Norfolk and Suffolk NHS
NHS Foundation Trust

Board of Directors – Public Session

Meeting to be held on Thursday 23rd January 2020 at 12.30 – 16:00
in Active Business Centre, 33 St Andrew Street South, Bury St Edmunds, IP33 3PH

AGENDA

LUNCH – members of the public welcome

Timing	Item No	Item	Presenter	Paper/ Verbal
12:30	**20.01**	Chair's welcome, apologies for absence and notification of any urgent business:	Marie Gabriel	
12:35	**20.02**	Declarations of Interest	Marie Gabriel	Paper A
12:40	**20.03**	Voice of the Service User and Staff Story	Diane Hull	Verbal
13.00	**20.04**	To approve the minutes of the previous public meeting, held on 21st November 2019	Marie Gabriel	Paper B
13.05	**20.05**	To address any Matters Arising from the minutes of the previous meeting and Action Log	Marie Gabriel	Paper C
13.10	**20.06**	Chair's report	Marie Gabriel	Paper D
13.20	**20.07**	Chief Executive's report	Jonathan Warren	Paper E
Quality				
13.30	**20.08**	Patient Safety and Quality Report CQC report	Diane Hull	Paper F Paper G
13.45	**20.09**	Mortality and Learning from Deaths Report	Dan Dalton	Paper H
13.55	**20.10**	Safer Staffing – including community numbers	Diane Hull	Paper I
14.05	**20.11**	Guardian of Safe Working Reports	Dan Dalton	Paper J
14.15	**20.12**	Access and Waiting Times Eating Disorders Deep Dive	Stuart Richardson	Paper K
BREAK				
Strategy				
14.40	**20.13**	Strategic Activity Update	Mason Fitzgerald	Paper L
Performance				
14.50	**20.14**	Integrated Performance Report	Stuart Richardson Daryl Chapman	Paper M
15.00	**20.15**	Freedom to Speak Up Report	Jonathan Warren	Paper N
15.10	**20.16**	People and Workforce Report	Mark Gammage	Paper O
Governance				

15.20	**20.17**	**Items for Information:**		
	i.	Quality Assurance Committee Chair's Report	Tim Newcomb	Verbal
	ii.	Audit & Risk Committee Chair's Report	Adrian Matthews	Paper P
	iii.	Finance, Business and Investment Committee Chair's Report	Adrian Matthews	Paper Q
	iv.	People Participation Committee Chair's Report	Pip Coker	Paper R
	v.	Mental Health Act Committee	Katy Steward	Paper S
	vi.	Appointments and Remuneration Committee Chair's Report	Tricia Fuller	Paper T
15.35	**20.18**	Questions from the public in relation to the Board papers presented at today's meeting	Marie Gabriel	
15.50	**20.19**	Any other business previously notified to the Chair	Marie Gabriel	
16.00	**20.20**	**Date, time and location of next meeting** The next meeting of the Board of Directors in public will be held on Thursday 19th March 2020 in Lowestoft		
		Motion to exclude public and press from the confidential part of the meeting to be held on 19th March 2020		
	CLOSE			

Norfolk and Suffolk NHS Foundation Trust

Board of Directors Declaration of Interests: 2019/20

Norfolk and Suffolk NHS Foundation Trust is committed to openness and transparency in its work and decision making. As part of that commitment, we maintain and publish this Register which draws together Declaration of Interests made by members of the Board of Directors.
In addition, at the commencement of each Board meeting, members of the Board are required to declare any interests on items on the agenda.

TITLE	FIRST NAME	LAST NAME	POSITION / BASE	DETAILS OF INTEREST
Ms	Marie	Gabriel	Chair	Chair: East London Foundation Trust Trustee East London Business Alliance Foundation for Future London West Ham United Foundation Member of the Labour Party Independent Chair, North East London STP
Mr	Tim	Newcomb	Non-Executive Director	NIL
Mr	Adrian	Matthews	Non-Executive Director	Owner - XE Associates Consulting Specialist Advisor - CQC National Job Evaluation Trainer - NHS Employers Trustee/NED - Diversa Multi Academy Trust Director - Diversa Trading Ltd. Trustee/NED - Evolution Academy Trust
Mr	Ken	Applegate	Non-Executive Director	NIL
Ms	Pip	Coker	Non-Executive Director	Continued relationship with Julian Support Trustees and Management Team. I will not take part in any matters relating to their business relationship with the Trust. 2008 to present. Former CEO of Julian Support
Ms	Katy	Steward	Non-Executive Director	NHS - Isle of Wight Trust, Belfast NHS Trust, London Leadership Academy Trustee of Oxfam GB (ongoing until April 2020)

Norfolk and Suffolk NHS Foundation Trust

Board of Directors Declaration of Interests: 2019/20

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Ms	Tricia	Fuller	Non-Executive Director	Co-Opted Governor West Earlham Junior School
Mr	Jonathan	Warren	CEO	Faculty Member - Institute Healthcare Innovation Chairman - Ardingly Rowing Club Employed by East London NHS Foundation Trust and seconded to Norfolk and Suffolk NHS Foundation Trust.
Mr	Mason	Fitzgerald	Deputy CEO and Director of Strategic Partnerships	Employed by East London NHS Foundation Trust and seconded to Norfolk and Suffolk NHS Foundation Trust
Mr.	Daryl	Chapman	Interim Finance Director	Volunteer Treasurer for Spooner Row Primary School Pre-School
Ms	Diane	Hull	Chief Nurse	NIL
Mr.	Stuart	Richardson	Chief Operating Office	NIL
Dr	Daniel	Dalton	Chief Medical Officer/Hellesdon	National Specialist Adviser (Specialised commissioning) Mental Health, remunerated, NHSE Honorary member of the Secretary of State for Transport's Clinical Advisory Panel on mental disorders and driving, DfT Spouse is a clinical psychologist employed by Cambridgeshire Community Services NHS Trust who also undertakes private clinical practice in Norfolk
Dr	Jan	Falkowski	Medical Director/Workforce	Private and Medical Legal Work - Self Employed Trustee Royal College of Psychiatrists
Mr	Mark	Gammage	HR Advisor to the Board	Managing Director of Dearden HR an HR management consultancy company and Managing Director of Dearden interim, an interim management company

Date:	23rd January 2020	B
Item:	20.04	

Norfolk and Suffolk NHS
NHS Foundation Trust

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Unconfirmed

Minutes of the Board of Directors – held in public

held on Thursday 21st November 2019 from 12:30
in IP-City Centre, 1 Bath Street, Ipswich, IP2 8SD

Present:

Board of Directors	Marie Gabriel (MG)	Trust Chair
	Ken Applegate (KAp)	Senior Independent Director
	Adrian Matthews (AM)	Non-Executive Director
	Tim Newcomb (TN)	Vice Chair – Suffolk
	Katy Steward (KS)	Non-Executive Director
	Prof Jonathan Warren (JW)	Chief Executive Officer
	Daryl Chapman (DC)	Interim Director of Finance
	Diane Hull (DH)	Chief Nurse
	Mason Fitzgerald (MF)	Director of Strategic Partnerships (Deputy CEO)
	Stuart Richardson (SR)	Chief Operating Officer
	Dr Bohdan Solomka (BS)	Medical Director
Attendees:	Jean Clark (JC)	Trust Secretary
	Dr Daniel Dalton (DD)	Chief Medical Officer (Designate)
	Dr Jan Falkowski (JF)	Workforce Medical Director
	Sarah Goldie (SGo)	Head of Organisational Development & Human Resources
	Liz Keay (LK)	Freedom to Speak Up Guardian (Item 19.138)
	Karn Purvis (KP)	Equality Advisor (Item 19.139)
	Andrea Goldsmith (AGh)	Corporate Governance Support (minutes)

Item No	Agenda title	Action
19.127	**Chair's welcome, notification of any urgent business and apologies for absence**	
i.	MG welcomed those present, especially DD, TF and KS who were attending their first NSFT Board meeting, and advised that apologies had been received from Pip Coker, Tricia Fuller and Tim Stevens. MG also announced that MF had been appointed Deputy Chief Executive, Strategy and Partnerships, a role he would take up in December.	
ii.	MG advised that this was BS's last meeting who was the longest-serving member of the NSFT Board. MG thanked BS for his work on the Board and welcomed that he would be continuing his clinical work. JW added his thanks, before those present added their appreciation.	

Item No	Agenda title	Action
19.128	**Declarations of Interest**	
i.	There were no additional declarations of interest.	
19.129	**Voice of the service user**	
i.	MG welcomed Tracey, who shared her story about her own mental ill-health and recovery. Tracey was now volunteering in the Trust as a peer mentor, had sat on interviews, been involved with training sessions and completed her Level 3 Support Worker with distinction. She hoped to move into paid work in the future. Initially she had not been able to be take on some roles because of the DBS check, which was resolved following discussions highlighting the value of her experiences to support others. As part of her recovery, she had a number of tools to keep herself well, and thanked the staff at Oliver Court for their care.	
ii.	MG thanked Tracey for sharing her story and congratulated her on her qualifications, which was echoed by those present.	
iii.	The Board requested that JW and SGo would discuss the DBS checks to ensure that the Trust benefited from service users' experiences: **ACTION**. MG suggested that Tracey's story be shared during staff induction sessions: **ACTION**.	**JW, SGo** **SGo**
19.130	**To approve the minutes of the last meeting – held on 19 Sept 2019**	
i.	The minutes were **approved** with no changes.	
19.131	**Matters arising from the minutes**	
i.	Following a request from MG, JC agreed to keep the closed items from the preceding meeting on the list with a narrative where relevant: **ACTION**.	**JC**
ii.	Min 19.75: The next safer staffing report would come to the January 2020 Board and include community figures **Action**	**DH**
iii.	Min 19.89: The patient safety strategy would be updated once the CQC report had been received and would be reported to the March 2020 Board, not the January 2020 meeting.	**DH**
iv.	Min 19.103iv: The Board requested an update on the transition from CAMHS to Adult Services, JW advised that national plans were for a 0-25year-old service, which the Trust was working with partners to implement. The Trust was also looking to establish a Youth Ward for 18-25year-olds. It was confirmed that there had not been any individuals who had moved directly from CAMHS to adult inpatient since the last meeting.	
v.	Min 19.108v: The programme of NED visits was now in place, additional improvements to ensure there smooth running and feeding back were being taken forward by Tim Newcomb.	

Item No	Agenda title	Action
19.132	**Chair's report**	
i.	MG advised that the Council of Governors had appointed two NEDs since the last Board meeting and been involved in Executive Director appointments as well. The Council had also informed the Trust Strategy, with inclusions such as a commitment to sustainability added. JW stated that following Governor input, sustainability discussions were underway, with one of the suggestions being using electric cars to reduce the impact of travelling. A sustainability management plan was being developed,	
ii.	The Governors had also raised a number of queries regarding the New Models of Care programme, which was a national initiative. The queries raised would be discussed at the next Council meeting. A joint Board and Council meeting had been held to consider the quality of services, the results of which would inform the next iteration of the Trust's Quality Strategy. The report on the next round of NED visits would be presented to the next Board meeting.	
iii.	The Chair had been on a number of visits with voluntary partners and NSFT services. A recurrent theme was that there was a need for clarity on how to access services and pathways through the services. MG will be taking this forward with the Deputy Chief Executive, Strategy and Partnerships when he is post.	
19.133	**Chief Executive's report**	
i.	JW stated that the CQC inspection had involved 40-50 inspectors across Norfolk and Suffolk, and also considered the well-led domain. The final report was expected in January 2020, although a number of actions that may be required within that report, were already underway or were planned, such as improvements to Walker Close.	
ii.	As part of World Mental Health Day, JW had been interviewed on BBC Look East and took the opportunity to apologise to the family of Henry Curtis-Williams. The start of Black History Month had been celebrated by a conference in Suffolk.	
iii.	Following a recent story in the national press about rising numbers of suicides, JW advised that DD was working with Public Health and partners to review processes and resources; partnership was critically important given that approximately only 50% of people who take their lives have been in contact with mental health services. BS noted, for example, that in recent years, the limits on the amount of paracetamol and ibuprofen that could be bought had led to a significant reduction. DD added that there had been a very successful partnership between National Rail and mental health providers to reduce suicides.	
iv.	There had also been a report on BBC 5Live regarding IAPT recovery targets and concerns that service users were being asked leading	

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	questions and discharged before they were ready. DD welcomed this emphasis on IAPT and the importance of listening to service users in appointments and reviewing the quality of services provided. The Board noted that NSFT teams follow the prescribed programme.	
19.134	**Patient safety and quality report**	
i.	DH advised that in the two-month reporting period, there had been 25 serious incidents (SIs), with 16 as unexpected deaths which would be fully investigated. One patient safety alert had been issued in relation to plastic bags.	
ii.	There had been one prevention of future deaths report from the Coroner relating to a young person who had died following a paracetamol overdose. SR confirmed that the Access and Waiting Time Group was looking at the eating disorder waiting times and would report back to the Board: at the next meeting **ACTION**. There were also conversations with the service and CCGs regarding the learning from this case and potential review of the model. The Board asked for	**SR**
iii.	Following on from the lunch time staff story regarding carer involvement in safety planning the Board were advised that, funding had been secured for suicide prevention work and carer involvement. In addition, the Family Liaison Officer had been in post since July 2019 and was currently supporting ten families.	
iv.	Flu vaccinations sessions have been arranged, and every effort was being made to ensure that the take-up will exceed last year's, and the Board gave their support for this.	
v.	DH advised that the Quality and Safety reviews were looking at care plans to make sure they are recorded properly and were meaningful.	
vi.	JW reported that 230 extra staff had been recruited, including 35 student nurses from UEA starting September 2020. A recruitment session would be held in University of Suffolk in early December 2019. The Board discussion noted that - There had been a focus on development and career opportunities for registered and non-registered nurses. - The skills mix and staffing of teams was being reviewed - A report to the March 2020 meeting would bring all this workforce information together with information about medics and AHPs along with STP requirements: **ACTION**.	**DH, DD, SGo, JW**
19.135	**Access and waiting times**	
i.	SR presented the report which detailed the actions to date to reduce waiting times.	

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ii.	As part of our plans to improve the Quality and Safety Reviews had focused on waiting list management. Teams were also looking at ways to reduce "do not attends" (DNAs), with real-time information available on access and waiting times. The DNA rate varied across the Trust and teams. The Trust was also working with primary care to look at demand and referrals.	
iii.	There were currently nine people out of area, with two of these being working age adults and seven as delayed transfer of care (DToC). The Trust was discussing all the DToCs with Norfolk County Council, not just those out of area. While nine people was still too many, the Board noted the significant progress made and thanked everyone involved.	
19.136	**Strategic activity update**	
i.	MF presented the report, highlighting the national items that could be reported during the NHS General Election purdah. The set of priorities for the remainder of the financial year have been developed following the approval of the Trust strategy, which include sustainability and technology to reduce travelling. There had also been an away-day with the Care Groups. The events for the annual plan would be set up for members and Governors in early 2020. The performance measures were being developed and would be accessible and easy to understand.	
ii.	NHS England have written to all providers to support reducing the use of plastic, which the Board **agreed** to support.	
iii.	While it was not possible to discuss the STPs and ICS plans in detail in public, due to purdah, the Trust was very much involved, and the Governors have been active in both informing out response and in promoting the importance of their role in the plans and governance. A Project Board will be established for the new Hellesdon Hospital development which will have representatives from key stakeholders including service users, carers, NEDs and Governors.	
19.137	**Integrated performance report**	
i.	DC presented the report, noting the performance against waiting time targets. This was an urgent area for the new service directors, with each care group developing their own action plan, to include areas such as appointment times and locations. The care groups were also looking to make sure people were safe while they waited for their appointments with real-time information. There did not appear to be any seasonality to referrals. SR agreed to report back to the next meeting with a separate report: **ACTION**.	**SR**
ii.	Care planning had fallen slightly for completeness; however, feedback received has shown that quality had increased.	
iii.	The Trust was working with partners to reduce the number of delayed transfers of care (DToCs) for older people and out-of-area placements.	

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iv.	SR advised that lack of assessments against the target for eating disorders referrals for under-19s was due to inaccurate data and holidays: the team were looking at this urgently. There had been no incidents of harm while they waited for assessment. SR agreed to circulate details on the Suffolk youth autism figures when this had been looked in more detail. MG asked for a focus on children on young people and waiting times feature as part of the access and waiting times report, which should incorporate an update on out of area placements. **ACTION**.	**SR**
v.	The timing of physical health checks was being investigated, to offer this at the most appropriate time for the service user. DH agreed to look at benchmark information against other trusts: **ACTION**.	**DH**
vi.	MG suggested that the Board review the KPIs as a whole in March 2020 with the Quality Assurance Committee looking at them in February 2020, which was agreed: **ACTION**.	**DC, SR, JC**
vii.	DC advised that the financial position was on track for Month 7, with higher capital than expected due to slippage on projects. There was £1.5m of cost improvement plan savings to be found, and there was an underlying financial deficit. It was agreed that the Board would review the finances in detail at their January 2020 meeting: **ACTION**. There was work underway to reduce the locum spend, with doctors moving on to substantive contracts.	**DC**
viii.	The Board noted that slippage on capital projects is to be discussed by new Care Groups and it is positive that they are involved in the discussions relating to their geography. The Capital Projects Group were looking at proposals for what could be done before year-end for the benefit of service users and improved service delivery.	
ix.	JC presented the Board Assurance Framework, with the new risks agreed in September 2019 and the Board noted the movement since the last meeting.	
x.	Although lots of work had been done on Risk 3.2, the Trust was waiting for the final CQC report before this could be reviewed. MG asked that CPA targets be included in Risk 2.1 or as a separate risk: **ACTION**.	**JC**
	BREAK: 14:12-14:26	
19.138	**Freedom to Speak Up Guardian (FTSUG) Report**	
i.	LK presented the report, which showed a higher number of cases compared to the same time last year. This was due, in part, to the role becoming full-time and more awareness, as well as concerns about the last CQC visit. LK had visited most sites now, with staff being very welcoming. It was hoped that the role would empower and enable people to resolve issues informally and at a local level. The Board noted that increased use of the FTSUG was a positive as more staff were being	

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	supported to speak up.	
ii.	The themes in the current period were staff being asked to go beyond their job description without an acknowledgment or recompense, and a lack of clarity on HR and employment systems. The case study showed how the FTSUG and HR Business Partners worked together to resolve the needs of the service with the staff members' work-life balance.	
iii.	LK advised that the self-assessment for NHS Improvement would be updated soon, with the policy being reviewed as well. MG confirmed that the self-assessment would be shared with the Board	
iv.	JW stated that he met with LK every month and could take the themes, trends and feedback to the most appropriate Executive Director to look into and share learning.	
19.139	**People & Workforce Report**	
i.	SGo stated that the care group leadership had been appointed and had had their induction in September 2019, with the staff consultation on the next phase starting in early 2020. The remaining vacancies were being recruited to, including the Clinical Director role previously occupied by the new Chief Medical Officer. The current vacancy rate was down to 8%, due to changes in skill mix and recruitment of unregistered clinical staff.	
ii.	The annualised sickness absence rate was now tracking with the national average and should achieve target by April 2020. The appraisals and supervision rates remained low and was a focus for the new care groups. It was agreed that this would be discussed at the next Appointments & Remuneration Committee: **ACTION**.	**SGo, JC**
iii.	A detailed report on the culture work would be brought to the January 2020 meeting. It was agreed that the People Before Process work with Staffside would be a future Staff Voice item: **ACTION**. The response to the staff survey was less than previous years, though still over 40%.	**SGo, JC**
19.140	**Equality, Diversity & Inclusion (EDI) Strategy**	
i.	SGo presented the strategy to support the delivery of the Trust Strategy to be in the top quartile for safety and quality by 2023. The Workforce Race Equality Scheme (WRES) and the first Workforce Disability Equality Scheme (WDES) have been published. Both highlight the progress made, but that there was still much work to be done.	
ii.	The EDI strategy has been developed with feedback received, survey results, and information from staff networks. It focuses on four key areas: to challenge behaviours that do not align with the Trust's values; remove inequalities and barriers; improve progression and development opportunities; and full integration into the care group structures. MG	

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	declared that she was the Chair of the WRES Strategic Advisory Group and a member of the NHS Employers Policy Board, and welcomed the work which addressed areas of concern for the Board and staff. There were a number of areas being looked at following the development of the strategy, such as disabled parking. The Trust was also one of the six pilot trusts for Stage 3 of the Workplace Race Equality Scheme, which had a focus on transforming culture.	
iii.	The Board **approved** the strategy and the action plans, and thanked SGo, KP and the staff involved for the development of this strategy.	
19.141	**Emergency preparedness resilience and response (EPRR) update**	
i.	SR updated the Board from the paper presented to the last meeting, which now gave a partially compliant rating, with training and business continuity plans now to be embedded. The Board **approved** the Resilience Policy Statement, and thanked SR and colleagues for their work.	
19.142	**Statement of Compliance revalidation**	
i.	BS advised that following a review, there were currently three doctors who are defined as "non-engaging" and have been reported to the General Medical Council. Doctors were required to have five appraisals within five years, but there were exceptions for ill-health or maternity leave for example. The GMC had also changed their approach and would accept a wider range of evidence. The GMC could defer or strike off a doctor who did not complete their revalidation process. This report was to assure the Board that robust processes were in place and learning from this year would be taken forward to next year.	
19.143	**Board Terms of Reference**	
i.	JC advised that these had not been reviewed for some time and should be read with the Constitution. The Board **approved** the Terms of Reference and noted that the Council were to begin a review of the Constitution with recommendations made to the Board for consideration.	
19.144	**Governance structure**	
i.	JC presented the revised governance structures which had been developed following the CQC inspection and had been welcomed by staff to clarify where items should be taken. There was some debate as to where the Culture Steering Group should sit, and it was agreed that this would be discussed during a Board development session: **ACTION**. JC advised that Internal Audit were asked to review the actions taken following the PwC report and reported significant assurance. The Board **approved** the structure.	**MF, JC**

Item No	Agenda title	Action
19.145	**Charitable Funds – annual report and accounts for approval**	
i.	DC reminded the Board that they were Trustees of the Fund, which had approx. £240k. This would be monitored by the Finance, Business & Investment Committee in future, which was **approved** by the Board. The Board **approved** the annual accounts and report.	
19.146	**Items for information**	
a.	**Quality Assurance Committee – Chair's report**	
b.	**Audit & Risk Committee – Chair's report**	
c.	**Finance, Business & Investment Committee – Chair's report**	
d.	**People Participation Committee – Chair's report**	
e.	**Appointments & Remuneration Committee – Chair's report**	
i.	MG advised that Tricia Fuller would take over as Chair of the Appointments & Remuneration Committee.	
19.147	**Questions from the public in relation to the Board papers presented at today's meeting**	
i.	Cllr Michael Chenery asked whether the 35 student nurses would have a choice in work location: DH confirmed that they would. Cllr Chenery passed on a number of reasons that he was knew why people did not attend their appointments: parking; lack of continuity of staff and so having to go back over previous information; simply forgetting the appointment; and transport to and from the location.	
ii.	Derek Sanders, Suffolk Service User Governor, asked when the new nurses would be coming to the Trust and staffing levels. DH confirmed that the student nurses were finishing their final year, and while there was work to be done on registered nursing vacancies, the levels was safe.	
iii.	Andrew Good, Suffolk Public Governor, advised that from his work with The Samaritans, it was clear that people did not always get key contact information on discharge from inpatient wards: it was not possible to identify the service provider during a call. DH agreed that telephone numbers should be within a service user's discharge and safety plan and agreed to follow this up: **ACTION**.	**DH**
iv.	Andrew Good, Suffolk Public Governor, asked about the People Participation Leads and co-production, and the flexibility to develop their practice within their care group while being consistent across the Trust. MG advised that this was part of the development of the role, working with staff, service users, carers and other information sources. DH added that a meeting had been held earlier in the week, and they had lots of ideas and areas to work and were sharing information and	

Item No	Agenda title	Action
	practices to balance local needs with consistency.	
v.	Jill Curtis, Staff Governor, asked about the themes raised in the FTSUG report, and the administration and forms staff needed to complete. DH replied that a development programme for Band 3 staff was being put together, as well as development plans for Allied Health Professionals. Unregistered staff would be supported to achieve registration or have other opportunities if they did not want to become registered. JF added that work was underway for medics as well to look at career options and development programmes. JW agreed that banding and recognition needed to be looked at, as well as tasks that staff undertake which have little or no benefit to care. MG suggested that this be included in the report on staffing across the Trust. **Action**	**MG**
vi.	Ian Hartley, Suffolk Public Governor, stated that supervision and appraisal should be seen as an opportunity to listen, learn, improve relationships and for personal development, which was agreed by the Board.	
19.148	**Any other business, previously notified to the Chair**	
i.	There were no items of Any Other Business.	
19.149	**Date, time and location of next meeting**	
i.	The next meeting of the Board of Directors in public will be held on Thursday 23 January 2020 in the Active Business Centre, 33 St Andrew's Street South, Bury St Edmunds, IP33 3 PH	
ii.	Motion to exclude public and press from the confidential part of the meeting to be held on 23rd January 2020	

There being no other business, the Chair thanked those present for their contribution and closed the meeting at 15:42.

Chair: ……

Date: ……

Date:	**23rd January 2020**
Item:	**20.05**

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NHS
Norfolk and Suffolk
NHS Foundation Trust

Board of Directors – Action Log

Agenda item no	Date	Item	Action	Action by	Due Date	Status / Comments	Date Closed
19.75	30/05/2019	AOB	Next Safer Staffing Report to include community care	Diane Hull	January 2020	community numbers added in the January report	23/01/20
19.89	18/07/2019	Strategic Activity Update	To update the Board on the patient safety strategy once discussed by the Quality Assurance Committee (QAC)	Diane Hull	March 2020	Developing Quality Strategy with all quality & safety ambitions; will be discussed by QAC	
19.123	19/09/2019	Questions from the public	Report back to the Board on the progress of the cardio-metabolic assessment audit	Stuart Richardson		Annual audit carried out in October. This is now part of physical health offer and will reported as part of this	
			Check IAPT waiting times and contact Councillor Michael Chenery	Stuart Richardson		Closed. Discussed with Councillor Chenery	21/11/19
19.129ii	21/11/2019	Voice of the service user	Discuss the DBS checks to ensure that the Trust benefits from service users' experiences	Jonathan Warren, Sarah Goldie	January 2020	HR recruitment team ensuring that PPLs and Service Users DBS checks carried out and escalation process in place for managers where there are issues	23/01/20
			Tracey's story to be shared during staff induction sessions	Sarah Goldie		Complete. Shared at all inductions	01/12/19
19.131	21/11/2019	Matters arising from the minutes	Closed actions from the preceding meeting to be included on the Action Log with accompanying narrative	Jean Clark	January 2020	Completed	19/12/19

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Item:	20.05	

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19.134ii	21/11/2019	Patient safety and quality report	Report to be received from the Access and Waiting Time Group regarding eating disorder waiting times	Stuart Richardson	January 2020	On January agenda	23/01/20
19.134vi			Paper to the Board to include recruitment, development and career opportunities being developed, skill mix and staffing within teams and medics, AHPs and STP requirements	Diane Hull, Dan Dalton, Sarah Goldie	March 2020		
19.137i	21/11/2019	Integrated Performance Report	Report back to the Board on progress of waiting times	Stuart Richardson	January 2020	On January agenda	23/01/20
19.137iv			Circulate details on the Suffolk youth autism figures when available	Stuart Richardson	January 2020	Details in January's performance report	23/01/20
19.137v			Timing of physical health checks against other Trusts to be looked at in benchmarking information	Diane Hull		Looking at other Trusts for benchmarking information	
19.137vi			QAC to review KPIs as a whole in February 2020 and Board to consider the information in March 2020	Daryl Chapman, Stuart Richardson	March 2020		
19.137vii			Board to review finances in detail at January 2020 meeting	Daryl Chapman, Jean Clark	January 2020	Discussion at January FBIC, January Board and in depth at March Board	23/01/20
19.137x			CPA targets to be included in Risk 2.1 or as a separate risk	Jean Clark		Complete – BAF updated	23/01/20
19.139ii	21/11/2019	People and Workforce Report	Appraisals and supervision rates to be discussed at next Appointments and Remuneration Committee	Sarah Goldie, Jean Clark	December 2019	Closed. Was discussed at the December meeting of the committee	21/12/19
19.139iii			People before Process work with Staffside to be a future Staff Voice item	Sarah Goldie, Jean Clark		On board planner	22/11/19

Date:	23rd January 2020	C
Item:	20.05	

Norfolk and Suffolk NHS Foundation Trust

19.144i	21/11/2019	Governance Structure	Position of the Culture Steering Group in the governance structure to be discussed at a future Board Development session	Mason Fitzgerald, Jean Clark		This is a working group that reports to Board sub committees. Future Board development session to review effectiveness of governance structure	22/11/19
19.147i	21/11/2019	Questions from the public	Follow up to ensure telephone numbers are within service user discharge and safety plans	Diane Hull		Following this up with Lead Nurses and will be part of Quality & Safety reviews	
19.147v	21/11/2019	Questions from the public	To include more detail in the Workforce report on banding and recognition	Mark Gammage	March 2020	As action 19.134vi, paper to board in March to include additional information	

0Date:	**23rd January 2020**	**D**
Item:	**20.06**	

Norfolk and Suffolk NHS Foundation Trust

Report to:	Board of Directors
Meeting date:	23rd January 2020
Title of report:	Chair's report
Action sought:	For assurance
Estimated time:	10 minutes
Author:	Marie Gabriel, Chair
Director:	Marie Gabriel, Chair

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Executive Summary:

The report informs the Board of the

- key points arising from the Council of Governors discussions to ensure their views are taken into account in Board decision making
- Chair and NED most significant activities that will particularly inform the strategic direction of the Trust

The report specifically outlines the Council of Governors focus on New Models of Care, the establishment of a Significant Business Committee and the outcome of Governor elections. The report also highlights key learning from Non-Executive Director visits to children and young people services and to Care Group geographical services.

The report will impact on service users and carers by ensuring that, with enhanced input from Governors and staff, we maintain our focus on improvement

1.0 Background/Introduction

1.1 This report informs the Board of the Council of Governors key conclusions so that the Council views inform Board decisions. It also provides information on the Chair's main activities and strategic outcomes of those activities.

2.0 Council of Governors

2.1 The results of the recent elections to the Council of Governors have now been announced. I am pleased to advised that Ron French, Paddy Fielder and Andrew Good have been re-elected and I am also pleased to welcome Donald Campbell, Safiyya Mair, Sarah Miller, Michelle O'Toole and Emma Reed as newly elected Governors. Congratulations to you all.

I thank Sheila Preston who has come to the end of her final term and Clare Smith, who has resigned, for their dedication to the Trust and the people we serve. I wish them both every success and I am pleased that Sheila is going to continue to support the Trust through her contribution to an Assertive Outreach pilot in Norwich. An induction programme and buddying arrangements have been established as an introduction for our new Governors, with the induction day open to existing Governors as a refresher.

2.2 The Council focused discussion was on the New Models of Care Collaborative. The Governors highlighted the need for the Board to ensure that there was systematic service user and carer participation, that the governance arrangements ensured that the Trust was an equal partner and that outcomes were service user and carer defined along with being responsive to individual service user ambitions.

2.3 Given the range of new initiatives that were developing it was agreed that Governors would establish a Significant Business Committee as a forum where the Trust could seek Governor input at an early stage. The Council agreed that the remit of this Committee would also go beyond the statutory definition of "significant" and look at non-financial aspects of new business. The Board will be asked to agree an alternative definition once this has been developed by the new Governor Committee. It was also agreed that whilst the Committee would have a core membership other Governors could attend and that the full Council would be regularly updated on the Committee's discussions.

2.4 The Council were advised of the NED vacancy created by Tim Steven's resignation and agreed, through their Nominations and Conduct Committee, to begin the recruitment of a NED with financial and estates experience. It was also advised of the NED appraisal outcomes and their agreed accountabilities.

2.5 Finally, but importantly the Council agreed Meeting Standards that they would like to recommend are adopted by the Trust. These are attached to this report at Appendix A for information.

3.0 Chair Activities

3.1 It has been almost a year since my appointment as Chair of NSFT and I would like to thank staff, Governors service users, carers and partners for their support and participation in our journey of improvement. I am pleased that our joint work has been recognised by the CQC and I know that we will continue to work together to sustain and build on these early foundations.

There is much still to do but I believe we have the necessary clarity of intent through our strategy; the drive, skills and knowledge of our staff, service users and carers; and the active support of our partners and Governors, to succeed.

3.2 The Non-Executive Directors have continued their themed visits across our geography, since my last visit report NEDs have visited Children and Young People's Services in Bury St Edmunds, West Suffolk; Thurlow House in Kings Lynn; 80 St Stephen's and Mary Chapman House both in Norwich. They have also visited Community Mental Health Services within different geographical Care Groups including West Suffolk Dementia Intensive Support Group; Mariner House in Ipswich which hosts the Access and Assessment Service, Suffolk Wellbeing and Community Team Memory and Assessment Service; and the Well Being Service and the South Central Norfolk Adult Psychology Team at Gateway House. Even though these were different services across the two counties there were a number of cross-cutting themes. The first was that teams were striving to balance addressing the growing demand for services, the provision of good quality care, managing staff vacancies and supporting staff well-being. We were pleased to meet teams with a clear focus on their purpose, a drive to improve and a clear dedication to the people using our services. There were real examples of compassionate leadership and it would be useful to find a systematic way to gather the local initiatives that these leaders have put in place.

3.3 The teams were clear on what would assist them in their common themes of joined up IT across partners, addressing staff vacancies and creating better physical environments in which to work and deliver services. In responding to staff vacancies innovative new ways of working are appreciated but there is a need to consider how we ensure we retain the right levels of professional capability. There was also a need to address vacancies in therapeutic support and to develop a systematic approach to psychology, where our establishment is considerably less than the national average. Indeed, it was felt by some that it was time to have a formal review of staffing establishment given increasing demand and requirements to work in different ways. This includes considering whether there is a need to have an administration strategy for the effective support of clinical services across the Trust. Along with this, historical arrangements within Norfolk and within Suffolk teams led to different pressures on staff so the need for one Trust approach with local variation is an important area to develop.

3.4 There was a desire to become more involved in emerging locality arrangements, particularly the Primary Care Networks so that they were thinking mental health, particularly in Suffolk, and also to inform negotiations with commissioners to address challenges. For example, 40% of young people accessing Mary Chapman House Children and Young People's service have autism and ADHD, which we are not commissioned to provide.

3.5 There was not a consistent understanding of the rationale for the creation of Care Groups amongst all staff although those who were briefed and involved welcomed this more local focus. There is also a need to consider how we can systematically ensure that all staff understand the Trust vision and their team's role in its delivery and a desire to improve how we systematically gather patient feedback.

4.0 Action Being Requested

4.1 The Board is asked to RECEIVE and NOTE the report.

Quality implications

The focus on systematic approaches across our geography whilst responding to local context will enable a focus on sustained improvement

Equality implications / summary of consultation

Ensuring that our strategic decisions are informed by the diverse views of our Membership and public through our Governors will assist the Trust in ensuring that our services are inclusive

Risks / mitigation in relation to the Trust objectives

Effectively engaging with our Governors, (including through the newly established Significant Business Committee) Staff and partners will help in identifying risks and the solutions for their mitigation.

Recommendations

To receive and note the report

Background papers / information

6th December 2019 Council of Governor meeting draft minutes

Appendix A

Standards for meetings

Approved by the Nominations & Conduct Committee on 22 November 2019 and the Council of Governors on [6 December 2019]

The standards are grouped into the following sections:

I. Chair's responsibilities – before the meeting
II. Chair's responsibilities – during the meeting
III. Chair's responsibilities – after the meeting
IV. Members' and Attendees' responsibilities
V. Meeting Secretary's responsibilities

I. Chair's responsibilities – before the meeting

a. To work with the Meeting Secretary to agree all items as a realistic agenda and any subsequent amendments. If the meeting lasts longer than 1.5h, a break should be scheduled.
b. To ensure that all supporting papers provide the information required for the attendees to be able to prepare and fulfil their duties, avoiding jargon

II. Chair's responsibilities – during the meeting

a. To start the meeting on time, asking for items of Any Other Business to ensure sufficient time is available for discussion
b. To ensure all attendees know each other, with introductions if necessary
c. To give apologies for absence to the meeting
d. To ask voting attendees to confirm the accuracy of the minutes, ensuring any amendments are recorded and actioned
e. To confirm and sign the minutes as an accurate record, and where appropriate release under the Freedom of Information Act
f. To ensure any changes in order clearly advised to all attendees
g. To explain the objective of the item and topic for discussion or ask the person who is responsible for the papers to do so
h. To propose the motion "*that representatives of the press and members of the public be excluded from the meeting, having regard to the confidential nature of the business to be transacted*"
i. In private session, to clarify if an item should **not** be minuted and when minuting can continue
j. To ensure and balance contributions from all attendees (voting and non-voting) making reasonable adjustments for behaviour, being mindful of any declared disability
k. To address any behaviour in the meeting that steps outside of the Trust's values "Positively … Respectfully … Together …"
l. To ensure the discussions stay on topic and no side-discussions start, and that discussions do not become heated; closing the item or calling a break if necessary
m. To ensure any votes taken are in accordance with the Trust's Standing Orders (Sections 21 and 22)
n. If a firm conclusion cannot be reached for an agenda item, state that it will be carried forward to the next meeting for further discussion

o. To ensure all actions have an owner, a deadline and process for feeding back on completion of the action

p. To summarise the discussion and decisions at the end of the item, and any actions taken to ensure that the attendees and minute-taker are clear on the outcomes

q. To close the meeting on time, unless the majority of attendees agree to a short extension, with all agenda items having been discussed

III. Chair's responsibilities – after the meeting

a. To work with the Meeting Secretary to review and circulate the unconfirmed minutes to all attendees as soon as possible after the meeting

b. To follow-up on discussions or items where an attendee has not been comfortable or has had to leave the room

IV. Members' and Attendees' responsibilities

a. To submit items to the Chair, via the Meeting Secretary, well in advance of the next meeting

b. To make best efforts to attend meetings (in person or by telephone / video if appropriate) or send apologies as soon as possible. If allowed in the Standing Orders or Terms of Reference, a nominated deputy should be asked to attend.

c. To switch all mobile phones and other devices to silent, and not take a call unless urgent and after alerting the Chair

d. To inform the Chair and Meeting Secretary if reasonable adjustments are required

e. To arrive in good time to ensure that the meetings can start on time

f. To prepare by reading the papers in advance and preparing questions for contribution at the meeting

g. To support the Chair to enable business to be conducted effectively on the agenda item only, so the meeting can function and attendees work together as an effective team.

h. To not introduce any business which is not on the agenda without prior agreement as an item for Any Other Business

i. To indicate the Chair when they wish to contribute and wait to be invited to speak

j. To recognise the value of open debate and be prepared to explain the rationale for their views, constructively and concisely

k. To act in the best interests of the Trust's improvement plans and strategy and not as a representative of any outside body or pressure group

l. To treat colleagues with respect at all times and in a way that is fair and inclusive, addressing the problem and not the person

m. To listen to others' contributions attentively and courteously, without starting side-conversations, avoiding jargon, complying with the Nolan Principles and the Trust values "Positively … Respectfully … Together …"

n. To disagree with others courteously

o. To not dominate the discussion, speak over someone else or repeat the same points

p. To be aware of language and tone when speaking, especially if meetings are in public, and avoid jargon, acronyms and abbreviations

q. To understand and accept that some attendees may have declared disabilities that may affect how they present at meetings

r. To respect the Chair if asked to move on from a topic to allow others to contribute or to close the item

V. Meeting Secretary's responsibilities

a. To prepare a workplan for future meetings with the Chair and other key attendees
b. To check the logistics for the meeting to meet the attendees' physical health, mental health and neuro-diverse needs, such as adequate space, access, transport links, refreshments, audio-visual, ventilation, additional rooms – complying with the Equality Act 2010
c. To prepare the draft agenda for the Chair's approval
d. To receive the papers and collate the packs, and send to the Chair for approval if necessary
e. To circulate the agenda and associated papers to all attendees at least seven (7) calendar days in advance of the meeting, but no later than four (4) calendar days
f. To prepare for the meeting, such as bringing spare copies of papers, pens, and sign-in sheets and name plates for meetings in public
g. To collate and pass apologies to the Chair at the meeting, sit next to the Chair where possible.
h. To ask the Chair to clarify any points they are not clear on during the meeting
i. To type up the minutes in the style agreed with the Chair using the past tense, being consistent when referring to attendees and checking for spelling and grammar
    i. Verbatim – not recommended
    ii. Action only – decisions and actions only may be sufficient for some meetings
    iii. **Blended approach** – concise summaries of discussions that led to the decisions without identifying who said what unless specifically required or requested to do so, with actions clearly stated
j. To use the following labels for the minutes:
    i. **Draft** – sent from the meeting secretary to the Chair for checking as soon possible after the meeting
    ii. **Unconfirmed** – after the Chair has reviewed the minutes, the meeting secretary sends to other attendees as soon as possible after the meeting, with any amendments to be agreed with the Chair, before sending with the next meeting's papers
    iii. **Confirmed** – agreed at the next meeting and minuted as such, with any agreed amendments
k. If the meeting has been stood down, the final minutes should be submitted to the successor meeting or the meeting the stood-down meeting reported to for approval
l. To make sure the approved / confirmed minutes are signed, filed and retained in accordance with Trust standards and published on the Trust's website as appropriate
m. To make sure that all meeting papers, noted and confirmed minutes are stored in accordance with the Trust's Retention Policy

VI. Review of these Standards

An initial review will be carried out after one year, and every two years thereafter

Date of next review Dec 2020

Date:	**23rd January 2020**	**E**
Item:	**20.07**	

Norfolk and Suffolk NHS Foundation Trust

Report to:	Board of Directors
Meeting date:	23 January 2020
Title of report:	Chief Executive Officer Report
Action sought:	For Information
Estimated time:	10 minutes
Author:	Jonathan Warren, Chief Executive Officer
Director:	Jonathan Warren, Chief Executive Officer

Executive Summary:

The purpose of this report is to provide the Trust Board with the Chief Executive Officer's update on significant developments and key issues over the past two months. The Board is asked to receive and note this report.

8

1.0 Purpose

1.1 The purpose of this report is to provide the Trust Board with the Chief Executive Officer's update on significant developments and key issues over the past two months.

2.0 Trust Changes

2.1 The CQC inspection has dominated since my last CEO report in November and we now know that NSFT has been upgraded to 'Requires Improvement' which is down to the hard work and dedication of our staff.

2.2 We know there's still a long way to go but this is a step in the right direction. The next 12 months will be crucial as we continue to embed changes being made, so that when we're next inspected in 12 months' time, we have improved further in the CQC rankings and be some way to realising our ambition to be in the top quarter of mental health trusts for quality and safety by 2023.

2.3 For most of the period covered by this report we've been in purdah while the General Election took place. That hasn't stopped the hard-work behind the scenes and I have

been busy with work around the £40m development of the Helllesdon Hospital site and Chloe Smith, MP for Norwich North, visited the site on Friday to find out more.

2.4 The biggest single media issue affecting the Trust since the last Board of Directors meeting has been the death last month of Norfolk grandmother Peggy Copeman, aged 81, as she was being brought to Norfolk from an out of area placement in Somerset and I'd like to extend my heartfelt condolences to her family. We are continuing our investigations together with the care home and patient transport supplier and are determined to learn from what happened to Peggy and also reduce the number of Out of Trust Placements.

2.5 The Nursing Times published a story about Kathryn Lake, a community mental health nurse at the Julian Hospital, Norwich, who experienced more than a decade of domestic abuse and is urging healthcare professionals to have more conversations about the issue to help others in similar situations to come forward.

2.6 The East Anglian Daily Times (EADT) and Ipswich Star carried a report about an Ipswich man praising mental health services and Suffolk Police after he experienced a mental health crisis one Saturday evening. Stephen King said "he would no longer be alive" if it wasn't for the support he received.

2.7 BBC Radio Norfolk sent out a reporter to interview staff from the Enhanced Treatment Service at Marlpit Community Garden where they spoke about how service users benefit from working in the garden.

2.8 The EADT, EDP and Norwich Evening News carried a feature looking at what had changed at our Trust since the publication of the CQC inspection report in 2018. We have, of course, since had the CQC report, which shows improvements have been made.

2.9 We have been asked to play a bigger role in the transformation of the health systems in Norfolk, Waveney and Suffolk and I now chair the Norfolk STP Programme Board. There are some real opportunities to bring about positive change for the patients and people of the area. There are some concerns around the pace and delivery of changes and ensuring that we have adequate cover whilst also transforming our own Trust. But we are determined to play a full part because many of the solutions we seek are to be found within the system, not just within the Trust. We meet regularly with colleagues in NCH&C to ensure we have an integrated approach to mental health and physical health services.

2.10 Phase two of the formation of the Care Groups has been making progress with consultations taking place with staff affected. I appreciate this can be a difficult time for some staff and so want to hear from them and ensure we've got the right structures in place. I'm always impressed with the dedication of the staff I meet on my site visits and when meeting individual members of staff.

2.11 Our performance as a Trust in key areas continues to hold up, but I am mindful that we need to continue to focus on reducing Out of Trust Placements. We are currently stuck around the 10-12 mark and yet have zero patients being sent out of county in

central Norfolk. We need to learn from our successes so that by July this year, we will have zero patients being sent out of county for the whole Trust.

3.0 Recommendation

3.1 The Board is asked to **RECEIVE** and **NOTE** the report.

Date:	**23rd January 2020**	**F**
Item:	**20.08**	

Norfolk and Suffolk NHS
NHS Foundation Trust

Report To:	Trust Board of Directors – Public
Meeting Date:	23rd January 2020
Title of Report:	Quality and Patient Safety – November – December 2019
Action Sought:	For information and discussion
Estimated time:	10 mins
Author:	Saranna Burgess, Deputy Director for Patient Safety and Quality
Director:	Diane Hull, Chief Nurse.

Executive Summary:

The Trust received the draft inspection report on 13th December 2019 this provided an opportunity to respond to the findings of the inspection undertaken on October – November 2019, including the quality and factual accuracy of the report. The Trust submitted responses to all areas found to be inaccurate or where further evidence could be provided to support a challenge on findings. Our response has been considered and we can confirm that the overall rating is *Requires Improvement*; this is an improvement on the last inspection findings in 2018 which rated the Trust as *Inadequate* overall. The final report was published on 15th January 2020.

The Trust has reported 19 serious incidents tin this reporting period, these will be investigated to gather findings and any practice issues which require improvement action. A number of safety alerts have been issued in response to the *early learning process* undertaken by the organisation and disseminated to the relevant teams for action. The Trust has received one prevention of future deaths notice this relates to a gentleman seen by our acute hospital liaison service.

Annual incident reporting data highlights that the Trust is not an outlier in terms of unexpected/patient safety incident deaths in comparison with similar Trust, it is however a high reporter of *'no harm'* incidents. A low threshold for reporting incidents is consistent with the characteristics of a safe culture as endorsed by NRLS, and regulators. NSFT is not out of sync with others in reporting against '*low – death'* levels of harm at 21%, the national average being 37% (CQC Insight Report Dec 19).

We continue to progress with our use of quality improvement methodology

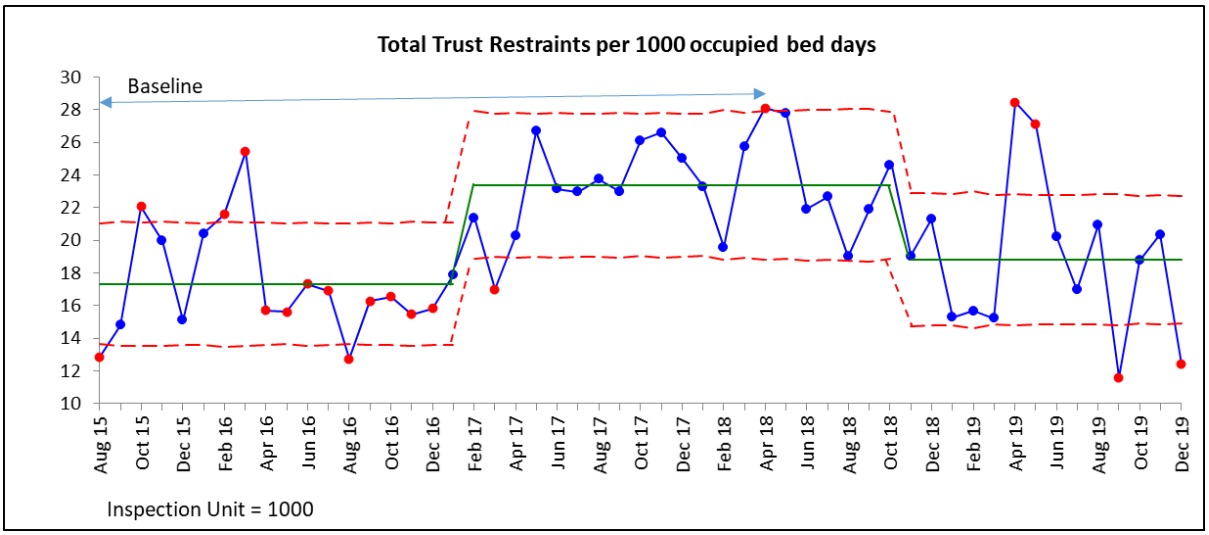
The report references BAF risks 3.1, 3.2, 4.1

1.0 Report Contents

2.0 Reducing Restrictive Interventions

2.1 Restraint

Data informs us that the four indicators (restraint, prone restraint, seclusion, rapid tranquillisation) are in common cause variation.


Total Trust Restraints per 1000 occupied bed days
Baseline
30
28
26
24
22
20
18
16
14
12
10
Aug 15
Oct 15
Dec 15
Feb 16
Apr 16
Jun 16
Aug 16
Oct 16
Dec 16
Feb 17
Apr 17
Jun 17
Aug 17
Oct 17
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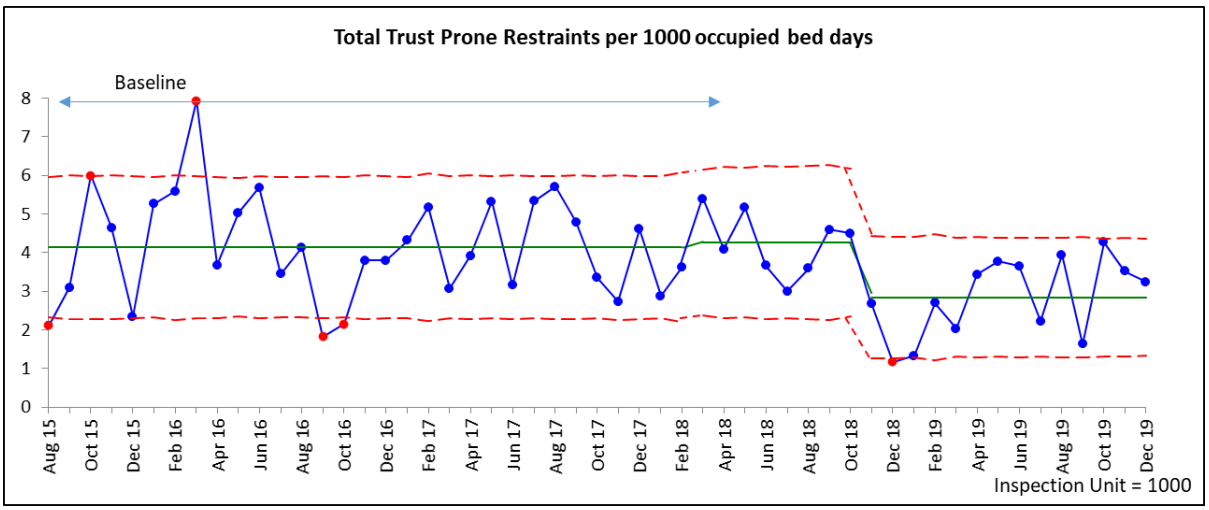
Dec 19
Inspection Unit = 1000


Total Trust Prone Restraints per 1000 occupied bed days
Baseline
8
7
6
5
4
3
2
1
0
Aug 15
Oct 15
Dec 15
Feb 16
Apr 16
Jun 16
Aug 16
Oct 16
Dec 16
Feb 17
Apr 17
Jun 17
Aug 17
Oct 17
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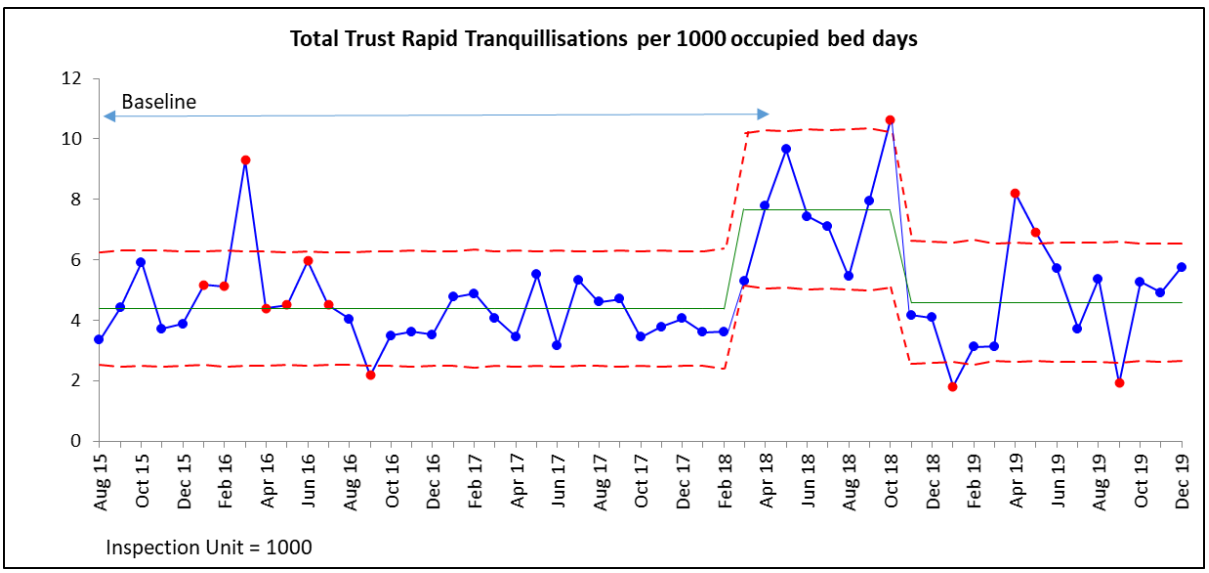
Oct 19
Dec 19
Inspection Unit = 1000


Total Trust Rapid Tranquillisations per 1000 occupied bed days
Baseline
12
10
8
6
4
2
0
Aug 15
Oct 15
Dec 15
Feb 16
Apr 16
Jun 16
Aug 16
Oct 16
Dec 16
Feb 17
Apr 17
Jun 17
Aug 17
Oct 17
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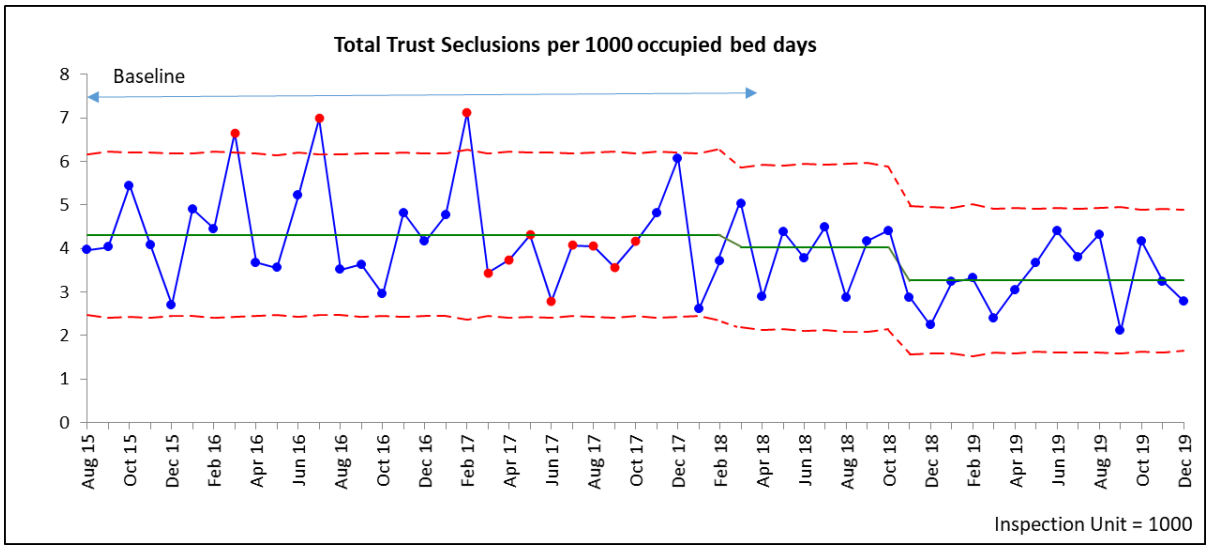
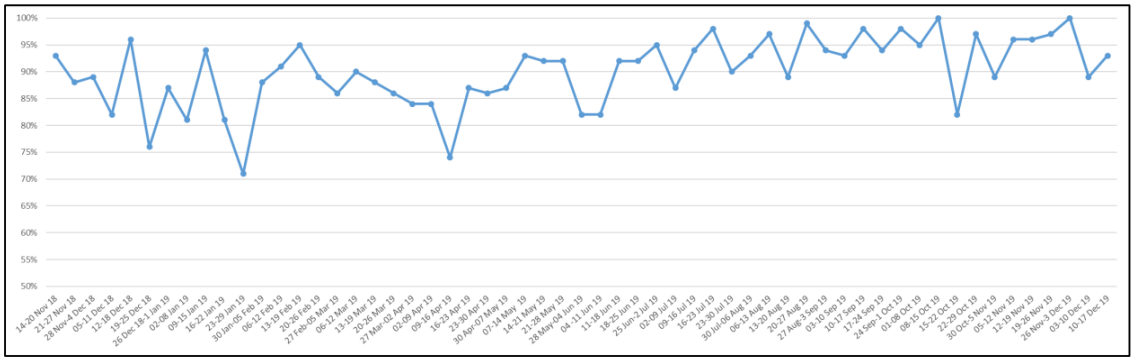
Oct 19
Dec 19
Inspection Unit = 1000

9.1

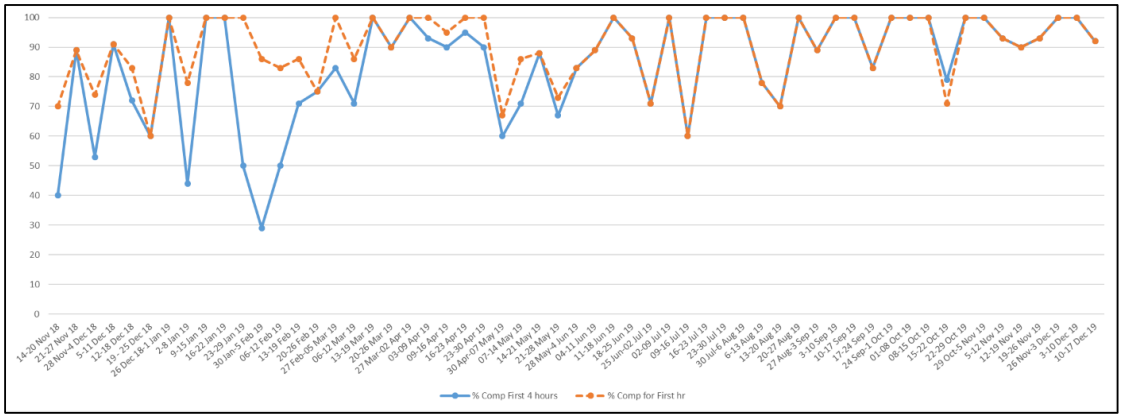


2.2 Seclusion and rapid tranquillisation compliance

Seclusion compliance – in November 2019 the Trust achieved 97% compliance (94% in October 96% in September and 95% in August 2019).



Rapid tranquillisation compliance - in November 2019 the Trust achieved 93% compliance (85% in October 94% in September and 86% in August).



9.1

2.3 Innovation

Key learning across the last year is the microsystem complexity within each individual ward and its impact on efforts of restrictive interventions reduction. The experience of the three wards who have been part of the national collaborative shows the benefit of a shared programmed approach. This is an area of focus with an in-house year-long Trust collaborative commenced from January 2020. Formed of six wards, the collaborative will be using quality improvement methodology with teaching and coaching from the Quality Improvement Team.

3.0 Serious Incidents and Patient Safety Updates

3.1 Serious incidents within the Trust

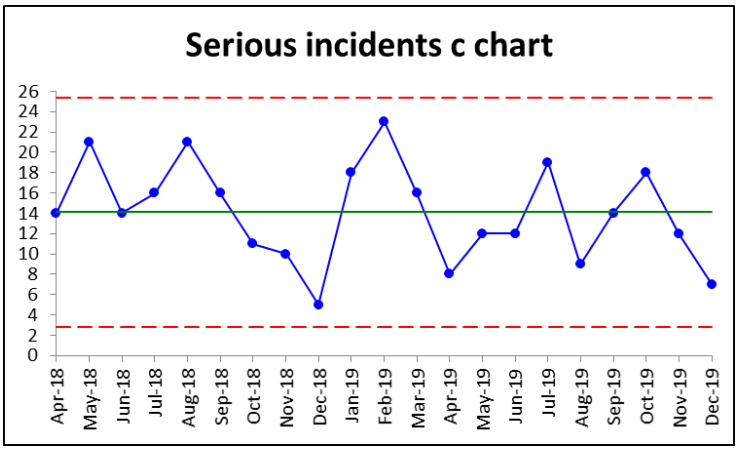
There have been 19 serious incidents identified during the two-month period from 1 November 2019 to 31 December 2019; 12 of these were unexpected deaths, all are to be fully investigated. It is not apparent at this stage whether care and/or service delivery issues contributed to any of these patients' deaths. The remaining cases related to:

- One absconsion resulting in no harm within specialist services.
- Four unexpected injuries, three relating to specialist services – inserting/swallowing foreign objects and one regarding a fracture on an older people's ward.
- One instance of disruptive, aggressive behaviour relating to a community patient who attacked a neighbour.
- One injury of a discharged inpatient who was hit by a car on a local A road.

There have been three patient safety alerts issued because of early learning findings and action was needed immediately. These related to:

- No. 18 - During an inspection, two anti-ligature shower curtain rails failed to break away at the recommended load bearing limit. The shower rails were fitted in high risk rooms where patients have little or no observation which poses a significant ligature risk. Some of the breakaway clips were also identified to twist as only one fixing was installed. It is also possible to wedge a shower rail that has broken away between the walls where the wall narrows.
- No. 19 – Noted that an anti-ligature door handle may have a visible ligature point requiring very little ingenuity. This appears to be due to a product fault which exposes a gap between the handle base and the base plate. These handles may be fitted to high risk rooms including patient bedrooms, toilets and bathrooms where the risk of ligature is high.
- No. 20 – An alert has been received from the Central Alerting System, identifying several patient incidents involving door stops or door buffers which have resulted in harm. Potential risks include ligature, slips/trips and impact damage with wall, furniture, structure or person.

  In accordance with the alert, the Trust is required to identify all types of door stops and door buffers in patient settings. The Trust will then convene a multidisciplinary team to review what we have identified and make an informed decision on any action.



3.2 Prevention of future deaths (PFD - Regulation 28)

A Prevention of Future Deaths regulation has been received in respect of the death of a service user since the last report. The Coroner recorded a verdict of "took their own life. intent unknown" and raised issues for the Trust which caused the Coroner concern which included:

- No-one appeared to look at his mental health except to note he was alcohol dependent,
- His mental state was not classed as a psychiatric illness and not taken on,
- Home Treatment was not offered or explored and a referral to Wellbeing was not made,
- Various teams seem to be unaware of each other's referral criteria, displayed little or no professional curiosity and appeared to dismiss GP's opinion of worsening presentation.

The Trust will respond by 6th February 2020 to the Coroner.

9.1

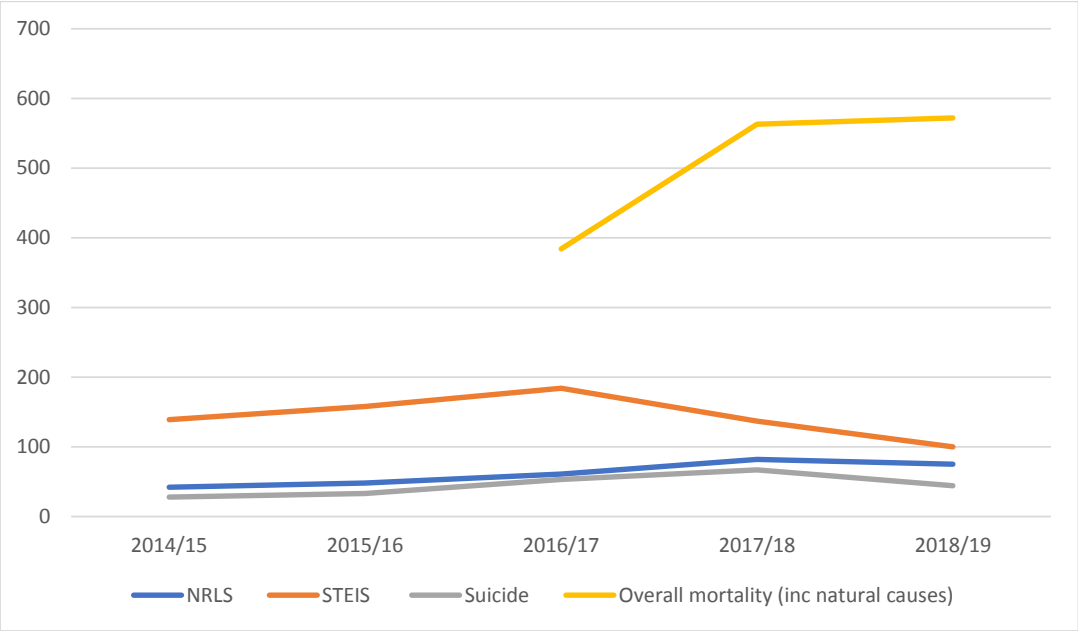
3.3 Incident reporting and duty of candour

There are several reporting platforms, and available data sources, with differing criteria where Trusts report deaths of patients. There are four sources of figures that represent the number of deaths experienced within Trusts; NRLS (unexpected deaths), STEIS (unexpected deaths) and overall Trust mortality figures (expected and unexpected). The Office of National Statistics (ONS) also collate figures of both expected and unexpected deaths. Both National Reporting and Learning System (NRLS) and Strategic Executive Information System (STEIS) stipulate that consideration must be made to report and investigate unexpected deaths of patients who are open to the organisation or were discharged within the previous six months.

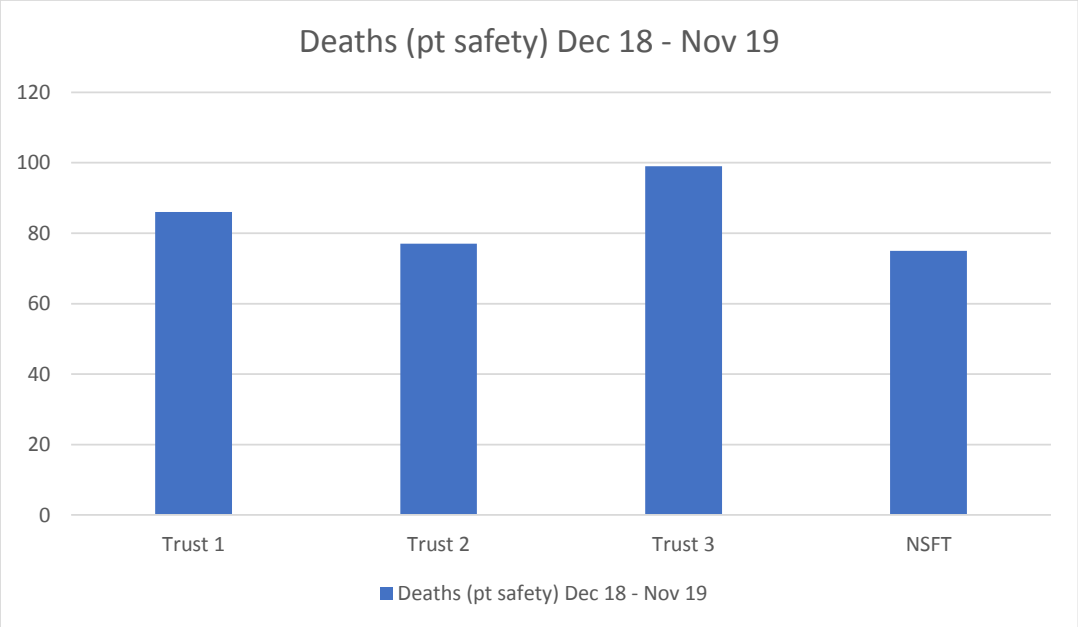
The purpose of reporting is to promote learning, increase patient safety and improve the quality of services. There are several points to note:

- The data published is based on the date that the incident report was submitted to NRLS not the date the incident occurred. This means that data may differ from that available on STEIS where the incident is logged against the date it occurred.
- There are peaks in reporting at the end of May and November (NRLS) due to data deadlines (see 'no harm' graph illustration below).
- Accuracy of reporting; there is a strong correlation between NRLS reporting and confirmed suicides.

- From the data it is possible to deduce that NSFT is not an outlier, and equally that the rate of deaths appears to demonstrate normal variation across comparable organisations; the proportion of deaths of NSFT patients is similar to other Trusts of comparative demographics and size. The graph below shows the correlation between reporting of patient safety deaths and confirmed 'took own life' conclusions confirmed at inquest (note that the overall mortality figure has been recorded since 2016 in line with Learning from Deaths guidance and includes all deaths):

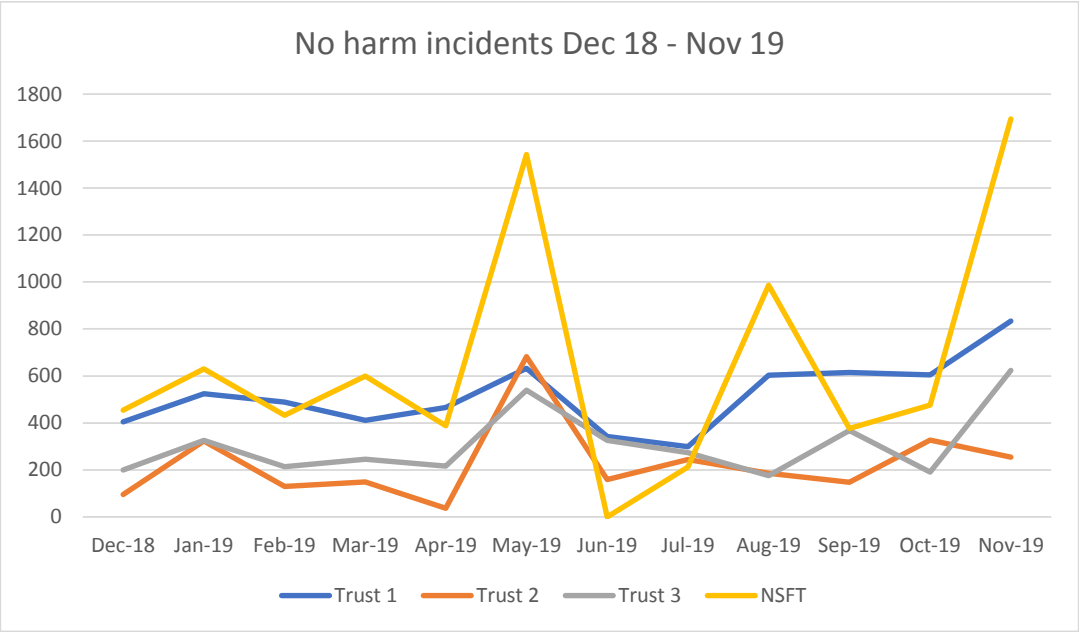


Comparison with similar Trusts:



The NRLS reports, in theory, provide an opportunity to compare incident data across different Trusts. However, this comes with a series of caveats; not all Trusts report on NRLS as it is voluntary, not all report incidents consistently and the data does not take account of the size or breadth of services provided.

In comparison to other Trusts, NSFT has a low threshold for reporting incidents and a high proportion where there is no or low levels of harm. This low threshold is consistent with the characteristics of a safe culture as endorsed by NRLS, and regulators. NSFT is not out of sync with others in reporting against low – death levels of harm at 21%, the national average being 37% (CQC Insight Report Dec 19). However, it is a high reporter in comparison to other Trusts in terms of no harm incidents. The graph below shows a comparison against similar Trusts across a 12-month period:



The new Patient Safety Investigation Response Framework (PSIRF is outlined in 3.4) is to be adopted within Suffolk this Spring as part of the NHSE/I's early adopter's programme. In response to this NSFT has an opportunity to focus on 'near misses' and incidents that cause concern either due to being moderate or severe, or as a cumulative pattern, as well as continued investigation of unexpected deaths. Currently the highest reported incidents are: AWOL, unauthorised objects (principally smoking paraphernalia except in Gt Y & W and Secure Services), medication errors, self-harm and assaults both non-physical and physical.

Further analysis of these areas should inform the type of incident investigated as part of the new approach outlined in the PSIRF and be published in the Trust Patient Safety Incident Response Plan (PSIRP) which will be publicly available. A workshop has been set for early February 2020 to discuss and make further recommendation on this to the Trust Board.

Duty of Candour

The Trust is fully compliant with Duty of Candour (DoC) duties. There have been 59 incidents which meet the threshold for DoC in this reporting period. The majority of these relate to self-harm incidents including those which are deaths reported via STEIS and NRLS as patient safety incidents (72%). Our Family Liaison Officer supports the delivery of duty of candour duties, escalating concerns around the quality of this where appropriate.

3.4 Mortality; learning from deaths

This is covered in a separate paper to the Board – Mortality and Learning from Deaths annual report.

4.0 Quality and Clinical Effectiveness

4.1 CQC Inspection October – November 2019 outcome briefing

The Trust received the draft inspection report on 13th December 2019 this provided an opportunity to respond to the findings including the quality and factual accuracy of the report. The Trust submitted responses to all areas found to be inaccurate or where further evidence could be provided to support a challenge on findings. Our response has been considered and we can confirm that the overall rating is *Requires Improvement*; this is an improvement on the last inspection findings in 2018 which rated the Trust as *Inadequate* overall. The final report was published on 15th January 2020. The key lines of enquiry (KLOEs) overall ratings are as follows;

- Safe - *Requires Improvement*
- Effective - *Requires Improvement*
- Caring – *Good*
- Responsive - *Requires Improvement*
- Well led - *Requires Improvement*

Areas of improvement highlighted by the inspection are:

- Care planning; personalised and collaborative plans were seen in all areas.
- Environmental risks had been addressed in all areas.
- Staff reported learning from incidents and shared opportunities to reflect on findings from reviews.
- Improved visibility of senior leadership teams and engagement with staff.
- Accurate data used to improve services e.g. access to services and management of waiting lists.

Areas requiring improvement include:

- Medicines management (see section 4.4) and medical devices checks
- Access to CAMHS services
- Record keeping within 136 suites
- Staffing; recruitment, retention and morale
- Environment of our learning disability inpatient unit

4.2 Quality and Safety Reviews

During November and December 2019 there were 15 QSRS; 5 Learning Disabilities Community, 5 Older People Community, 5 Secure services.

Community Learning Disability Services

Highlights:

- Care Planning was person centred and co-production with service users and carers was evident.
- Documentation in general demonstrated a thorough, compassionate and humanistic approach to patient care.
- Service user feedback was all positive and the most common phrase used was that staff "go above and beyond."
- Recruitment of substantive and locum psychiatrists appears to be an issue across the teams.
- Some teams could benefit from how they engage with and take forward organisational learning and apply it to practice.
- There were no waiting lists for allocation to a care coordinator, but in some services there were internal waits for therapies, for example in the adult team in GY&W some people have been awaiting a sensory assessment from the OT since 2018.

Older People's Community Services

Highlights:

- Service users and carers fed back that they had been involved in decision making around treatment and that they felt well informed of support that offered by the teams and the local community. This was echoed in the documentation.
- Physical health was high on the priority

Secure Services

Highlights:

- Patients explained that they are involved in the decisions about their care and that they understand what their plan is around steps to discharge.
- The wards have engaged in QI and national project to reduce restrictive interventions. Numbers of seclusions, restraints and rapid tranquilisations have reduced.

4.3 MHA Inspections

During November and December 2019 there were two CQC MHA Inspections, one on Beach Ward and the other at SRRS.

The action plan themes are:

- Evidence of assessments of capacity and consent to treatment on admission and after three months of detention under S3.

- Evidence of risk assessment prior to, and detailed documentation of the outcomes of S17 leave.
- Updating risk assessments on admission and following incidences

The action plans are due back to CQC on 15th January 2020. Meetings with the lead nurses, matrons and ward managers have been arranged with the Acting Assurance and Clinical Effectiveness Manager to develop meaningful and SMART actions.

4.4 Quality Improvement

Progress continues in delivering the Trust's priority to develop the use of quality improvement methodology. Currently, 62 improvement projects are registered, with 26 in the last three months.

The Trust's Reducing Restrictive Interventions Collaborative commenced on 9 January 2020. Formed of six wards, this year long programme uses learning from the Trust's involvement in the national Reducing Restrictive Interventions collaborative. The three wards involved in the national collaborative have been able to effect positive change which is the ambition for this Trust programme.

Formed of five wards, a Trust Medicine Management QI Collaborative is commencing from 23rd January 2020. Focussed on all elements of a safe and effective ward medicine management system the collaborative's ambition is to improve performance following a set of baseline audits completed in November and December 2019.

Two improvement programmes from training cohort 1 are reaching a conclusion and moving to the sustain stage. Glaven Ward made improvement to people's daily experience through enhanced shift coordination and colleagues in West Suffolk Care group used QI to increase the number of people participation fivefold from 5 to 35.

Dragonfly Unit and Beach Ward continue their improvement work as part of a sexual safety national collaborative. The programme is at the stage of understanding the current system through collecting baseline data. This will provide knowledge, enabling insight and opportunity for improvement.

Bi-monthly waves of Quality Improvement training programmes are commencing from March 2020 to support the acceleration of capability within the Trust. These year-long programmes will support teams learn the tools of quality improvement to apply to their improvement ideas. Through regular action learning sets improvement teams will receive shared support and continued development of knowledge applicable to their programme.

Quality Improvement Meds Management Collaboration Briefing

Concerns were highlighted by CQC in their October 2019 inspection, around standards of medication management across the Trust. Examples given included the use of PRN medication, gaps in recording CDs, overage of Methadone and administration gaps in record charts.

In response, the Trust identified this as a priority and established a Meds Management Review Group comprising of senior nursing staff, the Chief Pharmacist and colleagues with expertise

in Quality Improvement methodology. An audit/assurance tool was selected from the Quality and Safety review toolkit. Audits on all acute and older people's wards were conducted in October 2019, to provide a base line, informing a QI Medicines Management Collaborative.

The Meds Management Audits highlighted 11 key themes for the QI meds management collaborative. Out of these themes, 5 were considered to be transactional issues and the leaderships teams were informed that they were required to have made significant improvement with these issues by December 2019. The transaction issues were:

- Prescribing – legibility and stop / start dates
- Patient Information and identifiers on medicine cards
- Medical devices – calibration and understanding trust processes
- Controlled Drugs – record keeping
- Competency assessment and training compliance.

5 wards were invited to join the Meds Management Collaborative based on the results of the audits. These wards are:

- Samphire (Kings Lynn)
- Thurne (Norwich)
- Yare (Norwich)
- Northgate (Bury St Edmunds)
- Avocet (Ipswich)

The QI team met with the wards independently in November 2019 and agreed some initial driver diagrams and developed a measurement tool for the teams to track improvement.

The Meds Management Review Team returned to conduct and further full audit in December 2019, to establish whether the transactional issues had been addressed, share good practice and provide further information to the collaborative.

The audits found that there has been significant improvement on Samphire, Rollesby, Thurne and Yare Wards. Some improvement was noted on Northgate, Southgate and Waveney. There has been no change on Avocet, Lark and Glaven. Poppy indicated a slight decline. Detailed reports were sent to the clinical management teams for their action and were fed into the QI collaborative.

The clinical staff and QI coaches involved in the collaborative are due to meet in late January for two days where staff will receive training in QI methodology, review strengths and priorities for improvement, develop local driver diagrams and improvement plans. Thereafter the collaborative will meet every 6 - 8 weeks for the next year.

4.5 Clinical audit

Clinical Audit Strategy: In order to provide strategic direction to the use of clinical audit within NSFT, the Medical Director has requested the development of a clinical audit strategy. This will be developed in consultation with care groups and specialist services and support the aim

of NSFT being in the top quarter of mental health trusts for Quality and Safety by 2023. An initial draft is scheduled for April 2020 which will be used during the consultation process.

Audit Schedule 2020/21: The clinical directors of care groups and specialist services have submitted local audit schedules for approval by the Quality Committee in January 2020. Each care group / specialist service has included audit topics that have been identified as priorities for improvement by the Board, locally or through contractual requirements. These audit schedules form the plan for the year recognising that they will be subject to change as priorities are identified.

5.0 Family Liaison Officer Update

5.1 Jenni Carvey, the Trust's Family Liaison Officer, will be speaking at the first national conference held by the charity "Making Families Count" in May 2020. The charity delivers training to NHS staff utilising the lived experience of families where a loved one has either died as a result of homicide (where the perpetrator has a mental illness) or taken their own life. The purpose is to explore how Trusts can improve engagement with families, involve them fully in a review of the death to improve services and build on good practice.

6.0 Recruitment and Retention

6.1 The Employee Experience team are working with Care Group leadership teams, the Wellbeing service, and the Trust's Consultant Psychologists' group to develop a more robust approach for supporting staff with sickness issues and those requiring mental health support. This is also geared at promoting the Trust's offering for staff health and wellbeing.

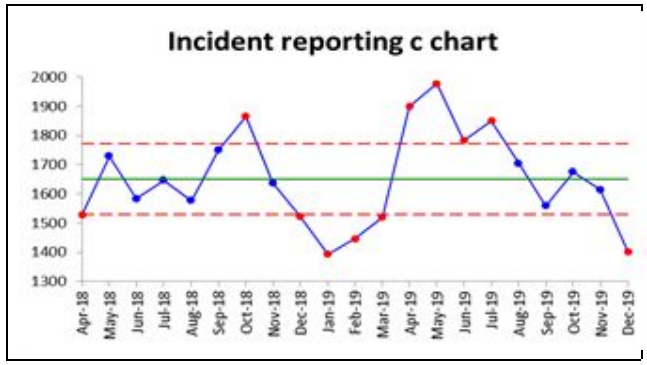
Voluntary turnover within the first two years of employment is a concern. A deep dive report has been submitted for consideration at January 2020's Quality Committee to engage senior clinical leaders in how we best prevent this.

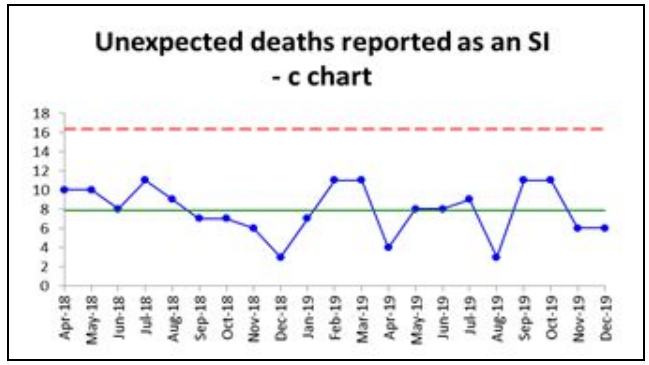
The recruitment of registered nurses and doctors continues to be challenging. Approximately 40 student nurses have, however, been offered positions for when they qualify following a recent assessment process**.**

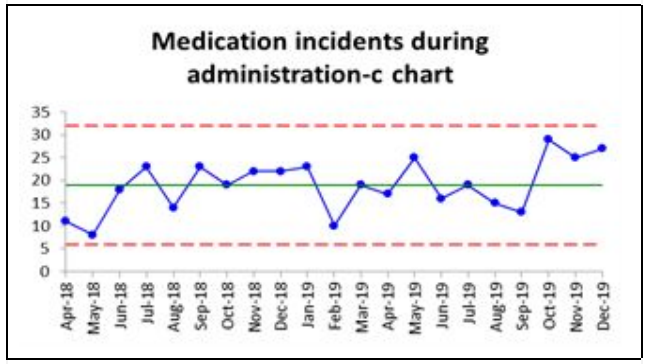
End.

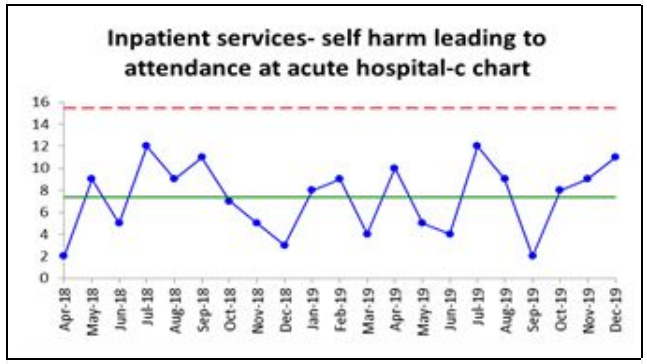
Appendix 1

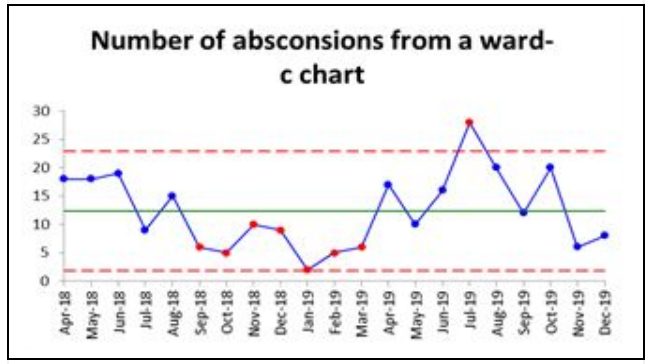
Patient Safety SPC Charts

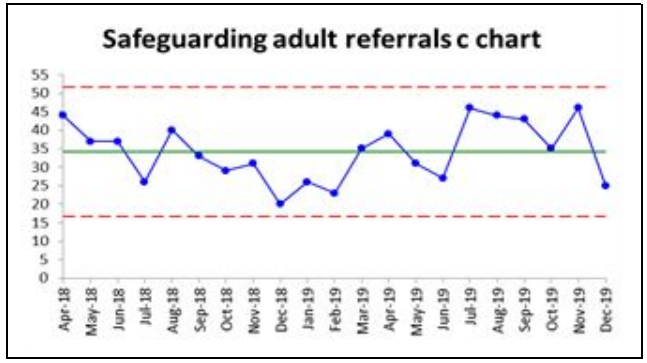


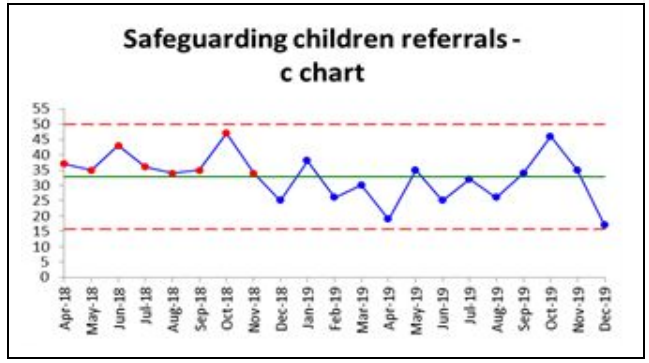




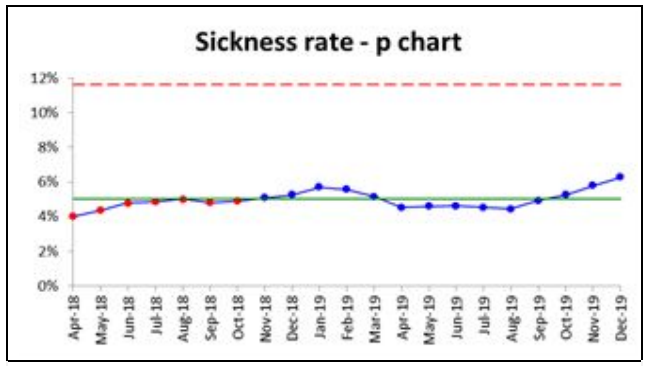


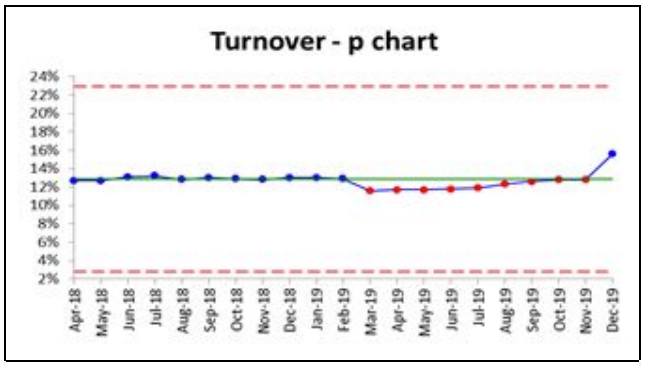


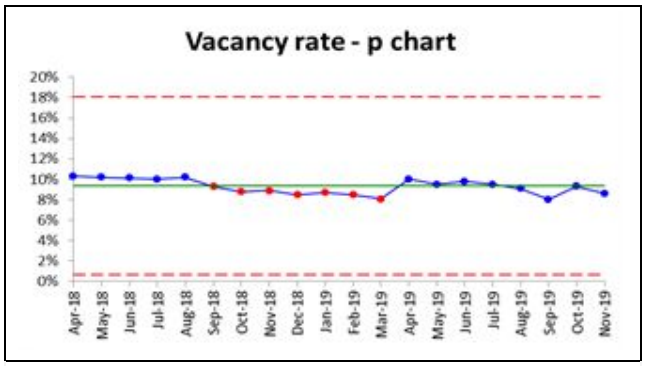


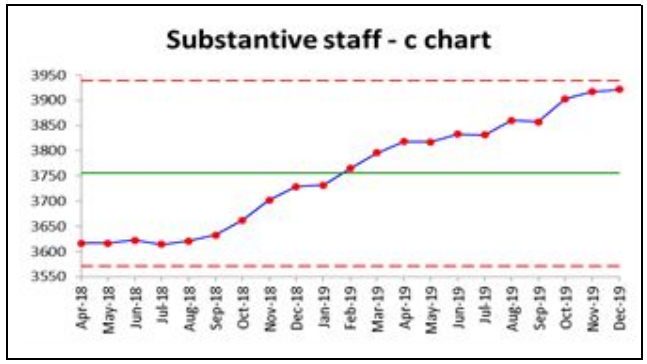


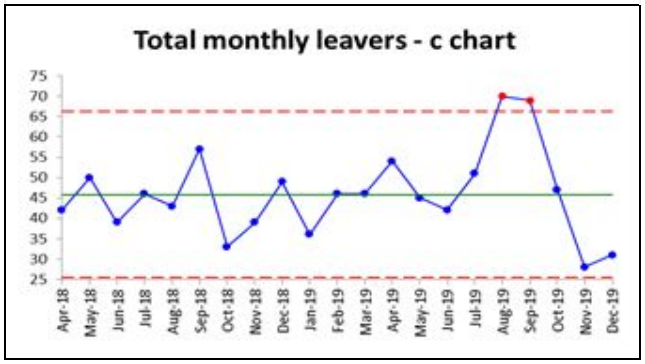
Staffing SPC charts



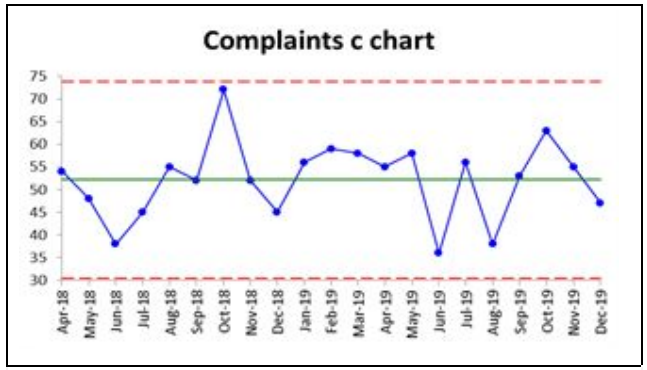


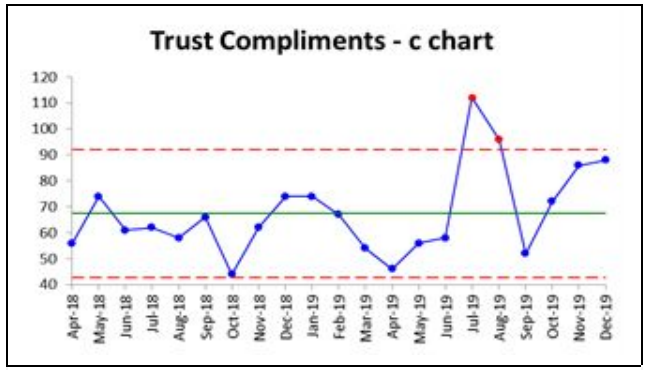


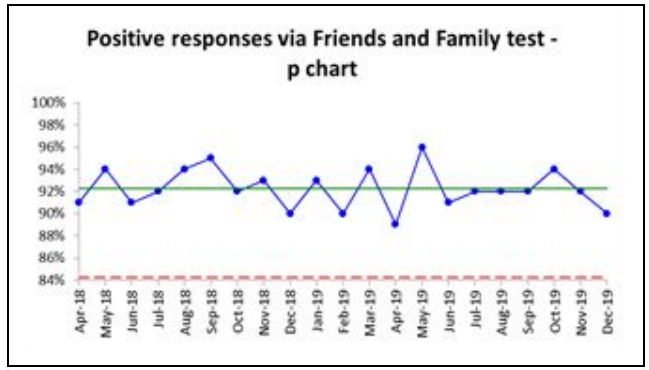


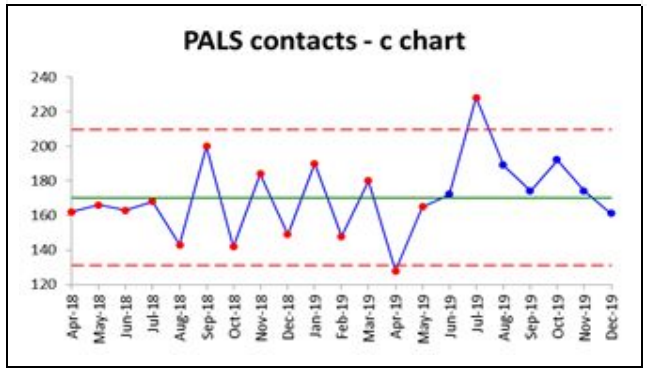


Service user experience SPC charts









Norfolk and Suffolk NHS Foundation Trust

Inspection report

Hellesdon Hospital
Drayton High Road
Norwich
Norfolk
NR6 5BE
Tel: 01603421421
www.nsft.nhs.uk

Date of inspection visit: 07 Oct to 06 Nov 2019
Date of publication: 15/01/2020

We plan our next inspections based on everything we know about services, including whether they appear to be getting better or worse. Each report explains the reason for the inspection.

This report describes our judgement of the quality of care provided by this trust. We based it on a combination of what we found when we inspected and other information available to us. It included information given to us from people who use the service, the public and other organisations.

This report is a summary of our inspection findings. You can find more detailed information about the service and what we found during our inspection in the related Evidence appendix.

Ratings

Overall trust quality rating	Requires improvement
Are services safe?	**Requires improvement**
Are services effective?	**Requires improvement**
Are services caring?	**Good**
Are services responsive?	**Requires improvement**
Are services well-led?	**Requires improvement**

We rated well-led (leadership) from our inspection of trust management, taking into account what we found about leadership in individual services. We rated other key questions by combining the service ratings and using our professional judgement.

Summary of findings

Background to the trust

Norfolk and Suffolk NHS Foundation Trust provides services for adults and children with mental health needs across Norfolk and Suffolk. Services to people with a learning disability are provided in Suffolk. They also provide secure mental health services across the East of England and work with the criminal justice system. A number of specialist services are also delivered including a community-based eating disorder service.

The trust has 392 beds and runs over 100 community services from more than 50 sites and GP practices across an area of 3,500 square miles. The trust serves a population of approximately 1.6 million and employs just over 3,600 staff. It had a revenue income of in excess of £227 million for the period of April 2018 to March 2019. In May 2019, the trust had worked with over 25,000 individual patients.

Norfolk and Suffolk NHS Foundation Trust has a total of 13 locations registered with CQC and has been inspected 22 times since registration in April 2010.

The trust collaborates with seven clinical commissioning groups.

The trust delivers the following mental health services:

- Acute wards for adults of working age and psychiatric intensive care units.
- Long stay/rehabilitation mental health wards for working age adults.
- Forensic inpatient/secure wards
- Wards for older people with mental health problems
- Learning Disability Ward
- Community-based mental health services for adults of working age
- Mental health crisis services and health-based places of safety
- Specialist community mental health services for children and young people
- Community-based mental health services for older people
- Community mental health services for people with learning disabilities or autism
- Other specialist mental health services

Since the last inspection, the trust had relocated one forensic inpatient ward and updated and re-opened the empty ward as an acute assessment ward in September 2019. The trust also opened a mother and baby unit in January 2019.

The trust has had 21 Mental Health Act monitoring visits since November 2018. Across all visits, there were 96 actions the trust was required to address.

The trust has previously been inspected four times under the comprehensive mental health inspection programme, in October 2014 (published February 2015), in July 2016 (published October 2016), July 2017 (published October 2017) and September 2018 (published in November 2018). Following the July 2017 inspection, the trust received an overall rating of inadequate and was placed in special measures. In September 2018 the Trust was inspected again and remained in special measures. The safe, responsive and well led domains were rated as ‘inadequate’, the effective domain was rated ‘requires improvement’ and caring was rated as ‘good’.

We issued seven requirement notices against mental health core services as follows:

- Regulation 9 HSCA (RA) Regulations 2014 Person-centred care

Summary of findings

- Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect
- Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment
- Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment
- Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints
- Regulation 17 HSCA (RA) Regulations 2014 Good governance
- Regulation 18 HSCA (RA) Regulations 2014 Staffing

We undertook three focussed inspections in April 2019 of three core services:

- Community-based mental health services for adults of working age
- Mental health crisis services and health-based places of safety
- Specialist community mental health services for children and young people

These inspections were focussed and not rated.

At this inspection, we found that the trust continued to show they did not meet the requirements of six of these regulations. However, the trust had met the requirement for Regulation 10.

Our rating of this trust improved since our last inspection. We rated it as Requires improvement 

What this trust does

Norfolk and Suffolk NHS Foundation Trust provides services for adults and children with mental health needs across Norfolk and Suffolk. Services to people with a learning disability are provided in Suffolk. They also provide secure mental health services across the East of England and work with the criminal justice system. Several specialist services are also delivered including a community-based eating disorder service, a peri natal community service and a new mother and baby unit.

Key questions and ratings

We inspect and regulate healthcare service providers in England.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led?

Where we have a legal duty to do so, we rate the quality of services against each key question as outstanding, good, requires improvement or inadequate.

Where necessary, we take action against service providers that break the regulations and help them to improve the quality of their services.

What we inspected and why

We plan our inspections based on everything we know about services, including whether they appear to be getting better or worse.

We inspected eight core services, which were either previously rated as inadequate, requires improvement or which we risk assessed as requiring inspection this time.

We inspected eight complete services:

Summary of findings

- Acute wards for adults of working age and psychiatric intensive care units
- Wards for older people with mental health problems
- Wards for people with learning disabilities or autism
- Mental health crisis services and health-based places of safety
- Specialist community mental health services for children and young people
- Community-based mental health services for adults of working age
- Community-based mental health services for older people
- Community mental health services for people with learning disabilities or autism

We did not inspect the other three core mental health services during this inspection because the risk-based assessment did not indicate these services required an inspection this time or they were rated as good in a previous inspection.

Our comprehensive inspections of NHS trusts have shown a strong link between the quality of overall management of a trust and the quality of its services. For that reason, all trust inspections now include inspection of the well-led key question for the trust overall. What we found is summarised in the section headed Is this organisation well-led?

What we found

Overall trust

Our rating of the trust improved. We rated it as requires improvement because:

- We rated well-led, responsive, effective and safe as requires improvement and caring as good. In rating the trust, we took into account the previous ratings of the three core services not inspected this time. We rated the trust overall for well-led as requires improvement. This was an improvement from the last inspection. Four of the trust's 11 core services are now rated as good and five as requires improvement, one service was outstanding and one inadequate.
- The trust board and senior leadership team were newly formed. At our inspection in 2018 we had significant concerns about the safety, culture and leadership of the trust. Since then, there had been a change in leadership. At this inspection, we found that, although some of the concerns had not fully been addressed, there had been a shift in approach and foundations had been laid to improve the direction of travel. We saw early improvements in almost all areas, but there had not been enough time to judge if these changes would be sustained. For instance, recent changes to the leadership structure had not yet embedded throughout the whole organisation and there were still a few key posts to be filled. We saw early improvement with the trust moving in the right direction, however, there was still much work to be done.
- Our findings from key questions demonstrated that whilst governance processes had improved, they had not yet fully ensured that performance and risk were managed well. For instance, waiting lists remained high in the specialist children and young people community mental health teams. Staffing was also a concern within this core service. We saw risk assessments were not always updated within this core service.
- The environment in the learning disability inpatient service was not safe or fit for purpose. The trust had made little attempt to remove or reduce the number of ligature points or improve lines of sight, nor was it a recovery focussed environment, as it did not encourage independence due to the number of risks within the environment. We had identified in the last inspection that not all wards were safe and fit for purpose.

Summary of findings

- Managers did not have effective oversight of medicines management nor checking of emergency equipment in six of the eight core services we inspected. Despite increased assurance work and an improved board assurance framework, medicines management issues we found had not been identified as a concern by the trust.
- The trust missed opportunities to prevent or minimise harm. For instance, we found that the management of patients on enhanced observations was not always robust within the inpatient wards with gaps being found in some documents. This posed a direct risk to patient safety. Staff did not ensure patient records in all section 136 suites were completed or added to the system in a timely manner. This posed a risk to patient safety as if the patient accessed another service within the trust there would be no information or previous plan for staff to access and use when making clinical decisions. Staff did not consistently implement the smoke free policy. This led to patient frustration and increased the risk of fire setting.
- We continued to see similar themes and recommendations (such as poor documentation in clinical records) from serious incident reviews which demonstrated learning was not always effective in improving practice. The trust recognised this and were proactively exploring ways to ensure learning took place across teams.
- Some services had not yet embraced the cultural changes leaders were trying to develop. In one location in Suffolk, across four core services, we were concerned that some staff continued to report a lack of engagement with managers and pockets of low morale. We also saw evidence of bullying in one team in Norwich. The trust had sight of these issues and had acted, however action taken had not yet been sufficiently embedded to create wholesale change.
- Some stakeholders did not feel that changes had truly positively impacted all patients, with feedback advising that some still did not feel listened to, with poor communication being a key feature of feedback from patients or their families. Equally, a lack of access to attention deficit hyperactivity disorder (ADHD) services and specialist children and adolescent community services (CAMH) was raised as a concern by stakeholders. We found that this aligned with our findings at this inspection.
- The new governance and management structure were not yet fully implemented and embedded within the new care groups. For example, the role of the people participation lead was new and not yet fully developed. Not all staff fully understood the roles and responsibilities of the leads. Leaders had not yet successfully provided all teams across the organisation with an understanding of how the new care groups worked. Some staff expressed concern that the organisational changes were too fast and lacked consultation.
- Not all teams provided a range of treatment and care for patients based on national guidance and best practice. For instance, some community services had significant waiting times for psychological therapies. Teams lacked enough psychology staff to provide the range of care recommended by the National institute for Health and Care Excellence guidelines.

However:

- Since the last inspection the trust had implemented a new quality strategy to include quality improvement (QI) as a core component within their strategic direction. The trust quality improvement plan (QIP) had been revised and was aligned to the new strategy. One hundred and eighty-seven staff had completed the three-day improvement leaders programme and were developing initiatives within local teams designed to improve care. Some of these initiatives had been identified as important by the local service users reflecting leaders increased focus on service user participation and co-production. We saw some of these initiatives within the local teams and noted increased efforts made to engage and listen to the service users voice. Staff across services told us that they were involved in the planning and delivery of their own service. This initiative was in the very early stages of implementation and had, therefore, not yet brought about the improvements that were envisaged.

Summary of findings

- The trust had a 'putting people first' strategy aimed at improving service user participation and to facilitate cultural change and de-centralise decisions. Concerns had been raised about organisational culture in the last four inspection reports, and the 2018 inspection report identified concerns that there was widespread low morale with staff feeling 'done to'. Following the 2018 inspection, the trust leadership team undertook (and continued to undertake) a range of engagement visits to services ensuring they were accessible to staff, although some staff reported that were unaware of visits to their services. At this inspection, more staff reported a sense of optimism and hope that real change was happening. More staff felt listened to, felt they could influence change, felt supported and had good working relationships with their managers.
- The trust had improved its approach to learning from and managing serious incidents as a result of feedback from families and staff. Trust committees and the trust board had sight of incident data. The trust took proactive steps to address themes identified and improve ways to share learning across services. A new serious incident scrutiny panel and serious incident team had been created to report findings from investigations to the board. The trust recognised there was still work to be done to embed and improve this process further.
- The trust collected reliable data and analysed it. This was a significant improvement from the last inspection. Staff across most services could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Staff submitted data or notifications to external organisations as required. New ways of monitoring and addressing waiting lists had been implemented with evidence that many lists had reduced. This meant leaders were able to understand what was happening in their organisation and act when needed.
- The trust had participated in some national improvement and innovation projects and undertook a wide range of quality audits and research. The trust was involved in 65 approved research projects during 2018-19 with 1800 people recruited over the year. The trust was recognised as being in the top 15 highest mental health organisations nationally for research recruitment. The trust had undertaken a quality improvement programme, steered by the Royal College of Psychiatrists, to reduce the incidents of restrictive interventions and restraints as part of a national programme. This was a significant piece of work which continued to have impact. The programme involved the patient voice who shared their experiences with staff. This success has been recognised by the Royal College of Psychiatrists who are leading the national programme.

Are services safe?

Our rating of safe improved. We rated it as requires improvement because:

- Staff had not always followed best practice when storing, dispensing and recording medication in six out of the eight core services. Internal audits were not effective in identifying concerns. This was raised as a concern following the last inspection in 2018. Medication management across five of the eight services we inspected was poor, despite reported trust oversight and audit. For instance, the hospital carried out internal audits which did not identify the concerns we found on inspection relating to errors.
- Staff did not always fully complete or update risk assessments for each patient in the community adult community service and specialist children and adolescent community services. This was raised as a concern following the last inspection in 2018.
- The environment in the learning disability inpatient service was not safe or fit for purpose. The trust had made little attempt to remove or reduce the number of ligature points or improve lines of sight. We had identified in the last inspection that not all wards were safe and fit for purpose.
- The trust missed opportunities to prevent or minimise harm. For instance, staff did not ensure patient records in all section 136 suites were completed or added to the patient notes system in a timely manner. This posed a risk to patient safety. Staff did not consistently implement the smoke free policy. This led to patient frustration and

Summary of findings

increased risk of fire setting. Inspectors found cigarette lighters in patient rooms on two occasions during inspection. Lighters were not permitted on the wards but systems to prevent this were not always effective. We found that the management of patients on enhanced observations was not always robust within the inpatient wards with gaps being found in some documents. This posed a direct risk to patient safety.

- The trust did not have sufficient staff in three core services, to effectively manage caseloads. This impacted on staff ability to carry out tasks such as record keeping, one to one sessions, physical health checks, and update risk assessments. There was a lack of suitably qualified medical staff within the crisis and home treatment teams. The trust had not ensured that sufficient numbers of suitably qualified staff were available in all teams to meet the needs of people who used the service. In August 2019, there were 34 occasions, in Norfolk crisis teams, where staff had not been able to assess patients within the four-hour emergency target due to staffing levels. The trust had not ensured that sufficient numbers of suitably qualified medical staff were available to meet the needs of people who used the service.
- Equipment was not always maintained, and staff were not always completing checks on automated external defibrillators in community teams.

However:

- Staff had made significant improvements in reducing restrictive interventions within the acute wards for adults of working age and psychiatric intensive care units. Seclusion episodes had reduced and there was evidence of attempts by staff to use less restrictive interventions before considering the use of seclusion. Clinical documentation of seclusion episodes followed MHA code of practice guidance in most instances.
- Staff completed risk assessments on all patients within the inpatient wards which were updated as required. We saw evidence that incidents were reviewed, and immediate learning was acted on and shared within the team.
- Most of the premises were clean, well equipped, well-furnished and well maintained, with the notable exception of the learning disability inpatient service.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so.
- Staff had training on how to recognise and report abuse, and they knew how to apply it.
- Access to clinical information overall had improved.

Are services effective?

Our rating of effective stayed the same. We rated it as requires improvement because:

- Not all teams provided a range of treatment and care for patients based on national guidance and best practice. There were vacancies throughout teams in two core services which impacted on the ability to provide psychological therapies. Teams lacked sufficient psychology staff to provide the range of treatment recommended by the National institute for Health and Care Excellence guidelines. This was a concern raised at the last inspection.
- Not all teams received supervision and appraisal as per the trusts' policy. This was raised as a concern at the last inspection.

However:

- We found an improvement in care plan completion and saw that most reflected current need, were personalised and individual to the patient.
- Staff assessed the mental health needs of people on admission, and there were comprehensive physical health plans in most core services.

Summary of findings

- Staff knew and understood their role in compliance with the Mental Health Act and Mental Capacity Act. Staff routinely carried out capacity assessments where necessary and consent to treatment was recorded for patients in most services. The trust provided effective support and governance to ward staff with Mental Health Act compliance, and paperwork showed correctly completed documentation.

Are services caring?

Our rating of caring stayed the same. We rated it as good because:

- Staff showed caring attitudes towards their patients. We saw numerous positive interactions between staff and patients with complex needs and staff managed extremely challenging situations with knowledge and compassion. Staff demonstrated a respectful manner when working with patients, carers, within teams and showed kindness in their interactions.
- Patients and carers gave positive feedback about the caring nature and kindness of staff and made positive comments about the therapeutic relationships they had with their loved ones. Patients had access to advocacy services.

However:

- Stakeholder feedback told us that there were still times when patients where not spoken to with kindness and sometimes families told us there was a lack of communication.
- Not all teams could show how they involved patients, parents, carers and nearest relatives in the design and delivery of the service.

Are services responsive?

Our rating of responsive improved. We rated it as requires improvement because:

- The design of the learning disability inpatient environment was not fit for purpose. It was not a therapeutic environment. The building was tired, poorly maintained and did not promote a welcoming or comfortable space for recovery.
- Waiting lists within the children and adolescent community services continued to be high. Trust data at the time of inspection showed that 421 patients were waiting for assessment. Only 39% of referrals were seen within the trust target of ten working days, with 150 people waiting more than ten days. This was raised as a concern at the last inspection.
- Some people waited over 12 months for assessment within the attention deficit hyperactivity disorder service. This team had just one nurse with a caseload of 175 patients with 120 people on the waiting list in August 2019. This had reduced to 80prior to the inspection in October 2019.
- Two core services had significant waiting times for psychological therapies in most teams.
- Discharge planning did not always contribute to patients staying out of hospital. There had been insufficient improvement within the acute and psychiatric intensive care service in the last 12 months. The number of readmissions had reduced on four wards but had increased on six wards.
- Staff had not always communicated effectively when transferring patients from one ward to another. This impacted on patient experience.
- There was not an effective system to record and review complaint outcomes and look at themes and trends. We saw plans to improve efficiency of the end to end complaint process, with plans to co-produce responses and a new electronic system had been approved, aimed at improving the recording and sharing of information in an effective

Summary of findings

and speedier manner. These initiatives were yet to be implemented. The trust also confirmed there was a backlog of complaints. Complaints were not responded to in a timely manner with just 28% of complaints being resolved within target. We saw improved involvement with patients when responding to complaints and a new process for tracking and logging complaints was in place.

However;

- The trust was able to demonstrate how they responded to emergency and urgent referrals. Whilst we saw there remained breaches of targets, we also saw there was a reason given and a review undertaken when targets were missed. The process was an improvement from the last inspection.
- Bed management had improved. Figures provided by the trust demonstrated that the number of patients using out of area beds had significantly reduced since April 2019 which, at that time, had high numbers of patients placed out of area. However, further work was required to embed changes and improve this further so that beds were available not just within the trust but within the town closest to the patient's home.
- The trust had taken positive steps to reduce all other waiting lists and this had been successful in reducing waiting times, particularly within older peoples and adult community services. The trust had implemented a weekly 'tracker list' meeting and system to monitor patient waiting times, and ensure clinical priority was considered. This was undertaken for all services.
- The trust met the needs of all patients including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.
- We saw that people using the older people's community service, could access the service easily. Its' referral criteria did not exclude patients who would have benefitted from care. Staff assessed and treated patients who required urgent care promptly and patients who did not require urgent care did not wait too long to start treatment. Staff followed up patients who missed appointments. The service had significantly reduced the waiting times for patients to be assessed and commence treatment following referral since the last inspection.

Are services well-led?

Our rating of well-led improved. We rated it as requires improvement because:

- The trust board and senior leadership team were newly formed. At our inspection in 2018 we had significant concerns about the safety, culture and leadership of the trust. Since then, there had been a change in leadership. At this inspection, we found that although some of the concerns had not fully been addressed, there had been a shift in approach and foundations had been laid to improve the direction of travel. We saw early improvements in almost all areas, but there had not been enough time to judge if these changes would be sustained. For instance, recent changes to the leadership structure had not yet embedded throughout the whole organisation and there was still a small amount of key posts to be filled. We saw early improvement with the trust moving in the right direction, however, there was still work to be done.
- Some stakeholders did not yet feel that changes had truly benefited all patients, with feedback advising that some still did not feel listened to, with poor communication being a key feature of feedback from patients or their families. Equally, a lack of access to attention deficit hyperactivity disorder (ADHD) services and specialist children and adolescent community services (CAMH) was raised as a concern by stakeholders. We found that this aligned with our findings at this inspection.

Summary of findings

- Despite improved recruitment outcomes, we remained concerned about staffing, specifically within the CAMH community service and Adult ADHD team. Also, some Norfolk crisis teams were not meeting the target to see people within four hours with staffing being cited as the reason in 34 of the 46 breaches. Managers did not have effective oversight of medicines management and checking of emergency equipment across in six of the eight core services we inspected. This had not been identified as a concern by the trust.
- Managers did not have effective oversight of medicines management or checking of emergency equipment in six of the eight core services we inspected. Despite increased assurance work and an improved board assurance framework, medicines management issues we found had not been identified as a concern by the trust.
- Our findings from the other key questions demonstrated that while governance processes had improved, they had not yet fully ensured that performance and risk were managed well. Not all of the previous areas of concern had been addressed. Staffing levels were not sufficient in all areas. Some Norfolk crisis teams were not meeting the target to see people within four hours. Medication management required further work. The trust risk registers did not reflect all the concerns that we found regarding staffing levels, missed targets, record keeping and medication management.
- We raised concern about the effectiveness of systems to ensure learning took place across core services as appropriate. The quality assurance committee and trust board had sight of serious incident data. We saw similar themes and recommendations identified from serious incident reports such as poor documentation in clinical records. At the time of inspection there were 161 serious incidents open to the team. There were 80 serious incident actions outstanding, meaning that the recommendations and actions had not been signed off as completed within the services they related to.
- Morale remained low in some services such as inpatient wards and some community services at Bury St Edmunds, learning disability inpatient services and some children and young people services in Suffolk. In these services staff did not always feel listened to and expressed concern that care was not improving at a pace they would like. This was supported by core service findings in these areas.
- The trust had not yet addressed all the concerns raised in previous inspections.

However:

- We saw early improvements in almost all areas, (such as the points below) but there had not been enough time to judge if these changes would be sustained. For instance, recent changes to the leadership structure had not yet embedded throughout the whole organisation and there were still a few key posts to be filled. We saw early improvement with the trust moving in the right direction, however, there was still much work to be done.
- The trust quality improvement plan (QIP) had been revised and aligned to the new strategy. Further development work was ongoing supported by NHS Improvement/England to develop the reporting and monitoring aspects of the plan.
- Since the last inspection the trust had implemented a new quality strategy to include quality improvement (QI) as a core component within their strategic direction. One hundred and eighty-seven staff had completed the three-day improvement leaders programme and were developing initiatives within local teams designed to improve care. Some of these initiatives had been identified as important by the local service users in line with leaders increased focussed on service user participation and co-production. We saw some of these initiatives within the local teams and noted increased efforts made to engage and listen to the service users voice. Staff across services told us that they were involved in the planning and delivery of their own service.
- The trust had undertaken a quality improvement programme, steered by the Royal College of Psychiatrists, to reduce the incidents of restrictive interventions and restraints. This was a significant piece of work which continues to have impact. The programme involved the patient voice who shared their experiences with staff. This success has been recognised by the Royal College of Psychiatrists who are leading the national programme.

Summary of findings

- The trust had a 'putting people first' strategy aimed at improving service user participation with a key aim to facilitate cultural change and de-centralise decisions. Concerns had been raised about organisational culture in the last four inspection reports, and the 2018 inspection report identified concerns that there was widespread low morale with staff feeling 'done to'. Following the 2018 inspection, the trust leadership team undertook (and continued to undertake) a range of engagement visits to services ensuring they were accessible to staff, although some staff reported that were unaware of visits to their services. At this inspection, more staff reported a sense of optimism and hope that real change was happening. More staff felt listened to, felt they could influence change, felt supported and had good working relationships with their managers.
- The trust had worked hard to ensure that the service user voice was integral to care delivery. The new people participation lead was one aspect, however there were numerous initiatives underway to increase the service user voice in all areas of the organisation. This was beginning to develop and grow.
- The trust had improved how they collected and used information and data to consider its performance. New ways of monitoring and addressing waiting lists had been implemented with evidence that many lists were reducing. The trust data was more reliable than we found in the 2018 inspection. This meant leaders were able to understand what was happening in their organisation and act when needed.
- We saw improvement of learning from lessons within local teams immediately following an incident. We saw the use of reflection, safety huddles, debrief and early learning took place with action taken to improve practice.
- The trust had participated in some national improvement and innovation projects and undertook a wide range of quality audits and research. The trust was involved in 65 approved research projects during 2018-19 with 1800 people recruited over the year. The trust was recognised as being in the top 15 highest mental health organisations nationally for research recruitment.

Acute wards for adults of working age and psychiatric intensive support units

- Our rating of this service improved. We rated it as requires improvement because:
- Staff did not always complete hourly observations in line with Trust policy. We found missing signatures on observation sheets and gaps in observations on four out of five wards that we checked. We could not be assured that observations were being completed correctly which could have an impact on patient safety.
- Staff did not always follow systems and processes when safely prescribing, administering, recording and storing medicines or completing daily and weekly checks of emergency equipment. Patients could be at risk of harm if medications are not safely prescribed.
- There were vacancies for psychology staff in Suffolk. Patients in Suffolk were not able to access adequate psychological therapies in accordance with National Institute for Clinical Excellence guidelines.
- The planning of patient's discharge did not always contribute to people staying out of hospital. The total number of readmissions within 28 days had not changed significantly since the last inspection from 253 to 245 readmissions. The number of readmissions to any ward had decreased on four wards but had increased on six wards. The trust told us that the readmission rates were slightly better than the national average.
- Managers did not provide consistent support to staff to implement the trust smoke free policy

However:

- Ward staff participated in the provider's promoting positive practice strategy and there had been a reduction in the number of episodes of restrictive practice, including restraint, across all wards.
- Staff had made improvements to care planning since the last inspection. We reviewed 78 care records and found that staff developed individual, holistic care plans through co-production with patients and their carers.

Summary of findings

- Staff treated patients with compassion and kindness. They respected patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.
- The trust had developed a system-wide action plan and opened a new ward to address the high number of out of area placements which was a concern at the last inspection
- The trust had introduced a quality improvement leadership programme for staff at all levels and, as of September 2019, had trained 200 staff.
- Most of the staff we spoke with felt that the culture of the trust was improving. Staff felt more listened to, more positive about working for the trust and that senior managers were more visible.

Community mental health service for adults of working age

Our rating of this service improved. We rated it as requires improvement because:

- Staff did not always update risk assessments routinely or after incidents at all teams; we found this in 20 out of 57 records reviewed. We found out of date risk assessments at North Norfolk CMHT and Bury South IDT by up to four years. We found one patient who had been referred to Norwich City CMHT in January 2019 did not have a risk assessment or care plan present. Not all care plans were reviewed regularly and not all were up to date. We reviewed 57 care and treatment records. We found two patients at Norwich City CMHT and one patient at North Norfolk CMHT did not have a care plan present.
- We found that the recording of physical health was poor across most adult community teams. We reviewed 49 care records in this area, 30 of these records did not have physical health assessments recorded and 25 had no evidence of ongoing physical health monitoring. At Waveney CMHT we saw evidence of recording physical health checks on paper, but this was not transferred to their electronic system.
- There were waiting lists across all community sites for psychological therapies. Waiting lists for psychological therapies ranged from six and half weeks to one year. Staff told us they did not feel there was enough psychology staff which impacted on rising caseloads.
- We found staff at North Norfolk CMHT had not ensured medical equipment had been regularly checked or cleaned. Medicines management systems did not always adhere to trust guidance and policy. We found issues with stock management, poor oversight of clinic rooms and access to keys for medicine cabinets.
- The ligature risk assessment at Bury South IDT did not capture all risks in each room.
- Managers at Norwich City CMHT had little oversight of caseload allocation of incoming referrals. The referral process did not ensure equity of caseloads for staff. To ensure there was no waiting list for allocation, all new referrals were allocated immediately resulting in high caseloads ranging from 11 to 70 with an average of 47 per care co-ordinator. Staff told us they were unaware of trust plans to review the process, however the trust shared information on how they were acting to address caseload concerns. This demonstrated there was a need to ensure there was improved communication between managers and the staff teams.
- Suffolk staff reported a disconnect between them and higher senior management. Some community service staff within Suffolk teams said that they felt communication and visibility of higher senior management was poor.
- There was inconsistency with what was placed on the risk register. For instance, demand and capacity had been highlighted on the risk register in Norfolk community services, however, Suffolk services experienced the same issue and it had not added to their risk register.

Summary of findings

- Managers had not reviewed capacity versus demand for services in the adult community mental health services, consequently the staffing establishment was based on a significantly lower number of open referrals to their services than the number of open referrals they had.

However:

- The number of patients on the waiting list had reduced and there was an improved system for monitoring patient waits. We saw systems in place to ensure those patients waiting were reviewed and emerging risks were identified earlier than before.
- Most clinical premises where patients received care were safe, clean, well equipped, well furnished, well maintained and fit for purpose. Staff managed waiting lists well to ensure that patients who required urgent care were seen promptly. Staff assessed and managed risk well and followed good practice with respect to safeguarding. This was an improvement since our last inspection.
- Staff provided a range of treatments that were informed by best-practice guidance and suitable to the needs of the patients. Staff engaged in clinical audit to evaluate the quality of care they provided.
- We saw effective multi-disciplinary working to benefit patients. The teams had effective working relationships with relevant services outside the organisation.
- Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and understood the individual needs of patients. They actively involved patients and families and carers in care decisions.
- The service was easy to access. Staff assessed and treated patients who required urgent care promptly and those who did not require urgent care did not wait too long to start treatment. The criteria for referral to the service did not exclude patients who would have benefitted from care.

Wards for older people with mental health problems

Our rating of this service stayed the same. We rated it as good because:

- The service provided safe care. The ward environments were safe and generally clean. The wards had enough nurses and doctors. Staff assessed and managed risk well. They minimised the use of restrictive practices, managed medicines safely and followed good practice with respect to safeguarding.
- Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment. They provided a range of treatments suitable to the needs of the patients and in line with national guidance about best practice. Staff had engaged in clinical audit to evaluate the quality of care they provided.
- The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers ensured that these staff received training, supervision and appraisal. The ward staff worked well together as a multidisciplinary team and with those outside the ward who would have a role in providing aftercare.
- Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and understood the individual needs of patients. They actively involved patients and families and carers in care decisions.

However;

- The environment on Laurel ward, Abbeygate did not meet dementia friendly environment guidance.

Summary of findings

- Managers did not have oversight of contract cleaning schedules on Maple ward, Abbeygate to ensure appropriate levels of cleanliness and infection control.
- Managers did not ensure that staff recorded capacity and best interest decisions on the correct document named in the trust policy.
- There were gaps in medicines administration records and clinic room checks on Abbeygate ward which meant that medicines related policies were not being followed.

Mental health crisis services and health-based places of safety.

Our rating of this service stayed the same. We rated it as requires improvement because:

- The trust had not ensured that sufficient numbers of suitably qualified staff were available in all teams to meet the needs of people who used the service. In August 2019, there were 34 occasions in Norfolk where staff had not been able to assess patients within the four-hour emergency target due to staffing levels. The trust had not ensured that sufficient numbers of suitably qualified medical staff were available to meet the needs of people who used the service.
- We reviewed 18 care records of patients using health-based places of safety. For ten patients who had used the section 136 suites at West Suffolk Hospital and Northgate Hospital there was a lack of contemporaneous records on the electronic recording system.
- The service had systems in place to safely prescribe, administer, record and store medicines but they did not always reflect local practice and staff did not always follow them. Each area conducted audits of prescription charts, but the audit process was inconsistent between teams and the good practice seen in some areas was not shared. The number of errors we found in some teams showed that the audit process was not effective in identifying and addressing gaps in recording.
- The crisis teams in Norfolk had not always met the target for seeing patients within four hours of receiving an emergency referral. Throughout 2019, the trust had not met its own target of 95%. The health-based places of safety were not always available when needed in West Suffolk.
- Our findings from the other key questions demonstrated that while governance processes had improved they had not yet fully ensured that performance and risk were managed well. Not all the previous areas of concern had been addressed. The corporate risk register did not reflect the concerns that we found regarding staffing levels, missed targets, record keeping and medication management.
- Managers in Norwich told us that while staff morale had improved it was not yet good, and that a positive culture was not fully embedded across the service. The trust needed to continue to develop communication across all staff groups.
- Some stakeholders had identified negative feedback from some patients regarding responsiveness and attitude of some staff. Whilst it was evident that work had been undertaken to address the culture of the organisation, this was evidence that more work was required.

However:

- Overall management of referrals and waiting times had improved. For example, managers had developed an electronic dashboard which showed them when patients had accessed the service, when referral to treatment targets had not been met the and the reasons for this. This allowed managers to support their teams to mitigate the risks to patients. Incidents were reported, investigated and learned from.
- Clinical premises where patients were seen were safe and clean and the physical environment of the health-based places of safety met the requirements of the Mental Health Act Code of Practice.

Summary of findings

- The number of patients on the caseload of the mental health crisis teams, and of individual members of staff had reduced since our last inspection and was not too high to prevent staff from giving each patient the time they needed. Staff ensured that patients who required urgent care were seen promptly. Staff assessed and managed risk well and followed good practice with respect to safeguarding.
- Staff working for the mental health crisis teams developed holistic, recovery-oriented care plans informed by a comprehensive assessment and in collaboration with families and carers. They provided a range of treatments that were informed by best-practice guidance and suitable to the needs of the patients. Staff engaged in clinical audit to evaluate the quality of care they provided.
- The mental health crisis teams included or had access to the full range of specialist staff required to meet patient's needs in line with the current standard operating procedure for the crisis pathway. Managers ensured that these staff received training, supervision and appraisal. Staff worked well together as a multidisciplinary team and with relevant services outside the organisation.
- Staff treated patients with compassion and kindness and understood the individual needs of patients. They actively involved patients and families and carers in care decisions.
- Leaders had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed, and were visible in the service and approachable for patients and staff. Staff knew and understood the provider's vision and values and felt respected, supported and valued.
- Staff collected analysed data about outcomes and performance and engaged actively in local and national quality improvement activities.

Community based mental health services for older people

Our rating of this service improved. We rated it as good because:

- The service provided safe care. Clinical premises where patients were seen were safe and clean. The number of patients on the caseload of the teams, and of individual members of staff, was not too high to prevent staff from giving each patient the time they needed. Staff managed waiting lists well to ensure that patients who required urgent care were seen promptly. Staff assessed and managed risk well and followed good practice with respect to safeguarding. The trust now had environmental risk assessments, including ligature risks, in place across the service where patients were seen on trust premises.
- Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment and in collaboration with families and carers. They provided a range of treatments that were informed by best-practice guidance and suitable to the needs of the patients. Staff engaged in clinical audit to evaluate the quality of care they provided.
- The teams included or had access to the full range of specialists required to meet the needs of the patients. The trust had actively recruited psychologists and occupational therapists into teams. Managers ensured that these staff received training, supervision and appraisal. Staff worked well together as a multidisciplinary team and with relevant services outside the organisation.
- Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and understood the individual needs of patients. They actively involved patients and families and carers in care decisions.

Summary of findings

- The service was easy to access. Staff assessed and treated patients who required urgent care promptly and those who did not require urgent care did not wait too long to start treatment. The criteria for referral to the service did not exclude people who would have benefitted from care. The service had significantly reduced the waiting times for patients to be assessed and commence treatment following referral since the last inspection.
- The service was well led, and the governance processes ensured that procedures relating to the work of the service ran smoothly.

Community mental health services for people with a learning disability or autism

Our rating of this service stayed the same. We rated it as good because:

- Staff assessed and managed risks to patients and themselves. They responded promptly to sudden deterioration in a patient's health. When necessary, staff worked with patients and their families and carers to develop crisis plans. Staff monitored patients on waiting lists to detect and respond to increases in level of risk. Staff followed good personal safety protocols.
- Staff took a function-based approach to assessing the needs of all patients. They worked with patients, families and carers to develop individual care plans and updated them as needed. Care plans reflected the assessed needs, were personalised, holistic, function-based and recovery-oriented.
- Staff provided a range of treatment and care interventions that were informed by best-practice guidance and suitable for the patient group. They ensured that patients had good access to physical healthcare and supported patients to live healthier lives.
- Staff treated patients with compassion and kindness. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.
- Staff had the skills, or access to people with the skills, to communicate in the way that suited the patient.
- Leaders had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed, were visible in the service and were approachable for patients and staff.

However:

- The service did not meet the trust's target time of 12 weeks from referral to assessment. Patients were waiting for up to eight months for an assessment by the autism child and adolescent mental health team and up to nine months for an assessment by the autism adult team. Patients were waiting for over 12 months for an assessment by the attention deficit hyperactivity disorder adult team who had just one qualified nurse managing a caseload of up to 175 patients and a waiting list of 120 patients for over a year. The Waveney adult team and the Ipswich adult learning disability teams did not achieve supervision rates above 75 percent for their staff between July 2019 and September 2019.
- The Waveney adult team and the Ipswich adult learning disability teams did not achieve supervision rates above 75 percent for their staff between July 2019 and September 2019.
- The décor at the Waveney adult and child and adolescent service was tired, had peeling paint on its walls and required updating.

Wards for people with a learning disability or autism

Our rating of this service stayed the same. We rated it as requires improvement because:

- The trust had made little attempt to remove or reduce the number of ligature points in the bungalows, though this issue had not been raised in the previous inspection report. Bedrooms had several ligature points and no clear lines of observation from the corridor.

Summary of findings

- The fence around the garden area created a potential safety risk. Patients could climb over the fence and abscond or attempt to climb the fence and injure themselves. There had not been any reported serious incidents relating to this risk.
- The design and safety of the bungalows did not support patient's treatment. It did not enable patients to develop their optimum level of independence or effective independent living skills. The environment was not homely, and décor was tired and dated.
- The design of the buildings used for learning disability inpatient services, meant one patient was cared for on an alternative ward, which was not a ward that was designed to meet their individual needs.
- Staff had not picked up a medicine error as part of their medicines check and audit. The administration of PRN medication was an issue reported on at a previous inspection, the trusts action plan for this was that the clinical team lead would ensure that PRN medication was being given appropriately, monitored and recorded.
- Staff found it difficult to locate care plans and risk assessments on the electronic system. There were numerous different care plans in different places on the electronic system. To overcome this staff kept summarised paper copies as well. This meant that staff could miss key information. Staff may not always have all the information they needed to implement or update care plans.
- There were no nurse call bells in any patient areas, patients could not summon help in an emergency.

However:

- This core service overall rating of requires improvement remained the same as the last inspection. Effective, caring and well led had improved from requires improvement to good, while safe went down from requires improvement to inadequate and responsive went down from good to requires improvement.
- Staff had the skills required to develop and implement good positive behaviour support plans to enable them to work with patients who displayed behaviours that staff found challenging. Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment. They provided a range of treatments suitable to the needs of the patients cared for in a ward for people with a learning disability and or autism. Treatments were in line with national guidance about best practice.
- The care team included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers ensured that these staff received training, supervision and appraisal. Staff worked well together as a multidisciplinary team and with those people in other services who would have a role in providing aftercare.
- Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. Staff treated patients with compassion and kindness, respected their privacy and dignity, and understood the individual needs of patients. They actively involved patients and families and carers in care decisions.

Specialist mental health services for children and young people

Our rating of this service stayed the same. We rated it as inadequate because:

- The trust had not fully addressed all issues reported at previous inspections. We rated responsive and well-led as inadequate. We rated safe and effective as requires improvement and caring as good.
- The trust had not addressed all actions identified at the inspection in 2018.These related to ensuring adequate staff available to reduce the patient waiting lists for triage, assessment and treatment, staff, for engagement of staff in development of the service in Suffolk, regular line management, clinical supervision and appraisal, risk assessments and infection control.

Summary of findings

- The trust had not ensured adequate staffing to meet the needs of the service. This meant staff had extra pressure on them to deliver a better service without much additional resources.
- We continued to find examples of backlogs where patients waited a long time before receiving triage, assessment and treatment.
- The multi-agency 'emotional well-being hub' team triaged referrals for young people needing health or social care across Suffolk. They had reduced the number of patients awaiting triage from our 2018 inspection from 394 to 389. We found examples where staff took more than the trust target time of 28 days to contact patients and then direct them to the right service. Children and family and youth teams gave examples where assessments were not adequate which meant more work was required to effectively screen referrals.
- Staff had not fully completed or updated 28 patients (39%) comprehensive risk assessments. Staff did not always complete a comprehensive mental health assessment of each patient who were receiving treatment as 15 care plans (21%) across teams needed improvements. Staff in Norfolk and Suffolk still had different systems for assessing and monitoring risks for patients awaiting assessment.
- We found risks to patients' safety as staff did not always identify and report safeguarding concerns. Haverhill, Sudbury satellite clinics and North Bury did not have separate children waiting areas.
- Thirteen of 19 patients (68%) and 21 of 45 (47%) carers gave negative feedback about the support provided. Feedback themes included a lack of support when they contacted teams for help during a crisis and a lack of information or communication.
- Trust systems for engaging patients, carers, staff and stakeholders in the development of the children and young person service were not fully effective as we received concerning feedback about the accessibility and communication of the service. Staff at Ipswich youth did not record informal complaints and there was no evidence of how these were resolved. Responses were not always timely.
- The trust had not supported new managers (particularly in Suffolk) to help them access key performance indicator data, which posed a risk they would not have clear information to be able to check how their team was performing. We found pockets of low staff morale, for example, in Ipswich, South Bury and Central Norfolk teams.
- Improvements were still needed to ensure a safe and clean environment. Staff were not completing checks of automated external defibrillators at South Bury IDT and Ickworth Lodge locations. We found examples where teams were not routinely monitoring cleaning of rooms and equipment. The trust had not completed accurate ligature assessments at South Bury, Great Yarmouth, Waveney and West Norfolk teams, which captured all potential risks. This meant staff would not be aware of all areas which needed more supervision.

However:

- Staff treated patients with compassion and kindness, respected their privacy and dignity, and understood the individual needs of patients. They actively involved patients and families and carers in care decisions.
- The trust had made extensive changes to the leadership and were changing their systems for monitoring, assessing and mitigating the risks to patients. The trust now had two care groups for children families and young people services across the trust to give clearer accountability and oversight of this core service. The trust had improved the quality of their risk registers with more identification of the service risks. The backlog of patients waiting for treatment had reduced. The culture of children and young people's services had changed since our 2018 inspection. Staff told us their morale was improving and they were more hopeful that trust changes would make the service better.

Summary of findings

- Staff provided a range of treatment and care for patients based on national guidance and best practice. We found examples of staff using the 'THRIVE' integrated, person-centred and needs-led approach. Staff used recognised rating scales to assess and record severity and outcomes such as Routine Outcome Measures (ROMS). They supported patients to live healthier lives.
- The trust had involved patients and staff in the development of Kingfisher ward their mother and baby unit.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice.

Ratings tables

The ratings tables show the ratings overall and for each key question, for each service, hospital and service type, and for the whole trust. They also show the current ratings for services or parts of them not inspected this time. We took all ratings into account in deciding overall ratings. Our decisions on overall ratings also took into account factors including the relative size of services and we used our professional judgement to reach fair and balanced ratings.

Outstanding practice

We found examples of outstanding practice in two core services we inspected.

For more information, see the Outstanding practice section of this report.

Areas for improvement

We found examples of outstanding practice at some services. For more information, see the outstanding practice section of this report.

Action we have taken

We issued six requirement notices to the trust. Our actions related to a breach of six legal requirements relating to six core services.

For more information, see the Areas for improvement section of this report.

What happens next

We will check that the trust takes the necessary action to improve its services. We will continue to monitor the safety and quality of services through our continuing relationship with the trust and our regular inspections.

Outstanding practice

- In the acute wards for adults of working age and psychiatric intensive care units, the trust had undertaken a quality improvement programme, steered by the Royal College of Psychiatrists, to reduce the incidents of restrictive interventions and restraints. This was a significant piece of work which has reduced the number of restraints used on the pilot acute wards. This programme has now rolled out to other wards for implementation. The programme involved the patient voice who shared their experiences with staff. This success has been recognised by the Royal College of Psychiatrists who are leading the national programme.
- In the community mental health services for people with a learning disability or autism, services had liaison staff who attended general practitioner surgeries to ensure that all patients had access to yearly physical health checks and to support general practice surgeries in making their services learning disability friendly. Liaison staff also had good links with the local general hospital to ensure that any physical health interventions were managed effectively.

Summary of findings

Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is to comply with a minor breach that did not justify regulatory action, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the trust MUST take to improve

We told the trust that it must take action to bring services into line with six legal requirements. This action related to six services.

Wards for people with Learning Disability or autism

- The trust must ensure that the internal and external environments at Walkers Close bungalows 3 and 4 are clean, secure, maintained and suitable for the purpose for which they are being used.
- The trust must ensure that they are following the trusts ligature removal and reduction policy and are doing all that is reasonably practicable to reduce ligature risks in bungalows 3 and 4 Walkers Close.

This was a breach of Regulation 12 Safe Care and Treatment

- The trust must ensure that the environment is conducive to effective therapeutic intervention.

This was a breach of Regulation 15 premises and equipment

Community mental health services for people with learning disabilities or autism

- The trust must ensure there are enough staff at the adult ADHD service and that caseloads are safe and manageable.

This was a breach of Regulation 12 Safe care and treatment

- The trust must improve the waiting times for patients to access an assessment at the adult and CAMHS autism service and the adult ADHD service.

This was a breach of Regulation 9 Person-centred care

Acute wards for adults of working age and psychiatric intensive care units.

- The trust must ensure staff complete observations in line with trust policy.
- The trust must ensure that medicine administrations are recorded clearly on prescription charts.
- The trust must ensure that medicines are administered in line with prescribers intended limits.
- The trust must ensure controlled drugs are stored and managed in line with trust and national guidance.
- The trust must ensure that a robust audit process is in place that identifies and rectifies errors and omissions on prescription charts.
- The trust must ensure that a female only day space is available on Yare ward.

This was a breach of Regulation 12 Safe care and treatment

- The trust must ensure that staff implement the trust smoke free policy.
- The trust must ensure that staff clearly communicate when patients are transferred between wards in Suffolk.
- The trust must ensure that staff record whether a patient's carer/advocate has been informed and the decision making around termination of seclusion when a patient has been secluded

Summary of findings

- The trust must ensure that all staff complete mandatory training.
- The trust must ensure that all eligible staff have a regular appraisal.

This was a breach of Regulation 17 Good Governance

Community-based mental health services for adults of working age

- The trust must ensure risk assessments are updated routinely and after incidents to reflect the patient's current presentation
- The trust must ensure medical equipment is regularly checked and each service has the necessary medical equipment to carry out physical health checks as required
- The trust must ensure they adhere to the medicines management policy, processes and procedures regarding safe storage and dispensing of medication.
- The trust must ensure all ligature risk assessments capture all risks
- The trust must ensure physical health checks are recorded on their electronic system
- The trust must ensure all patients have a care plan
- The trust must ensure all staff are supervised regularly
- The trust must ensure all mandatory training meets the trust target
- The trust must ensure psychology waiting lists are addressed

This was a breach of Regulation 12 Safe care and treatment

- The trust must ensure all patients have a care plan and that this addressed their needs

This was a breach of Regulation 9 Person-centred care

Specialist community mental health services for children and young people

- The trust must ensure adequate staff resources are available to reduce the patient waiting lists for triage, assessment and treatment in the children and young person service and for attention deficit hyperactivity disorder patients.
- The trust must ensure that staff receive regular line management, clinical supervision and appraisal in the children and young person service.

This was a breach of Regulation 18 Staffing

- The trust must review governance systems to ensure compliance with actions from past CQC inspections in the children and young person service.
- The trust must ensure they support all managers to use the trust's governance systems and performance management systems in the children and young person service.
- The trust must review and improve their systems for engaging and communicating with patients, carers, staff and stakeholders about the children and young person service.

This was a breach of Regulation 17 Good Governance

- The trust must review their systems to ensure that patients have risk assessments and care plans in the children and young person service.

Summary of findings

- The trust must review their policy and process for ligature risk assessment in community teams, to ensure ligature risks are identified and managed in the children and young person service.
- The trust must ensure checks of automated external defibrillators take place as per the trust's standard.
- The trust must ensure that staff in the children and young person service follow the trust's infection control procedures and processes.

This was a breach of Regulation 12: Safe care and treatment

- The trust must ensure that systems and processes are established and operated effectively to prevent abuse of patients in the children and young person service.

This was a breach of Regulation 13: Safeguarding service users from abuse and improper treatment.

Mental health crisis services and health-based places of safety

- The trust should ensure that there are effective audit processes in place to identify and rectify medicines administration shortfalls and compliance with medicines related policies.
- The trust must ensure that contemporaneous records are kept for people who use health- based places of safety.

This was a breach of Regulation 12: Safe care and treatment

- The trust must ensure all staff are aware of the trust provision for senior medical cover.

This was a breach of Regulation 18: Staffing

- The trust must ensure that teams have access to policies that reflect the service provided.
- The trust must ensure that there are enough staff to safely manage the health-based places of safety and to meet emergency referral targets.

This was a breach of Regulation 17 Good governance

Action a trust SHOULD take is to comply with a minor breach that did not justify regulatory action, to prevent it failing to comply with legal requirements in future, or to improve services.

Wards for people with a Learning Disability or autism

- The trust should ensure that medicines audits are robust, and all medication errors are reported as per trust policy.
- The trust should ensure that all care plans are easy to find and in the correct place on the electronic record.

Community mental health services for people with learning disabilities or autism

- The provider should ensure speech and language provision is sought as soon as possible for the learning disability Waveney service.
- The provider should ensure that supervision is provided for all staff.

Acute wards for adults of working age and psychiatric intensive care units

- The trust should ensure that body maps are completed after incidents or record where there is not appropriate.
- The service should ensure a process is in place for debriefing staff and patients after administration of rapid tranquilisation medicines.

Community-based mental health services for adults of working age

- The trust should ensure the risk register is consistent across all services

Summary of findings

- The trust should ensure all managers have oversight of allocation of referrals and staff caseloads
- The trust should ensure the staffing establishment reflects the current pace of referrals incoming to services

Specialist community mental health services for children and young people

- The trust should ensure that all staff understand and follow the trust's complaints policy in the children and young person service.

Mental health crisis services and health-based places of safety

- Managers at Woodlands House, Ipswich Hospital should review the security arrangements for keys for the clinic room.

Wards for older people with mental health problems

We found the following areas for improvement:

- The trust should review the environment on Laurel ward, Abbeygate to meet dementia friendly environment guidance.
- The trust should ensure that there are appropriate levels of cleanliness and infection control on Maple ward, Abbeygate and that internal systems provide this assurance.
- The trust should ensure that staff record capacity and best interest decisions on the correct document named in the trust policy.
- The trust should ensure that staff complete medicines administration records and clinic room checks on Abbeygate ward.

Is this organisation well-led?

Our comprehensive inspections of NHS trusts have shown a strong link between the quality of overall management of a trust and the quality of its services. For that reason, we look at the quality of leadership at every level. We also look at how well a trust manages the governance of its services – in other words, how well leaders continually improve the quality of services and safeguard high standards of care by creating an environment for excellence in clinical care to flourish.

Our rating of the trust improved. We rated it as requires improvement because:

- We rated well-led, responsive, effective and safe as requires improvement and caring as good. In rating the trust, we took into account the previous ratings of the three core services not inspected this time. We rated the trust overall for well-led as requires improvement. This was an improvement from the last inspection. Four of the trust's 11 core services are now rated as good and five as requires improvement, one core service was rated as outstanding and one core service rated as inadequate.
- The trust board and senior leadership team were newly formed. At our inspection in 2018 we had significant concerns about the safety, culture and leadership of the trust. Since then, there had been a change in leadership. At this inspection, we found that although some of the concerns had not fully been addressed, there had been a shift in approach and foundations had been laid to improve the direction of travel. We saw early improvements in almost all areas, but there had not been enough time to judge if these changes would be sustained. For instance, recent changes to the leadership structure had not yet embedded throughout the whole organisation and there was still a small amount of key posts to be filled. We saw early improvement with the trust moving in the right direction, however, there was still work to be done.

Summary of findings

- The trust had not fully addressed all issues reported at previous inspections. For instance, waiting lists remained high in the specialist children and young people community mental health teams. Staffing was also a concern within this core service. We saw risk assessments were not always updated within this core service.
- The environment in the learning disability inpatient service was not safe or fit for purpose. The trust had made little attempt to remove or reduce the number of ligature points or improve lines of sight, nor was it a recovery focussed environment, as it did not encourage independence due to the number of risks within the environment. We had identified in the last inspection that not all wards were safe and fit for purpose.
- Managers did not have effective oversight of medicines management nor checking of emergency equipment in six of the eight core services we inspected. Despite increased assurance work and an improved board assurance framework, medicines management issues we found had not been identified as a concern by the trust.
- The trust missed opportunities to prevent or minimise harm. For instance, we found that the management of patients on enhanced observations was not always robust within the inpatient wards with gaps being found in some documents. This posed a direct risk to patient safety. Staff did not ensure patient records in all section 136 suites were completed or added to the system in a timely manner. This posed a risk to patient safety as if the patient accessed another service within the trust there would be no information or previous plan for staff to access and use when making clinical decisions. Staff did not consistently implement the smoke free policy. This led to patient frustration and increased the risk of fire setting. Inspectors found cigarette lighters in patient rooms on two occasions during inspection. Lighters were not permitted on the wards but systems to prevent this were not always effective.
- We continued to see similar themes and recommendations (such as poor documentation in clinical records) from serious incident reviews which demonstrated learning was not always effective in improving practice. The trust recognised this and were proactively exploring ways to ensure learning took place across teams.
- Some services had not yet embraced the cultural changes leaders were trying to develop. In one location across two core services we were concerned that some staff continued to report a lack of engagement with managers and pockets of low morale. We also saw evidence of bullying in one team in Norwich. The trust had sight of these issues and had acted, however action taken had not yet been sufficiently embedded to create wholesale change.
- Some stakeholders did not feel that changes had truly positively impacted all patients, with feedback advising that some still did not feel listened to, with poor communication being a key feature of feedback from patients or their families. Equally, a lack of access to attention deficit hyperactivity disorder (ADHD) services and specialist children and adolescent community services (CAMH) was raised as a concern by stakeholders. We found that this aligned with our findings at this inspection.
- The new governance and management structure were not yet fully implemented and embedded within the new care groups. For example, the role of the people participation lead was new and not yet fully developed. Not all staff fully understood the roles and responsibilities of the leads. Leaders had not yet successfully provided all teams across the organisation with an understanding of how the new care groups worked. Some staff expressed concern that the organisational changes were too fast and lacked consultation. However, some staff from the specialist community and children and adolescent teams felt change was not fast enough to ensure patient care was sufficiently improved.
- Not all teams provided a range of treatment and care for patients based on national guidance and best practice. Some community services had significant waiting times for psychological therapies. Teams lacked sufficient psychology staff to provide the range of care recommended by the National institute for Health and Care Excellence guidelines.

However:

- Since the last inspection the trust had implemented a new quality strategy to include quality improvement (QI) as a core component within their strategic direction. The trust quality improvement plan (QIP) had been revised and was

Summary of findings

aligned to the new strategy. One hundred and eighty-seven staff had completed the three-day improvement leaders programme and were developing initiatives within local teams designed to improve care. Some of these initiatives had been identified as important by the local service users reflecting leaders increased focus on service user participation and co-production. We saw some of these initiatives within the local teams and noted increased efforts made to engage and listen to the service users voice. Staff across services told us that they were involved in the planning and delivery of their own service.

- The trust had a 'putting people first' strategy aimed at improving service user participation and to facilitate cultural change and de-centralise decisions. Concerns had been raised about organisational culture in the last four inspection reports, and the 2018 inspection report identified concerns that there was widespread low morale with staff feeling 'done to'. Following the 2018 inspection, the trust leadership team undertook (and continued to undertake) a range of engagement visits to services ensuring they were accessible to staff, although some staff reported that were unaware of visits to their services. At this inspection, more staff reported a sense of optimism and hope that real change was happening. More staff felt listened to, felt they could influence change, felt supported and had good working relationships with their managers.
- The trust had improved its approach to learning from and managing serious incidents as a result of feedback from families and staff. Trust committees and the trust board had sight of incident data. The trust took proactive steps to address themes identified and improve ways to share learning across services. A new serious incident scrutiny panel and serious incident team had been created to report findings from investigations to the board. The trust recognised there was still work to be done to embed and improve this process further.
- The trust collected reliable data and analysed it. This was a significant improvement from the last inspection. Staff across most services could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Staff submitted data or notifications to external organisations as required. New ways of monitoring and addressing waiting lists had been implemented with evidence that many lists had reduced. This meant leaders were able to understand what was happening in their organisation and act when needed.
- The trust had participated in some national improvement and innovation projects and undertook a wide range of quality audits and research. The trust was involved in 65 approved research projects during 2018-19 with 1800 people recruited over the year. The trust was recognised as being in the top 15 highest mental health organisations nationally for research recruitment. The trust had undertaken a quality improvement programme, steered by the Royal College of Psychiatrists, to reduce the incidents of restrictive interventions and restraints as part of a national programme. This was a significant piece of work which continued to have impact. The programme involved the patient voice who shared their experiences with staff. This success has been recognised by the Royal College of Psychiatrists who are leading the national programme.

Ratings tables

Key to tables					
Ratings	Not rated	Inadequate	Requires improvement	Good	Outstanding
Rating change since last inspection	Same	Up one rating	Up two ratings	Down one rating	Down two ratings
Symbol *	➔➔	↑	↑↑	↓	↓↓
Month Year = Date last rating published					

* Where there is no symbol showing how a rating has changed, it means either that:

- we have not inspected this aspect of the service before or
- we have not inspected it this time or
- changes to how we inspect make comparisons with a previous inspection unreliable.

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires improvement ↑ Oct 2019	Requires improvement ➔➔ Oct 2019	Good ➔➔ Oct 2019	Requires improvement ↑ Oct 2019	Requires improvement ↑ Oct 2019	Requires improvement ↑ Oct 2019

The rating for well-led is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions are from combining ratings for services and using our professional judgement.

Ratings for mental health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Requires improvement ↑ Oct 2019	Requires improvement → ← Oct 2019	Good ↑ Oct 2019	Requires improvement ↑ Oct 2019	Requires improvement ↑ Oct 2019	Requires improvement ↑ Oct 2019
Wards for older people with mental health problems	Good ↑	Good → ←	Good → ←	Good → ←	Good ↑	Good ↑
Wards for people with a learning disability or autism	Inadequate ↓ Oct 2019	Good ↑ Oct 2019	Good ↑ Oct 2019	Requires improvement ↓ Oct 2019	Good ↑ Oct 2018	Requires improvement → ← Oct 2019
Community-based mental health services for adults of working age	Requires improvement ↑ Oct 2019	Requires improvement → ← Oct 2019	Good → ← Oct 2019	Good ↑ Oct 2019	Requires improvement ↑ Oct 2019	Requires improvement ↑ Sept 2019
Mental health crisis services and health-based places of safety	Requires improvement → ← Oct 2019	Good → ← Oct 2019	Good → ← 2019	Requires improvement → ← 2019	Requires improvement ↑ 2019	Requires improvement → ← 2019
Specialist community mental health services for children and young people	Requires improvement ↑ Oct 2019	Requires improvement ↓ Oct 2018	Requires improvement ↓ Oct 2019	Inadequate → ← Oct 2019	Inadequate → ← Oct 2019	Inadequate → ← Oct 2019
Community-based mental health services for older people	Good ↑ Oct 2019	Good ↑ Oct 2019	Good → ← Oct 2019	Good ↑ Oct 2019	Good ↑ Oct 2019	Good ↑ Oct 2019
Community mental health services for people with a learning disability or autism	Good → ← Oct 2019	Good → ← Oct 2019	Good → ← Oct 2019	Requires improvement ↓ Oct 2019	Good → ← Oct 2019	Good → ← Oct 2019

Overall ratings for mental health services are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

9.1

Wards for people with a learning disability or autism

Requires improvement 

Key facts and figures

Norfolk and Suffolk NHS Foundation Trust have one inpatient ward for adults with learning disability and autism. The ward is located at Walker Close, Ipswich and consists of two bungalows. Bungalow number 3 has four male beds, and bungalow number 4 has four female beds, there is a further bungalow number 2 which is the administrative hub for this core service. However, at the time of our inspection managers had decommissioned two of the four female bedrooms and one of the male bedrooms because they had failed a fire inspection. At the time inspection there were two male patients and one female patient in residence.

The trust is registered with the Care Quality Commission (CQC) for the following regulated activities:

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Treatment of disease, disorder, or injury.

At the last inspection of this core service in September 2018, the overall rating for this service was requires improvement. Safe, Effective, Caring, and Well led we rated as requires improvement while Responsive was rated as good.

At that time, we identified the following areas as actions the provider must take to improve:

- Staff must ensure that all patients have a detailed positive behaviour support plan or equivalent
- Staff must ensure that best interest decisions are clearly documented for patients who lack capacity to consent.
- Staff must ensure that Deprivation of Liberty Safeguards paperwork was completed correctly.

We also identified the following areas as actions the provider should take to improve:

- Staff should ensure that patients were supported to make decisions about their care and this is documented in their notes.
- Staff should ensure that patients with communication difficulties are involved in the planning of their care.

On this occasion our inspection was announced with 30 minutes notice to the leaders. Staff did not know we were coming. We carried out a comprehensive inspection of both the male and female bungalows.

Our inspection team consisted of a CQC inspector, a specialist advisor nurse, a specialist advisor social worker and an expert by experience.

At this inspection we found that the trust had met the requirements from the previous inspection regarding, positive behaviour support plans, documented best interest decisions for people who lacked capacity to consent, and correct completion of Deprivation of Liberty Safeguards paperwork.

Following a one-month closure in early 2019 the trust had installed a new management team to improve leadership and governance in this core service.

The service had also improved their involvement of patients in care decisions and planning for their care. The service actively used the patient participation leads to support the co-production of new care plans with patients that included risk issues and management of those risks.

Wards for people with a learning disability or autism

Before the inspection visit, we reviewed information that we held about these services along with information requested from the trust.

During the inspection visit, the inspection team:

- spoke with two managers for the service
- carried out an inspection of the care environments
- spoke with nine other staff members, including nurses, clinical support workers, occupational therapists, behavioural therapists, social workers, and a doctor
- examined medicine management across the service
- reviewed three medication charts
- reviewed 3 patient care records
- observed three episodes of care
- spoke with two patients who were using the service and two carers, and
- Reviewed documentation and paperwork relating to the running of the ward.

Summary of this service

Our rating of this service stayed the same. We rated it as requires improvement because:

The summary for this service appears in the Overall Summary of this report.

Is the service safe?

Inadequate 

Our rating of safe went down. We rated it as inadequate because:

- The rating of inadequate was directly due the poor physical environment of the building.
- Bedrooms had several ligature points and no clear lines of observation from the corridor. We acknowledge some work had been undertaken but this was insufficient to ensure a safe environment. Mitigation was that patients always had to be supervised and escorted. This practice had the potential to restrict patients' development of confidence and skills to become independent.
- There were no nurse call bells in any patients' bedrooms, therefore patients could not summon help in an emergency. The environment was not homely, and the décor was tired and dated.
- The fence around the garden area created a potential safety risk. Patients could easily climb over the fence and abscond or attempt to climb the fence and injure themselves. Mitigation was that staff had to always supervise and escort patients. This was restrictive for patients who wanted to use the outside garden space for relaxation and leisure. There had not been any serious incidents reported relating to this risk.

Wards for people with a learning disability or autism

- Clinical information was difficult to locate on the electronic system. There were numerous risk assessments and care plans in different places on the electronic system. To overcome this staff kept summarised paper copies as well. This meant that key information could be missed, and staff may not always have all the information they needed to deliver care.

However:

- The service had enough nursing and medical staff, who knew the patients and received basic training to keep patients safe from avoidable harm. This was an improvement from earlier in the year when there was no Consultant Psychiatrist which meant they could not accept admissions for a period of eight weeks.
- Staff assessed and managed risks to patients and themselves well. Staff had the skills required to develop and implement good positive behaviour support plans and followed best practice in anticipating, de-escalating and managing challenging behaviour.
- Although there were no designated seclusion rooms at the bungalows we did find evidence showing that staff had secluded patients in the quiet rooms. This had happened on two occasions in a six-month period, and for the shortest possible time, 15 minutes and one hour ten minutes respectfully. These rooms had suitable furniture for this purpose and staff kept correct and timely records during the seclusion period. Ward staff participated in the provider's restrictive interventions reduction programme. Recording of incidents and the use of body maps had all improved since our last inspection.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it.
- The service had a good track record on safety. The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. However, there was very little evidence of sharing learning from serious incidents from other services.

Is the service effective?

Good ↑

Our rating of effective improved. We rated it as good because:

- Staff assessed the physical and mental health of all patients on admission. They developed individual care plans, which they reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected the assessed needs, were personalised, holistic and recovery-oriented. Staff had worked with the patient's participation leads to co-produce a new style of care plan that, wherever possible, supported patients to make decisions about their care for themselves. This was an improvement on our previous inspection.
- Staff had undertaken care planning training, they demonstrated that they understood the difference between Care Program Approach (CPA) and non-Care Program Approach (NCPA), and their roles and responsibilities as a care co-ordinator for CPA. This was an improvement on what we found during our last inspection.
- Staff used recognised rating scales to assess and record severity and outcomes. Outcome measures included Health of the Nations Outcome Score (LD); Malnutrition Universal Screening tool (MUST); Physiological and Early Warning Signs (NEWS); and Stool record charts. Staff participated in clinical audit, benchmarking and quality improvement initiatives. Quality improvements included action plans for establishing routine use of ECG, Transfer pathway; skill mix and staff establishment.

Wards for people with a learning disability or autism

- The team included or had access to the full range of specialists required to meet the needs of patients. Managers made sure they had staff with a range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their knowledge and skills. Managers provided both a corporate and local induction program for new staff.
- Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The team had effective working relationships with staff from services that would provide aftercare following the patient's discharge and engaged with them early in the patient's admission to plan discharge.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain patients' rights to them in a way they could understand and repeated this as and when required. Staff understood the provider's policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity. We saw evidence of best interest meetings having taken place.

However:

- Care planning information was not easy to find on the electronic record system. Staff confirmed that while all required information was on the system it was not always in the correct place, there were several care plans for each patient. To overcome this problem staff created their own hard copy summary care plans. This meant that some information may not always be available in a timely manner.

Is the service caring?

Good 

Our rating of caring improved. We rated it as good because:

- Staff treated patients with compassion and kindness. They respected patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.
- Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. Staff had been working with patients to coproduce new care plans based around "this is me". These care plans were considered alongside the standard electronic care plans. As part of care planning staff encouraged patients to discuss their likes and dislikes using visual cue cards to identify their hopes and fears. This was an improvement on our previous findings. Staff ensured that patients and their carers and family had easy access to independent advocates.
- Patient participation leads, people who were employed by the trust to ensure that patients and carers voices were heard at senior management level, had regular contact with the ward, the patients and their families and carers.
- Staff informed and involved families and carers appropriately. One carer told us staff had been particularly informative about why their relative behaved the way they did when they visited the ward and gave them some practical advice on how to respond to these behaviours. Another carer told us staff had explained the complexity of their relative's mental health condition and how they planned to ensure they would find the correct placement upon discharge, so that this did not break down as other placements had done.

Wards for people with a learning disability or autism

Is the service responsive?

Requires improvement 

Our rating of responsive went down. We rated it as requires improvement because:

- The design and safety of the bungalows did not support patient's treatment. Due to the high level of ligature points, mitigation for this was always that staff supervise and observe patients. This restricted patient's ability to develop enough confidence or coping skills to achieve their optimum level of independence or effective independent living skills. The décor was tired and dated and not homely.
- We were told of at least one patient who had to receive care out of service for a period of time due to the building at Walker Close not being appropriate to meet their needs. This patient was eventually brought back to the Trust. However, the design of the buildings used for learning disability inpatient services, meant this patient and one other, were cared for on alternative wards not designed to meet their individual needs.

However:

- Staff planned and managed discharge well. They liaised with services that would provide aftercare and were assertive in managing the discharge care pathway. As a result, patients did not have excessive lengths of stay and discharge was rarely delayed for other than a clinical reason.
- When patients were moved between services, such as from Walker Close to acute or PICU wards, staff maintained contact with patients during their stay on another ward and gave support to the receiving nursing staff. Staff continued to work with other agencies to locate appropriate aftercare placements and support, if transfer back to Walker Close was not possible.
- The food was of a good quality and staff made patients hot drinks and snacks at any time they requested them. The bungalows met the needs of all patients who used the service – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and the wider service.

Is the service well-led?

Good 

Our rating of well-led improved. We rated it as good because:

- Leaders had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed, and were visible in the service and approachable for patients and staff. Leadership within this core had recently been reviewed to address the leadership issues we found on our last inspection.
- Staff knew and understood the provider's vision and values and how they were applied in the work of their team. Though some staff told us they were anxious that the trust had been considering plans to close this core service. Staff felt the trusts vision for how people with learning disability and autism should be managed in the hospital setting appeared to be leaning towards more mainstream mental health hospital care.

Wards for people with a learning disability or autism

- Staff felt respected, supported and valued. They reported that training to enable them to carry out their roles effectively was readily available. Healthcare support workers told us managers encouraged them to be involved in clinical discussion about the people they cared for, and psychologists or the doctors facilitated education sessions to help them better understand their patients' behaviours.
- Staff reported that the provider promoted equality and diversity in its day-to-day work and in providing opportunities for career progression. They felt able to raise concerns without fear of retribution.
- Our findings from the other key questions demonstrated that governance processes operated effectively at ward level and that performance and risk were managed well.
- Managers were aware of the limitations that the environment at Walkers placed on them and their ability to offer a more therapeutic environment. We heard about a service review that was due to take place regarding this service, and which would be addressing this issue.
- Earlier in the year managers had taken the decision to close this ward for four weeks, as they did not have a suitably qualified responsible clinician to oversee the service. Managers told us this decision was discussed at length with the trust board, medical and senior multidisciplinary colleagues. Patients were transferred to other services and staff continued to support them and their nursing colleagues in the new environments. Some staff took advantage of this down time to refresh and update their training, while managers had opportunity to revise their admission criteria to ensure that they only took priority patients who they could work with effectively and safely within the limitations of their environment.
- Managers had access to the information they needed to provide safe and effective care and used that information to good effect.
- Staff engaged actively in local and national quality improvement activities. Managers had implemented the Green Light Tool Kit for learning disability, a range of practical materials including an audit framework designed to improve the quality of mental health services for adults with learning disability and autism.

However:

- Staff had not picked up a medicine error as part of their medicines check and audit. The error was that staff had administered, as required (PRN), medicines outside of the prescribed limits within a 24-hour period. We asked staff to complete an incident form in line with Trust policy. The administration of PRN medication was an issue reported on at a previous inspection, the trusts action plan for this was that the clinical team lead would ensure that PRN medication was being given appropriately, monitored and recorded.
- The new care groups had only just been implemented and some staff were not clear on how this would impact on their service or what it meant.

Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

Acute wards for adults of working age and psychiatric intensive care units

Requires improvement  

Key facts and figures

Norfolk and Suffolk NHS Foundation Trust provides acute and psychiatric intensive care support across twelve inpatient wards at five locations across Norfolk and Suffolk.

There are 206 beds in total.

Wards are located at:

Chatterton House, King's Lynn:

Samphire is a 16 bedded mixed sex acute admission ward.

Hellesdon Hospital, Norwich:

Thurne is a 15 bedded mixed sex admission and assessment ward.

Waveney is a 20 bedded female acute admission ward.

Glaven is a 20 bedded male acute admission ward.

Yare is a 16 bedded mixed sex acute admission ward (opened in September 2019).

Rollesby is a 10 bedded mixed sex psychiatric intensive care unit.

Coastlands-Northgate, Great Yarmouth:

Yarmouth Acute Ward is a 20 bedded mixed sex ward for acutely unwell patients.

Wedgwood House, Bury St Edmunds:

Northgate is a 21 bedded mixed sex acute admission ward.

Southgate is a 16 bedded mixed sex acute admission ward.

Woodlands Ipswich:

Avocet is a 21 bedded mixed sex acute ward.

Poppy is a 21 bedded mixed sex acute ward.

Lark is a 10 bedded mixed sex psychiatric intensive care unit.

This was an unannounced, comprehensive inspection.

The service was last inspected in September 2018 when an unannounced inspection took place to review actions required from previous inspections. The following requirement notices were issued to the Trust, following the inspection in September 2018 for the following regulatory breaches:

- Regulation 9 HSCA (RA) Regulations 2014 Person-centred care
- Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect
- Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment
- Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment

Acute wards for adults of working age and psychiatric intensive care units

- Regulation 16 HSCA (RA) 2014 Receiving and acting on complaints
- Regulation 17 HSCA (RA) Regulations 2014 Good governance
- Regulation 18 HSCA (RA) Regulations 2014 Staffing.

Before the inspection visit, we reviewed information that we held about these services and information requested from the trust.

During the inspection visit, the inspection team:

- spoke with 42 patients who were using the service and 11 carers
- spoke with the managers/leaders for each of the wards
- spoke with four modern matrons and a lead nurse
- spoke with 50 other staff members; including doctors, nurses, healthcare workers, occupational therapists, psychologists and pharmacists
- observed nine meetings and nine episodes of care
- reviewed documentation relating to the service, including policies and procedures and meeting minutes
- reviewed 78 records relating to patient risk assessments, physical health and care plans, and 62 patient prescription charts
- reviewed 37 records relating to episodes where staff secluded patients.

Summary of this service

Our rating of this service improved. We rated it as requires improvement because:

The summary for this service appears in the Overall Summary of this report.

Is the service safe?

Requires improvement  

Our rating of safe improved. We rated it as requires improvement because:

- Staffing and retention remained a challenge for the trust and wards frequently worked with fewer staff than planned. Staff described difficulties in meeting the demands of their roles.
- Staff were not completing hourly observations in line with trust policy. We found missing signatures on observation sheets and gaps in observations on four out of five wards that we checked. We could not be assured that observations were being completed correctly which could have an impact on patient safety.
- Staff did not always follow systems and processes when safely prescribing, administering, recording and storing medicines. Staff did not always keep accurate records of medicines administered, and sometimes medicines were administered above the limits of the prescription.
- Staff were not sufficiently supported with implementing the trust smoke free policy. Staff told us there was inconsistency in the way that managers implemented the policy

Acute wards for adults of working age and psychiatric intensive care units

- Staff had not completed daily and weekly checks of emergency equipment, including defibrillators and emergency grab bags, on five wards

However:

- All wards were safe, clean, well equipped, well furnished, well maintained and fit for purpose. The trust had addressed the inconsistent quality of environmental risk assessments and addressed the environmental risks found at the last inspection, including identification and mitigation of fixed ligature points, replacing unsafe soap and towel dispensers and installation of improved CCTV systems.
- Staff assessed and managed risks to patients and themselves well and followed best practice in anticipating, de-escalating and managing challenging behaviour. Ward staff participated in the provider's promoting positive practice programme and there had been a reduction in the number of episodes of restrictive practice across all wards.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it.
- Staff had easy access to clinical information and it was easy for them to maintain high quality clinical records.

Is the service effective?

Requires improvement

Our rating of effective stayed the same. We rated it as requires improvement because:

- There was not adequate psychology provision in Suffolk. Patients on some wards had not had access to adequate psychological therapies and support, in accordance with National Institute for Clinical Excellence guidelines, since December 2018.
- The appraisal rates for non-medical staff were lower than the trust target of 90% for seven wards.

However:

- Staff assessed the physical and mental health of all patients on admission. They developed individual care plans, which they reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected the assessed needs, were personalised, holistic and recovery-oriented. This was an improvement since the last inspection when care plans were generic and lacked the patient voice.
- Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.
- Managers made sure they had staff with a range of skills need to provide high quality care. They supported staff to update and further develop their skills. Managers provided an induction programme for new staff.
- Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain patients' rights to them.
- Staff supported patients to make decisions on their care for themselves. They understood the provider's policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

Acute wards for adults of working age and psychiatric intensive care units

Is the service caring?

Good 

Our rating of caring improved. We rated it as good because:

- Staff treated patients with compassion and kindness. They respected patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.
- Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to independent advocates.
- Staff informed and involved families and carers appropriately.

Is the service responsive?

Requires improvement 

Our rating of responsive improved. We rated it as requires improvement because:

- The planning of patient's discharge did not always contribute to people staying out of hospital. The total number of readmissions within 28 days had not changed significantly since the last inspection from 253 to 245 readmissions. The number of readmissions to any ward had decreased on four wards but had increased on six wards.
- Staff did not always clearly communicate when patients were transferred between wards in Suffolk.

However

- The design, layout, and furnishings of the ward/service supported patients' treatment, privacy and dignity. Each patient had their own bedroom and could keep their personal belongings safe. There were quiet areas for privacy.
- The food was of a good quality and patients could make hot drinks and snacks at any time.
- The service met the needs of all patients who used the service – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.
- The trust had developed a system-wide action plan and opened a new ward to address the high number of out of area placements which was a concern at the last inspection. As of October 2019, the trust had 19 out of area placements which was a significant reduction since March 2019.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and the wider service.

Is the service well-led?

Requires improvement 

Our rating of well-led improved. We rated it as requires improvement because:

Acute wards for adults of working age and psychiatric intensive care units

- Managers did not have effective oversight of medicines management and checking of emergency equipment. We found errors with medicine management and checking of emergency equipment on all wards across the acute service.
- Managers did not provide consistent support to staff to implement the trust smoke free policy.
- Managers did not have effective systems in place to ensure staff were observing patients in accordance with trust policy.
- The trust did not provide opportunities for staff across all disciplines to meet together and share learning.

However:

- Leaders had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed, and were visible in the service and approachable for patients and staff.
- Staff knew and understood the provider's vision and values, how they were applied in the work of their team and demonstrated them in their day to day work.
- Most of the staff we spoke with felt that the culture of the trust was improving. Staff felt more listened to, more positive about working for the trust and that senior managers were more visible. Staff told us they felt empowered to make changes and the new management structure was working well.
- Our findings from the other key questions demonstrated that governance processes operated effectively at ward level and that performance and risk were managed well.
- Ward teams had access to the information they needed to provide safe and effective care and used that information to good effect.
- Staff engaged actively in local and national quality improvement activities.

Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

Wards for older people with mental health problems

Good ➔➔

See guidance note ICS 1 – then delete this text when you have finished with it.

Key facts and figures

Norfolk and Suffolk NHS foundation Trust provides inpatient care to older patients in seven wards at four locations.

At Julian Hospital, Norwich in the Norfolk area there are four wards for older patients.

- Sandringham Ward is an acute admissions unit. It provides care and treatment to men and women with a functional mental health diagnosis. It had 16 beds, at the time of inspection and there were 16 patients.
- Beach ward is an acute admission ward for men with dementia. It offers assessment, and treatment for patients with acute care needs. It had 13 beds, at the time of inspection and there were 13 patients.
- Rose Ward is a mixed gender, sub-acute treatment ward for men and women experiencing dementia. It had 13 beds, at the time of inspection and there were 13 patients.
- Reed Ward is an acute admission ward for women with dementia. It offers assessment and treatment for patients with acute care needs. It had 12 beds, at the time of inspection and there were 12 patients.

At Carlton Court, Lowestoft in the Great Yarmouth and Waveney area there is one ward, Laurel Ward.

- Laurel Ward is a mixed gender admission and treatment unit. It provides care and treatment to men and women with dementia. The ward had 11 beds. At the time of inspection there were 10 patients.

At Ipswich hospital in the East Suffolk area, there is one ward known as the Willows, it is divided into two distinct and separate areas for older adults.

- The Willows is a mixed gender admission, assessment and treatment unit. It provides assessment, care and treatment for men and women with functional mental health diagnosis and dementia. The ward had 21 beds, 11 of these beds where for patients experiencing dementia, and 10 beds for patients experiencing functional mental illness.

At West Suffolk Hospital, Bury St Edmunds there is one ward for older patients known as Abbeygate, divided into two wards known as Laurel and Maple.

- Laurel Ward is a mixed gender acute admission and treatment ward for older people with dementia. It has seven beds, and at the time of inspection there were seven patients.
- Maple Ward is a mixed gender, acute admission and treatment ward for older people with functional mental illness diagnosis. It has 10 beds, and at the time of inspection there were 10 patients.

The last comprehensive inspection of this core service was in September 2018. At that time, we found the service had breached the following regulations: -

Regulation 12(2)a,b.

The trust must ensure they assess the risks to health and safety of patients while they are receiving treatment and care and do all that is reasonably practical to mitigate any such risks, including ligature reduction work on the wards.

The trust must ensure that they assess prevent and reduce the risk associated with the control and spread of, infections, including those that are health care associated.

Wards for older people with mental health problems

Regulation 17(2)e

The Trust must ensure they seek and act on feedback from relevant persons and other persons in the services provided in the carrying on of the regulated activity, for the purposes of continually evaluating and improving such services.

We reviewed the breaches in detail at this inspection and found that the provider had taken actions to address the breaches and improve the care and treatment provided to patients.

The inspection of older adult inpatient wards took place between 8 and 18 October 2019. During the visits the inspection team:

- visited all seven wards and looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with 14 patients who were using the service
- spoke with 14 carers of people using the service
- interviewed the managers or acting managers for each of the wards and two senior managers
- spoke with 32 other staff members; including nurses, doctors, occupational therapists, support workers and an advocate
- attended and observed two handover meetings two multidisciplinary clinical meetings, one board-round and two safety huddles
- looked at 34 care and treatment records of patients
- carried out a specific check of 45 medication charts
- Looked at a range of policies, procedures and other documents relating to the running of the service.

Summary of this service

Our rating of this service stayed the same. We rated it as good because:

The summary for this service appears in the Overall Summary of this report.

Is the service safe?

Good  

Our rating of safe stayed the same. We rated it as good because:

- All wards were safe, generally clean, well equipped, well furnished, well maintained and fit for purpose.
- The service had enough nursing and medical staff, who knew the patients and received basic training to keep patients safe from avoidable harm
- Staff assessed and managed risks to patients and themselves well and followed best practice in anticipating, de-escalating and managing challenging behaviour. Staff used restraint and seclusion only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme.

Wards for older people with mental health problems

- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it.
- Staff had easy access to clinical information and it was easy for them to maintain high quality clinical records – whether paper-based or electronic.
- The wards had a good track record on safety. The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

However;

- We inspected the male corridor of Maple ward, Abbeygate and were struck by very offensive odours emitting from a patient's bedroom. The contract cleaning team had been instructed not to clean if the patient was in his room, this had not been relayed to the nursing team. We raised this with the ward manager, who arranged for an immediate deep clean of the room. This was completed at the time of our inspection.
- There were gaps in medicines administration records and clinic room checks on Abbeygate ward which meant that medicines related policies were not being followed.

Is the service effective?

Good ➔➔

Our rating of effective stayed the same. We rated it as good because:

- Staff assessed the physical and mental health of all patients on admission. They developed individual care plans, which they reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected the assessed needs, were personalised, holistic and recovery-oriented.
- Staff provided a range of care and treatment interventions suitable for the patient group and consistent with national guidance on best practice. They ensured that patients had good access to physical healthcare and supported patients to live healthier lives.
- Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.
- The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers made sure they had staff with a range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.
- Staff from a wide range of different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The ward teams had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain patients' rights to them.

However;

Wards for older people with mental health problems

- We reviewed 34 patient records we saw capacity assessment records relating to hospital admission and treatment, but not best interest decision records, where patients did not have capacity. We looked at 16 records where medication was administered covertly, we saw that staff had assessed capacity and were able to locate evidence of best interest's discussion in narrative of patient notes, but not on the required form.

Is the service caring?

Good ➔➔

Our rating of caring stayed the same. We rated it as good because:

- Staff treated patients with compassion and kindness. They respected patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.
- Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to independent advocates.
- Staff informed and involved families and carers appropriately.

Is the service responsive?

Good ➔➔

Our rating of responsive stayed the same. We rated it as good because:

- Staff told us that a bed was usually available when needed and that patients were not moved between wards unless this was for their benefit. Discharge was rarely delayed for other than clinical reasons. The service had dedicated bed managers allocated to each ward who liaised between the ward and community services and providers. The service also participated in the "red to green" initiative which aimed to facilitate safe and timely discharge from hospital.
- The design, layout, and furnishings of the wards generally supported patients' treatment, privacy and dignity. Each patient had their own bedroom with an en-suite bathroom and could keep their personal belongings safe. There were quiet areas for privacy.
- The food was of a good quality and patients had access hot drinks and snacks at any time.
- The service met the needs of all patients who used the service. Staff helped patients with communication, advocacy, cultural and spiritual support.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and the wider service.

However;

- The environment on Laurel ward, Abbeygate, did not meet dementia friendly environment guidance.

Is the service well-led?

Good ➔

Wards for older people with mental health problems

Our rating of well-led improved. We rated it as good because:

- Leaders had the skills, knowledge and experience to perform their roles and were visible in the service and approachable for patients and staff.
- Staff knew and understood the provider's vision and values and how they were applied in the work of their team.
- Staff felt respected, supported and valued. They reported that the provider promoted equality and diversity in its day-to-day work and in providing opportunities for career progression. They felt able to raise concerns without fear of retribution.
- Ward teams had access to the information they needed to provide safe and effective care and used that information to good effect.
- Staff engaged actively in local and national quality improvement activities.

However;

- Managers did not ensure there were appropriate levels of cleanliness and infection control measures on Maple Ward, Abbeygate.
- Managers did not ensure the environment on Laurel ward, Abbeygate met dementia friendly environment guidance.
- Managers did not ensure that staff recorded capacity and best interest decisions on the correct document named in the trust policy.

Areas for improvement

We found the following areas for improvement:

We found areas for improvement in this service. See the Areas for Improvement section above.

Community-based mental health services of adults of working age

Requires improvement **Requires improvement**

Key facts and figures

Norfolk and Suffolk foundation Trust provides community-based mental health services for adults of working age.

This service was last inspected in November 2018 and received an overall rating of inadequate, with inadequate for safe, responsive and well-led, requires improvement for effective and a rating of good for caring. A further focussed inspection was carried out in May 2019.

Community-based mental health services for adults of working age provided support to patients and their families and carers living in Norfolk and Suffolk experiencing moderate to severe mental health problems. Staff visit patients in their own homes, at community hubs and GP surgeries.

Since the inspection in 2018, the trust had restructured the senior managers into five care groups for community services across the trust and there were now four care group leads for each community core service. These leads comprised of a people participation lead, service director, lead nurse and clinical director.

In Norfolk the services were known as Community Mental Health Teams (CMHT) and in Suffolk as Integrated Delivery Teams (IDTs). In Norfolk, the CMHT comprised of professionals solely working in the adult community mental health pathway. Those patients assessed to require a high level of contact were reviewed daily using the FACT approach – Flexible Assertive Community Treatment. In Suffolk, the IDTs comprised of professionals from a range of pathways including, but not solely, adult community mental health care. The adult IDTs divided into two teams, Enhanced Care Pathway (ECP), and the adult pathway in most of the IDTs we visited. However, Coastal IDT had merged these pathways and some other IDTs were due to do this shortly. The ECP pathway provided short-term intervention, with an emphasis on developing community networks and reintegration to reduce isolation. This service worked mainly with patients with moderate depression, anxiety and personality disorders. The adult pathway provided longer term intervention for patients aged 25 years and over, with severe and enduring mental health problems, including patients over 65 years if clinically appropriate.

In Suffolk a Section 75 partnership agreement with the Local Authority was in place. This is an arrangement between a local authority and an NHS body related to the National Health Services Act 2006. There was no similar arrangement for Norfolk.

Services received their referrals via the ‘single point of access’ team in Norfolk and the ‘access and assessment team’ in Suffolk. Referrals were also received from acute teams if the patient had been seen by inpatient or crisis services.

In our November 2018 inspection, we found breaches of the following:

• Regulation 12 HSCA (RA) Regulations 2014 Safe care and Treatment

• Regulation 17 HSCA (RA) Regulations 2014 Good Governance

Although we found improvements at this inspection, we found that this core service had not fully addressed all actions from our inspection in November 2018. We found continued breaches of the following:

• Regulation 12 HSCA (RA) Regulations 2014 Safe care and Treatment

• Regulation 17 HSCA (RA) Regulations 2014 Good Governance

The trust is registered for the following regulated activities:

• Assessment or medical treatment for persons detained under the Mental Health Act 1983

Community-based mental health services of adults of working age

• Treatment of disease, disorder or injury.

The inspection team visited 11 community teams across Norfolk and Suffolk between 07 October and 18 October. During the inspection we visited the following teams and look at all five key questions:

• Bury North IDT

• Bury South IDT

• Coastal IDT

• Great Yarmouth CMHT

• Ipswich IDT

• Long Term Treatment team

• North Norfolk CMHT

• Norwich City CMHT

• South Norfolk CMHT

• Waveney adult CMHT

• West Norfolk CMHT

Our inspection of this core service was short announced (staff knew we were coming 5 days prior to our visit) to ensure that everyone we needed to talk to was available. Before the inspection visit, we reviewed information that we held about these services and information requested from the trust. We also asked a range of other stakeholders for information and sought feedback from patients and carers at focus groups.

We inspected all five key questions for this core service.

During the inspection visit, the inspection team:

- visited 11 teams, looked at the quality of the care and observed how staff were caring for patients
- spoke with 22 managers including team managers
- interviewed 67 staff including nurses, occupational therapists, psychiatrists, psychologists, health care support workers, administration, peer support workers and carers leads
- reviewed 57 care records of patients
- spoke with 23 patients who were using the service
- spoke with 15 carers of patients who were using the service
- attended and observed 10 meetings and activities including multidisciplinary meetings and telephone support to patients
- reviewed 32 treatment cards
- carried out a specific check of the medication management in all teams looked at policies, procedures and other documents relating to the running of the service.

Summary of this service

Community-based mental health services of adults of working age

The summary for this service appears in the Overall Summary of this report.

Is the service safe?

Requires improvement ↑

Our rating of safe improved. We rated it as requires improvement because:

- Staff had not always updated risk assessments routinely or after incidents in all teams. This was identified as a concern at our previous inspection. We found staff had not updated risk assessments routinely or after incidents across all teams in 20 out of 57 records reviewed. We found out of date risk assessments at North Norfolk CMHT and Bury South IDT by up to four years. We found three risk assessments dated from September 2015 to April 2018 in North Norfolk CMHT, one risk assessment was dated April 2017 in Bury South. We found one patient who had been referred to Norwich City CMHT in January 2019 and did not have a risk assessment or care plan present.
- Staff at North Norfolk CMHT had not ensured medical equipment had been regularly checked. We also found this at our previous inspection. North Norfolk CMHT did not complete first aid box checks. Great Yarmouth CMHT had items out of date in the first aid box, however, replacements had been ordered before our visit. Bury North IDT had no stethoscope or ECG machine. The blood pressure machine was due for calibration in August 2019 and no update on this was present. We found West Norfolk CMHT stored cups and coffee in the clinic room. Waveney CMHT and North Norfolk CMHT did not routinely change the code to the clinic room after staff had left therefore there was a risk of unauthorised entry from previous staff.
- Staff at Great Yarmouth CMHT did not always sign medications in and out when visiting patients in the community. At Bury South IDT staff did not routinely carry out medication stock checks and we found medications unaccounted for. All IDT teams at the Bury South location used the clinic but there appeared to be no oversight of the clinic room management. Although North Norfolk CMHT were carrying out medication stock checks, we found a depot injection had expired in March 2018. This meant we could not be confident processes designed to provide assurance were effective. At North Norfolk CMHT staff could not show us spare keys for the medication cabinet. This meant that if the keys were misplaced, staff would not be able to access medicines stored in the medication cabinet.
- The ligature risk assessment at Bury South IDT did not capture all risks in each room. Environmental plans were also not always printed in colour so staff would not easily know which room was RAG rated.
- The staffing establishment had not kept pace with the number of referrals made into the service. At South Norfolk CMHT the staffing establishment was set for 750 open referrals, but the team had 1111 open referrals at the time of inspection. This impacted on the number of staff the trust was able to employ.
- At Norwich City CMHT, caseloads were very high, and the allocation of new referrals was inequitable across the staff team. Caseloads varied from 11 to 70 averaging 49. This was higher than at our previous inspection. This was above the Royal college of Psychiatrists Accreditation for Community Mental Health Services Standards for Adult Community Mental Health Services, which say full-time care co-ordinators should have a caseload of no more than 35 (reduced pro-rata for part-time staff). The earliest opportunity staff had of discussing their case load was at monthly management supervision sessions. Managers knew staff were unhappy about this situation but had no plans to address it.
- Mandatory training for Safeguarding Adults Level 3 was lower than the trusts target for compliance. Norwich City CMHT team 3 was 73%, Waveney adult community team was 70%, Bury South IDT team was 66% and at Ipswich IDT it

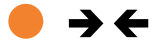
Community-based mental health services of adults of working age

was 33%. These were all below our target of 75% compliance. We found the Safeguarding Children Level 3 training at Waveney adult community team and Bury North IDT it was 73%, at South Norfolk CMHT south east team it was 68%, at Ipswich IDT it was 67%, at Bury South IDT it was 59%, at Great Yarmouth CMHT and North Norfolk north west team it was 53% and at Norwich City CMHT team 3 it was 50%. These were all below our target of 75% compliance.

However:

- Staff assessed and managed risks to patients and themselves. They responded promptly to sudden deterioration in a patient's health. When necessary, staff worked with patients and their families and carers to develop crisis plans. Staff monitored patients on waiting lists to detect and respond to increases in level of risk. Staff followed good personal safety protocols.
- The teams had a good track record on safety. The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.
- Most clinical premises where patents received care were safe, clean, well equipped, well furnished, well maintained and fit for purpose.

Is the service effective?

Requires improvement 

Our rating of effective stayed the same. We rated it as requires improvement because:

- Recording of physical health was poor across most adult community teams. We reviewed 49 care records in this area and 30 did not have physical health assessments recorded and 25 had no evidence of ongoing physical health monitoring. At Waveney CMHT we saw evidence of recording physical health checks on paper, but this was not transferred to their electronic system.
- The waiting list for psychological therapies was lengthy across all community sites we visited. Details of this can be found in the evidence appendix. Staff told us they did not feel there was enough psychology staff which impacted on rising caseloads.
- Not all care plans were reviewed regularly or up to date. We reviewed 57 care and treatment records. We found two patients at Norwich City CMHT and one patient at North Norfolk CMHT did not have a care plan present.
- Supervision rates were not meeting the trusts compliance rate. Data provided by local managers ranged from 47% in the Norwich City team 3 to 95.2% in North Norfolk CMHT. The trust's target rate for supervision compliance is 90%. Details of this can be found in the evidence appendix.

However:

- Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.
- Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The teams had effective working relationships with relevant services outside the organisation.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice.

Community-based mental health services of adults of working age

- Staff supported patients to make decisions on their care for themselves. They understood the provider's policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

Is the service caring?

Good ➔➔

Our rating of caring stayed the same. We rated it as good because:

- Staff treated patients with compassion and kindness. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.
- Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to advocates when needed.
- Staff informed and involved families and carers appropriately.

Is the service responsive?

Good ↑

Our rating of responsive improved. We rated it as good because:

- The service was easy to access. Its referral criteria did not exclude patients who would have benefitted from care. Staff assessed and treated patients who required urgent care promptly and patients who did not require urgent care did not wait too long to start treatment. This had improved since our previous inspection. Staff followed up patients who missed appointments.
- The service met the needs of all patients including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff. This had improved since our previous inspection.

Is the service well-led?

Requires improvement ↑

Our rating of well-led improved. We rated it as requires improvement because:

- There was a disconnect between some staff and senior management in Suffolk. Some community service staff within Suffolk teams said that they felt communication and visibility of higher senior management was poor. This was the same as our previous inspection. Staff across all community adult services said that a lot of things had changed and were continuing to change but it was still early days. Staff felt the introduction of the new care group leads may improve this connection, but they were all very new to post so hadn't seen much impact yet. Staff told us the care group leads were more accessible than higher senior managers. However, some staff felt that there was still a lack of cascading much needed information to move forward and were not sure of the impact this would have on their future, their jobs and the services.

Community-based mental health services of adults of working age

- Managers at Norwich City CMHT had little oversight of caseload allocation of incoming referrals. The referral process within this team meant that the duty worker allocated patients to care coordinators and not managers, as occurred in all the other community services we visited. In Norwich City staff were aligned to the GP practices and new referrals were allocated to staff according to GP surgery. This meant that some staff had much higher caseloads than their colleagues and managers did not have oversight of the allocation process. The first chance staff were able to officially address this with managers was in monthly caseload management meetings. In this team some staff had caseloads above the maximum of 35 recommended by the Royal College of Psychiatry. Seventeen out of 41 staff had caseloads higher than 41. Eleven out of 41 staff had caseloads higher than 51. Caseloads across the whole of Norwich City CMHT varied from 11 to 70 averaging 49. Managers in this team had decided to have higher caseloads of patients to mitigate the need for a waiting list. Managers were aware that staff did not feel comfortable with this practice, however we did not hear how they intended to address the issue.
- There was inconsistency with what was placed on the risk register. Whilst demand exceeding capacity was on the risk register in Norfolk community services this also impacted on Suffolk community services, but it was not identified as a concern. Managers told us the staffing establishment was based on a significantly lower number of open referrals to their services than the number of open referrals they have. For example, South Norfolk CMHT the staffing establishment was set for 750 open referrals, but the team actually had 1111 open referrals at the time of inspection. Managers felt the staffing establishment had not kept pace with the number of referrals into the services and this impacted on staff caseloads, the services they could provide to patients and waiting lists.

However:

- Managers had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed, and were visible in the service and approachable for patients and staff. Staff felt respected, supported and valued by local managers. They felt able to raise concerns without fear of retribution.
- Staff knew and understood the provider's vision and values and how they were applied in the work of their team.
- Staff collected analysed data about outcomes and performance and engaged actively in local and national quality improvement activities.

Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

Specialist community mental health services for children and young people

Inadequate 

Key facts and figures

Norfolk and Suffolk NHS Foundation Trust provides specialist community mental health services for children and young people for patients aged 0 to 25 years throughout Norfolk and Suffolk under one registered location: Hellesdon Hospital.

We inspected 18 teams across the specialist community mental health services for children and young people:

Suffolk

- **Emotional Wellbeing Hub**, Landmark House, Ipswich (0-25 years). Suffolk multi-agency triage team for referrals.
- **Ipswich team**, Mariner House, 43 Handford Road, Ipswich IP1 2GA. Teams include: 0-14 years and 14-25 years youth teams.
- **Bury South team**, G Block, Hospital Road, Bury St. Edmunds, IP33 3NR. Teams include: 0-14 years, 14-25 years youth and the West Suffolk ADHD team under 18 years teams. Ickworth Lodge treatment centre is on site.
- **Bury North team**, Newmarket Hospital, Exning Road Newmarket CB8 7JG. 14-25 years youth team.
- **Coastal team**, Foxhall Road, Ipswich IP3 8LS West Suffolk 14-25 years youth team, Walker Close treatment centre is on site.
- **Central team**, Haymills House, Station Road East, Stowmarket IP14 1RF 14-25 years youth team.

Norfolk

- **Central Norfolk Child, Family and young Person Service,** St Stephens Road, Norwich NR1 3RE. Teams include: 14-25 years youth and crisis teams. Mary Chapman House Hotblack Road Norwich, NR2 4HN 0-14 years team.
- **Great Yarmouth and Waveney**, **Child, family and young people's service**, Northgate Hospital, Northgate Street, Great Yarmouth NR30 1BU Teams include: 0-14 years, 14-25 years youth and crisis teams. Silverwood treatment centre is on site.
- **West Norfolk Child, family and young people's service**, Thurlow House, Kings Lynn PE30 Teams include: 0-14 years, 14-25 years youth and crisis teams.

At this inspection we found that this core service had not fully addressed actions from our 2018 inspection. We found breaches of:

- Regulation 12 HSCA (RA) Regulations 2014 Safe care and Treatment
- Regulation 17 HSCA (RA) Regulations 2014 Good governance
- Regulation 18 HSCA (RA) Regulations 2014 Staffing
- Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment.

The trust had addressed some findings of the inspection in 2018 and was no longer in breach of:

- Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints

The CQC have registered the location Hellesdon Hospital (which this core service is under) for the following regulated activities:

Specialist community mental health services for children and young people

- Assessment or medical treatment for persons detained under the Mental Health Act 1983
- Treatment of disease, disorder or injury

Our inspection of this core service in October 2019 was unannounced (staff knew we were coming at short notice).

Before the inspection visit, we reviewed information that we held about these services and information requested from the trust.

The inspection team visited community teams on 8, 9, 10, 15, 16 and 17 October 2019.

During the inspection visit, the inspection team:

- visited teams to look at the environment
- had feedback from 19 patients who were using the service
- had feedback from 44 carers of patients who were using the service
- spoke with 20 managers of the service
- spoke with 60 staff including nurses, support workers, doctors, occupational therapists, peer support worker,
- psychologists, therapists, social workers and administration staff
- Spoke with three other professionals from external agencies
- Reviewed stakeholder feedback about the service
- observed eight staff multi-disciplinary team meetings
- observed six episodes of care
- reviewed 73 patient care and treatment records including, referral information, risk assessments and care plans.
- reviewed 24 staff records including supervision, appraisal and training records
- reviewed a range of policies, procedures and other documents relating to the running of the service.

Summary of this service

Our rating of this service stayed the same. We rated it as inadequate because:

The summary for this service appears in the Overall Summary of this report.

Is the service safe?

Requires improvement  

Our rating of safe improved. We rated it as requires improvement because:

- The trust had not fully addressed all issues reported at previous inspections.

Specialist community mental health services for children and young people

- The trust had not ensured there were adequate staff available to meet the needs of the children and young person service and reduce the patient waiting lists for triage, assessment and treatment, since identified at our last inspection in 2018. Forty of 60 staff (67%) and nine of 20 (45%) managers we spoke with told us of staffing problems in their teams. Eleven of 18 teams we visited reported staffing vacancies and issues with not being able to recruit or gain agency staff to meet shortfalls.
- Improvements were still needed to ensure a safe and clean environment. Staff were not completing checks of automated external defibrillators at South Bury IDT and Ickworth Lodge locations as per the trust standard. We found examples where teams were not routinely monitoring cleaning of rooms and equipment. The trust had not completed accurate ligature assessments at South Bury, Great Yarmouth, Waveney and West Norfolk teams, which captured all potential risks. This meant staff would not be aware of all areas which needed more supervision.
- Staff had not fully completed or updated 28 patients (39%) comprehensive risk assessments. Staff in Norfolk and Suffolk still had different systems for assessing and monitoring risks for patients awaiting assessment.
- We found risks to patients' safety as staff did not always identify and report safeguarding concerns. HaverHill, Sudbury satellite clinics and North Bury did not have separate children waiting areas.

However:

- The trust had improved the quality of their risk registers with more identification of the service risks.
- The trust had increased the Emotional Wellbeing Hub staff establishment to include two additional band seven staff.
- The trust had given staff information for lone working to help keep them safe.
- Staff had systems in place to clean toys.
- Where managers gave us data on site teams had achieved 75% or above compliance with mandatory training.

Is the service effective?

Requires improvement  

Our rating of effective went down. We rated it as requires improvement because:

- The trust had not ensured that all staff had regular supervision and appraisal to ensure they had the right skills and knowledge for their role. Trust data for September 2019 showed six teams had achieved less than 75% staff compliance for appraisals, five teams did not have regular line management supervision and four teams did not have regular clinical supervision.
- Staff did not always complete a comprehensive mental health assessment of each patient who were receiving treatment as 15 care plans (21%) across teams needed improvements. Care notes across teams did not always implicitly link to care plans.
- Not all teams had a range of skilled staff, due to staff vacancies. Two stakeholders and two professionals stated that multi-disciplinary working between teams and external agencies could be improved.

However:

Specialist community mental health services for children and young people

- Staff supported patients to make decisions on their care for themselves proportionate to their competence. They understood how the Mental Capacity Act 2005 applied to young people aged 16 and 17 and the principles of Gillick competence as they applied to people under 16. Staff assessed and recorded consent and capacity or competence clearly for patients who might have impaired mental capacity or competence. Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice.
- Staff provided a range of treatment and care for patients based on national guidance and best practice. We found examples of staff using the 'THRIVE' integrated, person-centred and needs-led approach. They supported patients to live healthier lives.
- Staff used recognised rating scales to assess and record severity and outcomes such as Routine Outcome Measures (ROMS).

Is the service caring?

Requires improvement ↓

Our rating of caring went down. We rated it as requires improvement because:

- During inspection, we found that thirteen of 19 patients (68%) and 21 of 45 (47%) carers gave negative feedback about the support provided. Feedback themes included a lack of support when they contacted teams for help during a crisis and a lack of information or communication. However, trust data indicated that 82% of patients felt they had a positive experience of the service.
- Teams were unable to show how they involved patients and parents and carers in the design and delivery of the service.

However:

- Staff treated patients with compassion and kindness, respected their privacy and dignity, and understood the individual needs of patients. They actively involved patients and families and carers in care decisions. Seventeen of 19 patients (89%) and 35 of 44 carers (78%) gave positive feedback about how caring staff were, often individuals and how staff were responsive and supported patients to manage their mental health.
- From a review of 73 care records, we saw that staff involved patients in care planning and risk assessment. When appropriate, staff involved families and carers in assessment, treatment and care planning. They supported or signposted carers for assessments.
- The emotional wellbeing hub had a peer support worker whose role was to contact families to give support, offer appointments and share information about community resources
- Youth managers said they involved patients in interviews for new staff.

Is the service responsive?

Inadequate →←

Our rating of responsive stayed the same. We rated it as inadequate because:

- The trust had not fully ensured since our 2018 inspection that patients were receiving the service they needed in a timely way. We found many patients were waiting longer than expected for triage, assessment and treatment. Trust data as of 21 October 2019 showed there were 421 patients currently awaiting assessment. One patient had been

Specialist community mental health services for children and young people

waiting for a 'routine' appointment since March 2019. As of 21 October 2019, there were 223 patients waiting for treatment. Two patients had been waiting since February 2019. Central Norfolk Youth team had the highest number of patients waiting for treatment with 70. Trust data for April to September 2019 sent post inspection showed 16 occasions where the trust had breached their commissioned targets.

- The emotional wellbeing hub was the single point of access to Suffolk services. Whilst staff had reduced their waiting list backlog for telephone triage from 1100 (in April 2019) to 389, this was only a decrease by five patients since our 2018 inspection which had been 394. In the 12-month period between inspections, 39% of referrals had been seen within the trust's target of 10 working days and 150 patients had waited over 10 days. One patient was waiting 73 days. However, the more recent monthly figures in September and October 2019, demonstrated a slight improvement to 50%.
- Staff could not always respond as quickly as they wanted to patient referrals due to workload pressure and lack of resources. We found that twenty-two staff and managers (28%), three stakeholders and two other professionals said that there were challenges with access to services and long waiting times, particularly in Suffolk.
- The trust had not ensured that information was easily available about how they met patients, carers and those with diverse needs. Most teams did not have information leaflets available to give to patients or carers about their service. Staff at Ipswich youth did not record informal complaints and there was no evidence of how these were resolved.

However:

- The backlog of patients waiting for treatment had reduced. The trust had implemented a weekly 'service user tracker list' meeting and system to monitor patients waiting.
- Several teams had tried to make more child friendly environments to help children and young people feel more at ease. Great Yarmouth and Waveney teams used Silverwood which had more bright colourful chairs and cartoon characters on walls.
- Staff supported patients to access to education and work opportunities, including their recovery college.
- The trust had involved patients and staff in the development of Kingfisher ward their mother and baby unit.

Is the service well-led?

Inadequate 

Our rating of well-led stayed the same. We rated it as inadequate because:

- The trust had not ensured effective leadership of this core service in a timely manner to fully address risks identified at previous inspections such as for staffing, improving waiting times for patients, staff appraisal and supervision and environmental risks. Leaders had not ensured that structures, processes and systems of accountability for the performance of the service were developed and embedded. Staff at all levels were not clear about their roles and accountabilities. Fourteen of 20 managers we met across teams were new in post. It was apparent they had not been developed and upskilled to take on their new responsibilities. For example, they did not all have easy access to key information about their team performance to show us when we visited. Some staff in teams did not know what was happening in the trust, particularly in Suffolk.
- Most staff told us they felt under pressure to do more without much additional resources. We found pockets of low staff morale, for example, in Ipswich, South Bury and Central Norfolk teams.

Specialist community mental health services for children and young people

- Managers did not always work closely with other local healthcare services and organisations (schools, public health, local authority, voluntary and independent sector) to ensure that there was an integrated local system that met the needs of children and young people living in the area, as we received concerns from three stakeholders.
- Team managers were not able to demonstrate at local level that they engaged well with patients, staff, equality groups, the public and local organisations to plan and manage appropriate services despite trust assurances that this was in place.

However:

- The trust had made extensive changes to the leadership and were changing their systems for monitoring, assessing and mitigating the risks to patients. The trust now had two care groups for children families and young people services across the trust to give clearer accountability and oversight of this core service. The trust had improved the quality of their risk registers with more identification of the service risks.
- The culture of children and young people's services had changed since our 2018 inspection as staff told us their morale was improving. A lot of staff said it was "early days" but said they were hopeful that there were meaningful changes taking place and things were getting better. They were proud of the care they gave despite the challenges they had.
- North Bury team was involved with the University of East Anglia in DECRYPT (Delivery of Cognitive Therapy for Young People after Trauma), a randomised controlled trial aimed at supporting children and young people aged eight to 17 years who have developed post-traumatic stress disorder) as a result of exposure to multiple traumas. The trust was involved in a research programme; brief education supported treatment (BEST) for adolescent borderline personality disorder.

Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

Community-based mental health services for older people

Good 

Key facts and figures

Community mental health services for older people offer assessment and intervention services for older people with dementia and other mental health conditions associated with later life. The service is made up of sixteen teams across Norfolk and Suffolk.

The dementia intensive support teams (DISTs) and intensive older people's services (IOPS) offer assessment and intensive support to people with dementia or suspected dementia or anyone with complex needs.

The dementia and complexity in later life (DCLL) teams offer assessment, diagnosis and treatment in the community for adults experiencing memory problems, cognitive impairment, dementia and other mental health issues associated with later life.

In Norfolk and Great Yarmouth and Waveney, these are separate teams while in East and West Suffolk the CLL pathway is provided through five integrated delivery teams (IDTs) in Ipswich, Stowmarket, Bury St Edmunds and Newmarket. Memory clinics operate alongside the CLL teams or pathway.

The trust is registered for the following regulated activities:

Assessment or medical treatment for persons detained under the Mental Health Act 1993

Diagnostic and screening procedures

Treatment of disease, disorder or injury

The service was last inspected in September 2018 and requirement notices were issued in relation to:

- Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment
- Regulation 18 HSCA (RA) Regulations 2014 Staffing

We found that the trust had addressed the issues from the previous inspection. Environmental risk assessments including ligature risks were in place across the service, staff had access to emergency medication where needed and the trust had actively recruited psychologists and occupational therapists into teams.

The inspection team visited 12 community teams across Norfolk and Suffolk between 07 October and 18 October. During the inspection we visited the following teams:

East Suffolk Dementia and intensive support team

East Suffolk Integrated Delivery Team

Coastal Suffolk Integrated Delivery Team

Central Suffolk Integrated Delivery Team

West Suffolk Dementia and Intensive support Team

Central Norfolk Dementia and Complexity in Later Life and memory assessment team.

Great Yarmouth Older Peoples services

Central Norfolk Intensive older peoples service

Community-based mental health services for older people

West Norfolk Dementia and Complexity in Later Life Team

West Norfolk Dementia and Intensive support Team

Waveney Dementia and Intensive support Team

Central Norfolk Dementia and Complexity in Later Life Team

Our inspection was announced at short notice (staff knew we were coming five days before we arrived) to ensure that everyone we needed to talk to was available. We inspected the whole service and looked at all key questions.

Before the inspection visit, we reviewed information that we held about these services and information requested from the trust.

During the inspection visit, the inspection team:

- visited 12 teams in 11 locations;
- spoke with 15 managers;
- spoke with 16 patients and 25 carers who were using the service;
- spoke with 41 members of staff including nurses, assistant practitioners, psychologists and occupational therapists;
- spoke with eight medical staff including consultant psychiatrists;
- Reviewed 83 patient care records; and
- Observed 13 episodes of care.

Summary of this service

Our rating of this service improved. We rated it as good because:

The summary for this service appears in the Overall Summary of this report.

Is the service safe?

Good 

Our rating of safe improved. We rated it as good because:

- All clinical premises where patents received care were safe, clean, well equipped, well furnished, well maintained and fit for purpose. The trust had ensured that environmental risk assessment, including ligature risks were in place across the service where patients were seen on trust premises. This was improved since the previous inspection.
- The service had enough staff, who knew the patients and received basic training to keep patients safe from avoidable harm. The number of patients on the caseload of the teams, and of individual members of staff, was not too high to prevent staff from giving each patient the time they needed.

Community-based mental health services for older people

- Staff assessed and managed risks to patients and themselves. They responded promptly to sudden deterioration in a patient's health. When necessary, staff worked with patients and their families and carers to develop crisis plans. Staff monitored patients on waiting lists to detect and respond to increases in level of risk. The service had implemented a robust monitoring system since the last inspection and patients assessed as high risk of harm were reviewed daily. Staff followed good personal safety protocols.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it.
- Staff kept detailed records of patients' care and treatment. Records were clear, up to date and easily available to all staff providing care.
- The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each patient's mental and physical health.
- The teams had a good track record on safety. The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

However,

- The trust did not have a service wide system in place to log when staff had checked medical equipment was working correctly.

Is the service effective?

Good ↑

Our rating of effective improved. We rated it as good because:

- Staff assessed the mental health needs of all patients. They worked with patients and families and carers to develop individual care plans and updated them when needed. Care plans reflected the assessed needs, were personalised, holistic and recovery-oriented.
- Staff provided a range of care and treatment interventions that were informed by best-practice guidance and suitable for the patient group. The service offered additional therapies since the last inspection including cognitive stimulation therapy and acceptance and commitment therapy. They ensured that patients had good access to physical healthcare and supported patients to live healthier lives.
- Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.
- The teams included or had access to the full range of specialists required to meet the needs of patients under their care. The trust had actively recruited psychologists and occupational therapists into teams since the last inspection. Managers made sure that staff had a range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.
- Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The teams had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.

Community-based mental health services for older people

- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice.
- Staff supported patients to make decisions on their care for themselves They understood the provider's policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

Is the service caring?

Good ➔➔

Our rating of caring stayed the same. We rated it as good because:

- Staff treated patients with compassion and kindness. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.
- Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to advocates when needed.
- Staff informed and involved families and carers appropriately.

Is the service responsive?

Good ↑

Our rating of responsive improved. We rated it as good because:

- The service was easy to access. Its referral criteria did not exclude patients who would have benefitted from care. Staff assessed and treated patients who required urgent care promptly and patients who did not require urgent care did not wait too long to start treatment. Staff followed up patients who missed appointments. The service had significantly reduced the waiting times for patients to be assessed and commence treatment following referral since the last inspection.
- The teams met the needs of all patients including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.

Is the service well-led?

Good ↑

Our rating of well-led improved. We rated it as good because:

- Leaders had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed, and were visible in the service and approachable for patients and staff.
- Staff knew and understood the provider's vision and values and how they were applied in the work of their team.

Community-based mental health services for older people

- Staff felt respected, supported and valued. They reported that the provider promoted equality and diversity in its day-to-day work and in providing opportunities for career progression. They felt able to raise concerns without fear of retribution.
- Our findings from the other key questions demonstrated that governance processes operated effectively at team level and that performance and risk were managed well. The trust had improved access to the systems and processes for leaders to monitor compliance and quality of the service.
- Teams had access to the information they needed to provide safe and effective care and used that information to good effect.
- Staff collected analysed data about outcomes and performance and engaged actively in local and national quality improvement activities.

Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

Mental health crisis services and health-based places of safety

Requires improvement 

Key facts and figures

The mental health crisis services and health-based places of safety are part of the mental health services delivered by Norfolk and Suffolk NHS Foundation Trust.

The crisis resolution and home treatment teams provide emergency assessments and an alternative to admission to hospital by providing intensive community support for adults who are experiencing acute mental illness with associated risks. The teams were also responsible for admitting patients to an inpatient unit if required. This service is available 24 hours a day, 365 days a year and covers the area of Norfolk and Suffolk.

In Norfolk there are three crisis resolution and home treatment teams. They are based at Hellesdon hospital in Norwich, Northgate hospital in Great Yarmouth and Fermoy unit in King's Lynn. In Suffolk there are two crisis teams and two home treatment teams based at Wedgewood House in Bury St Edmunds and Woodlands unit in Ipswich. Emergency referrals for assessment are passed directly to the Norfolk based teams by the Single Point of Access service and to the Suffolk based teams by the Access and Assessment service.

An acute mental health liaison service is provided for people who present to James Paget hospital in Great Yarmouth, Norfolk and Norwich University hospital in Norwich, Queen Elizabeth hospital in King's Lynn, West Suffolk hospital in Bury St Edmunds and Ipswich hospital in Ipswich. These teams aim to provide prompt assessment of a patient's needs and signpost care appropriately.

The health-based place of safety is a place where someone who may be suffering from a mental health problem can be taken by police officers, using the Mental Health Act, to be assessed by a team of mental health professionals. There are five health-based places of safety. These are at Northgate hospital in Great Yarmouth, Hellesdon hospital in Norwich, Chatterton House in King's Lynn, Woodlands unit in Ipswich and Wedgewood house in Bury St Edmunds.

This was an announced comprehensive inspection. The service was last inspected in May 2019 when an unannounced focused inspection took place to review actions required from previous inspections. The last comprehensive inspection took place in September 2018, we issued requirement notices to the trust, in respect of the following issues the trust must address:

- The trust must ensure that staffing levels out of hours are sufficient to meet local need.
- The trust must ensure that all premises are safe for their intended purpose.
- The trust must ensure that all ligature risks are identified and appropriate plans in place to reduce risk.
- The trust must ensure that processes are in place to ensure that lessons learned are shared across all crisis, home treatment and acute liaison services.
- The trust must ensure that all teams comply with the 4-hour emergency assessment target for referral to assessment.
- The trust must ensure that all teams are aware of their responsibilities for assessing patients presenting in emergency departments in crisis.
- The trust must ensure that staff are consulted and involved in service planning.
- The trust must ensure that systems accurately reflect the nature of patient contacts within their electronic patient record system in order to monitor the effectiveness of the assessment and treatment delivered to patients.

Mental health crisis services and health-based places of safety

- The trust must ensure that all repairs to environments are completed in a timely manner to protect the privacy and dignity of patients.

During this inspection visit, the inspection team:

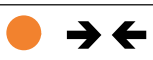
- visited 14 trust locations where care was delivered
- spoke with 13 patients who were using the service and two carers
- spoke with 20 managers/leaders
- spoke with 48 other staff members; including doctors, nurses, occupational therapists, mental health associate practitioners, peer consultants, social workers, psychologists and pharmacists
- observed five telephone triage/support calls with patients
- attended two staff handover meetings and one case formulation meeting
- reviewed documentation relating to the service, including policies and procedures and meeting minutes
- reviewed seven serious incident investigations
- reviewed 66 care records of patients using three crisis services
- reviewed 18 records for patients detained under Section 136 Mental Health Act 1983 in a health based place of safety
- reviewed medicines management
- reviewed information supplied by local commissioners and champions of people who use healthcare services
- reviewed information from staff focus groups held with the trust since our last inspection
- reviewed a range of feedback from stakeholders external to the organisation.

Summary of this service

Our rating of this service stayed the same. We rated it as requires improvement because:

The summary for this service appears in the Overall Summary of this report.

Is the service safe?

Requires improvement 

Our rating of safe stayed the same. We rated it as requires improvement because:

- The trust had not ensured that sufficient numbers of suitably qualified staff were available in all teams to meet the needs of people who used the service. In August 2019, there were 34 occasions in Norfolk where staff had not been able to assess patients within the four-hour target due to staffing levels. The trust had not ensured that sufficient numbers of suitably qualified medical staff were available to meet the needs of people who used the service.

Mental health crisis services and health-based places of safety

- We reviewed 18 care records of patients using health-based places of safety. For 10 patients who had used the section 136 suites at West Suffolk Hospital and Northgate Hospital there was a lack of contemporaneous records on the electronic recording system.
- Staff did not always follow trust systems to safely prescribe, administer, record and store medicines. The trust's approach to audits to monitor prescribing, administration and compliance with medicines policies was inconsistent and did not always identify errors. In the Woodlands centre, the security arrangements for the clinic room keys were ineffective and access was not restricted to authorised staff only. Medicines were stored securely in all other areas.

However:

- The overall management of referrals and waiting times had improved. For example, managers had developed an electronic dashboard which showed them when patients had accessed the service, when referral to treatment targets had not been met the reason for these. This allowed managers to support their teams to mitigate the risks to patients. Incidents were reported, investigated and learned from. Breaches were reviewed to ensure patients remained safe.
- All clinical premises where patients received care were safe, clean, well equipped, well furnished, well maintained and fit for purpose. The physical environment of the health-based places of safety met the requirements of the Mental Health Act Code of Practice.
- Staff assessed and managed risks to patients and themselves. They responded promptly to sudden deterioration in a patient's health. When necessary, staff working in the mental health crisis teams worked with patients and their families and carers to develop crisis plans. Staff monitored patients to detect and respond to increases in level of risk. Staff followed good personal safety protocols.
- Staff received basic training to keep patients safe from avoidable harm. The number of patients on the caseload of the mental health crisis teams, and of individual members of staff had reduced since our last inspection and was not too high to prevent staff from giving each patient the time they needed.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it. This was an improvement from the last inspection.

Is the service effective?

Good 

Our rating of effective stayed the same. We rated it as good because:

- Staff assessed the mental health needs of all patients. Staff working for the mental health crisis teams worked with patients and families and carers to develop individual care plans and updated them when needed. Care plans reflected the assessed needs, were personalised, holistic and recovery-oriented.
- Staff working for the mental health crisis teams provided a range of care and treatment interventions that were informed by best practice guidance and suitable for the patient group. They ensured that patients had good access to physical healthcare.
- Staff working for the mental health crisis teams used recognised risk assessments and rating scales to assess and record severity and outcomes. For example, in addition to the Health of the Nation Outcome Scale (HoNOS), staff in

Mental health crisis services and health-based places of safety

the crisis resolution home treatment team in west Suffolk used the describe, identify, choose, explain, share (DICES) risk assessment to formulate and contextualise individual patient presentation and risk. Staff working for other the crisis teams and in the health-based places of safety participated in clinical audit, benchmarking and quality improvement initiatives.

- The mental health crisis teams included or had access to the full range of specialists required to meet the needs of patients under their care. Managers made sure that staff had a range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.
- Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The teams had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice.
- Staff supported patients to make decisions on their care for themselves. They understood the provider's policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

However:

- There was not always evidence that rights had been provided for patients under detention within the section 136 suites.
- We reviewed 84 care records across this core service, for people who accessed support from the crisis, home treatment, psychiatric liaison team or health-based places of safety. We found the quality of care records had improved since our last inspection. However, 18 of these care records related to patients using health-based places of safety. For 10 of these patients who had used the 136 suites at West Suffolk Hospital and Northgate Hospital there was a lack of contemporaneous records on the electronic recording system.

Is the service caring?

Good ➔➔

Our rating of caring stayed the same. We rated it as good because:

- Staff treated patients with compassion and kindness. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.
- Staff in the mental health crisis teams involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to advocates when needed.
- Staff informed and involved families and carers appropriately.

Is the service responsive?

Requires improvement ➔➔

Our rating of responsive stayed the same. We rated it as good because:

Mental health crisis services and health-based places of safety

- The mental health crisis service phone line was not available to people who weren't currently using services. The trust had a contract for Norfolk to refer patients to MIND which we were told would extend to Waveney from December 2019. At the time of inspection there was no Crisis line for unknown patients in Suffolk other than to attend Accident and Emergency or to call 111. The trust was working with both Suffolk and Norfolk STP's to provide 24/7 Crisis support for all the population by 1 April 2020. This was raised in previous inspections. For people known to services, the mental health crisis service was available 24-hours a day and was easy to access.
- The service did not always meet the four-hour target for patients referred to the crisis resolution and home treatment teams in Norfolk. Throughout 2019, the trust had not met its own target for referral to assessment of 95%. In September 2019, the trust had met the target in just 73% of cases. In August 2019, there were 34 occasions out of forty four breaches in Norfolk attributable to staff not being able to assess patients within the four-hour emergency target due to staffing levels.
- The health-based places of safety were not always available when needed in West Suffolk. This was due to the suite being used for seclusion or as an additional bed when the acute wards were full.

However:

- Referral criteria for the mental health crisis teams did not exclude patients who would have benefitted from care. Staff assessed and treated patients promptly. Staff followed up patients who missed appointments.
- There was an effective local arrangement for young people who were detained under Section 136 of the Mental Health Act. Section 12-approved doctors and approved mental health professionals attended promptly when required.
- The services met the needs of all patients who use the service – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural support.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.

Is the service well-led?

Requires improvement ↑

Our rating of well-led stayed the same. We rated it as requires improvement because:

- Our findings from the other key questions demonstrated that while governance processes had improved they had not yet fully ensured that performance and risk were managed well. Not all of the previous areas of concern had been addressed. Staffing levels were not sufficient in all areas. Some Norfolk crisis teams were not meeting the target to see people within four hours. Medication management required further work.
- The corporate risk register did not reflect the concerns that we found regarding staffing levels, missed targets, record keeping and medication management.
- While multi-agency arrangements, to agree and monitor the governance of the mental health crisis service and the health-based places of safety were in place, further work was required in some areas to ensure that people in the area received help when they experienced a mental health crisis.
- Staff did not fully understand the new system of care groups and some felt there was a lack of involvement in the development of this structure.

Mental health crisis services and health-based places of safety

- Managers in Norwich told us that while staff morale had improved it was not yet good, and that a positive culture was not fully embedded across the service. The trust needed to continue to develop communication across all staff groups.
- Stakeholders had identified negative feedback from some patients regarding responsiveness and attitude of some staff. Whilst it was evident that work had been undertaken to address the culture of the organisation, this was evidence that more work was required.

However:

- Staff had implemented recommendations from reviews of deaths, incidents, complaints and safeguarding alerts at the service level. This was an improvement from the last inspection.
- Leaders had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed, and were visible in the service and approachable for patients and staff.
- Staff knew and understood the provider's vision and values and how they were applied in the work of their team.
- Staff we spoke to felt respected, supported and valued. They reported that the provider promoted equality and diversity in its day-to-day work and in providing opportunities for career progression. They felt able to raise concerns without fear of retribution.
- Teams had access to the information they needed to provide safe and effective care and used that information to good effect.
- Staff collected analysed data about outcomes and performance and engaged actively in local and national quality improvement activities.

Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above

Community mental health services for people with a learning disability or autism

Good 

Key facts and figures

Community mental health services for people with learning disabilities or autism provide care for adult and child patients across Suffolk at a variety of accessible bases, as part of the wider integrated delivery teams (IDTs). All patients lived at home or in residential care, with home visit support from a care co-ordinator and/or outpatient appointment. These services operated from 9am until 5pm, Monday to Friday.

The trust had worked within the principles of the transforming care agenda. The trust closed several wards and the services were more focussed in the community. The inpatient and community teams are part of the same service and work as one team.

The trust did not provide any community mental health services for people with learning disabilities or autism in Norfolk.

Adult services offered care to people from the age of 18 upwards, except for Lothingland where adult services were offered from aged 25 years. In general, caseloads varied from 11 to 20 people per care co-ordinator. Although this was not the case for the adult attention deficit hyperactivity disorder service where caseloads were up to 175 for one nurse.

People supported by the Suffolk Child and Adolescent Learning Disability team attended outpatient appointments with the consultant psychiatrist in the East of the county at Walker Close and in West Suffolk at the Child Health Centre in Bury St. Edmunds. The age range of people who used this service ran from 0 years to 25 years.

We inspected the Suffolk intensive support at home team as part of the community services. Based at Walker Close, Ipswich, this team offered advice and extra support to families and carers through observation and formulation to avoid a hospital admission when the needs of the patients changed. The intensive support at home team operated from 7am until 9pm each day of the week.

The trust is registered with the CQC for the following regulated activities:

- Assessment or medical treatment for persons detained under the Mental Health Act 1983
- Treatment of disease, disorder, or injury.

At the last inspection in September 2018, the overall rating for this service was good. All domains were rated as good.

The following areas were identified as actions the provider should take to improve:

- Staff should ensure that patients are supported to make decisions about their care and this is documented in their notes.
- Staff should ensure that patients with communication difficulties are involved in the planning of their care.

Our inspection was announced (staff knew we were coming) to ensure that everyone we needed to talk to was available. We inspected sites at Lowestoft, Stowmarket and Ipswich and looked at all key questions.

This inspection has found that the trust had met the areas identified for improvement from the previous inspection regarding staff documenting support they provided to patients to make decisions and involving patients in the planning of their care.

Community mental health services for people with a learning disability or autism

Before the inspection visit, we reviewed information that we held about these services and information requested from the trust. During the inspection visit, the inspection team:

- spoke with the managers of the adult services and the managers of the child and adolescent services
- spoke with 29 other staff members, including nurses, clinical support workers, occupational therapists and psychologists.
- examined medicine management across the service and medication charts
- reviewed 25 patient care records
- observed one multidisciplinary meeting
- observed three activity sessions
- observed one patient forum
- observed one home visit
- spoke with ten patients who were using the service and seven carers.

Summary of this service

Our rating of this service stayed the same. We rated it as good because:

The summary for this service appears in the Overall Summary of this report.

Is the service safe?

Good ➔➔

Our rating of safe stayed the same. We rated it as good because:

- Staff assessed and managed risks to patients and themselves. They responded promptly to sudden deterioration in a patient's health. When necessary, staff worked with patients and their families and carers to develop crisis plans. Staff monitored patients on waiting lists to detect and respond to increases in level of risk. Staff followed good personal safety protocols.
- Staff provided examples where incidents were reviewed, and effective action was taken to reduce the risk of further incidents.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it.
- Data requested from the provider for September 2019, showed that staff in the seven learning disability teams had undertaken mandatory training at a range between 87 percent to 96 percent that the trust had set as mandatory.

Is the service effective?

Good ➔➔

Community mental health services for people with a learning disability or autism

Our rating of effective stayed the same. We rated it as good because:

- Staff took a function-based approach to assessing the needs of all patients. They worked with patients and with families and carers to develop individual care plans and updated them as needed. Care plans reflected the assessed needs, were personalised, holistic, function-based and recovery-oriented.
- Staff provided a range of treatment and care interventions that were informed by best-practice guidance and suitable for the patient group. They ensured that patients had good access to physical healthcare and supported patients to live healthier lives.
- Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.
- Staff supported patients to make decisions on their care for themselves proportionate to their competence. Staff understood the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity. Staff worked with the patient's support network to ensure best interest decisions were made when relevant.

However:

- The Waveney adult team and the Ipswich adult learning disability teams did not achieve supervision rates above 75 percent for their staff between July 2019 and September 2019.

Is the service caring?

Good ➔➔

Our rating of caring stayed the same. We rated it as good because:

- Staff treated patients with compassion and kindness. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.
- Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to advocates when needed.
- Staff informed and involved families and carers fully in assessments and in the design of care and treatment interventions.

Is the service responsive?

Requires improvement ↓

Our rating of responsive went down. We rated it as requires improvement because:

- The service did not meet the trust's target time of 12 weeks from referral to assessment. Patients were waiting for up to eight months for an assessment by the autism child and adolescent mental health team and up to nine months for an assessment by the autism adult team. Patients were waiting for over 12 months for an assessment by the attention deficit hyperactivity disorder adult team who had just one qualified nurse managing a caseload of 175 patients and a waiting list of 120 patients over a year.

However:

- Staff assessed and initiated care to patients who required urgent care promptly.

Community mental health services for people with a learning disability or autism

- Staff had the skills, or access to people with the skills, to communicate in the way that suited the patient.
- The service treated concerns and complaints seriously, investigated them, learned lessons from the results and shared these with all staff.

Is the service well-led?

Good  

Our rating of well-led stayed the same. We rated it as good because:

- Leaders had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed, and were visible in the service and approachable for patients and staff.
- Staff knew and understood the provider's vision and values and how they were applied in the work of their team.
- Staff felt respected, supported and valued. They reported that the provider promoted equality and diversity in its day-to-day work and in providing opportunities for career progression. They felt able to raise concerns without fear of retribution.
- Our findings from the other key questions demonstrated that governance processes operated effectively at team level and that performance and risk were managed well.
- Teams had access to the information they needed to provide safe and effective care and used that information to good effect.
- Staff collected analysed data about outcomes and performance and engaged actively in local and national quality improvement activities.
- Managers from the service participated actively in the work of the local transforming care partnership.

Outstanding practice

- Services had liaison staff who attended general practitioner surgeries to ensure that all patients had access to yearly physical health checks and to support general practice surgeries in making their services learning disability friendly. Liaison staff also had good links with the local general hospital to ensure that any physical health interventions were managed effectively.

Areas for improvement

We found the following areas for improvement in this service:

We found areas for improvement in this service. See the Areas for Improvement section above.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that the service provider was not meeting. The provider must send CQC a report that says what action it is going to take to meet these requirements.

For more information on things the provider must improve, see the Areas for improvement section above.

Please note: Regulatory action relating to primary medical services and adult social care services we inspected appears in the separate reports on individual services (available on our website www.cqc.org.uk)

This guidance (see goo.gl/Y1dLhz) describes how providers and managers can meet the regulations. These include the fundamental standards – the standards below which care must never fall.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing

This section is primarily information for the provider

Enforcement actions

We took enforcement action because the quality of healthcare required significant improvement.

Our inspection team

Julie Meikle, Head of Hospital Inspection, CQC and Jane Crolley, Inspection Manager, CQC led this inspection. One executive reviewer and two specialist professional advisor with board experience and knowledge of governance supported our inspection of well-led for the trust overall. The team for the eight core service inspections included three inspection managers, 17 further inspectors,16 specialist advisors and 10 experts by experience.

Executive reviewers are senior healthcare managers who support our inspections of the leadership of trusts. Specialist advisers are experts in their field who we do not directly employ. Experts by experience are people who have personal experience of using or caring for people who use health and social care services.

Date:	**23rd January 2020**	**H**
Item:	**20.09**	

Norfolk and Suffolk NHS Foundation Trust

Report to:	Board of Directors
Meeting date:	January 2020
Title of report:	Mortality and Learning from Deaths
Action sought:	For assurance and debate
Estimated time:	10 minutes
Author:	Dr Daniel Dalton, Chief Medical Officer
Director:	Dr Daniel Dalton, Chief Medical Officer

Executive Summary:

This paper:

- Describes how the Trust learns from all incidents leading to death of a service user, to help eliminate preventable mortality and its causes
- Describes some of the projects where NSFT is working to reduce mortality, with a Zero Suicide Ambition
- Outlines the work of the newly established Serious Incident and Mortality Review Group (SIMRG)
- Proposes to broaden the range of data that is incorporated into future reports to support meaningful analysis and discussion.

Publishing the data, discussing trends and learning and monitoring changes to practice is part of the Trust's ongoing duty for compliance with National Guidance on Learning from Deaths.

The NSFT Learning from Deaths policy is scheduled for review by April 2020. It will describe our new approach, considering best practice in other organisations and alignment with the proposed National Patient Safety Incident Framework (PSIF), to support continuous improvement.

The information in the paper relates to BAF risk 3.2

The Board is asked to note the report and comment on these proposals.

1.0 Morality Governance

1.1 Since September 2019 the Serious Incident and Mortality oversight groups have merged into a single entity, the Serious Incident and Mortality Review Group (SIMRG). This meets monthly and is chaired by the Chief Medical Officer and Chief Nurse. Attendance from the senior leadership of all care groups is essential.

1.2 The SIMRG reports to the Board of Directors through a written report to the Quality Committee, which reports in turn to the Quality Assurance Committee, a subcommittee of the Board.

1.3 Each month, the SIMRG undertakes a deep dive into a serious incident; considers any trustwide recommendations emerging from all Serious Incident Reports; considers any learning from Structured Judgement Reviews undertaken following deaths that are not considered Serious Incidents; ensures that there is awareness and engagement amongst all care groups of important strategic priorities, such as the Zero Suicide Ambition for Norfolk and Suffolk, and reviews any trends in mortality

2.0 LeDeR

2.1 NSFT continues to support the Learning Disability Mortality Review (LeDeR) process in Norfolk and Suffolk, hosted by the Clinical Commissioning Groups. Only a single case has been reported to LeDeR, from Suffolk, in the review period. This reflects a longstanding trend for lower-than-predicted levels of reporting in the county, addressing which is a focus for the Suffolk LeDeR board.

3.0 Emerging themes from Structured judgement Reviews

3.1 Four Structured Judgement Reviews were commissioned in November and December 2019, and three reports were completed. None of these reviews concluded that death was likely to have resulted from problems in care. There were two recommendations from these reviews, which related to completion of risk assessment and the importance of seeking timely medical support for a person who appeared to be suffering with deteriorating physical health.

4.0 Zero Suicide Ambition

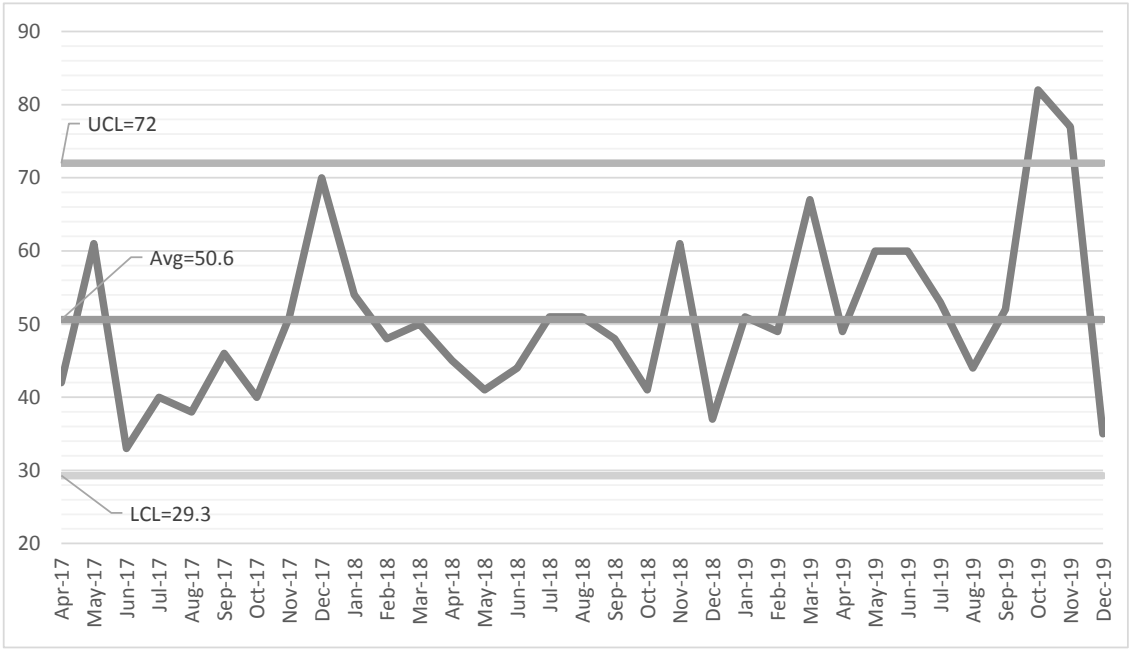
NSFT continues to aspire towards zero suicides for people who are in contact with our services, and to work with health and other partners to tackle the root causes of suicide in Norfolk and Suffolk. The Chief Medical Officer is due to meet with Norfolk's Public Health consultants in February 2020, to consider and plan how NSFT can support systems in Norfolk and Waveney to address the underlying causes of suicide in the population. It is NSFT's position that a single suicide amongst people who use our services is one too many.

NSFT is working with NHS England's regional suicide prevention team to deliver a number of projects intended to support the Zero Suicide Ambition. These include:

- From February 2020, 7 NSFT inpatient wards will join a Quality Improvement (QI) project to deliver a perfect follow up pathway, within 48 hours of discharge.

- From February 2020, Samphire, the inpatient ward in King's Lynn, will launch an Evidence-Based Co-Design (EBCD) project to coproduce a safe and therapeutic ward environment
- 6 NSFT wards will benefit from Wave 2 National Suicide Prevention Funding to improve safety planning for inpatients, embedding peer support and co delivered staff training

5.0 Trends in Mortality



9.2

5.1. As shown in the graphic above, there is common cause variation in the number of deaths reported in any given month; this means that the numbers generally vary from month to month with no pattern or reason to assume an underlying cause. Although there was an apparent increase in the rate of reporting for October and November 2019, there is no basis to suggest this is a trend, and few deaths have been reported in December. Overall, this heterogeneity is so great that it is highly unlikely that using these data alone will support meaningful and sensitive detection of problems in services or support the trust to perfect the delivery of care and treatment. This is likely to be an inevitable problem when using mortality data as a primary source of intelligence, because of the relatively small number of people in contact with our services who die, in comparison to the number of people whom we see and treat and who suffer other adverse outcomes.

5.2 In discussion with other Mental Health Trusts, this is a common situation. As far as can be ascertained, there is no organisation that has yet been able to use this metric alone to identify underlying service concerns or to track beneficial impact from service improvement projects.

5.3 We are working with our Research and Development team to consider what other metrics we might consider, including thematic incident analyses, incidents leading to moderate harm, or near-miss incidents, alongside these mortality data, to increase the sensitivity of the analysis. A priority will be to refresh training in the use of Datix, to ensure we have

consistent and effective reporting of incidents to describe these trends. This will be completed by March 2020, in preparation for the implementation of the national Patient Safety Incident Framework (PSIF).

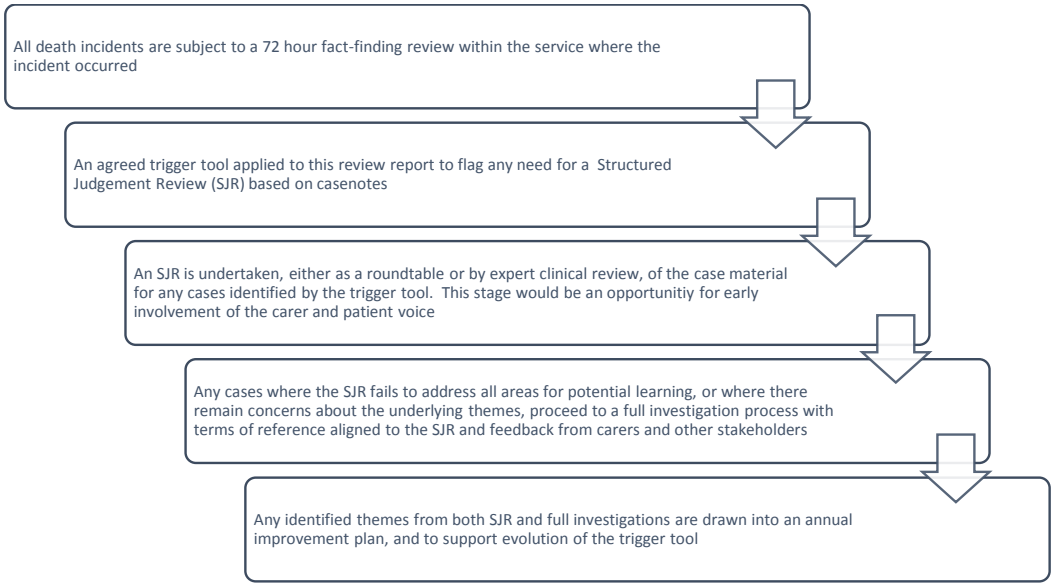
5.4 Even though review of these numbers alone will support only limited learning, we are still determined to learn from every death of a person who uses our services and will always strive to improve our services following any serious incident. In order to do so, there is a case for taking a different approach to routinely learning from incidents; one proposed methodology is discussed below.

6.0 Proposed future direction for learning from deaths

6.1 The Trust's Learning from Deaths Policy will be reviewed, including consideration of an updated approach, by April 2020. This update presents an opportunity to align our policy with best practice, and the principles of the PSIF. Having discussed with clinical leaders in mental health trusts that have been rated good or outstanding by the CQC, the following themes emerge:

- There is less to learn from review of mortality data trends in isolation than if these are aligned to thematic, near-miss and moderate harm incidents
- There is value in developing a systematic approach to identification of deaths where there is a need for a structured judgement review; development of a trigger tool can support this process
- Approaches to learning that focus on individual action plans, arising from individual incidents, often do not lead to meaningful changes in service delivery or outcomes. There is greater merit in grouping thematic learning into an improvement plan that focusses on consistent change over an annual cycle
- There is a clear need for a collective approach to learning, where those responsible for implementing actions are involved in setting the direction of travel for change
- The same approach to learning from unexpected deaths, or deaths that might be serious incidents, is often applicable when learning from expected deaths.

6.2 We have adapted the approach being implemented at Merseycare and suggest a model process for systematically reviewing incidents as follows:



This approach is aligned with the PSIF. It represents a departure from the universal root cause investigation of all unexpected deaths, and generation of individual action plans following any incident, towards a more targeted and strategic approach to embedding improvement. This should achieve greater scope for consistent improvement in patient care, whilst supporting care teams to remains focussed on their clinical responsibilities to the people under our care.

7.0 Recommendations

The board is invited to:

- Note the contents of this report, and that there are no indications of underlying trends in the mortality data that give rise to concern
- Note that no death has been identified by an SJR that is more likely than not to have arisen from a problem in care
- Support the proposal to enrich the data landscape to work towards bringing near miss, moderate harm, and targeted-category incident data into future mortality reports
- Consider the example model for learning from deaths and support the further exploration of how this could be incorporating into the NSFT Learning from Deaths Policy.

Date:	**23rd January 2020**	**I**
Item:	**20.10**	

Norfolk and Suffolk NHS Foundation Trust

Report to:	Board of Directors
Meeting date:	23rd January 2020
Title of report:	Safer Staffing Report
Action sought:	For assurance
Estimated time:	10 minutes
Author:	Ben Askew & Sarah Moy – Workforce Deployment (HR)
Director:	Diane Hull – Chief Nurse

Executive Summary:

This report provides assurance that all efforts are being made to ensure detailed internal oversight and scrutiny is in place to ensure safer staffing levels are maintained.

The Trust is required to meet the National Quality Board (2016) guidance, which provides a set of expectations for nursing and care staff and an expectation that Trusts' measure and improve patient outcomes, people productivity and financial sustainability. This includes implementation of the Carter report (2016) recommendation of a new metric, Care Hours Per Patient Day (CHPPD), as the first step in developing a single consistent way of recording and reporting staff deployments. From April 2018, all Mental Health and Community Trusts have reported CHPPD figures. The National Quality Board (NQB) released further guidance for Mental Health Trusts (January 2018) which sets out the expectation that a triangulated approach (right staff, right skills, right place and time) be applied to staffing decisions.

The Chief Operating Officer and Chief Nurse have recently under taken reviews of all inpatient areas to ensure all rosters are set at the correct levels and that all appropriate disciplines are included in the overall staffing ratio.

This report provides information on the previous 6-month period from July to December 2019 focusing on both Inpatient and Community areas and relates to BAF risk 4.1

9.3

Contents

9.3

1.0 Introduction

1.1 Ensuring our clinical services are staffed safely continues to be a priority for the Trust.

1.2 This report provides an analysis of inpatient and community staffing levels; highlighting exceptions where staffing levels have been below the required levels. Reporting on inpatient services staffing levels is well developed. There is no national mechanism for reporting community staffing levels.

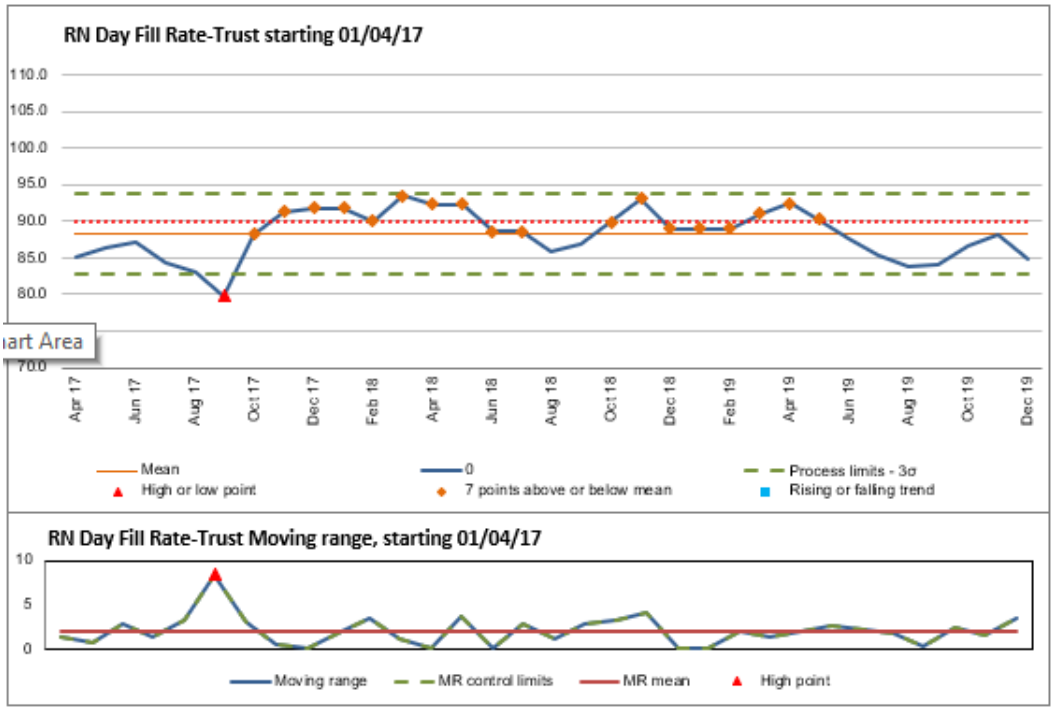
1.3 Due to minimum staffing levels, for the purpose of this report, exceptions for inpatient are reported at below 80% and above 120%. Community services have no developed mandated minimum staffing levels.

1.3 Determining safe staffing is complex and has to take account of multiple factors such as patient and clinical need, skill mix, recruitment and retention, clinical activity and acuity and the availability and skill of other professional groups. It relies on good management so that shifts are filled, organised effectively and the staff employed have the correct skill set.

2.0 Inpatient Services – current performance

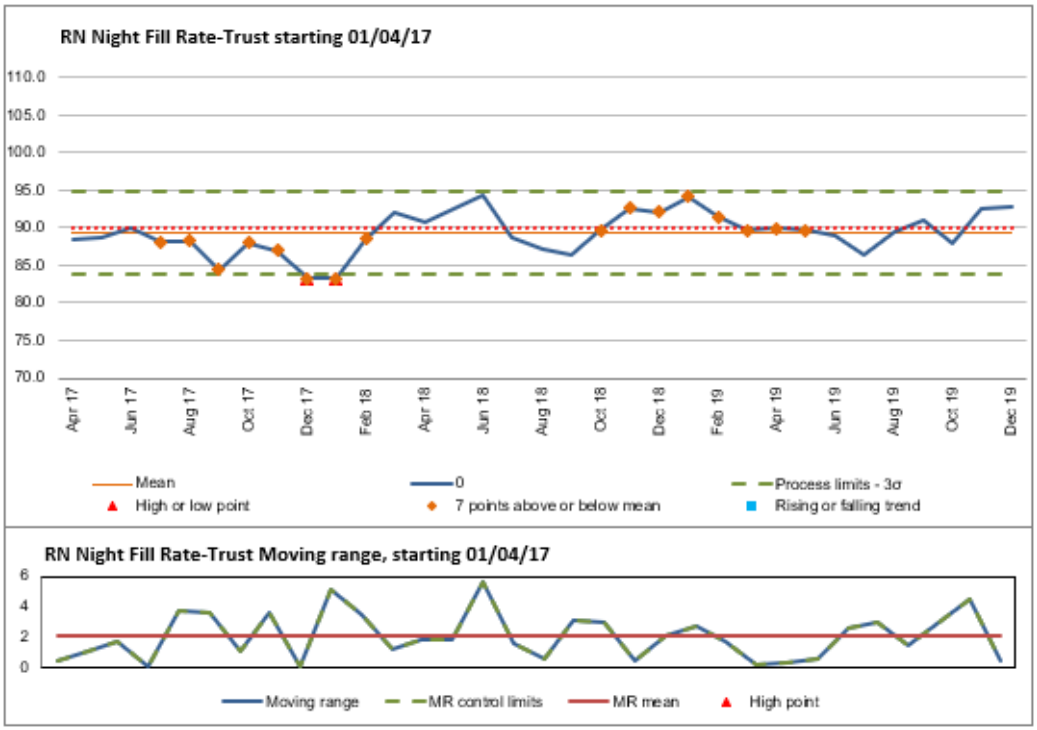
2.1 In line with the Government's requirements, the Trust continues to submit data every month via the National reporting system in inpatient services.

2.2 Overall fill rates for registered nurse day shifts within inpatient services were reported at 84% for December 2019. The fill rate has remained within expected levels, as shown in the SPC chart below since September 2017. However, the average fill rate has continued to be below the target since May 2019.



9.3

2.3 Night fill rates for registered nurses are also within expected tolerances, and in December, were above target rate. The average fill rate since April 2017 is slightly below the target at 89%.



2.4 However, within these overall average rates there is a range of performance. For context the table below shows the number of inpatient units that have fallen below the 80% threshold split by day & night shifts over the last six-month period;

9.3

Month	RN Day	RN Night
July	10	8
Aug	11	7
Sep	12	8
Oct	6	8
Nov	8	5
Dec	10	4

2.5 Appendix 1 shows performance per ward on both day and night shifts for registered staff. Of most concern are 5 units; Beach Ward, Catton Ward, Foxhall House, Southgate and Whitlingham Ward which consistently fall under the 80% threshold.

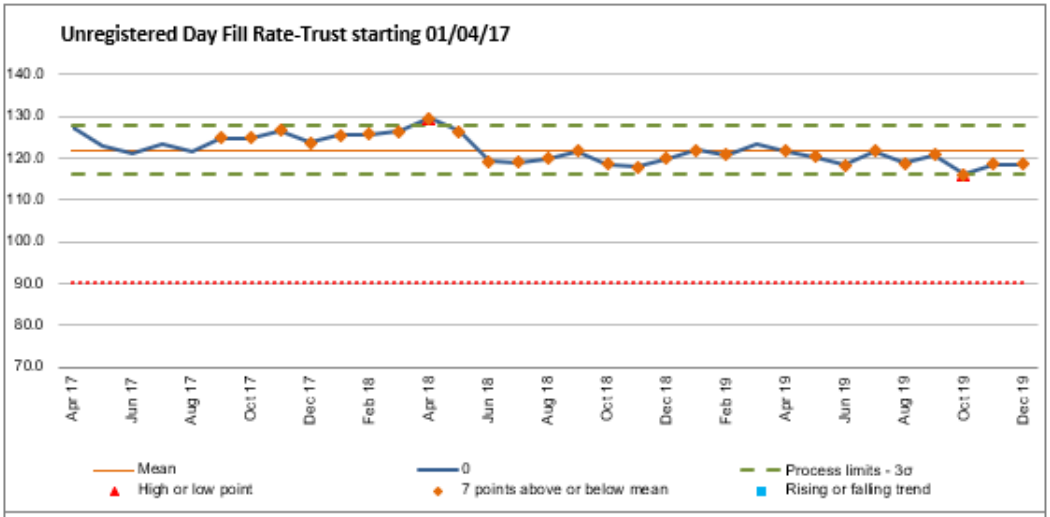
2.6 Reasons for low fill rates are varied, but consistent themes around recruitment difficulties, long-term absences (sickness and maternity leave) and study leave. Support from long-term agency staff and recruitment activity is helping to mitigate.

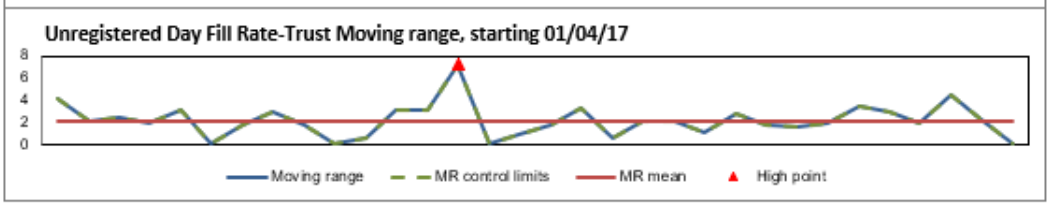
Ward name	Commentary
Beach Ward	One of the RN team recently returned from a long-term sickness episode and is being supported with a phased return.
Catton Ward	Managerial changes over the past 6 months and currently have an acting Ward Manager in post, however a substantive ward manager has now been appointed and will be starting next month One RN on a long-term sickness episode with another on non-clinical duties and unable to be part of a PMA team. The B6 on the ward is in a developmental role and has dedicated time away from the ward for this. The matron for secure services has now planned to work clinical shifts throughout January & February.
Foxhall House	Currently have 5wte RN vacancies within the team and the Ward Manager also covering Acting DSM role. These posts have been recruited to but people will not be starting until June One RN on maternity leave with another in a current HR process. Currently have two long-term temporary workers in place.
Southgate Ward	Focused recruitment campaign to take place at Wedgwood over the next twelve weeks as currently have 6wte RN vacancies. One of the B6 team currently on secondment. Three long-term temporary staffing placements have been arranged with a further 3 being sought.
Whitlingham Ward	Currently have an acting Ward Manager in post. Due to recruitment challenges previous manager preferred to skill mix RN night shifts and backfill with an additional CSW.

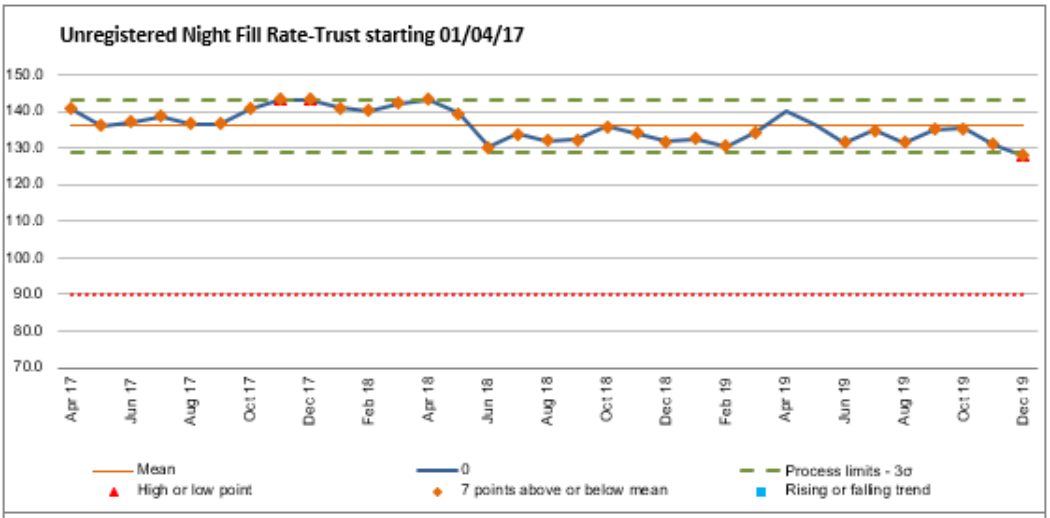
2.7 Only Sandringham Ward, Samphire Ward & Suffolk RRS have reported over a 120% fill rate for Registered Nurses in the period between July to December 2019.

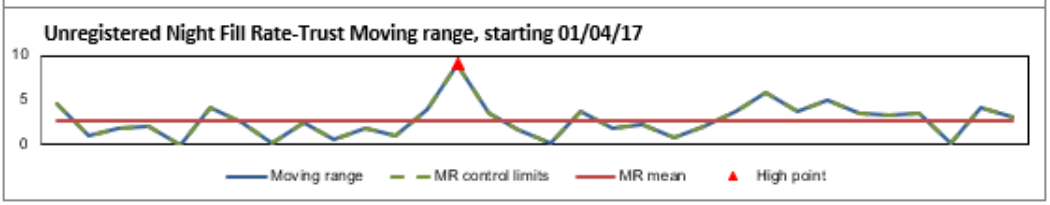
2.8 There continues to be a high fill-rate for Unregistered Nurses for day & night shifts (see SPC Charts below).

2.9 The fill rate may be low in some areas however this is always compensated by additional unqualified and does not take into consideration that often the Ward Managers, Modern Matrons & Lead Nurses for each area are there providing experienced support. We are never in a position where don't have qualified cover and our base line staffing remains generous. Going forward these more senior roles will be included in the rosters and the fill rates will increase accordingly.









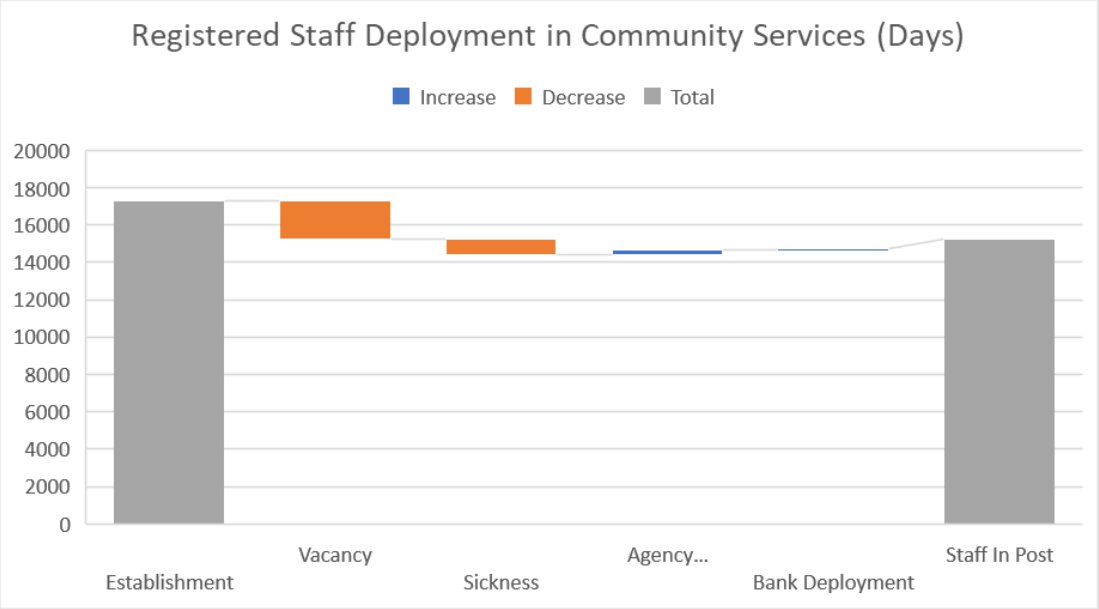
2.10 The detail on the individual fill-rates for December ’19 are listed on Appendix 3

3.0 Community Staffing

3.1 As with inpatient services, deployment of adequate staff into these services at the right time with the right skills is critical for safety and quality.

3.2 A first review of the deployment of staff in adult and older persons community teams in the Trust during December 2019 show's

- 90% of established days for registered staff were worked (excluding annual leave and time taken to attend training, but including sickness)
- Of these days, 1.4% were worked by agency staff and 0.4% by bank staff
- 95% of established days for unregistered staff were worked (excluding annual leave and time taken to attend training, but including sickness)
- Of these, 0.3% days were worked by agency staff. No unregistered bank staff worked within community teams during December 2019.



3.3 The waterfall illustrates the deployment of registered staff in community teams by showing the starting establishment, then how vacancy, sickness, along with agency and bank usage impact upon the final deployment.

3.4 Whilst deployment was at overall at 90% for registered staff within community teams, some services, particularly community secure services and adult and older persons services in West Suffolk struggled during December 2019. West Suffolk in particular had a high reliance on agency and bank staff.

Registered Staff	%Substance Days Worked	%Agency Fill Days	%Bank Fill Days	% Unfilled
NORFOLK & WAVENEY TOTAL	94%	1%	0%	-5%
GREAT YARMOUTH & WAVENEY CARE GROUP TOTAL	85%	0%	0%	15%
Great Yarmouth & Waveney - Adult Community	86%	0%	0%	14%
Great Yarmouth & Waveney - Older People	84%	0%	0%	16%
NORTH NORFOLK & NORWICH TOTAL	104%	3%	0%	-7%
North Norfolk & Norwich - Adult Community	108%	4%	0%	-13%
North Norfolk & Norwich - Older People	96%	0%	0%	3%
WEST & SOUTH NORFOLK TOTAL	100%	1%	1%	-1%
West & South Norfolk - Adult Community	94%	1%	1%	4%
West & South Norfolk - Older People	108%	0%	0%	-8%
SECURE SERVICES TOTAL	79%	0%	1%	20%
SECURE SERVICES TOTAL	79%	0%	1%	20%
Secure Services - Community	79%	0%	1%	20%
SUFFOLK TOTAL	77%	3%	0%	20%
EAST SUFFOLK CARE GROUP TOTAL	84%	1%	0%	15%
East Suffolk - Adult Community	82%	1%	0%	17%
East Suffolk - Older People	90%	1%	0%	9%
WEST SUFFOLK CARE GROUP TOTAL	65%	6%	1%	29%
West Suffolk - Adult Community	61%	7%	0%	32%
West Suffolk - Older People	72%	4%	2%	22%
Grand Total	88.0%	1.6%	0.4%	10%

3.5 Similar to registered staff, unregistered staff deployment also varied across the organisation. Whilst an overall deployment of 95% was achieved, this was largely bolstered by instances of services being 'over establishment' in Great Yarmouth and Waveney Adult service, and West and South Norfolk Adult Services. Services in West Suffolk had the largest 'gap'.

3.6 A feature of unregistered staff deployment is the very small use of bank and agency staff.

Unregistered Staff	%Substance Days Worked	%Agency Fill Days	%Bank Fill Days	% Unfilled
NORFOLK & WAVENEY TOTAL	96%	0.0%	0.0%	-4%
GREAT YARMOUTH & WAVENEY CARE GROUP TOTAL	99%	0.0%	0.0%	1%
Great Yarmouth & Waveney - Adult Community	107%	0.0%	0.0%	-7%
Great Yarmouth & Waveney - Older People	89%	0.0%	0.0%	11%
NORTH NORFOLK & NORWICH TOTAL	96%	0.0%	0.0%	4%
North Norfolk & Norwich - Adult Community	97%	0.0%	0.0%	3%
North Norfolk & Norwich - Older People	91%	0.0%	0.0%	9%
WEST & SOUTH NORFOLK TOTAL	105%	0.0%	0.0%	-5%
West & South Norfolk - Adult Community	126%	0.0%	0.0%	-26%
West & South Norfolk - Older People	67%	0.0%	0.0%	33%
SECURE SERVICES TOTAL	98%	0.0%	0.0%	2%
SECURE SERVICES TOTAL	98%	0.0%	0.0%	2%
Secure Services - Community	98%	0.0%	0.0%	2%
SUFFOLK TOTAL	86%	1.0%	0.0%	13%
EAST SUFFOLK CARE GROUP TOTAL	96%	1.3%	0.0%	3%
East Suffolk - Adult Community	90%	2.2%	0.0%	7%
East Suffolk - Older People	104%	0.0%	0.0%	-4%
WEST SUFFOLK CARE GROUP TOTAL	77%	0.7%	0.0%	23%
West Suffolk - Adult Community	73%	0.9%	0.0%	26%
West Suffolk - Older People	87%	0.0%	0.0%	13%
Grand Total	95%	0.3%	0.0%	5%

4.0 Substantive Fill Rate vs Temporary Staffing

4.1 There is a significant reliance on bank and agency staff to support staffing demands in inpatient services. The table below demonstrates the current use of temporary staffing with inpatient units across rosters during December 2019. Many rosters contain more than 20% of temporary nurses (either bank or agency).

Care Groups	Ward name	Percentage of bank and agency used in worked roster			
		Day Qualified	Day Unqualified	Night Qualified	Night Unqualified
Norfolk & Norwich	Glaven Ward	8%	22%	70%	38%
Norfolk & Norwich	Rollesby Ward	27%	40%	54%	38%
Norfolk & Norwich	Thurne Ward	18%	31%	64%	58%
Norfolk & Norwich	Waveney Ward	18%	17%	58%	27%
Norfolk & Norwich	Yare Ward	50%	10%	91%	10%
GY&W	Beach Ward	2%	30%	6%	49%
GY&W	Reed Ward	6%	43%	17%	63%
GY&W	Rose Ward	7%	44%	29%	43%
GY&W	Sandringham Ward	1%	25%	22%	44%
GY&W	Great Yarmouth Acute Services	8%	34%	22%	39%
GY&W	Laurel Ward	4%	1%	70%	3%
East Suffolk	Avocet Ward	21%	52%	46%	62%
East Suffolk	Lark Ward	26%	51%	69%	68%
East Suffolk	Poppy Ward	2%	17%	66%	57%
East Suffolk	Walker Close	73%	45%	64%	52%
East Suffolk	Willows Ward	16%	42%	37%	76%
East Suffolk	Suffolk Rehabilitation and Recovery Service	1%	12%	21%	26%
Secure Services	Catton Ward	15%	34%	3%	79%
Secure Services	Drayton Ward	2%	28%	16%	52%
Secure Services	Foxhall House	10%	52%	99%	31%
Secure Services	Whitlingham Ward	2%	42%	35%	55%
Secure Services	Blakeney Ward	7%	16%	39%	32%
West Norfolk	Samphire Ward	4%	9%	68%	13%
West Suffolk	Abbeygate Ward	26%	28%	49%	47%
West Suffolk	Northgate Ward	1%	12%	21%	26%
West Suffolk	Southgate Ward	12%	30%	69%	102%
CFYP	Dragonfly Unit	26%	22%	23%	47%
CFYP	Kingfisher Mother and Baby Unit	32%	24%	7%	58%

4.2 A considerate number of our substantive staff are multi-post holders therefore are known in the clinical areas and these are included in the percentages above.

4.3 The reason of Vacancy remains to be the highest booking reason for temporary staffing with Specialing and Sickness after this.

4.4 Many temporary staff used are booked on a long-term basis to maintain consistency and stability in the team to ensure safety is met. Currently there are 96 requests for long-term agency placements across the organisation. Fifty-one of these remain open (unfilled).

4.5 There are 28 requests for placement within inpatient areas. Seven of these are filled. These are in the following areas;

Unit	No of Long-Term Placements	
	Open	Filled
Yare Ward	5	4
GY&W Acute	2	0
Lark Ward	4	0
Laurel Ward	4	0
Northgate/Southgate Ward	6	1
Foxhall House	7	2

4.6 Several workers fall outside of a long-term placement as shift fill is more ad-hoc however and are treated in the same manner as substantive workers being included in team meetings as well as regular clinical & management supervision.

4.7 Some of these placements are being scrutinised regarding their validity and if there is scope to transfer to a fixed term contract within the required areas.

5.0 Nurse Recruitment

5.1 We have established relationships with both the UEA and UOS, which unfortunately, historically was absent. We are currently supporting students from day 1 of their studies and we are also running a selection day for 3rd year students in their first placement of their last year of training.

5.2 In conjunction with the HEI's we have reviewed our recruitment process. This change/investment has resulted in 46 newly qualified RN's into NSFT during 2020. Moving forward we have a recruitment event in Suffolk 27th March interviewing 29 UoS students (qualifying Feb 2021), and anticipate interviewing 40-45 UEA students (qualifying Sept 2021) in October 2020. We are confident that we shall be able to appoint between 60 -70 wte student nurses this year, joining NSFT throughout 2021..

5.3 We have a number of recruitment days organised and are working with HR to think creatively about a nurse recruitment campaign with input from a senior nurse supported by the Deputy Chief Nurse. We are actively developing the unregistered nursing workforce and creating more opportunities to become registered nurses.

6.0 Nurse Retention

6.1 We have used the funding (£100k) from HEE to appoint a new member of staff who is leading on preceptorship, rolling out a new preceptorship package supported by a development programme, action learning sets and reflective practice.

6.2 We have introduced new development programmes for all bands of nurses and early feedback is that staff who are attending these courses feel more valued and more confident in their clinical roles. We are offering a range of other one- and two-day courses specifically for nurses and access to coaching forums. The lead nurses are visible, present and using their role to support and inspire.

7.0 Apprenticeships

7.1 We have continued to support the Assistant Practitioner apprenticeship with 22 qualifying in 2020. We are anticipating an increase of new AP starter in 2020 to a maximum of 36 (2 cohorts of 18).

7.2 In 2020 we will see the very first Training Nursing Associate qualifying for the Trust. It is our ambition to increase and invest in the TNA apprenticeship.

7.3 We have 15 Nursing Degree apprenticeships qualifying in 2020, with 16 starting training in February 2020.

7.4 In 2020 we will see the very first OT apprenticeship being launched (first ever nationally) with 7 new apprentices starting in February.

7.5 We have yet to have confirmed the cohort for a Learning Disabilities Nursing Apprenticeship. NSFT has had 12 potential applicants identified but awaiting figures from other local NHS providers to submit commissions, we anticipate a potential Sept 2020 cohort.

8.0 Quality Implications

8.1 A total of 1,000 reports had been logged in the 6 month period between July and December 2019 in regard to incidents relating to staffing (173 for community services and 827 for inpatient services). The table below shows the breakdown per month;

Number of Datix Reports	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Total
Community	33	24	29	40	22	25	173
Inpatient	97	185	210	159	*86*	*90*	827
Total	**130**	**209**	**239**	**199**	**108**	**115**	**1000**

8.1 In the last 6 months, Datix issues reached a peak in September 2019 when 239 concerns were raised. This has since decreased to 115 in December 2019.

8.2 The most frequently reported incidents were

- Low staffing levels
- No or lack of trained / supervisor staff

8.3 The top 3 areas for reporting Staffing Concerns in the six-month period from July to December were all inpatient teams;

Ward	Total No of Reports
Willows Ward	132
Southgate Ward	129
Poppy Ward	61

9 Financial Implications

9.1 The impact of maintaining safe staffing adds increased financial cost to the organisation specifically in relation to covering existing vacancies, sickness and additional unplanned activities. The information contained within this section of the report outlines fill rates within NSFT inpatient areas and indicates areas of high/low fill rates for the Boards information.

9.2 In order to maintain safe environments and provide consistency in care many areas continue to increase care support worker (CSW's) fill rates to maintain safe numbers where gaps in RN's are identified in the roster.

10 Equality Implications

10.1 Equality implications are assessed as part of the development of policies and approaches to improve workforce performance**.**

11 Risks / mitigation in relation to the Trust objectives

11.1 Staffing is a major risk to the Trust that is reviewed by the existing governance framework.

11.2 A report is sent to Locality/Service Managers daily regarding the number of shifts unfilled for their inpatient areas.

11.3 An additional daily report is sent to the Chief Nurse, the Chief Operating Officer and the Deputy Chief Nurse providing further detail on areas with unfilled shifts of five or above, together with further detail of the wider Multi-Disciplinary Team on shift for the day.

12 Recommendations

It is recommended that the board:

- Receives the report for information and assurance

Appendix 1a – Ward day fill shift rates for registered staff

Registered Nurse Day Shift Fill Rate Ward	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19
SECURE SERVICES TOTAL	**75.73%**	**69.09%**	**72.88%**	**78.94%**	**74.52%**	**77.39%**
Secure Services - Inpatient (MSU)	**83.43%**	**62.59%**	**64.46%**	**66.15%**	**77.87%**	**75.00%**
Catton Ward	83.43%	62.59%	64.46%	66.15%	77.87%	75.00%
Thorpe Ward						
Secure Services - Inpatient (LSU)	**73.79%**	**70.71%**	**75.02%**	**82.14%**	**73.69%**	**77.98%**
Drayton Ward	63.68%	59.14%	63.81%	91.71%	66.74%	91.75%
Foxhall House	88.55%	85.80%	78.98%	85.65%	69.31%	66.19%
Whitlingham Ward	84.71%	74.11%	78.99%	82.25%	93.78%	91.76%
Yare Ward						
Blakeney Ward	58.01%	64.64%	78.45%	68.75%	64.84%	62.09%
SUFFOLK TOTAL	**92.05%**	**90.83%**	**89.09%**	**89.83%**	**97.51%**	**88.75%**
West Suffolk - Older People (Inpatient)	**92.79%**	**93.18%**	**79.81%**	**87.37%**	**93.50%**	**92.13%**
Abbeygate Ward	92.79%	93.18%	79.81%	87.37%	93.50%	92.13%
East Suffolk - Adult Acute	**97.62%**	**89.37%**	**91.56%**	**92.18%**	**99.99%**	**89.85%**
Avocet Ward	100.27%	100.85%	88.50%	98.23%	100.93%	101.09%
Lark Ward	113.51%	97.79%	95.88%	84.83%	105.36%	92.68%
Poppy Ward	79.23%	71.98%	88.39%	90.11%	95.51%	77.15%
Suffolk Rehabilitation and Recovery Service	105.18%	90.24%	96.25%	93.28%	99.97%	89.79%
West Suffolk - Adult Acute	**83.49%**	**93.91%**	**85.28%**	**91.05%**	**90.53%**	**82.37%**
Northgate Ward	97.13%	97.71%	95.21%	96.84%	101.13%	90.63%
Southgate Ward	73.54%	90.73%	77.58%	86.51%	81.18%	75.91%
East Suffolk - LD	**78.78%**	**88.14%**	**87.82%**	**83.20%**	**112.74%**	**96.31%**
Walker Close	78.78%	88.14%	87.82%	83.20%	112.74%	96.31%
East Suffolk - Older People (Inpatient)	**96.68%**	**90.82%**	**94.20%**	**85.99%**	**94.38%**	**90.16%**
Willow Ward	96.68%	90.82%	94.20%	85.99%	94.38%	90.16%
NORFOLK & WAVENEY TOTAL	**83.90%**	**83.57%**	**84.32%**	**86.71%**	**86.32%**	**84.56%**
Great Yarmouth & Waveney - Older People (Inpatient)	**76.50%**	**82.50%**	**85.61%**	**81.81%**	**81.21%**	**81.13%**
Beach Ward	74.01%	77.78%	79.16%	72.96%	74.89%	75.70%
Laurel Ward	87.47%	92.81%	91.50%	79.41%	80.39%	93.86%
Reed Ward	87.81%	100.42%	104.70%	107.20%	92.53%	93.06%
Rose Ward	60.10%	68.20%	74.31%	79.33%	66.38%	71.11%
Sandringham Ward	73.75%	74.01%	80.50%	74.65%	90.67%	74.94%
West & South Norfolk - Adult Acute	**129.89%**	**120.13%**	**112.06%**	**90.14%**	**107.38%**	**101.87%**
Samphire Ward	129.89%	120.13%	112.06%	90.14%	107.38%	101.87%
Norfolk & Waveney CFYP - Gt Yarmouth and Waveney	**81.26%**	**72.83%**	**77.33%**	**82.54%**	**83.36%**	**82.72%**
Dragonfly Unit	81.26%	72.83%	77.33%	82.54%	83.36%	82.72%
North Norfolk & Norwich - Adult Acute	**75.97%**	**72.00%**	**76.42%**	**86.71%**	**82.89%**	**81.60%**
Glaven Ward	85.30%	82.88%	93.34%	91.26%	90.86%	86.40%
Rollesby Ward	74.44%	65.38%	65.67%	80.88%	77.37%	77.19%
Thurne Ward	65.56%	60.61%	68.17%	82.38%	85.40%	71.44%
Waveney Ward	84.35%	87.58%	82.19%	80.98%	59.85%	82.42%
Central Adult Yare Ward			107.90%	102.78%	103.05%	98.10%
Great Yarmouth & Waveney - Adult Acute	**118.10%**	**113.79%**	**99.89%**	**117.74%**	**109.36%**	**95.10%**
Great Yarmouth Acute Services	118.10%	113.79%	99.89%	117.74%	109.36%	95.10%
Norfolk & Waveney CFYP - Central Norfolk	**91.86%**	**96.93%**	**86.93%**	**84.98%**	**92.35%**	**96.29%**
Kingfisher Mother and Baby Unit	91.86%	96.93%	86.93%	84.98%	92.35%	96.29%
Grand Total	**85.49%**	**83.79%**	**84.18%**	**86.59%**	**88.28%**	**84.82%**

Appendix 1b – Ward night fill shift rates for registered staff

Sum of Reg Nurse Night Rate Ward	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19
SECURE SERVICES TOTAL	**70.10%**	**77.70%**	**80.49%**	**77.76%**	**77.24%**	**84.34%**
Secure Services - Inpatient (MSU)	**79.36%**	**91.98%**	**85.88%**	**87.23%**	**74.89%**	**93.61%**
Catton Ward	79.36%	91.98%	85.88%	87.23%	74.89%	93.61%
Thorpe Ward						
Secure Services - Inpatient (LSU)	**67.00%**	**72.92%**	**78.68%**	**75.41%**	**77.84%**	**82.50%**
Drayton Ward	77.44%	96.30%	102.66%	93.06%	85.83%	107.42%
Foxhall House	60.35%	69.29%	79.08%	68.84%	90.62%	90.62%
Whitlingham Ward	48.45%	51.19%	55.35%	59.44%	50.17%	50.17%
Yare Ward						
Blakeney Ward	106.76%	100.00%	100.33%	101.13%	100.00%	104.68%
SUFFOLK TOTAL	**89.37%**	**85.64%**	**85.71%**	**88.23%**	**93.24%**	**90.64%**
West Suffolk - Older People (Inpatient)	**89.85%**	**88.37%**	**95.01%**	**94.33%**	**94.57%**	**81.64%**
Abbeygate Ward	89.85%	88.37%	95.01%	94.33%	94.57%	81.64%
East Suffolk - Adult Acute	**95.06%**	**87.49%**	**90.49%**	**97.98%**	**95.61%**	**93.07%**
Avocet Ward	89.17%	85.04%	85.06%	101.83%	99.97%	91.09%
Lark Ward	92.68%	78.60%	79.16%	97.01%	96.09%	96.09%
Poppy Ward	94.01%	87.05%	91.54%	87.23%	84.58%	84.58%
Suffolk Rehabilitation and Recovery Service	112.89%	110.17%	120.81%	113.33%	107.56%	107.56%
West Suffolk - Adult Acute	**82.31%**	**76.67%**	**75.32%**	**72.47%**	**85.91%**	**85.91%**
Northgate Ward	99.44%	87.34%	90.47%	81.06%	101.08%	101.08%
Southgate Ward	65.17%	65.90%	60.12%	63.85%	70.67%	70.67%
East Suffolk - LD	**74.11%**	**67.74%**	**75.15%**	**69.51%**	**95.06%**	**95.06%**
Walker Close	74.11%	67.74%	75.15%	69.51%	95.06%	95.06%
East Suffolk - Older People (Inpatient)	**98.47%**	**112.31%**	**91.54%**	**98.34%**	**96.53%**	**96.53%**
Willow Ward	98.47%	112.31%	91.54%	98.34%	96.53%	96.53%
NORFOLK & WAVENEY TOTAL	**89.93%**	**96.28%**	**98.24%**	**90.79%**	**96.45%**	**96.96%**
Great Yarmouth & Waveney - Older People (Inpatient)	**92.19%**	**97.70%**	**94.06%**	**90.58%**	**100.44%**	**96.23%**
Beach Ward	71.19%	54.76%	53.77%	72.30%	65.00%	52.86%
Laurel Ward	90.45%	96.77%	96.68%	90.51%	100.00%	100.00%
Reed Ward	100.00%	138.00%	112.75%	103.55%	99.08%	99.08%
Rose Ward	91.11%	100.23%	147.71%	107.02%	103.33%	103.33%
Sandringham Ward	128.58%	134.17%	97.42%	98.08%	168.33%	168.33%
West & South Norfolk - Adult Acute	**86.95%**	**100.91%**	**94.00%**	**104.98%**	**109.91%**	**109.91%**
Samphire Ward	86.95%	100.91%	94.00%	104.98%	109.91%	109.91%
Norfolk & Waveney CFYP - Gt Yarmouth and Waveney	**98.31%**	**93.94%**	**98.98%**	**96.72%**	**95.00%**	**114.69%**
Dragonfly Unit	98.31%	93.94%	98.98%	96.72%	95.00%	114.69%
North Norfolk & Norwich - Adult Acute	**86.37%**	**88.97%**	**98.46%**	**89.29%**	**95.69%**	**95.69%**
Glaven Ward	87.13%	91.18%	96.93%	96.62%	96.74%	96.74%
Rollesby Ward	91.94%	110.33%	128.10%	103.70%	99.71%	99.71%
Thurne Ward	88.99%	91.37%	99.63%	79.14%	94.76%	94.76%
Waveney Ward	77.24%	62.93%	78.35%	71.59%	90.65%	90.65%
Central Adult Yare Ward			25.00%	95.09%	96.14%	96.14%
Great Yarmouth & Waveney - Adult Acute	**96.85%**	**106.60%**	**99.38%**	**109.13%**	**101.08%**	**101.08%**
Great Yarmouth Acute Services	96.85%	106.60%	99.38%	109.13%	101.08%	101.08%
Norfolk & Waveney CFYP - Central Norfolk	**83.47%**	**108.11%**	**113.57%**	**60.73%**	**68.88%**	**68.88%**
Kingfisher Mother and Baby Unit	83.47%	108.11%	113.57%	60.73%	68.88%	68.88%
Grand Total	**86.44%**	**89.43%**	**90.88%**	**87.92%**	**92.43%**	**92.91%**

Appendix 3 – Inpatient Team performance December 2019

	Day		Night		Day		Night	
Ward name	Average fill rate - registered nurses (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses (%)	Average fill rate - care staff (%)
Abbeygate Ward	92.1%	98.3%	81.6%	116.1%	-1%	-1%	-13%	4%
Avocet Ward	101.1%	107.8%	91.1%	127.6%	0%	-30%	-9%	-59%
Beach Ward	75.7%	110.3%	52.9%	133.9%	1%	-3%	-12%	3%
Blakeney Ward	62.1%	111.3%	104.7%	100.0%	-3%	-3%	5%	0%
Catton Ward	75.0%	127.1%	93.6%	129.5%	-3%	21%	19%	-47%
Dragonfly Unit	82.7%	96.0%	114.7%	145.3%	-1%	-4%	20%	7%
Drayton Ward	91.7%	105.9%	107.4%	132.7%	25%	-23%	22%	-28%
Foxhall House	66.2%	169.6%	90.6%	155.1%	-3%	4%	0%	0%
Glaven Ward	86.4%	93.4%	96.7%	132.7%	-4%	-22%	0%	0%
Great Yarmouth Acute Services	95.1%	95.0%	101.1%	118.9%	-14%	0%	0%	0%
Kingfisher Unit	96.3%	106.7%	68.9%	150.3%	4%	1%	0%	0%
Lark Ward	92.7%	215.0%	96.1%	149.7%	-13%	9%	0%	0%
Laurel Ward	93.9%	97.3%	100.0%	96.8%	13%	1%	0%	0%
Northgate Ward	90.6%	101.4%	101.1%	108.0%	-11%	18%	0%	0%
Poppy Ward	77.1%	98.5%	84.6%	123.5%	-18%	4%	0%	0%
Reed Ward	93.1%	120.9%	99.1%	105.1%	1%	11%	0%	0%
Rollesby Ward	77.2%	122.3%	99.7%	130.8%	0%	-18%	0%	0%
Rose Ward	71.1%	137.5%	103.3%	149.4%	5%	-16%	0%	0%
Samphire Ward	101.9%	105.7%	109.9%	101.8%	-6%	-1%	0%	0%
Sandringham Ward	74.9%	113.2%	168.3%	105.0%	-16%	-2%	0%	0%
Southgate Ward	75.9%	88.0%	70.7%	111.0%	-5%	7%	0%	0%
Suffolk Rehabilitation and Recovery Service	89.8%	87.8%	107.6%	96.9%	-10%	-2%	0%	0%
Thurne Ward	71.4%	172.4%	94.8%	112.0%	-14%	59%	0%	0%
Walker Close	96.3%	114.5%	95.1%	158.1%	-16%	-6%	0%	0%
Waveney Ward	82.4%	104.9%	90.6%	130.7%	23%	-8%	0%	0%
Whitlingham Ward	91.8%	155.0%	50.2%	198.7%	-2%	-16%	0%	0%
Willow Ward	90.2%	185.4%	96.5%	165.1%	-4%	27%	0%	0%
Yare Ward	98.1%	92.5%	96.1%	118.7%	-5%	-16%	0%	0%

Key:	
	Fill rate below 80%
	Shift Fill Rate 90%-120%
	Shift Fill Rate above 120%

9.3

Date:	**23rd January 2020**	**J**
Item:	**20.11**	

Norfolk and Suffolk NHS
NHS Foundation Trust

Report To:	Trust Board of Directors
Meeting Date:	23rd January 2020
Title of Report:	Guardian of Safe Working Report (GOSW)
Action Sought:	For Assurance and information
Estimated time:	10 minutes
Author:	Dr Sara Ramirez Overend – Guardian of Safe Working Hours
Director:	Dr Dan Dalton – Chief Medical Officer

Executive Summary:

The new Junior Doctors' Contract has been implemented and exception reporting systems are in place to monitor any resulting problems. Since coming into post as guardian it has been evident that there is confusion amongst junior doctors around the purpose of exception reporting. Part of the confusion may have been caused that the junior doctor handbook stating that exceptions should only be reported if they could not be resolved locally. This information is misleading, and all exceptions should be reported. The handbook has now been corrected and junior doctors have been informed of the error.

The information given at induction does request that all exceptions are logged but the information in the handbook contradicted this and may have led to some confusion. Further ways of improving the use of the system both amongst junior doctors but also clinical supervisors will be explored. The exception reports for the period of December since I have been in post do not appear to reflect significant systemic problems of unsafe working. However, this needs to be understood in the context of currently low levels of reporting.

The report relates to BAF risks 1.1 and 4.1

9.4

1.0 Progress So Far

1.1 All except 1 doctor is on the new contract. The mentioned doctor has chosen to stay on the old contract

1.2 The Allocate exception reporting system is up and running and demonstrations of the system have taken place at Junior Doctor forums and at Junior Doctor induction. Periodic training is available as needed.

1.3 The Junior Doctor Forum has been established and has met at various locations around the Trust. However engagement is challenging due to work commitments and morale. GOSW is meeting with Doctors in training (DIT) in a variety of locations to increase engagement and morale.

1.4 GOSW is also attending induction for doctors in training.

1.5 A DIT away day is being planned for February 2020.

1.6 Meetings with regional GOSW have been arranged and some have already taken place. GOSW is part of the East of England regional network.

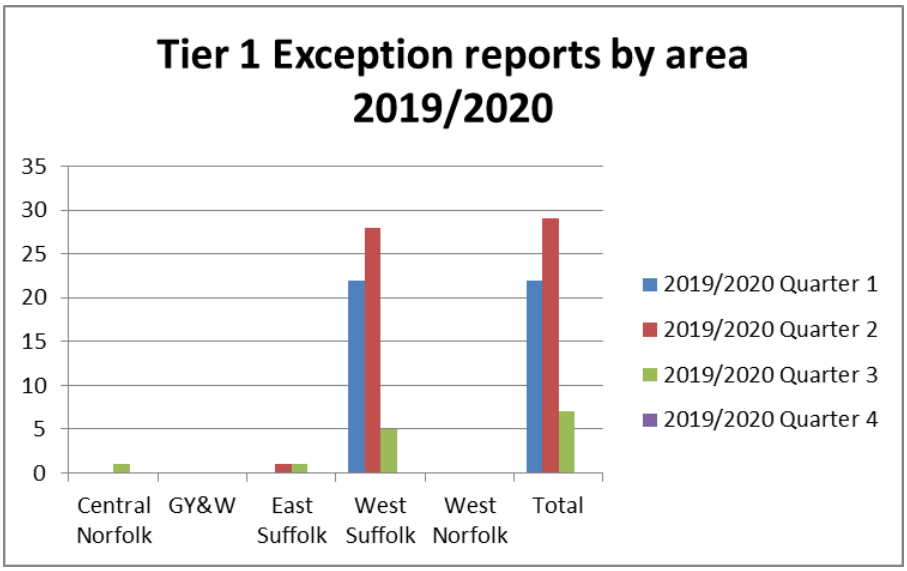
2.0 Exception reporting

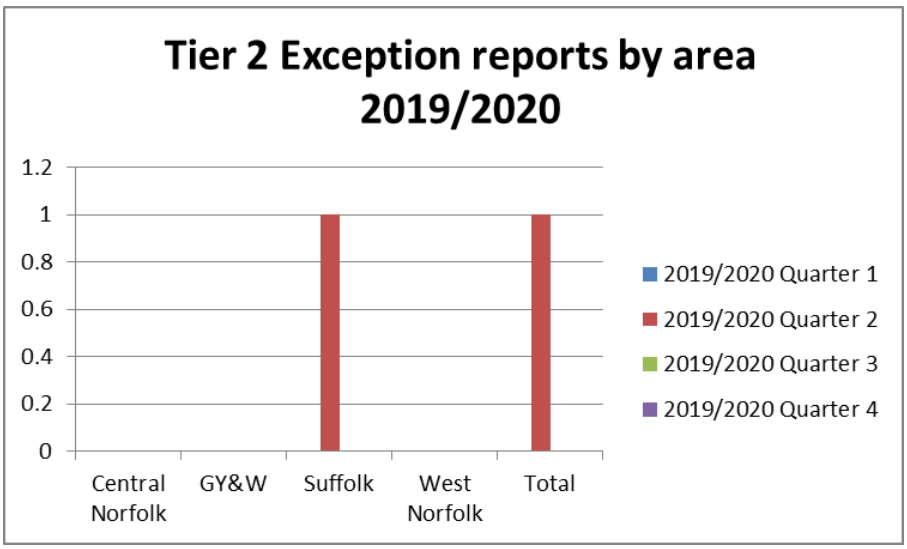
2.1 The Trust is using the Allocate system for online exception reporting and resolution of rota and hours of work issues. This system is live and is central to the implementation of the new contract. The level of reporting is low. Reasons for this are being explored, however it has been identified that the information in the Junior Doctors Handbook was wrong encouraging junior doctors to resolve issues locally rather than report. All exceptions should be reported, and this has now been corrected in the handbook. It was also identified that not all junior doctors had their Allocate system passwords. HR has now contacted the junior doctors giving them information on how to obtain a password.

2.2 The Medical Staffing Manager emailed all trainees and requested that they submit any exceptions that may have occurred previously that they have not logged even though they would normally be logged within 7 days of occurrence. None of the exceptions reported have related to immediate safety concerns

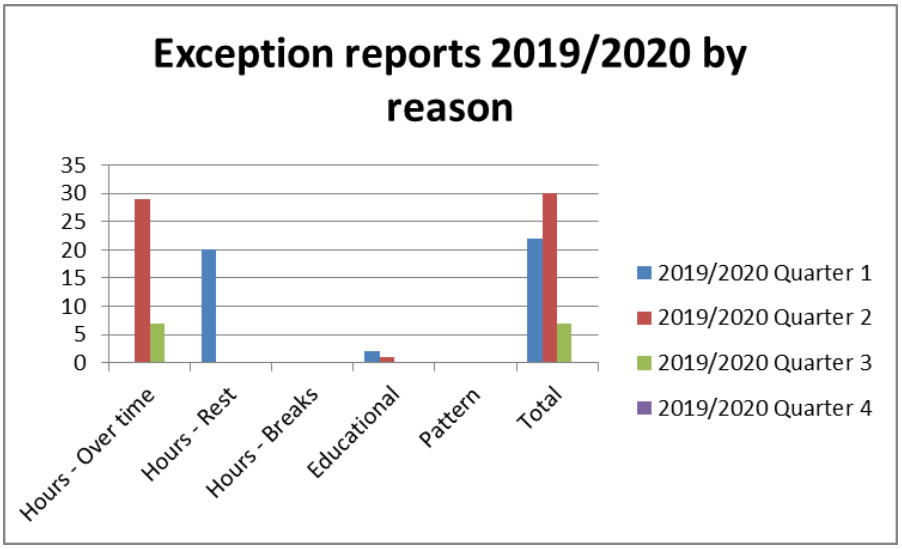
2.3 Exception reports are increasing as doctors become more familiar with the system. Since the system was introduced there have been a total of 113 exceptions.

Most exception reports within the Trust have been from West Suffolk. The graphs below show the activity each quarter for year 2019/2020





9.4



2.4 During the last 3 months there have been 7 exception reports all for additional hours worked

2.5 There is currently 1 live exception submitted in December which is in the process of being dealt with.

2.6 Difficulties have been encountered with the Allocate system in respect of doctors on short-term rotations who leave the Trust, and who lose access to NSFT accounts, resulting in exceptions not being closed even though they have been resolved and showing as in breach of time limits. This issue has been raised with the software providers.

9.4

3.0 Remedial actions and fines

3.1 All reported exceptions have been resolved at the most local level of review, either by overtime payment of by provision of time in lieu. It has not been necessary or appropriate for the Guardian to levy any fines on the Trust for persistent breaches of contract.

4.0 Junior Doctor Engagement

4.1 The Junior Doctors' Forum is established, and venues continue to be reviewed to facilitate attendance. The Director of Medical Education and local supervisors are encouraging attendance and promoting the forum.

4.2 The new GOSW has written to all junior doctors to introduce herself and encourage them to raise concerns and make contact. Further efforts will be made to contact supervisors and DIT to clarify any questions or concerns they may have around exception reports.

4.3 In order to improve DIT experience and retention we have established regular Junior/Senior meetings. Consultants meet with DIT to discuss local issues and de-escalate appropriately.

4.4 We are working on ensuring good quality exposure in Psychiatry for trainees including experience in acute as well as community Psychiatry. We are taking steps to train others professions in procedures that do not require a trainee doctor to perform (such as phlebotomy, ECG).

4.5 In order to improve the quality of training and morale we are organising a DIT away day.

Dr Sara Ramirez Overend
Guardian of Safe Working

Background Papers / Information

None

Date:	**23rd January 2020**
Item:	**20.12**

K

Norfolk and Suffolk NHS
NHS Foundation Trust

Report To:	Board of Directors
Meeting Date:	23rd January 2020
Title of Report:	Access and Waiting Times Report
Action Sought:	For information
Estimated time:	10 mins
Author	Amy Eagle Deputy Chief Officer Gill Morshead Access Improvement Director
Director:	Stuart Richardson, Chief Operating Officer

Executive Summary:

NSFT has identified the improvement of access to services and the reduction in waits as one of its highest strategic priorities.

It is recognised that timely intervention and treatment supports better outcomes for service users and their significant others and is a basic tenet of the NHS Constitution 2010.

Improvement Plans are in place for all teams with waits, with measurable actions required to meet access standards, these are owned by the Care Group Service Directors with progress monitored by at the bi-monthly Quality and Performance Meetings.

A Waiting Times Report is in use operationally to ensure responsive and consistent information to drive remedial action and ongoing referral management.

Waiting list management is monitored by the Access Improvement Taskforce which reports to the Quality Committee and is referenced in the performance report to the Board.

An update on action within the Eating Disorder service is provided.

The information in report relates to BAF risk 4.2

Recommendation:

For the Board to note the content of the report

1.0 Introduction

1.1 NSFT has identified the improvement of access to services and the reduction in waits as one of its highest strategic priorities. It is recognised that timely intervention and treatment is key to better outcomes for service users and their significant others and is a basic tenet of the NHS Constitution 2010.

1.2 Trust wide performance for access and waiting times for the period to 31st October 2019 is highlighted in the Integrated Performance Report. The purpose of this report is to provide assurance to the board on progress made and of future actions planned.

2.0 Achieved in last period

2.1 The weekly Trust wide Service User Tracker meetings to track the progress of community referrals has been transferred to each Care Group and owned by the Service Director.

2.2 Each care group has a series of data check points from weekly team level to monthly care group governance meetings to ensure waits are safely managed and improvement noted.

2.3 This detailed Waiting Times Report is used operationally to ensure availability of responsive and consistent information to drive remedial action planning and ongoing referral management.

2.4 Remedial Action Plans (RAPs) in place for all teams where performance does not meet standard for referral to assessment or referral to treatment.

2.5 The Single Point of Access for over 18 and under 18 in Norfolk (SPOA) now provides an administrative only function for referrals, with triage and ongoing management of referrals for assessment with operational clinical teams, reducing un necessary steps in the process to assessment.

2.6 The single point of access for over 18's in Suffolk (AAT) has also been reviewed to ensure new routine referrals are managed directly by clinical teams, providing timely and streamlined access to support via removal of the previous step.

3.0 Our Current Focus

3.1 Oversight of Remedial Action Plans to include measurable actions required to meet access standards, owned by the Care Group Service Directors with progress monitored at Quality and Performance Meetings. Progress is monitored by the Access improvement Taskforce which reports to the Quality Committee and is referenced in the performance report to the Board.

3.2 Support provided to teams to implement local waiting list reduction includes:

3.2.1 Several community teams are now offering evening and weekend appointments, reducing DNAs by contacting people with reminders about appointments or arranging them in different ways to help people attend.

3.2.2 Great Yarmouth and Waveney Community Teams have begun phoning patients 1-2 days prior to their Initial Assessment appointment to remind them of the time/venue etc.

3.2.3 The Great Yarmouth and Waveney Care Group adult community teams run two late night clinics per week (alternate weeks at Silverwood Great Yarmouth and Meridian House Lowestoft), which allows for people who have work/childcare commitments to come along to a late appointment (7pm is last slot those nights).

3.2.4 The Care Group adult teams are also running a drop in every Wednesday from 1pm-4.30pm, which again is alternated each week between Silverwood and Meridian House, patients are given this information at their assessment appointment.

3.2.5 The Youth teams in Norwich are offering Drop in clinics and will be part of a pilot to launch Text messaging to remind service users of their appointments.

3.2.6 The Youth Team in Norwich admin team continue to support teams by telephoning all patients 2-5 days before their appointment as a reminder.

3.2.7 The Youth Team in the West have introduced a call for any appointments being offered under 2 weeks alongside a letter sent to support attendance.

3.3 Increased focus on recruitment and retention of our workforce and implementation of phase 2 of our clinical leadership model; ensuring clear local clinical oversight of access issues.

4.0 Next Steps

4.1 Support to Care Groups to develop demand and capacity analysis for all community teams across Norfolk and Suffolk. This is a twelve-month plan with an initial focus on working through the demand and capacity of the NSFT teams with most challenged waits. With Suffolk demand data completed, Norfolk and Waveney demand data will be completed by end of January 2020 which will support the next steps in terms of understanding the team-based demand and capacity to support future modelling.

4.2 Quality and Safety Summits focussing on Access and Waiting List management at a team level, reviewing CQC report findings for access to confirm current focus and inform future action.

4.3 NSFT will continue to work closely with the Norfolk and Waveney Sustainability and Transformation Partnership and the Suffolk and North East Essex Integrated Care System to review and implement the Community Mental Health Framework. This describes how the Long-Term Plan's vision for a place-based community mental

health model can be realised, and how community services will modernise to offer whole-person, whole-population health approaches, aligned with the new Primary Care Networks. This will support the development of primary care-based interventions and crisis support.

5.0 Eating Disorders

5.1 Suffolk

The Eating Disorders Service (Under 19 and Adult) moves into the newly formed Suffolk Children, Family and Young People Care Group at the end of January 2020.

The teams will retain their geographical locations (Ipswich and Newmarket), but their clinical governance would be centralised within the Suffolk CFYP Care Group.
The CCG has requested as part of the clinical safety service review that the Suffolk CFYP Care Group develop a Trajectory demonstrating when the required under 19 access and treatment KPIs will be achieved, providing weekly assurance updates to demonstrate the ongoing actions of the teams to meet the KPIs

Since December, all suitable referrals have been offered appointments within the specified timescale as appropriate to the priority type of the referral. Assurance is provided by the clinical team leader sending weekly reports to the Suffolk CFYP Care Group Leadership team to demonstrate that the teams are offering appointments within the required timescales.

The next steps are to ensure that this approach is consistently achievable to enable a service offer that is line with the National Waiting Times Staffing Standards.

5.2 Norfolk

Review and Improve engagement with client group in collaboration with CCG

An ED specific referral document is being developed in GYW and will be piloted. If successful, this will be rolled out across teams and will support improved quality of referral information.

Consideration is currently being given via. steering group to option of an evening clinic to support assessment where parent/ carers are unable to leave work for whatever reason.

The referral pathway previously developed to enable access to more timely assessment requires revisiting. This has proved difficult in recent months to sustain with the capacity issues within team. This is an issue in Central primarily.

6.0 Recommendations

6.1 For the Board to note the content of the report.

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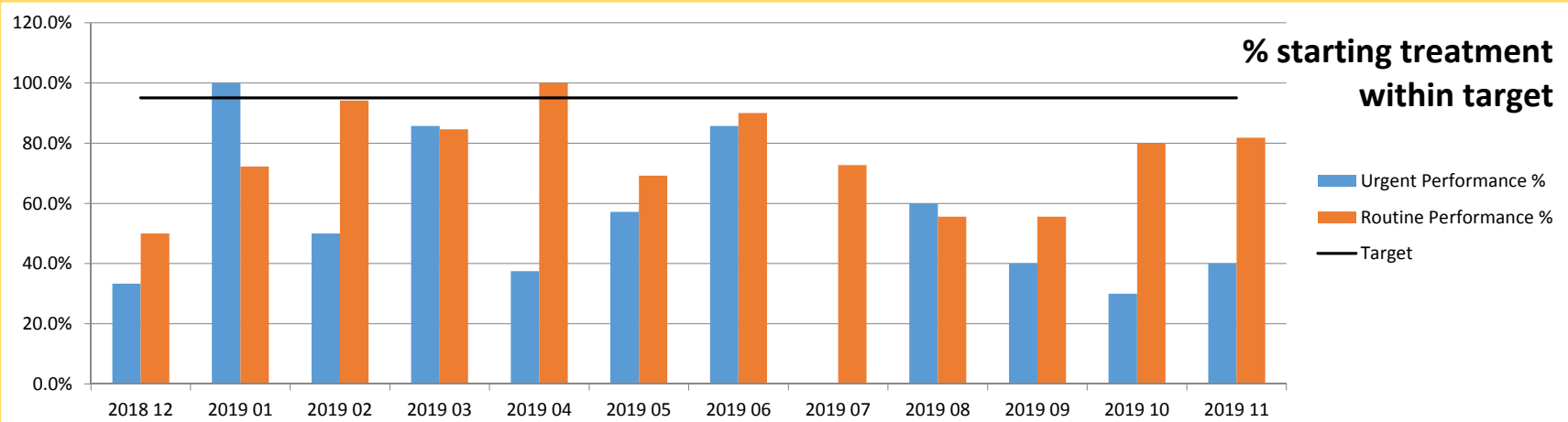
Access Improvement
Eating Disorder – Deep Dive

Working together
for better mental health

Trustwide Performance

Norfolk and Suffolk NHS Foundation Trust

Activities	Month 2018 12	2019 01	2019 02	2019 03	2019 04	2019 05	2019 06	2019 07	2019 08	2019 09	2019 10	2019 11
Urgent												
Completed - Treatment	6	3	6	7	8	7	7	3	5	5	10	5
Completed - Treatment within 1 week	2	3	3	6	3	4	6		3	2	3	2
Urgent Performance %	33.3%	100.0%	50.0%	85.7%	37.5%	57.1%	85.7%	0.0%	60.0%	40.0%	30.0%	40.0%
Routine												
Completed - Treatment	14	18	17	13	13	13	10	11	9	9	10	11
Completed - Treatment within 4 weeks	7	13	16	11	13	9	9	8	5	5	8	9
Routine Performance %	50.0%	72.2%	94.1%	84.6%	100.0%	69.2%	90.0%	72.7%	55.6%	55.6%	80.0%	81.8%



Working together for better mental health

Norfolk and Suffolk NHS Foundation Trust

Breakdown of Breaches (from Oct breach exception report)

Suffolk

- Data errors
- Difficulties around getting to clinic for assessment due to family circumstances.
- Difficulties engaging SU parents for telephone triage and gaining further information as GP referral was limited

Norfolk

- Delay in securing a joint assessment appointment with 'core' services where a comorbidity is indicated and a single joint assessment is considered clinically preferable to asking the young person to go through assessment twice.
- Non- outcome or lack of SNOMED coding – generally cleansed before data submission.
- Cancellation of appointments by families
- Poor quality of referral information from GP requiring further liaison before accepting referral.
- Data errors
- Summer holidays- patient unable to attend sooner

Norfolk and Suffolk NHS Foundation Trust

Actions to Improve safety and performance

Suffolk

- Clinical governance to be centralised within the Suffolk CFYP Care Group to ensure consistent model
- Developed a Trajectory Chart demonstrating when the KPIs (Urgent & Routine) would be achieved by teams- The impact of this has been that since November, all suitable referrals have been offered appointments within the specified timescale as appropriate to the priority type of the referral

Norfolk

- Review and Improve engagement with client group in collaboration with CCGs
- An ED specific referral document is being developed in GYW and will be piloted. If successful this will be rolled out across teams and will support improved quality of referral information.
- Consideration is currently being given via. steering group to option of an evening clinic to support assessment where parent/ carers are unable to leave work for whatever reason.
- The referral pathway previously developed to enable access to more timely assessment requires revisiting. This has proved difficult in recent months to sustain with the capacity issues within team. This is an issue in Central primarily.

Date:	**23 January 2020**	**L**
Item:	**20.13**	

Norfolk and Suffolk NHS Foundation Trust

Report to:	Board of Directors
Meeting date:	23 January 2020
Title of report:	Strategic Activity Update
Action sought:	For Information
Estimated time:	10 minutes
Author:	Mason Fitzgerald, Deputy CEO / Director of Strategic Partnerships
Director:	Mason Fitzgerald, Deputy CEO / Director of Strategic Partnerships

Executive Summary:

The aim of this report is to provide the Trust Board with an update on key areas of the Trust's strategic decision-making, planning and management. It is structured to provide information on:

- The national context.
- Our partnership working in local integrated care systems.
- Progress in developing the new Trust strategy.

The report contains a number of national news items that will be of interest to the Trust, as well as updates from our local systems. The report provides an update on the project to develop new wards at the Hellesdon Hospital site.

The report also provides an update on the implementation of the Trust strategy. The key next steps are to develop of care group plans aligned with the strategy, and the development of Trust-wide annual priorities for 2020/21, following consultation with governors, staff and other stakeholders.

The report links to the risk 2.2 on the BAF.

Recommendation:

The Board is asked to discuss and discuss the contents of this report.

Norfolk and Suffolk NHS Foundation Trust

Strategic Activity Update

1.0 National Context: Emerging Themes, Policies and Initiatives

1.1 Any solution to health and care workforce challenges will continue to rely on overseas recruitment

- New Nuffield Trust analysis revealed that one in four hospital staff is born outside of the UK, compared to 14% of the general population.
- The analysis of data also revealed that 50% of the increase in the health and social care workforce over the last decade was from workers born abroad.
- The figures were obtained from the Office for National Statistics.

1.1.1 The analysis made it clear how much the NHS depends on and values people born outside of the UK or who are recruited internationally to adequately staff health and care services and deliver high-quality care to patients. The analysis also highlighted the dedication and commitment of those staff who are working under intense levels of pressure day in and day out. There are over 105,000 vacancies across the trust sector alone. Both in the NHS and the social care sector, any solution to reducing these vacancies will continue to rely on overseas recruitment. It will be several years before domestic supply increases enough to help close the gap.

1.2 NHS fighting back against rising tide of gambling ill health

1.2.1 The NHS is facing a rising tide of gambling related ill health as more betting addicts than ever before are being taken to hospital. New data released showed a record number of admissions last year related to gambling addiction, including care for severe mental ill health conditions like psychosis. The number of gambling related hospital admissions has more than doubled in the last six years from 150 to 321. Cases of pathological gambling, where people turn to crime to fund their addiction has increased by a third in the last 12 months, bringing the total to 171.

1.2.2 The steady rise in admissions has prompted the NHS to commit to opening 14 new problem gambling clinics by 2023/24, alongside the first ever gambling clinic aimed at young people

earlier this year as part of its Long-Term Plan. A person affected by gambling related harm addiction has an intense desire to bet that interferes with their day-to-day lives. 171 patients were admitted for 'pathological gaming' last year, where a patient's addiction to gambling is so severe that it can lead them to crime.

1.2.3 The NHS estimates that over 400,000 people in England have an addiction to gambling and two million people are at risk of developing the condition. There has also been an increase in the number of young people that are affected by gambling related harm. 46 people under the age of 25 attended a hospital as a result of their addiction last year, with one person as young as 15 receiving treatment, compared to 37 people under 25 receiving treatment the year before – an increase of a quarter.

1.2.4 NHS Digital data published earlier in December 2019 found that more than half of people living in Britain gamble. Research has shown betting firms spent an estimated £1.5bn in 2017 on marketing ads, while a report in the British Medical Journal called for the introduction of a mandatory tax on the industry to fund and prioritise treatment. Bookmakers are currently encouraged by the Gambling Commission to donate a combined £10m to charities which help victims of gambling addictions – just 0.07% of what gambling companies currently receive from punters.

1.3 'Never a better time to join the NHS' says health chief Simon Stevens

1.3.1 NHS Chief Simon Stevens is urging people of all ages to consider embarking on a career in the health service next year, as he thanks those current staff who will be working over Christmas. People who apply for nursing, midwifery and some Allied Health Professional degrees by 15 January 2020 will be eligible for financial support of up to £8,000 a year if they start their studies in September 2020. Extra support is available for people with childcare responsibilities as well as for mental health nursing.

1.3.2 The NHS will publish plans to help make the health service the best place to work, in a bid to attract and retain more nurses and other clinical staff. 2020 sees the 200th anniversary of Florence Nightingale's birth and has been designated *International Year of the Nurse and Midwife*, a worldwide celebration of the huge contribution made by all those who have followed in her footsteps. Nurses and midwives will be central to delivering the

improvements and expansion of care and treatment for patients set out in the NHS Long Term Plan, published at the beginning of the year.

1.3.3 Over the last 12 months alone, the NHS has delivered a number of firsts, including opening new clinics for children with gambling and gaming addictions, providing new treatments for conditions like cystic fibrosis, and funding miracle cures to restore children's sight. The NHS is central to so many of our communities across the country, whether it's the local pharmacy, the GP surgery or the local hospital.

1.3.4 An estimated 12,000 midwives across the country who are expected to welcome around 1,400 babies into the world on Christmas Day. Another 98,000 nurses and 55,000 nursing assistants will be working in hospitals and in the community over the bank holidays while around 12,000 ambulance staff, including paramedics, will be on duty on Christmas day. Hospital catering staff will serve up an estimated 400,000 Christmas dinners to ensure staff, patients and their families don't miss out on their festive favourites. And some 145,000 care workers and home carers will also be providing care like any other day.

1.4 Eleven million wait more than three weeks to see GP

1.4.1 A report in the Times revealed that eleven million patients have endured waits of more than three weeks to see a GP since prime minister Boris Johnson pledged to eradicate such delays. Of those, 5.6 million waited more than a month. The data emerged from the Sunday Times investigation into waiting times. Improving access to GPs is the second-highest health priority for the public, after increasing NHS staff numbers, according to a recent Ipsos Mori poll.

1.4.2 NHS Digital figures show that within the 11 million, 5.6 million patients waited over a month. The figures also revealed October 2019 had the highest number on record of patients waiting more than 21 days for a GP appointment. Over three million patients (3.3m) waited over 21 days in October – a 16% rise from the same time in 2018. Almost half of those (1.6m) waited more than four weeks.

1.4.3 The BMA GP Committee chair reported the figures come amid a backdrop of falling GP numbers as, despite their best efforts, many practices simply do not have the capacity to meet the ever-increasing demand. While the creation of primary care networks should facilitate more patients being seen, the need for more fundamental changes if we are to create a sustainable primary care service for patients in the long term. Ultimately, the

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Government needs to tackle the root of the problem including stopping experienced family doctors leaving the profession or reducing their hours, tackling rising workloads, modernising premises and addressing the punitive pension regulations.'

1.4.4 The RCGP chair noted that it is totally unacceptable to expect patients to wait weeks for a GP appointment and that the new Government should take this seriously and deliver quickly on its General Election manifesto pledge of 6,000 additional GPs and many more thousands of the wider general practice team. Over 1 million patients are seen in general practice every day, and GPs are doing their best but the service cannot keep stretching. There are limits beyond which GPs can no longer guarantee safe care to patients and the potential for error or misdiagnosis increases.

1.5 More work needed to drive out bullying and unfair treatment in NHS

- The General Medical Council (GMC) has published the initial results of its first ever survey of specialty and associate specialist (SAS) and locally employed (LE) doctors.
- The survey found that 30% of SAS doctors and 23% of their LE counterparts had been bullied, undermined or harassed at work in the last year.
- Around one in six respondents reported suffering threatening or insulting comments or behaviour.
- Where bullying related to protected characteristics was reported, race was the most commonly-cited factor.

1.5.1 Responding to the GMC survey of SAS and LE doctors, the deputy chief executive of NHS Providers highlighted that today's survey findings are extremely concerning. It is unacceptable for any NHS member of staff to experience bullying and undermining behaviour from colleagues and patients. These actions fundamentally contradict the core values of the NHS of respect and dignity, compassion and inclusion.

1.5.2 Professionals working in SAS and locally employed roles are essential members of the NHS workforce. And yet it is clear that SAS doctors have been experiencing disproportionate feeling of isolation, and being undervalued, for some time. It is particularly distressing to see

that race is the most commonly-cited factor in reports of bullying behaviour. We know that there are strong links between a diverse workforce and good patient care.

1.5.3 Trusts are aware of the need to improve the offer to staff working in these roles, but more work and wider support is needed to ensure that this trend discontinues across the health and care system. Trusts are aware of the need to improve the offer to staff working in these roles, but more work and wider support is needed to ensure that this trend discontinues across the health and care system.

1.6 NHS Provider's Winter Watch:

1.6.1 NHS England released the January monthly performance summary, which reflects significant demand across the sector.

1.6.2 In the monthly performance summary, A&E performance was again bleak, as the highest December attendances on record led to a new low of only 79.8% of patients seen within the four-hour target. Almost 100,000 patients waited longer than four hours, and of these, 2,347 waited longer than 12 hours. This is more than double the number of the previous month and eight times more than a year ago. Additionally, all three major cancer targets were missed, as were the targets for elective care, diagnostics and ambulance services, as good news was in short supply.

1.6.3 Turning to the sitreps data, a similar pattern to previous years, with slight reductions in a number of indicators as hospitals paused elements of planned care over the break.

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However, the week five data featured below shows no respite from many of the pressures observed over the first two weeks of winter.

1.6.4 Key week five headlines include:

- Bed occupancy is back up to 94.2% after the Christmas break. While this is very high, it is slightly lower than where we began at the start of winter.
- There were 97,143 beds open in total this week, with escalation beds up by over 28% compared to the same point last year (925 more beds).
- More patients are staying longer in hospital, with significantly more staying longer than 7, 14 and 21 days than the previous week. Compared to the same point last year there are approximately 6% more patients staying longer than 7, 14 and 21 days.
- Ambulance arrivals are very high at 100,569, and handover delays are much higher than anything seen last winter. Almost one in five (18.1%) patients arriving by ambulance were delayed by 30 minutes or more, and 5.4% were delayed by 60 minutes or more.
- Beds closed with D&V and norovirus are down to 555, much lower than the start of the winter and only slightly higher than the same time last year.
- As an overall indicator of demand, it is hard to avoid looking first at bed occupancy, which rose above 94% after a relatively quiet week in week four (89.4%). Trusts are continuing to open more escalation beds, but this alone will not solve the issue as ever more patients require treatment. Ambulance arrivals topped 100,000 again this week, and we have seen three of the four highest weeks on record already this winter. There were more handover delays than previously seen at any time in the last two winters as patient flows in hospitals feel the pinch.

1.6.5 With almost one in five patients arriving by ambulance being delayed by 30 minutes or more there are serious concerns for patient safety. Of these, 775 patients were delayed by 60 minutes or more each day, with 114 trusts reporting delays of this length (86% of the total). Last winter, ambulance handovers were noticeably lower than the previous year, and improvements to the way hospitals handled these patients were justifiably celebrated.

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Unfortunately, it appears the current volume of arrivals coupled with higher occupancy rates is leading to these gains being swamped in 2019/20.

1.7 Questions remain over how quickly NHS can deliver long term strategy

Commenting one year on from the publication of the NHS long term plan, the deputy chief executive of NHS Providers commented that a year ago, trust leaders welcomed the broad vision and ambitious programme of transformation for a 21st-century health service set out in the NHS long term plan. A year ago, trust leaders welcomed the broad vision and ambitious programme of transformation for a 21st-century health service set out in the NHS long term plan. However, the questions they raised then - about the need to prioritise these ambitions, and to set out clearly what should be delivered, by when, within the funding and workforce constraints remains.

We will not be able to deliver on these ambitions, and risk setting the NHS up to fail, if we do not turn around the severe workforce challenges that health and care services are facing. The full NHS people plan, which we are expecting soon, must meet the challenge of rapidly rising demand for care.

While we have seen some positive announcements on capital investment into health service buildings, IT and equipment, we have a long way to go to cover years of underinvestment in order to rebuild our NHS. While we have seen some positive announcements on capital investment into health service buildings, IT and equipment, we have a long way to go to cover years of underinvestment in order to rebuild our NHS.

We also need a clear path and a realistic timeline for recovering performance in areas such as emergency care, cancer and planned operations, and additional investment in community, mental health and ambulance services.

Finally, if the NHS is to deliver its plan, government must ensure support for a sustainable and fair social care system and reverse years of public health budget cuts.

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2.0 New Care Models Collaborative

2.1.1 Data has been received by the Collaborative from NHSE relating to the activity commissioned for the region for each service. However, this only extends to April 2019. The data is currently being analysed and will be reflected in the business cases which are being prepared. The Collaborative's service leads for Secure, Adult specialist eating disorders and Tier 4 CAMHS have now drafted the case for change for each, with the input of lead clinicians and managers from each Trust. These are being consulted on further before forming part of the business case submission.

2.1.2 The issues will be discussed at the Council's Significant Business Committee in February, and at the Finance, Business and Investment Committee, which will consider the business cases.

2.2 Suffolk Mental Health Alliance

2.2.1 There is currently intense focus on the process mapping of care pathways within each of the four priority workstreams, to which our clinical and operational leaders are contributing, along with other Alliance members. Community is a particular focus, as it comprises so many pathways and is being so thoroughly revised, and this is putting considerable pressure on the capacity of the three Suffolk Care Groups.

2.2.2 Stuart Richardson, Chief Operating Officer has joined the children's workstream as joint Senior Responsible Officer and Amy Eagle, Deputy Chief Operating Officer has assumed the same role in the community workstream.

2.3 Norfolk & Waveney STP

2.3.1 Jonathan Warren will be the Chair of the Mental Health Programme Board from February 2020, and terms of reference and membership of the programme board and supporting workstreams are being revised in order to ensure appropriate representation and focus on the delivery of the STP mental health plan.

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3.0 Hellesdon Hospital New Wards Development

3.1.1 Following the Election result, the communication and engagement activity for the project has begun. Several expressions of interest have been received from current and ex-service users who have recently experienced in-patient services. Co-production training for all workstream members has been scheduled for January 2020.

3.1.2 The clinical workstream has begun a review of Must Do features for the new service. The group also confirmed all the data (both historical data and future predictions) needed to make recommendations on the services to be provided. The group intends to be able to identify a first draft option of services to be provided by the end of January 2020.

3.1.3 An initial planning meeting was held with Broadland District Council in December 2019 and clear guidance has been given on the key areas for the outline planning application to consider. A Project Board has been established and will meet for the first time in February 2020. The recruitment of a lead Project Director has been approved by the Executive Team and an appointment is expected in January 2020.

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4.0 Trust strategy

4.1 The Trust Board has recently approved the new Trust strategy, and work is underway to ensure that the strategy is implemented across the Trust. The annual planning process provides the opportunity to do this in a structured way.

4.2 The key components of the annual planning process for 2020/21 are as follows:

October 2019

- Budget setting/CIP development begins

December 2019:

- Initial Trust Board discussion to reflect on progress in 19/20 and identify key priorities for 2020/21

January 2020:

- Care group away day to develop annual plans for 2020/21, including key priorities and risks
- Contract negotiations with commissioners commence

February 2020:

- Consultation begins with members, staff and stakeholders

March 2020:

- Council of Governors discussion of consultation feedback and identification of key priorities to submit to the Trust Board
- Contract negotiations with commissioners conclude
- FBIC review of draft plans and Board approval for submission

April 2020:

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Final Trust and care group annual plans

Submission of NHSE/I template annual plan

Incorporation of key priorities/risks etc. into performance and risk frameworks for in-year monitoring

Date:	**23rd January 2020**	**M**
Item:	**20.14**	

Norfolk and Suffolk NHS Foundation Trust

Report To:	Board of Directors
Meeting Date:	23rd January 2020
Title of Report:	Integrated Performance Report
Action Sought:	For Assurance
Estimated time:	10 Minutes
Author:	Daryl Chapman, Director of Finance
Directors:	Daryl Chapman, Director of Finance Stuart Richardson, Chief Operating Officer

Executive Summary:

The purpose of this report is to provide information on Trust wide performance against a range of key performance indicators for the period to 30th November 2019.

Financial performance is reported for the period ending 31st December 2019.

The Board Assurance Framework is included in Appendix 2, showing the risks to delivery of the Trust's strategic objectives and in relation to performance and mitigations to address those risks. It shows the movement in risk rating this month and target dates for meeting the target risk rating governed by the Board's risk appetite in each area. Significant risks identified are relating to implementing learning from incidents (Risk 3.2) and waiting times (Risk 4.2)

The information contained within this report is to inform practices and policies, identify areas for improvement, and to ensure NSFT delivers effective and efficient care for its service users.

Operational Performance

Waiting Times - The Trust continues to face challenges in meeting waiting time targets for commencement of both assessment and treatment. Performance against the 4-hour assessment waiting target for Emergency referrals is reported at 76%, this is an improvement on Septembers reported figure by 1.92% although 17.45% below the reported percentage of November 2018.

Performance against the 28-day waiting target for Routine referrals has improved from 71.97% reported in September 2019 to 76.05% in November 2019, a 4.08% improvement. This is also 4.13% above the November 2018 percentage (71.92%).

The Trust has three Contract Performance Notices outstanding for failure to meet waiting time standards, assurances remain from Commissioners that financial sanctions will not be taken. Commissioners are involved in the waiting time programme workstreams.

11.1

This is a priority area of focus for operational teams and Service Directors. Care Groups have provided Remedial Action Plans to address their waiting time performance, and these will be tracked through the ongoing Quality and Performance Meetings. A review against policy for downgrading effectively is also underway.

Care Planning – After previous periods of improvement both CPA and Non CPA completeness performance continues to be an area of limited improvement. Feedback from Quality and Safety Reviews, People Participation Lead sample tests, and external inspections have suggested that the quality of care planning has improved over this period.

Initial conversations involving Commissioners conclude that the current metric is no longer helping to measure NSFTs approach to Care Planning although appropriate at the time it is not sufficiently quality focused. Further meetings are scheduled and in the meantime the trust will continue to ensure that the importance of CPA and nCPA documentation remains a focus.

Delayed Transfers of Care (DToC) - • Delayed Transfers of Care (DToC) are below target for the first time in 7 months. Performance was 1.4% below target for November 2019. However, the Norfolk and Waveney DToC position, which reports at 10.3% for November 2019, remains above target and is largely driven by delays within older people services. We have seen an improvement in social care delays and an increase in health-related delays in relation to accessing continuing health care support.

Inappropriate OAP bed days – Inappropriate OAP bed days for adult mental health services reported 510 bed days. This is 105 bed days behind target (405). This is an increase of 76 from October but an improvement from the figure reported in September (574 OBDs) which was the lowest reported to the Board at that point. OAPs in Norfolk and Waveney account for c95% of the bed days reported in November 2019.

Suffolk Youth Autism service – In the month of November, 12 service users received NICE compliant assessments. However, none of these were within the targeted 13 weeks from referral. Service demand has been higher than the service is contracted for and as such the target assessment time will continue to not be achieved. There are ongoing discussions with commissioners to redesign the current pathways and to support the waiting list pressures.

Local commissioner specific metrics

- The Norfolk and Waveney Wellbeing service was 2.3% under the cumulative IAPT access target for November 2019, this is a further deterioration from 1.89% reported to the Board in September
- In Suffolk the % of young people under 19 with an eating disorder receiving NICE-approved treatment within 1 week for urgent cases was 20% (September 30% achieved) against an 84% target. And for 4 weeks for routine cases 81.82% was achieved which is 2.82% above locally agreed targets. The Norfolk and Waveney performance for 4 weeks for routine cases is 11.7% below the 95% target (September 30.7% below)
- Across Suffolk, emergency referrals seen within 1 hour reported 11.3% (September 6.8%) under target. The 24 hour target was achieved in November 2019. For Central Norfolk Psychiatric Liaison service reported as not achieving target in September have met targets in November 2019

- In Suffolk the Emotional Wellbeing Hub service has 388 cases open to the Hub who have been open more than 10 working days at the end of September, up from 220 in September (334 reported in July). A recovery plan did not achieve the trajectory of meeting the target in November 2019. Additional posts have been recruited to increase capacity and agency staff have been temporarily appointed to prevent further increases in the waiting list
- In Suffolk the % of LD Service users who have an up to date appropriate care plan was reported at 90.3%, a 2.1% reduction on October's performance
- In Suffolk the % of inpatients admitted with a mental illness who received a physical health check was reported at 71.4% (September 70.4%) against a target of 95%

Finance Performance

- The position for the month was a deficit of £0.1m which was in line with annual plan
- Out of Trust (OOT) placements expenditure was £0.4m in December
- Secondary commissioned placements expenditure was £0.4m in December
- The spending on agency staffing was in line with the NHS Improvement agency cap for the month and is £0.6m overspent YTD
- Cash held by the Trust at 31st October 2019 was £17.2m
- The 2019/20 CIP target of £10.9m is forecast to be delivered in full

The full performance and finance reports were discussed at the Finance, Business and Investment Committee on 16th January 2020.

Section A (i): Operational Performance Indicators not achieved in the period

This section summarises the indicators which were not achieved in the period to the end of November 2019.

Area	Indicator	Indicator Reference	Target	Actual	Change
SOF	Inappropriate out of area placements for adult mental health services	OP09	405	510	⇧ 76
WAITS	Emergency referrals assessed within 4 Hours	OP11	95%	75.81%	⇧ 1.69%
WAITS	Routine referrals assessed within 28 days	OP12	95%	76.05%	⇧ 1.25%
WAITS	Referrals awaiting treatment >18 weeks	OP14	0	156	⇧ 1
CPA	Service users allocated to either a CPA or Non CPA level	OP17	95%	93.30%	⇧ 0.31%
CPA	CPA Service Users Completeness	OP18	95%	66.73%	⇧ 1.51%
CPA	Non CPA Service Users Completeness	OP19	95%	51.69%	⇧ 1.04%
INPAT	Long-term inpatients that have received an annual Physical health check	OP21	100%	97.92%	⇩ 2.08%
INPAT	Medium Secure Bed Occupancy Rate (including leave)	OP22	90.0%	87.88%	⇩ 4.69%
INPAT	Women's Secure Service Bed Occupancy Rate (Inc. leave)	OP24	95%	75.00%	⇧ 3.02%
INPAT	No. of Adult Acute inpatients with Length of Stay > 117 days	OP25	0	11	⇩ 1
LOCAL	Suffolk Under 19's with an eating disorder receiving NICE-approved treatment within 1 week for urgent cases	OP15a	84.0%	20.00%	⇩ 6.67%
LOCAL	Suffolk Psychiatric Liaison - Emergency referrals seen within 1 hour	OP28a	95.0%	83.65%	⇩ 7.09%
LOCAL	Suffolk Connect Service - Time from referral to treatment	OP30a	90.0%	85.71%	⇧ 4.46%
LOCAL	Suffolk DIST Service users have individual care plan once DIST take over active case management	OP33a	95.0%	88.41%	⇩ 0.41%
LOCAL	All patients admitted with a mental illness should receive a physical health check	OP41a	95.0%	71.43%	⇧ 1.22%
LOCAL	Suffolk Learning Disability Service users have an up to date appropriate care plan	OP42a	95.0%	90.27%	⇩ 2.05%
LOCAL	Suffolk CMAS Service - Time from referral to first assessment within 6 weeks	OP44a	95.0%	58.51%	-
LOCAL	Suffolk CMAS Service - The diagnosis is given within 12 weeks of referral, unless any further specialist assessments or investigations are required	OP45a	95.0%	34.21%	-
LOCAL	Suffolk EWH Patients will have a total time in the Hub from point of referral to discharge (encompassing Screening, triage and discharge) of 10 working days	OP51a	95.0%	49.61%	⇩ 0.11%
LOCAL	Suffolk Youth Autism services (ages 0-18): 13 Weeks from Referral to Assessment in accordance with NICE guidance	OP52a	95.0%	0.0%	⇔ 0.0%
LOCAL	Norfolk and Waveney IAPT: Proportion of people that enter treatment	OP10b	12.7%	10.33%	⇩ 0.14%
LOCAL	Norfolk and Waveney Under 19's with an eating disorder receiving NICE-approved treatment within 4 weeks for routine cases	OP16b	95.0%	83.33%	⇧ 20.83%
LOCAL	Norfolk and Waveney DIST urgent referrals assessed within standard (72 hour GY&W Only)	OP31b(ii)	95.0%	92.0%	⇩ 4.15%

Community Performance

Wait to Assessment Metric 4 hours and 28 days

Performance

Emergency referrals assessed within 4 hours are reported under target at 75.8%. This is a 1.7% improvement on the reported performance for October. Chart 1 shows the 95% target with a chart range adjusted using the data points now available following the clinical change for 100% of emergency (4 hour) referrals to be seen face to face by a clinician as from the 1st December 2018. This will allow the recalculation of the upper and lower control limits from the time the clinical change was made in doing this we can also see that there is a consistent level of achievement at 74% and that there would now need a significant variation to occur to meet target levels of 95%. The under achievement of this target has been further impacted by the decision to not downgrade any referrals which are referred in an emergency but to be seen due to presenting clinical need, this results in some people being seen appropriately outside of the 4-hour time period, but with an agreed safety plan in place. This process is reviewed daily by operational leads and weekly by Care Group Leadership Teams.

Chart 1

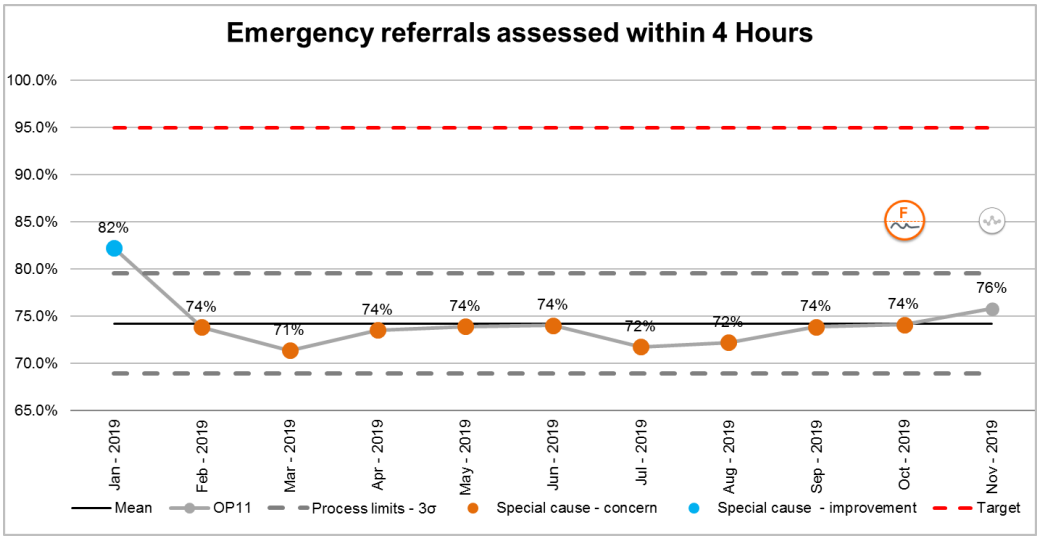


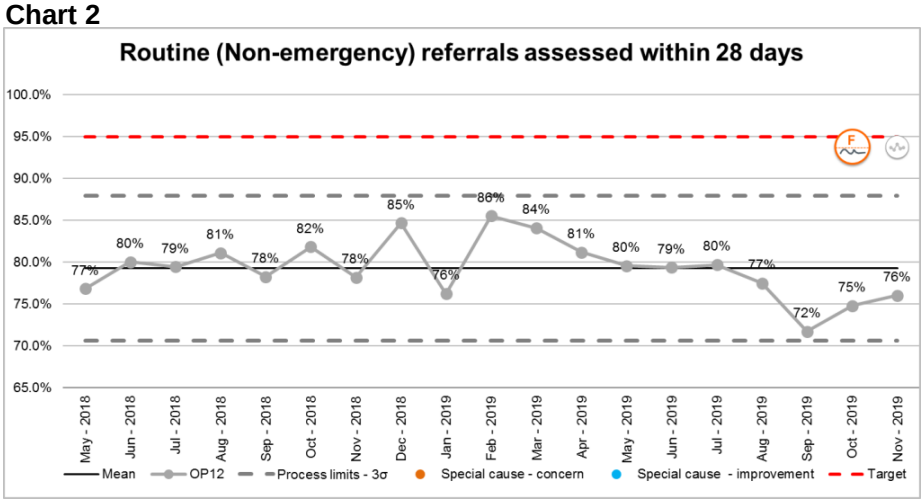
Table 1 demonstrates that although trust wide performance has improved there have been reported drops in performance for under 18's across both Norfolk & Waveney (7.4% fall) and Suffolk (7.7% fall).

Table 1

Region	Age Group	Sep-19	Oct-19	Nov-19
Trust wide	All	73.9%	74.1%	75.8%
Norfolk & Waveney	Under 18	92.1%	88.0%	84.7%
	18 and Over	56.9%	57.2%	60.1%
Suffolk	Under 18	94.1%	90.0%	86.4%
	18 and Over	94.2%	91.1%	91.2%

Routine (non-emergency) referrals assessed within 28 days reported under target at 76%, a 1.3% improvement on October's reported performance. As chart 2 demonstrates the system will be expected to consistently fail this target unless significant actions are taken to address performance.

Chart 2



Actions

Breaches are now being reviewed under the clinical harm review policy to provide assurance. Teams are looking to free capacity by releasing staff from training, offering additional working hours, finding alternative venues, reducing DNA's and recruitment of additional staff. A minimum 24/7 staffing requirement across the crisis pathway is in place. In Suffolk a review of the access and assessment team (AAT) and service delivery is underway. Current AAT processes have been fully mapped and an initial workshop was held in December to discuss transitioning routine assessment s back into community teams. A steering group has been set up to identify any additional resources required in community teams to support the transition.

NSFT CRHT standard operational policy outlines the expected referral procedure for emergency 4-hour referrals:

- All 4 hour emergency referrals will be directed or passed-through immediately to the Crisis Service line without prior triage/review by a single point of access
- All accepted referrals not being actively considered for downgrade will have assessments by face to face within 4 hours
- 4 hour referrals at triage point shall not be downgraded without a second clinical review within the timescale
- In the event of a 4 hour referral being downgraded it can only be downgraded into a 72/120 hour urgent status
- Where contact cannot be made within 4 hours the referrer and service user will be informed. An action plan is formulated regarding the follow up of the service user in agreement with the referrer i.e. welfare checks to evidence that people not being seen within four hours are safe and the delay is not increasing their risk of harm
- Where a breach will occur due to capacity within the team this is to be escalated to the Clinical Team Manager immediately

<u>Wait to Treatment Metric</u>

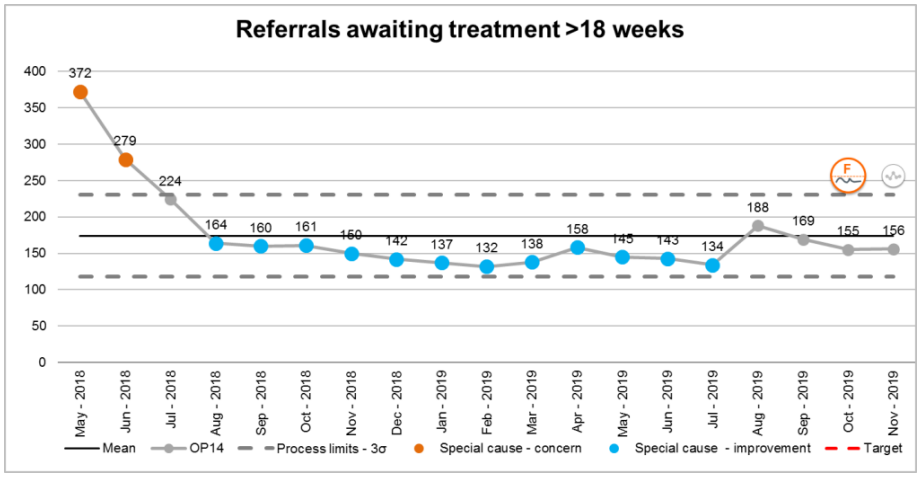
Performance

The number of service users waiting for treatment greater than 18 weeks is reporting 156 incomplete waits, which equates to 3.7% of all incompletes. This is an increase of 1 when compared to October 2019. Of the 18 week waits:

- 56 (35.9%) relate to ADHD services in Suffolk, up 10 from 46 in October 2019
- 65 (41.7%) relate to CFYP services in Norfolk and Waveney, down 3 from 68 in October 2019

Chart 3 shows that current performance is not expected to improve.

Chart 3



Actions

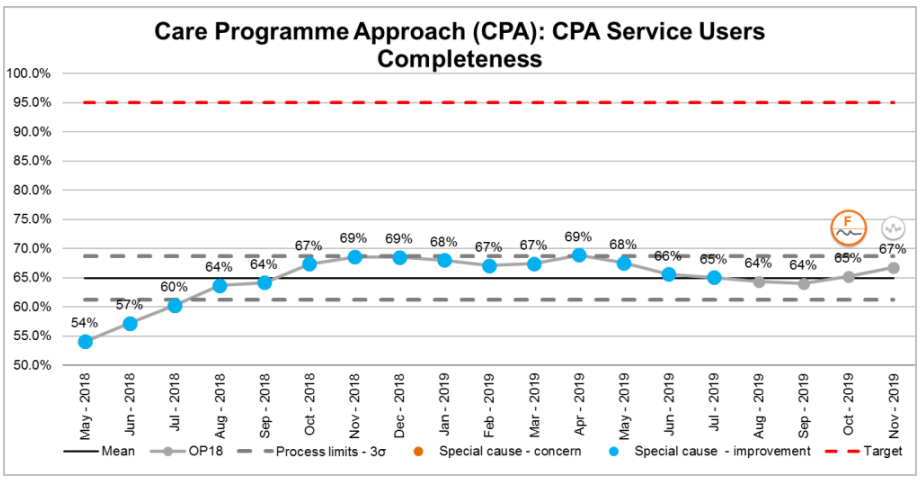
Across the Trust targeted work is underway with teams to ensure the waits are monitored and specific areas of concern are escalated when service design is identified as limiting performance. In Suffolk CFYP there is an agreed action plan for the Children's ADHD service. In CFYP services in Norfolk and Waveney the number waiting reflects the waiting list for treatment in Central Norfolk Youth teams. Waiting list coordinators within the Youth teams have been employed to support clinical teams in the management of waits and to ensure that data is accurate to inform effective safety planning. All waits across the Trust continue to be monitored through the weekly Service User Tracker Meetings, with escalation to Care Group leadership teams and Chief Operating Officer as appropriate.

<u>CPA and Non CPA completeness</u>

Performance

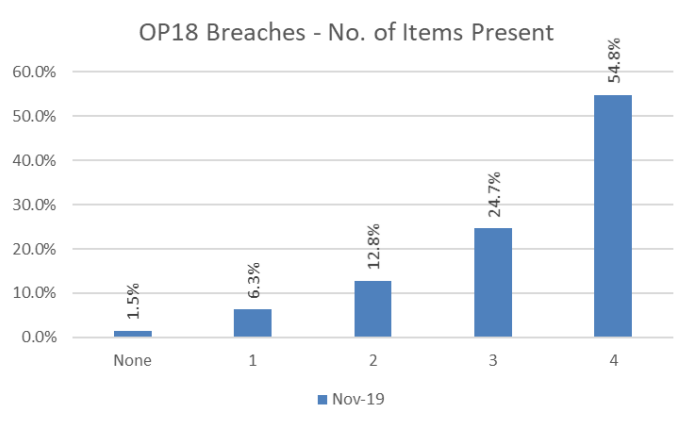
The percentage of Service users allocated to either a CPA or Non CPA level was 93.0%, a 4.3% improvement on the reported performance 12 months previous. However, performance has not improved since January 2019 and remains under the 95% target. CPA (Care Programme Approach) completeness (all 5 items required are completed within the service user electronic record) was reported 66.7%, a 1.9% reduction on the reported performance 12 months previous. Chart 4 demonstrates the system will be consistently expected to fail this target unless significant actions are taken to address performance.

Chart 4



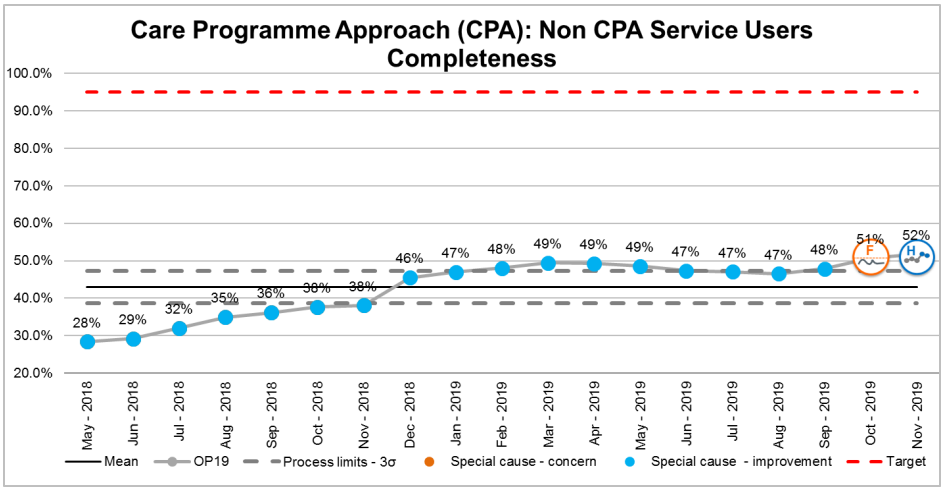
Of those cases not achieving the completeness target, 54.8% had four of the five required components present, therefore 84.9% of service users had four or more components present. Chart 5 shows the breakdown of the cases that did not achieve all five components.

Chart 5



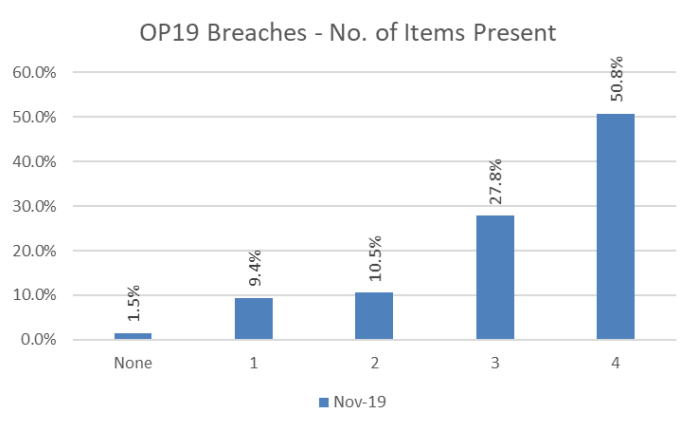
Non CPA completeness was 51.7%, a 13.6% improvement on the reported performance 12 months previous. Charts 4 and 5 demonstrate the system will be consistently expected to fail this target unless significant actions are taken to address performance. Chart 6 demonstrates the system will be consistently expected to fail this target unless significant actions are taken to address performance.

Chart 6



Of those non CPA cases not achieving the completeness target, 50.8% had four of the five required components present, therefore 75.3% of service users had four or more components present. Chart 7 shows the breakdown of the cases that did not achieve all five components.

Chart 7



Actions

A phased introduction of a new Care Planning Approach (CPA) system is taking place across five early adopter sites within the Trust. These teams are using DIALOG+, a simple evidence-based intervention, to assess satisfaction with quality of life, treatment and address concerns, while helping to pave the way to good communication between service users and their clinicians. A Trust wide CPA Lead and deputy continue to lead on delivery of the new approach. It is planned that training in this new approach will be delivered across all Care Groups by Autumn 2020.

The Trust has engaged with commissioners to review the appropriateness and effectiveness of this measure, with a view to look at alternative solutions that will deliver a clearer understanding, aligned to the quality of care planning. The first meeting of this group occurred in December 2019, in the meantime the trust will continue to ensure that the importance of correct, quality documentation remains a focus.

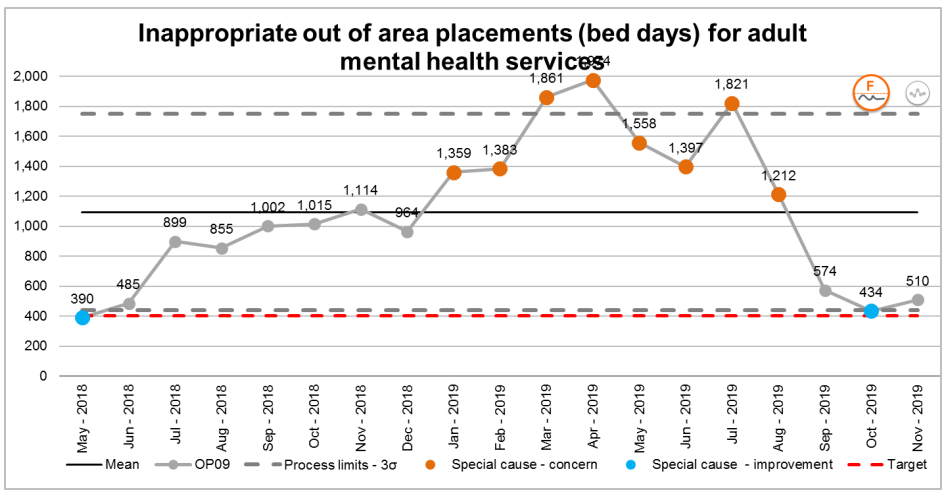
Inpatient Performance

Inappropriate Out of Area Placements (OAP) bed days for adult mental health services

Performance

Chart 7 demonstrates inappropriate OAP bed days for adult mental health were 105 bed days above target for November 2019. OAPs in Norfolk and Waveney account for c95% of the 510 bed days reported in November 2019.

Chart 7



11.1

Actions

NSFT, Norfolk & Waveney CCGs and NHS England have collaborated through a Patient Flow Mobilisation group to review and approve, monitor and challenge a number of change projects designed specifically to positively impact on the inappropriate OAP position. There are three key areas of focus:

- Community mental health services capacity and transformation – with plans to deliver as much mental health care as possible at a Primary Care Network level.
- Crisis responses – additional funding is being used to strengthen crisis team services in NSFT and increase mental health support within the QEHKL and JPUH acute hospitals
- Reducing delayed transfer of care (DToC) – actions are outlined in the section below

Executive level governance and assurance on OAP occurs every week on plans for the upcoming week

Long-term inpatients that have received an annual physical health check

Performance

The 97.92% performance equates to one breach in Older People service line where the service user was admitted in November 2018 that is being followed up with the service.

Local Commissioner Specific Metrics

IAPT Access metric

Performance

The Norfolk and Waveney Wellbeing service was 2.3% under the cumulative IAPT access target for September 2019. The cumulative target is based on achieving the currently commissioned 19% annual target in Norfolk and Waveney by the end of the 2019/2020 financial year.

Actions

An Access Strategy Group continues to meet monthly to review actions to improve access and updating the strategy when necessary. Actions include initiatives to; continue to work with Primary Care Networks to source increased clinical space in GP Practices to increase service visibility, improve waiting times to reduce dropout rates to improve the image of the service, the implementation of an online choose and book system to reduce demand on the telephony system and increase capacity, a targeted social media campaign and utilising underspend accrued from staff vacancies to purchase additional digital treatment options. Each of the five locality groups have produced trajectories to show how they will achieve a rate of at least 4.75% of local prevalence entering services in quarter 4 of 2019/20, which will meet the target.

Eating Disorders Wait to Treatment Metric

Performance

In Suffolk the % of young people under 19 with an eating disorder receiving NICE-approved treatment within 1 week for urgent cases was 64.0% below the locally agreed target. This equates to 12 breaches out of 15 which were primarily delays in the Emotional Wellbeing Hub service and referrals which were subsequently downgraded. The expectation nationally is that CYP Eating Disorder services will achieve the 95% target by Q4 2019/2020 and in Suffolk a trajectory has been agreed with commissioners to achieve this.

In Norfolk and Waveney the % of young people under 19 with an eating disorder receiving NICE-approved treatment within 4 weeks for routine cases was 11.7% below the national 95% target. This equates to 3 breaches out of 18 which were primarily attributable to non-engagement by service users with the service.

Actions

In Suffolk Eating Disorders teams move to CFYP pathway as at the start of January 2020. In addition, a process change will be implemented meaning referrals no longer go to teams via the Emotional Wellbeing Hub service, they will instead be passed directly from GPs to the Eating Disorders teams. In Norfolk and Waveney, the service are working collaboratively with commissioners to address service user non-engagement.

Psychiatric Liaison Emergency Wait to Assessment

Performance

In Suffolk the Psychiatric Liaison emergency referrals seen within 1 hour reported 11.3% under target

Actions

A business case for the Psychiatric Liaison service has been approved by the Suffolk Alliance for additional investment and performance is expected to improve once the new posts are filled. Additionally, the referral process is to be reviewed to ensure that patients referred to the team are medically fit to be assessed.

Emotional Wellbeing Hub

Performance

In Suffolk the Emotional Wellbeing Hub service has 388 cases open to the Hub who have been open more than 10 working days at the end of November, up from 220 reported in September. A recovery plan was originally working towards a trajectory of meeting the target in November 2019, however due to a combination of an increase in the number of new referrals received by the service and staff vacancies this was not met. However, the recovery plan continues to have an effect as the average length of wait of those waiting at month end has reduced from 73 days in April to 15 days in November for under 18's and has reduced from 33 days in April to 10 days in November for 18 to 25's.

Actions

Additional posts have been recruited to increase capacity and agency staff have been temporarily appointed to prevent further increases in the waiting list

Learning Disability (LD)

Performance

In Suffolk the % of LD Service users who have an up to date appropriate care plan was reported at 90.3%, a 2.1% reduction on October's performance. This equates to 28 service users behind the 95% target.

Actions

Deputy Service Managers and Clinical Team Leads across Suffolk have worked closely with teams to support clinicians in completing care plans to increase compliance.

Physical Health Checks at admission

Performance

In Suffolk the % of inpatients admitted with a mental illness who received a physical health check was reported at 71.4%, a 1.2% improvement on October's performance. The majority of breaches relate to either; data entry issues which are being addressed or service users who have declined physical health checks.

Actions

Training is currently being set up for clinical support workers to work with junior doctors to set up physical health clinics. The Deputy Service Manager has been working with ward managers and modern matrons to improve the recording of reasons why physical health checks are not done at point of admission. There is ongoing work to identify frequent data entry issues and resolve these prior to reporting.

Community Memory Assessment Service (CMAS)

A number of new local commissioner KPI's for the CMAS service in Suffolk have been incorporated into reporting for the 2019/20 financial year for the first time. The work to investigate recording practices to ensure that these KPI's reflect true performance has taken place, and the services have checked and agreed that the new performance calculations reflect work accomplished by the CMAS service. Full exception reporting will commence from next month to describe any actions being taken to address any underperformance.

Youth Autism Service

Performance

In Suffolk none of the service users out of nine aged 0-18 received an assessment within 13 weeks of referral.

Actions

The service is working collaboratively with commissioners to review the Autism pathway. Longer term, Transformation work is expected to support the capacity issues this team are facing with a high level of inappropriate referrals currently being received. In the interim the Trust will liaise with the Early Help Team to understand whether they are able to support in the early stage of the pathway. Proposals to use slippage funding have been shared with the commissioners for approval, this will provide additional capacity for a fixed term period until the Neurodevelopmental Pathway work is implemented.

Connect Service

Performance

In the Suffolk Connect Service the time from referral to treatment performance has fallen beneath the 90% target for the past 2 months after being met for the previous 11 months prior to this. The November performance of 85.71% equated to 2 breaches out of 14, both of these were attributable to parents requesting appointments outside of the standard.

Dementia Intensive Support Teams (DIST)

Performance

In Suffolk the % of service users having an individual care plan once DIST take over active case management has been under target for the past 5 months. This is primarily attributable to service capacity in the West Suffolk team. In Great Yarmouth and Waveney the % of DIST urgent referrals assessed within 72 hours reported as 92% which equated to 2 breaches out of 25. One breach was a data quality issue which takes performance above the 95% target.

Actions

West Suffolk's Service Director is meeting with Service Managers early in the January to agree plans to address DIST performance.

Section B: Financial performance in the period – December 2019

Our financial position is as follows:

STATEMENT OF COMPREHENSIVE INCOME (SOCI) - YTD

	Plan	Actual	Variance
	£'000	£'000	£'000
Operating Income	(186,519)	(188,301)	1,782
Pay Costs (Substantive, Bank & Overtime)	133,429	130,298	3,131
Agency & Locum Costs	6,093	8,400	(2,307)
Drugs Costs	1,723	2,028	(305)
Other Costs	36,888	38,871	(1,983)
EBITDA	8,386	8,704	318
Depreciation	6,066	6,556	(490)
Non Operating Income	(32)	(103)	71
Non Operating Expenses	3,049	2,953	96
Net surplus / (deficit)	(697)	(702)	(5)
EBITDA margin	4.5%	4.6%	

OUT OF TRUST & SECONDARY COMMISSIONED PLACEMENTS

Total OOT bed days increased from 285 in November to 440 in December. Total expenditure for the month was £0.4m.

Secondary commissioned placements spend was £0.4m.

Per the Norfolk and Waveney contract risk share agreement, NSFT fund the first £3.1m from within block funding, CCG's fund the next £2.9m, with a 50:50 risk share on any further spend.

The current forecast trajectory of OOT spend coupled with the current level of specialist placements suggests NSFT has a forecast cost pressure of c.£3.3m

TEMPORARY STAFFING

The NHS Improvement (NHSI) Trust agency spending cap has been set to the same limit as 2018/19 at £10.3m.

The following table provides a summary on overall temporary staffing spend.
The key booking reason for agency for qualified nursing and medical staff is unfilled vacancies.

ACTUAL SPEND £'000s	DECEMBER		
	Agency	Bank	Total
Medical	450	-	450
Qualified nursing	298	197	495
Unqualified nursing	41	481	522
Clinical A&C	(13)	29	16
Scientific & Therapeutic	11	-	11
Corporate	23	-	23
	810	707	1,517
NSFT Annual Plan	801		
NHSI Cap	852		

ACTUAL SPEND £'000s	YEAR TO DATE		
	Agency	Bank	Total
Medical	4,797	-	4,797
Qualified nursing	2,566	1,808	4,374
Unqualified nursing	175	4,670	4,845
Clinical A&C	166	258	424
Scientific & Therapeutic	251	12	263
Corporate	462	-	462
	8,417	6,748	15,165
NSFT Annual Plan	7,378		
NHSI Cap	7,827		

CIP
The agreed CIP target for 2019/20 submitted in the revised Annual Plan is £10.9m, and this is forecast to be achieved in full, although there remains £0.4m of unidentified savings as at the end of December.

CASH FLOW
As at the end of October, the Trust held cash and cash equivalents of £17.2m, which was £10.3m ahead of annual plan.

CAPITAL SPEND
The total capital spend YTD is £4.1m against the planned capital spend of £7.6m.

Quality implications
Adherence to our financial plan and compliance with Standing Financial Instructions enables the Trust to improve its service quality within the financial resources available.

Equality implications / summary of consultation
There are no equality implications arising from the plan.

Risks / mitigation in relation to the Trust objective
Based upon current performance and to achieve the revised control total, the following areas need to be closely monitored and controlled.

(i) Agency and locum spend
(ii) External placement trajectory and forecast costs for the year
(iii) Financial impact of CQC recommendations and requirements
(iv) Directorates not manging their financial performance
(v) Identification and delivery of CIP programme

Appendix 1: Operational Performance Dashboard September 2019

NHS Oversight Framework KPI's	Indicator Reference	Reporting Period	Target	Current Performance	Change	Performance Tracker	Trend
People with a first episode of psychosis begin treatment within 2 weeks of referral	OP01	Rolling 3 months	56%	66.67%	0.00%		
Ensure that cardio-metabolic assessment and treatment for people with psychosis is delivered routinely:							
a) in inpatient wards	OP02	Annual	90%	20.83%			
b) early intervention in psychosis services	OP03	Annual	90%	43.59%			
c) community mental health services (people on Care Programme Approach)	OP04	Annual	65%	45.45%			
Data Quality Maturity Index (DQMI) – MHSDS dataset score	OP05	Quarterly	95%	94.69%	0.15%		
IAPT: Proportion of people completing treatment who move to recovery	OP06	Quarterly	50%	54.79%	0.45%		
IAPT: waiting time to begin treatment (from IAPT minimum data set) within 6 weeks	OP07	Rolling 3 months	75%	94.10%	0.45%		
IAPT: waiting time to begin treatment (from IAPT minimum data set) within 18 weeks	OP08	Rolling 3 months	95%	100.00%	0.00%		
Inappropriate out of area placements (bed days) for adult mental health services	OP09	Monthly	499	574	-638		

Waiting Times KPI's	Indicator Reference	Reporting Period	Target	Current Performance	Change	Performance Tracker	Trend
Emergency referrals assessed within 4 Hours	OP11	Rolling 3 months	95.0%	73.89%	1.68%		
Routine (Non-emergency) referrals assessed within 28 days	OP12	Monthly	95.0%	71.92%	-5.49%		
Referrals treated within standard	OP13	Monthly	95.0%	95.15%	-1.61%		
Referrals awaiting treatment >18 weeks	OP14	Monthly	0	169	-19		

Care Programme Approach KPI's	Indicator Reference	Reporting Period	Target	Current Performance	Change	Performance Tracker	Trend
Service users allocated to either a CPA or Non CPA level	OP17	Monthly	95.0%	92.84%	-0.06%		
Care Programme Approach (CPA): CPA Service Users Completeness	OP18	Monthly	95.0%	63.99%	-0.34%		
Care Programme Approach (CPA): Non CPA Service Users Completeness	OP19	Monthly	95.0%	47.85%	1.30%		

Inpatient KPI's	Indicator Reference	Reporting Period	Target	Current Performance	Change	Performance Tracker	Trend
Inpatients whose transfer of care was delayed	OP20	Monthly	7.5%	9.36%	0.01%		
Long-term inpatients that have received an annual Physical health check	OP21	Monthly	100.0%	100.00%	2.27%		
Medium Secure Bed Occupancy Rate (including leave)	OP22	Monthly	90.0%	91.11%	0.01%		
Low Secure Bed Occupancy Rate (including leave)	OP23	Monthly	90.0%	100.66%	4.10%		
Women's Secure Service Bed Occupancy Rate (including leave)	OP24	Monthly	95.0%	68.54%	-0.21%		
Number of Adult Acute inpatients with Length of Stay > 117 days	OP25	Monthly	0	14	1		
Patients requiring acute care who received a gatekeeping assessment	OP26	Rolling 3 months	95.0%	97.25%	0.82%		
Care programme approach (CPA) - proportion of discharges from hospital followed up within 7 days	OP27	Rolling 3 months	95.0%	94.94%	0.63%		

Outcomes KPI's	Indicator Reference	Reporting Period	Target	Current Performance	Change	Performance Tracker	Trend
IAPT Service users shall demonstrate reliable improvement	OP36	Monthly	60.0%	70.56%	2.88%		

Notes: 1) OP01 - Only reporting on referrals to existing (a) 14-35 year old early intervention services in Suffolk, and (b) 14-65 year old early intervention services in Norfolk & Waveney. No NSFT early intervention services currently commissioned to triage, assess and treat people with an at-risk mental state

Appendix 1: Operational Performance Dashboard September 2019 (cont.)

Local - Suffolk CCG Specific KPI's	Indicator Reference	Reporting Period	Target	Current Performance	Change	Performance Tracker	Trend
IAPT: Proportion of people that enter treatment	OP10a	Cumulative YTD	9.5%	10.77%	-0.01%		
Under 19's with an eating disorder receiving NICE-approved treatment within 1 week for urgent cases	OP15a	Rolling 3 months	67.0%	30.00%	-24.55%		
Under 19's with an eating disorder receiving NICE-approved treatment within 4 weeks for routine cases	OP16a	Rolling 3 months	69.0%	60.00%	1.67%		
Psychiatric Liaison - Emergency referrals seen within 1 hour	OP28a	Monthly	95.0%	88.16%	5.87%		
Psychiatric Liaison - Routine referrals seen within 24 hours	OP29a	Monthly	95.0%	97.16%	-0.82%		
Connect Service - Time from referral to treatment	OP30a	Monthly	90.0%	100.00%	10.00%		
DIST referrals (excluding referrals from A&E) - assessment within 1 Operational Day of receipt of the referral	OP31a	Monthly	95.0%	91.84%	-3.51%		
DIST referrals from A&E - Assessment within 4 hours of receipt of referral during DIST operational hours	OP32a	Monthly	95.0%	N/A	N/A		
DIST Service users have individual care plan once DIST take over active case management	OP33a	Monthly	95.0%	91.86%	0.85%		
Discharges that have a Valid Pair of HoNOS scores where applicable	OP39a	Monthly	25.0%	31.72%	-0.83%		
Active Referrals with no activity recorded within 9 months	OP40a	Monthly	4.0%	3.20%	-0.36%		
All patients admitted with a mental illness should receive a physical health check	OP41a	Monthly	95.0%	70.37%	11.94%		
Learning Disability Service users have an up to date appropriate care plan	OP42a	Monthly	95.0%	90.78%	1.25%		
CMAS - Initial contact is made with all people who are newly referred within two weeks of referral	OP43a	Monthly	95.0%	98.95%	-1.05%		
CMAS - Time from referral to first assessment within 6 weeks	OP44a	Monthly	95.0%	71.43%	8.18%		
CMAS - The diagnosis is given within 12 weeks of referral, unless any further specialist assessments or investigations	OP45a	Monthly	95.0%	27.78%	-3.17%		
Patients will have a total time in the Hub from point of referral to discharge (encompassing Screening, triage and	OP51a	Monthly	95.0%	49.68%	-17.65%		
Youth Autism services (ages 0-18): 13 Weeks from Referral to Assessment in accordance with NICE guidance	OP52a	Monthly	95.0%	0.00%	0.00%		
Youth ADHD services (ages 0-18): 13 Weeks from Referral to Diagnosis (point at which ICD10 code is applied)	OP53a	Monthly	TBC	0.00%	-10.34%		

Local - Norfolk and Waveney CCG Specific KPI's	Indicator Reference	Reporting Period	Target	Current Performance	Change	Performance Tracker	Trend
IAPT: Proportion of people that enter treatment	OP10b	Cumulative YTD	9.5%	7.61%	-0.17%		
Under 19's with an eating disorder receiving NICE-approved treatment within 1 week for urgent cases	OP15b	Rolling 3 months	95.0%	66.67%	-33.33%		
Under 19's with an eating disorder receiving NICE-approved treatment within 4 weeks for routine cases	OP16b	Rolling 3 months	95.0%	64.29%	-19.05%		
Psychiatric Liaison - Emergency referrals seen within 1 hour (NNUH Psy Liaison only)	OP28	Monthly	90.0%	83.84%	-5.48%		
Psychiatric Liaison - Emergency referrals seen within 4 hours (JPUH & QEHKL only)	OP28b	Monthly	95.0%	99.30%	0.88%		
Psychiatric Liaison - Routine referrals seen within 24 hours (NNUH Psy Liaison only)	OP29b	Monthly	95.0%	96.09%	-1.49%		
DIST urgent referrals assessed within standard (120 hours Central & West CCG's Only)	OP31b(i)	Monthly	95.0%	83.56%	-10.96%		
DIST urgent referrals assessed within standard (72 hour GY&W Only)	OP31b(ii)	Monthly	95.0%	91.67%	-8.33%		
DIST Emergency referrals assessed within 4 Hours	OP32b	Monthly	95.0%	25.00%	-25.00%		
Adult Acute Service (CRHT) - Referral to Treatment met the 12 hour standard (Central Norfolk CCG areas Only)	OP34b	Monthly	50.0%	77.00%	5.73%		
CAMHS LD - Percentage of assessments to be initiated within 8 weeks of acceptance of the referral.	OP46b	Monthly	90.0%	80.00%	-20.00%		
Under 18 urgent referrals assessed within standard (120 hours Central & West CCG areas Only)	OP47a(i)	Monthly	95.0%	64.71%	18.04%		
Under 18 urgent referrals assessed within standard (72 hour GY&W CCG areas Only)	OP47a(ii)	Monthly	80.0%	100.00%	0.00%		
18 and Over urgent referrals assessed within standard (120 hours Central & West CCG areas Only)	OP47b(i)	Monthly	95.0%	70.31%	-2.79%		
18 and Over urgent referrals assessed within standard (72 hour GY&W CCG areas Only)	OP47b(ii)	Monthly	80.0%	90.00%	-0.44%		
Percentage of dedicated 136 staff available in s136 suite within a maximum standard (1 hour) of police arrival in the	OP48b	Monthly	95.0%	100.00%	7.14%		
Increase the number of people being diagnosed with dementia, and starting treatment, within six weeks from referral	OP49b	Monthly	TBC	57.83%	-5.63%		
CAMHS Service (under 18 years of age) Percentage of accepted and assessed as requiring crisis support having a	OP50b	Monthly	TBC	0.00%	0.00%		

National	Indicator Reference	Reporting Period	Target	Current Performance	Change	Performance Tracker	Trend
Completion of a valid NHS Number field in mental health and acute commissining data sets submitted via SUS.	NQR02	Monthly	99.0%	100.00%	0.31%		
Completion of Mental Health Services Data Set ethnicity coding for all Service Users.	NQR03	Monthly	90.0%	93.82%	0.94%		

Strategic Objectives	Risk Ref	Risk Description	Inherent Risk Rating (LxC)	Existing Controls *(measures in place to reduce likelihood)*	Assurances on controls	Jan 2020 Risk Rating LxC	Gaps in controls and/or assurance	Target Risk Rating	Progress with actions to address gaps	Date for Review	Lead Assurance Committee	Lead
1. Engage and inspire our staff	1.1	Lack of focus on staff engagement and development will adversely impact on leadership and staff morale, resulting in poor outcomes for patients and carers.	R 4 x 4 = 16	Culture change programme, led by HR and overseen by NED-led Cultural Change Group. Medical Education Improvement Plan working closely with Health Education England. Nursing education programme. People Before Process group jointly chaired with staff-side focussing on compassionate leadership and improvements in ER. increased focus on clinical supervision. Staff Governors.	Annual Staff Survey with clear deliverables and regularly monitored Monthly Pulse Surveys Workforce reports to Board. Regular HR reports to executive Service Delivery Board and Quality Committee. Quality Assurance Committee and Appts & Remuneration Committee take assurance of effective staff engagement. Council of Governors - have set this as focus area. Medical Education Survey WRES data. FTSUG reports to BoD	A 3 x 4 = 12 →	Annual Staff Survey and WRES data highlights improvements needed. Internal audit report on consultant job planning raised concerns on assurance clinical staff vacancies remain high	A 2 x 4 = 8 Mar 2020	1. Culture Change programme underway, monitored by Culture Change Group and synthesis meeting on outcomes of diagnostic 29 Jan 2020. 'People Before Process' group formed and work underway. People report provided to each Board. 2. Trust's People Strategy implementation 3. Medical Director for workforce reviewing support for medical workforce, training for junior doctors and consultant job planning. Working closely with HEE. Deputy Chief Nurse and AHP lead focusing on nursing and AHP development and Preceptorship programme. 4. Implementation of Equality & Diversity Strategy approved by Nov 19 BoD 5. Care Groups implementing priority actions from Staff Survey results.	Mar-20	Service Delivery Board Appointments & Remuneration Committee	MG
	1.2	Lack of development and support for the new Care Group management structures, and their relationship with the executive and Board, impacts on the effectiveness of those leadership teams and results in poor clinical outcomes.	R 4 x 4 = 16	Programme of NED and exec visits to teams. Care Group Leadership induction programme underway. Regular comms bulletins. Breakfast meetings with teams. Phase 2 of the leadership restructure commenced Jan 2020. New governance framework of reporting and accountability co-produced with care groups	Quality Performance Meetings. Monthly Pulse Surveys. Executive walkabouts and breakfast meetings. Clinical outcome KPIs and performance reporting dashboards reviewed by BoD, Executive, FBIC	A 2 x 4 = 8 →	Phase 2 of care group management re-structure underway and will complete April 2020	Y 1 x 4 = 4 March 2020	1. Leadership programme continues for Care Group - Trust Five-year leadership development strategy for all levels of staff. 2. People before Process culture change programme continues (as above) 3. Focused work on improving recruitment 4. Further support to Care Groups to develop local governance structures	Feb-20	Service Delivery Board Quality Assurance Committee	MG
2. Co-production and partnerships	2.1	Poor engagement with service users and carers and other stakeholders will mean that their views are not heard and responded to, and result in services that do not meet the needs of local communities.	A 3 x 4 = 12	Appointment of People Participation Leads in each Care Group. BoD Patient Participation sub- Committee overseeing PP Strategy. Triangle of Care. Working Together Hub. Carers Network. Service User Engagement Forums. Service Users, Carers and Governors trained in QI methodology and taking forward QI projects. Making Families Count conferences	Reports to BoD and People Participation Committee. Progress with Quality Improvement projects involving SUs reviewed by Quality Committee. CQC inspection Reports. Progress reported In Quality Improvement Plan at Board. Council of Governors. Healthwatch. HOSC	A 3 x 4 = 12 →	People Participation Strategy and implementation plan	Y 1 x 4 = 4 Jul 2020	1.People Participation Strategy under development, with comitment to finalise by April 2020 2. People Participation Committee overseeing work of PPLs and development of strategy 3. Service user and carer forums continuing to meet to inform and shape Trust services 4. Re-focusing Working Together Groups with support from PPLs 5. PPL development programme 6. Consulting on improving CPA, re-developing a new care plan and safety plan to be more collaborative, person-centred and recovery-focused.	Apr-20	People Participation Committee	DH
	2.2	Not working in a collaborative way with STP colleagues and other system partners will prevent the transformation of services and result in risks to services and Trust sustainability.	A 3 x 4 = 12	Key member of STP/ICS groups Norfolk & Waveney and Suffolk & North East Essex. NSFT CEO is SRO for N&W STP MH Programme Board and will be Chair from February 2020. Working with partners to deliver the two adult MH and CYP strategies (Norfolk and Suffolk). New Models of Care Work in collaboration with regional MH Trusts.	Feedback from STP/ICS partners, including commissioners, primary care, Healthwatch, HOSC. OAG meetings open to all stakeholders. BoD and CoG receive regular updates on implementation of the strategies and implications for NSFT	A 3 x 4 = 12 →	Implementation of Mental Health strategies in partnership with Norfolk & Waveney and Suffolk & North East Essex STP/ICS - Alliance working	A 2 x 4 = 8 Mar 2020	1.Active partner in development of MH offer to Primary Care Networks (PCNs) 2. Suffolk Alliance - work underway to implement Suffolk MH & Emotional Wellbeing strategy; high level models agreed for workstreams 3. NSFT and NCH&C signed MoU to work together to deliver better integrated services . 4. Working with both STP/ICS to develop local 5 Year plans 5. Working closely with all partners and agencies on EU Exit plans 6. Mapping and prioritisation of transformation work being completed	Feb-20	Service Delivery Board	MF

3. Building quality improvement skills	3.1	Lack of support for the Trust's Quality Improvement programme will jeopardise the successful establishment of the programme and result in poor staff morale and patient outcomes.	R 4 x 4 = 16	Quality Improvement Team provide support and training to staff, service users, governors, stakeholders on QI methodology. Building capacity and capability. Individual coaching sessions for each project. Working with Care Group Leadership. Provided pocket introductory QI session in December.Board training on QI methodology in October.	Quality Improvement Report to BoD. Quality Assurance Committee scrutinises performance. Quality Performance Meetings with Care Groups	A 2 x 4 = 8 →	Address CQC recommendations on quality and safety and to be a learning organisation	Y 1 x 4 = 4 Mar 2020	1. Continuing to embed Quality Improvement (QI) methodology throughout the Trust; advertising for more infrastructure support. 2. More staff and service users trained in QI methodology and increase in people requesting sponsorship for QI, including one focused on Joy at Work 3. Participating in National QI projects: Reducing Restrictive Intervention, Sexual safety 4. Quality& Safety reviews underway, learning from these and from incidents 5. Established internal RIs collaborative mirroring national work and a trust wide medicines management collaborative QI project.	Feb-20	Quality Assurance Committee	DH
	3.2	Not implementing learning from complaints, incidents, Coroner's recommendations and other information means that issues continue to occur and may result in harm to patients.	R 4 x 4 = 16	Serious Incident (SI) policy and process - RCAs, liaising closely with families for each incident. Duty of Candour. SI Scrutiny panel. newly appointed Family Liaison Officer. Suicide Prevention Lead. Patient Safety Manager. Patient Safety Alert process. Organised variety of learning events. Complaints and PALs process. Quality and safety reviews. E9	Quality Performance Meetings CQC inspections Quality Improvement Plan monitored by Quality Committee and Quality Assurance Committee. SI reports to BoD CCGs review performance at contract meetings. OAG and OSM with NHSI. Commissioner contract meetings	R 4 x 4 = 16 →	Address CQC recommendations on quality and safety, to be a learning organisation	Y 1 x 4 = 4 Mar 2020	1. Changes to Serious Incident process, piloting national strategy; involving families and carers in every review. New SI and Mortality Review Group. 2. Pop Up Learning events, Patient Safety Alert process, co-produced learning events 3. Care Group Lead Nurse and Clinical Director now responsible for leading complaints process to enusre learning and embedding of changes to practice 4.Learning from Quality & Safety reviews 5. Continuing to roll out QI methodology with Care Groups 7. Chief Nurse and Chief Medical Officer developing Quality Strategy, which incorporates patient safety, to ensure meaningful learning	Feb-20	Quality Assurance Committee	DH

				Sustainability & Transformation Partnership	STP			Memorandum of Understanding	MoU		
				Health Overview & Scrutiny Committee	HOSC			Integrated Care System	ICS		
		Jonathan Warren	JW	Clinical Commissioning group	CCG			Primary Care Networks	PCN		
		Diane Hull	DH	NHS England	NHSE			Workforce Race Equality Scheme	WRES		
		Stuart Richardson	SR	NHS Improvement	NHSI			Workforce Disability Equality Scheme	WDES		
		Mark Gammage	MG	Cost Improvement Plans	CIP			Freedom to speak up Guardian	FTSUG		
		Bohdan Solomka	BS	Business Continuity Plan	BCP			Care Programme Approach	CPA		
		Daryl Chapman	DC	East London Foundation Trust	ELFT						
		Mason Fitzgerald	MF	Non executive Director	NED						
				Care Quality Commission	CQC						
				Likelihood x Consequence	LXC						
				Primary Care Network	PCN						
				Oversight and Assurance Group	OAG						
				Performance Review Meeting	PRM						
				Children & Young People	CYP						
				Service Users	SU						
				Remedial Action Plan	RAP						
				Access Improvement Team	AIT						
				Quality Improvement Plan	QIP						

4. Align our governance and systems	4.1	Not achieving compliance with CQC essential standards results in risks to patient and carers, as well as the Trust's sustainability and reputation.	R 4 x 4 = 16	"Buddy" arrangement with ELFT for Trust support. Quality Improvement Plan - QI methodology, Quality & safety reviews, learning organisation. Culture change programme New Governance architecture to improve assurance reporting and flow of information ward to board to ward. New clinically led Care groups established. MH Act compliance work. Recruitment of new NEDs and Executive Directors	Oversight & Assurance Group meetings and PRM with NHSI Quality Improvement Plan reported to each Board and scrutiny by Quality Assurance Committee; CQC Inspections; Contract meetings with commissioners	A 3 x 4 = 12 ↓	CQC report - Requires Improvement January 2020 - work continues to address issues raised	Y 1 x 4 = 4 January 2021	1. CQC report issued January 2020 with move from Inadequate to Requires Improvement; early improvements in most areas except CFYP 2. Quality Improvement Plan will be updated to reflect latest CQC report; work continues to address quality and safety 2. Clinical leadership in Care Groups, with support from corporate services and revised governance taking forward improvement actions	Mar-20	Board of Directors	JW
	4.2	Not making progress in reducing waiting times creates a risk to service users, as well as breaches of contractual and regulatory standards.	R 4 x 4 = 16	Clinical harm review process reviewed. Service User tracker in place. Quality & Safety Reviews. New Director appointed to address waiting times. Access Improvement Team in place reporting to COO. Service users' safety & experience is always maintained with visibility of those awaiting treatment & system for clinical review. Access Improvement Director workign with Care Groups re SU Tracker List. RAPs in place for non compliant areas	High level Performance Dashboard reports reviewed by Board include deep dives on waiting times and processes for keeping people safe; Quality Assurance Committee provides scrutiny. Access Improvement Task Force receives escalations from SUTL. CQC Inspections OAG and OSM monthly meetings with NHSI. Contract meetings with commissioners	R 4 x 4 = 16 →	Increasing demand leading to high waiting times, particularly in older people who require functional support Ensuring service user safety is maintained and visibility of those awaiting treatment	A 2 x 4 = 8 Nov 2020	1. Care Groups are implementing Trust wide Access Policy from Jan 20 2. Access Improvement Director (AID) and Clinical Leads are conducting deep dives into ADHD, Autism and ED pathways by 29.02.20 and shared with key stakeholders by 31.03.20 3.Quality Summits to be held before March to include feedback from the Quality Safety Reviews and Clinical harm Audits. 4. AID and Deputy Director Contracts, Performance and Information to undertake a demand and capacity analysis for 2 PCNs in partnership with local Care Groups by march to determine the effect on access rates and compliance following proposed transformational changes and access to services via PCN's.	Jan 20 Feb 20 Mar 20 Mar 20 Mar 20	Service Delivery Board Quality Assurance Committee	SR
	4.3	Non-delivery of savings and income plans, including plans to reduce out of area placements, and investment required to deliver change programme, adversely impacts on the Trust's financial position and results in a risk of regulatory action and risks to long-term financial viability.	R 4 x 5 = 20	Agreed mitigation plan in Sept to achieve Control Total, Standing Financial Instructions, finance controls, monthly review with budget managers, Monthly scrutiny and challenge by Executive Group	Finance & Business Investment Committee scrutiny, Finance reports to Board, Internal and external audit reports, Annual Accounts approval OAG and PRM	A 3 x 4 = 12 ↓	Gap on delivery of mitigation plan of £1.0m, High reliance on non-recurrent schemes, Unknown cost pressures in response to Quality Improvement Plan, Poor budget management within operational teams, Delay in implementing and ongoing slippage OOT/SP reduction plans	Y 1 x 4 = 4 March 2020	1. Executive have committed to delivering mitigation plan, and confirmed appropriate and achievable 2. Ongoing executive discussions on cost pressures with individual Executive Director ownership and accountability 3. External placement recovery plan being reviewed and prioritised by COO 4. New Service Directors in place and undertaking leadership training to include financial management 5. Establishment of Significant Business Committee	Feb 20 Feb 20 Jan 20 Feb 20 Jan 20	Finance, Business and Investment Committee	DC
	4.4	An imbalance between the pace of change required to address quality and safety issues, versus the need for long-term cultural change, undermines change efforts and results in disengaged staff, patients and stakeholders.	A 3 x 4 = 12	Cultural change programme overseen by Cultural Change Group led by NED. Regular reports to BoD. BoD reviews balance of financial sustainability and quality and safety requirements. FBIC provides deep dive scrutiny	BoD and committee oversight. Monthly Pulse reports Staff Survey Internal audit reports OAG and PRM Council of Governors CQC inspection NHSIE - exec to exec meetings, OAG/OSM	A 3 x 4 = 12 →	Balancing pace of change vs cultural programme with some parts of the organisation. Time and resource to adequately address quality and safety issues	Y 1 x 4 = 4 Oct 2020	1. Cultural Change programme cultural change work 2. Quality Impact Assessments for CIP and change projects, reviewed by Quality Committee 3. Phase 2 of Care Group management structure underway to provide capacity to address any outstanding issues 4. Quality Improvement approach to change projects	Feb-20	Quality Assurance Committee	JW

Date:	**23rd January 2020**	**N**
Item:	**20.15**	

Norfolk and Suffolk NHS
NHS Foundation Trust

Report To:	Board of Directors
Meeting Date:	23rd January 2020
Title of Report:	Freedom to Speak up
Action Sought:	For information
Estimated time:	10 mins
Author:	Liz Keay, Freedom to Speak up Guardian
Director:	Jonathan Warren, Chief Executive Officer

Executive Summary:

- This report provides a summary and analysis of concerns raised to the Freedom to speak up Guardian (FTSUG) during November and December 2019.
- There were 20 cases recorded in this period
- The case study gives an example of a timely response to an individual speaking up in difficult circumstances

The report relates to BAF risks 1.1, 1.2, 3.2

1.0 Case activity

There were 20 cases recorded in this period: 13 in November and 7 December, a similar position to this time last year and an expected quieter time over the holiday period.

Four of the cases were closed on the day of contact, with individuals feeling able to address and resolve their issues locally as a result of the conversation had with the FTSUG.

The six cases within Secure Services noted in the table below are all linked. Formal investigations are ongoing.

11.2

Breakdown of cases by Care Group

	Approx. % of head count	Attitudes & behaviours	B & H	Staffing levels	Systems, procedures & process	Leadership & mgt	Other
N Nfk & Nch	0.13	1					
W & S Nfk	0.00						
GY&W	1.17	1			1	2	
Corp / Spt serv	0.29	1			1		
W Sfk	0.96	1	1	1		1	
E Sfk	0.49				3		
Wellbeing	0.00						
CFYP	0.00						
Secure	1.85	2			1	2	1
Sfk AAT	0.00						

Themes and trends

As noted previously, the numbers of new cases are low for the period this report covers. The exceptions to this are Great Yarmouth and Waveney and Secure Services. However, there doesn't appear to be any specific cause for this upturn in numbers.

Once again human interactions are the cause of most people seeking FTSUG intervention. More coaching style conversations are having an effect in this regard however this needs to feed into and inform other leadership/management training programmes being planned.

The FTSUG will continue engagement with staff through 'speak up' clinics in different areas one or two days a week. The current focus of this is at Foxhall House

Case Study

A member of staff contacted the FTSUG about a situation in their workplace where the lack of staff, particularly nursing staff, was seriously affecting the care they were able to give and also how safe they felt in their working environment.

On one occasion during the night, the individual was attempting to get some information about medication, the on-call manager wasn't a clinician so was unable to help and the on-call Dr also didn't have the information. The individual had to do a lot of chasing around to find what they needed which again impacted negatively on the care they were able to give and on the safety of patients and colleagues.

Communication between work areas had broken down and the individual I spoke to commented that all areas were short of staff and as such wouldn't or couldn't help each other out as they might have done in previous times by moving staff around as and when the service need required it.

The individual initially wanted to remain anonymous and after questioning stated that they didn't know the members of the Care group quartet. Following an email discussion, the

person changed their mind and agreed to the Guardian contacting the care group. On passing the information on, the Lead Nurse emailed back the following day saying they had been at work the previous evening and had met with the individual.

They thanked the individual for speaking up and shared the plans for staffing in the area and what other resources can be called upon when staffing is tight. They also gave assurance that they would address the issues with work areas being unable to support each other directly with the managers and the issues around poor information available on medication.

This timely response is exactly how Sir Robert Francis envisaged FTSUG working. Where people felt fear or trepidation in speaking up they would contact the Guardian who would broker a response and resolution by having contact with the right people.

It's a hugely encouraging sign that the Care Group model is taking positive action in this area. This also demonstrates how important it is for the Care Group leaders to be visible and get to know the staff in their areas. This learning will be shared with all care group leaders.

Upcoming Activity

Responding to the recent audit of the FTSU service, the policy is being reviewed and amended in line with some of the recommendations and users are being surveyed around whether Datix is an appropriate method for people wishing to speak up.

Ongiong visits to inpatient areas are to be scheduled throughout the year

2.0 Financial implications

No current financial implications

3.0 Quality implications

Encouraging people within the organisation to speak up when they see things that aren't right and thanking them when they do, is crucial to preventing situations similar to those reported in the press over recent years.

There have recently been some negative comments around the outcomes from the FTSU process resulting in detrimental treatment of individuals following speaking up. Whilst as an organisation we believe in the FTSU process, if this is happening, further details are being sought and will be investigated.

4.0 Equality implications

The Trust must ensure that minority groups within the staff cohort are supported and encouraged to raise concerns without discrimination. The FTSUG role is discussed and contact details shared, in Equality and Diversity training settings and the FTSUG is invited to BME, Equality Leads and Disability Group meetings.

The guardian attends the disability group regularly but has not been able to schedule regular attendance at other meetings as yet.

5.0 Risks / mitigation in relation to the Trust objectives

Continued work to ensure staff feel able to speak up and are listened for when they do will assist the Trusts objective to be in the top quartile of trusts for safety and quality and staff engagement by 2023

Liz Keay

Date:	**23rd January 2020**
Item:	**20.16**

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NHS
Norfolk and Suffolk
NHS Foundation Trust

Report To:	Trust Board
Meeting Date:	23 January 2020
Title of Report:	People and Workforce Performance
Action Sought:	For information and assurance
Estimated time:	10 minutes
Author:	Charlotte Stewart, HR Business Intelligence Manager; Sarah Goldie, Head of Human Resources
Director:	Mark Gammage, HR Advisor to the Board

Executive Summary:

This report provides information and an update on key people issues, particularly focused on our People Plan priorities, as well as workforce performance.

The following are key highlights:

Equality, Diversity and Inclusion – In line with the Trust's new Equality, Diversity and Inclusion Strategy, work is progressing on the strategy's priority of not tolerating behaviour out of line with our Values or which is bullying, harassing or discriminatory in nature. A new campaign, 'Expect Respect', will launch in late January 2020. The campaign will promote a culture of inclusion. The Trust has also become a national culture change pilot with support from the national Workforce Race Equality Standard team.

Leadership Review – Consultation for phase 2 of the leadership review for clinical services commenced on 6 January 2020 and will conclude on 20 February. This impacts Band 8a leadership and managerial roles. The review is designed to strengthen clinical leadership and to simplify our leadership and management structures.

Recruitment – The recruitment of registered nurses and doctors continues to be challenging. Over 45 student nurses have, however, been offered positions for when they qualify later in the year following a recent assessment process.

Voluntary turnover – Voluntary turnover within the first two years of employment is a concern. A 'deep dive' report has been submitted for consideration at January 2020's Quality Committee to engage senior clinical leaders in how we best prevent this. Work is already in place to strengthen preceptorship.

Time to hire – The medical time to hire key performance indicator is being reviewed to provide a more meaningful assessment of performance. Non-medical time to hire has decreased to target levels.

Sickness absence – After a continuous trend of reduction in sickness absence, the annualised sickness absence rate has increased in October and November 2019 to 5.09%, largely due to seasonal illness. The Employee Experience team are working with Care Group leadership teams, the Wellbeing service, and the Trust's Consultant Psychologists' group to develop a more robust approach for supporting staff with sickness issues and those requiring mental health support. This is also geared at promoting the Trust's offering for staff health and wellbeing.

Appraisals and supervision – Rates continue to be below target and are of concern. Performance is being managed through Quality Review Meetings.

Culture Programme – A synthesis meeting to review all the diagnostics that have been undertaken under the NHS Improvement culture change programme is taking place on 29 January 2020. A report on the outcome of this and next steps will be brought to the March 2020 Board meeting.

Staff Survey – Some initial raw data from the survey provider has been received and is being analysed. Official results from NHS England will be published in February 2020. A report will be brought to the March Board meeting. An away day is to be held with Care Groups / Corporate teams to consider key themes and how we respond to these corporately and locally.

People Before Process – Work continues in partnership with trade union colleagues which includes the co-production of an investigation officer role and changes to how employee relations cases are managed to ensure these are in line with a just and learning culture and are undertaken expeditiously.

Pension Flexibilities – As an update to the Board, potential options to help reduce the risk of individual's pension tax liabilities particularly where it may impact on their work with the Trust have been developed and are being considered by the Executive Team

The Board is recommended to receive this report for information and assurance.

1.0 Introduction

1.1 This report provides information and an update on key people issues, particularly focused on our People Plan priorities, as well as workforce performance exceptions.

1.2 Figures presented are those that relate to performance as at end of November 2019. A copy of the Trust's Workforce Performance Dashboard can be seen in Appendix 1. The main source of the data is the Electronic Staff Record. The information was taken during November 2019 (between 1st and 12th) to allow for data processing.

2.0 People Plan

2.1 Equality, Diversity and Inclusion

2.1.1 In November 2019, the Board approved our Equality, Diversity and Inclusion Strategy for the next two years. A key priority is developing a more inclusive culture and taking an approach where behaviours that do not align to our Trust's Values of Positively, Respectfully and Together, especially bullying, harassing or discriminatory behaviour, are not tolerated. This work will be taken forward under the banner 'Expect Respect'. Staff communications will commence towards the end of January 2020. The campaign will serve as a vehicle for celebrating our diversity and fostering inclusion. The campaign will involve all the Trust's Equality Network groups with various activities planned to help close gaps in historical inequalities.

2.1.2 The Trust has been successful in its bid to be a cultural change pilot site, along with five other Trusts, with intensive support from the national Workforce Race Equality Standard (WRES). The first meeting with the national team and the other pilot Trusts, to be attended by the Chair, CEO and HR Advisor to the Board, is on 22nd January 2020.

2.2 Leadership Review

2.2.1 Following discussion with the Staff Partnership Forum in December, 2019, consultation on Phase 2 of the leadership review commenced on 6 January 2020, led by the Care Group senior leaders. This includes all Care Groups with the exception of Secure Services, Norfolk Child Family and Youth and Wellbeing Services. It impacts Band 8a leadership and managerial roles. Consultation runs until 20 February 2020. The review is designed to strengthen clinical leadership and to simplify the structure to support better communications, innovation and transformation.

2.3 Recruitment and Retention

2.3.1 At the end of November 2019, the Trust's vacancy rate slightly increased to 8.5% of our funded establishment. This is equivalent to 366 whole time equivalent (wte) vacant posts.

2.3.2 Since September 2019 the overall funded establishment has increased by 59 wte posts and overall staff in post by 35 wte. The establishment increase is mostly due to the reopening of Yare Ward and phase 1 of the leadership review. Since April it should be noted that we have increased our overall workforce by 96 wte staff (83 of which are clinical staff).

2.3.3 Vacancies for medical and registered nursing staff remain of concern. 20% of medical roles are vacant, and 14% of nursing roles remain vacant. Some progress has been made in the year to reduce the number of nursing vacancies (from 193 to 187), and medical vacancies have improved from a high of 34.5% in April 2019. Additionally, 26.15 wte medical vacancies are covered by agency locums. Factoring this cover in reduces the vacancy rate to 11.15%, with a 6.35% vacancy rate for

Consultants. Two SAS doctors joined the Trust in early January 2020, one in Medium Secure and the second working in the Mother and Baby Unit. Five consultants have accepted posts and will join the Trust in the near future, one in late January to work in Norfolk CFYP and a further 4 in April 2020, 3 in West Norfolk and 1 in East Suffolk.

2.3.4 In terms of the recruitment to nursing positions, a new process for recruiting student nurses has been designed. The process is led by Lead Nurses from across all service lines and supported by Human Resources. It focuses on third year students. Using this process, three assessment centres for third year nursing students have been undertaken – two at the University of East Anglia and one at the University of Suffolk. Over 45 employment offers have been made and accepted so far.

2.3.5 The Government has recently announced that a nursing bursary will be reintroduced from September 2020 which includes a higher level for mental health nurses (£8,000). This is a positive development to support the mental health nurse supply pipeline.

2.3.6 Voluntary turnover to the end of November 2019 has been slightly higher at 10.9% than our more typical rate (10.1%) since August 2019. This equates to 428 voluntary leavers in the last months). Voluntary turnover is now 2.44% points above the target rate.

2.3.7 A total of 72 employees left the Trust during October and November 2019. The main reasons given for leaving being:

Leaving Reason	Headcount
Voluntary Resignation – Work Life Balance	19
Retirement Age	10
Voluntary Resignation – Relocation	8
Voluntary Resignation – Promotion	7

2.3.8 3% of all leavers are returning through our 'retire and return' policy, which continues to be promoted. The Chief Nurse will be writing to all registered nurses who may retire over the next five years and to invite them to meet with her and the Head of Human Resources.

2.3.9 Of concern is that we continue to have a high proportion (40%) of staff who leave before completing 2 years' service. Worst affected are within the Clinical Support Services, Admin and Clerical and Allied Health Professionals which are all over 40%. Registered nursing is 35%. Medical is much more satisfactory at 6.7%. Work is already being undertaken to strengthen preceptorship for newly qualified nurses.

2.3.10 A deep dive report on retention is being presented to the Quality Committee at its meeting on 13 January 2020. In particular, the Committee has been asked to consider what actions can be taken to reduce turnover in the first two years of employment and to reduce the number of staff leaving due to work-life balance. A recommendation is that all registered nurses who resign are seen by a Lead Nurse/

Service Director (or more senior) for their exit interviews and doctors are seen by the Lead Clinicians.

2.3.11 The Medical 'Time to Hire' key performance indicator (KPI) is being reviewed so that a more meaningful measure can be used. This follows a review of the non-medical KPI which has previously been reported to the Board.

2.3.12 The Trust's Recruitment group has been re-established and its second meeting is on 22nd January 2020. Its focus is particularly on medical and nursing recruitment, both internationally and domestically, as well as ensuring that our offer as a Trust to all staff is as well developed as possible.

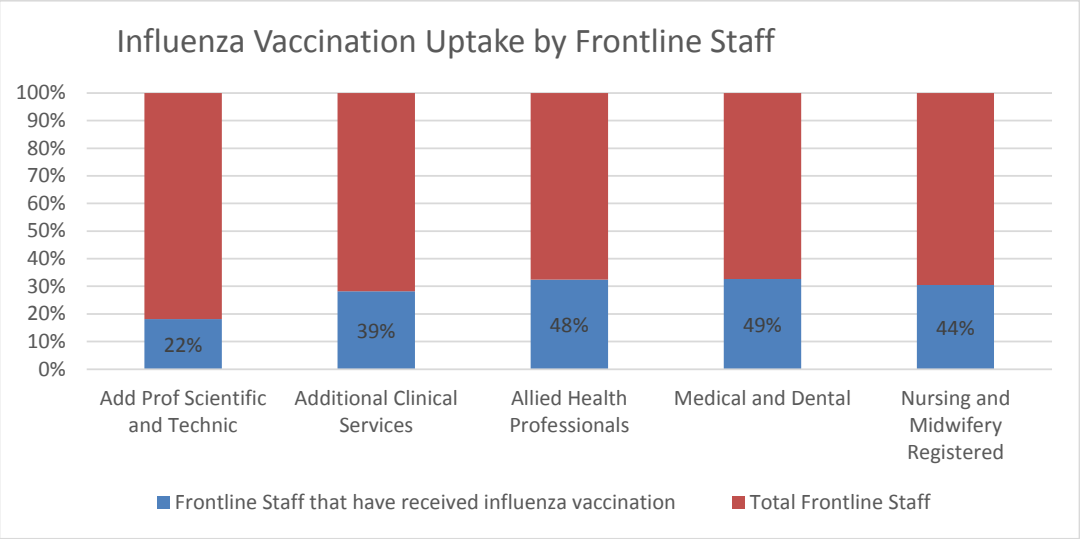
2.4 Core Workforce Metrics (Exceptions)

2.4.1 Sickness Absence

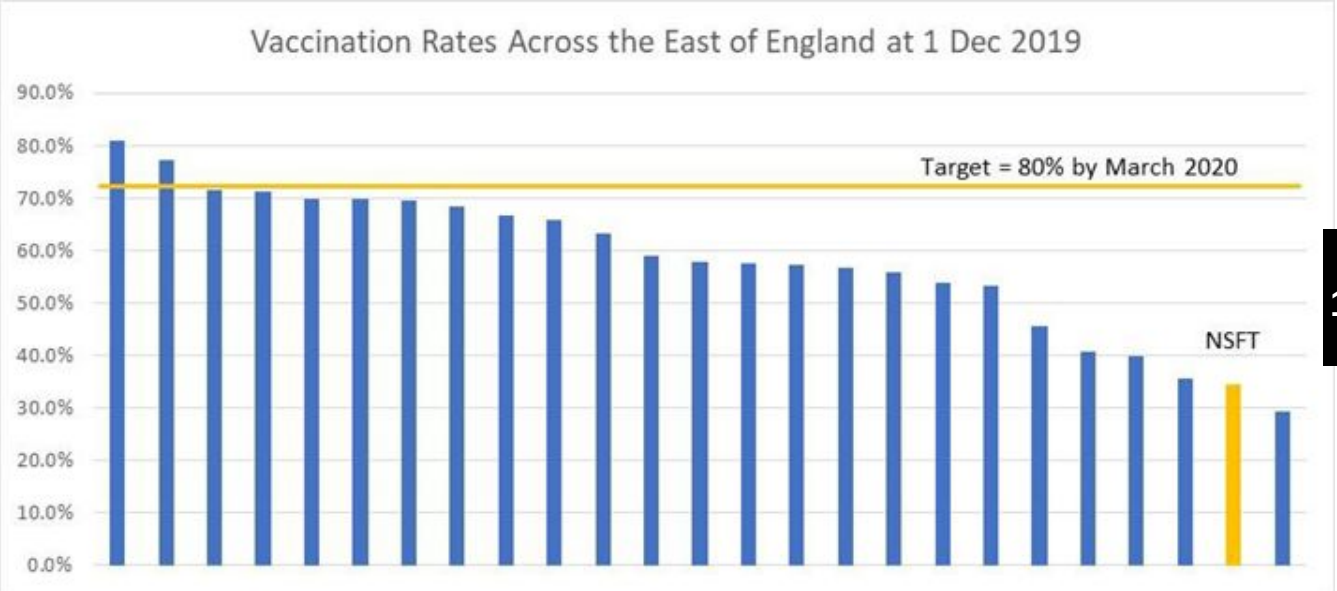
2.4.1.1 As at the end of November 2019, the Trust's absence rate was recorded at 5.09% on an annualised basis (rolling 12 months) and at 5.79% on an in-month basis. There has been a significant increase in absence rates during October and November 2019; the monthly rate has increased by 0.85% points overall with the impact on the annualised rate being an increase of 0.15% points. This is a change in pattern following a trend of decreasing sickness absence since March 2019, largely attributable to seasonable illnesses of coughs, cold and 'flu and gastrointestinal; absences for these reasons are at their highest levels since January 2019. There is also, however, an increasing amount of absence due to 'unknown causes / not specified' with over 600 fte days lost in November 2019 to this reason. This is a recording issue as a specific category of absence should be identified. This will be followed up with managers through the Human Resources Business Partners. Alongside this, time lost to anxiety / stress / depression also increased in November with over 1.6% of time lost being attributed to this reason

2.4.1.2 The 2019 influenza vaccination campaign has been underway since early October 2019. At 17 December,1,922 members of staff had received the vaccination, which represents 45.4% of Trust staff. 42.6% of these are front line clinical.

The graph below shows the uptake of the vaccination by front line staff only.



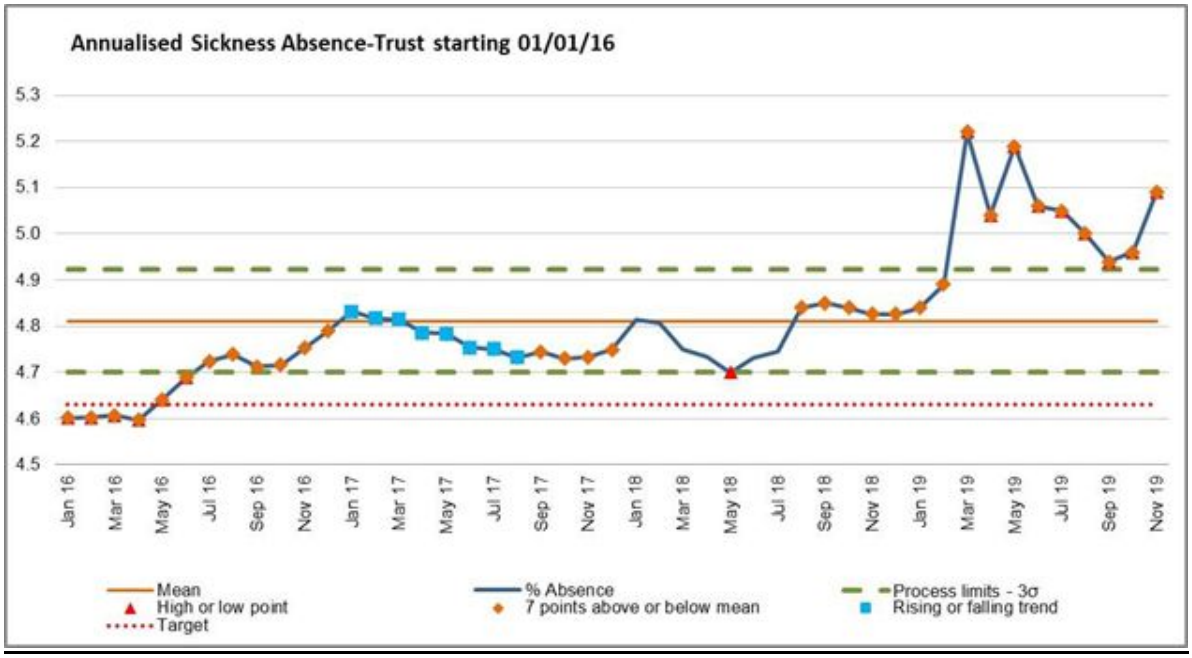
2.4.1.3 The graph below shows the uptake rates across the East of England (all providers) at 1 December 2019 for front line staff. We are considerably below target. A number of actions are being taken which include: regular communications to all staff regarding influenza vaccination clinics with an option to 'dial a jab', weekly updates on uptake to Service Leads, emails to staff with direct patient contact that have not engaged in the vaccination programme, 'get a jab, give a jab campaign' and a prize draw open to all staff that have received their vaccination. In addition, the uptake by Care Group is published weekly in Trust update with accreditation certificates awarded to areas that reach specific uptake figures, the lowest being bronze with 50% uptake up to platinum for 80% uptake.



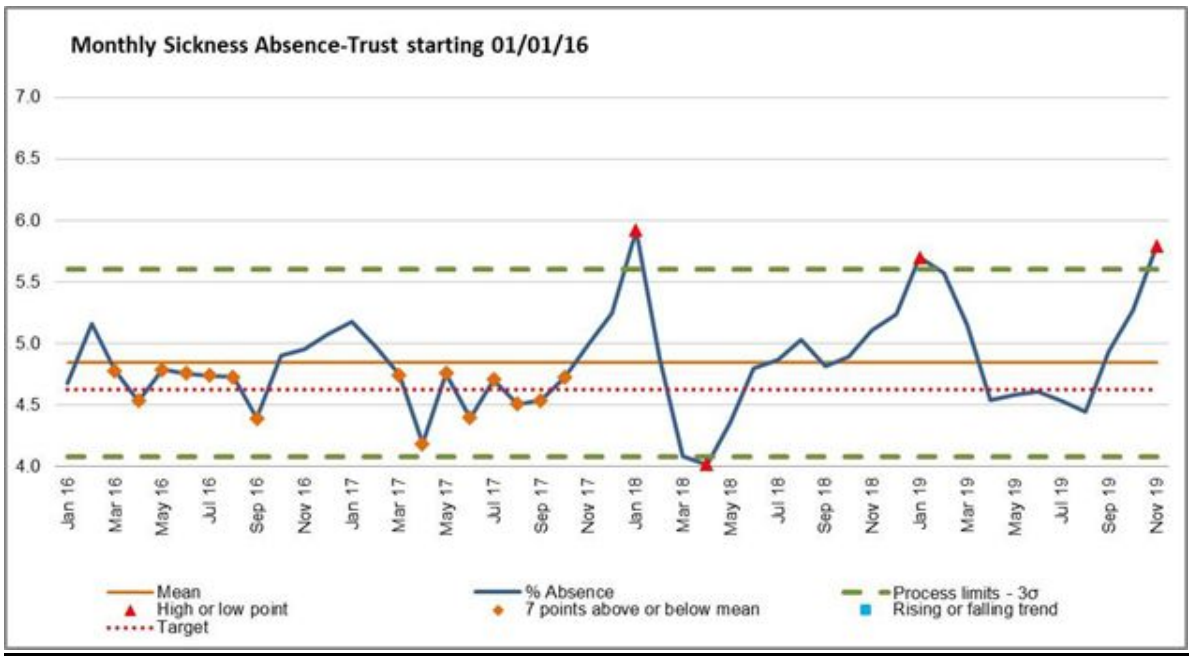
11.3

2.4.1.4 The annualised cost of absence is estimated at just over £6.4 million in lost capacity (excluding backfill costs). This is equal to 194 full-time equivalent staff not attending work for a year. The true cost is higher factoring in bank, agency and other staff cover to keep services safe.

2.4.1.3 The Statistical Process Control Chart (SPC) chart below shows the impact of recent increases in monthly absence on the annualised absence rate. Currently we are 0.46% points away from our target rate of 4.63% but have been above the mean absence level since August 2018.



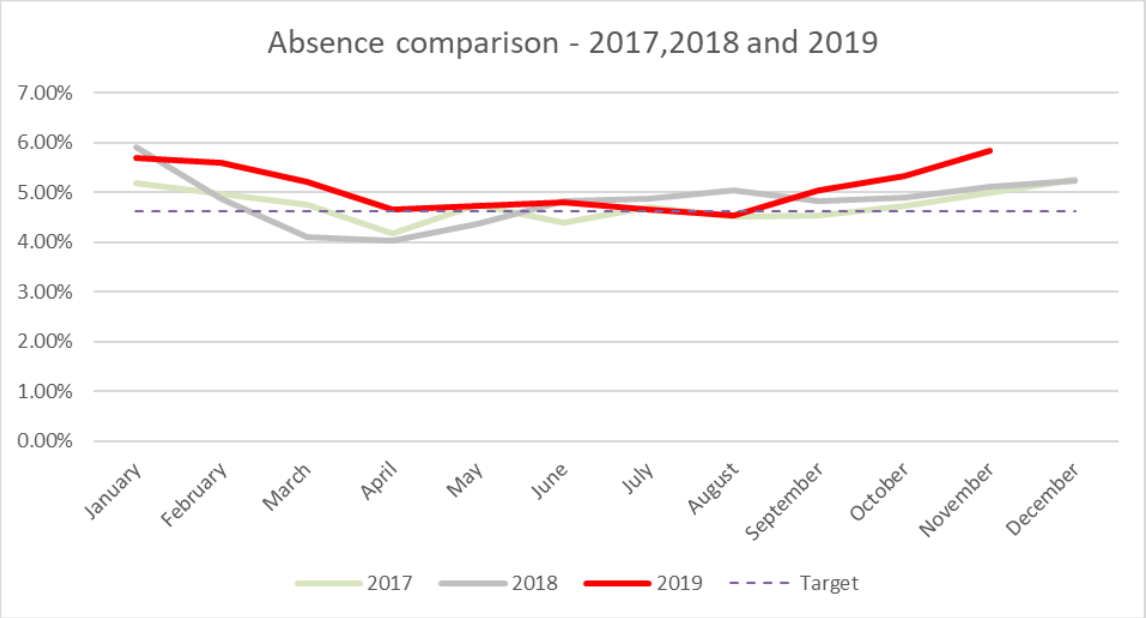
2.4.1.5 The recent spike in monthly absence can be seen in the SPC chart below, with November absence above the upper process limit for the first time since January 2019.



11.3

2.4.1.6 Since the absence position has increased in both October and November 2019 (and comparative to values 2017 and 2018 are much lower than the current position) there is concern that without significant improvement in December 2019 and January 2020 that the target for absence at 4.63% is at risk of not being met by April 2020.

2.4.1.7 The graph below provides a comparison of monthly absence values in 2017, 2018 and 2019.



2.4.1.8 It has previously been reported that the 'top fifty' longest sickness absence were being reviewed by a senior HR Manager to ensure that these were being managed as proactively as possible. This review has now been completed. Of these 50 cases, 27 cases have now concluded or are in the final stages of concluding with staff either being supported back to work (with ESR now updated to reflect this) or supported with medically recommended ill-health retirement plans. 18 cases continue to be supported and appropriately managed by line mangers with advice from HR. The review highlighted 5 cases that were not being managed closely and HR support has been increased in these circumstances.

2.4.1.9 The Employee Experience team are working with Care Group leadership teams, the Wellbeing service, and the Trust's Consultant Psychologists' group to develop a more robust approach for supporting staff with sickness issues and those requiring mental health support. This is also geared at promoting the Trust's offering for staff health and wellbeing. This will include providing access to mental health services for staff to support them remaining at work.

2.4.2 Appraisals and Management Supervision

2.4.2.1 Non-medical appraisal rates continue to fluctuate around 79% region. Prior to November 2018 the rate had been consistently over 86% for the previous ten months, including an extended period of over 92%. This shows that this level of performance is achievable.

2.4.2.2 Medical appraisal rates have had a deteriorating trend since July 2019 when performance was 95%; this is down to 85.7%. Outstanding appraisals are being followed up by the Clinical Directors. Six appraisals need to be completed in order to return to above target. A business case for an electronic system is being developed to support the medical appraisal process. Consideration is also being given to transferring the responsibility for medical appraisals and revalidation administration to the Human Resources team (currently sits with Education) to improve governance and alignment with wider medical workforce strategy.

2.4.2.3 Management supervision rates have slightly deteriorated. This continues to be considered as part of the Care Group and Corporate Quality Review Meetings and along with appraisal forms a key requirement for the new Care Groups.

2.4.3 Training Compliance

2.4.3.1 Mandatory training compliance is 0.8% points below the 90% target. Compliance has been consistently on or just below the 90% target since February 2019. Overall, this is not a major area of concern although performance continues to be variable for different subjects. In line with national strategy on streamlining, the Trust will be accepting, on a 'passport' basis, in-date mandatory training that has been undertaken elsewhere in the NHS where the training has been verified as in line with the national NHS Core Skills Training Framework.

2.4.4 Registered Nurse shift fill rates

2.4.3.1 A separate safer staffing report has been submitted to the Board covering the period to end December 2019.

2.5 Leadership Development

2.5.1 Quotes are currently being sought for team and individual coaching for the new Care Group senior leadership teams to support them in their development and embedding their leadership effectiveness over the next year. As highlighted to the Board previously, proposals on wider leadership development offerings for implementation in 2020/21 focused on new managers as well as more senior and experienced managers will be shaped by the learning from the culture diagnostics work. To deliver something with scale and impact, investment will be required.

2.6 Culture Programme / Employee Experience

2.6.1 The Culture Group has continued to meet monthly and on 29th January 2020 will be assimilating each of the different aspects of the NHS Improvement culture change framework diagnostic tool that it has been undertaking. This work will set the agenda for the next phase of work. This may include the establishment of an Employee Experience Committee, or similar, to lead this work going forward and incorporating the oversight of Staff Survey priorities. A separate report will be provided to the March meeting of the Board of Directors.

2.6.2 In respect of the Staff Survey, our final response rate was 48%. This is 5% less than our response in the previous year and not typical of our usual rate. It is

possible that the lower rate was influenced by survey fatigue having run pulse surveys in the period from April 2019 to the Staff Survey commencing. Some raw data has now been received from the survey provider and is being analysed. Final results from NHS England are expected in February 2020. A detailed report will be provided to the March 2020 Board meeting.

2.6.3 An employee experience infographic has been developed as a tool to explain key moments that impact staff experience (see attached). These map to our People Strategy priorities.

2.7 People Before Process

2.7.1 The People Before Process Group, comprising staff-side colleagues and members of the Human Resources team, has been meeting fortnightly since September 2019 and is focussing on:

- developing a new Investigating Officer role and recruiting to this position (the role has now been agreed and is being banded)
- the questions that should be asked when a new employee relations issue is raised as part of a 'just and learning' culture and to minimise restrictions to practice and suspensions to a minimum
- the support that should be given to staff who are going through an employee relations (ER) process, including when staff are suspended or on restricted duties.

2.7.2 There continue to be relatively high levels of ER cases. These include 34 disciplinary cases with six staff suspended and eighteen with other restrictions in place. As work on a just and learning culture embeds, formal cases should reduce.

2.7.3 More stringent monitoring arrangements have been put in place to improve the tracking of ER cases to ensure these are appropriately expedited. Cases are averaging 121 days from start to finish and the immediate target is to reduce this to 90 days.

2.8 Human Resources Restructure

2.8.1 Selection to the new structure and transition to the new model is almost complete. The final stage is to complete selection to the Employee Experience team which will be undertaken within the next couple of months. Interim arrangements are in place. The new model aligns to the new Care Group structure and supports the delivery of our People Strategy priorities.

3.0 Other Workforce Updates/ Issues

3.1 EU Exit

3.1.1 Monitoring and contingency planning regarding the potential workforce implications of the United Kingdom (UK) leaving the European Union (EU) continue. We have 178 staff from the EU within clinical and non-clinical services. There have been no notable negative impacts to date in terms of EU staff leaving.

3.2 Pension Flexibilities

3.2.1 As an update to the briefings previously provided to the Board, potential options to support staff to mitigate pension tax risks have been identified and are being considered by the Executive Team. Additionally, NHS England and NHS Improvement have put an arrangement in place for the 2019/20 financial year enabling doctors to defer pension tax liabilities for this tax year to retirement and guaranteeing that these will be covered by the NHS.

3.3 NHS People Plan

3.3.1 A Core Offer for staff and Leadership Compact which form key elements of the new NHS People Plan have been endorsed by a joint Board of NHS England and NHS Improvement in November 2019. Our own People Strategy will be reviewed to ensure alignment.

4.0 Financial implications (including workforce effects)

4.1 Focus in the areas set out above will positively impact financial performance (directly and indirectly).

4.2 Some aspects of the People Strategy are likely to require some investment which will be explored with the Executive Team as necessary.

5.0 Quality implications

5.1 Focus on the areas set out in this report support the delivery of the Trust's Strategy, in particular, the priority of engaging and inspiring our staff. This will lead to improved experience for our staff and service users.

6.0 Equality implications

6.1. Addressing issues of equality, diversity and inclusion is a key element of our People Strategy.

7.0 Risks / mitigation in relation to the Trust objectives

7.1 Risks and mitigation in relation to strategic workforce issues are presented throughout this paper, relating to BAF risks 1.1, 1.2

8.0 Recommendations

8.1 The Board is recommended to note the contents of this report, including actions and progress being made.

8.2 The Board is asked to advise on any further steps it requires to be assured that the issues highlighted are being managed effectively.

Appendix 1 – Workforce Performance Dashboard

Workforce Dashboard 2019/20

November 2019

TOTAL TRUST

<< Pick view here

NHS
Norfolk and Suffolk
NHS Foundation Trust

Engaged Workforce KPI	Indicator Reference	Reporting Period	Target	Current Performance	Change	Performance Tracker	Trend	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19
Annualised Sickness absence %	WF01	Rolling 12 months	4.63%	5.09%	0.13%			4.83%	4.83%	4.83%	4.89%	5.22%	5.04%	5.19%	5.06%	5.05%	5.00%	4.94%	4.96%	5.09%
In Month Total Sickness Absence Rate %	WF02	Monthly	4.63%	5.79%	0.52%			5.08%	5.26%	5.26%	5.57%	5.15%	4.54%	4.59%	4.63%	4.53%	4.44%	4.94%	5.27%	5.79%
of which is Short Term Sickness Absence Rate %	WF02a	Monthly	N/A	2.81%	0.79%	N/A		2.09%	2.04%	2.04%	2.44%	1.96%	1.52%	1.59%	1.53%	1.62%	1.41%	2.13%	2.02%	2.81%
of which is Long Term Sickness Absence Rate %	WF02b	Monthly	N/A	2.99%	-0.27%	N/A		2.99%	3.21%	3.21%	3.13%	3.19%	3.02%	3.00%	3.10%	2.92%	3.03%	2.81%	3.25%	2.99%
% of time lost to stress/anxiety/depression	WF03	Monthly	1.16%	1.60%	0.23%			1.77%	1.85%	1.85%	1.67%	1.66%	1.42%	1.40%	1.61%	1.42%	1.42%	1.39%	1.37%	1.60%

Skilled Workforce KPI	Indicator Reference	Reporting Period	Target	Current Performance	Change	Performance Tracker	Trend	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19
In Month Overall Vacancy Rate %	WF04	Monthly	7.3%	8.49%	0.13%			8.9%	8.6%	8.6%	8.6%	8.1%	10.0%	9.5%	9.8%	9.5%	9.1%	8.0%	8.4%	8.5%
of which NHS Infrastructure Vacancy %	WF04a	Monthly	5.0%	5.57%	-0.22%			5.2%	4.5%	4.5%	4.4%	4.2%	7.2%	6.3%	5.9%	6.0%	5.2%	5.0%	5.8%	5.6%
of which Medical Staff Vacancy Rate %	WF04b	Monthly	12.4%	20.53%	0.00%			18.3%	20.8%	20.8%	20.8%	22.3%	34.5%	29.5%	32.3%	30.8%	26.0%	21.9%	20.5%	20.5%
of which Registered Nursing Vacancy Rate %	WF04c	Monthly	5.0%	14.44%	0.14%			14.5%	15.2%	15.2%	14.9%	14.8%	14.6%	14.7%	15.2%	14.8%	14.5%	14.3%	14.3%	14.4%
of which Support to Clinical Staff Vacancy Rate %	WF04d	Monthly	11.0%	3.01%	0.62%			6.9%	6.2%	6.2%	6.6%	5.4%	5.6%	5.5%	4.9%	4.4%	3.3%	0.1%	2.4%	3.0%
of which Qualified AHP Vacancy Rate %	WF04e	Monthly	5.0%	5.66%	-0.05%			1.9%	-0.6%	-0.6%	-0.3%	-1.4%	2.1%	2.5%	3.4%	3.9%	5.8%	6.1%	5.7%	5.7%
All Staff Turnover %	WF05	Rolling 12 months	11.5%	12.83%	0.02%			12.8%	13.0%	13.0%	12.9%	11.6%	11.7%	11.7%	11.8%	11.9%	12.3%	12.6%	12.8%	12.8%
Voluntary turnover %	WF06	Rolling 12 months	8.5%	10.94%	-0.10%			10.2%	9.2%	9.2%	10.3%	10.1%	10.1%	10.1%	10.1%	10.1%	10.7%	10.8%	11.0%	10.9%
Time to Hire (non-medical)*	WF07a	Monthly	62.0	59.78	-3.87													67	64	60
Time to Hire (medical)*	WF07b	Monthly	75.0	127.00	11.50														116	127
Management Supervision %	WF08	Monthly	89.0%	63.55%	-0.88%			76.5%	73.9%	96.4%	75.0%	81.4%	68.8%	66.7%	65.2%	67.0%	61.8%	67.0%	64.4%	63.5%
% Total Appraisal Rate	WF09	Monthly	90.0%	79.99%	-1.25%			86.2%	86.3%	86.3%	83.5%	81.4%	81.1%	79.6%	78.9%	79.0%	78.5%	79.0%	81.2%	80.0%
% Non-Medical Staff Appraisal Rate	*WF09a*	Monthly	90.0%	79.77%	-1.32%			86.2%	86.1%	86.1%	83.4%	81.4%	80.8%	79.4%	78.4%	78.4%	78.1%	78.6%	81.1%	79.8%
% Medical Staff Appraisal Rate	*WF09b*	Monthly	90.0%	85.71%	0.33%			87.6%	90.1%	90.1%	86.6%	81.8%	88.8%	83.8%	92.8%	95.0%	91.2%	90.0%	85.4%	85.7%
% Mandatory Training Completed	WF10	Monthly	90.0%	89.24%	-1.03%			93.1%	91.8%	91.8%	90.3%	89.6%	90.2%	90.1%	89.9%	90.3%	90.3%	88.8%	90.3%	89.2%

Safe Workforce KPI	Indicator Reference	Reporting Period	Target	Current Performance	Change	Performance Tracker	Trend	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19
Day Time Average shift fill rate - registered nurses (%)	WF11a	Monthly	90.0%	88.28%	1.69%			93.2%	89.0%	89.0%	89.1%	91.1%	92.4%	90.3%	87.6%	85.5%	83.8%	84.2%	86.6%	88.3%
Day Time Average shift fill rate - care staff (%)	WF11b	Monthly	90.0%	118.44%	2.32%			117.8%	119.8%	119.8%	120.7%	123.5%	121.7%	120.2%	118.2%	121.7%	118.7%	120.7%	116.1%	118.4%
Night Time Average shift fill rate - registered nurses (%)	WF11c	Monthly	90.0%	92.43%	4.50%			92.6%	92.1%	92.1%	91.4%	89.7%	89.9%	89.6%	89.0%	86.4%	89.4%	90.9%	87.9%	92.4%
Night Time Average shift fill rate - care staff (%)	WF11d	Monthly	90.0%	131.18%	-4.16%			134.1%	131.8%	131.8%	130.7%	134.5%	140.2%	136.5%	131.5%	134.9%	131.7%	135.1%	135.3%	131.2%

Staff in post	Indicator Reference	Reporting Period	Target	Current Performance	Change	Performance Tracker	Trend	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19
Substantive Staff at the end of month	WF12	Monthly	N/A	3916.86	13.81	N/A		3729	3732	3732	3765	3796	3818	3817	3833	3831	3860	3857	3903	3917

Bank and Agency Usage	Indicator Reference	Reporting Period	Target	Current Performance	Change	Performance Tracker	Trend	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19
Day Time Bank/Agency registered nurses (%)	WF13a	Monthly	N/A	39.11%	1.52%	N/A		32.6%	29.9%	29.9%	38.1%	34.0%	39.6%	39.6%	39.5%	40.9%	40.2%	38.0%	37.6%	39.1%
Day Time Bank/Agency Care Staff (%)	WF13b	Monthly	N/A	49.04%	1.44%	N/A		52.8%	51.5%	51.5%	54.7%	53.1%	57.7%	55.4%	56.3%	58.8%	54.9%	49.9%	47.6%	49.0%
Night Time Bank/Agency registered nurses (%)	WF13c	Monthly	N/A	51.89%	1.63%	N/A		42.8%	44.5%	44.5%	41.0%	45.9%	40.1%	42.3%	47.0%	43.8%	46.2%	47.6%	50.3%	51.9%
Night Time Bank/Agency Care Staff (%)	WF13d	Monthly	N/A	71.94%	1.73%	N/A		57.1%	58.9%	58.9%	59.5%	60.1%	70.4%	70.1%	67.7%	69.0%	71.9%	73.0%	70.2%	71.9%

Employee Relations	Indicator Reference	Reporting Period	Target	Current Performance	Change	Performance Tracker	Trend	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19
Number of open employee relations cases	WF14	Monthly	N/A	40.00	-20.00	N/A		44	43	43	45	38	42	27	53	54	54	60	60	40
Of which open 'Capability No UHR' cases	WF14a	Monthly	N/A	1.00	-7.00	N/A		1	1	1	6	6	2	2	2	3	3	8	8	1
Of which open 'Capability UHR' cases	WF14b	Monthly	N/A	17.00	-4.00	N/A		14	13	13	14	13	13	11	13	20	17	21	21	17
Of which open 'Disciplinary' cases	WF14c	Monthly	N/A	15.00	-7.00	N/A		25	25	25	21	13	21	9	31	26	28	25	22	15
Of which open 'Grievance' cases	WF14d	Monthly	N/A	4.00	-2.00	N/A		1	2	2	2	4	4	1	2	2	3	4	6	4
Of which open 'Harassment' cases	WF14e	Monthly	N/A	3.00	0.00	N/A		3	2	2	2	2	2	4	5	3	3	2	3	3

*Please note, from 1st April 2019 the defintion for calculating time to hire has changed. See meta-data tab for details.

Date:	**23rd January 2020**	**P**
Item:	**20.17ii**	

Norfolk and Suffolk NHS
NHS Foundation Trust

Report To:	Board of Directors
Meeting Date:	23rd January 2020
Title of Report:	Chair's report to BOD in respect of the Audit and Risk Committee meeting held on 7th January 2020
Action Sought:	For Assurance
Estimated time:	5 minutes
Author:	Adrian Matthews, Non-Executive Director; Jean Clark, Trust Secretary

Executive Summary:

This report provides an update to the Board on the meeting of the Audit and Risk Committee held on the 7th January 2020.

External Audit
The Audit plan for year end 2019/20 was presented. Risks and proposed audit focus were discussed including the change mid year to a new financial system and the development of the estates strategy. There are also changes from April 2020/21 to the International Financial Reporting Standards in respect of accounting for leases, and the audit will check the Trust's preparedness for these changes.

Internal Audit and Counter Fraud
A re-designed progress report and the scope of upcoming audits, specifically in relation to the CQC report, were discussed.

The committee recognised the improved executive grip in relation to the internal audit plan and completion of audit recommendations in a timely manner, however, many recommendations were still outstanding and this remains a concern to the Committee. There was still a challenge to complete the audit plan by year end. The 2020/21 plan would be reviewed by the Board at a development session. The improved governance had been encapsulated in an Internal Audit Framework and agreed by the Committee.

Further information has been provided in respect of the management response to audits on Out of Area placements and Consultant Job Planning follow ups and these will be finalised shortly. They will be reviewed by the relevant Board sub-committee prior to this committee.

The committee received the final internal audit report on the PWC external governance review action plan This report gave a significant assurance opinion. This effectively closes the original PWC external governance review from May 2028 and will be reported at OAG.

The Committee requested more publicity and awareness raising by counter fraud and it was suggested they participate in the up-coming Care Group away days. A new Counter Fraud framework was agreed. The committee proposed more integration of counter fraud, Freedom to Speak up Guardian and whistleblowing work.

Risk Management
The Board Assurance Framework and Corporate Risk Register were reviewed. More challenge with Care Group risk reporting was required, whilst a simpler reporting form and less frequent risk review dates should improve the administrative burden.

The Chair asked for more discussion on the BAF at Board meetings.

Compliance
Reports were received on Information Governance, Legal Claims, Losses, special payment, Trust receivables, and use of single tender waivers. Finance, Business & Investment Committee will conduct a deep dive of the procurement process at its January meeting.

Emergency Planning
The committee received an update on EU Exit and progress with business continuity planning.

The CEO attended the meeting to discuss his risk concerns, with the key issue being how to move operationally from crisis management to business as usual.

Recommendation

The Board is asked to note the report.

Date:	**23rd January 2020**	**Q**
Item:	**20.17iii**	

Norfolk and Suffolk NHS
NHS Foundation Trust

Report To:	Board of Directors
Meeting Date:	23rd January 2020
Title of Report:	Chair's report to BOD in respect of the Finance, Business & Investment Committee meeting held on 16th January 2020
Action Sought:	For Assurance
Estimated time:	5 minutes
Author:	Adrian Matthews, Non-Executive Director; Jean Clark, Trust Secretary

Executive Summary:

This report provides an update to the Board on the meeting of the Finance, Business & Investment Committee held on the 16th January 2020.

Board Assurance Framework
The Committee reviewed the BAF and the risks that are attributable to this committee. The Committee requested that the risk in respect of financial stability of the Trust is split into two, one for in year financial balance, and the second for longer terms viability of the Trust.

Financial Position
The Committee received the regular finance report and were assured that the Trust will meet its financial obligations for 2019/20. The Committee also reviewed the five-year plan. Whilst this contains many assumptions and caveats, it is evident that the Trust will need to take a firm grip of the underlying operational overspend, that is being managed non-recurrently, and provide recurrent savings to turn this around to meet future requirements. The income position remains fluid, with contract negotiations now taking place.

Estates
The Committee received an update on the estates plan for 2020. There is a need to create a strategy to cover at least the next two years whilst the local health system undertakes the strategic changes through the Integrated Care System model, as care is focused upon more locally delivered services.

Norfolk Prison Service Contract
The Committee received a very good analysis of the Norfolk prison service contract that NSFT won and started to deliver in April 2019. It detailed the changes that have been made since the legacy service moved to the Trust, the issues of TUPE and created a fully integrated service at Norwich prison, and working with different providers at Wayland and Bure. This contract is still very much in its infancy, but the staff and management team were commended for the work that has already been undertaken and that which is being planned.

Hellesdon Hospital new wards
The Committee received an update on the governance processes being put in place to manage the significant estates project to deliver the new wards on the Hellesdon site following the government announcement for specific funding for this project. Whilst this is early days, there are some encouraging conversations already in place with the local council around planning and the way forward.

ICT Contract renewals
The Head of ICT presented a paper outlining the need to renew two significant ICT software contracts. The contract for the Trust's patient care record has reached its mid-way break clause. The Head of ICT recommended that the contract be renewed for five years, but with the flexibility to for break clauses to be used to shorten this period if required. The other contract was for the renewal of licence foe the Trust's use of Microsoft products. The Committee recommended approval of these contract renewals to the Board.

Recommendation

The Board is asked to note the report and approve the two ICT contract renewals.

Date:	**23rd January 2020**	**R**
Item:	**20.17iv**	

Norfolk and Suffolk NHS
NHS Foundation Trust

Report To:	Board of Directors
Meeting Date:	23rd January 2020
Title of Report:	Chair's report to BOD in respect of the People Participation Committee meeting held on 9th December 2019
Action Sought:	For Assurance
Estimated time:	5 minutes
Author:	Jean Clark, Trust Secretary

Executive Summary:

This report provides an update to the Board on the meeting of the People Participation Committee held on the 9th December 2019.

The Chair prompted a discussion about the committee operating more strategically, rather than exploring operational issues.

The Committee heard progress on the development of the new People Participation strategy and committed to a timeframe of April, with the Patient Participation Leads (PPLs) presenting the final strategy at the May Board. The role of the committee is to hold the Board to account for participation and co-production and the strategy is key to this.

The role of the Working Together Groups was discussed – some are very effective while others need more service user involvement and a fresh approach. Work is underway to review principles and to report back at the next committee meeting.

The Governors had elected two Committee representatives who attended their first meeting.

The Committee reviewed the relevant BAF risks and discussed the role of PPLs alongside existing Service User and Carer forums. The value of the work of service users and carers was emphasised, and comms would be shared to ensure the various forums continue to meet and to offer any support needed.

PPL involvement in developing the action plans from the community mental health survey and the new digital strategy was discussed.

Recommendation

The Board is asked to note the report.

Date:	**23rd January 2020**	**S**
Item:	**20.17v**	

Norfolk and Suffolk NHS
NHS Foundation Trust

Report To:	Board of Directors
Meeting Date:	23rd January 2020
Title of Report:	Chair's report to BOD in respect of the Mental Health Act Committee meeting held on 12th December 2019
Action Sought:	For Assurance
Estimated time:	5 minutes
Author:	Jean Clark, Trust Secretary

Executive Summary:

This report provides an update to the Board on the meeting of the Mental Health Act Committee held on the 12th December 2019.

The Committee received updates on the following matters:-

MH Act Performance
The committee received a report on the CQC visits that had taken place since the last meeting. Future reports will include key concerns and actions being taken to improve within care groups.

The MH Act run rates showed monthly monitoring by the MHA administrators on the wards. Again, more information was requested by the Committee to highlight the operational action being taken to address compliance. Members requested the executive define a clear process with care groups to provide assurance to the Committee and to the Board. This will be debated fully at the next meeting.

Approved mental health professionals (AMHPs) Update
The Suffolk AMHP provided an update on the review of AMP services in the county.
Norfolk County Council are introducing an app to improve the accessibility of S12 doctors.

Inter-Agency Update
It was reported that a S136 steering group had been established and had reviewed the compliance and training issues raised at the Service Delivery Board. The Board had confirmed the medical assessment of detainees should be completed within 4 hours of admission and datix reporting to enable monitoring for non compliance. The Committee asked for executive to address this with care groups and for a report at the next meeting along with assurance that the medical scrutiny rota had been resolved.

Audits for 2020
The plan for audits for the year was discussed and agreed. Progress would be a standing item for the committee.

The Committee recognised it is still developing its role in the new governance architecture and the Chair will discuss this in more detail with the executive to ensure the relevant workplan to provide appropriate assurance to the committee in future. The new Terms of Reference were approved.

Recommendation

The Board is asked to note the report.

Date:	**23rd January 2020**	**T**
Item:	**20.17vi**	

Norfolk and Suffolk NHS
NHS Foundation Trust

Report To:	Board of Directors
Meeting Date:	23rd January 2020
Title of Report:	Chair's report to BOD in respect of the Appointments & Remuneration Committee meeting held on 19th December 2019
Action Sought:	For Assurance
Estimated time:	5 minutes
Author:	Jean Clark, Trust Secretary

Executive Summary:

This report provides an update to the Board on the meeting of the Appointments and Remuneration Committee held on the 19th December 2019.

The Committee received updates on the following matters:-

Employment tribunals
A summary of current Employment Tribunal cases was discussed, along with NED involvement in panels. The committee requested sight of cases, with themes for learning, on an on-going basis and for summaries to be submitted to Audit and Risk Committee for completeness along with other legal costs.

Pay, terms and conditions
The committee received a report on national issues affecting the pay, terms and conditions of staff, in particular:

- Pension tax and how the Trust was responding
- Junior doctors' terms and conditions and changes being introduced from December 2019
- The requirement for managers to positively confirm pay step progression from 1 April 2020, with pay progression no longer being automatic. Members discussed the approach to performance management in the Trust and ensuring the quality of appraisals and requested a further review at the next meeting.

Appraisal and supervision
The Trust performance on carrying out appraisals and supervision was discussed, and problems with recording, along with action to improve.

Phase 2 of the organisational re-structure
An update of the process was noted.

Executive Appraisals
The appraisals of the executive directors were carried out by the CEO in August and September and objectives set to support the delivery of the Trust strategy. The committee discussed performance and the composition of the executive.

Terms of Reference

12.1

The role of the committee was discussed and its terms of reference and workplan agreed.

Recommendation

The Board is asked to note the report.