td>05-May-15</td>
<td>Leigh Howlett</td>
<td>5</td>
<td>3</td>
<td>15</td>
<td>1</td>
<td>4</td>
<td>3</td>
<td>Open</td>
<td>Board and executive team are developing the vision but it is not fully articulated yet. Links to staff engagement work being developed</td>
</tr>
<tr>
<td>7</td>
<td>05-May-15</td>
<td>Michael Scott</td>
<td>3</td>
<td>4</td>
<td>12</td>
<td>2</td>
<td>4</td>
<td>8</td>
<td>Open</td>
<td>The Trust has a need for flexible resource to be available so it can be allocated to projects as and when required. Varying levels of resource have been made available in different localities. Whilst the Trust has capacity to deliver transactional CIPs, large transformational CIPs may need additional resource investment. The current size of the PMO may not be sufficient to provide the necessary project management support going forward. 3 managers recruited in N &amp; W; ongoing effort to recruit in Suffolk</td>
</tr>
<tr>
<td>8</td>
<td>05-May-15</td>
<td>Michael Scott</td>
<td>3</td>
<td>4</td>
<td>12</td>
<td>2</td>
<td>3</td>
<td>6</td>
<td>Open</td>
<td>Executive sponsors and the Transformation Directors are responsible for ensuring the Trust go after the maximum opportunity. To be managed at Transformation Board. A CIP and transformation pipeline is in place to ensure ongoing delivery and ensure that all ideas are captured and regarded.</td>
</tr>
<tr>
<td>9</td>
<td>05-May-15</td>
<td>Leigh Howlett</td>
<td>3</td>
<td>4</td>
<td>12</td>
<td>3</td>
<td>4</td>
<td>12</td>
<td>Open</td>
<td>Trust to put in place a plan to develop a longer term quality strategy - exec team and Board to review overview of strategy and resulting implementation plans during June and July 2015</td>
</tr>
<tr>
<td>10</td>
<td>05-May-15</td>
<td>Michael Scott</td>
<td>2</td>
<td>5</td>
<td>10</td>
<td>1</td>
<td>4</td>
<td>4</td>
<td>Open</td>
<td>Executive sponsors will be required to report and be challenged at the transformation board on delivery of projects through exception reporting. Any slippage will be captured by the PMO from milestone, KPI and financial reports, which will then be escalated to executive sponsor and the transformation board.</td>
</tr>
<tr>
<td>11</td>
<td>05-May-15</td>
<td>Jane Sayer</td>
<td>5</td>
<td>2</td>
<td>10</td>
<td>3</td>
<td>2</td>
<td>6</td>
<td>Open</td>
<td>GIP lead to monitor resource requirements and costs of the GIP programme with support of the PMO. Clear action logs are also taken at each TPB to drive ownership and accountability.</td>
</tr>
<tr>
<td>12</td>
<td>05-May-15</td>
<td>Leigh Howlett</td>
<td>3</td>
<td>3</td>
<td>9</td>
<td>3</td>
<td>3</td>
<td>9</td>
<td>Open</td>
<td>Communication plan in place and presented (successfully) to Monitor. Lead identified and process for information sharing in place. Putting People First engagement work in hand; communication messages for staff developed after each TPB</td>
</tr>
<tr>
<td>13</td>
<td>05-May-15</td>
<td>Leigh Howlett</td>
<td>3</td>
<td>3</td>
<td>9</td>
<td>2</td>
<td>2</td>
<td>4</td>
<td>Open</td>
<td>Executive sponsors are responsible for ensuring that project leads fully own all projects they are assigned to. Any slippage in delivery will be reported to the TPB as will any shortfall on GIP identification.</td>
</tr>
</tbody>
</table>
Executive Summary:

Monitor require FTs to make annual self-certification corporate governance statements. There are two submissions and last month the Board self-certified on the first set. This month the final set must be submitted by 30.06.15. This paper sets out the statements and the supporting evidence for each declaration.

The key issue for the Board to consider is whether the Trust’s current special measures status (and the actions currently underway to address the issues that led to this position) are adequately reflected in the declarations.

1.0 Declarations

4. Corporate Governance Statement (confirmed / unconfirmed – risks and mitigations)

1. The Board is satisfied that the Trust applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.

| Confirmed. The risk is that corporate governance standards are not applied consistently. The mitigation is that the Audit and Risk Committee carried out a review of the Trust’s corporate governance arrangements against the Monitor Code of Governance Code in 2014/5 and presented the outcomes to the board. In addition action has been taken on recommendations of the external board evaluation as they relate to internal |
2. The Board has regard to such guidance on good corporate governance as may be issued by Monitor from time to time.

3. The Board is satisfied that the Trust implements:

(a) Effective board and committee structures;

(b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees;

and

(c) Clear reporting lines and accountabilities throughout its organisation.

Overall response for Statement 4(a) to (h) : Unconfirmed

4. The board is satisfied that the Trust effectively implements systems and/or processes:

(a) To ensure compliance with the Licensee’s duty to operate efficiently, economically;

Risks / Mitigating Actions:
Whilst FT4(5)(a) of the provider license does not currently form part of the Provider Enforcement Undertakings, the Trust’s CoSRR remains at ‘1’. The Trust is working on financial recovery plans but at this stage the Board has not yet seen evidence of a sustained improvement on key financial pressures including temporary staffing, an end to significant levels of Out of Area Placements, and the realisation of CIPs plans. For this element the Board therefore declares ‘unconfirmed’.

(b) for timely and effective scrutiny by the Board of the Licensee’s operations;

FT4(5)(b) forms part of the Provider Enforcement Undertakings. As a result of changes made to information that comes to the board, changes in Board committee structures, Terms of Reference and committee membership, scrutiny of the
| (c) to ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions; | FT4(5)(c) forms part of the Provider Enforcement Undertakings. The Trust has addressed all of the urgent requirements of the CQC following their inspection in October 2014 and the Trust is licensed to provide services. For this element the Board therefore declares ‘confirmed’.

| (d) for effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee’s ability to continue as a going concern); | FT4(5)(d) does not form part of the Provider Enforcement Undertakings. On the basis of the Board’s own scrutiny of the Trust’s systems of financial decision-making and controls including the ‘going concern’ statement and supported by the opinion of the external auditors’ report the Board declares ‘confirmed’ for this undertaking.

| (e) to obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making; | FT4(5)(e) forms part of the Provider Enforcement Undertakings. This area is addressed by the Trust’s Quality Improvement work. Whilst progress has been made it is too early in the process to be able to declare that the progress is sufficient. For this element of the declaration the Board therefore declares ‘unconfirmed’.

| (f) to identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence; | FT4(5)(f) forms part of the Provider Enforcement Undertakings. The Board has reviewed the Trust’s approach to managing risk and made improvements to these arrangements including the Board Assurance Framework. Whilst there is reason to have increased confidence in the robustness of these arrangements it is too early to state confidently that the systems are working satisfactorily. For this element the Board therefore declares ‘unconfirmed’.

| (g) to generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and | FT4(5)(g) does not form part of the Provider Enforcement Undertakings. However, the financial outturn for 2014/15 was significantly below plan, and the continued CoSRR of 1 mean that, until there is evidence that the financial recovery plan is taking effect, for this element of the declaration the Board declares ‘unconfirmed’.

| (h) to ensure compliance with all applicable | FT4(5)(h) does not form part of the Provider Enforcement Undertakings.

Trust’s work has improved. Whilst this work continues it is too early to say that the changes have been consolidated. For this element the Board therefore declares ‘unconfirmed’.
<table>
<thead>
<tr>
<th>Legal requirements.</th>
<th>Enforcement Undertakings. The Trust has systems in place to identify legal compliance with applicable statute. For this element of the declaration the Board therefore declares ‘confirmed’.</th>
</tr>
</thead>
</table>

**Overall response for Statement 5(a) to (f): Unconfirmed**

5. The systems and/or processes referred to in paragraph 5 should include but not be restricted to systems and/or processes to ensure:

<table>
<thead>
<tr>
<th>(a)</th>
<th>Risks / Mitigating Actions FT4(6)(a) forms part of the Provider Enforcement Undertakings. The Board has seen significant changes in membership over the last 12-18 months and now has a refreshed leadership team. For this element the Board therefore declares ‘confirmed’.</th>
</tr>
</thead>
<tbody>
<tr>
<td>(b)</td>
<td>FT4(6)(b) forms part of the Provider Enforcement Undertakings. Although significant improvements have been made in relation to care quality planning and decision making, some important aspects, such as the strengthening of the Quality Governance Committee, are in relatively early stages of embedding. For this element the Board therefore declares ‘unconfirmed’.</td>
</tr>
<tr>
<td>(c)</td>
<td>FT4(6)(c) forms part of the Provider Enforcement Undertakings. Information on quality of care has improved in recent months but the Board remains dissatisfied with some aspects of the analysis of this information and work is currently underway to address this. For this element of the declaration the Board therefore declares ‘unconfirmed’.</td>
</tr>
<tr>
<td>(d)</td>
<td>FT4(6)(d) forms part of the Provider Enforcement Undertakings. As a result of the reservations that the Board has in relation to (c) above, notwithstanding the work to address these issues, for this element of the declaration the Board declares ‘unconfirmed’.</td>
</tr>
<tr>
<td>(e)</td>
<td>FT4(6)(e) forms part of the Provider Enforcement Undertakings. The Board has put in place a set of actions to improve stakeholder engagement on care quality. These include a service user and carer involvement strategy and the ‘Putting People First’ staff engagement work led by the executive director team. Although there are local examples where engagement is</td>
</tr>
</tbody>
</table>
working well, the Trust’s overall position still requires time to embed. For this element of the declaration the Board therefore declares ‘unconfirmed’.

(f) that there is clear accountability for quality of care throughout the Licensee’s organisation including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.

FT4(6)(f) forms part of the Provider Enforcement Undertakings. The changes in Board governance have improved the systems for escalation of quality issues. A revised operating model was also approved in May 2015 which clarifies accountability. However, until the revised model is fully implemented it is too early for the Board to be assured that the systems and processes are fully functioning. For this element the Board therefore declares ‘unconfirmed’.

6. Overall response for Statement 6: Unconfirmed

6. The Licensee shall ensure the existence and effective operation of systems to ensure that it has in place personnel on the Board, reporting to the Board and within the rest of the Licensee’s organisation who are sufficient in number and appropriately qualified to ensure compliance with the Conditions of this Licence.

Risks / Mitigating Actions

As described in 5(a) above significant changes have been made at Board level. Senior management structures have been reviewed and locality management accountability structures clarified. In areas where operational pressures have been identified additional funding has been allocated to address waiting times. At this time these arrangements have yet to be fully implemented and so for this element the Board declares ‘unconfirmed’.

Signed on behalf of the Board of Directors and having regard to the views of the governors

Gary Page (Chair)  Michael Scott (CEO)

Other certifications

5 Certification on AHSCs and governance

"For NHS foundation trusts:
• that are part of a major Joint Venture or Academic Health Science Centre (AHSC); or
• whose Boards are considering entering into either a major Joint Venture or an AHSC."

Not applicable
"The Board is satisfied it has or continues to:
• ensure that the partnership will not inhibit the trust from remaining at all times compliant with the conditions of its licence;
• have appropriate governance structures in place to maintain the decision making autonomy of the trust;
• conduct an appropriate level of due diligence relating to the partners when required;
• consider implications of the partnership on the trust’s financial risk rating having taken full account of any contingent liabilities arising and reasonable downside sensitivities;
• consider implications of the partnership on the trust’s governance processes;
• conduct appropriate inquiry about the nature of services provided by the partnership, especially clinical, research and education services, and consider reputational risk;
• comply with any consultation requirements;
• have in place the organisational and management capacity to deliver the benefits of the partnership;
• involve senior clinicians at appropriate levels in the decision-making process and receive assurance from them that there are no material concerns in relation to the partnership, including consideration of any re-configuration of clinical, research or education services;
• address any relevant legal and regulatory issues (including any relevant to staff, intellectual property and compliance of the partners with their own regulatory and legal framework);
• ensure appropriate commercial risks are reviewed;
• maintain the register of interests and no residual material conflicts identified; and
• engage the governors of the trust in the development of plans and give them an opportunity to express a view on these plans."
6 **Training of Governors**

The Board is satisfied that during the financial year most recently ended the Trust has provided the necessary training to its Governors, as required in s151(5) of the Health and Social Care Act, to ensure they are equipped with the skills and knowledge they need to undertake their role.

Confirmed. The Trust provides a range of training and development opportunities for governors, overseen by a subgroup of the Board of Governors, to enable them to undertake their role.

Signed on behalf of the Board of Directors and having regard to the views of the governors

| Gary Page (Chair) | Michael Scott (CEO) |

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2.0 **Financial implications (including workforce effects)**

2.1 Declarations 4(a), 4(d) and 4(g) relate specifically to finance although the scope of the broader governance declarations includes financial management.

3.0 **Quality implications**

3.1 All of the declarations are quality related.

4.0 **Equality implications / summary of consultation**

4.1 The statements were reviewed with governors at their Planning and Performance Subgroup in May 2015.

5.0 **Risks / mitigation in relation to the Trust objectives**

5.1 The self-certificate declarations are based on the risks to the Trust objectives as reviewed by the Board in the BAF at its May 2015 meeting.
6.0 Recommendations

6.1 The board is asked to consider each of the self-certifications and confirm the declaration on the basis of the statements provided.

Robert Nesbitt
Company Secretary

Background Papers / Information

None
Report To: Board of Directors – Public
Meeting Date: 25th June 2015
Action Sought: For Information
Estimated time: 10 minutes
Author: Adrian Brooke – Head of Reporting & Income
Director: Andrew Hopkins, Finance Director

Executive Summary:

Key headlines for the month are:

- A deficit in the month of £0.87m, which increases the year to date deficit position to £1.47m. The monthly run rate remains broadly in line with the underlying monthly run rate attained during the latter months of 2014/15 financial year. This is currently a favourable position against the Annual Plan by £1.23m, but is considered to be a timing difference.
- Of the £11m planned cost improvements, there still remains £3.2m unidentified schemes and of the £7.8m with associated plans £3.8m have been deemed medium to high risk of non-delivery.
- The Continuity of Service Risk Rating (COSRR) is 1 as per Plan.
- Temporary staffing expenditure in the month has increased again to £2.42m and is now at the highest expenditure level reported by the Trust. The year to date expenditure totals £4.50m. The plan in 2015/16 to reduce the annual expenditure level from £24m to £18m is under threat and will require immediate and significant reductions in expenditure levels across the Trust in order to achieve this target.
- Out of Area Acute (OOA) placements saw a further increase in bed days against the previous month, to 713 bed days, which in turn has cost £0.34m. The responsibility for payment of OOA remains an area of dispute with CCGs.
- The cash held by the Trust at the end of May was £8.40m, a decrease of £2.42m against the plan of £10.82m. This is currently considered a timing difference.
- Capital expenditure of £0.43m during May was ahead of plan due to the catch up in expenditure of prior year projects. The overall Capital expenditure plan of £8.0m is still expected to be achieved.
1.0 Financial Position

Appendix 1 summarises the high level financial performance with an attached report showing further detail and narrative behind this performance. (Please see attached).

2.0 Risks

The Trust is currently on track to meet the full year Plan, but already there is a high risk associated with the required reductions in temporary pay and the likelihood that this will not be met. As previously reported all Localities and Departments areas are now being asked to identify how they will deliver these temporary pay reductions as part of the Performance Review Process, and through the Transformation Programme Board (TPB).

Similarly there is the risk of not meeting planned cost reduction targets during the year which will also impact on delivery of the plan.

3.0 Recommendations

The Board of Directors is asked to review and note the report.

Adrian Brooke
Head of Reporting & Income
15th June 2015
### Statement of Comprehensive Income (SOCl)

<table>
<thead>
<tr>
<th>£m</th>
<th>Actual</th>
<th>Plan</th>
<th>Variance (adverse)</th>
<th>Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>May-15</td>
<td>May-15</td>
<td>May-15</td>
<td>Mar-16</td>
</tr>
<tr>
<td>YTD</td>
<td>YTD</td>
<td>YTD</td>
<td>FY</td>
<td></td>
</tr>
<tr>
<td>Operating Income</td>
<td>35.0</td>
<td>33.7</td>
<td>1.3</td>
<td>202.5</td>
</tr>
<tr>
<td>Pay Costs</td>
<td>(28.1)</td>
<td>(28.0)</td>
<td>(0.1)</td>
<td>(162.0)</td>
</tr>
<tr>
<td>Drug Costs</td>
<td>(0.6)</td>
<td>(0.5)</td>
<td>(0.1)</td>
<td>(3.2)</td>
</tr>
<tr>
<td>Other Costs</td>
<td>(5.8)</td>
<td>(5.9)</td>
<td>0.1</td>
<td>(34.9)</td>
</tr>
<tr>
<td>EBITDA</td>
<td>0.5</td>
<td>(0.7)</td>
<td>1.2</td>
<td>2.4</td>
</tr>
<tr>
<td>Depreciation</td>
<td>1.1</td>
<td>1.1</td>
<td>(0.0)</td>
<td>(7.2)</td>
</tr>
<tr>
<td>Net interest</td>
<td>(0.2)</td>
<td>(0.2)</td>
<td>0.0</td>
<td>(1.0)</td>
</tr>
<tr>
<td>Other</td>
<td>(0.7)</td>
<td>(0.7)</td>
<td>(0.0)</td>
<td>(3.6)</td>
</tr>
<tr>
<td>Exceptionals</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Net surplus / (deficit)</td>
<td>(1.5)</td>
<td>(2.7)</td>
<td>1.2</td>
<td>(9.4)</td>
</tr>
<tr>
<td>EBITDA margin</td>
<td>1.5%</td>
<td>(2.1%)</td>
<td>3.6%</td>
<td>1.2%</td>
</tr>
</tbody>
</table>

### Statement Of Financial Position (SOFP)

<table>
<thead>
<tr>
<th>£m</th>
<th>Actual</th>
<th>Plan</th>
<th>Variance (adverse)</th>
<th>Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>May-15</td>
<td>May-15</td>
<td>May-15</td>
<td>Mar-16</td>
</tr>
<tr>
<td>YTD</td>
<td>YTD</td>
<td>YTD</td>
<td>FY</td>
<td></td>
</tr>
<tr>
<td>Non-Current Assets</td>
<td>155.5</td>
<td>140.7</td>
<td>14.9</td>
<td>137.6</td>
</tr>
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<td>Current Assets</td>
<td>28.5</td>
<td>27.6</td>
<td>0.8</td>
<td>18.0</td>
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<tr>
<td>Current Liabilities</td>
<td>(30.9)</td>
<td>(32.1)</td>
<td>1.2</td>
<td>(26.7)</td>
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<tr>
<td>Non-Current Liabilities</td>
<td>(20.9)</td>
<td>(20.3)</td>
<td>(0.6)</td>
<td>(19.2)</td>
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<tr>
<td>TOTAL ASSETS EMPLOYED</td>
<td>132.2</td>
<td>115.8</td>
<td>16.4</td>
<td>109.8</td>
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<tr>
<td>Public dividend capital</td>
<td>81.9</td>
<td>81.5</td>
<td>0.4</td>
<td>81.5</td>
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<tr>
<td>Retained Earnings (Accumulated Losses)</td>
<td>7.3</td>
<td>5.3</td>
<td>1.9</td>
<td>(0.7)</td>
</tr>
<tr>
<td>Revaluation reserve</td>
<td>43.1</td>
<td>29.1</td>
<td>14.0</td>
<td>29.1</td>
</tr>
<tr>
<td>Donated asset reserve</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
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<tr>
<td>TOTAL FUNDS EMPLOYED</td>
<td>132.2</td>
<td>115.8</td>
<td>16.4</td>
<td>109.8</td>
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</tbody>
</table>

### Statement of Cashflow (SOCF)

<table>
<thead>
<tr>
<th>£m</th>
<th>Actual</th>
<th>Plan</th>
<th>Variance (adverse)</th>
<th>Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>May-15</td>
<td>May-15</td>
<td>May-15</td>
<td>Mar-16</td>
</tr>
<tr>
<td>YTD</td>
<td>YTD</td>
<td>YTD</td>
<td>FY</td>
<td></td>
</tr>
<tr>
<td>EBITDA</td>
<td>0.5</td>
<td>(0.7)</td>
<td>1.2</td>
<td>2.4</td>
</tr>
<tr>
<td>Change in working capital</td>
<td>(6.4)</td>
<td>0.8</td>
<td>(7.2)</td>
<td>1.0</td>
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<tr>
<td>Cashflow from operations</td>
<td>(5.9)</td>
<td>0.1</td>
<td>(6.0)</td>
<td>3.4</td>
</tr>
<tr>
<td>Net cash inflow / (outflow) from investing activities</td>
<td>(1.4)</td>
<td>(1.1)</td>
<td>(0.3)</td>
<td>(0.7)</td>
</tr>
<tr>
<td>Financing and other</td>
<td>(0.2)</td>
<td>-</td>
<td>(0.2)</td>
<td>(6.3)</td>
</tr>
<tr>
<td>Net cash inflow / (outflow)</td>
<td>(7.5)</td>
<td>(1.0)</td>
<td>(6.5)</td>
<td>(3.6)</td>
</tr>
<tr>
<td>Closing cash and cash equivalents</td>
<td>8.4</td>
<td>10.8</td>
<td>(2.4)</td>
<td>8.9</td>
</tr>
</tbody>
</table>
Financial Performance for the Period ending May 2015

Meeting Date: 25th June
Index

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Slide 2 - Finance Dashboard
Slide 3 - Statement of Comprehensive Income (SOCl)
Slides 4-6 - Income – Clinical and Non Clinical
Slides 7-11 - Expenditure – Pay & Non Pay
Slide 12 - Capital
Slide 13 - Balance Sheet
Slide 14 - Cash flow
Slide 15 - COSRR Analysis
Executive Summary

A deficit in the month of £0.87m, which increases the year to date (YTD) deficit position to £1.47m. The monthly run rate of income and expenditure remains broadly in line with that achieved during the latter months of 2014/15. The overall YTD deficit position is favourable against the Annual Plan by £1.23m but this is considered to be a timing difference, which has been caused by the phasing of some reserves in the earlier part of the year which will be utilised over the coming months.

The financial position equates to a Continuity of Service Risk Rating (COSRR) of 1 for May, which is as planned.

Temporary staffing expenditure increased significantly during May to £2.42m. This is the highest monthly expenditure level ever reported by the Trust and pushes the YTD total up to £4.50m and it is highly likely that the target level of £17m on temporary staffing for 2015-16 financial year will be exceeded.

Out of Area Acute (OOA) placements saw an increase in bed days against the previous month, this time up from 381 to 713 bed days (increase of 332), with an associated cost of £0.34m. YTD costs now stand at £0.53m. This area of expenditure is still the subject of negotiation in contracts.

The cash held by the Trust at the end of May was £8.40m, which is £2.42m behind the plan of £10.82m. This is considered a timing difference (see Balance Sheet page for details).

Capital expenditure of £0.43m during May was once again slightly ahead of plan and due both to timing differences and slippage on ICT projects from 2014/15. The overall Capital expenditure plan of £8.0m is still expected to be achieved.
Finance Dashboard

COSRR

<table>
<thead>
<tr>
<th></th>
<th>Actual</th>
<th>Plan</th>
<th>Variance</th>
</tr>
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<tbody>
<tr>
<td>YTD</td>
<td>1</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td>Forecast</td>
<td>1</td>
<td>1</td>
<td>-</td>
</tr>
</tbody>
</table>
## Statement Of Comprehensive Income (SOCl)

### Statement of Comprehensive Income (SOCl)-Year to date

<table>
<thead>
<tr>
<th></th>
<th>Annual Plan</th>
<th>Actual</th>
<th>Variance to Annual Plan</th>
<th>Full Year SOCl</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£'000</td>
<td>£'000</td>
<td>£'000</td>
<td>£'000</td>
</tr>
<tr>
<td>Operating Income</td>
<td>(33,735)</td>
<td>(35,027)</td>
<td>1,292</td>
<td>(202,481)</td>
</tr>
<tr>
<td>Pay Costs</td>
<td>27,995</td>
<td>28,071</td>
<td>(77)</td>
<td>161,999</td>
</tr>
<tr>
<td>Drug Costs</td>
<td>538</td>
<td>608</td>
<td>(70)</td>
<td>3,228</td>
</tr>
<tr>
<td>Other Costs</td>
<td>5,921</td>
<td>5,830</td>
<td>91</td>
<td>34,899</td>
</tr>
<tr>
<td>EBITDA</td>
<td>(718)</td>
<td>517</td>
<td>1,235</td>
<td>2,355</td>
</tr>
<tr>
<td>Depreciation</td>
<td>1,131</td>
<td>1,145</td>
<td>(14)</td>
<td>7,163</td>
</tr>
<tr>
<td>Net interest</td>
<td>846</td>
<td>842</td>
<td>4</td>
<td>4,599</td>
</tr>
<tr>
<td><strong>Exceptionals</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Net surplus / (deficit)</td>
<td>(2,694)</td>
<td>(1,470)</td>
<td>1,225</td>
<td>(9,407)</td>
</tr>
<tr>
<td>EBITDA margin</td>
<td>-2%</td>
<td>1%</td>
<td></td>
<td>1%</td>
</tr>
<tr>
<td></td>
<td>Annual Plan £'000</td>
<td>Actual £'000</td>
<td>Variance to Annual Plan £'000</td>
<td>Full Year Income Annual Plan £'000</td>
</tr>
<tr>
<td>--------------------------------</td>
<td>-------------------</td>
<td>--------------</td>
<td>-------------------------------</td>
<td>----------------------------------</td>
</tr>
<tr>
<td>Block contracts</td>
<td>29,578</td>
<td>30,006</td>
<td>428</td>
<td>178,038</td>
</tr>
<tr>
<td>Clinical Partnerships</td>
<td>1,645</td>
<td>1,547</td>
<td>(98)</td>
<td>9,584</td>
</tr>
<tr>
<td>Clinical income-Secondary Commissioning</td>
<td>367</td>
<td>373</td>
<td>6</td>
<td>2,202</td>
</tr>
<tr>
<td>Other clinical income</td>
<td>490</td>
<td>602</td>
<td>113</td>
<td>2,996</td>
</tr>
<tr>
<td><strong>NHS Mental Health activity Income, Total</strong></td>
<td><strong>32,080</strong></td>
<td><strong>32,528</strong></td>
<td><strong>448</strong></td>
<td><strong>192,821</strong></td>
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<tr>
<td>Research and Development</td>
<td>126</td>
<td>200</td>
<td>74</td>
<td>728</td>
</tr>
<tr>
<td>Education and Training</td>
<td>568</td>
<td>570</td>
<td>2</td>
<td>3,507</td>
</tr>
<tr>
<td>Misc. Other Operating</td>
<td>961</td>
<td>1,729</td>
<td>767</td>
<td>5,425</td>
</tr>
<tr>
<td><strong>Other Operating income, Total</strong></td>
<td><strong>1,656</strong></td>
<td><strong>2,499</strong></td>
<td><strong>843</strong></td>
<td><strong>9,660</strong></td>
</tr>
<tr>
<td><strong>Operating Income, Total</strong></td>
<td><strong>33,735</strong></td>
<td><strong>35,027</strong></td>
<td><strong>1,292</strong></td>
<td><strong>202,481</strong></td>
</tr>
</tbody>
</table>
**Income – Clinical**

**Block Contracts** – £428k favourable to plan:
- £50k Norfolk reflects the Trust’s assumptions as to the income contracts to be agreed with each of the CCG's. This position will change once contracts are formally agreed and signed.
- (£83k) GY&W which currently reflects the rollover of 2014-15 income levels until a final contract position has been agreed and signed.
- £187k old year CQUIN provisions released into the position.
- £160k Suffolk reflecting the formally agreed and signed contract. The favourable YTD position is driven by improvements in the final contract against original assumptions for the West Suffolk CCG and will be matched by investment going forward.

**Clinical Partnerships** – (£98k) behind plan:
- Timing differences on the Norfolk Recovery Programme contract with Norfolk County Council due to incorrect phasing assumptions made when finalising the budget. This will not catch up to plan until the latter months of the year.

**Other Clinical Income** - £113k ahead of plan:
- Various changes to services or new services now being provided for. All have matching expenditure.
The graph below shows the breakdown of miscellaneous other income against plan.

During the month Lorenzo income of £212k was once again earned, bringing the YTD income for Lorenzo up to £424k. All of this income has matching Pay and Non Pay expenditure. No income budget for Lorenzo was submitted as part of the Annual Plan.

A favourable variance of £340k is reported against deferred/other income for the month. Again this has matching Pay and Non Pay expenditure. This favourable position will continue to increase month on month throughout the year due to the more conservative assumptions used over levels of additional income when setting the Annual Plan. The main contributors to this additional YTD income are ICT (£104k), Norfolk DCS localities (£146k) and Pharmacy (£65k).

ICT trading accounts reports a £44k favourable position against plan.

Estates trading income for the month is slightly behind plan by £39k.
Expenditure – Summary

- There has been minimal change in the vacancy level being reported across the Trust, - 497 WTE’s at the end of May. Vacancy levels are higher than in the previous year due to the additional staffing investment for safer staffing levels and other service changes.

- The level of temporary pay expenditure increased this month to £2.42m (£2.08m prior month), pushing the YTD total to £4.50m. Whilst the vacancy level that exists in the Trust funds the majority of this temporary staffing, the overall level once again exceeds the funding available. Whilst there is a plan to reduce the temporary pay expenditure down to £17m in the year, there is already a significant deviation to that proposed plan during May with the current level of expenditure being reported. With no immediate and significant reduction in the levels of expenditure the Trust will not achieve this target. The DCS localities continue to be the main drivers of this expenditure, with increases reported in both Agency and Locum expenditure these last two months due to recent leavers, retirements and special observation requirements, Corporate services also have work to do to reduce their reliance on temporary admin and agency staff.

- A further increase in the bed days and subsequent costs for Out of Area Placements is again reported this month. Specialist Placement expenditure is also up on last month. (see non-pay section).

- Overall, non pay expenditure is below that budgeted, although where favourable variances exist these are currently only considered to be timing differences and expenditure levels will catch up in the coming months.
Expenditure – Pay

Against the original plan, Pay costs report an adverse YTD position of £0.08m. The swing from the favourable position last month is due to the increase in temporary staffing expenditure levels during May, specifically the Agency and Medical Locum costs.

The chart opposite shows total spend by pay type in the month against the overall budget.

Within this overall position, Medical related roles remain adverse against budget by £0.34m YTD. This is a continuing trend with that reported in the prior year. Expenditure levels in this area have gradually increased over the months as recruitment to vacant posts have been unsuccessful. The Medical Director and Directors of Ops have now been tasked with taking remedial action to reduce the average costs of these agency doctors going forward in an attempt to restrict this area of overspend.

The bank and agency ratio (excluding medical locum agency) worsened this month to 38%/62% due to increased agency expenditure across DCS localities.

Non-trading account agency costs within ICT remained relatively static this month as the department continues its attempt to curb expenditure. Agency staffing levels do still remain high however (around £0.08m per month), in order to cover vacancies, infrastructure projects and Service desk requirements. Full year Agency costs on these non-trading accounts now stand at £0.16m.
Current levels of expenditure on Drugs continues to be of concern as the YTD adverse position has risen to £0.07m, of which £0.03m relates to prior year costs which will be adjusted for next month with the release of identified provisions. A further £0.01m overspend is due to no budget provision being made for drugs issued from Thurne Ward. It is currently being investigated as to whether there are alternatives to the current branded drugs being issued that could potentially see the levels of drug expenditure reduced going forward.

Premises costs currently reflect an underspend against Annual plan of £0.17m. Some of this is due to one-off gains and prior year adjustments. Further analysis will be undertaken to ascertain whether any permanent savings can be realised in this area going forward.

Miscellaneous other operating expenses also reflects a favourable YTD position, but at present is only considered a timing difference as expenditure levels catch up as the year progresses.

The adverse position currently being reported for depreciation costs continues to be driven by the catch up in expenditure to progress and complete prior year capital projects. It is expected that depreciation levels will fall back within budget during the second half of the year.

All other non pay expense categories are broadly in line with budget.
Expenditure – Non Pay 2
(Specialist and OOA Placements)

Total spend on Specialist and Out of Area placements for the month was £0.59m increasing the YTD position to £1.03m. The graph overleaf shows the breakdown of expenditure between the different types of placements.

Specialist placement expenditure in Norfolk, for which funding is received from the CCGs accounts for £0.20m of this total in the month, with £0.39m YTD. There were no new placements in the month. The expenditure level relates to costs for 10 longer term patients with a further 1 that has an agreed level of therapy sessions arranged in the coming weeks. If current run rate of expenditure continues, the budgeted level will be exceeded during the year, so patient numbers will need to be managed closely.

Out of Area placements have once again increased on the previous months levels with 713 bed days during May (up from 381 in April). This has led to expenditure in the month of £0.34m pushing the YTD costs up to £0.54m. In the month there were 17 admissions with 23 discharges. At the end of May patient numbers stand at 20, (13 in Central locality, 3 in GY&W and 4 over in the West).

There were only 23 days activity in PICU during May with associated expenditure of £0.02m bringing the YTD costs up to £0.04m.

There has been no change to the number of NHS funded Care patients, which remains at 9, costing the Trust £0.03m which is consistent with previous months expenditure levels. The YTD costs is £0.06m.
Expenditure – Non Pay 2 (Placements)
The cumulative capital spend at the end of month 2 was £1.2m, which is 138% against the submitted plan.

The capital spend for the period was £0.4m, of which £0.2m related to ICT projects. This significant increase in spend in the period is primarily due to additional costs on ICT projects in the first five months of the year, to reflect the timing of the roll out of projects such as the PC replacement programme in relation to Lorenzo and the clinical portal for Lorenzo. The IT plan will come back into line with budget by the year end.

Other property plant and equipment is also ahead of plan due to a number of projects slipping from 2014-15 to 2015-16, and additional funding required for Haymills and the Hollies refurbishment on the St Clements site. The savings required in the plan will be achieved from slippage of the Hospital Road development project and other ICT and Estates projects within the year.
Balance Sheet

At the end of month 2, the Trust held cash of £8.4m. This is behind the Annual Plan forecast by £2.4m.

This is primarily due to trade receivables being higher than plan with a balance of invoices with Norfolk County Council for Drugs & Alcohols services. These have now been received. There is also an outstanding balance with Norfolk County Council regarding s75 payments.

Non current assets are £14.9m ahead of plan. This is due to the results of the Trust Estate quinquennial valuation, which was too late to be confirmed within the submitted Annual Plan. This also impacts on the Revaluation Reserve which is also ahead of plan by £14.0m.
Cash flow

The cash position at Month 2 is behind plan by £2.42m. As previously stated this is primarily to a higher than forecast number of debtors which are outstanding for more than one month, including £1.3m with Norfolk County Council which has since been resolved.

It is anticipated that the cash balance will return to plan in future months if the overall I&E targets are met. Additional monitoring tools are being developed in order to provide a more detailed 13 week rolling forecast.
The Trust continues to report a COSRR of one for the month, and is in line with in the Annual Plan.

The headroom/improvement required to achieve a two in both liquidity and capital service cover is set out below.

### 2015-16 COSRR forecast

<table>
<thead>
<tr>
<th>Month</th>
<th>Capital Service</th>
<th>Liquidity</th>
<th>Continuity of Service Risk Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£m</td>
<td>£m</td>
<td>£m</td>
</tr>
<tr>
<td>Month 1</td>
<td>£0.543</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Month 2</td>
<td>£0.430</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Month 3</td>
<td>£0.563</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Month 4</td>
<td>£2.341</td>
<td>£2.393</td>
<td>£2.721</td>
</tr>
<tr>
<td>Month 5</td>
<td>£2.902</td>
<td>£3.392</td>
<td>£3.407</td>
</tr>
<tr>
<td>Month 6</td>
<td>£3.932</td>
<td>£4.477</td>
<td>£3.477</td>
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<tr>
<td>Month 7</td>
<td>£5.024</td>
<td>£5.747</td>
<td>£3.649</td>
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<tr>
<td>Month 8</td>
<td>£5.296</td>
<td>£6.296</td>
<td>£3.787</td>
</tr>
<tr>
<td>Month 9</td>
<td>£6.847</td>
<td>£6.847</td>
<td>£3.758</td>
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<tr>
<td>Month 10</td>
<td>£7.883</td>
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<td></td>
</tr>
<tr>
<td>Month 11</td>
<td>£0.013</td>
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<td></td>
</tr>
<tr>
<td>Month 12</td>
<td>£0.020</td>
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</tbody>
</table>

**Capital Service - to achieve a rating of 2**
- would need to be
- is currently
(Headroom available)/Improvement Required

**Liquidity - to achieve a rating of 2**
Cash for CoS liquidity purposes
- would need to be
- is currently
(Headroom available)/Improvement Required
Report To: Board of Directors – Public

Meeting Date: 25th June 2015

Title of Report: Trust Fire Policy Annual review

Action Sought: For Approval

Estimated time: 15 Minutes

Author: Mark Kittle: Head of Estates and Maintenance

Director: Leigh Howlett: Director of Strategy and Resources

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Executive Summary:

The annual review and update of the Trust Fire Policy has been undertaken by the Trust Fire Safety Advisers and the Head of Strategic Estates and Maintenance. At the request of the Board of Directors this report has been prepared to bring to their attention the significant changes that have been made to the existing policy to bring it in line with other Trust policies, changes in job titles and statutory compliance.

A copy of the new policy is included with this report.

1.0 Significant Changes

The following additions have been made to the 2014/15 Fire Policy.

- Page 1 - Trust policies Q15 and Q20 added to policy.
- Page 7 – Bank, agency and NHS Professional staff added to those staff requiring familiarisation training on their first with the Trust.
- Page 9 – Under section 5 a paragraph has been added which requires the Fire Incident Manager to contact the Hellesdon switch board to update them on all fire incidents.
- Page 12 – Under section 10 a paragraph has been added instructing all Estates and Maintenance staff to seek advice from the fire Safety Officer on all building related projects and changes that could affect the fire safety of the building.
• Page 12 – Under section 13 paragraphs have been added regarding the reporting of fire incidents on Datix in accordance with trust Policy Q20. This section also stipulates that all fire events no matter how small are reported to the Fire Service.

• Page 13 – Under section 14 a paragraph has been added requiring all staff to complete the Trust’s Induction Training (policy Q15)

The following sections have been removed from the 2014/15 Fire Policy.

• Page 11 – Under section 8 the paragraph outlining the requirement to undertake a further fire risk assessment in line with Part K has been removed as no longer relevant.

• Page 12 – Under section 13 the paragraph regarding the report of unwanted fires has been removed as this has been replaced with reporting on DATIX in accordance with policy Q20.

• Page 13 - Under section 14 the paragraph regarding the delivery of workplace induction by staff members line manager has been removed as this has been superseded by Trust policy Q15.

• Pages 17 to 24 – These pages have been removed as this has been issued a protocol and does not form part of the policy document.

2.0 Risks / mitigation in relation to the Trust objectives

The revised Fire Policy will ensure that the Trusts has in place processes that will ensure that Service Users, Staff and Visitors are cared for and work in a safe environment that complies with the latest legislation.

3.0 Recommendations

The Board of Directors is asked to approve the attached policy.

Mark Kittle
Head of Strategic Estates and Maintenance

Background Papers / Information

Updated Trust Fire policy for 2015/16.
<table>
<thead>
<tr>
<th>Title:</th>
<th>Fire Policy</th>
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</thead>
<tbody>
<tr>
<td>Outcome Statement:</td>
<td>Staff will be aware of the responsibilities of Directors, Managers, Employees and themselves for fire safety as required by current legislation in areas that they are responsible for.</td>
</tr>
<tr>
<td>Written By:</td>
<td>Mark Kittle, Fire Safety Manager</td>
</tr>
<tr>
<td>In Consultation With:</td>
<td>Malcolm Codd, Fire Safety Adviser</td>
</tr>
<tr>
<td>Approved By and Date:</td>
<td>NSFT Board of Directors – March 2014</td>
</tr>
<tr>
<td>Applicable To:</td>
<td>Trust wide (upgrading and alteration works to existing NSFT premises and the provision of new Trust premises)</td>
</tr>
<tr>
<td>For Use By:</td>
<td>All staff, employees of third parties, contractors and temporary workers who are engaged to work in NSFT premises.</td>
</tr>
<tr>
<td>Reference Number:</td>
<td>Q03</td>
</tr>
<tr>
<td>Version:</td>
<td>02</td>
</tr>
<tr>
<td>Published Date:</td>
<td>April 2014</td>
</tr>
<tr>
<td>Review Date:</td>
<td>April 2016</td>
</tr>
<tr>
<td>Equality Assessment</td>
<td>Completed Form submitted to the Trust Secretary for independent assessment</td>
</tr>
<tr>
<td>Implementation</td>
<td>Routine distribution procedures (publication on the Trust intranet, email notification to identified senior staff for distribution throughout the team and inclusion in the Trust Update e-bulletin).</td>
</tr>
</tbody>
</table>
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1.0 Introduction
The Norfolk and Suffolk NHS Foundation Trust Board are committed to achieving and maintaining the highest standards of fire safety management required by legislation, the Department of Health’s firecode and other relevant guidance notes and codes of practice. This Policy has been written in accordance with the Department of Health Technical Memorandum 05-01: Managing Healthcare Fire Safety. Second edition April 2013.

Fire is a potential hazard in all Norfolk and Suffolk NHS Foundation Trust (NSFT) premises. The consequence of a fire in a hospital and other health care premises can be especially serious because of the difficulties and dangers associated with the emergency evacuation of service users.

This policy is intended as the main policy statement of the NSFT on fire safety, and is supported by local fire procedures and evacuation plans developed and detailed in the site specific fire safety information manuals.

Where NSFT employees work in premises owned or managed by others the fundamental precautions will still apply however there will be site specific details which those employees will need to familiarise themselves with in order to cooperate with local management.

2.0 Purpose
The purpose of this policy therefore is to ensure that, if possible, outbreaks of fire do not occur but that if and when fires do occur, they are rapidly detected, effectively contained and quickly extinguished. This means that fire safety will depend on physical factors, including the building design and construction, equipment and furnishings, the installation and proper maintenance of detection and alarm systems, and on local management procedures for handling emergencies together with staff training in these matters.

3.0 Definitions/Glossary of Terms
Active fire safety systems:
- Characterised by items which require a certain amount of motion and response in order to work. This includes manual and automatic fire alarm systems and fire suppression systems.

Assembly point:
- A pre-determined area of safety where persons should assemble in the event of an emergency.

Authorising Engineer (Fire):
- A chartered fire engineer or a chartered member of an appropriate professional body, with extensive experience in healthcare fire safety.

Compartmentation:
- The fire-resisting elements including walls, floors, and where applicable, roofs and/or other structures used in the separation of one fire compartment from another.

Competence:
- Where a person is required to be competent, he/she must be able to demonstrate through training and experience or knowledge and other qualities that they have the ability to properly assist in undertaking the preventative and protective measures.

Competent Person (Fire):
- A person who can provide skilled installation and/or maintenance of fire-related services (both passive and active fire safety systems).

Complex healthcare organisations:
- Hospitals or other healthcare premises that perform invasive procedures and other treatments that place a dependence on staff for evacuation.

Fire emergency action plan:
- The pre-determined plan that describes the actions necessary in the event of a fire to protect relevant persons and facilitate their safe evacuation.

Fire-fighting equipment:
- The fire extinguishers, fire blankets and other equipment made available to trained personnel for the purpose of fighting fire.
Fire Incident Manager:
- The most senior person present at the time of a fire or the on call manager or director as dictated by the size and severity of the fire.

Fire resistance:
- the ability of an element of building construction, component or structure to fulfil, for a stated period of time, the required load-bearing capacity, fire integrity and/or thermal insulation and/or other expected duty in a standard fire resistance test.

Fire risk assessment:
- the process of identifying fire hazards and evaluating the risks to people, property, assets and the environment arising from them, taking into account the adequacy of existing fire precautions, and deciding whether the fire risk is acceptable without further fire precautions.

Fire Safety Adviser (Authorised Person – Fire):
- A person who has sufficient training and experience or knowledge and other qualities to enable them to properly assist in undertaking preventative and protective measures.

Fire safety information manual:
- A bespoke fire safety manual with specific information pertinent to staff working in each ward, department or area.

Fire safety management system:
- A robust framework of protocols and processes used to ensure that an organisation can fulfil all tasks required to achieve the fire safety objectives set out in the fire safety policy.

Fire Safety Manager:
- The person within the organisation tasked with coordinating fire safety issues throughout the organisation’s activities.

Fire Safety Order:
- The Regulatory Reform (Fire Safety) Order 2005.

Fire safety policy:
- A high level statement of intent, as expressed by the board, partners, or equivalent controlling body, setting out clear fire safety objectives for the organisation.

Fire safety procedure:
- A detailed document setting out each step of a process intended to prevent fire, maintain fire precautions, minimise fire hazards or effectively respond to a fire incident.

Fire safety protocols:
- A set of organisation-specific guidelines that set the fire safety parameters of any activity that may impact on fire risk.

Fire Marshal:
- Member of the staff who, in the event of a fire, conducts a sweep of a small section of the premises in order to confirm the evacuation.

Fire Warden:
- A member of the staff who acts as a focal point for local staff on matters of fire safety and assists the manager in fire safety issues.

Healthcare building:
- A hospital, treatment centre, health centre, clinic, surgery, walk-in centre or other building where patients are provided with medical care, diagnostics or other associated treatment.

Hot works:
- Operations involving the use of open flames or the local application of heat or friction such as welding, soldering, cutting or brazing.

Material change:
- A change in arrangements or circumstances that may have an impact on the validity of fire risk assessments, fire precautions, fire emergency action plans etc.

Passive fire safety systems:
- This is an integral component of the building such as fire resisting walls, floors and doors to contain a fire and slow its spread.
Place of relative safety:
- An initial place away from the immediate danger of fire and from which further evacuation is possible to a place of safety.

Place of safety:
- A place where persons are no longer in danger from fire.

Premises:
- The land, building, or part of a building which is owned, occupied or managed by the organisation.

Preventative and protective measures:
- The measures which have been identified by the responsible person in consequence of a risk assessment as the general fire precautions necessary to comply with the requirements and prohibitions imposed by the Fire Safety Order.

Progressive horizontal evacuation:
- Evacuation of patients away from a fire into an adjacent fire-free compartment on the same level.

Relevant person:
- Any person who may be lawfully on, or in the immediate vicinity of, the premises and who is at risk from a fire on the premises.

Responsible person:
- The employer of persons working at the premises, a person who has control of the premises, or the owner of the premises.

Young person:
- Any person who has not attained the age of 18.

4.0 Duties, Roles and Responsibilities
The Norfolk and Suffolk NHS Foundation Trust Board has overall accountability for the activities of the organisation, which includes fire safety.

Chief Executive
- The Chief Executive, on behalf of the Board, is responsible for sufficient governance arrangements being in place to ensure that current fire legislation is complied with and, where appropriate, the Department of Health’s Firecode guidance is implemented in all premises owned, occupied or under the control of the NSFT.
- Ensuring that this policy is reviewed annually and updated as necessary to address any changes to legislation, working practices, incidents or significant risks identified by the fire risk assessments.
- Ensuring that adequate resources are made available to implement the policy and carry out any remedial action or amendments to this policy.
- Discharging the day-to-day operational responsibility for fire safety through the Director with fire safety responsibility.
- Nominating a Board Level Director with responsibilities for fire safety. The Chief Executive will be responsible for notification of any change of the nominated Director.

Board Level Director (with fire safety responsibility)
- The Nominated Director is the Director of Strategy & Resources who is responsible for ensuring that all officers within the Trust having a responsibility for fire safety matters meet that responsibility.
- Overseeing and monitoring the response by managers, including the Fire Safety Manager, to reports received from Fire Safety Advisers or from the Fire and Rescue Service.
- In line with delegated authority, the Director with fire safety responsibility devolves day-to-day fire safety duties to the Fire Safety Manager.

At an operational level the Director with fire safety responsibility will:
- Assist the Chief Executive with board level responsibilities for fire safety matters.
- Ensure that the Trust has in place a clearly defined fire safety policy and relevant supporting protocols and procedures.
• Ensure that all work that has implications for fire precautions in new and existing Trust buildings is carried out to a satisfactory technical standard and conforms to all prevailing statutory and mandatory fire safety requirements including the Department of Health’s Firecode.
• Ensure that all proposals for new buildings and alterations to existing buildings are referred to the Fire Safety Manager before building control approval is sought.
• Ensure that all passive and active fire safety measures and equipment are maintained and tested in accordance with the latest relevant legislation/standards, and that comprehensive records are kept.
• Ensure cooperation between other employers where two or more share Trust premises.
• Ensure through senior management and line management structures that full staff participation in fire training and fire evacuation drills is maintained.
• Ensure that agreed programmes of investment in fire precautions are properly accounted for in the trust’s annual business plan.
• Ensure that an annual audit of fire safety and fire safety management is undertaken, and the outcomes communicated to the Trust Board.
• Fully support the Fire Safety Manager function.

Fire Safety Manager
• The Head of Strategic Estates and Maintenance has been identified as the Fire Safety Manager who will have overall responsibility for co-ordination and implementation of the Trust Fire Policy and will provide regular, reports to the nominated Director and the Health and Safety and Risk Management Group.
• The role of Fire Safety Manager is primarily a managerial role. The role does not necessitate the duty holder to possess fire safety competencies provided that they have sufficient access to competent fire safety advice provided either from an internal Fire Safety Adviser or an external source.
• The Fire Safety Manager and/or the nominated Director will ensure that all fire alarms, emergency lighting systems and items of fire fighting equipment are regularly serviced, tested and recorded in accordance with statutory and Firecode requirements.
• The Fire Safety Manager will ensure all proposals for new work and alterations to premises within the Trust are managed and that all contractors are fully informed of and comply with the Trust’s fire policy and permit to work procedures.
• The Fire Safety Manager will maintain an electronic register of Fire Risk Assessments for all Trust owned or occupied premises and ensure that the original signed document is sent to the relevant premises for retention on site so as to be readily available for inspection as necessary.
• The Fire Safety Manager will liaise with the Trust’s Fire Safety Advisers’ concerning all aspects of fire safety, fire risk assessment, staff training, identified action points, prioritisation of works ensuring work identified as capital is costed and prioritised for inclusion in the capital programme.
• The Fire Safety Manager is tasked with developing and managing the fire safety management system and will be responsible for:
  o The day to day implementation of the fire safety policy
  o Reporting non compliance with legislation, policies and procedures to the Director with fire safety responsibility
  o Obtaining expert advice on the application and interpretation of fire safety guidance including the Department of Health’s Firecode
  o Raising awareness of all fire safety features and their purpose throughout the Trust
  o The development, implementation, monitoring and review of the Trusts fire safety management system
  o The development, implementation and review of the Trusts fire safety policy and protocols
  o Ensuring that fire risk assessments are undertaken, recorded and suitable action plans devised
  o Ensuring that any exceptionally high significant risks identified in the Workplace Fire Risk Assessment are included in the Trusts risk register.
The operational management of fire safety risks identified by the Workplace Fire Risk Assessments
- Ensuring that requirements related to fire procedures for less-able staff, patients and visitors are in place
- The development, delivery and audit of an effective fire safety training programme
- The reporting of fire incidents in accordance with Trust Fire Safety Protocol and external requirements
- Monitoring, reporting and initiating measures to reduce false alarms and unwanted fire signals
- Liaising with external enforcing agencies
- Liaising with Trust Managers
- Liaising with Authorised Engineers (Fire)
- Ensuring that suitable fire safety audits are undertaken, recorded and the outcomes suitably reported

Local Management
- Modern Matrons, heads of service and departmental managers have responsibility for the operational management of Health and Safety matters including fire safety within their areas of responsibility to ensure that contraventions of fire safety precautions do not take place. They have responsibility for:
  - Ensuring local fire risk assessments are undertaken and maintained up to date and staff made aware of its contents and any significant findings.
  - Notifying the Fire Safety Adviser of any changes of use, including temporary changes, that may impact on the fire risk assessment and reporting any defects in fire safety equipment and ensuring that appropriate remedial action is taken.
  - Ensuring that local fire emergency action plans are developed and revised as necessary in response to changes, brought to the attention of staff and adequately rehearsed to ensure sufficient emergency preparedness.
  - Ensuring the availability of a sufficient number of trained staff at all times to implement the local fire emergency action plan, and to be responsible for the co-ordination and direction of staff action during an incident.
  - Ensuring that all staff under their supervision participates annually in fire safety training and fire drills. A record of fire safety training is to be kept for all staff under their supervision.
  - Ensuring that the duties outlined in this document and relevant fire safety instructions are brought to the attention of staff through local induction and ongoing staff briefings;
  - Ensuring that all new, bank, agency and NHS Professional staff, on their first day in the ward/department, are given basic familiarisation training within their workplace (see Q15: Corporate Induction), to include:
    - Local fire procedures and evacuation plan
    - Means of escape
    - Location of fire alarm manual call points
    - Fire-fighting equipment
    - Any hazardous substances
    - Any fire risks identified;
  - Keeping a record of staff induction and attendance at fire safety training;
  - Ensuring staff at all levels understand the need to report all fire alarm actuations and fire incidents as detailed in fire safety protocols
  - Ensuring that the staff record is completed and returned denoting how this policy has been brought to the attention of staff;
  - Where appropriate, ensuring that sufficient Fire Wardens and Fire Marshals are identified appointed and trained for their specific areas of responsibility.
Fire Safety Adviser
The Fire Safety Manager will appoint suitably qualified Fire Safety Advisers whose principal duties will be:

- Undertake record and report Fire Risk Assessments of all Trust owned or occupied premises.
- Undertake Fire Safety Training.
- Give fire compliance advice in respect of new work and alterations to premises.
- Give professional advice in regard to Fire compliance.
- Assist with the review of the content of the trust's fire safety policy.
- Assist with the development and delivery of a suitable and sufficient training programme for staff.
- The preparation of fire prevention and emergency action plans;
- The investigation of all fire-related incidents and fire alarm actuations;
- Liaison with the enforcing authorities on technical issues;
- Liaison with managers and staff on fire safety issues;
- Liaise with the Authorising Engineer (Fire).

Where specialist solutions are required to resolve fire safety issues, the Fire Safety Adviser would not necessarily be expected to have the level of skill required but would know the limits of their capabilities and, when necessary, seek specialist advice from an Authorising Engineer (Fire).

Fire Wardens
- Depending upon the size and complexity of the Trust's buildings and activities, Local Managers may appoint Fire Wardens to ensure there is a focal point for local staff on matters of fire safety.
- Fire Wardens essentially will be the "eyes and ears" within that local area but will not have an enforcing role. They will report any issues identified to their matron and/or head of service or departmental manager and if necessary to the Fire Safety Adviser or Fire Safety Manager.
- Fire Wardens will attend specialist fire training to allow them to carry out their duties and this training will count as their mandatory fire training for that year. In subsequent years refresher training will be given alongside the annual fire safety refresher training. All Fire Wardens will be issued with high visibility jackets.

The Fire Warden should:
- Act as the focal point on fire safety issues for the local staff;
- Organise and assist in the fire safety regime within local areas;
- Raise issues regarding local fire safety with their line management,
- Support line managers in their fire safety issues.

Fire Marshals
- In order to account for staff and visitors at the assembly point and to ensure the complete evacuation of a building in an emergency, the local manager may appoint Fire Marshals.
- Fire Marshals will not have an enforcing role but will check the building and confirm the state of the evacuation at the assembly point.
- Fire Marshals may be issued with high visibility jackets and additional training will be arranged as required.

Employees
All NSFT members of staff, employees of third parties, contractors, volunteers and temporary workers have a duty of care to themselves, patients, other staff and visitors.

- It is the duty of all staff to familiarise themselves with fire procedures, to comply with fire safety measures, to attend fire training and comply with fire instructions.
- All staff while at work must take reasonable care for the safety of themselves and of other relevant persons who may be affected by their acts or omissions at work.
- It is also an obligation on all staff to report failings to their Managers if they are unable to remedy a fire hazard.
Managers have personal and corporate responsibility but must always ensure that fire risk and non-compliance issues reported to them are either rectified or are reported to the Maintenance Services/Estates Department for action.

The most senior manager in a ward, department or building, has a particular responsibility to ensure that all fire safety measures are exercised and to reinforce the responsible person position and responsibilities.

Failure to comply with the spirit of Fire Policy and its application is considered a most serious matter and could lead to disciplinary action (see HRP016: Disciplinary policy).

5.0 Management in the event of fire

In the event of a fire in any of the Trusts premises, the most senior person in charge of an area and present at the time that an incident occurs will assume the role of the Fire Incident manager.

The Fire Incident Manager will ensure that Hellesdon Switchboard (01603 421421) is informed and updated of all fire incidents. Hellesdon Switchboard will contact the on call Maintenance Services Engineer, on call Manager and on call Director as appropriate.

As the situation develops the following personnel will be advised and the responsibility for fire incident manager will be passed on to the next level as indicated below.

- Small fire restricted to single room – managed by local Manager
- Large fire in single room or fire in multiple rooms involving the attendance of the emergency services – managed by On-call Manager
- Serious fire in critical area e.g. boiler house/kitchen causing loss of essential services resulting in the patients not being easily accommodated on site or a fire affecting multiple rooms/wards/whole building and requiring the evacuation of the site – managed by the On-call Director

6.0 Fire Safety Protocols

The Fire Safety Manager will ensure that a comprehensive set of fire safety protocols is available to provide sufficient guidance on fire safety issues to all areas of the Trusts organisation.

The contents of the fire safety protocol will provide a broad range of topics with information and procedures for fire safety related issues with coordinated input from all relevant disciplines of the Trust. The protocols will address fire safety issues concerning the following list of activities.

- fire management structure
- fire risk assessments
- fire prevention
- fire alarm and automatic fire detection systems
- reporting fires and unwanted fire signals
- portable fire extinguishers
- portable appliance testing
- construction, refurbishment and other works
- personal emergency evacuation plan
- fire emergency action plans
- fire safety information manuals
- fire safety training
7.0 Fire Safety Information Manual
Each of the Trust's premises will have a comprehensive Fire Safety Information Manual which will be maintained up to date and located in a secure position in the main entrance and if possible adjacent to the main fire alarm panel. In larger and more complex healthcare organisations, specific information pertinent to each ward, department or area will also be provided to staff that work within that area.

The NSFT Trust is working towards the issue of a fire safety information manual by the fire safety adviser following an in depth fire safety inspection of each site. The Fire Safety Manager and the Senior Maintenance Service Managers and Maintenance Managers will have access to a copy of the issued Fire Safety Information Manuals.

The Fire Safety Information Manual will be maintained by the local manager. Staff training records and records of fire drills/fire emergency action plan rehearsals should be updated as appropriate. Changes to the fire risk assessments, fire emergency action plans, salvage plans etc should be reflected in the Fire Safety Information Manual following discussion with the Fire Safety Manager or Fire Safety Adviser.

The Fire Safety Information Manual must be available for inspection by any auditor, regulator or, for operational purposes the Fire and Rescue Service.

The information contained within the Fire Safety Information Manual should be freely available to be viewed by any member of staff, patient or patient’s representative. Information which will be included in the manual:

- A description of the building.
- A brief description of the area, its extent, location and use.
- The name/position of the responsible person for the premises together with the name/position of deputies.
- A comprehensive fire drawing of the premises/ward showing all fire safety systems, equipment and arrangements. Including the locations of:
  - Fire compartmentation and sub-compartmentation;
  - Fire detection and alarm system devices;
  - Fire hazard rooms;
  - Fire doors
  - Fire extinguishers;
  - Emergency signage and lighting
  - Fire escape routes;
  - Evacuation equipment
  - Details of the fire procedure (also displayed in building)
- A copy of the emergency action plan specific to the ward/department/area. including:
  - Actions to be take on discovering a fire;
  - Actions to be taken on hearing the fire alarm;
  - Detailed procedures for evacuation;
  - The location of fire exits and evacuation equipment;
  - The location of fire extinguishers.
- A fire record or log book giving details of tests on installations,
  - Staff fire safety training records.
  - Records of fire drills and emergency fire action plan rehearsals.
  - Records of fires, false alarms and unwanted fire signals.
- Items required to support the continuation of care such as patient notes, specialist drugs or equipment;
- Fire training questionnaire
- Evacuation drill guidance notes
- Fire safety check list responsibilities
- Personal Emergency Evacuation Plans
- Copy of the current fire risk assessment for the building
- A copy of the fire risk assessment specific to the ward/department/area. Include any specific hazard items that have been identified and the protective and preventative measures in place to mitigate the resultant risk.
A fire safety checklist. A schedule of the fire safety checks that should be undertaken on commencement of work by the person in charge of the area during that work period, including for example:

- check that the nearest fire alarm repeat panel displays a healthy condition;
- check that the manual call points are unobstructed;
- check that the fire extinguishers are in place and readily accessible;
- check that escape routes are clear and unobstructed;
- check that the fire doors that should be kept shut are fully closed;
- Significant findings as identified by the Fire Safety Order;

• Staff Induction check list
• Details on the procedure for reporting fires and unwanted fire signals

Fire Safety Arrangements
8.0 Fire Risk Assessments
The Board of the Norfolk and Suffolk NHS Foundation Trust acknowledges its responsibilities under the Regulatory Reform (Fire safety) Order 2005 (FSO) and will ensure that suitable and sufficient fire risk assessments are carried out on all of its premises to determine the standard of fire precautions and any additional measures necessary to comply with the requirements imposed under the Order.

The fire risk assessment will follow the requirements of the FSO and will be carried out by the Fire Safety Adviser in conjunction with the local manager.

The Fire Risk Assessment will be undertaken in accordance with the Trust Fire Safety Protocols and a copy of the completed assessment will be forwarded to the Head of Strategic Estates and Maintenance and to the Senior Maintenance Service Manager and Maintenance Managers who will oversee and monitor the works identified in the action sheets as either maintenance or new work.

9.0 Regular Fire Safety Inspections
Regular Fire Safety Inspections will be carried out on each site as required by the Fire Safety Order and the fire risk assessment.

The inspections should be carried out at least monthly and should be undertaken by a member of the staff as designated by the Local Manager. The check list included within the Fire Safety Information Manual for the premises will be used to ensure that;

- The provided means of escape including corridors, circulation areas staircases and fire exits are unobstructed, signed and freely available for use in an emergency
- Fire resisting doors appear to be in reasonable condition with no obvious signs of damage. Smoke and heat seals intact and the door either self closing or kept locked shut
- Fire fighting equipment unobstructed in its allotted position with security seals in place and no obvious signs of damage
- That combustible materials and potential ignition sources are being maintained at a level which is as low as reasonable practical

Items identified which require remedial action will be reported or actioned by the Local Manager who will retain a copy of the check list and sign off the actions when completed.

10.0 Building Alterations
When alterations are planned for any building, including changes of use, due consideration will be given to ensure that the fire safety measures will not be compromised. Local Managers will notify the Fire Safety Manager and the Fire Safety Adviser of all proposed structural alterations and material changes to the use of rooms/areas to ensure continued compliance with the Building Regulations 2010, Regulatory Reform (Fire Safety) Order 2005 and Trust policies and protocols.
NSFT Estates staff and project managers will seek advice from the Fire Safety Adviser at an early stage concerning all new buildings, extensions, alterations and changes of use to any Trust property.

11.0 Premises Information Box/Grab Bag
All NSFT sites considered complex or accommodating in patient care will be provided with a premises information box sited adjacent to the main entrance. The contents of the premises information box will be agreed with the Fire and Rescue Service and in the event of a fire, the information will provide them with all relevant information concerning the premises.

In other sites consideration will be given to the provision of a Grab Bag which will contain similar information and will be brought to the assembly point by a member of the staff and handed to the attending fire crews.

In small Trust premises which do not involve patient accommodation the provision of a fire drawing adjacent to the main fire panel/entrance will be considered sufficient.

12.0 Disabled Staff/Visitors
The Local Manager will ensure that procedures are in place including the use of a Personal Emergency Evacuation Plan (PEEP) for disabled staff and regular visitors to the premises to ensure that in an emergency they can exit the building or if on a floor other than the ground floor, evacuate safely to a predetermined place of relative safety.

On reaching the predetermined location, which will normally be a safe refuge area within a staircase enclosure, it will be safe to remain there until the cause of the alarm is confirmed as a fire.

If a fire is confirmed anywhere in the building, the Local Manager will have arrangements in place, together with evacuation equipment and trained staff, to continue the evacuation to a place of safety.

In the event of a confirmed false alarm anyone at the refuge point will be safe to remain there until the person in charge has given staff at the assembly point the all clear to re-enter the building at which time they can resume their normal activities.

13.0 Fires and Unwanted fire Signals
Fires and Unwanted fire Signals will be reported using DATIX in accordance with Trust Policy Q20 – Accident and Incident Reporting. Any event which results in the fire alarm sounding which could or does result in damage to property, evacuation of persons from an area or the attendance of the Fire and Rescue Service will be reported by DATIX the Trust wide Incident, Accident & Untoward Event Reporting Form.

In the event of a fire, no matter how small or when a fire is suspected but not confirmed, staff must not hesitate in calling the fire and rescue service. A call should also be made for small fires which have been extinguished, possible without causing the fire alarm to operate.

The information regarding fire and unwanted fire Signals will be reported annually by the Fire Safety Manager as required by the Health and Social Care Information System and the Estates Return Information Collection (ERIC).

14.0 Induction
All staff (including part time, new, bank, agency and NHS Professional staff) are required to complete the Trust's Corporate induction (Q15 Corporate Induction Policy) which consists of a site specific workplace induction session together with fire training, on or before their first day of employment, or on relocating to a new work area.
The local fire safety induction training should include:

- Details of the risk identified in the fire risk assessments for the area(s) concerned;
- Details of the protective and preventative measures in place;
- Any specific instruction necessary to prevent fire in the area as a result of hazardous processes, substances and/or equipment;
- Details of the local fire emergency action plan including:
  - The action to be taken on discovery of a fire
  - Means of raising the fire alarm
  - The actions to take on hearing the fire alarm
  - Staff responsibilities during a fire incident
  - Procedures for evacuation
  - The location of fire exits and evacuation equipment
  - The location of fire extinguishers
  - Other relevant equipment etc.
- A physical tour of the escape routes and assembly points, if appropriate, or places of relative safety.

Temporary staff (NHS professionals, bank and agency) must complete fire safety induction training as part of their workplace induction (see Workplace Induction for Temporary Staff checklist in Q15: Corporate Induction policy)

**15.0 Fire Safety Training**

NSFT recognises that adequate fire safety training is essential to ensuring that fire prevention and emergency action plans can be put into practice. The safe evacuation of patients in the event of a fire will rely on the effective action of staff in implementing the emergency plan.

The Fire Safety Manager is responsible for ensuring that an appropriate programme of fire safety training is developed and suitable arrangements are in place for the delivery of that training by the Fire Safety Adviser to all employees and other relevant staff.

The provision of adequate fire safety training is a legal duty placed on the responsible person by the Fire Safety Order and it is the responsibility of matrons, heads of service and departmental managers to arrange training sessions and ensure that all members of the staff attend an appropriate fire safety training session.

All staff training should be site specific and take place during the normal working hours and on the premises of those being trained. Exceptions to this may include community based staff and admin staff who have no responsibilities in an emergency for others and may receive their training at a central location.

In order to verify that appropriate training has been undertaken by each member of staff, records will be kept which will include:

- names of those attending;
- location, date and duration of the training;
- nature and content of training given; and
- name and details of those providing the instruction

A copy of the record will be forwarded to Education and Development to update each student’s record and this will also be available to local management to enable them to monitor the training of all staff under their supervision.

The use of e-learning is not acceptable as the sole means of training staff and e-learning will only be used to support training delivered by the Fire Safety Adviser.

Education and Development will be responsible for monitoring the fire safety training to ensure that it is having the desired effect and will report to the Nominated Director and the Board of Directors.
16.0 Fire Safety Refresher Training
All staff will receive fire safety refresher training and instruction arranged by the local manager and delivered by the Fire Safety Adviser; this will include some or all of the following;

- raising the alarm, informing the main telephone switchboard and requesting assistance;
- removing patients (and others) in immediate danger to a place of safety;
- fighting the fire with approved equipment, but only if it is safe to do so and if they have been trained in their use;
- evacuation of the area in accordance with the emergency evacuation plan;
- closing all doors, windows, hatches etc to prevent further spread of fire, smoke and toxic fumes;
- the reasons for fire and smoke compartmentation of buildings and for protected escape routes to the open air;
- the importance of ensuring that the intended functions of fire/smoke doors are not prejudiced by the dangerous practice of wedging them in the open position;
- the significant findings of relevant fire risk assessments;
- the need to be familiar with escape routes, site layout, and the internal layout of the premises in which they work and reside, and to recognise the need to keep escape routes free of obstruction and rubbish;
- the potentially fatal consequences of the spread of fire, smoke and toxic gases;
- the importance and benefits of reducing false alarms and unwanted fire signals;

With due consideration to the recommendations of HTM 05-01 and the requirements of the Regulatory Reform Order, the policy of the Board of Directors of NSFT is that fire safety refresher training will be delivered annually to all members of staff.

17.0 Specialist Training
At the request of the local manager, additional training will be provided by the Fire Safety Adviser to meet the special needs of particular locations and for those staff who have special responsibilities such as;

- Nursing staff and any others who may have to assist in the evacuation of patients
- Telephone switchboard operators
- Maintenance staff
- Cleaning and housekeeping staff
- Fire wardens and fire marshals
## 18.0 Monitoring Statement

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Appendix 1

Fire Safety Protocols

The following Fire Safety Protocols have been written to support this policy:

1. Fire Management Structure.
2. Fire Risk Assessments.
3. Fire Prevention. (see Appendix 2 for example)
5. Reporting Fires and Unwanted Fire Signals.
6. Portable Fire Fighting Equipment.
8. Construction, Refurbishment and Other Works.
10. Fire emergency action plan.
12. Fire safety training.
Executive Summary:

The OD & Workforce Committee met on 18 May. This report is additional to the verbal report presented at the May meeting of NSFT Board & highlights issues that need to be brought to the attention of the Board of Directors.

1.0 Report contents

1.1 Staffing Levels

In examining all the workforce performance information presented the Committee focused on concerns about vacancy levels and the heavy dependency on temporary staffing - in part because of increased posts from the 'safer staffing' investment, why NHSP were unable to cover more of the shortfall and both longer term strategies and shorter term ideas to address the issues. Several sources of improvement existed including pay recognition in particular places, e rostering, speeding up recruitment practices, early notification and clear expectations of NHSP and framework agreements with agencies when appropriate. Some of the costs the Trust was incurring were unacceptable. Particular concerns focussed on medical cover in West Norfolk, nursing strength in Lowestoft and CAMHs more widely, but not certainly excluding other concerning services or areas.

1.2 Staff Engagement

The committee is tracking as carefully as it can what is actually happening, and feels to staff that it is happening, in localities and services, notwithstanding central initiatives to address many of the weaknesses identified in staff survey and Friends and Family responses. The committee needs assurance that the different elements of weaknesses in different places and for different reasons are being differentially addressed by local senior managers. It is too easy to generalise - some places are producing more acceptable
results in particular areas and Locality/Service managers need to recognise the reasons for this, to challenge & seek to improve matters in sufficiently targeted ways.

It is clear however that reductions in staffing and feelings about changed care pathway configurations post TSS, combined with increasing ever increasing demand and inability to recruit sufficient staff to even existing vacancies are the prime causes of unrealistic workload expectations of staff and damaged morale.

1.3 Other Workforce issues

The Committee were appreciative of the changed presentation of workforce data in which it was easier to identify trends. The Committee sought assurances about medical staffing aspects (e.g. psychotherapy training, supervision of trainees - the Core Programme Director will be attending the July Committee meeting), the sustainability of improvements in appraisals (not withstanding over complex paperwork which the Committee wished to see amended at the earliest possible date) and statutory and management training areas of concern to the CCGs. A particular highlight is the very positive relationship with nurse training programmes at UEA and UCS, and potentially as sources of future employees. Attention similarly needs to focus on occupational therapy, psychology, social work and other clinical areas of practice education, development and future recruitment.

An outstanding and ‘nagging’ question remains for the Committee Chair and two Non-Executive colleagues as to whether since the role of a single Director of Workforce there is - and can be - sufficient strength of leadership, focus and coherence to workforce matters with all the many other pressures and priorities for the Director of Strategy and Resources and the Director of Nursing. If the model is correct, then is there sufficient strength at the next ‘level’? Is this a more immediate issue for the Chief Executive to consider and should not await the completion of the Corporate Service review process? The Committee believes that this question must continue to be asked.

2.0 Recommendations

2.1 That this report be accepted by the Board.

Brian Parrott
NED & Chair OD&W Committee
29 May 2015
Executive Summary:

The Committee is awaiting copies of the QIP PID and Action plans for Ligature Risks and Line of Sight for which it has oversight responsibility.

The Committee received the Annual Reports in respect of Counter Fraud and Internal Audit for 2014/15.

The Committee approved the Annual Plans for Internal Audit and Counter Fraud for 2015/16.

The Committee asked for the Trusts’ cyber risk to be assessed and reported.

The Annual Self Assessment and Annual Report of the Committee for 2014/15 were approved and are submitted to the Board of Directors for consideration.

1.0 Report from the Audit & Risk Committee on 10th June 2015

As in previous years Governors were issued with an open invitation to attend the June meeting of the Committee when annual reports and plans are considered and approved and annual plans received. Four Governors joined the meeting.

The main issues discussed and to be brought to the Board’s attention from the Audit and Risk Committee meeting on 10th June 2015 are as follows:
1.1 The Committee asked for the Business Continuity and Disaster Recovery risks and actions to be reviewed as the proposed long term 'cloud based' solution has been delayed. The Chair has raised this with Leigh Howlett.

1.2 The Committee has requested and is awaiting copies of the QIP PID and Action plans for Ligature Risks and Line of Sight for which the Committee has been assigned responsibility for overseeing. Urgency has been requested in providing these documents.

1.3 The Committee raised concerns about the increasing number of salary overpayments. This had been a problem in the past but had, in recent years improved. The situation is being monitored and action taken by the Finance Department. The Committee asked Internal Audit to check the operation of controls by line managers.

1.4 The Counter Fraud Annual Plan for 2015/16 was approved

1.5 The Counter Fraud Annual Report for 2014/15 was received and noted. The main points were:
   - 90% of staff have completed the mandatory counter fraud training
   - There was a poor response of 5% to the counter fraud survey. The Committee suggested a new approach
   - 10 investigations were conducted in the year. Most were employment related. The exception was the ongoing investigation of potentially bogus temporary staff from a particular agency which is now no longer used

1.6 The Internal Audit Plan for 2015/16 was approved.

1.7 The Internal Audit Annual Report for 2014/15 was received and noted. The main points were:
   - The Head of Internal Audit’s opinion of the control environment. This has previously been reported to the Board.
   - The self assessment by Internal Audit against the public sector audit standards had been completed and an action plan prepared to address areas for improvement. The service is mainly compliant against best practice.
   - The three audits completed since the year end (Penetration Testing, Procurement Strategy and Policy and IG Governance Toolkit) all reported ‘substantial’ assurance. This is encouraging.

1.8 The Committee agreed the Chair’s assessments of the performance of Internal Audit. The self assessment by Internal Audit was received and noted. Assessments are awaited from the Director of Finance and the external auditors before the overall assessment can be completed and reported to the Board of Directors.

1.9 The Committee asked for the cyber security risk to the Trust to be evaluated and reported to the next meeting.
The Committee approved its self assessment of performance against best practice, established standards and its terms of reference and work plan for the year 2014/15 concluding compliance with each. The main concern was that despite this outcome the Trust had received adverse reports by the CQC and Monitor. The Committee acknowledged its part in this disappointing situation. The Self-Assessment is attached. Because Clinical Audit is now the responsibility of the Quality Governance Committee (QGC), it is suggested that they Self-Assessment checklist in respect of this activity is completed by the QGC.

The Committee agreed its Annual Report to the Boards of Directors and Governors for 2014/15 which is attached.

Financial and Quality Implications

There are no direct financial or quality implications of this report. The Committees’ work provides assurance on the control environment and the risk management of the Trust highlighting appropriate issues to the Board of Directors.

Recommendations

The Board are asked to note the work of the Audit and Risk Committee, the issues and actions raised and to receive the Committee’s Self Assessment and Annual Report in respect of 2014/15.

John Brierley
Chair of the Audit & Risk Committee
Non-Executive Director
15th June 2015.
Report To: Audit & Risk Committee  
Meeting Date: 10th June 2015  
Title of Report: Self-Assessment of the Committee 2014/15  
Action Sought: For approval  
Purpose of the Report: To provide assurance that the performance of the Committee is in accordance with its terms of reference and with best practice.

Author: John Brierley, Non-Executive Director (Chair of the Committee)  
Director: John Brierley, Non-Executive Director (Chair of the Committee)

Executive Summary:

The attached checklist has been used to assess various aspects of the Committee’s performance for the year 2014/15. The Committee’s assessment indicates that the Committee can provide the Board of Directors with assurance that it has operated in accordance with best practice and its terms of reference.

This Committee are asked to approve this assessment for presentation to the Board of Directors.

1.0 Report Content

1.1 The Committee has self-assessed that it has acted in accordance with its terms of reference and with best practice. It has used the attached checklist Appendix 1 to assist in this review.

1.2 The Committee has benefitted from an external assessment by the Foresight Partnership in 2014/15 which carried out an independent review of the performance of the Board of Directors and its Committees. This review reported positively on the performance of the Committee.

1.3 The main concern that arises from the review of the Committee and its performance must be that the Trust was rated as inadequate by the Care Quality Commission and placed in special measures by Monitor. In carrying out this review in relation to the above the following comments can be made:

- Best practice has been applied by the Committee.
• Processes in respect of the internal control and governance have been followed and issues of concern reported to the Board of Directors.
• The Chair of the Service Governance Committee (now the Quality Governance Committee) has reported concerns in respect of clinical and quality governance throughout the year. These concerns have been reported directly to the Board by the Chair of Service Governance Committee and reaffirmed by the Chair of Audit and Risk Committee.
• Monitor Governance ratings have been consistently met for most of the year.
• Improvements have been achieved and more are planned and are being worked on in respect of board assurance and risk management.

Nevertheless the Trust has found itself with unsatisfactory assessments in reports by the CQC and Monitor and the Committee accepts its part in those conclusions. Work is underway by the Trust to improve leadership and governance and these arrangements will be reviewed by the Committee.

2.0 Risks to Trust Objectives

2.1 The Trust must have in place and apply sound governance and internal control arrangements. It is clear these have fallen short of expectations despite processes being in place which are generally assessed as being in line with best practice. The major weaknesses and therefore risks to Trust objectives are that risk practices have not been consistently applied and/or that, in respect of clinical governance, actions have not been fully or consistently applied or evidenced.

3.0 Recommendations

3.1 The Committee members are asked to approve this report and comments by the Chair of the Committee and agree or suggest suitable amendments for submission to the Board of Directors.

John Brierley
Committee Chair
1 June 2015

Background Papers / Information

Appendix I: Audit Committee Self-Assessment Checklist
Audit Committee: Self-Assessment Checklist 2014/15

Status Key:
1 = must do
2 = should do
3 = could do

<table>
<thead>
<tr>
<th>Status</th>
<th>Issue</th>
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<th>No</th>
<th>N/A</th>
<th>Comments / Action</th>
</tr>
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<tr>
<td><strong>Composition, Establishment and Duties</strong></td>
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</tr>
<tr>
<td>1</td>
<td>Does the Audit Committee have written terms of reference that adequately and realistically define the Committee’s role in accordance with the Department of Health / Monitor guidance?</td>
<td>✔</td>
<td></td>
<td></td>
<td>Reviewed Feb 2014 and incorporated all current guidance. <strong>To be checked and updated.</strong></td>
</tr>
<tr>
<td>1</td>
<td>Have the terms of reference been adopted by the Board?</td>
<td>✔</td>
<td></td>
<td></td>
<td>Approval at Board meeting in May 2014.</td>
</tr>
<tr>
<td>1</td>
<td>Are the terms of reference reviewed annually to take into account governance developments (including integrated governance principles) and the remit of other committees within the organisation?</td>
<td>✔</td>
<td></td>
<td></td>
<td>Done at June 2014 Committee meeting with Governors in attendance. The Committee’s ToR were amended to recognise the creation of the Service Governance Committee as a full committee of the BoD from Jan 2014. The review considered the different governance responsibilities of the Committees with the A&amp;RC maintaining an overview of the overall governance arrangements. <strong>To be reviewed in April 2015 by the BoD.</strong></td>
</tr>
<tr>
<td>2</td>
<td>Has the Committee established a plan for the conduct of its own work across the year?</td>
<td>✔</td>
<td></td>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>1</td>
<td>Has the Committee been provided with sufficient membership, authority and resources to perform its role effectively and independently?</td>
<td>✔</td>
<td></td>
<td></td>
<td>3 Non-Executive Director members – one of whom has a clinical background / profession</td>
</tr>
<tr>
<td>2</td>
<td>Are changes to the Committee’s current and future workload discussed and approved at Board level?</td>
<td>✔</td>
<td></td>
<td></td>
<td>Reviewed throughout the year as necessary.</td>
</tr>
<tr>
<td>1</td>
<td>Are Committee members independent of the management team?</td>
<td>✔</td>
<td></td>
<td></td>
<td>The committee members are all NEDs</td>
</tr>
<tr>
<td>1</td>
<td>Does the Committee report regularly to the Board?</td>
<td>✔</td>
<td></td>
<td></td>
<td>Chair of Audit &amp; Risk reports to Board of Directors after each meeting</td>
</tr>
</tbody>
</table>
## Status | Issue | Yes | No | N/A | Comments / Action
--- | --- | --- | --- | --- | ---
1 | Has the Chair of the Committee a prior understanding of, or received training in, finance and internal control or other relevant expertise? | ✓ | | | Chair is a qualified accountant who attends regular regional and national updates and seminars as part of his CPD |
1 | Are new members provided with appropriate induction | | | | Any new members have received an induction. |
1 | Does the Board ensure that members have sufficient knowledge of the organisation to identify key risk areas and to challenge both line management and the auditors on critical and sensitive matters? | ✓ | | | Committee membership includes an accountant, a consultant psychiatrist, and includes the SID. |
1 | Does the Committee prepare an annual report on its work and performance in the preceding year for consideration by the Board? | ✓ | | | This is completed annually. |
1 | Does the Committee assess its own effectiveness periodically? | ✓ | | | Reviewed annually. |

### Meetings

| Status | Issue | Yes | No | N/A | Comments / Action |
--- | --- | --- | --- | --- | ---
1 | Has the Committee established a plan of matters to be dealt with across the year? | ✓ | | | Plan which is approved by the Board of Directors – and reviewed during the year at each Committee meeting |
1 | Does the Committee meet sufficiently frequently to deal with planned matters and is enough time allowed for questions and discussion? | ✓ | | | Work plan organised to reflect planned events in the Trust. Seven meetings per annum. Additional meetings can be arranged as may be needed. |
1 | Does the Committee’s calendar meet the Board’s requirements and financial and governance calendars | ✓ | | | Yes |
2 | Are Committee papers distributed in sufficient time for members to give them due consideration? | ✓ | | | Trust standards and standing orders met for meetings |
2 | Are Committee meetings scheduled prior to important decisions being made? | ✓ | | | Yes and described in the Committee’s Workplan |
2 | Is the timing of Committee meetings discussed with all the parties involved? | ✓ | | | Via paper of committee proposed dates External and Internal Audit consulted re Annual Accounts and Report dates Dates amended as required by Monitor timetable |
<table>
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<tr>
<th>Status</th>
<th>Issue</th>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
<th>Comments / Action</th>
</tr>
</thead>
</table>

### Compliance with the law and regulations governing the NHS

1. **Does the Committee review assurance and regulatory compliance reporting processes?**
   - Yes
   - **Internal audit reports and reviewed BAF and risk processes during the year.**

3. **Has the Committee formally assessed whether there is a need for the support of a “Trust / Company Secretary” role or its equivalent?**
   - Yes
   - **Support has always been provided by the Trust Secretary and nominees.**

2. **Does the Committee have a mechanism to keep it aware of topical, legal and regulatory issues?**
   - Yes
   - **Internal & External Audit advice, Trust solicitors briefings, NHS Providers seminars and Network Updates from KPMG and other accountants. Other seminars as appropriate.**

### Internal control and risk management

1. **Has the Committee formally considered how it integrates with other committees that are reviewing risk: e.g. risk management and clinical governance?**
   - Yes
   - **The Committee will continue to oversee risk and governance arrangements although those relating to clinical risk and governance were strengthened by the Service Governance Committee (now Quality Governance Committee) becoming a full committee of the board from January 2014.**

1. **Has the Committee formally considered how its work integrates with wider performance management and standards compliance?**
   - Yes
   - **Cross referencing with Service Governance and Finance & Performance Committees for 2014/15.**

1. **Has the Committee reviewed the robustness and content of the organisation’s Assurance Framework?**
   - Yes
   - **Internal Audit report and work on the new BAF which is continuing development and improvement. BAF reviewed with the Trust Secretary. Further developments planned.**

1. **Has the Committee reviewed the robustness of the draft Statement of Internal Control / Annual Governance Statement before it is presented to the Board?**
   - Yes
   - **Yes the A&RC reviews annually before the BoD receives the Annual Report and Accounts.**
<table>
<thead>
<tr>
<th>Status</th>
<th>Issue</th>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
<th>Comments / Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>Has the Committee reviewed whether the reports it receives are timely and have the right format and content to enable it to discharge its internal control and risk management responsibilities?</td>
<td>✓</td>
<td></td>
<td></td>
<td>Yes, this is kept under review throughout the year.</td>
</tr>
<tr>
<td>1</td>
<td>Has the Committee reviewed the robustness of the data behind reports and assurances received by itself and the Board?</td>
<td></td>
<td></td>
<td></td>
<td>A&amp;RC continues to maintain an overview. Any concerns are raised by the Chair in reports to the Board.</td>
</tr>
<tr>
<td>1</td>
<td>Is the Committee satisfied that the Board has been advised that assurance reporting is in place to encompass all the organisation's responsibilities?</td>
<td>✓</td>
<td></td>
<td></td>
<td>Monthly reports on Board Assurance Framework contributing to the ongoing review of assurance received. BAF review and improvements and introduction of Service Governance Committee from Jan 2014. Further work ongoing following internal and external concerns on assurance.</td>
</tr>
<tr>
<td>1</td>
<td>Is the Committee's role in reviewing and recommending to the Board the annual report and accounts clearly defined</td>
<td>✓</td>
<td></td>
<td></td>
<td>In A&amp;RC Terms of Reference to review the report and accounts before the BoD</td>
</tr>
<tr>
<td>1</td>
<td>Does the Committee consider the External Auditor's report to those charged with governance including the proposed adjustments to the accounts?</td>
<td>✓</td>
<td></td>
<td></td>
<td>Review of report and accounts before the BoD approved</td>
</tr>
<tr>
<td>1</td>
<td>Does the Committee review the management's letter of representation?</td>
<td>✓</td>
<td></td>
<td></td>
<td>The Committee recommends the letters of representation to the BoD annually.</td>
</tr>
<tr>
<td>1</td>
<td>Is there clarity over the timing and content of the assurance statement received by the Committee from the Head of Internal Audit?</td>
<td>✓</td>
<td></td>
<td></td>
<td>Yes Roling 12-month assurance opinion</td>
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### Internal Audit

<table>
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<tr>
<th>Status</th>
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<th>No</th>
<th>Comments / Action</th>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>Is there a formal “charter” or terms of reference defining Internal Audit’s objectives, responsibilities and reporting lines?</td>
<td>✓</td>
<td></td>
<td>IA Charter approved annually</td>
</tr>
<tr>
<td>1</td>
<td>Are the terms of reference approved by the Committee and routinely reviewed?</td>
<td>✓</td>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>2</td>
<td>Are the key principles of the terms of reference set out in the Standing Financial Instructions</td>
<td>✓</td>
<td></td>
<td>SFI 3.1 (cross-checked ref 27 Feb 2014). Check and update</td>
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<tr>
<td>Status</td>
<td>Issue</td>
<td>Yes</td>
<td>No</td>
<td>N/A</td>
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<tr>
<td>1</td>
<td>Does the Committee review and approve the Internal Audit plan at the beginning of the financial year?</td>
<td>✓</td>
<td></td>
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<tr>
<td>1</td>
<td>Does the Committee approve any material changes to the plan?</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Are audit plans derived from clear processes based on risk assessment with clear links to the Assurance Framework?</td>
<td>✓</td>
<td></td>
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<tr>
<td>1</td>
<td>Does the Committee receive periodic reports from the Head of Internal Audit?</td>
<td>✓</td>
<td></td>
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</tr>
<tr>
<td>1</td>
<td>Do these reports inform the Audit Committee about progress or delays in completing the audit plan?</td>
<td>✓</td>
<td></td>
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<tr>
<td>3</td>
<td>Has the Committee established a process whereby it reviews any material objection to the plans and associated assignments that cannot be resolved through negotiation?</td>
<td>✓</td>
<td></td>
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<tr>
<td>2</td>
<td>Does the Committee effectively monitor the implementation of management actions arising from audit reports?</td>
<td>✓</td>
<td></td>
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</tr>
<tr>
<td>1</td>
<td>Does the Head of Internal Audit have a direct line of reporting to the Committee and its Chair</td>
<td>✓</td>
<td></td>
<td></td>
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<tr>
<td>2</td>
<td>Is internal audit free of any scope restrictions, and if not, what are they and who established them?</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Is Internal Audit free from any operating responsibilities or conflicts of interest that could impair its objectivity?</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Has the Committee determined the appropriate level of detail it wishes to receive from Internal Audit?</td>
<td>✓</td>
<td></td>
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<tr>
<td>Status</td>
<td>Issue</td>
<td>Yes</td>
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<tr>
<td>1</td>
<td>Does the Committee hold periodic private discussions with the Head of Internal Audit?</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Does the Committee review the effectiveness of Internal Audit and the adequacy of staffing and resources of Internal Audit?</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Has the Committee evaluated whether internal audit complies with the NHS internal audit standards (or Government internal audit standards in an FT?)</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Has the Committee agreed a range of Internal Audit performance measures to be reported on a routine basis?</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Does the Committee receive and review the Head of Internal Audit’s annual report and opinion?</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Is there appropriate cooperation with the External Auditors?</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Are there any quality assurance procedures to confirm whether the work of the Internal Auditors is properly planned, completed, supervised and reviewed?</td>
<td>✓</td>
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**External Audit**

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<tr>
<th>Status</th>
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<th>No</th>
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<th>Comments / Action</th>
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<tbody>
<tr>
<td>1</td>
<td>Do the External Auditors present their audit plans and strategy to the Committee for approval?</td>
<td>✓</td>
<td></td>
<td></td>
<td>Yes, annually.</td>
</tr>
<tr>
<td>2</td>
<td>Has the Committee satisfied itself that work not relating to the financial statements work is adequate and appropriate?</td>
<td>✓</td>
<td></td>
<td></td>
<td>No issues of concern. External Audit plans are considered and agreed each year. Letter of independence reviewed annually.</td>
</tr>
<tr>
<td>Status</td>
<td>Issue</td>
<td>Yes</td>
<td>No</td>
<td>N/A</td>
<td>Comments / Action</td>
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<tr>
<td>2</td>
<td>Does the Committee receive and monitor actions taken in respect of prior years' reviews?</td>
<td>✓</td>
<td></td>
<td></td>
<td>Via reports presented to each meeting and in the annual report/management letter.</td>
</tr>
<tr>
<td>1</td>
<td>Does the Committee review the External Auditor’s ISO 260 Report?</td>
<td>✓</td>
<td></td>
<td></td>
<td>Yes, annually.</td>
</tr>
<tr>
<td>1</td>
<td>Does the Committee review the External Auditor’s use of resources conclusions</td>
<td>✓</td>
<td></td>
<td></td>
<td>Yes covered by the review of External Auditor’s report</td>
</tr>
<tr>
<td>1</td>
<td>Does the Committee hold periodic private discussions with the External Auditor?</td>
<td>✓</td>
<td></td>
<td></td>
<td>Pre-meetings held annually and other meetings as necessary.</td>
</tr>
<tr>
<td>2</td>
<td>Does the Committee assess the performance of External Audit?</td>
<td>✓</td>
<td></td>
<td></td>
<td>Assessed by the Committee Chair and Director of Finance annually and reported to committee. Audit contract retendered in 2014. KPMG reappointed by the BoG.</td>
</tr>
<tr>
<td>3</td>
<td>Does the Committee require assurance from External Audit about the policies for ensuring independence and compliance with staff rotation requirements?</td>
<td>✓</td>
<td></td>
<td></td>
<td>Reviewed during appointment process and annual review. Letter of independence. Staff have been rotated whilst maintaining sufficient continuity and knowledge.</td>
</tr>
<tr>
<td>3</td>
<td>Does the Committee review the nature and value of non-audit work carried out by External Audit</td>
<td>✓</td>
<td></td>
<td></td>
<td>Reviewed and independence letter received and reviewed annually</td>
</tr>
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</table>

**Clinical Audit**

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<thead>
<tr>
<th>Status</th>
<th>Issue</th>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
<th>Comments / Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Is the Committee clear about where clinical audit assurances are received and monitored?</td>
<td>✓</td>
<td></td>
<td></td>
<td>Since January 2014 responsibility of the Service Governance Committee with annual and bi-monthly update reports by the Chair of that committee to A&amp;RC. Others as required by regulators to BoD</td>
</tr>
<tr>
<td>2</td>
<td>If it is the Audit Committee that receives and monitors clinical audit assurances, does it:</td>
<td>/</td>
<td></td>
<td>N/A</td>
<td>in 2014/15 by Service Governance Committee.</td>
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<tr>
<td></td>
<td>• Review the clinical audit plan at the beginning of each year?</td>
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<td></td>
<td>• Confirm that clinical audit plans are derived from clear processes based on risk assessment with clear links to the Assurance Framework</td>
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<tr>
<td>Status</td>
<td>Issue</td>
<td>Yes</td>
<td>No</td>
<td>N/A</td>
<td>Comments / Action</td>
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<td></td>
<td>• Receive periodic reports from the person responsible for clinical audit?</td>
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<td></td>
<td>• Effectively monitor the implementation of management actions arising from clinical audit reports?</td>
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<td></td>
<td>• Ensure the person responsible for clinical audit has a direct line of access to the Committee and its Chair</td>
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<td></td>
<td>• Hold periodic private discussions with the person responsible for clinical audit?</td>
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<td></td>
<td>• Review the effectiveness of clinical audit and the adequacy of staffing and resources available for clinical audit?</td>
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<td></td>
<td>• Evaluate clinical audit against the Healthcare Quality Improvement Partnership's publication Clinical Audit: A simple guide for NHS Boards?</td>
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<td></td>
<td>• Confirm that there are quality assurances procedures in place to confirm whether the work of clinical auditors is properly planned, completed, supervised, and reviewed?</td>
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<td></td>
<td>• Confirm that there are terms of reference for clinical audit that define its objectives, responsibilities and reporting lines?</td>
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<td></td>
<td>• Review clinical audit’s terms of reference regularly?</td>
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</table>

### Counter-fraud

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<thead>
<tr>
<th></th>
<th>Does the Committee review and approve the counter fraud work plan at the beginning of each year</th>
<th>✓</th>
<th>Yes – annually and confirmed at June meeting when Governors are invited to attend.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Does the Committee satisfy itself that the work plan adequately covers each of the areas defined in NHS counter fraud policy?</td>
<td>✓</td>
<td>Reported by CF specialist and monitored by NHS Protect</td>
</tr>
<tr>
<td></td>
<td>Does the Committee approve any material changes to the plan?</td>
<td>✓</td>
<td>Yes – through interim reports</td>
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<tr>
<td></td>
<td>Are counter fraud plans derived from clear processes based on risk assessment?</td>
<td>✓</td>
<td>Yes – annual plan.</td>
</tr>
<tr>
<td></td>
<td>Does the Audit Committee receive periodic reports from the local counter fraud specialists?</td>
<td>✓</td>
<td>Yes – at every meeting and an annual report</td>
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<tr>
<td></td>
<td>Does the Committee effectively monitor the implementation of management actions arising from counter fraud reports?</td>
<td>✓</td>
<td>Yes – at every meeting</td>
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<tr>
<td>Status</td>
<td>Issue</td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>1</td>
<td>Does the local counter fraud specialist have a right of direct access to the Committee and its Chair?</td>
<td>✓</td>
<td></td>
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<tr>
<td>1</td>
<td>Does the Committee review the effectiveness of the local counter fraud service and the adequacy of its staffing and resources?</td>
<td>✓</td>
<td></td>
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<tr>
<td>1</td>
<td>Does the Committee receive and review the local counter fraud specialist’s annual report of counter fraud and qualitative assessment?</td>
<td>✓</td>
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<tr>
<td>1</td>
<td>Does the Committee receive and discuss reports arising from quality inspections by NHS Protect?</td>
<td>✓</td>
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<td></td>
<td><strong>Annual Accounts and disclosure statements</strong></td>
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<tr>
<td>1</td>
<td>Is the Committee’s role in the approval of the annual accounts clearly defined?</td>
<td>✓</td>
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<tr>
<td>2</td>
<td>Is a Committee meeting scheduled to discuss proposed adjustments to the accounts and issues arising from the audit?</td>
<td>✓</td>
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<tr>
<td>1</td>
<td>Does the Committee specifically review: • Changes in accounting policies? • Changes in accounting practice due to changes in accounting standards? • Changes in estimation techniques? • Significant judgements made?</td>
<td>✓</td>
<td></td>
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<tr>
<td>3</td>
<td>Does the Committee review the draft accounts before the start of the audit?</td>
<td>✓</td>
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<tr>
<td>1</td>
<td>Does the Committee ensure it receives explanations as to the reasons for any unadjusted errors in the accounts found by External Audit?</td>
<td>✓</td>
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<tr>
<td>1</td>
<td>Does the Committee receive and review a draft of the organisation’s Annual Governance Statement?</td>
<td>✓</td>
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<tr>
<td>Status</td>
<td>Issue</td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>2</td>
<td>Does the Committee receive and review the evidence required to demonstrate fitness to register with the Care Quality Commission?</td>
<td>✔</td>
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<tr>
<td>2</td>
<td>Does the Committee receive and review a draft of the organisation’s annual report?</td>
<td>✔</td>
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<tr>
<td>3</td>
<td>Has the Committee considered the costs that it incurs: and are the costs appropriate to the perceived risks and benefits?</td>
<td>✔</td>
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</tbody>
</table>
| 2      | Has the Committee reviewed its performance in the year for its consistency with its:  
• Terms of reference?  
• Programme for the year? | ✔   |    |     | On workplan In completing this checklist As part of Annual Report. Progress monitored throughout the year. In 2014/15 as part of the independent assessment of the BoD the Committee received positive feedback from Foresight who were commissioned to undertake the review. |
| 3      | Does the Annual Report and Accounts of the Trust include a description of the Committee’s establishment and activities? | ✔   |    |     | Annual Report defines                                                                                                                                  |
Executive Summary

The Committee has worked in accordance with and completed its work plan for the 2014/15 year.

Committee membership was consistent throughout the year although Graham Creelman retired as an Executive Director at the end of February 2015 and is to be replaced by Marion Saunders who is also the new Senior Independent Director (SID).

The main issue to be raised is the deterioration in some aspects of the control environment from the previous year. Despite improvements in both risk management and governance these require further improvement. The Board can take substantial assurance from the Finance, Information Management and Performance domains reviewed by Internal Audit but all other domains audited require improvement.

A common message is that policies and processes are generally in place but that these are not consistently followed and agreed remedial actions are not always implemented or evidenced.

1.0 Report Content

1.1 Formal compliance with code of practice

The Audit and Risk Committee incorporates the formal requirements of audit committees as required by the code of governance.

1.2 Access to impartial review support and evidence

The Committee has direct access to both external and internal auditors. The Committee’s role is to review the control and risk environments, including the Trust’s financial systems and annual financial statements. It considers any matters...
concerning the external auditors, including their value for money reports, and also the adequacy of the Trust's internal audit arrangements. The Committee also has responsibility for overseeing the Trust's overall governance arrangements including the Board Assurance Framework (BAF) and Risk Management.

1.3 Committee membership

Membership of this committee is three non-executive directors, and their attendance at meetings is set out in Appendix I. Graham Creelman was a member of the Committee throughout the year but ceased to be a NED at the end of February 2015 and has been replaced by Marion Saunders who is also the new SID.

1.4 Control Environment

The Committee can, through its work throughout the year, report that for the six main domains reviewed by Internal Audit the opinions given were:

a) Quality
- Overall assessment of assurance for 2014/15 is ‘Requires Improvement’.
- No change from 2013/14
- Particular concern is in respect of clinical supervision and some aspects of safeguarding processes not followed.

b) Finance
- Overall assessment of assurance for 2014/15 is ‘Significant’
- No change from 2013/14
- In need of improvement is the single tender waiver practice.

c) Information Management and Technology
- Draft overall assessment of assurance for 2014/15 is ‘Significant’.
- Improvement from 2013/14.

d) Performance
- Draft overall assessment of assurance for 2014/15 is ‘Significant’.
- Improved from ‘Requires Improvement’ in 2013/14.

e) HR & Workforce
- Draft overall assessment of assurance for 2014/15 is ‘Requires Improvement’.
- No change from 2013/14
- All audits reflect this opinion.

f) Governance and Risk
- Draft overall assessment for 2014/15 ‘Requires Improvement’.
- Worsened from ‘Significant’ in 2013/14.
- Both Risk Management and the BAF have improved but are assessed as requiring improvement.
The overall opinion is that the Board can only take ‘Significant’ assurance from its control environment but there has been some deterioration since 2013/14.

1.5 Throughout the year it has become apparent that the control environment has been under pressure with some individual internal audit opinions on reviews reflecting a downward trend. This is clearly an unsatisfactory position and will need to be addressed as part of the Trust’s improvement plans.

1.6 Committee work during the year
The Committee had a work plan for 2014/15 attached as Appendix II. Work from that plan has been completed.

Key aspects of the work the Committee has completed are:

- Reviewed and recommended the approval of the annual accounts and annual report for 2013/14 to the Board of Directors
- Self assessment and annual report of the Committee for 2013/14 – which was approved at the June 2014 Committee meeting with the Governors in attendance
- Received, reviewed, commented on and recommended for submission the Monitor Code of Governance Statements.
- Revised and made recommendations on the Trust Business Continuity assessment and plans and Disaster Recovery Plan.
- Reviewed the accounting policies and timetable for the annual accounts and report for 2014/15
- Reviewed the Standing Financial Instructions for the Trust.
- Received the results of the staff counter-fraud survey, and the counter-fraud qualitative assessment and the resulting actions
- Reviewed the external assurance on the Quality Account for 2013/14.
- The Committee reviewed the performance and effectiveness of the external auditors.
- Following competitive tendering recommended the reappointment of KPMG.
- Reviewed the performance of Internal Audit
- Approved the Internal and External Audit and Counter Fraud plans for 2014/15
- Approved the Internal and External Audit and Counter Fraud annual reports for 2013/14.
- Reviewed the Independence letter from the Trust’s external auditors, KPMG, and gained assurance of their independence.
- Received the Head of Internal Audit Opinion rolling opinion throughout the year
- Reviewed the Hospitality Register and the Register of Seals
Continued to review the Risk Management Strategy and policies, planning and reporting.
Continued to monitor losses and special payments.
Continued to keep under review the IT procurement practices and in particular requested further monitoring reports on the arrangements for replacing photocopiers.
Received and reviewed regular reports from the Chair of Service Governance Committee which include clinical risk, governance and assurance matters.
Considered the reviews of the placement of service users at Cawston Park and Milestones hospitals. These reviews were considered in the context of the Business Conduct Policy.
Towards the end of the year the Trust received the adverse CQC report. The Committee has started to seek explanations and action in respect of some of the findings which relate to its work and information previously presented by management.

2.0 Conclusion

2.1 As can be seen from the above paragraphs, the Committee has completed some detailed and important work. Thanks are recorded to my fellow Non-Executive Directors who have carried out this work diligently and often in their own time. The Audit and Risk Committee checklist asks, “Has the committee been effective”. The committee has completed its work plan and drawn the Board of Directors’ attention to concerns throughout the year. However, as the Trust is assessed as being inadequate by the Care Quality Commission and has been placed in special measures by Monitor, it is not possible to conclude that the Committee has been wholly effective.

3.0 Risk to Trust Objectives

3.1 The Audit and Risk Committee has a key role on the oversight of the Trust governance, risk and control environments and seeks to ensure good practices are in place. It is disappointing that although sounds practices are generally in place these have not been consistently followed and remedial actions have not always been implemented or evidenced. The Committee will seek improvements in 2015/16.

4.0 Recommendations

4.1 The Committee are asked to approve the report for submission to the Board of Directors.

John Brierley
Committee Chair
1 June 2015
Background Papers / Information
Appendix i: Committee work plan 2015/16
Appendix ii: Terms of Reference 2015/16
# Norfolk & Suffolk NHS Foundation Trust
## Audit & Risk Committee workplan for 2015

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<tbody>
<tr>
<td>Pre-meeting</td>
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<td>Internal Audit</td>
<td>External Audit</td>
<td>Governors to attend</td>
<td>Clinical Audit</td>
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</table>

### Annual Report and Annual Accounts

- **Agreement of final accounts and annual report timetable and plans**
  - DoF

- **Review of progress on preparation of annual accounts**
  - DoF

- **Review and approval of accounting policies**
  - DoF

- **Review and approval of audited annual accounts and financial statements (Monitor Code of Governance F3.2)**
  - DoF

- **Governance statements**
  - Chief Exec

- **Head of internal audit opinion – DRAFT**
  - Chief Internal Auditor (2016)

- **Head of internal audit opinion – FINAL**
  - Chief Internal Auditor

- **Review and approval of annual report, including:**
  - Remuneration report
    - DoF
  - ISA 260 report to those charged with governance
    - DoF

- **Statement of compliance with Monitor’s NHS FT Code of Governance**
  - DoF

- **ISA 260 report to those charged with governance**
  - External Audit
# Agenda Item

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## Governance, Risk Management and Internal Control

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<tbody>
<tr>
<td>Risk Register exception reporting</td>
<td>Risk Manager</td>
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<td>BAF development process</td>
<td>Trust Sec</td>
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| Review of policies and procedures relating to governance, risk management and internal control. In particular:  
  - Risk Management Strategy & Policy                                      |            |            | Risk Manager (2015 only)      |                               |             |             |             |
  - Risk reporting monitoring and integration (Monitor Code of Governance F3.2) |            |            |                               |                               |             |             |             |
| Receive the SGSC Chair’s report                                          | Chair SGC   | Chair SGC  | Chair SGC                     | Chair SGC                     | Chair SGC   | Chair SGC   | Chair SGC   |
| Legal claims – 6-monthly report                                          |             |            | Risk Mgt Coordinator          | Risk Mgt Coordinator          |             |             |             |
| Trust Accounts Receivable – 6-monthly report                             |             |            | DoF                           | DoF                           |             |             |             |
| Report on losses and special payments, SFIs / SOs                        | DoF         | DoF        | DoF                           | DoF                           | DoF         | DoF         | DoF         |

## Counter-fraud

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<tr>
<td>Approval of Draft Counter Fraud Annual Plan (last approval: Feb 2015)</td>
<td>LCFS</td>
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<td>Approval of Final Counter Fraud Annual Plan (last approval: Jun 2014)</td>
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<td>LCFS</td>
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</table>
| Review of Counter Fraud Progress Updates and Counter Fraud reports  
  - CF interim report                                                     | LCFS        | LCFS       | LCFS                          | LCFS                          | LCFS        | LCFS        | LCFS        |
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<tr>
<td>Review of Counter Fraud Performance and Annual Report (last review: Oct 2014)</td>
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<td>LCFS</td>
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<td>Results of Annual Counter Fraud survey (last done: )</td>
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<td>LCFS</td>
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<td>Report on declaration of interests annual review</td>
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<td>Trust Secretary</td>
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<td><strong>Internal Audit</strong></td>
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<td>To receive the draft Internal Audit Plan</td>
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<td>Chief Internal Auditor</td>
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<td>To approve the final Internal Audit Plan (last approved: Jun 2014)</td>
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<td>Chief Internal Auditor</td>
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<td>Review and approval of Internal Audit Terms of Reference / Charter (last approved: August 2014)</td>
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<td>Chief Internal Auditor</td>
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<td>Review of Internal Audit Progress Updates and Internal Audit Reports</td>
<td>Internal Audit</td>
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<td>• Interim report</td>
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<td>• Recommendations follow-up</td>
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<td>Annual Internal Audit report and opinions with an annual review of the internal audit work (last report: Jun 2014)</td>
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<td>Chief Internal Auditor</td>
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<td>Draft performance review of Internal Audit (last review: Jun 2014)</td>
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<td>A&amp;R Chair / DoF</td>
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<td>Full performance review of Internal Audit</td>
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<td>A&amp;R Chair / DoF</td>
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## Agenda Item

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### Market testing the IA service from June 2014 – tender spec being developed

|------------|-------------|------------|-----------------------------|-----------------------------|-------------|-------------|-------------|

### External Audit

- **External Audit progress report**
  |-------------|-------------|------------|-----------------------------|-----------------------------|-------------|-------------|-------------|

- **External Audit reports on Annual Report and Accounts**
  |-------------|-------------|------------|-----------------------------|-----------------------------|-------------|-------------|-------------|

- **Agreement of External Audit plans and fees**
  |-------------|-------------|------------|-----------------------------|-----------------------------|-------------|-------------|-------------|

- **Review performance of External Audit (last review: Jun 2014)**
  |-------------|-------------|------------|-----------------------------|-----------------------------|-------------|-------------|-------------|

- **Receive annual statement on non-audit services**
  |-------------|-------------|------------|-----------------------------|-----------------------------|-------------|-------------|-------------|

### Other Assurance Functions

- **Review of other reports and policies as appropriate e.g. changes of Standing Orders and Standing Financial Instructions, changes to accounting policies (last review: Feb 2014)**
  |-------------|-------------|------------|-----------------------------|-----------------------------|-------------|-------------|-------------|

### Management

- **Declarations of Interest**
  |-------------|-------------|------------|-----------------------------|-----------------------------|-------------|-------------|-------------|

- **Self-assessment of A&R Committee’s effectiveness (last approved: Jun 2014)**
  |-------------|-------------|------------|-----------------------------|-----------------------------|-------------|-------------|-------------|

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I:\Trust Secretariat\Board of Directors - Public\2015 Public BoD\06. 25th June 2015\Copy\Att Jiv - A&R Comm workplan 2015 v0.5 (amended 25Mar2015).doc
Page 4 of 7
## Agenda Item

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<tbody>
<tr>
<td>Review Terms of Reference of the A&amp;R Committee and make publicly available (last review: 12 Feb 2014)</td>
<td>A&amp;R Chair / Trust Sec – to be done every 2 years (next 2016)</td>
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<td>Produce Annual Report of the A&amp;R Committee for BoG and BoD (last approved: Jun 2014)</td>
<td></td>
<td>A&amp;R Chair (1st draft)</td>
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<td>A&amp;R Chair</td>
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<td>Review the Register of Seals (last review: Oct 2014)</td>
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<td>A&amp;R Chair / Trust Sec</td>
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<tr>
<td>Review of the Register of Gifts &amp; Hospitality (last review: Oct 2014)</td>
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<td>A&amp;R Chair / Trust Sec</td>
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<tr>
<td>Produce the attendance report of the Committee members</td>
<td></td>
<td>Deputy Trust Sec</td>
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<tr>
<td>Review the Committee’s work plan</td>
<td>A&amp;R Chair / Trust Sec</td>
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<tr>
<td>Meeting dates for next year</td>
<td>A&amp;R Chair / Trust Sec</td>
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<td>Last item – “have the most pertinent items of the agenda have been reviewed adequately and at the beginning of the agenda?”</td>
<td>All</td>
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</table>
Monitor Code of Governance (March 2010) – Section F: Accountability and Audit

F2 Internal Control
The board of directors should maintain a sound system of internal control to safeguard public and private investment, the NHS foundation trust’s assets, patient safety and service quality.

Monitor’s publications, *NHS Foundation Trust Annual Reporting Manual* and the latest *NHS Foundation Trust Accounting Officer Memorandum* provide further guidance.

Code provision
F.2.1 The board should conduct, at least annually, a review of the effectiveness of the NHS foundation trust’s system of internal control and should report to members that they have done so. The review should cover all material controls, including financial, clinical, operational and compliance controls and risk management systems.

F3 Audit committee and auditors
The board should establish formal and transparent arrangements for considering how it should apply the financial reporting and internal control principles and for maintaining an appropriate relationship with the NHS foundation trust’s auditors.


Code provisions
F.3.1 The board must establish an audit committee composed of non-executive directors which should include at least three independent non-executive directors. The board should satisfy itself that at least one member of the audit committee has recent and relevant financial experience.

F.3.2 The main role and responsibilities of the audit committee should be set out in written terms of reference and should include details of how it will:

- monitor the integrity of the financial statements of the NHS foundation trust, and any formal announcements relating to the trust’s financial performance, reviewing significant financial reporting judgements contained in them;
- review the NHS foundation trust’s internal financial controls and, unless expressly addressed by a separate board risk committee composed of independent directors, or by the board itself, review the trust’s internal control and risk management systems;
- monitor and review the effectiveness of the NHS foundation trust’s internal audit function;
Norfolk & Suffolk NHS Foundation Trust
Audit & Risk Committee workplan for 2015

- review and monitor the external auditor’s independence and objectivity and the effectiveness of the audit process, taking into consideration relevant UK professional and regulatory requirements;
- develop and implement policy on the engagement of the external auditor to supply non-audit services, taking into account relevant ethical guidance regarding the provision of non-audit services by the external audit firm; and
- report to the board of governors, identifying any matters in respect of which it considers that action or improvement is needed and making recommendations as to the steps to be taken.

F.3.3 The terms of reference of the audit committee, including its role and the authority delegated to it by the board of directors and by the board of governors, should be made publicly available. A separate section of the annual report should describe the work of the committee in discharging those responsibilities.

F.3.4 The board of governors should take the lead in agreeing with the audit committee the criteria for appointing, reappointing and removing external auditors.

F.3.5 The audit committee should make a report to the board of governors in relation to the performance of the external auditor, including detail such as the quality and value of the work, and the timeliness of reporting and fees, to enable the board of governors to consider whether or not to reappoint them. The audit committee should also make recommendations to the board of governors in relation to the appointment, re-appointment and removal of the external auditor and approve the remuneration and terms of engagement of the external auditor.

If the board of governors does not accept the audit committee’s recommendation, the board of directors should include in the annual report a statement from the audit committee explaining the recommendation and should set out reasons why the board of governors has taken a different position.

F.3.6 The NHS foundation trust should appoint an external auditor for a period of time which allows the auditor to develop a strong understanding of the finances, operations and forward plans of the NHS foundation trust. The current best practice is for a three to five year period of appointment.

F.3.7 When the board of governors ends an external auditor’s appointment in disputed circumstances, the chairman should write to Monitor informing it of the reasons behind the decision.

F.3.8 The annual report should explain to members how, if the external auditor provides non-audit services, auditor objectivity and independence is safeguarded.

F.3.9 The audit committee should review arrangements by which staff of the NHS foundation trust may raise, in confidence, concerns about possible improprieties in matters of financial reporting and control, clinical quality, patient safety or other matters. The audit committee’s objective should be to ensure that arrangements are in place for the proportionate and independent investigation of such matters and for appropriate follow-up action.
Audit & Risk Committee
Terms of Reference – May 2014

Note: The relevant sections of the Monitor Code of Governance are included in brackets and at the end of this document for ease of reference
The NHS LA Monitoring Statement is enclosed at the end of this document for ease of reference

1. Constitution
1.1 The Board of Directors hereby resolves to establish a Committee of the Board of Directors to be known as the Audit and Risk Committee (“the Committee”) (F3).
1.2 The Committee is a non-executive committee of the Board of Directors and has no executive powers, other than those specifically delegated to it in these Terms of Reference.
1.3 The Committee shall be supported administratively by the Trust Secretary, or their nominee, whose duties in this respect will include:
   1.3.1 Agreement of agenda with Chair and attendees and collation of papers;
   1.3.2 Taking the minutes and keeping a record of matters arising and issues to be carried forward;
   1.3.3 Following-up outstanding items;
   1.3.4 Advising the Committee on pertinent areas; and
   1.3.5 Assisting the Chair with relevant reports (for example – Annual Report)

2. Role of the Audit and Risk Committee
2.1 The Board of Directors has responsibility for ensuring the effective internal control of all of the Trust’s affairs, including management of the Trust’s activities in accordance with laws and regulations, the establishment and maintenance of the system of internal control designed to ensure that assets are safeguarded, waste or inefficiency avoided and reliable financial information produced, and that “value for money” is continuously sought.
2.2 The Committee will provide the Board of Directors and Board of Governors with the means of independent and objective review, and assurance (F3.3). Its main roles and responsibilities being:
2.2.1 to ensure the Trust has effective systems of internal control and risk management, including clinical risk management;

2.2.2 to provide the Board of Directors with assurance on governance arrangements across the Trust;

2.2.3 to ensure the Board Assurance Framework is properly established and monitored;

2.2.4 to advise on, and approve, the Annual Governance Statements;

2.2.5 to review and monitor Financial Control systems and financial information used by the Trust, including returns to Regulators;

2.2.6 to review and monitor Quality Control systems and clinical information used by the Trust, including returns to Regulators;

2.2.7 to ensure the Annual Accounts are produced in accordance with all relevant legislative and accounting requirements and that sufficient review has been undertaken by management;

2.2.8 to ensure the Quality Account is produced in accordance with all relevant legislative and accounting requirements and that sufficient review has been undertaken by management;

2.2.9 to ensure both Internal, and External Audit deliver their planned activity, and to review the appropriateness of the planned activity. To ensure recommendations arising from such work are acted on by management. To monitor the joint work of Clinical and Internal Audit; and

2.2.10 to provide an Annual Report of the Committee’s work to the Board of Directors (see Section 17).

3. **Membership (F3.1)**

3.1 Members of the Committee shall be appointed by the Board of Directors, on the recommendation of the Nominations Committee in consultation with the Chair of the Committee. The Committee shall be made up of at least three members. The members will attend at least 50% of meetings during a 12-month period.

3.2 All members of the Committee shall be independent Non-Executive Directors at least one of whom shall have recent and relevant financial experience. The Chair of the Board of Directors shall not be a member of the Committee.

3.3 Only members of the Committee have the right to attend Committee meetings. However, other individuals such as the Chair, the Chief Executive, the Director of Finance, other Directors, the heads of risk and internal audit and representatives from the finance function will be invited to attend all or part of any meeting, as and when appropriate.

3.4 The External Auditors will be invited to attend meetings of the Committee on a regular basis.

3.5 Appointments to the Committee shall be for a period of up to three years, which may be extended for two further three-year periods provided the Non-Executive Director remains independent.
3.6 The membership of the Committee should be refreshed to ensure that undue reliance is not placed on particular individuals. (A3)

3.7 The Board of Directors shall appoint the Committee Chair who shall be an independent Non-Executive Director. In the absence of the Committee Chair the remaining members present shall elect one of themselves to chair the meeting.

3.8 Governors are formally invited to attend the meeting at which the review of the external auditors is considered. Governors are welcome to attend as observers by prior arrangement with the Chair of the committee and the Board of Governors may wish to nominate a governor (ideally a member of the governors’ Planning and Performance Subgroup) to attend regularly in order to provide continuity of feedback to the Board of Governors.

4. Quorum

4.1 The necessary quorum for the transaction of business shall be two members. A duly convened meeting of the Committee at which a quorum is present shall be competent to exercise all or any of the authorities, powers and discretions vested in or exercisable by the Committee.

5. Attendance

5.1 At least once a year the Committee should meet privately with the External and Internal Auditors (separate meetings). (See paragraph 3.3 and 3.4)

5.2 The Chief Executive and other Executive Directors should be invited to attend meetings, particularly when the Committee is discussing areas of risk or operation that are the responsibility of that director.

5.3 The Chief Executive should be invited to attend meetings at least annually, to discuss with the Committee the process for assurance that supports the Annual Governance Statements.

6. Authority

6.1 The Committee is authorised by the Board of Directors to scrutinise any activity within its terms of reference.

6.2 The Committee is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

6.3 The Committee is authorised by the Board of Directors to obtain outside legal or other independent professional advice and to secure the attendance of people with relevant experience and expertise if it considers this necessary.

7. Frequency of meetings

7.1 The Committee will meet bi-monthly. The Chair's report will be presented at the next full meeting of the Board of Directors highlighting matters requiring the attention of the full Board of Directors. Additional meetings for specific tasks may be arranged with due notice (see paragraph 8).
8 Notice of Meetings
8.1 Meetings of the Committee shall be summoned by the Secretary of the Committee at the request of any of its members or at the request of the External or Internal Auditors, if they consider it necessary.

8.2 Unless otherwise agreed, notice of each meeting confirming the venue, time and date together with an agenda of items to be discussed, shall be forwarded to each member of the Committee, any other persons required to attend and all Non-Executive Directors, no later that five working days before the date of the meeting. Supporting papers shall be sent to the Committee members and to other attendees as appropriate, at the same time.

9. Minutes of Meetings
9.1 The Trust Secretary, or their nominee, shall minute the proceedings and resolutions of all meetings of the Committee, including recording the names of those present and in attendance.

9.2 The Trust Secretary, or their nominee, shall ascertain, at the beginning of each meeting, the existence of any conflicts of interest and minute them accordingly.

9.3 Minutes of the Committee’s meetings shall be circulated according to the Trust’s Standards for Meetings to all members of the Committee and, a report to all members of the Board of Directors.

10. Reporting Responsibilities
10.1 The Committee Chair shall report formally to the Board of Directors on its proceedings after each meeting on all matters within its duties and responsibilities.

10.2 The Committee shall make whatever recommendations to the Board of Directors it deems appropriate on any area within its remit where action or improvement is needed.

10.3 The Committee shall hold one meeting per year which the governors will be invited to attend

10.4 The Committee shall report on its activities in the Trust’s Annual Report.

11. Duties of the Committee
11.1 Governance, Risk Management and Internal Control

11.1.1 The Committee shall monitor the integrity of the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation’s activities (both clinical and non-clinical), which supports the achievement of the organisation’s objectives (F3.2).

11.1.2 In particular, the Committee will review the adequacy of:
all risk and control-related disclosure statements (in particular the Annual Governance Statements), together with any accompanying Head of Internal Audit opinion, External Audit opinion or other appropriate independent assurances, prior to endorsement by the Board of Directors;

the underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements;

the policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements;

the structures, processes and responsibilities for identifying and managing key risks facing the organization, including the Board Assurance Framework;

the operational effectiveness of policies and procedures;

monitor and review the Risk Register; and

review and approve the statements to be included in the Annual Report concerning internal controls and risk management

11.1.3 In carrying out this work the Committee will primarily utilise the work of Internal Audit, External Audit and other assurance functions, but will not be limited to these audit functions. It will also seek reports and assurances from Directors and managers as appropriate, concentrating on the over-arching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.

11.1.4 This will be evidenced through the Committee’s use of an effective Assurance Framework to guide its work and that of the audit and assurance functions that report to it.

11.2 Management

11.2.1 The Committee shall request and review reports and positive assurances from Directors and managers on the overall arrangements for governance, risk management and internal control.

11.2.2 The Committee may also request specific reports from individual functions within the organisation (e.g. clinical audit), as they may be appropriate to the overall arrangements.

12 Financial Reporting

12.1 The Committee shall review the Annual Report and Financial Statements before submission to the Board of Directors, focusing particularly on:

12.1.1 the wording in the Annual Governance Statement and other disclosures relevant to the Terms of Reference of the Committee;

12.1.2 changes in, and compliance with, accounting policies and practices;
12.1.3 unadjusted mis-statements in the financial statements;  
12.1.4 major judgemental areas; and
12.1.5 significant adjustments resulting from external audits.

12.2 The Committee should also ensure that the systems for financial reporting to the Board of Directors, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Board of Directors.

12.3 The Committee should also ensure that the systems for reporting on the Quality Account to the Board of Directors are subject to review as to completeness and accuracy of the information provided to the Board of Directors.

14. **Internal Audit**

14.1 The Committee shall ensure that there is an effective Internal Audit function, established by management, which meets mandatory NHS Internal Audit Standards and provides appropriate independent assurance to the Audit and Risk Committee, Chief Executive and Board. This will be achieved by:

14.1.1 consideration of the provision of the Internal Audit service, the cost of the audit and any questions of resignation and dismissal;
14.1.2 review and approval of the Internal Audit strategy, operational plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the Board Assurance Framework
14.1.3 review and monitor management’s responsiveness to the findings and recommendations of the Internal Auditor;
14.1.4 ensuring that the Internal Audit function is adequately resourced and has appropriate standing within the organisation;
14.1.5 annual review of the effectiveness of Internal Audit;
14.1.6 reviewing the annual report of the Head of Internal Audit and reporting relevant matters to the Board of Directors;
14.1.7 to receive from the Director of Finance (annually) an appraisal on the performance of Internal Audit; and
14.1.8 reviewing promptly all reports prepared by Internal Audit.

15. **External Audit**

15.1 The Committee should make recommendations to the Board of Governors in relation to the appointment, re-appointment and removal of the external auditor and approve the remuneration and terms of engagement of the external auditor (F3.2, F3.4, F3.5, F3.6)

15.2 The Committee shall develop and implement a policy on the engagement of the external auditor for audit and non-audit services (F3.2, F3.4, F3.6)
The Committee shall review the work and findings of the External Auditor appointed by the Board of Governors and consider the implications and management’s responses to their work. This will be achieved by:

15.3.1 discussion and agreement with the External Auditor, before an audit commences, of the nature and scope of the audit as set out in the Annual Plan, and ensure co-ordination, as appropriate, with other External Auditors in the local health economy;

15.3.2 discussion with the External Auditors of their local evaluation of audit risks and assessment of the Trust and associated impact on the audit fee;

15.3.3 review all External Audit reports, including agreement of the Annual Audit Letter before submission to the Board of Directors and any work carried outside the annual audit plan, together with the appropriateness of management responses;

15.3.4 to assess the extent of the reliance placed on Internal Audit by External Audit;

15.3.5 to discuss problems and reservations arising from the External Auditor’s work and any matters that the External Auditor may wish to discuss in order to brief the Board of Directors; and

15.3.6 to consider the content of any report involving the Trust issued by the Public Accounts Committee or Comptroller and Auditor General and reviewing management’s proposed response before presentation to the Board of Directors.

16. **Public Disclosure / Whistleblowing (F3.9)**

16.1 The Committee shall ensure that the Trust's arrangements for its employees to raise concerns, in confidence, about possible improprieties in matters of financial reporting and control, clinical quality, patient safety or other matters are overseen by the Service Governance Committee.

16.2 The Committee shall ensure that these arrangements allow proportionate and independent investigation of such matters and appropriate follow-up action.

17. **Other Assurance Functions**

17.1 The Committee shall review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications to the governance of the organisation. These will include, but will not be limited to, and any reviews by Department of Health Arms Length Bodies or Regulators / Inspectors (e.g., NHS Litigation Authority etc).

17.2 The Committee will review the work of other board committees within the organisation, whose work can provide relevant assurance to the Committee’s own scope of work. This will particularly include the Service Governance Committee. Minutes from these meetings may form part of the agenda for the Committee.
17.3 The Committee will ensure that the Trust has policies and procedures for all work relating to Fraud and Corruption as set out in the Secretary of State’s Directions and as required by the NHS Protect.

17.4 The Committee will receive relevant reports from the Trust’s Local Counter Fraud Specialist, including their Annual Report.

17.5 The Committee will review any proposed changes to Standing Orders and Standing Financial Instructions, and examining circumstances associated with each occasion when Standing Orders are waived.

17.6 The Committee will review schedules of losses and compensations.

17.7 The Committee will review the Register of Hospitality at least annually.

17.8 The Committee will annually review its own performance, constitution and terms of reference to ensure it is operating at maximum effectiveness and recommend any changes it considers to the Board of Directors for approval.

18.0 **Annual Report of the Committee**

18.1 The Committee is required to provide an annual report, which will include (F3.3, F3.5, F3.8):

18.1.1 a specific statement confirming that the draft Annual Governance Statements are consistent with the view of the Committee on the organisation’s system of internal control and that it supports the Board of Director’s approval of the statement, subject to any reasonable limitations that the Committee may draw attention to;

18.1.2 that the system of risk management in the organisation is adequate in identifying risks and allowing the Board of Directors to understand the appropriate management of those risks;

18.1.3 that the Committee has reviewed and used the Board Assurance Framework and believes that it is fit for purpose;

18.1.4 that there are no areas of significant duplication or omission in the systems of governance in the organisation that have come to the Committee’s attention and not been adequately resolved; and

18.1.5

18.2 In addition, the report should highlight to the Board of Directors the main areas that the Committee has reviewed and any particular concerns or issues that it has addressed. These should include:

18.2.1 the financial position and financial reporting systems of the organisation;

18.2.2 any major breakdown in internal control that has led to a significant loss in one form or another; and

18.2.3 any major weakness in the governance systems that has exposed, or continues to expose, the organisation to an unacceptable risk.
19. Annual General Meeting of the Trust

19.1 The Chair of the Committee, or his / her representative, shall attend the Annual General Meeting and be prepared to respond to any Stakeholder’s questions on the Committee’s activities.

20. Other Matters

20.1 The Committee shall:

20.1.1 have access to sufficient resources in order to carry out its duties, including access to the Trust secretariat for assistance as required;

20.1.2 be provided with appropriate and timely training, both in the form of an induction programme for new members and on an ongoing basis for all members;

20.1.3 give due consideration to the laws and regulations, the provisions of the Combined Code and the regulator, Monitor;

20.1.4 review arrangements for the co-ordination of the Internal and External Auditors;

20.1.5 oversee any investigation of activities which are within its terms of reference and act as a court of last resort.

21. Review of the Terms of Reference

21.1 Unless otherwise required, these Terms of Reference will be reviewed every two years.

Robert Nesbitt
Trust Secretary
03th February 2014

Version Control
Amended to take account of creation of Service Governance Committee February 2014
Amended to remove “sub” from Service Governance Committee May 2014
Original: September 1994
Section B: Effectiveness
The board of directors and its committees should have the appropriate balance of skills, experience, independence and knowledge of the NHS foundation trust to enable them to discharge their respective duties and responsibilities effectively.

B.1.e The value of ensuring that committee membership is refreshed and that undue reliance is not placed on particular individuals should be taken into account in deciding chairpersonship and the membership of committees.

C.3 Audit committee and auditors

Main principle
C.3.a The board of directors should establish formal and transparent arrangements for considering how they should apply the corporate reporting and risk management and internal control principles and for maintaining an appropriate relationship with the NHS foundation trust’s auditors. Monitor’s publications, Audit Code for NHS Foundation Trusts and Your statutory duties: A reference guide for NHS foundation trust governors, provide further guidance.

Code provision
C.3.1. The board of directors should establish an audit committee composed of at least three members who are all independent non-executive directors. The board should satisfy itself that the membership of the audit committee has sufficient skills to discharge its responsibilities effectively, including ensuring that at least one member of the audit committee has recent and relevant financial experience. The chairperson of the trust should not chair or be a member of the audit committee. He can, however, attend meetings by invitation as appropriate.
C.3.2. The main role and responsibilities of the audit committee should be set out in publicly available, written terms of reference. The council of governors should be consulted on the terms of reference, which should be reviewed and refreshed regularly. It should include details of how it will:
• Monitor the integrity of the financial statements of the NHS foundation trust, and any formal announcements relating to the trust’s financial performance, reviewing significant financial reporting judgements contained in them;
• Review the NHS foundation trust’s internal financial controls and, unless expressly addressed by a separate board risk committee composed of independent directors, or by the board itself, review the trust’s internal control and risk management systems; • Monitor and review the effectiveness of the NHS foundation trust's internal audit function, taking into consideration relevant UK professional and
regulatory requirements;
• Review and monitor the external auditor’s independence and objectivity and the effectiveness of the audit process, taking into consideration relevant UK professional and regulatory requirements;
• Develop and implement policy on the engagement of the external auditor to supply non-audit services, taking into account relevant ethical guidance regarding the provision of non-audit services by the external audit firm; and
• Report to the council of governors, identifying any matters in respect of which it considers that action or improvement is needed and making recommendations as to the steps to be taken.

C.3.3. The council of governors should take the lead in agreeing with the audit committee the criteria for appointing, re-appointing and removing external auditors. The council of governors will need to work hard to ensure they have the skills and knowledge to choose the right external auditor and monitor their performance. However, they should be supported in this task by the audit committee, which provides information to the governors on the external auditor’s performance as well as overseeing the NHS foundation trust’s internal financial reporting and internal auditing.

C.3.4. The audit committee should make a report to the council of governors in relation to the performance of the external auditor, including details such as the quality and value of the work and the timeliness of reporting and fees, to enable to council of governors to consider whether or not to re-appoint them. The audit committee should also make recommendation to the council of governors about the appointment, re-appointment and removal of the external auditor and approve the remuneration and terms of engagement of the external auditor.

C.3.5 If the council of governors does not accept the audit committee’s recommendation, the board of directors should include in the annual report a statement from the audit committee explaining the recommendation and should set out reasons why the council of governors has taken a different position.

C.3.6. The NHS foundation trust should appoint an external auditor for a period of time which allows the auditor to develop a strong understanding of the finances, operations and forward plans of the NHS foundation trust. The current best practice is for a three- to five-year period of appointment.

C.3.7. When the council of governors ends an external auditor’s appointment in disputed circumstances, the chairperson should write to Monitor informing it of the reasons behind the decision.

C.3.8. The audit committee should review arrangements that allow staff of the NHS foundation trust and other individuals where relevant, to raise, in confidence, concerns about possible improprieties in matters of financial reporting and control, clinical quality, patient safety or other matters. The audit committee’s objective should be to ensure that arrangements are in place for the proportionate and independent investigation of such matters and for appropriate follow-up action. This should include ensuring safeguards for those who raise concerns are in place and operating effectively. Such processes should enable individuals or groups to draw formal attention to practices that are unethical or violate internal or external policies, rules or regulations and to ensure that valid concerns are promptly addressed. These processes should also reassure individuals raising concerns that they will be protected from potential negative repercussions.

C.3.9. A separate section of the annual report should describe the work of the

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Audit and Risk Ctte May2014

ToR

Page 11 of 13 Date produced: 03Jan2014 Retention period: 30 years

Editor: Robert Nesbitt

Department: Corporate
committee in discharging its responsibilities. The report should include:

- the significant issues that the committee considered in relation to financial statements, operations and compliance, and how these issues were addressed;
- an explanation of how it has assessed the effectiveness of the external audit process and the approach taken to the appointment or re-appointment of the external auditor, the value of external audit services and information on the length of tenure of the current audit firm and when a tender was last conducted; and
- if the external auditor provides non-audit services, the value of the non-audit services provided and an explanation of how auditor objectivity and independence are safeguarded. Monitoring Compliance with this Terms of Reference Process for Reporting Arrangements to the Audit and Risk Committee (A & RC)

### Reports:
- Governance, Risk Management and Internal Control
- Internal Audit
- External Audit
- Other Assurance Functions
- Management
- *Ad Hoc reports* as stated in the A&RC Work Plan

(Frequency: As specified in the A & R C Work Plan)
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<th>Aspects of the TOR to be monitored</th>
<th>Monitoring Method</th>
<th>Individual / team responsible for the monitoring</th>
<th>Frequency</th>
<th>Findings: Group / committee that will receive the findings / monitoring report</th>
<th>Action: Group / committee responsible for ensuring actions are in place</th>
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<tbody>
<tr>
<td>Reporting arrangements to the Board</td>
<td>Audit of 25% of Board minutes (over 12 month period) to evidence the Audit and Risks Chairs report to BoD highlighting matters requiring attention from the BoD</td>
<td>Assurance Manager</td>
<td>Annual</td>
<td>Assurance Managers annual report of High Level Risk Committee Governance to the Audit and Risk Committee</td>
<td>Audit and Risk Committee</td>
</tr>
<tr>
<td>Reporting arrangements to the high level committee</td>
<td>Audit of Audit and Risk Committee minutes for the past 12 month period to show evidence reporting to the Committee as shown in the process and detailed in the A&amp;RC Work Plan</td>
<td>Assurance Manager</td>
<td>Annual</td>
<td>Assurance Managers annual report of High Level Risk Committee Governance to the Audit and Risk Committee</td>
<td>Audit and Risk Committee</td>
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Report To: Board of Directors

Meeting Date: 25th June 2015

Title of Report: Chairs report – Quality Governance Committee 26th May 2015

Action Sought: For Information

Estimated time: 5 minutes

Author: Gary Page - Chair

Executive Summary:

This report highlights the key issues arising out of the Quality Governance (“QG”) Committee on 26th May.

1.0 Key Issues

1.1 Restrictive Interventions Annual data – We received a detailed report showing the use of restraint and seclusion across the various services in the Trust over the last 12 months. Airey Close was an outlier in the use of restraint and was also a high user of seclusion. The report lacked an analysis behind the numbers and I asked for the report to come back to QG next month with an analysis provided by the localities and services with a specific focus on Airey Close. The Committee asked for future reports including Trust wide data to include this analysis as a matter of course. This will require a new way of working between the Governance function and the localities. All present agreed that this would make for a more meaningful discussion at the Committee.

The Report also outlined the key points from last year’s DOH guidance on “reducing the need for restrictive interventions”. The committee gained assurance that following criticism in the recent CQC Report, the Executive Team had responded with a project Plan which included a thorough overhaul of our training and the appointment of a new substantive Band 7 to lead the PMA team. It has also been acknowledged that as well as training there needs to be a cultural change in the organisation with the roll out of Safe wards in the Trust being a key component in that. The data referred to above will be used as the baseline against which to measure a reduction in the use of restrictive interventions. There will be quarterly reporting to QGC.
1.2 Embedding of Lessons Learnt – At the May Board we received a paper from the Director of Nursing on how Lessons Learned will be embedded in the organisation. A key part of the process was that QG will receive details of Lessons Learnt which have significance across the Trust with the objective of discussing the learning, confirming the proposed actions and have evidence of assurance is received. We received the first two examples this month. There is still some work to be done to properly embed this in the Trust but with the creation of a standardised Locality Quality Governance committee structure with consistent Terms of Reference the architecture is now in place.

1.3 Complaints report – we received a very comprehensive report with an analysis of the number and type of complaints together with the outcome. This showed an increase of 12% year on year. Key themes identified were around communication in connection with medication; service users being discharged too early, appointments being cancelled (often without notification) and the attitude of staff.

As with 1.1 above whilst the report provided data at the locality/service level it lacked input from the localities and the Committee requested the report to be resubmitted with that information to enable the committee to gain assurance around what was happening at a locality/service line level. This will enable us to gain a better understanding of what is behind the increase in complaints.

The Committee noted the improvement in the Complaints process following changes introduced earlier this year as evidenced by the review conducted by a sub Group of Governors.

1.4 Policy Ratification report – The committee was asked to approve the Seclusion and Long Term Segregation Policy which had been recommended by the Clinical Effectiveness and Policy group. We were asked to note that this policy did not meet the DOH guidelines because our estate what not enable us to fully comply. The policy was approved on the basis that it would not be sensible to approve a policy which we knew we could comply with. However the Committee asked for details to be provided at the next meeting illustrating those areas in which we were not compliant with DOH guidelines and what work would be necessary to enable compliance.

The committee also noted that there were 5 overdue policy reviews and were disappointed to see that two of these were non merged policies. The committee asked that dates be provided at the next committee for when these policies would be reviewed.

1.5 Service User Experience Quarterly Report – We received the Quarterly Report based on the Family and Friends Test and comments posted on NHS Choices. Given the very low level of responses (12 and 83 respectively) it is hard to draw any meaningful conclusions. Localities reported that they collect service User and Carer feedback from a variety of other sources and it was agreed that these would be pooled together to endeavour to provide a richer source of information from which to extract more meaningful conclusions.
1.6 Quality Improvement programme – The latest version of the Trust QIP was tabled. Assurance was obtained about how this was being implemented and evidenced at a local level:

- All Localities/services confirmed that Locality plans are in place and are being implemented. This is being monitored and evidenced by Local Quality governance and reported up to the respective Director of operations. I have subsequently had a meeting in Norfolk to see how this is working in practice and have evidenced this process.

- The local plans are in the process of being retrofitted into the Trust Plan (where appropriate). This will be completed before the next QG meeting.

- A programme of Quality Improvement visits has been developed and commenced in April involving staff, service users, carers, commissioners and Healthwatch. Feedback is provided to local management and is a source of assurance for the QIP and evidence was provided to show how this is reported and referenced to the Action Plan. The 3 major areas where work still needs to be done were around Storage of medication in community teams, MHA Administration of Section Papers and Staffing issues. These have been escalated appropriately.

- The quality dashboard has been developed with Commissioners to provide assurance around quality improvements. A draft dashboard was available and we were assured that this would be populated and available in real time for the June meeting following the Lorenzo implementation.

2.0 Equality implications

2.1 None

3.0 Risks / mitigation in relation to the Trust objectives

3.1 Ensuring a fit for purpose Quality Governance structure is fundamental to ensuring high standards of patient care and specifically will facilitate Lessons Learned being embedded throughout the Trust. It will also be an important step in addressing some of the Quality concerns arising out of the recent CQC Report which will help enable the Trust to exit Special Measures e.g. use of restrictive interventions.

4.0 Recommendations

4.1 Again all localities and services were represented at appropriate levels of seniority.

4.2 I was encouraged this month by the progress made in implementing the QG structure throughout the Trust and some signs that it is beginning to get embedded. I was also encouraged by the willingness of both Governance and Localities to work more collaboratively in order to provide reports with data and analysis informed by locality input. This needs to become common practice and will take some time to get established but the direction of travel is very positive.
4.3 The Board is asked to note the Report

Gary Page
Chair
3rd June 2015

Background Papers / Information

None
Executive Summary:

The key event in the last 3 months was the Deanery Quality Performance Review (QPR) visit on 19th June 2015.

The purpose of the visit was to review of the Trust’s performance against the Learning and Development Agreement (LDA) including the GMC and Non-Medical Commissioned Programmes standards, and the review and triangulation of the evidence gathered through HEEoE’s quality management processes. The visit was fully multi-professional, reflecting the whole workforce and the clinical learning environments that the Trust provides. HEEoE considered the overall governance of education and training within the Trust for all professions and specialties.

Formal response will be presented to the Trust on 24th July, having sent a document for fact checking 2 weeks prior to that date.

The will be a preliminary meeting at the GMC’s London office on 20 July 2015 to learn more about the upcoming regional review of the East of England in October 2015.

1.0 Report contents

1.1 Core Programme Director was praised for notable practice in setting up Faculty of Post Graduate Training

1.2 There was an overall good response to the action plan delivered so far.

1.3 There were 2 immediate concerns, 7 significant concerns and 5 developmental areas fed back by the visiting team on the day.
2.0 Immediate Concerns

2.1 Investigation must occur immediately into a situation where a Trainee (Coastal) has not been receiving regular supervision due to locum consultant being in place – immediate review has occurred and supervision with the consultant is taking place from now. No placement there in August due to Carlton Court closing within the following 6 month period.

2.2 Information about how the tariff is being spent in NSFT; a review by Finance Director was requested. Jo Graham and Peadar Langan are holding meetings with the medical director and CPD to clarify this.

3.0 Significant concerns

3.1 The Central Norfolk 1st tier rota involves 1 doctor covering 15 wards across Norwich after 9pm. There is already a plan to consider adding second doctor from 2100 to 0900 once a survey of activity is complete and the clinical need is demonstrated.

3.2 Doctors in training expressed concerns about gaps in the rota leading to 2nd tier doctors acting down, which has required the 2nd tier doctor to cancel the following day’s clinic due to tiredness. Gaps are often filled by locum night cover but there were complaints that this locum work has not been not paid in timely manner.

3.3 Induction poor lack of relevance of central induction to local needs

3.4 Doctors in training complained that Lorenzo training was not specific for them. Dr Kharbteng is exploring a Lorenzo training schedule more tailored to doctors’ work.

3.5 There were complaints that accessing mandatory training is difficult and this seems to be preventing study leave being granted or funded.

3.6 There was a lack of transparency about educational governance in general. The visiting team recommended that the Core Programme Director and the to sit on same committee, e.g. OD&W. There was a lack of clarity regarding the Core Programme Director’s role particularly how it relates to Director of Medical education role. The tariff provides for DME, so clarity about how the CPD role accounts for the DME role is required.

3.7 Trust delivery of GMC medical educator approval policy needs clarifying: delivery of supervisors and appraiser selection. There was also a request to clarify the rules around Revalidation for a doctor working for more than one Designated Body.

4.0 Developmental areas

4.1 How to widely disseminate learning from SIs.

4.2 The East Suffolk on call room still not sorted for the second tier for those who live far away. Not mandatory but good practice happening in other Trusts in the region.
4.3 Doctors mess / resource room to be installed – computers, refreshments / microwave, fridge

4.4 Lack of access for generality of trainees to MHA OOA assessments due to small number of SAS doctors who are always the first to be called.

4.5 Funding for psychotherapy training agreed for extra medical Pas supervising, but psychology supervisors need funding too.

5.0 Recommendations

5.1 To investigate the areas of immediate and significant concern indicated by the feedback on 19th June 2015.

5.2 To fact-check draft report and prepare for formal feedback on 24th July 2015 and implement recommendations.

5.3 To prepare for GMC visit on 20th July and October 2015.

5.4 The key risk of not implementing is the removal of trainee posts from the Trust.

Name Bohdan Solomka
Title of Author Medical Director
Executive Summary:

As agreed with the Board of Directors the May 2015 reporting is temporarily suspended whilst the Lorenzo implementation is completed. As a consequence the report is not as comprehensive as other months however there are updates from the Directors of Operations along with a Workforce update and an update has also been provided by the Norfolk Recovery Partnership.

Key highlights to note are:

- Continued reduction in the sickness absence rate – down to 4.93% from 4.96%.
- Ongoing contract concerns with Access and Assessment services in Norfolk and performance against waiting time standards.
- A small fall in the vacancy rate from 13.27% to 13.22%. This rate is higher due to the inclusion of additional posts to ensure agreed service developments can take place and that safe staffing levels are in place across the Trust.

1.0 Report contents and Summary

The Business Performance Report is submitted to the Board for month 02 2015/16. Due to the Lorenzo implementation, reporting for May 2015 has been temporarily suspended in order to focus on the implementation work taking place.

2.0 Director of Operations

2.1 Norfolk and Waveney Summary

The main areas to highlight in Norfolk and Waveney are:
• There are upcoming changes in West Norfolk that will see some team caseloads transfer from West Norfolk to Central Norfolk. This is happening for the adult service line from 1st June 2015 and for CAMHS and Youth and DCLL from 1st July 2015. It is anticipated that these moves will help to reduce waiting times for treatment in West Norfolk.

There are 16 Out of Area placements at the time of writing, 10 in the adult service line and 6 older people. This is down from the 20 that were reported on 30th April 2015, although more bed days were used in total outside of NSFT in May than in April. There were no out of area placements for the PICU (Psychiatric Intensive Care Unit).

• A change to the Access and Assessment service took place on 1st June. The AAT (Access and Assessment team) is now a hub for new referrals and all referrals are passed to the service line for assessment. This new way of working is being monitored within the locality.

• The Norfolk CCGs’ decision to pull funding form the MIND crisis line is likely to result in increased pressures on CRHT teams. The locality is now making preparations for this change because this is likely to increase the pressure in terms of referrals in to the CRHT.

Contract Update Norfolk

• **AAT CQN** - There is a Contract Query Notice (CQN) for AAT issued in Dec 2014. This was as a consequence of 2 breaches of (i) 95% 28 days referral target and (ii) 95% 72 hour referral target. The Remedial Action Plan (RAP) actions are on-going and a meeting between Debbie White (Director of Operations Norfolk and Waveney) and the CCG agreed a temporary extension to 120 hours to replace 72 hours until end of June. If this continues it is hopeful that this item will be closed. NSFT are likely to miss the 28 day target and so will risk a 2% maximum withholding of income. There is no data available since AAT reporting was suspended at the time of the Lorenzo implementation. The CCGs will look at 28 days performance when the monthly data report is available for May and June. Current indications suggest that NSFT is breaching the reduced 90% target for May, however, without the evidence, the CCG are unable to withhold payment for May’s breach. The main concern from the service remains levels of staffing.

• **Access CQN - Norfolk IAPT** This service has an outstanding CQN due to the breach of the 15% entering treatment target. A joint investigation report with a summary of discussions and recommendations was approved by the April CCG Network meeting. 4 Recommendations including CCGs supporting NSFT with the action plan by hosting events and supporting marketing. The existing RAP will be developed and will be monitored in the IAPT sub group to the main Contract meeting.
2.2  Director of Operations Suffolk Summary

The main areas to highlight in Suffolk are:

- Good progress is being made on the Liaison Psychiatry balanced scorecard. The locality is close to an agreement between NSFT, CCGs and Ipswich Hospital.

- A change has been made in the management for Chilton Houses. These now come under management of the West Suffolk Locality from Secure Services. Over the next two months a significant amount of work is taking place to positively impact patient safety and quality.

Contract Update

- **Staff Training CQN** – As reported previously, MCA and DOLs training achieved three consecutive months ahead of target. MCA performance dropped to 94.8% (one member of staff was below target for March).

  At the request of Suffolk CCG’s, safeguarding Level 3 training figures have been investigated by Sue Miller (Associate Director Delivery & Change, Suffolk). This shows an increase of staff requiring this training, which has led to March 2015 performance dropping to 75.7% (81/107 staff trained). Consequently the RAP has not been met. NSFT met with the Suffolk CCG’s on 18 May 2015. It was agreed that NSFT would revise the RAP to include a trajectory to achieve the 90% contractual target.

Information Notice from Suffolk CCGs - The Information Notice dated 6th March 2015 in respect of staffing information remains open and Suffolk CCG’s continue to withhold 1% of the Actual monthly value. NSFT submitted the initial staffing report in the agreed format on schedule in May 2015, this is being reviewed by Commissioners and a meeting will be arranged to discuss this further.

Under 18 referral increases – The Trust and Suffolk CCGs have jointly written to Suffolk County Council about the increased referrals to the Access and Assessment Team following the Council’s decision to close the Integrated Access Team. A resolution to this issue is required as it is causing NSFT to miss its contractual targets.

3.0  Financial implications (including workforce effects)

3.2  Percentage of IAPT patients who have depression and or anxiety disorders who receive psychological therapy (OD12)

The IAPT service was below the 15% access trajectory for month two in Central Norfolk and West Norfolk. Great Yarmouth and Waveney achieved the access rate requested for month 1 however was below the target for May 2015. In Norfolk overall the service was at 2.0% against a target of 2.3% for month one. This
represents 228 service users accessing the service in Norfolk. Norwich was above the access rate, West Norfolk, North Norfolk and South Norfolk were below the access rate in May 2015. Internally the access figures are now reported weekly to the service managers so that the necessary actions can be put in place.

In Norfolk, the recovery was below the 50% target at 46%. This target will get more attention and this is being addressed by the service manager.

3.3 Workforce - Vacancy Rate

More detailed workforce metrics are presented and discussed at the Trust’s bi-monthly Workforce and Organisational Development Committee. The commentary below highlights key issues and areas of assurance for the Board.

The vacancy rate decreased in the month from 13.27% to 13.22%. The current rate sits at 3.04% above the in-month target to reach 8% by the end of March 2016. The rate is 12.89% (-0.80%) within Norfolk clinical services, 10.97% (-0.26%) within Suffolk clinical services and 7.98% (+1.71%) in Specialist Clinical services. Vacancies are highest within Corporate Services (20.59%) pending restructure and Norfolk West (15.49%).

Net recruitment in the 12 month period to the end of April 2015 was 266 whole time equivalents, 252 of which were clinical.

The Trusts campaign to recruit ‘soon to be qualified’ nurses finishing their studies in summer 2015 has ended. Interviews were held over the 3rd and 4th June.

The Trusts advertising campaign to recruit ‘return to practice’ nurses which was ran across social media channels has been largely successful. In total 4 candidates have been interviewed with 3 placements offered. A further 3 are to be interviewed over the next two weeks.

National adverts have been placed for Band 5 nurse roles within Central Norfolk Acute services.

To supplement the Trusts ‘work for us’ internet site and provide more online content resource to supplement job advertisements, the Trust has been engaging with local media companies to design two promotional videos. These are due to go live shortly.

The Trusts time-to-recruit metric continues to increase. On average new recruits for May received their unconditional Trust offer 108 days after the advert launching. The most recent Senior Management Forum highlighted ongoing delays within the recruitment process and the importance of forward planning to help support a quick and smooth recruitment process. Time to recruit is clearly a significant factor in the use of temporary staff.

3.4 Employee Turnover

The Trust’s turnover rate has increased in the month from 11.96% to 14.66%.
Turnover is highest is within Substance misuse services at 31.03%, this has increased by 4.84% in the month and overall is largely due to the change in service provision of Suffolk Alcohol Services.

Further detailed analysis is being undertaken to investigate the increasing turnover rates in Central Norfolk and West Norfolk. This will be reported to the Trusts Recruitment and Retention Group and proposals to remedy the issue identified.

As part of the first phase of reviewing the staff recognition processes. It has been identified at 261 people in the Trust have completed 25 years’ service with the Trust. To celebrate this achievement, all have received an invite (along with a guest) to a presentation at one of four board meetings that are being held throughout the year. So far, 34% have responded.

3.5 Sickness absence

Overall, the Trust’s annualised sickness absence rate has slightly decreased in the month to 4.93%. This is below the trajectory needed to achieve 4.5% by March 2016.

The latest figures released by the Health and Social Care Information centre (HSCIC) show that NHS staff sickness absence has risen by 0.28 per cent in the year from January 2014 (4.44 per cent) to January 2015 (4.72 per cent).

NSFT have reduced their staff sickness absence rate by 0.55 per cent during this same period.

Over the last quarter the following activity has supported the decreasing absence rate.

- 643 staff were regular active users of the Revitalised Staff wellbeing zone.
- 628 staff accessed support from Workplace Health and Wellbeing, the Trust’s Occupational Health provider.
- 53 staff received counselling via Insight, the Trust’s confidential independent employee assistance programme.
- Improving sickness absence was embedded in the objectives of every manager within the Trust.

3.6 Appraisals

The appraisals rate within the month has largely stayed the same at 80.33% since last month. Managers are now awarding the incremental pay point through the appraisal/ staff pathways systems.

HR Business partners are monitoring compliance and working alongside managers who highlight any problems or misunderstanding. Local appraisal training continues to take place.
Wellbeing review activity remains low at 8.68%. The development of the Trust values and wellbeing strategy will be used to inform how wellbeing is captured as part of the appraisal process.

3.7 Employee Relations

The number of grievances raised in the Trust has reduced to 7. The number of capability cases is unchanged at 8, while the active disciplinary has increased from 21 to 23.

The overall activity for sickness absence reviews has increased and correlates with the reducing Trust sickness absence rate.

3.8 Norfolk Recovery Partnership (NRP)

In May the Monthly Contract and Performance meeting took place with NRP Commissioners. Overall commissioners are pleased with NRP’s performance collated via the monthly report (this is also known as the PMF – Performance Management Framework). Review TOP (treatment Outcome Profile) has improved and the service is currently at 84% compliance which is in line with the trajectory agreed at the May 2015 Performance Review meeting (a 3% increase from April 2015). NRP are at 86% compliance with sub-modalities with a planned trajectory for 100% compliance by September 2015 as requested by Commissioner. This will be an area where the service will be focussing further attention in the coming months.

4.0 Recommendations

The Board is requested to consider the Trust’s performance as described within the Business Performance Report.

Tim Walsh
Information Manager
17th June 2015
Business Performance Report
May 2015 version 2.0

NSFT Informatics
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<td>CPA patients receiving follow up within 7 days of discharge</td>
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<td>Minimising delayed transfers of care</td>
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<td>Admissions to inpatient services had access to CRHT teams</td>
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Trend is calculated using Actual at Month 12 2014/2015 as compared to the Actual in the current month.

- Performance is neither improving or worsening
- Performance is worsening
- Performance is improving
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<td>CPA patients having formal review within 12 months</td>
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<td>Minimising delayed transfers of care</td>
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<td>Admissions to inpatient services had access to CRHT teams</td>
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<td>% of qualifying patients with a MHCT cluster</td>
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<td>Number of contacts recorded on Trust systems within 3 working days of event (Last 30 days)</td>
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<td>% of inpatient Finished Consultant episodes during the period with an ICD10 code</td>
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<td>OD12</td>
<td>% of IAPT patients who have depression and/or anxiety disorders who receive psy therapy</td>
<td>Month YTD</td>
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<td>1.20%</td>
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<td>% of IAPT patients who complete treatment and 'move to recovery during the month</td>
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<td>Medium Secure Bed Occupancy Rate (including leave)</td>
<td>Month YTD</td>
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<td>OD15</td>
<td>Low Secure Bed Occupancy Rate (including leave)</td>
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<td>Average Length of Stay - Adult Acute Service</td>
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Trend is calculated using Actual at Month 12 2014/2015 as compared to the Actual in the current month.
## Quality, Safety and Experience

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<td>QU01</td>
<td>CPA patients receiving follow up within 7 days of discharge</td>
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<td>Actual</td>
<td>91%</td>
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<td>Waiting Times - Number of incomplete pathways waiting &gt; 18 weeks</td>
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<td>Waiting Times - % of CAMHS patients seen within standard</td>
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<td>87%</td>
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<td>Patient Safety Thermometer (Development KPI)</td>
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<td>QU17</td>
<td>% of long-term (over 12 months) inpatients that have received an annual health check</td>
<td>Month YTD</td>
<td>Actual</td>
<td>92%</td>
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<td>Annualised sickness absence rate</td>
<td>Month YTD</td>
<td>Actual</td>
<td>4.96%</td>
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<td>% of staff with 4 or more absence episodes (WD2)</td>
<td>Month YTD</td>
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<td>9.33%</td>
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<td>WD03</td>
<td>% of sickness absence episodes &gt;= 21 days</td>
<td>Month YTD</td>
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<td>10.44%</td>
<td>10.62%</td>
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<td>WD04</td>
<td>% of sickness absence days attributed to Anxiety/stress/depression/etc.</td>
<td>Month YTD</td>
<td>Actual</td>
<td>25.82%</td>
<td>25.15%</td>
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<td>WD05</td>
<td>% of staff with an appraisal since April 2013</td>
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<td>79.17%</td>
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<td>WD06</td>
<td>% of medical staff compliance with planned 2014/15 appraisal timetable (Cohort 1)</td>
<td>Month YTD</td>
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<td>WD07</td>
<td>Mandatory/statutory training compliance.</td>
<td>Month YTD</td>
<td>Actual</td>
<td>71.30%</td>
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<td>WD08</td>
<td>Vacancy Rate</td>
<td>Month YTD</td>
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<td>13.27%</td>
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<td>10.39%</td>
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# Workforce Development and Effectiveness

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<tr>
<td>WD09</td>
<td>Turnover Rate</td>
<td>Month</td>
<td>Actual</td>
<td>11.96%</td>
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<td>WD10</td>
<td>% of resignations which are voluntary</td>
<td>Month</td>
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<td>52.18%</td>
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<td>WD11</td>
<td>Staff engagement - mini survey (Development KPI)</td>
<td>Month</td>
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<td>WD12</td>
<td>Staff in post to caseload ratio (Development KPI)</td>
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Trend is calculated using Actual at Month 1 2015/2016 as compared to the Actual in the current month.
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<td>Debtor &gt; 90 days past due account for more than 5% of the total debtor base</td>
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<td>FM05</td>
<td>Creditors &gt; 90 days past due account for more than 5% of the total creditor balances</td>
<td>Month YTD</td>
<td>Actual</td>
<td>1.50%</td>
<td>1.56%</td>
<td>5.00%</td>
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<td>Target</td>
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<td>FM06</td>
<td>CAPEX % of plan spent</td>
<td>Month YTD</td>
<td>Actual</td>
<td>9.56%</td>
<td>14.90%</td>
<td>5.84%</td>
<td>10.74%</td>
<td>16.92%</td>
<td>25.91%</td>
<td>33.71%</td>
<td>42.66%</td>
<td>51.33%</td>
<td>63.39%</td>
<td>75.02%</td>
<td>84.96%</td>
<td>92.64%</td>
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<td>Target</td>
<td>5.84%</td>
<td>10.74%</td>
<td>16.92%</td>
<td>25.91%</td>
<td>33.71%</td>
<td>42.66%</td>
<td>51.33%</td>
<td>63.39%</td>
<td>75.02%</td>
<td>84.96%</td>
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<td>FM07</td>
<td>CIP % of planned CYE (R&amp;NR) savings achieved</td>
<td>Month YTD</td>
<td>Actual</td>
<td>4.07%</td>
<td>8.77%</td>
<td>2.51%</td>
<td>5.02%</td>
<td>7.53%</td>
<td>15.87%</td>
<td>25.16%</td>
<td>34.45%</td>
<td>45.42%</td>
<td>56.40%</td>
<td>67.37%</td>
<td>78.32%</td>
<td>89.27%</td>
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<td>Target</td>
<td>2.51%</td>
<td>5.02%</td>
<td>7.53%</td>
<td>15.87%</td>
<td>25.16%</td>
<td>34.45%</td>
<td>45.42%</td>
<td>56.40%</td>
<td>67.37%</td>
<td>78.32%</td>
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