

Board of Directors – session in public

Meeting to be held on Thursday 23rd June 2016 from 09:30 to 12:35
at the Elisabeth Room, Endeavour House, Russell Road, Ipswich, IP1 2BX

AGENDA

Time	Item No		
09:30	16.101	Chair's welcome, apologies for absence and notification of any urgent business Apologies: Leigh Howlett, Debbie White	
09:35	16.102	<u>Standing Item</u>: Declarations of Interest	
09:40	16.103	To approve the minutes of the previous meeting in public, held on 26th May 2016 <i>i. To approve the release of the minutes under the Freedom of Information Act</i>	Attachment A
09:45	16.104	Matters arising from the meeting in public held on 26th May 2016	Attachment B
09:50	16.105	Chair's Report (<i>Gary Page</i>)	Attachment C
09:55	16.106	CEO's Report (<i>Michael Scott</i>)	Attachment D
	16.107	Items for Approval	
10:05	<i>i.</i>	<i>Quality Improvement Plan</i> (<i>Michael Scott</i>)	Attachment E
10:20	<i>ii.</i>	<i>Finance Report M02</i> (<i>Julie Cave</i>)	Attachment F
10:30	<i>iii.</i>	<i>Finance Committee Chair's Report for 21st June 2016</i> (<i>Tim Newcomb</i>)	Verbal
10:35	<i>iv.</i>	<i>Workforce and Organisational Development Strategies: Recruitment and Retention; Staff Wellbeing; Leadership and Management Development</i> (<i>Michael Scott</i>)	Attachments G, Gi, Gii, Giii
10:55	<i>v.</i>	<i>NHSI self-certification declarations</i> (<i>Robert Nesbitt</i>)	Attachment H
11:00	<i>vi.</i>	<i>Audit and Risk Committee Annual Report</i> (<i>Ian Brookman</i>)	Attachment I
11:05		<i>Questions from public</i>	

Time	Item No		
11:15		<i>BREAK</i>	
	16.108	Items for Assurance	
11:35	<i>i.</i>	<i>Workforce Race Equality Scheme report (Robert Nesbitt)</i>	Attachment J
11:40	<i>ii.</i>	<i>Assurance on quality of care in private hospitals used by NSFT (Bohdan Solomka)</i>	Verbal
11:45	<i>iii.</i>	<i>Medical Education Report (Bohdan Solomka)</i>	Attachment K
11:50	<i>iv.</i>	<i>Update on actions since CQC inspection (Jane Sayer)</i>	Attachment L
12:05	<i>v.</i>	<i>Safe Staffing Report (Jane Sayer)</i>	Attachment M
12:10		<i>Committee Meeting Chairs' Reports</i>	
	<i>vi.</i>	<i>Audit & Risk Committee Chair's Report for 10th June 2016 (Ian Brookman)</i>	Attachment N
	<i>vii.</i>	<i>Quality Governance Chair's Report for 26th June 2016 (Gary Page)</i>	Attachment O
	<i>viii.</i>	<i>Organisational Development and Workforce Committee Report for 23rd May 2016 (Brian Parrott)</i>	Attachment P
	<i>ix.</i>	<i>Remuneration and Terms of Service Committee Chairs report for 6th June 2016 meeting (Gary Page)</i>	Attachment Q
	<i>x.</i>	<i>MHA Hospital Managers' Committee Annual Report including MHA scheme of delegation for approval (Gary Page)</i>	Attachment R
12:25	16.109	Any other urgent business, previously notified to the Chair	
		~ Questions from the public ~	
	16.110	Date, time and location of next meeting	
		The next meeting of the Board of Directors will be held in public on Thursday 28th July 2016 at the Main Hall, Hellesdon Hospital, Drayton Road, Hellesdon, Norwich NR6 5BE.	
12.35	16.111	Motion to exclude public and press from confidential part of the meeting	
		CLOSE	

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Date:	23 June 2016	A
Item:	16.103	

Norfolk and Suffolk

NHS Foundation Trust

Unconfirmed

Minutes of the Board of Directors Public Session

held on Thursday 24th May 2016

in the Main Hall, Hellesdon Hospital, Drayton High Road,
Norwich, NR6 5BE

Present:

Alison Armstrong: Director of Operations, Suffolk
 Ian Brookman: Non-Executive Director
 Julie Cave: Director of Finance
 Leigh Howlett: Director of Strategy and Resources
 Tim Newcomb: Non-Executive Director
 Gary Page: Trust Chair (Chair)
 Brian Parrott: Non-Executive Director
 Jill Robinson: Non-Executive Director
 Marion Saunders: Non-Executive Director
 Jane Sayer: Director of Nursing, Quality and Patient Safety
 Michael Scott: Chief Executive Officer
 Bohdan Solomka: Medical Director
 Tim Stevens: Non-Executive Director
 Debbie White: Director of Operations, Norfolk & Waveney

In attendance:

Robert Nesbitt: Company Secretary
 Lucy Want: Committee & Meetings Secretary (minutes)

There were 6 governors, 3 members of staff, and 10 members of the public present.

Meeting commenced at: 09:30

There was a break 11:01 – 11:18 and 11:41 – 11:49

Certain items were taken out of order, but for clarity the minutes reflect the agenda order.

16.82 Chair's welcome, notification of any urgent business and apologies for absence

The Chair welcomed those present. There were no apologies for absence and no items of any urgent business.

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16.83 Standing Item: Declarations of Interest

None.

16.84 To approve the minutes of the previous meeting in private, held on 28th April 2016

The minutes were approved subject to the following amendments:

- Min 16.66ii: The final sentence in the second paragraph should be amended to refer to 'older people with dementia' rather than just 'people'.
- Min 16.66iii: Fourth paragraph, amend '7/8%' to '7-8%'.
- Min 16.67iii: Penultimate paragraph to refer to 'individual issues' rather than 'individuals'.

i. To approve the release of the minutes under the Freedom of Information Act

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

16.85 Matters Arising from the meeting in private held on 28th April 2016

The Committee reviewed the actions not already marked as 'Complete' or 'On agenda' as follows:

i. Min 16.63: Suffolk – cardio metabolic assessment training rate improvement plan to be sent to Board members via email before next meeting (Alison Armstrong)

Alison Armstrong advised that a mitigation plan is in place and cascade training is being conducted. 38% of staff who require the training have now completed it and progress will continue to be monitored via the Quality Governance Committee (QGC). The NEDs requested sight of the mitigation plan and it was agreed this would be circulated to the Board of Directors (BoD).

Action 16.85i

- a) Suffolk – cardio metabolic assessment training rate improvement plan to be sent to Board members via email before next meeting (Alison Armstrong)
- b) Progress on cardio-metabolic assessment training to be monitored via QGC (Robert Nesbitt to contact Veronica Collins to include in QGC agenda planning)

ii. Min 16.66i: PMO to ensure that dates for 'return to green' are given (or an explanation is given if not available) (Michael Scott)

See item 16.89ii.

iii. Min 16.66: Ensure that the NSFT web page on service user and carer involvement is updated. Leigh Howlett to report back on timescales for updating by next board meeting (Leigh Howlett)

Leigh Howlett confirmed this had been completed and the website updated.

- iv. Min 16.66via: *Financial implications of clinical strategies to be included in future reports as work moves towards implementation. Financial implications of freeing up clinicians to develop strategies to be considered as part of project plan (Bohdan Solomka)*

Bohdan Solomka confirmed this had been incorporated into the implementation plan and meetings are being held to ensure the implementation is on track.

- v. Min 16.66vib: *Change 'point of access' to 'process of access' page 8 and clarify 'clinical risk management' on page 16*

As for item 16.85iv.

- vi. Min 16.66vic: *Learning disability to have a standalone pathway for Suffolk in future iteration (within three months) (Bohdan Solomka)*

As for item 16.85iv.

- vii. Min 16.68: *Clinical strategies to clarify that single point of access for Children and Young People remains (not single process – process refers to all client groups) (Bohdan Solomka)*

Completed.

16.86 Chair's Report

The report was noted.

16.87 CEO's Report

Michael Scott highlighted the following points:

- Congratulations were passed to all those involved in the Putting People First Staff Awards, particularly the winners of each category.
- Contract negotiations with Great Yarmouth & Waveney were challenging and the arbitration process was followed which found in favour of NSFT on the 2 largest items in dispute. This is a positive result and puts approximately £1.5m extra resources into mental health services.
- The Environmental Scan document was referred to. It is currently unclear whether Cambridgeshire will join the Norfolk & Suffolk devolution plan. Local plans are taking shape. There is no indication that local CCGs are looking at coming together as they are in other parts of the country.

16.88 Items for approval

- i. *NHSI Governance Declarations*

Robert Nesbitt advised that the self-certification is required annually.

In 2015 NSFT completed declaration 1 as 'unconfirmed' on the basis that the Trust had just entered special measures. It was recommended that the return be submitted as 'confirmed' for 2016 as we are ready for reinspection and there is evidence that the requirements have been met. The Board approved the recommendation.

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Declaration 2 was submitted as 'confirmed' in 2015 and it was proposed that the same return be submitted for 2016, along with the continued caveat regarding special measures. The Board approved this proposal.

16.89 Items for assurance

i. Quality and Safety Report

Jane Sayer highlighted that trend lines for Serious Incidents (SIs) were included within the report. There has been a reduction in prone restraints and seclusion although the overall rate for restraints has risen slightly. An increase was seen in Wellbeing services which is unusual and questions were raised as to whether this related to the transfer of Cluster 4 patients. A deep-dive investigation is in progress to identify any trends.

National benchmarking information from August 2015 shows that NSFT is below the mean for adult restraint and within the upper and lower limit for prone restraint. However, there is concern regarding older adult as NSFT are above the mean and in the upper quartile for restraints but prone restraints are in the lower quartile. A report will be given to the BoD when the January 2016 data is available. Gary Page confirmed that the QGC will be scheduling a learning event to understand the numbers and to highlight best practice from each service once the new Benchmarking information is available. A QIP project is in place to look at reducing self-harm incidents as there has been an annual increase of 51%; these relate primarily to women's services.

Jill Robinson questioned how the 51% increase in self-harm incidents relates to the national Benchmarking data. It was explained that the benchmarking data is a snapshot in time and at the last set of data NSFT was not an outlier in this area. However, there has been an increase in the last 12 months. The QIP project in place will ensure that work is done with service users to explore how this coping mechanism can be replaced with other coping strategies. It was acknowledged that interventions would be individual to each service user.

Section 2.1 states there were 40 unexpected deaths in quarter 4, it was confirmed this should refer to 45 unexpected deaths.

It was clarified that section 2.6 should reflect a rise in physical assaults *over the course of the year*. Section 2.6.1 relates to quarter 4 only and correctly states that a reduction has been seen in that quarter.

Brian Parrott requested assurance on the use of restrictive practices within the community and it was agreed that a report would be given to the Board at the June 2016 meeting.

The Friends and Family Test response rate was considered; NSFT's response rate appears to be very low when compared with other Trusts, notably Cambridgeshire and Peterborough Trust. An action plan to increase participation is in place and a Volunteer Co-ordinator has been recruited. However it was suggested that staff should be encouraged to make it part of their day job to encourage feedback from service users and carers.

Ian Brookman questioned the actions being taken to improve mental health records for service users with complex needs. The QGC is due to have a report in June 2016 to provide assurance on care plans, crisis plans, core assessments and risk assessments.

On average NSFT reports 5 times more staffing concerns than other mental

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health Trusts, which could in part be due to the ease with which they can be reported via Datix. However, in the context of relatively low vacancy levels the area requires focus. The Executive Team have already considered this and clear guidance is being given to staff on what should be reported and how.

The importance of adherence to the staffing cap was emphasised and Bohdan Solomka assured the Board that the cap is only broken where a quality impact assessment determines it is necessary. The recruitment of capped rate doctors and substantive staff continues. This area continues to be monitored by the Executive Team on a weekly basis.

The level of attrition in student nurses was discussed as section 6.1 refers to only 14 nurses remaining from 34 starters. Assurance was given that the feedback received from student nurses is very positive and those who have left have cited family / personal reasons. Further information is being sought from the University involved.

Action 16.89i

- a) Report to come back to June 2016 Board meeting on the use of restrictive interventions in community settings (Jane Sayer).
- b) In response to a query over the high level of staffing concerns and in the context of our relatively low vacancies, a safer staffing report will come to the June 2016 BoD meeting (Jane Sayer).

ii. Quality Improvement Plan Report

A paper was tabled outlining the QIP timelines to 'green' and the following QIPs were highlighted:

- *QIP018, Supervision and annual appraisal.* The proposed time to 'green' is December 2016 although this is considered to be too long and will be re-assessed.
- *QIP042, Statutory / Mandatory training.* The numbers are steadily improving and it is anticipated this will be 'green' by September 2016.

It was explained that the structure of the programme has been changed and 3 Mobilisation Boards are in place to oversee the detailed project activities.

Tim Newcomb questioned how the TPB reacts to shortfalls in CIP savings, an example of which was mentioned in section 3.1 of the paper. Michael Scott advised that any shortfall is logged with another project either being brought forward, or newly identified, to fill the gap.

A discussion was held regarding the work required to evidence some projects are completed; in some instances the time to collect the evidence is disproportionate and therefore a judgment call is required by the TPB on when to close projects.

iii. Finance Report M01

Julie Cave outlined that Month 01 had seen good performance. The cash position is stronger than expected. Out of area spend for the month is in line with budget although it was noted that this will need to be carefully monitored throughout the year.

Marion Saunders requested an amendment in the language used in the Executive Summary which refers to 'only 22 bed days' being out of area. This

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could be seen to suggest there is a tolerance towards out of area placements and was noted for future reports.

In response to a query from Jill Robinson, it was clarified that the Executive Summary should reflect that the forecast outturn for the CIP Programme is 'green'.

The in-month total for agency staffing was met and it would be helpful to include this in the Executive Summary.

The report was noted.

iv. Finance Committee Chair's Report for 17th May 2016

The Financial Performance Report is due to be re-formatted to reflect feedback from NHSI. This will interpret the data so as to clearly identify any areas of concern and resulting actions. A draft will be available in June 2016 for review.

There was increased operational presence at the May 2016 meeting and the Committee members found this to be beneficial. The Executive Team will agree an approach for regular operational representation at the meetings.

Particular attention is being given to the Disaster Recovery process for the Trust and a report is expected for the June 2016 meeting.

v. Business Performance Report M01

Julie Cave advised that the Performance Management Framework is under review and a revised version should be in place for the next BoD meeting.

Debbie White provided an update on Norfolk & Waveney. An upward trend in performance has been seen with regards to the majority of indicators including 7 day follow up targets and gatekeeping. Issues remain around the 12 month review for CPA patients as there are some data quality issues which are being worked on. There has been significant pressure on beds with 20 patients out of Trust as at 24th May 2016; 19 are placed in Mundesley with 1 patient out of area. Actions are in place to address this. A remedial action plan is being developed to look at recovery rates in NRP.

Alison Armstrong updated the Board on the position in Suffolk. A lot of effort has been put into using the Abacus system and results are being seen from this. The target for the 12 month review for CPA patients was not met and 2 data technicians have been employed to resolve some reporting issues. The Suffolk CCGs have reviewed the care planning process and have confirmed they are happy with the approach and audits conducted. A number of older adults are awaiting a move to residential homes and this is being addressed with Suffolk County Council. ADHD services have now been commissioned for 6 months and it is hoped these will continue with a more robust pathway.

A workforce update was received from Leigh Howlett who advised that the Workforce Dashboard will be reviewed in the context of the recently approved OD&W Strategy. NSFT's vacancy rate has increased to 11% against a national rate of 13%. It is acknowledged that there are major recruitment challenges and different approaches to recruitment are being considered including social media, job fairs and visiting colleges and schools. A Recruitment and Retention Strategy is due to be presented at the June 2016 BoD meeting. The Trust's sickness rate is below average with the highest recorded reason as stress; HR are working with the teams to identify actions that can be taken to help improve this. The appraisal rate continues to be an area of focus and time

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needs to be allowed for the revised process to be embedded. The time to hire has improved to just under 11 weeks which is better than the national benchmark of 13 weeks.

Brian Parrott requested assurance on the general data confidence issues that are being experienced. A review with the CPA teams is in progress and results will be reported at the next BoD meeting. It was noted that corporate functions have been under-invested in and this includes the Informatics team. Jane Sayer advised that the CCGs have worked with the teams to understand the inputs and outcomes and are comfortable with the process.

A request was made for the language of the report to be clearer e.g. abbreviations to be explained and for the direction of travel on each measure to be clear. These points will be taken into account when the revised report is developed; this is expected to be in time for the July 2016 BoD meeting.

vi. Implications of Goddard Report

It was confirmed that the report presented was an interim report as the Goddard Investigation is ongoing. Several areas require further work by the Trust, specifically the retention and storage of health records, particularly investigation records, recording abuse categories correctly and quality of safeguarding supervision records. A Working Party has been established to identify any improvements required.

Questions from the public

The following questions were received:

- 1) It was noted that the figure given on the front page of the Quality and Safety Report should have been incorrect. The correct figure was given in the main body of the report.
- 2) The qualifications of clinicians at the hospital in Mundesley were questioned as no staff are members of the Royal College of Psychiatry or hold a Certificate of Completion of Training (CCT). Bohdan Solomka summarised the arrangements for private hospitals which are CQC registered. It was agreed that a report would be provided for the next BoD meeting to provide assurance that the level of provision in private organisations is adequate, and that staff are sufficiently qualified.
- 2) A comment was received that feedback has been given by staff members who are unhappy when the salary cap is broken for new staff. Bohdan Solomka advised that decisions are made on the basis of availability of very specifically trained doctors into specialist posts and the focus is on ensuring wards are safely staffed.
- 3) It was questioned when the Trust would realise that there are not enough beds to meet demand as staff have been voicing this since 2012. Debbie White confirmed this is an area of focus and is being reviewed.
- 4) Concerns were raised that only 1 doctor and 1 nurse had been recruited to provide ADHD services and that due to a lack of resources, care and support would not be available. Debbie White advised that 2 nurses joined the service on 23rd May 2016 and the team is therefore able to support patients.
- 5) Reports have been received that Wellbeing services do not have access to a

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patients historical records. Debbie White confirmed that access is available on a read-only basis.

- 6) In response to questions raised, Alison Armstrong clarified that East Suffolk have met the targets relating to the % of CAMHS patients seen within the standard times. The figures include both the 0-13 years and 14-25 years pathways.
- 7) Questions were raised regarding the CPA training, what it entails and whether it has been co-produced with service users and carers. Jane Sayer advised that there has been some co-production to date and the training will continue to develop. The training is being given in response to requests from staff and will compliment other sessions such as risk training and suicide prevention training. A recovery tool is being piloted which is completed by both the Care Co-ordinator and service user to set the agenda for the CPA review.
- 8) A governor requested assurance that there would be placement capacity for any students who may return. Jane Sayer confirmed that mental health students are prioritised.
- 9) Reports had been received that some staff are being given 'clinical holiday' prior to the CQC visit to ensure that paperwork is up to date. Questions were raised as to whether this indicates that staff have too many patients on their caseload. Michael Scott confirmed that clinicians have protected time in which to complete their paperwork which is part of normal practitioner duties.

Action 16.89vi

Report to come to the June 2016 BoD meeting on assurance regarding quality of care in private hospitals used by the Trust including level of qualifications of Psychiatrist and Mental Health Act requirements (Bohdan Solomka)

vii. Suicide Prevention Strategy

Jane Sayer outlined the work that has been ongoing with Norfolk and Suffolk Public Health to look at Suicide Prevention Strategies for the counties. Jane Sayer and Bohdan Solomka have been working with senior clinicians to develop an internal Suicide Prevention Strategy for NSFT. Priorities are being identified from data already collated, the national context and NICE guidelines for preventing suicide in the community. The resulting Strategy will be available for the Board to review in September 2016.

Tim Stevens questioned which interventions could be evidence based. There are challenges as many interventions are at population level and it is difficult to identify the specific cause of a positive change. Environments can be managed on inpatient units and there is evidence in the community that positive impacts can be made by educating staff at potential suicide locations e.g. train stations. It was emphasised that it is important to look outside of traditional evidence sources.

Links were made to the Quality and Safety Report which referred to unexpected deaths within Wellbeing and liaison services and it was requested that these areas be included in the Strategy. Additionally it would be beneficial to investigate how to achieve a wider reach into the community.

It was agreed that suicide prevention should be the subject of a future BoD development session.

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Action 16.89vii

Focus of future BoD development session will be on suicide prevention (Robert Nesbitt)

viii. Board Assurance Framework and Risk Register

Robert Nesbitt advised that the risk related to the Suffolk Wellbeing Services Contract had been removed and the 5 main risks remain unchanged.

The report was noted.

ix. Quality Governance Committee Chair's Report for 24th May 2016

Gary Page reported that work has started to look at the level of inappropriate GP referrals being received. The other main points from the QGC had been highlighted throughout the meeting.

x. Organisational Development and Workforce Committee Chair's Report for 23rd May 2016

Brian Parrott gave a verbal update on the meeting held on 23rd May 2016. Discussions were held in relation to progress with the strategic objectives set and staff engagement. Specific actions were given regarding appraisals, particularly in relation to the whole of performance management and professional supervision. Non-medical staff were considered and issues around leadership and education and skills specific to those roles. Targets for statutory and mandatory training were discussed and whether these were realistic.

There were no questions from the Board.

xi. Service User and Carer Trust Partnership Meeting Chair's Report for 22nd April 2016

It was reported that pilots are underway for the implementation of the Service User & Carer Involvement Strategy. The Partnership will continue in place until they are fully assured that the infrastructure is in place for the new 'Hub' set up.

xii. Verita Independent review of Unexpected Deaths, April 2012 - December 2015 / NHS England review of reporting and investigation of unexpected and expected deaths

Gary Page introduced the presentation and apologised that although the report was issued to the press under embargo this had been broken and announcements were made in the press prior to the meeting. Hard copies of the report would be available following the meeting. The Council of Governors will consider the report at their July 2016 meeting and a meeting has been scheduled with the Mental Health Campaign.

Jane Sayer ran through the presentation and explained that NSFT is committed to taking all possible actions to prevent unexpected deaths. The purpose of the review was to identify those actions and improve the quality of care. Unexpected deaths refers to the death of someone who was currently under NSFT's care or had received a service within the past 6 months.

Positive feedback had been received from both Verita and NHS England who both felt NSFT had been completely transparent and open throughout.

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Verita concluded that the number of deaths recorded is most likely determined by NSFT's approach of reporting early and reporting all deaths. They found that the number of suicides in Norfolk and Suffolk was not higher than average. There is a lack of reliable national data to benchmark against which makes it difficult to conduct meaningful analysis. The RCA investigation process meets requirements although quality of reporting can improve as well as analysis of the lessons to be learnt. Engagement with families during this time requires improvement.

Investigation & Improvement Managers (IIMs) have been recruited specifically to support the investigation into unexpected deaths and to support the bereaved families. The length of time the Trust now has to investigate the deaths has increased from 45 to 60 days and this, along with the dedicated resource of the IIMs, has led to an improved quality in the RCA reports produced.

Board oversight was another area that Verita investigated. They concluded that oversight was generally good, especially in Quality Governance and the Executive Team, and regular reports were received by the Board, although the depth of conversations and learning lessons needed to be evidenced. More work is required to take an in-depth look at the issues arising from the RCA reports.

Verita found that the Trust had conducted some good work into suicide prevention although there is a need for clearer strategic leadership and a strategy is required to determine the direction of travel.

NHS England concluded that NSFT's internal policies have the correct tone but required updates in line with the latest SI guidance. Jane Sayer confirmed this has been completed. They concluded that investigations were carried out for appropriate cases and the quality of reporting was good and timely.

13 recommendations were given by Verita and 3 by NHS England. A plan for addressing these is in place and, for example, includes:

- The recruitment of 2 additional IIMs who will oversee improved engagement with bereaved families, offering meetings in all cases. It was highlighted that staff members need to be given the skills to deal with difficulties that families experience.
- A training-needs review and refresher training via an electronic solution.
- A checklist to ensure all reports that are submitted for quality assurance have been approved at locality level.
- Working groups in Norfolk and Suffolk to undertake learnings from SI's in their areas.
- Informing NHS England of the lack of comparative data available.
- Continuing to develop suicide prevention strategies and initiatives.

It was noted that the actions relating to prioritising the programme of work for the two SI working groups and creating a checklist for RCAs should state the target dates as 2016, not 2017.

16.90 Any other urgent business, previously notified to the Chair

None.

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16.91 Questions from the public

The following questions were received:

- 1) The extent to which service users and carers would be involved in the production of the Suicide Prevention Strategy was questioned; they are experts by experience and should be included in the actions being taken. Jane Sayer advised that service users are involved in the multi-agency group in Norfolk. Survivors of Bereavement by Suicide (SOBS) are also invited to attend. Suffolk User Forum were suggested as potential contributors.
- 2) Feedback was given that carers do not feel that NSFT is listening and that clinical care in the community is not a priority. It was felt that this has led to people taking their own lives or dying through neglect. Gary Page reassured the attendees that the Trust is listening i.e. by commissioning reviews such as that conducted by Verita and NHS England. Suicide prevention is a key part of the Strategy along with safer staffing levels.
- 3) It was questioned whether better contact with carers would be effective in preventing suicides. Jane Sayer explained that this is not known although people who take their own lives often visit their GP with increased frequency prior to this. Discussions are ongoing to establish whether GP surgeries would be able to detect this.
- 4) The Board were asked to give support to the founding of a Recovery Café in Norwich. Jane Sayer said that she had been involved in a similar project in London and would be happy to look at any proposals.
- 5) There had been expectations from members of the public that the Verita report would state whether there was any relationship between a shortage of funding and a rise in unexpected deaths; this did not appear to be in the findings. Michael Scott emphasised that NSFT has been campaigning for increased resources in Mental Health and the report acknowledges that it is difficult to draw conclusions such as this due to a lack of comparative data. In response to further comment on this subject Gary Page assured attendees that work around prevention is key and is part of the Trust's strategy.
- 6) It appears that based on the figures up to April 2016 there were 17 unexpected deaths per month, an increase of 10 per month from the reported figures in 2012/13. A radical re-think was encouraged to prevent unexpected deaths as a new approach was felt to be required. Gary Page stated that prevention is key and is now receiving more emphasis within the Trust than ever before.
- 7) Encouragement was given to consider how support can be given to the friends of young people who take their own lives. Jane Sayer advised that support needs to be given individually and requested further details of the specific case mentioned outside of the meeting.
- 8) Concerns were raised that community home treatment teams do not support under 18s and that care from the family has to manage any risk. Alison Armstrong expressed confidence that the development of a single point of access, and crisis services for young people, will help with this area. Focus is also being given to supporting carers.
- 9) Views were expressed that the Board need to take action to address the lack in funding, rather than spend more time developing strategies and paperwork. Gary Page reassured attendees that the Board has been clear

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that Mental Health is underfunded and has taken, and will continue to take action. For example CCGs have been taken to arbitration to ensure Mental Health is treated, and funded, fairly.

10) Minutes from the multi-agency Suicide Prevention group do not appear to be available on the Norfolk County Council website. Together UK, a major provider, has also not been invited to be part of the group. Jane Sayer said that she would ensure the minutes of the meeting are available and will arrange for a formal invitation to be issued to Together UK.

Action 16.91

Jane Sayer to ensure that the minutes of the multi-agency Suicide Prevention Group are available to the public (Jane Sayer)

16.92 Date, time and location of the next meeting

The next meeting of the Board of Directors will be held in public on Thursday 23rd June 2016 in the Elisabeth Room, Endeavour House, Russell Road, Ipswich, IP1 2BX.

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

The meeting closed at 12:49.

Chair:

Date:

Matters arising from board of directors' meeting - public 26th May 2016

16.63 Matters arising	
<p>a. (<i>Min 16.46vi.</i>) Suffolk – cardio metabolic assessment training rate improvement plan to be sent to Board members via email before next meeting. (Alison Armstrong).</p> <p>b. Progress on cardio-metabolic assessment training to be monitored via Quality Governance Ctte (Robert Nesbitt to contact Veronica Collins to include in QGC agenda planning).</p>	<p>a. The percentage figure for staff who are required to have completed modules 1 and 3 of the Physiological workbook remains overall across Suffolk at 42%, as a result of refreshed figures. This is unfortunately as a result of unavailability of the trainer due to extended ill health. All Suffolk localities have maximised training opportunities available in July. To mitigate against any further impact on this training requirement, the Director of Operations for Suffolk has asked the Director of Nursing whether online training modules could be developed which can then be signed off the matrons</p> <p>b. Complete</p>
16.89i Quality and Safety report	
<p>a. Report to come back to June 2016 Board meeting on the use of restrictive interventions in community settings (Jane Sayer)</p> <p>b. In response to a query the over the high level of staffing concerns and in context of our relatively low vacancies, a safer staffing report will come to June 2016 BoD. (Leigh Howlett).</p>	<p>a. Email sent to BoD 14.06.16</p> <p>b. On agenda</p>
16.89 Questions from the public	
Report to come to the June 2016 BoD meeting on assurance regarding quality of care in private hospitals used by the Trust including level of qualifications of psychiatrist and Mental Health Act requirements. (Bohdan Solomka).	On agenda
16.89vii Suicide prevention strategy	
Focus of future BoD development session will be on suicide prevention. (Robert Nesbitt).	Added to planner
16.91 Questions from the public	
Jane Sayer to ensure that the minutes of the multi-agency Suicide Prevention Group are available to the public (Jane Sayer)	Jane Sayer has requested that Public Health add the

	minutes to their website – an update will be available following the next meeting on 20th June 2016.
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Norfolk and Suffolk

NHS Foundation Trust

Report To:	Board of Directors Meeting - Public
Meeting Date:	23 rd June 2016
Title of Report:	Chairs Report
Action Sought:	For Information
Estimated time:	5 Minutes
Author:	Gary Page, Chair
Director:	Gary Page, Chair

Executive Summary:

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

1.0 Key observations from the month:

1.1 Prevention has featured prominently this month with my involvement in an event in Norwich and at the NHS Confederation, together with discussions with a number of Third Sector Providers whose activities keep people out of our services. Our strategy in this area clearly resonates widely. Other Trusts are also struggling with how to concretely move forward in this area. Research published by MIND in 2015 revealed that Public Health, which has the formal mandate for this area spend just over 1% of their total budget on MH prevention (£40mln).

2. Key Meetings

2.1 Staff and Services:

- I had a one to one with CEO, Michael Scott;
- I attended the Clinical Team Meeting for the Youth Team in the Ipswich IDT and met separately with the Clinical Team Leader;
- I had an introduction meeting with David Nelson, the new Lead Clinician for East Suffolk;
- I visited the management team at Suffolk Wellbeing;
- I met with the Deputy Service Manager for the Single Point of Access for Norfolk;
- I visited Hammerton Court in Norwich with Stephen Fletcher, one of the Trust's governors;
- I chaired the Remuneration and Terms of Service Committee;
- I joined the Youth Team MDT meeting at the Stowmarket IDT;
- I visited Chatterton House in King's Lynn and attended the West Norfolk Governance Meeting;
- I visited the Wellbeing Service in Kings Lynn and met with staff members;
- I met with Ian Bell, Service Manager for the Youth Service in Kings Lynn;
- I met with Pauline Davis acting Locality Manager for West Norfolk;
- I had a one to one with the Trust's Lead Governor, Guenever Pachent;
- I attended the monthly Finance Committee;

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- I visited Gateway House in Wymondham;
- I met with Helen Dewson in preparation for the forthcoming Hospital Managers Committee;
- I chaired the Hospital Managers Committee
- I participated in a planning meeting for the next Governors member event which will be on Dementia.
- I had a one to one with Company Secretary Robert Nesbitt;

2.2 Service Users and Carers:

- I attended the Suffolk Learning Disability Service User & Carer Forum in Stowmarket.
- I opened the Triangle of Care Carers Forum as part of the National Carers Week;
- I met with Luke Woodley, the Founder and Director of the Walnut Tree Project to discuss how NSFT can support the growth of services for veterans;
- I sat on a panel for a Hospital Managers Appeal hearing at Woodlands Hospital in Ipswich
- I met with the mother of a man who had taken his own life in West Norfolk to receive some art equipment which she wanted to donate to the Fermoy Unit in Kings Lynn

2.3 External Organisations:

- I attended the Healthwatch Norfolk Mental Health Task and Finish Group;
- I met with Sue Gale Chair of the Mancroft Advice Project (MAP) to discuss the ways in which NSFT can work with MAP to improve the services to young people in Norfolk;
- I met with Tracey Williams, Chair of the Norwich CCG;
- I attended a planning meeting for an event due to be held in Norwich Cathedral in July tackling the stigma around mental illness;
- I spoke as part of a panel at a conference around combatting Norfolk's growing mental health challenges and focussed on the need for more resource and focus on Prevention;
- I met with Hilary De Lyon, Vice Chair of the West Norfolk CCG and their MH Lead;
- I attended the Annual NHS Confederation Conference & Exhibition in Manchester and joined in a meeting of NHS MH Trust Chairs on Prevention;
- I met with David White, the Chair of Ipswich Hospital, by way of an introduction.
- I met with Beverley Page to discuss the work of Inside Out Community Arts Project in Ipswich;
- Together with Michael Scott, CEO I participated in the monthly Conference Call with NHS Improvement and our Improvement Director;

3 Recommendations

3.1 The Board is asked to note the report.

Gary Page
Chair

Background Papers / Information
None.

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Norfolk and Suffolk

NHS Foundation Trust

Report To:	Board of Directors – Public
Meeting Date:	23 rd June 2016
Title of Report:	Chief Executive's Update
Action Sought:	For Assurance
Estimated time:	10 minutes
Author:	Michael Scott, CEO
Director:	Michael Scott, CEO

Executive Summary:

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

1. NHS Improvement

1.1 Our monthly meeting with Monitor and Stakeholders was held on the 15th June 2016 as planned; an update will be given at the Board.

2. Meetings and Visits

2.1 I have visited several sites over the last month including Woodlands and the Abbeygate Wards at Wedgewood House. In both I found very good leadership and care. Some residual concerns remain about e-rostering which I am taking up with the team.

2.2 I attended a meeting of the Healthwatch Norfolk Mental Health Task and Finish Group. The group has devised a new work programme and remains a critical friend of our trust.

2.3 I presented on 'What a great year in the Trust looks like' to our consultant development programme. This programme for newly appointed consultants is going well.

2.4 I attended the City Service User and Carer Forum. I was disappointed to see relatively few users and carers present.

2.5 Ruth May, the Executive Director of Nursing for NHS Improvement, visited the Trust to meet with myself and Jane Sayer, and the Clinical Team Leaders for Whitlingham Ward and Rollesby Ward. She gave positive feedback on her visit and the improvements she found in our trust.

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- 2.6 I presented at the Central Norfolk Teaching Programme to a mixed group of medical trainees and consultants on Mental Health & management
- 2.7 I attended a Carers Forum focused on the Triangle of Care, organised by Howard Tidman, where there was good attendance and national speakers.
- 2.8 I attended the Band 3 Development Day where care staff were engaged in their future development plans.
- 2.9 I attended a meeting where the emerging Sustainability and Transformation Plan was presented to local health providers in Norfolk & Waveney.
- 2.10 I attended an away day for the Recovery College and presented certificates to graduates.
- 2.11 I attended part of a 2 day training event facilitated by Greg Hinrichsen from the Albert Einstein College of Medicine in New York. This was on the subject of interpersonal psychotherapy.
- 2.12 I met with Dale Bywater, the Executive Regional Managing Director for NHS Improvement, by way of an introduction.

3. Environmental Scan

- 3.1 I have attached to the report our environmental scan information for the current period.

4. Recommendations

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

Michael Scott
Chief Executive

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Appendix – Environmental Scan

Environmental Scan June 2016

External	
National	Local System
<ul style="list-style-type: none"> NHS impact central to EU Referendum debate Mental Health Network stating little national investment in MH from CCGs despite guidance 30 June STP deadline now for proposals forming basis of discussion, rather than final position 	<ul style="list-style-type: none"> STPs in Norfolk and Waveney and Suffolk progressing Resignation of Mark Taylor, North CCG Chief Officer

Internal	
Trust-wide	Locality/Service-specific
<ul style="list-style-type: none"> Final preparation for CQC inspection Single bed management system QIP commenced Marcus Hayward appointed as Trust-wide ImROC lead 	<ul style="list-style-type: none"> Dialogue for Gt Yarmouth and Waveney Out of Hospital tender extended and potentially impacted by STP proposals Positive CQC MHA spot inspections at Thorpe Ward and 5 Airey Close

Norfolk and Suffolk

NHS Foundation Trust

Report To:	Board of Directors
Meeting Date:	23 rd June 2016
Title of Report:	PMO Programme - Progress Report
Action Sought:	For Assurance
Estimated time:	15 mins
Author:	Stuart Clifton, Head of PMO
Director:	Michael Scott, Chief Executive

Executive Summary:

The tables below give a summary of current activity in reference to CIPs and QIPs. Detailed explanations for amber and red are included within Appendix 1 & 2 of this report.

CIPs

There are currently 13 active and 6 inactive CIP projects.

	Schemes	Identified		
Red	3	292		
Amber	2	667		
Green	8	1,216		
DCS NR	0	2,887		
<i>Active Total</i>	13	5,063		
On Hold	0			
Closed	6	3,283		
<i>Inactive Total</i>	6	3,283		
			To be identified	Current forecast
Total	19	£8,346m	£1,804m	£10,150

The financial CIP target has a recurrent to non-recurrent ratio of 70:30 with a current prediction of 66:34; any increases in the non-recurrent CIP will create an additional burden in 2017/18. The CIP delivery for month 2 is on track with plan.

QIPs

There are currently 28 active and 14 inactive QIP projects:

	Schemes
Red	4
Amber	16
Green	8
Active Total	28
On Hold	1
Closed	13
Inactive Total	14

The report also highlights key activities undertaken in month by the mobilisation boards, the transformation programme Board and communication team.

1.0 Overview of Progress

Workforce Mobilisation Board (WMB)

The following is an overview of the key WMB activity in the last month.

Temporary staffing – the cost avoidance task and finish group continues to make good progress towards their target of reducing the unfunded temporary staffing year-on-year spend by £2.2m to deliver a capped 2016/17 spend of £10.783m. Current month two position shows a £318k positive variance against original plan. In addition to meeting the cap, it was noted that £250k of the 2016/17 FRP relates to the release of premiums associated with Temporary and Agency spend.

ESR functionality expansion – PID QO054 was approved. The project is scoped to deliver increased ESR functionality, manager and supervisor self service module, Oracle Learning Management (OLM), talent management ESR module and a HR and payroll transactions ESR module).

E-Job Plan - the business case has been approved by WMB. The next action is to convert this into a robust PID for TPB approval.

Clinical strategy – The five year clinical strategy has been developed in line with our over-arching Trust strategy. The clinical strategy implementation paper was presented to both WMB & TPB identifying the four costed options. Due to the fact these are unbudgeted costs; the option paper will need to be amended once further discussions have taken place between the Executive team.

E-Rostering – Now implemented in all in-patient areas across NSFT. WMB supported the recommendation that following a fully supported handover of rostering responsibilities to the clinical teams at Hammerton Court, the e-Rostering team will return to providing business as usual functional support.

June 2016 roster approval rates have shown a great improvement from the previous roster period increasing from 51% to 85%. Focus will continue to achieve the 100% target.

WMB areas of concern:

1. Operations Directors (Norfolk and Suffolk) need to ensure there is a rigorous challenge to any requests to break glass with agency caps
2. The need to address the ongoing lack of direct involvement and engagement from the Suffolk Operational Team in both WMB and Temporary Staffing Task and Finish group
3. QO018 Supervision and Annual Appraisal – support and drive required from all Executives and managers to improve compliance stats and monitoring returns.

Technology Mobilisation Board (TMB)

The following is an overview of the key TMB activity in the last month.

CIP/QIP pipeline – As the CIPs and QIPs managed by TMB are currently progressing well, it was decided to look ahead to projects that could materialise later in the year (and therefore help exceed the £290k CIP target) or for implementation in 17/18. Ideas generated are to be scoped in the coming month.

Mobile working – a pilot already underway as QIP050, which ends on 30th June 2016. Data from this project will be available in early August, which will then allow us to work out how significant the Trust-wide future CIP can be.

Electronic Referral Service (ERS) –the ERS initiative forms part of the wider Local Digital Roadmap requirement and a Trust-wide rollout has the potential to streamline or bypass AAT. A process pilot is in development.

eMMA – Trust-wide rollout is potentially high value savings, but also high cost to implement. Greater understanding of ICT integration (communications between ICT systems) is required. Leigh Howlett is the new executive sponsor with a re-scoped phase 2 PID under development.

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Disaster recovery – A paper is being developed for Finance Committee covering what our approach to DR will be, including the data centre review, which will determine where and how back-ups are held in future (currently on site at Hellesdon).

Local Digital Roadmap (LDR) – The latest version of the Norfolk LDR was reviewed. The consensus is that it is still very raw, so further iterations are expected. Without the LDR, it will be harder to get central funding for technology upgrade/rollout. Options for inter-Trust collaboration on ICT projects need to be discussed further. The LDR links closely to NSFT’s work on the Sustainability Transformation Plan. Suffolk LDR more mature and expected for review ahead of the national June 30th submission date.

Estates and Bed Mobilisation Board (EBMB)

The following is an overview of the key EBMB activity in the last month.

Trustwide Bed Management / Bed rationalisation- A new PID QO055 has been approved as a replacement for QO031. Key objectives are:

- Implementation of the Lorenzo Bed Management System as the single Trustwide system to support real time bed management
- Review, scope and implement a centralised NFST Bed Management Team
- Robust Trustwide gatekeeping processes/SOPs are in place based on best practice and are being actioned across all localities to avoid unnecessary in-patient admissions and ensure care is delivered in the least restrictive environment
- Provision of data (generated through application of best practice) to inform actual bed resource need by locality. This data to evidence discussions with key stakeholders around bed stock sustainability going forward.

This will deliver the expected outcomes to:

- Deliver oversight and management of overall Trust position on bed stock/status 24/7
- Ensure decisions to admit by NSFT teams to bed resources follow full consideration of delivering care in the least restrictive environment, based on assessment of clinical need
- Improve quality of care and service user satisfaction by ensuring that clinically unnecessary in-patient admissions and out of area placements are avoided, and that care needs will be met in the least restrictive environment.

Additional beds on Thurne Ward - A business case (CF2) has been completed to increase Thurne Ward beds from 12 to 15. There are three rooms on Thurne that are currently used as office accommodation which will be converted to patient bedrooms. The capital cost of the work is £41k. No increased staffing costs anticipated. Revenue savings will be delivered as a result of reduced out of Trust placements. A CIP PID is being created for approval and will be monitored and reported via EBMB.

Secure Service Option 1 (mobilisation) - Five key Workstreams have been established. They focus around clinical pathways (broken down into female blended, male low security and male medium security), estates, workforce, communications and finance.

A business case was submitted back in February 2016 identifying an investment of around £2.9m. By spending this money on closing Yare Ward, merging Thorpe and Acle and changes to the other wards a position was presented to generate a small surplus compared to the current £3.5m annual deficit.

Since February 2016 further work has been carried out and accurate drawings and costs have been produced. The project is now requesting approx £4.3m of investment to make the required changes. Due to the sizeable increase from the previous business case, the Finance Director and project team are working hard to understand the change from £2.9m to £4.3m. The outcome of this

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review (targeted for week commencing 13/06/2016) will determine the direction of the ongoing project.

West Beds Joint CCG/NSFT project - Four key Workstreams have been established. They focus around clinical pathways, estates, workforce and communications. Finance wraps around them as and when required. An initial consultation was held in May 2016 to discuss the future of the service and was attended by approx. 25 representatives from NSFT, CCG, QEH, NCC, service users, third sector organisations and unions. From this initial consultation, the following priorities were identified to help improve the pathway and determine the number of acute beds required in the service moving forwards:

- Enhanced A&E liaison
- Local assessment hub
- Day treatment where suitable
- Greater use of alternative to admission beds

The clinical pathways workstream is now leading on creating an options paper for the improved model for the West Norfolk Adult Acute services.

One of the major concerns is the current lease on the Fermoy property. The lease requires not less than 12 months' notice to the landlord (QEH) and the property must be vacant on transfer. Upon serving notice, NSFT will be required to instruct a District Valuer to determine the market value. QEH is obliged to pay that value to NSFT when vacating the property. Our estates department are now seeking advice on the likely value of the lease if we served notice (NSFT paid £5.3m for the lease back in 2007). Once we have an indication of likely value Julie Cave will discuss the situation with her FD counterpart at QEH.

2.0 QIPs and CIPs

The CIP delivery for month 2 is on track with plan.

Two New PIDs have been opened within this reporting period:

- QIP QO055: Trustwide Bed Management
- QIP QO054: ESR Functionality expansion.

A summary of the QIPs and CIPs currently reported as Red and Amber can be seen in Appendix 1 and 2 of this report.

3.0 QIP transfer to business as usual (BAU)

There have been discussions in various forums regards the difficulties in evidencing the QIP changes either through originally poorly designed KPI'S, no central reporting and / or the need to drive a cultural change as part of BAU and evidencing this.

There is agreement that the 6 QIPs this relates to will be reviewed at the meeting on June 22nd with the aim that a more robust and practical measurement of achievement can be agreed to meet both the quality and operational agendas.

For example, where a QIP has stipulated the development of a strategy or policy, it then goes on to require, (rightly), the need to embed. This is not then a project; it is BAU as the project was to complete the strategy/policy. The embedding would be measured through a relevant channel such as an audit and monitored through our regular governance channels.

This requires a clear steer from the executive team and a subsequent report to the relevant committee or group who will be required to accept responsibility for the BAU activity.

Once this work is done, these projects, which otherwise stay red, will be closed and monitored more appropriately elsewhere.

4.0 Risks / mitigation in relation to the Trust objectives

The following risks have been identified in relation to achieving the CIP and QIP programmes:

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- The Operations Directors (Norfolk and Suffolk) to ensure there is a rigorous challenge to any requests to break glass with agency staffing caps
- The need to address the ongoing lack of direct involvement and engagement from Suffolk Operational Team in both WMB and Temporary Staffing Task and Finish group
- Supervision and Annual Appraisal requires support and drive from the Executive team and wider Trust leadership team to improve compliance stats and submission of monitoring returns
- QIPs are being delivered against milestone but cannot be evidenced as embedded in BAU, meeting on June 22nd to address this.
- Concern over the ability of Secure Services redesign meeting the identified 16/17 saving target of £700k. An appraisal is underway to evaluate and priorities the capex spend to maximise the 16/17 savings.
- 16/17 cost improvement plan identifies £700k of bed optimisation. The expectation is £350k-£400k from PICU. This is at risk as no progress has been made to date. It has been agreed that we will engage with our buddy trust for independent review of bed numbers, any work relating to this review is unlikely to deliver significant savings within this financial year.

5.0 PMO Communication Update:

Transformation communication activity continues to focus on our preparation for the CQC visit in July 2016. The Transforming our Trust e-newsletter is currently highlighting our progress against each of the CQC themes (Safe, Effective, Caring, Responsive, and Well-led), to remind staff of the huge amount of hard work that has gone on over the last 12 months and help instil a sense of pride in what has been achieved and the difference it has made.

This will also help provide an improvement narrative from which staff can more confidently engage with inspectors when challenged as to the changes made since the last inspection.

Posters for each of the CQC themes have also been distributed across our Trust to help provide a visible reference to the themes and what they mean in practice, as well as challenge and encourage the behaviours of staff in relation to the theme itself.

In addition, service user and carer posters have also been sent out to all sites to inform them of the CQC visit and how they can engage with the process if they so wish.

A variety of CQC information packs and presentations are also being prepared for different stakeholders and the June 2016 Senior Management Engagement Forum will be focusing on the key messages from these to define 'our story' so that all staff have a comprehensive and consistent view of our transformation to date and our ongoing plans to improve our Trust.

Once CQC audit preparations have concluded then planned CIP/QIP developments will continue to be communicated via the 'Transforming our Trust' newsletter.

6.0 Recommendations

The Board is asked to note this report.

Stuart Clifton
Head of PMO
 June 2016

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QIP Plans:

There are currently 28 active QIP projects of which 8 are Green, 16 are Amber and 4 on Red status.

Key to Mobilisation Boards:

- Estates and Bed Mobilisation Board = EBMB
- Workforce Mobilisation Board = WMB
- Technology Mobilisation Board = TMB

Amber and Red are summarised in the Table below.

QIP number	Scheme Name (Mobilisation Board)	RAG Status	Main Issue	Estimated time to green
QO018	Supervision and Annual Appraisal WMB	R	<ul style="list-style-type: none"> • There are approximately 2000 staff Trust wide who require regular clinical supervision. • During March '16 supervision data was submitted for 827 NSFT staff. This is a low number as not all teams have submitted data. • The data based on the 827 staff indicates that 51% had supervision during March - KPI 90%. • Appraisal data via HR dashboard for April indicates 64% compliance. • RAG currently red as data is incomplete for supervision / appraisal and is not currently on a trajectory to achieve KPI of 100%. 	30/09/16
QO031	Review of In-patient Bed Requirement EBMB	R	<ul style="list-style-type: none"> • Finance Committee on 17th May 2016 have directed that QO031 is reopened as RAG red. • RAG status will change and QO031 will be closed when new QIP 055 is fully approved. 	04/07/16
QO031a	Review of PICU Bed Requirement EBMB	R	<ul style="list-style-type: none"> • The original PID is being revisited and scoped by the Estates and Bed Mobilisation Board • To help inform the PID development, it was agreed at TPB on 11th May that an independent review of PICU bed requirements is carried out by arrangement with Nottinghamshire Trust. Initial contact has been made by NSFT project lead, date to commence review TBC, provisionally August16. • Action being assigned: - <ul style="list-style-type: none"> ○ Understand benchmark activity in relation to costs and performance to form a baseline. ○ If best practice/gatekeeping processes where being followed, how many PICU beds in total would be needed for NSFT. ○ Once source data has been reviewed, options paper to be produced suggesting how the beds will be provided e.g. one 	Needs to be determined with the project team

QIP number	Scheme Name (Mobilisation Board)	RAG Status	Main Issue	Estimated time to green
			<ul style="list-style-type: none"> unit, one larger unit, or no change. The Director of Finance will be the new exec sponsor of this project/scheme. 	
QO048	Management of Section 17 leave WMB	R	<ul style="list-style-type: none"> A total of 219 section 17 leave forms were initiated during March/April. Percentage of compliance taken from the bi-monthly MHA heat map for March/April (compliance target 95% for all indicators):- <ul style="list-style-type: none"> Forms correctly filled in, leave parameters recorded, and signed by RC or nominated deputy:- 99% Signed by service user:- 68% Copy given to service user:- 50% Copy given to carers:- 23% Foxhall House is the only area to achieve 100% compliance with all the above. RAG red due to low compliance with 3 out of 4 of the indicators. 	29/07/16
QO001	Safer Ward Environments EBMB	A	<ul style="list-style-type: none"> Overall RAG amber based on the results from the mock CQC inspection. Locality Managers are implementing local action plans to address findings of the inspection Overall RAG remains at amber as assurance cannot yet be consistently evidenced regarding progress to improvement. Currently Quality Peer reviews are underway by teams Trustwide. Outcomes from these reviews when known will be used to assess future RAG status Exec sponsor suggests moving to BAU and closure of this scheme by next reporting period as milestones have been delivered and culture change needs to be driven by BAU. 	30/07/16
QO007	Seclusion facilities EBMB	A	<ul style="list-style-type: none"> One of the project outcomes has been an agreement of a standard NSFT seclusion suite specification. Yare Ward beds will be re-provided as part of the Secure Services option 1 approval and therefore Yare works have been postponed until future plans have been finalised. Foxhall House work completed. Whitlingham and Rollesby works started on 3/5/16, and was scheduled to finish 30/6/16. Lead time for doors was meant to be 6-8 weeks, but is now closer to 16 weeks, and not expected to arrive until end of July 2016. This means work will not be completed in advance of the CQC inspection. Evidence of ongoing estates work supported by a detailed plan and schedule will be available for CQC to 	12/08/16

QIP number	Scheme Name (Mobilisation Board)	RAG Status	Main Issue	Estimated time to green
			<p>review and interrogate.</p> <ul style="list-style-type: none"> Overall RAG status increased to Amber as work will not be complete in time for the CQC visit. 	
QO010	Reduction in restrictive interventions WMB	A	<ul style="list-style-type: none"> PMA training has recently been reviewed to provide differing levels of interventions based on Primary, Secondary and Tertiary interventions. Going forward, incidents will be recorded using this model to enable us to provide a clearer picture of the incidents recorded as described (physical care interventions, gentle guidance of service users away from situations) within older person's services. All restrictive interventions will continue to be monitored via the patient safety group meeting and reported to the Board on a quarterly basis. The PMA team also have established a Datix dashboard and have a practitioner monitoring activity to follow up if emerging trends or themes. With regard to the trend for general physical restraints not achieving the KPI target, this is considered to be due to the way that general restraints have been reported. For example within NSFT we report in line with the definition of physical restraint which will include staff providing physical care and interventions, or gently guiding SU's away from situations. The majority of these occur within older persons services, which are our highest reporting areas in the use of physical restraints. Amber rating relates to ill-defined measurement within KPI. Manual interrogation of data should help demonstrates that KPI are being achieved. Closure document to be submitted to July WMB. To be monitored as BAU via QGC. 	30/06/16
QO012	Community Care - Policy Compliance WMB	A	<ul style="list-style-type: none"> WMB decision is that this has progressed to BAU and that a closure document should be submitted to the July WMB/TPB. Then to be monitored as BAU via QGC Milestones on track but project rated 'amber' as mock CQC inspection shows areas of concern. Locality Managers are implementing local action plans to address findings of the inspection and a one Trust strategy regarding CQC preparation has been agreed for rapid implementation to drive improvement. A Trustwide document based on findings from the mock CQC inspection has been produced with a RAG rating for individual 	30/07/16

QIP number	Scheme Name (Mobilisation Board)	RAG Status	Main Issue	Estimated time to green
			<p>areas.</p> <ul style="list-style-type: none"> Change request approved by TPB 9th March 2016 to add the Lone Worker Policy aimed at monitoring for compliance which was a concern of the original CQC audit. A new system for recording and evidencing re-allocation of appointments as a result of staff absence has been implemented within all NSFT community teams week commencing 25th April. 	
QO014	Safety Incidents - Learning Lessons WMB	A	<ul style="list-style-type: none"> Key Milestones have been completed however the challenge now lies in embedding this into 'business as usual'. Systems & processes are in place. Need to ensure that key roles are targeted in training & development to ensure that safety & learning is part of individual's responsibility and accountability in delivery of Trustwide services. Modern Matrons to work on embedding continuous learning through locality action plans. The challenge is evidencing embedding of learning into practice. Overall RAG remains at amber as all milestones have been completed, but assurance cannot yet be consistently evidenced regarding progress to improvement. Currently a programme of Quality Peer reviews and spot-checks are underway by teams Trustwide. Outcomes from these reviews when known can be used to assess future RAG status. Matrons carry out regular audits NSFT wide, some of which are not collated centrally. This is to be explored to see if these audits can be used to evidence progress towards outstanding KPI targets. Workbook to be re-scoped following production of the Verita. Change request to be submitted to July WMB. 	30/07/16
QO016	Community Caseload Management WMB	A	<ul style="list-style-type: none"> RAG amber because there is as yet no data available by team to illustrate performance against allocation of cases, and the vacancy rate is above the KPI target Data to populate KPI's remains outstanding. Project Lead requested to update urgently in June 2016. 	29/07/16
QO022	Clinical Strategy Development WMB	A	<ul style="list-style-type: none"> Change notice has been developed and approved at WMB for submission to TPB detailing the new programme structure and to request funding required to deliver the three clinical strategy pathways. 	26/08/16

QIP number	Scheme Name (Mobilisation Board)	RAG Status	Main Issue	Estimated time to green
			<ul style="list-style-type: none"> Decision around implementation model and funding has been deferred and project status remains at Amber Once this programme structure is up and running it is expected this QIP will be closed (and monitoring take place through the new QIPs). 	
QO024	Physical healthcare monitoring WMB	A	<ul style="list-style-type: none"> RAG status remains at amber as all milestones are now on track, and robust KPI measurement processes and trajectories are in place, but audit results are below targets Data regarding number of in-patient staff trained in physical healthcare monitoring now available. First data regarding number of community staff trained in physical healthcare monitoring available June 16. Movement to green RAG status dependent on audits showing month by month improvements on trajectories likely to achieve milestone targets. 	26/08/16
QO030	Additional 5 beds & move to Carlton Court for Tier 4 EBMB	A	<ul style="list-style-type: none"> Programme of works commenced 15th February, with a completion date of 29th July 2016. Including time for the new environment to be furnished and commissioned and to allow for staff training and orientation, it is anticipated that the new unit will be ready to accept service users from the beginning of September 2016. Project scope has been increased to include pathway review to minimise, where possible, the pressure on CYP beds and reduce the Out Of Area [OOA]. This is to be seen as a quality/service improvement initiative as children OOA funding is paid by CCG (pass-through only). Option paper to be presented at the joint commissioning group (21st June 2016) concerning the commissioning of a Crisis Pathway for children (cost neural £600k). Procurement process reference to Tier 4 bed stock has started with the issuing of an initial letter from NHS England. Negotiations will need to take place to secure the additional 5 beds funding. Recruitment of staff (advert to appointment) can take up to 90 days; it is planned for this to be managed as a back-to-back, just in time process coordinated around any agreement of NHS England funding. The unit will be initially staffed as a 7 bedded unit. Although this project is a QIP, a new risk has been added to identify the concerns 	30/09/16

QIP number	Scheme Name (Mobilisation Board)	RAG Status	Main Issue	Estimated time to green
			<p>over revenue funding of 5 additional beds as the scheme increases bed stock from the existing 7 to 12.</p> <ul style="list-style-type: none"> RAG status remains at amber awaiting clarification of NHS England funding. 	
QO032	Medicines Management WMB	A	<ul style="list-style-type: none"> Heat-map in place Operational support needed to manage KPI's and compliance/completion of the heat-map Project status moved from Red to Amber. The results were based on a small sample size which created fluctuation on the heat-map 	29/07/16
QO035	Secure Services Improvement Plan EBMB	A	<ul style="list-style-type: none"> The Secure Services Reconfiguration Project has commenced with the Project team established and detailed planning underway. TPB have approved in principle the closure of this QIP once the new workbook for the service line redevelopment (blended female service) has been formally approved. The new workbook will be CIP066 which is completed awaiting final confirmation of capex requirements. Fulltime project manager assigned. 	30/07/16
QO037	Out of hours arrangements for children and young people WMB	A	<ul style="list-style-type: none"> One new concern is that have an implementation mechanism differing across Norfolk Suffolk may clash with clinical strategy and Trust vision to closely align services across our Trust. NSFT is a contributor to this process, which is being led by commissioners. Next steps:- <ul style="list-style-type: none"> Further internal review of internal crisis pathways by May/June 2016 and identification of NSFT training needs. Agreement of the service model in collaboration with partnership providers and commissioners by June 2016. KPIs yet to be agreed by commissioners targeted May/June. Assuming service model and performance targets are agreed with commissioners, NSFT recruitment of 5 x WTE plus an additional post for the police control room will commence. Target to have staff in post end of July/August 2016. This involves a change to existing services business times, including weekend working. This may include the need for staff consultation adding to a risk of slippage against planned timeline. Finances need to be added to the project 	29/08/16

QIP number	Scheme Name (Mobilisation Board)	RAG Status	Main Issue	Estimated time to green
			<p>finance tracker; this is dependent on the final service model being agreed by commissioners and NSFT.</p> <ul style="list-style-type: none"> o Proposal NCC 8pm-8am, being scoped with commissioners (potentially as a sec75 agreement) o NSFT 8am-8pm Mon Fri Weekend cover 4hrs per day sat Sun BH (involves recruitment of new staff as per LTP proposal) <ul style="list-style-type: none"> • Proposal for bank pool of staff, being scoped by NCC. • Further meeting planned for June with commissioner's finance and project leads to clarify budget to recruit new staff. 	
QO040	Open Mind- BME Mental Health WMB		<ul style="list-style-type: none"> • Acute pilot now considered impractical - this is because data reliability of survey is in question with high temporary staffing, and difficulties in releasing staff for training resulting in significant delays. • Change request approved by Workforce Mobilisation Board, so PID has been adjusted to cover current activity and reflect decision to stick to only community team for pilot. • Project will be aimed at improving staff awareness of BME service users' needs and using a control survey prior to training to allow for comparison. • Control survey is now underway, although uptake has been very low. • Initial training session had 7 attendees (13 targeted), and second training session on 1/6/16 had no attendees - mitigating plans underway to ensure training delivered (added to Issue Log). Overall RAG rating changed to Amber from Green due to low uptake of survey and low uptake of training. 	08/07/16
QO042	Statutory / Mandatory Training WMB	A	<ul style="list-style-type: none"> • RAG status moved from Red to Amber. • An action plan is in place with a trajectory to achieve 90% compliance by September '16. • Following implementation of the action plan, Workforce Performance Dashboards from April-June show consistent improvements in line with the trajectory target (from 76% at end April to 81.99% on 7/6/16). • Target is 82% by end June 2016. RAG status reduced to amber as a result. • There are three key areas that still have low compliance - overall RAG will be reduced to green once these have been addressed and showing areas of improvement, assuming overall trajectory 	11/07/16

QIP number	Scheme Name (Mobilisation Board)	RAG Status	Main Issue	Estimated time to green
			remains on target.	
QO043	Ligature Risk Reduction EBMB	A	<ul style="list-style-type: none"> All initial findings regarding ligature and line of sight from the CQC report have been achieved. In an on-going effort to improve risk management, a full assessment of risks for ligature and line of sight across all inpatient facilities has now been carried out. This included photographic and text descriptions of each identified risk, which has been delivered to the corresponding wards in May 2016. These risks have been prioritised by operational, risk and estates management to agree which areas need work to be done, and which areas can be managed by operations as mitigation for the risk. This focus on local management of risks has had a continued positive impact. Capital Expenditure of £1m approved to complete necessary works. Expenditure of £400k already underway on windows (Thurne, Glaven, Waveney), bathrooms (Yare, Glaven, Waveney, Thurne) and beds (Glaven and Waveney). Meeting to discuss management of any further risks taking place with Directors of Finance, Nursing, Operations & Head of Estates. Overall RAG Amber until outcome of assessment. Remaining funding (£600k) will be fully assigned, including detailed plans and programme of works, prior to CQC visit. Overall RAG Amber until outcome of assessment of costs. 	29/07/16

CIP Schemes:

There are currently 13 active CIP schemes of which 8 Green, 2 Amber and 3 Red.

Key to Mobilisation Boards:

- Estates and Bed Mobilisation Board = EBMB
- Workforce Mobilisation Board = WMB
- Technology Mobilisation Board = TMB

Amber and Red CIPs are summarised in the table below.

CIP number	Scheme Name (Mobilisation Board)	RAG Status	Main Issue	Current Gap to find
CIP004	Procurement Standalone	A	<ul style="list-style-type: none"> • This project has been carried over from 15/16. • The outstanding target of £128k has been removed from budgets as an achieved CIP. • Overall status changed from Green to Amber pending identification of a plan for the gap in savings (£372k). • If this plan cannot be identified during June then overall status will change to Red. 	(£372k)
CIP058	Pharmacy Site and Services WMB	R	<ul style="list-style-type: none"> • Informal contract meetings held with both Ipswich and Bury st Edmunds SLA's. • Formal notice is planned to be given end of the calendar year. • Project lead is advising that savings will not be realised until 2017/18. Re-scoping of timeline underway between PMO and project team to identify if any acceleration possible. • Additional CIP savings are looking to be identified to bridge deficit 	(£75k)
CIP060	Estates Rationalisation EBMB	A	<ul style="list-style-type: none"> • The savings for 16-17 had been reduced from £696k to £500k to reflect budget reductions taken as part of 16-17 annual plans. • Expected delivery is currently estimated at £348k due to delays in the sale of the upper Hellesdon site and reductions in the revenue saving relating to Northgate land. • Work is on-going with the service line project leads to identify additional savings to make up the shortfall. 	(£128k)
CIP066	Secure Services Reconfiguration (Option 1) EBMB	R	<ul style="list-style-type: none"> • Project Manager now in place. • Major focus on short term CIP requirement through workforce and finance. Workstreams have been tasked with identifying the best and worst case for savings along with timescales and dependencies for achievement. • Also focusing on the longer term CIP requirement (of approx £3.7m) through analysis and agreement of increased capex requirement of over £4m. • According to original business case from February 2016 the approved budget is £2.9m. Immediate work with estates and finance to 	(£700k)

			<p>determine the movement in the two requested budgets and retrospectively manage the change through a change request process.</p> <ul style="list-style-type: none"> • The PID for CIP066 cannot go fully live until the financials can be added. • Although this scheme is not fully live on the CIP Tracker, the workbook is being used for the project management and control tool. 	
CIP073	Removal of corporate posts 16/17 WMB	R	<ul style="list-style-type: none"> • Overall target is £400k. • Current £108k shortfall. Project sponsor is confident that this will be identified and achieved in financial year. 	(£108k)

Date:	23 June 2016	F
Item:	16.105iii	

Norfolk and Suffolk

NHS Foundation Trust

Report To:	Board of Directors - Public
Meeting Date:	23 rd June 2016
Title of Report:	2016/17 Financial Performance Report (for the two months ending 31 May 2016)
Action Sought:	For Information
Estimated time:	10 minutes
Author:	Simon Ledger – Head of Financial Management
Director:	Julie Cave, Director of Finance

Executive Summary:

The purpose of the report is to inform the Board of the Trust's financial performance for the period 1st April 2016 to 31st May 2016.

Key headlines for the month include:

- A deficit position in the year to date of £0.89m compared to the original planned deficit of £1.2m, a positive variance of £0.32m.
- A Financial Sustainability Risk Rating (FSRR) of 2, which is in line with plan.
- Temporary staffing expenditure increased to £1.57m in the month. (£1.43m in April) Year to date expenditure has now reached £3.0m. (2015/16 M2: £4.5m) Agency spend within temporary staffing remained below the Monitor control total.
- Out of Trust Acute (OOA) placements bed days totalling 647 during May (of which 15 bed days were out of area) with total associated costs of £0.35m (332 days in April with expenditure of £0.18m).
- Current CIP forecast is delivery of £8.2m against the target of £10m. The remaining £1.8m has clear schemes and owners.
- A cash balance of £12.82m at the end of May, which is above the planned level of £9.47m.
- Continued slippage on Capital projects from that planned with expenditure to date of £0.53m against a plan of £1.9m.

Board of Directors Month 2 Financial Performance Report	Version 1.0	Author: Simon Ledger Department: Finance
Page 1 of 2	Date produced: 8 th June 2016	Retention period: 30 years

1.0 Financial Position

The following power-point document details the overall Trust financial performance as at the end of May 2016 (please see attached).

2.0 Risks

The Trust needs to closely monitor and control out of Trust placements and temporary staffing levels throughout the year in order to achieve its financial plans.

3.0 Recommendations

The Board is asked to review and note the report.

Simon Ledger
Head of Financial Management.
8th June 2016

Board of Directors Month 2 Financial Performance Report	Version 1.0	Author: Simon Ledger Department: Finance
Page 2 of 2	Date produced: 8 th June 2016	Retention period: 30 years

Financial Performance for the Period ending 31st May 2016

Meeting Date: 21st June 2016



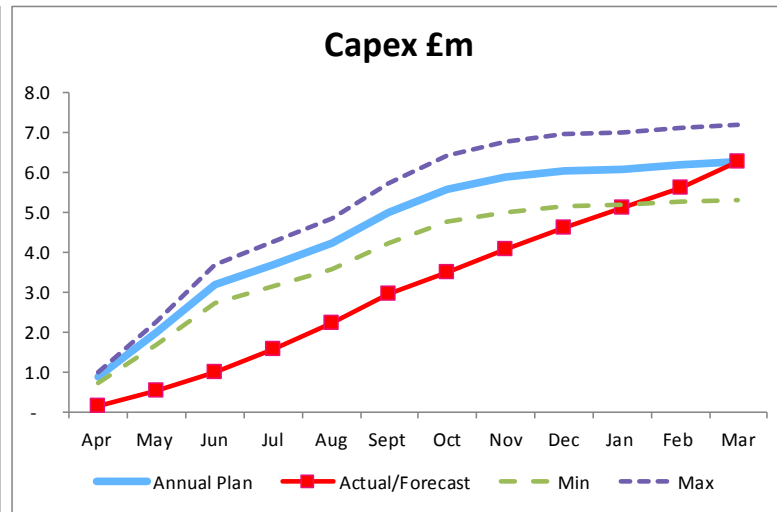
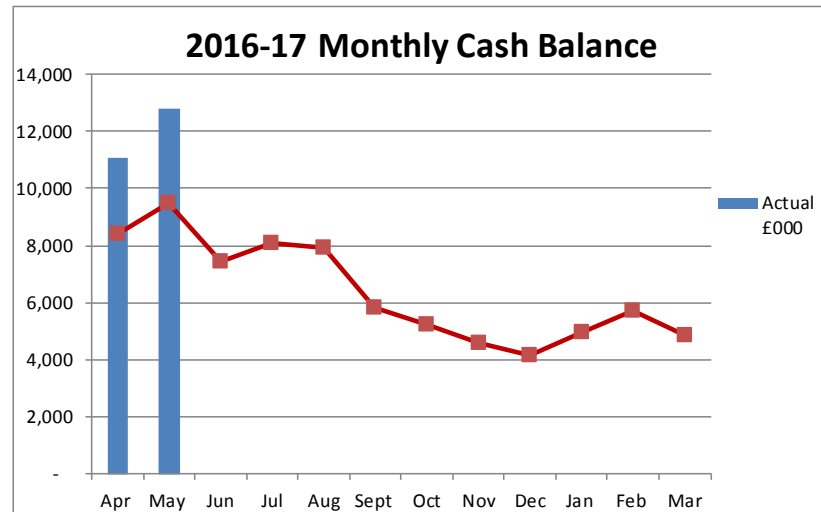
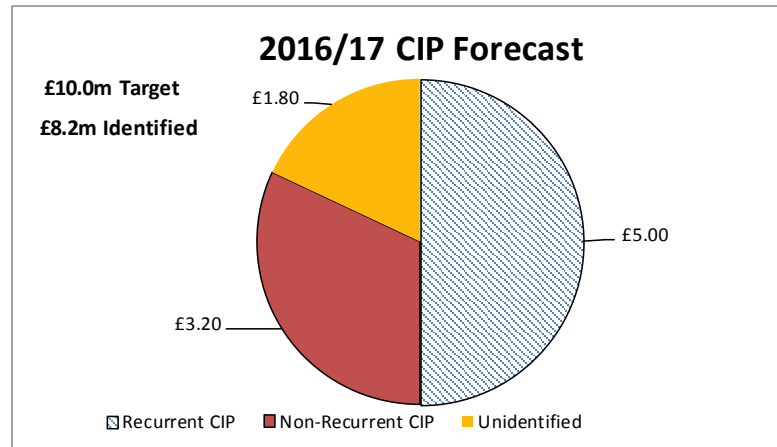
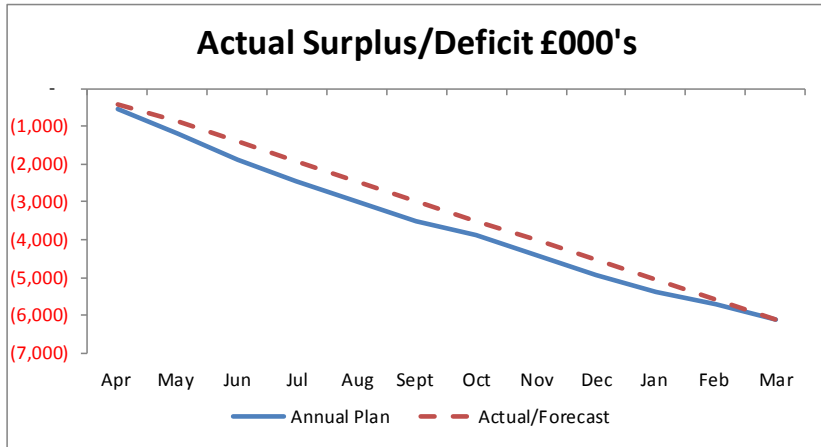
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Slide 15	Capital
Slide 16	Balance Sheet
Slide 17	Cash flow
Slide 18	Cost Improvement Plans (CIPs)

Executive Summary

Key Issue	Executive Summary	Year to date v budget	Forecast Outturn
EBITDA	EBITDA is £1.1m at the end of May, which is £0.32m favourable variance against our plan. Whilst the overall position is favourable due to additional clinical income and underspends on pay, there is a significant overspend against Out of Trust placements of £364k.	Green	Green
Surplus / (Deficit)	A deficit of £0.46m is reported this month, which is below the planned level of £0.65m. This variance is driven by the issues highlighted above.	Green	Green
CIP Programme	The 2016/17 CIP target is £10m of which £8.2m is fully identified. The remaining £1.8m is work in progress and has clear schemes and owners.	Green	Green
Cash & Liquidity	The cash held at the end of May was £12.8m compared to the plan of £9.5m. This favourable variance is due to strong cash management, including the policy of 'no purchase no pay'. In addition there is slippage in capital expenditure of £1.4m which has contributed to the variance.	Green	Green
Capital Expenditure	The capital programme has a plan of £6.25m for 2016/17. Due to the continued slippage on a number of projects during May the YTD expenditure was £0.53m compared to the plan of £1.9m. The forecast will be reviewed during July as part of the resubmission to NHS Improvement.	Red	Green
Financial Sustainability Risk Ratings (FSRR)	A Financial Sustainability Risk Rating of 2 was achieved in May. It is anticipated that this will continue throughout the year, as planned.	Green	Green

Finance Dashboard



Financial Sustainability Risk Ratings (FSRR)

	Actual	Plan	Variance
YTD	2	2	-
Forecast	2	2	-

Statement Of Comprehensive Income (SOCI)

Statement of Comprehensive Income (SOCI)-Year to Date			
	Annual Plan £'000	Actual £'000	Variance to Annual Plan £'000
Operating Income	(34,755)	(35,388)	633
Pay Costs (Substantive, Bank & Overtime)	25,468	25,833	(365)
Agency & Locum Costs	2,042	1,627	415
Drugs Costs	559	504	55
Other Costs	5,880	6,300	(419)
EBITDA	806	1,125	(319)
Depreciation	1,208	1,208	0
Non Operating Income	(3)	(5)	2
Non Operating Expenses	804	808	(4)
Exceptionals			
Net surplus / (deficit)	(1,203)	(886)	317
EBITDA margin	2%	3%	

Income – Summary

<u>Year to Date Income position</u>			
	Annual Plan	Actual	Variance to Annual Plan
	£'000	£'000	£'000
Block contracts	30,721	30,815	94
Clinical Partnerships	1,547	1,574	27
Clinical income-Secondary Commissioning	371	367	(4)
Other clinical income	808	956	148
NHS Mental Health activity Income, Total	33,447	33,713	266
Capital to Revenue Transfer	0	0	0
Research and Development	95	169	74
Education and Training	581	588	7
Misc. Other Operating	632	918	286
Other Operating income, Total	1,308	1,675	367
Operating Income, Total	34,755	35,388	633

CQUIN – 2016-17




- Schemes have been agreed apart from one left outstanding from GY&WCCG, this will be finalised by the end of June and is dependent on action from the CCG.
- Work has started and there will be a Q1 submission deadline.
- A breakdown of CQUIN values by CCG is shown in table below

	Total CQUIN	Local 1.5%	National 1%
North Norfolk	359,722	215,833	143,889
Norwich	579,571	347,743	231,828
South Norfolk	385,254	231,152	154,102
West Norfolk	311,590	186,954	124,636
Great Yarmouth and Waveney	682,200	409,320	272,880
Suffolk	102,045		102,045
NHS England	358,540	215,124	143,416
Norfolk and Waveney Wellbeing	254,494	152,696	101,798
	<u>3,033,416</u>	<u>1,758,823</u>	<u>1,274,593</u>


Contracts

-  Signed contracts are in place for all CCGs and NHSE





Central Norfolk

-  As previously reported there is an outstanding CQN in Central Norfolk relating to access for AAT. An agreed trajectory was not achieved and as a result a financial penalty of 1% was imposed, as per the contract terms. NSFT proposed that a joint investigation was required to analyse the service due to the changes in the model. The work has been well received by the CCGs and a proposal is that all withheld monies are returned to NSFT.
-  The Norfolk CCGs have advised of a number of concerns which they will issue performance notices if performance remains red, letters have been sent to the NSFT Director of Finance. Some of these are as a result of the standardisation programme being rolled out across all contracts, which have trajectories planned for new indicators on some contracts. Historic performances under scrutiny include, CAMHS 8 week wait, and outcomes on HONOS scheme and SWEMWEBS.
-  Central Norfolk CCGs have requested clarity on how the additional £1.5m investment will be allocated by NSFT.

Norfolk PCMHS

-  Norfolk PCMHS contract is still to be signed. A proposal from NSFT for full payment of the 15/16 CQUIN and a revised Performance Related Payment framework was submitted to the CCG CFOs as they had previously rejected the previous South Norfolk CCG proposal for full payment.

Suffolk

-  There are 3 performance notices open, one is expected to be closed and the others are progressing with the CCG.
 -  CMAS – closed
 -  AAT 28 day assessment - progressing
 -  12m COA review - progressing

Expenditure – Summary

- Due to a drop in the level of qualified Nursing staff across the Trust during May, the overall funded Trust vacancy position has increased to 447 WTE's representing on average 11.5% of total establishment.
- Overall pay & temporary pay spend are detailed on the following slides.
- Excluding Specialist and Out of Trust Placements (see following slides), the level of non pay expenditure dipped in the month by £0.1m. At present, fluctuations from plan against respective expense categories are considered to be timing, as the Trust anticipates full delivery against its submitted plan.
- A locality and departmental financial performance summary report is summarised in the following table.

Expenditure – Locality and Departmental Performance Summary

Budget	WTE		Locality / Department	FULL YEAR BUDGET (£000's)	YEAR TO DATE		
	Actual	Variance			BUDGET (£000's)	ACTUAL (£000's)	VARIANCE (£000's)
866.4	775.7	90.7	Norfolk Central	38,235	6,401	7,192	(791)
210.1	168.0	42.1	Norfolk West	9,619	1,610	1,704	(94)
547.1	482.1	65.0	Great Yarmouth & Waveney	22,394	3,829	3,748	81
556.9	497.3	59.6	Suffolk East	23,105	3,946	3,961	(15)
378.6	324.0	54.6	Suffolk West	15,231	2,592	2,552	40
102.3	95.0	7.3	Suffolk Wellbeing Service	4,896	816	803	13
88.0	66.4	21.6	Suffolk Access & Assessment	3,771	631	586	45
370.5	325.2	45.3	Secure Services	14,106	2,367	2,502	(135)
89.4	80.8	8.6	Substance Misuse	7,153	1,219	1,193	26
123.5	118.2	5.3	Wellbeing	8,675	1,453	1,382	71
3,332.80	2,932.70	400.10	Direct Care Services Sub-Total	147,184	24,864	25,623	(759)
17.0	14.6	2.4	Senior Operational Team	1,536	256	298	(42)
99.6	92.7	6.9	Service Governance	4,253	711	711	0
52.9	50.9	2.0	Medical	5,009	851	871	(20)
169.50	158.20	11.30	Support Services Sub-Total	10,798	1,818	1,880	(62)
53.7	51.4	2.3	Chief Executive	3,200	549	610	(61)
46.7	37.9	8.8	Commercial Directorate	2,061	355	383	(28)
126.6	114.4	12.2	Estates & Facilities	16,057	2,795	2,742	53
60.5	51.5	9.0	ICT	3,510	586	486	100
48.4	47.8	0.6	Human Resources	2,261	381	373	8
63.1	59.5	3.6	Finance (inc Comps & Losses)	4,318	729	797	(68)
399.0	362.5	36.5	Corporate Services Sub-Total	31,407	5,395	5,391	4
3,901.00	3453.50	447.50	Total Locality / Department	189,389	32,077	32,894	(817)
			Income	(206,770)	(34,478)	(34,307)	(172)
			Interest and Depreciation	12,517	2,009	2,009	0
			Reserves	10,958	1,596	290	1,306
			Total	6,094	1,204	887	317

Expenditure – Pay Summary

YTD Variance on overall pay (including agency and locums) is £0.05m, but there are additional costs included which have reduced the underlying positive variance.

£000's	YTD position
50	Overall pay variance
217	Services received overspend
237	Pay costs covered by DINC drawdown
<u>504</u>	<u>Core services pay variance</u>

Table below shows summary variances and the reasons for these on YTD spend

	Annual Plan	Actual	Variance	
Management & Board	1,572,136	1,574,061	(1,925)	}
Admin & Estates	3,716,202	3,459,418	256,784	}
Apprentice	19,230	30,337	(11,107)	}
Nursing Qualified	8,695,747	8,006,811	688,936	} Predominantly vacancies,
Nursing Unqualified	3,723,133	3,498,023	225,110	}
Medical	3,668,688	3,151,779	516,909	}
S&T / Social Workers	3,545,946	3,476,122	69,824	}
Services Received	1,046,354	1,263,133	(216,779)	Overspends in secure, wellbeing, and budget for substance misuse within non pay
Pay Reserves	1,498,796	0	1,498,796	Pay increment, inflation, NI rebate, agency premium not released into locality budgets
Locum Medical	0	22,771	(22,771)	
Agency Medical	0	558,250	(558,250)	Norfolk West & Norfolk Central being the 2 main drivers of locum spend
Agency Qualified	0	527,188	(527,188)	Covering vacancies
Agency Unqualified	0	98,370	(98,370)	
Agency A&C / Specialist	13,660	420,907	(407,247)	Predominantly corporate, but also includes trustwide admin
Bank Qualified	0	155,429	(155,429)	
Bank Unqualified	10,336	1,158,227	(1,147,891)	£472k specialising, £467k vacancies, £158k sickness
Bank A&C	0	59,347	(59,347)	
Total Pay	27,510,228	27,460,174	50,054	

Expenditure – Temporary Pay

 Total agency expenditure target cap set by Monitor for this financial year is £10.783m

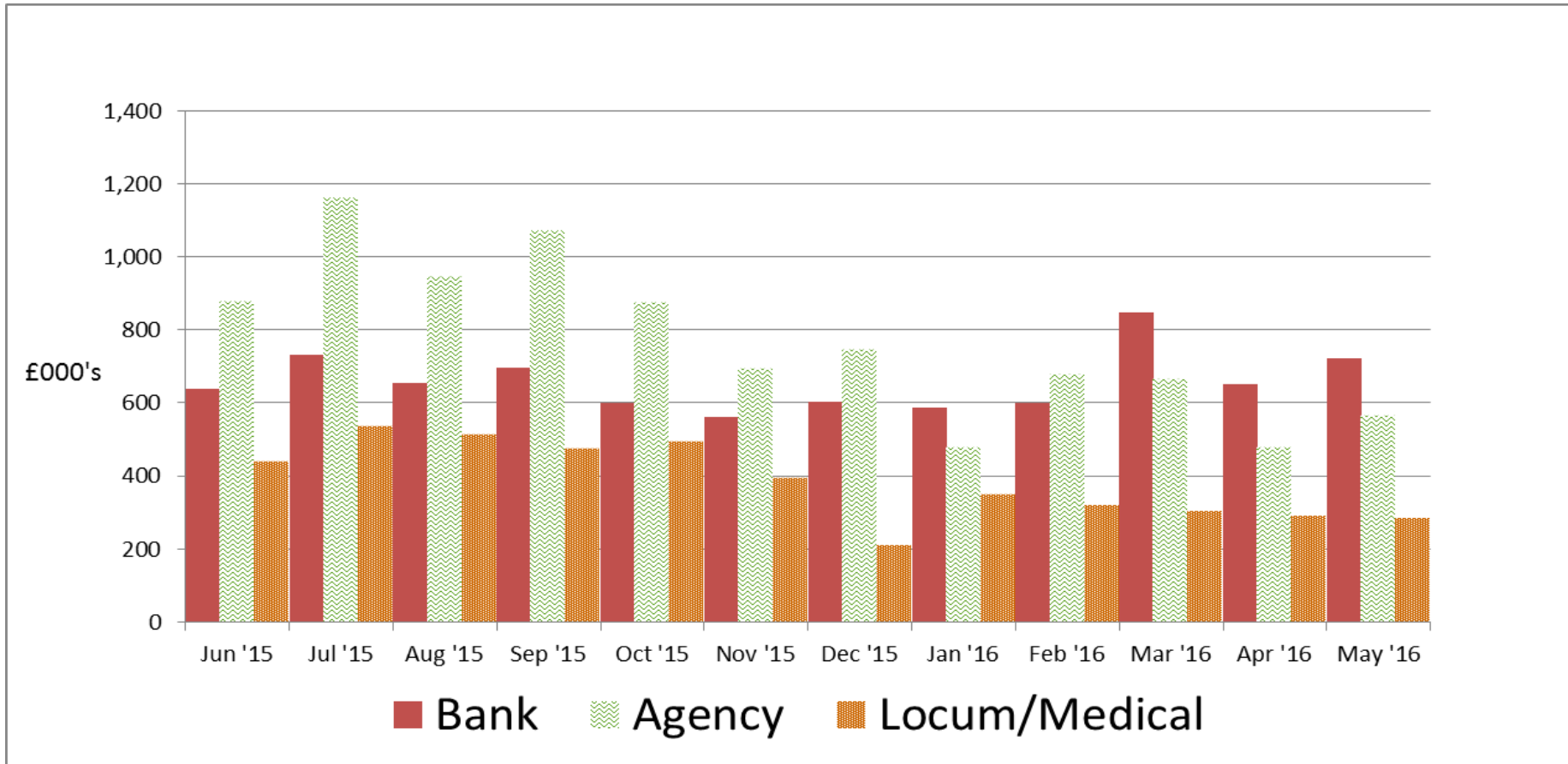
ACTUAL SPEND £'000s	MAY		Covered by			YTD		Corporate Breakdown - May	
	Agency	Bank	Total	Vacancy	Agency	Bank	Total		
Medical	287		287	360	581		581	Suffolk Ops	65
Qualified nursing	268	85	353	558	527	155	682	PMO	8
Unqualified nursing	62	604	666	165	98	1,158	1,256	ICT	30
Clinical a&c	42	33	75	86	73	59	132	HR& OD	16
Scientific & Therapeutic	39		39	110	66		66	Informatics	10
Corporate	155		155	96	282		282	Finance	11
	<u>853</u>	<u>722</u>	<u>1,575</u>	<u>1,375</u>	<u>1,627</u>	<u>1,372</u>	<u>2,999</u>	Estates & Facilities	<u>15</u>
Monitor Control Total	899				1,798				<u>155</u>

Includes £8k covered by WSCCG IT contract

NHSP BOOKING REASONS - MAY SHIFTS								NHSP BOOKING REASONS - YTD SHIFTS									
	BANK				AGENCY					BANK				AGENCY			
	QUALIFIED		UNQUALIFIED		QUALIFIED		UNQUALIFIED			QUALIFIED		UNQUALIFIED		QUALIFIED		UNQUALIFIED	
	£'000s	%	£'000s	%	£'000s	%	£'000s	%		£'000s	%	£'000s	%	£'000s	%	£'000s	%
Maternity	0	0%	2	0%	1	1%	0	0%	Maternity	1	1%	3	0%	1	0%	1	1%
Sickness	10	13%	78	13%	19	7%	12	12%	Sickness	18	12%	158	14%	34	7%	19	9%
Specialing	8	10%	242	41%	5	2%	44	44%	Specialing	16	11%	472	42%	10	2%	86	43%
Training	1	1%	7	1%	0	0%	0	0%	Training	1	1%	11	1%	1	0%	1	1%
Vacancy	62	76%	260	44%	236	90%	44	44%	Vacancy	114	76%	467	42%	448	91%	91	46%
	<u>81</u>		<u>589</u>		<u>262</u>		<u>101</u>			<u>150</u>		<u>1,111</u>		<u>495</u>		<u>199</u>	

Expenditure - Temporary Pay

12 month spend trend (£000's)



Expenditure – (Specialist and Out of Trust Placements)

- There was a significant increase in the number of Out Of Trust placements during May.
- YTD expenditure is £0.53m against a full year plan of £1.0m. If current level of activity was to continue throughout the year, there would be an overspend of around £2m against plan.

OOA PLACEMENTS - ACTUALS			
BED DAYS	APRIL	MAY	YTD
Mundesley	310	632	942
OOA	22	15	37
TOTAL	332	647	979
Monthly Spend £'000s	179	351	530
Budget £'000s	83	83	166
Variance	(96)	(268)	(364)

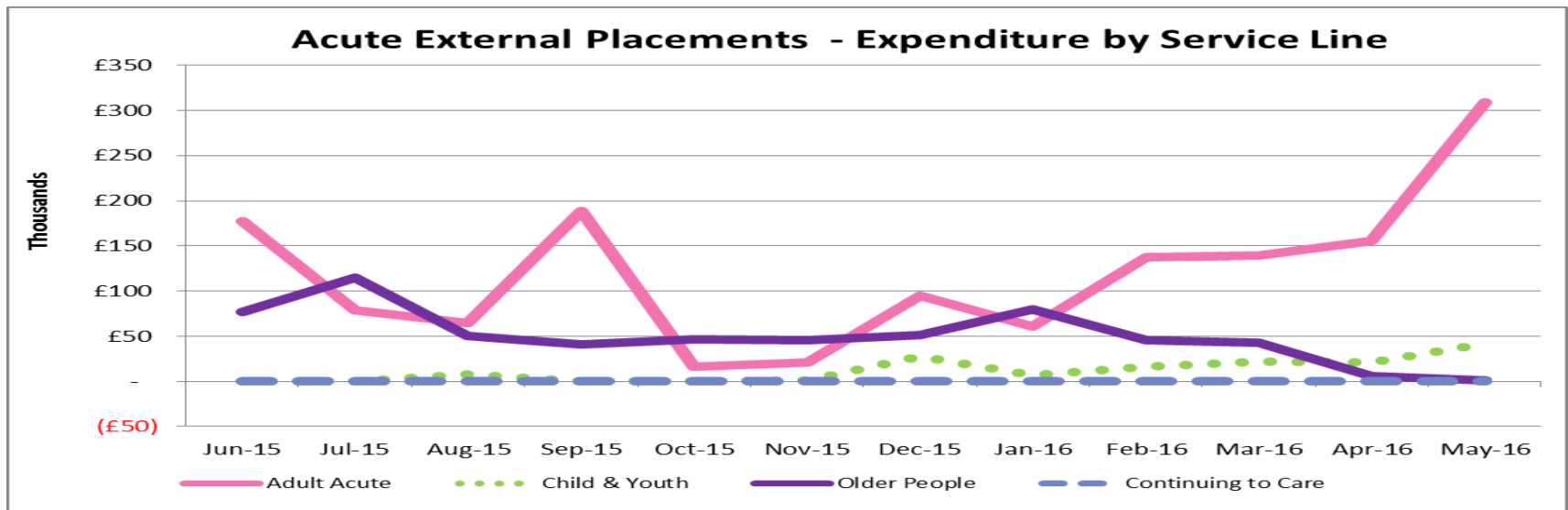
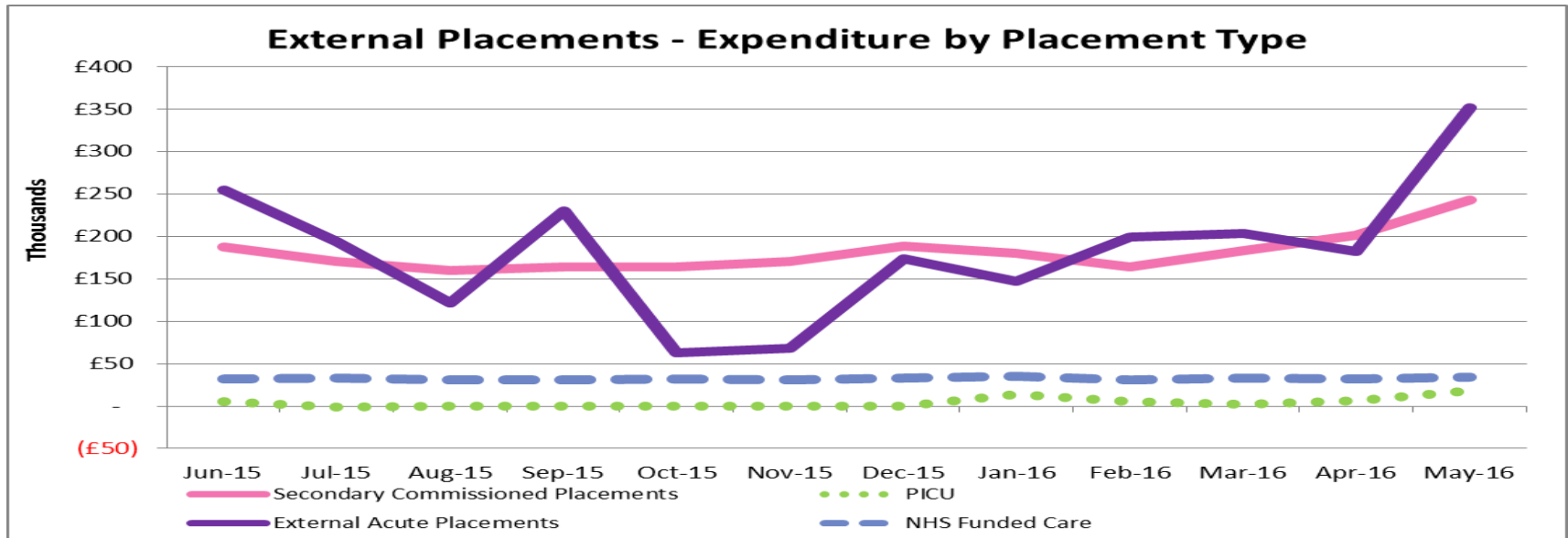
	OOA PLACEMENTS - NUMBER OF PLACEMENTS - MAY						
	BY LOCATION			BY LOCALITY			
	Mundesley	OOA	Total	Central GYW	West	Total	
01-May	20		20	14	2	4	20
Admissions	39	1	40	32	1	7	40
Discharges	(37)	(1)	(38)	(29)	(2)	(7)	(38)
31-May	22	0	22	17	1	4	22

- There were 2 further Secondary Commissioned placements made in the month.
- YTD expenditure is £0.44m against a full year plan of £2.0m. If current level of activity were to continue throughout the year, there would be an overspend of around £.9m against plan.

SECONDARY COMMISSIONED PLACEMENTS ACTUAL SPEND £'000s			
	APRIL	MAY	YTD
Actual Spend	201	243	444
Budget	167	167	334
Variance	(34)	(76)	(110)

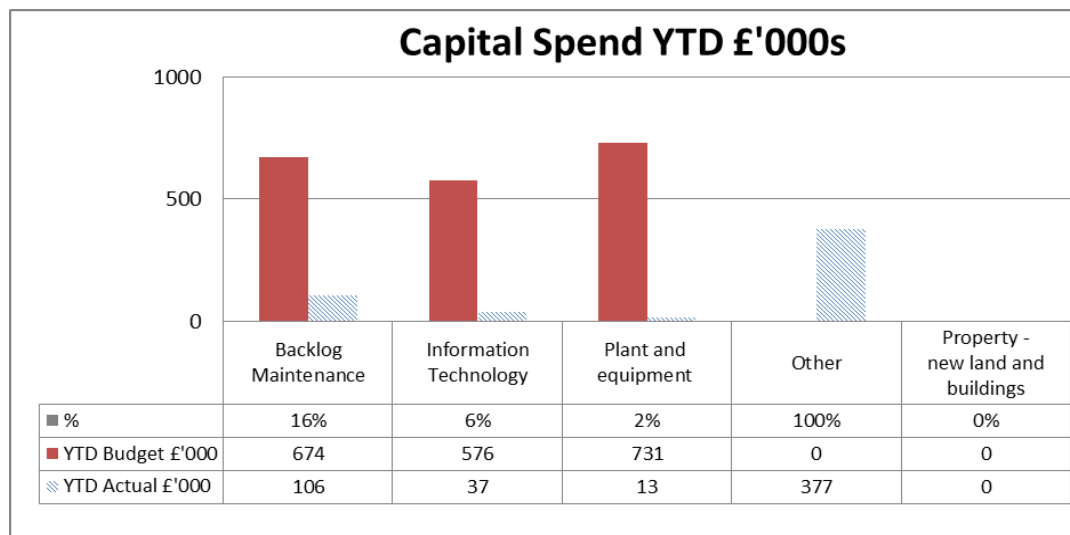
	SECONDARY COMMISSIONED PLACEMENTS NUMBER OF PLACEMENTS - MAY			
	BY LOCALITY			
	Central	GYW	West	Total
01-May	9	1	2	12
Admissions	2			2
Discharges				0
31-May	11	1	2	14

Expenditure – (Placements)



Capital

- The capital programme for the year is £6.25m
- The capital spend incurred year to date in 2016 was £0.53m against a budget of £1.98m (26.8%).
- There is still slippage on the anticipated projects for the year but projects are beginning to be established and a number of projects that had slipped from 2015/16 into 2016/17 are in the process of being completed.
- The following chart shows the current year to date performance against the current capital plan.



Balance Sheet

At the end of month 2, the Trust held cash and cash equivalents of £12.82m. This is ahead of the Annual Plan figure of £9.47m. The value of orders raised in May was £1.45m compared to a previous monthly average of £0.86m, a result of more non pay expenditure going through the procurement system.

Current assets are higher than planned due to the higher cash balance. Trade receivables are slightly below the forecast amount, partially due to a provision for impaired receivables as some NHS invoices are currently in dispute. This is also reflected in the balance of debt over 90 days outstanding which has not moved significantly from the year end position.

Net liabilities are higher than anticipated due to creditors and accruals set aside for the delayed invoices highlighted above. There are also higher than forecast provisions on the balance sheet, which have yet to be released.

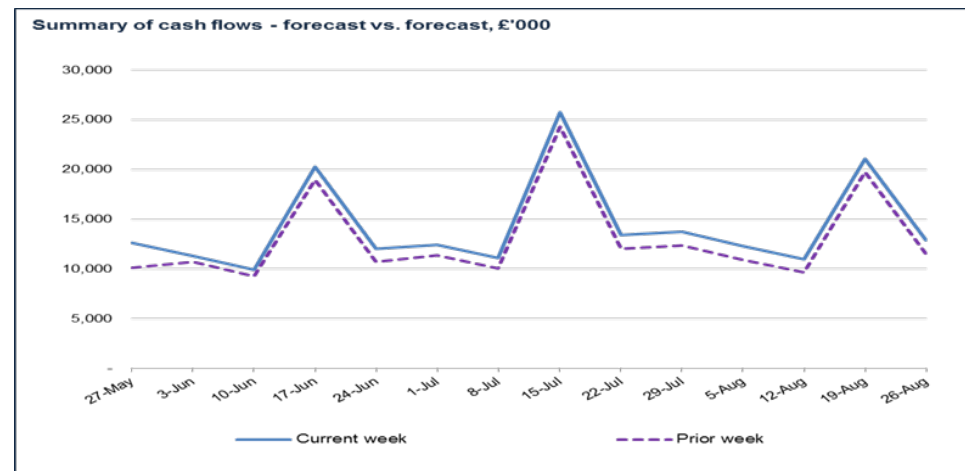
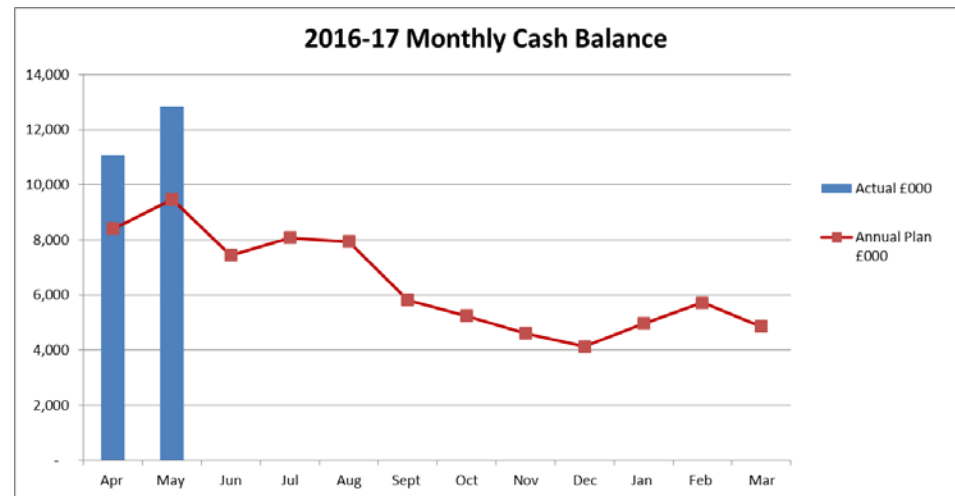
Statement Of Position	Actual	Annual Plan	Variance (adverse)
	May-16	May-16	May-16
	YTD	YTD	YTD
£m			
Non-Current Assets	149.6	151.5	1.9
Current Assets	21.3	18.0	(3.4)
Current Liabilities	(32.3)	(27.7)	4.6
Non-Current Liabilities	(18.6)	(18.4)	0.1
TOTAL ASSETS EMPLOYED	120.1	123.3	3.2
Public dividend capital	81.6	81.6	-
Retained Earnings (Accumulated Losses)	(4.2)	(1.3)	2.9
Revaluation reserve	42.7	43.1	0.4
Donated asset reserve	-	-	-
TOTAL FUNDS EMPLOYED	120.1	123.3	3.2

Aged Debtors	Q4 2015-16	Q1
< 30 Days	2,097	917
30-60 Days	1,600	994
60-90 Days	230	455
90+ Days	806	822
Total	4,734	3,188

Cash flow

■ The cash position in Month 2 is £3.35m higher than the Annual Plan figure. This is due to capital slippage of £1.4m, increased non-clinical income and the impact of cash controls ('no purchase order no pay'). The Trust's payment runs are below the expected levels, although an anticipated catch up for delayed agency invoices and purchase orders as a result of the "no purchase order no pay" policy is expected

■ The 13 week cash flow projection has also been completed for submission to NHS Improvement – at present there are no material differences from the forecast at this time.



Cost Improvement Plans (CIPs)

- The 2016/17 CIP target is £10m with a current forecast delivery of £8.2m. The remaining £1.8m has clear schemes and owners.
- In the year to date we have delivered £1.37m of CIP savings of which 62% is recurrent and 38% is non-recurrent. The planned split was 70% recurrent and 30% non-recurrent.

CIP Scheme	Executive Lead	2016/17 Target	2016/17 Identified	2016/17 Gap To Find	2016/17 Forecast	2016/17 Variance	2016/17 RAG
		£m	£m	£m	£m	£m	
CIP067 - Community Caseload N&W	Debbie White	0.80	0.80	0.00	0.80	0.02	Green
CIP070 - Safer Staffing N&W	Debbie White	1.60	1.60		1.60	-	Green
CIP071 - Out of Area Placements	Debbie White	0.50	0.58		0.58	0.08	Green
CIP072 - Psychiatric Liaison	Alison Armstrong	0.30	0.30		0.30	-	Green
Tier 4 CAMHS	Debbie White	0.06	-		0.00	(0.06)	Amber
CIP065 - Continuing Care Pathway Redesign	Debbie White	0.31	0.42	0.28	0.42	0.00	Red
To Be Identified	Debbie White	0.39	-	0.28	0.28	0.12	Green
						(0.11)	Red
CIP060 - Estates Rationalisation	Julie Cave	0.50	0.50	0.05	0.55	0.00	Green
Henderson Ward Rental	Julie Cave	0.05	-	0.05	0.05	0.00	Green
						-	Green
CIP073 - Removal of Corporate Posts	Leigh Howlett	0.40	0.29	0.11	0.40	-	Red
CIP035 - Reduction in Photocopying and Printing	Julie Cave	0.07	0.07	-	0.07	0.08	Green
CIP052 - ICT Clinical Applications Licencing	Leigh Howlett	0.07	0.15		0.15	-	Green
CIP053 - Travel Efficiencies - SKYPE for Business	Leigh Howlett	0.08	0.09		0.09	0.08	Green
CIP054 - Electronic Subject Access Requests	Leigh Howlett	0.01	0.01		0.01	0.01	Green
CIP061 - Landline Telephone	Julie Cave	0.06	0.06		0.06	(0.01)	Amber
						-	Green
CIP066 - Secure Services Reconfiguration	Debbie White	0.70	0.23	0.47	0.70	-	Red
Temporary Staff spend reduction		0.25	-	0.25	0.25	0.00	Red
						-	Green
CIP004 - Procurement	Julie Cave	0.13	0.16	0.34	0.50	0.00	Red
Procurement To Be Identified	Julie Cave	0.37	-	0.34	0.34	0.04	Green
						(0.03)	Red
CIP058 - Pharmacy Site & Services	Bohdan Solomka	0.07	-	0.07	0.07	-	Red
CIP063 - Prescribing	Bohdan Solomka	0.19	0.19		0.19	-	Amber
Pharmacy To be identified	Bohdan Solomka	0.23	-	0.23	0.23	-	Green
						-	Red
Trustwide Non-Recurrent CIP		2.85	2.74		2.74	(0.11)	Green
Total		10.00	8.20	1.80	10.00	(0.00)	

Date:	23 June 2016	G
Item:	16.107iv	

Norfolk and Suffolk

NHS Foundation Trust

Report To:	Board of Directors – Public
Meeting Date:	23 June 2016
Title of Report:	Workforce and Organisational Development Strategies: Recruitment and Retention; Staff Wellbeing; Leadership and Management Development
Action Sought:	For Approval
Estimated time:	15 minutes
Author:	Sarah Ball; Head of Organisational Development and Human Resources
Director:	Leigh Howlett: Director of Strategy & Resources

Executive Summary:

The Board approved Putting People First, our Workforce and Organisational Development Strategy 2016-21, at its meeting on 19 June 2016. The strategy sets out our vision and plans to transform our organisation and to deliver our strategic goals through an engaged, skilled and responsive workforce where we have:

- the right staff, in the right place, at the right time
- our staff feel valued and cared for
- they understand their role in relation to our vision and are supported by great leadership.

In support of Putting People First, three five year enabling strategies are presented to the Board for approval.

Recruitment and Retention Strategy 2016-21

Building upon the progress made in our previous strategy, this sets out our strategic approach and plans for the next five years to ensure we have a quality and sustainable workforce.

The strategy covers how we will attract staff; how we will improve our recruitment process to reduce the time it takes to hire staff; skill mix, new roles and career pathways, including our approach to 'growing our own' to mitigate national skills shortages and staff retention.

The outcome of the strategy will be a stable and effective workforce. It will be delivered through the clinical and non-clinical operational managers with support from the HR Business Partners and wider team.

Your Wellbeing First: Staff Wellbeing 2016-21

Our Trust has been referenced locally and nationally as an exemplar of good practice in regards to our approach and the range of support we provide to safeguard, promote and improve staff wellbeing. Our strategy for 2016-21 builds upon this success.

It includes emphasis on personal responsibilities for both employees and managers. We also wish to be seen as an exemplar on how we best support our own staff who may themselves experience mental ill health given our status as a mental health service provider.

Board of Directors – Public 23 June 2016 Workforce and Organisational Development Enabling Strategies	Version 1.0	Author: Sarah Ball, Head of Organisational Development and Human Resources Department: Human Resources
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Our focus will be on preventing ill health and improving wellbeing; early intervention in the event of physical or mental health issues; and timely and appropriate support.

An outcome of our strategy will be the achievement of the 'Excellent' standard across all domains of the National Wellbeing Workplace Charter by April 2021.

Delivery of the strategy will be supported by our network of seventy Wellbeing Champions based within our localities and services.

Leadership and Management Development Strategy 2016-21

We recognise that great leadership is key to the delivery of our strategic goals. Our strategy sets out our plans for the next five years to develop our leadership and management capability, as well as our commitment and approach to developing a fantastic leadership climate that makes our Trust a great place to train, work and receive treatment. As well as being a core element of our strategy, this will be a theme running throughout our wider development framework.

The strategy will support the development of aspirant and capable future managers and leaders to ensure we have a ready pipeline of talent; robust first line managers; inspirational and resilient leaders who have the skills and behaviours to operate within the changing NHS and local landscape; a capable Board that role-models the leadership climate our staff require in order to excel; and a culture of coaching, equipping our managers to empower their teams to reach their own solutions and to be accountable for these.

These strategies are presented together due to their interdependencies and their criticality to improving staff engagement. They take account of feedback from staff and service users through consultation, the Trust Partnership Meeting and the Organisational Development and Workforce Committee where they were presented for final comments (now incorporated) on 23 May 2016.

The Board is asked to approve these three strategies.

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1.0 Introduction

1.0 The Board approved Putting People First, our Workforce and Organisational Development Strategy 2016-21 at its meeting on 19 June 2016.

1.1 Putting People First sets out our vision and plans to transform our organisation and to deliver our strategic goals through an engaged, skilled and responsive workforce where we have:

- the right staff, in the right place, at the right time
- our staff feel valued and cared for
- they understand their role in relation to our vision and are supported by great leadership.

1.3 In support of Putting People First, this report sets out our strategic approach and plans for the next five years in regard to recruitment and retention, staff wellbeing and leadership and management development. These strategies are interdependent of one another and critical to our ongoing focus on improving staff engagement and patient experience.

1.4 The high level principles and priorities set out within these strategies have been tested with our staff and service users through consultation undertaken on the Workforce and Organisational Development Strategy and the versions presented to the Board also take account of feedback received from, for example, the Trust Partnership Meeting and the Organisational Development and Workforce Committee, where drafts were presented for final comments on 23 May 2016.

2.0 Recruitment and Retention Strategy 2016-21

2.1 Our ability to recruit and retain great people who have the right knowledge, skills, values and behaviours is fundamental to the delivery of our Trust Strategy 2016-21. Getting this right will not only improve staff morale and engagement but will also have a positive impact on patient care and experience.

2.2 A lot has been done over the last couple of years to improve staff recruitment and retention which has resulted in an overall reducing trend of vacancies.

2.3 We currently have a vacancy rate of 11.15% (at the end of April 2016) which is significantly lower than other Mental Health Trusts in the region that have average rates of 13.5%. That said, we still have considerable challenge recruiting to some roles in light of national skills shortages, particularly Band 5 registered nurses and medical staff. This difficulty is further compounded when overlaid in some areas by geographical challenges, particularly in our rural and coastal locations. Additionally, we have retention challenges with a relatively mature age profile of our workforce, with retirees making up a quarter of our voluntary leavers.

2.4 We are, however, fortunate to be the only NHS mental health provider across two counties with established clinical degree courses at the county universities, although the output of supply is not sufficient to meet our future workforce needs.

2.5 There are four key elements of focus for the strategy:

Attraction: to enable us to recruit high calibre staff, we must maximise every opportunity to positively promote the Trust as a desirable training provider and employer of preference.

Process: we want our recruitment processes to support the ethos of the right people, in the right jobs at the right time and for it to be a positive experience for the candidate and an effective and efficient process for the appointing manager.

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Skills mix, new roles and career pathways: taking account of the significant national skills shortages, exploring alternative ways to delivering our models of care through new roles, skills mixes and career pathways is critical.

Retention: Everything we do links to how engaged staff feel and how committed they are to our Trust. As set out in Putting People First, we want our staff to act as positive ambassadors for the Trust, proud of the work they do and positive about the Trust as a great place to work.

3.0 ‘Your Wellbeing First’: Staff Wellbeing Strategy 2016-21

3.1 Our staff are our most important asset. We recognise the importance of supporting our staff to work in healthy work environments, with manageable jobs, and to be as well as they can be – physically, mentally and emotionally – for the benefit of their own welfare and for those they provide care for.

3.2 On review of our previous wellbeing strategy, we have been highlighted nationally and locally as an exemplar of good practice in regards to our approach and the range of support we provide to safeguard, promote and improve staff wellbeing. We have seen the impact of the progress we have made in our sickness absence rates which, at 4.69% to the end of April 2016, is amongst the lowest in mental health within the region. We do, however, know from our sickness absence trends that improving mental ill health is a priority for us; this continues to be the highest reason for absence and, as a mental health Trust, we are committed to doing better in this area.

3.3 Our plans for 2016-21 build upon the success of the work we have done to date.

3.4 The three key elements of focus for the strategy are:

Improve and prevent: this focuses on the creation of a working environment that is conducive to a happy and healthy workforce and the prevention or reduction of issues that can impact wellbeing.

Early Intervention: we recognise that by routinely benchmarking our practice and reviewing trends in our internal data, referenced to appropriate benchmarks, we can identify issues and take action to minimise negative impacts.

Support: our strategy supports the delivery of timely and appropriate support for our staff when they experience short or longer term health issues.

4. Leadership and Management Development Strategy 2016-21

4.1 Having supportive, accountable and quality leadership is key to the delivery of our strategic Trust goals. Developing management and leadership capability with the right skills and behaviours to deliver transformational change is therefore one of our most important priorities within our Workforce and Organisational Development Strategy, Putting People First.

4.2 Whilst some bespoke programmes have been delivered, for example, Modern Matrons and Consultant Development programmes and a ‘Triumvirate’ Development Programme for our locality leadership teams, we have invested little over recent years in a co-ordinated strategic programme of management and leadership development. Leadership; Everybody’s Business seeks to address this.

4.3 The six key elements of focus for the strategy are:

Leadership Climate: the leadership climate we create as leaders - ‘how does it feel to be led by me’ - sets the tone for everything we do as an organisation. We believe that only by transforming our leadership climate can we create an environment in which positive change sticks i.e. it is truly transformational. This is backed by a clear evidence base that

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higher levels of emotional intelligence are linked to significantly higher levels of staff engagement and organisational performance.

Through a Leadership Climate Survey that was undertaken amongst all staff in April 2016, our staff have given us a clear direction on what creates an effective enabling environment for them. Put simply, this is about creating an environment that is visioning, stretching and encouraging with an inclusive culture that is collaborative, trusted and appreciative of individuals.

Aspirant Managers and Leaders: our strategy supports development of those who show the talent and commitment to progress and be great managers or leaders.

Fundamentals for Managers: it is essential that we build the foundations for new and existing managers to ensure they have the fundamental knowledge, skills and behaviours to be an effective manager or leader. This programme will be compulsory for all new managers and will be available on a modular basis for existing managers where they would benefit from some additional development.

Leadership Development: building on the fundamentals programme, this is aimed at managers at Band 7 and above. It will focus on leading transformation, delivering an inspiring and inclusive leadership climate, and will include a focus on clinical leadership. Out internal offering will be supplemented by NHS Leadership Academy programmes with nominations made on the basis of identifying talent rather than self-selection. We will hold an annual leadership conference to increase networking and share learning.

Board Development: annual plans for team and individual development will be informed by feedback from the annual independent review of the Board with development including bi-monthly development sessions, annual 360 degree appraisals and access to executive coaching and mentoring.

Coaching and Mentoring: we aspire to develop a culture of coaching whereby managers and leaders at all levels of the organisation are equipped with the skills to empower staff to explore and resolve issues for themselves, accepting accountability for performance within a supportive framework.

5.0 Implementation

- 5.1 In line with Putting People First, the strategies presented are ambitious but implementation will be phased over the course of the five year duration of the strategies with key milestones highlighted within the documents. Annual operational plans will be developed for each strategy and these will feed into the workforce aspects of the Trust's Annual Plan.
- 5.2 Each strategy clearly sets out the Executive leadership accountability for each aspect of the strategies set out.
- 5.3 Implementation of the strategies will be managed via the Workforce Mobilisation Board in regard to the recruitment and retention and leadership and management development strategies and via the Employee Wellbeing Steering Group in respect of the staff wellbeing strategy. Progress on all three strategies will also be reported through the Organisational Development and Workforce Committee.
- 5.4 Each strategy sets out success criteria for measuring impact, aligned to the Putting People First success criteria.
- 5.5 It should be noted that much of the change that will be delivered through these strategies is transformational, effecting and impacting culture change, and it will therefore take time to have a consistent impact across the organisation.

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6. Risks / mitigation in relation to the Trust objectives

- 6.1 Putting People First is a fundamental enabling strategy for the delivery of our strategic goals of:
- Improving quality and achieving financial sustainability
 - Working as One Trust
 - Focussing on prevention, early intervention and promoting Recovery.
- 6.2 Our strategic approaches to recruitment and retention, staff wellbeing and leadership and management development form core elements of Putting People First and our delivery of an engaged, skilled and responsive workforce.
- 6.3 Lack of engagement and capacity / resource to deliver are the key risks to the delivery of the strategies presented. To mitigate these risks, the strategies will be widely communicated and we will engage with managers and staff in their delivery. Progress will be monitored in line with the governance arrangements set out. Whilst much of the work described will be led by the Human Resources team (supported by Education and Development), elements of the management and leadership development programmes will be procured to provide the capacity and specialist skills required.

7. Recommendations

- 7.1 It is recommended the Board approves the following strategies:
1. Recruitment and Retention Strategy 2016-21
 2. Your Wellbeing First: Staff Wellbeing Strategy 2016-21
 3. Leadership and Management Development Strategy 2016-21

Sarah Ball

Head of Organisational Development and Workforce
June 2016

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(FINAL DRAFT V12)

**Recruitment and Retention:
Our Strategic Approach and Plans 2016 - 2021**

This document describes our strategic approach to recruitment and retention for the next five years and beyond. It is based on what we know from existing challenges, what is emerging, and what we need to ensure we have a quality driven and sustainable workforce.

Our ability to recruit and retain great people who have the right knowledge, skills, values and behaviours is fundamental to the delivery of our strategic goals set out in our Trust Strategy 2016 – 21 of:

- 1: Improving quality and achieving financial sustainability
- 2: Working as One Trust
- 3: Focusing on prevention, early intervention and promoting Recovery

The aim of this strategy is to ensure we can attract the right people with a skill mix that supports quality care through development of current as well as new roles and career pathways.

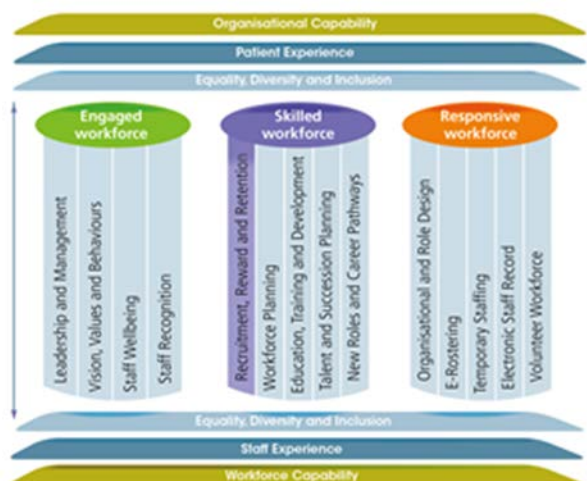
Leigh Howlett
Director of Strategy & Resources

Hannah Edwards
Strategic Organisational Development &
Human Resources Manager

Staffing for now and our future

This document sets out our strategic approach to recruitment and retention, taking account of current workforce projections, our Trust Strategy 2016 – 21 and its supporting plans; existing and emerging recruitment and retention challenges and opportunities; national direction in the Five Year Forward View for mental health and the Carter Review 2016 as well as local need. This includes the opportunity for greater collaboration with other organisations through the Sustainability and Transformation Plans.

This strategy sets out our strategic approach to managing these through delivery of the recruitment and retention elements of our Workforce and Organisational Development Strategy 2016-21, Putting People First. The following diagram shows how this work fits strategically within our overall workforce strategy.



It is a key enabler to achievement of our strategic Trust goals¹, as set out below:

Strategic Goal	How this strategy supports this
1. Improving quality and achieving financial sustainability	Through the provision of an engaged, committed, capable and regular workforce; reducing reliance on temporary staff
2. Working as One Trust	Through a Trust-wide collaborative approach to recruitment and the sharing of good practice in retention of staff by providing equal opportunities to training and development
3. Focussing on prevention, early intervention and promoting Recovery	By developing our recruitment and retention policies and practice to support a culture of employing staff who share our vision, values and behaviours

The recruitment and retention of skilled staff is a continuing challenge across the NHS due to national skills shortages and market competition. Additionally, lessons learnt from the Francis Inquiry compel us to recruit staff who not only have the clinical skills and experience to undertake their roles effectively but, equally importantly, also have the right attitudes and behaviours to deliver compassionate care.

Over recent times it has become increasingly more challenging to recruit staff groups such as registered nurses and psychiatrists, as well as skilled non-clinical staff in IT and estates maintenance.

¹ Trust Strategy 2016-21

While our clinical vacancy rate is currently lower when benchmarked against other Mental Health Trusts, we still face considerable challenges in recruiting to some areas given our geography with many rural and coastal locations and comparatively high house prices. This is compounded by there being a number of NHS employers within our patch, making it an employee's market with media and public perceptions of our Trust and mental health services also having an impact.

However, as the only NHS mental health provider across Norfolk and Suffolk with established nursing degree courses at both county universities we do have opportunities. Currently 96% of mental health nursing students from the University College Suffolk take up employment with the Trust and 88% of students from the University of East Anglia. We also have a close alliance with the University of East Anglia's Medical School. We will build on these further as national changes in funding for clinical and nurse training emerges along with our ability to influence different training packages and pathways.

We recognise that even without recruitment challenges, if we are unable to retain our staff, this impacts the quality of our service provision and it has significant financial implications in terms of the costs of recruitment and temporary staffing cover. We value and are proud of the commitment and contribution of every member of staff and want our staff to be equally proud to work for the Trust.

Through delivery of this strategy we want our staff to feel fulfilled, treated fairly and valued in their roles, recognised for the important contribution they make each day and for them to be engaged in positively shaping the services they provide and the culture of the environment they work in.

Our Focus

In order we make the right changes, at the right pace, over the lifetime of this strategy we will focus on the four areas shown in the diagram below.



Attraction

To enable us to recruit high calibre staff we must maximise every opportunity to positively promote our organisation as a desirable training provider and employer of preference. Therefore we will:

- Review what we offer as a place to study and train and put in place plans to improve our market position, the quality of educational provision, the quality of student and trainee experience and to improve the engagement of our students and trainees in future career opportunities within our Trust **(Medical Director and Director of Nursing)**
- Develop an innovative, consistent and relevant marketing and advertising plan which optimises social media to promote good news stories, achievements, career and employment opportunities **(Director of Strategy and Resources)**
- Use high impact and consistent organisational branding in all recruitment campaigns and promotion **(Director of Strategy and Resources)**
- Guarantee opportunities of employment for newly qualified nurses who have trained with us, subject to satisfactory assurance of their ability to work in line with our values **(Director of Nursing, Patient Safety and Quality)**
- Work closely with the public and third sectors (e.g. Ministry of Defence, ex-military groups, Princes Trust) to develop re-training routes that will attract individuals wishing to move to a new career within our Trust **(Director of Nursing, Patient Safety and Quality)**
- Promote career opportunities within the NHS and mental health services within local schools and colleges through the Ambassador Scheme and work experience programmes **(Director of Nursing, Patient Safety and Quality)**
- Regularly benchmark and review what we can offer as an employer to ensure we are competitive within the recruiting markets **(Director of Strategy and Resources)**
- Routinely monitor and our review our plans to ensure we attract and retain a diverse workforce, reflective of the communities we service **(Director of Strategy and Resources)**
- Review our current and emergent vacancies and deliver annual recruitment plans that are informed by our workforce plans and wider management information **(Director of Strategy and Resources)**
- Proactively engage with the local, regional and national labour markets through a variety of events and a combination of organisation-wide and local or profession focused targeted campaigns **(Director of Strategy and Resources)**
- Work in partnership with our temporary staffing bank provider to collaborate on targeted recruitment campaigns **(Director of Strategy and Resources)**

Process

Our recruitment process will support the ethos of the right people in the right jobs at the right time; professionally creating a positive experience for the candidate and an effective and efficient process for the recruiting manager. Therefore we will:

- Actively engage with streamlining work across the region. This will support the efficient portability of staff across NHS Trusts and minimise duplication of governance processes e.g. standardisation of systems, policies and processes **(Director of Strategy and Resources)**
- Regularly benchmark our recruitment process against other NHS employers and the public and private sectors and embed learning from our findings **(Director of Strategy and Resources)**
- Ensure our recruitment processes are efficient and effective through the application of lean methodology to increase the quality of services provided, within a shorter delivery time (time to hire) **(Director of Strategy and Resources)**
- Embed our values in all aspects of the recruitment process **(Director of Strategy and Resources)**
- Involve service users in our recruitment processes **(Director of Strategy and Resources)**

- Roll out development for managers on Values Based Recruitment and ensure this forms part of the future Leadership and Management Development Fundamentals Programme **(Director of Strategy and Resources)**
- Improve our evaluation techniques and processes to assess the success of our recruitment activities to ensure we focus on plans that deliver value for money **(Director of Strategy and Resources)**
- Manage recruitment delivery against key performance indicators (including time to hire) **(Director of Strategy and Resources)**

Skills Mix, New Roles and Career Pathways

Taking account of the significant national skills shortages, we need to look at alternative ways of delivering our models of care through the creation of new roles, skills mixes and career pathways. Therefore we will:

- Develop the Bands 1-4 clinical and non-clinical workforce embedding the national 'Talent for Care' strategy; this includes increasing and promoting our apprenticeship workforce as an attractive career pathway entry point and investing in their development **(Director of Nursing, Patient Safety and Quality)**
- Explore and develop more innovative approaches to access registered level training such as Assistant Practitioner pathways, flexible training programmes, accelerated graduate courses **(Director of Nursing, Patient Safety and Quality)**
- Regularly review our current and emergent hard to fill vacancies and consider skills mix variations and different ways of working prior to any recruitment campaign **(All Directors)**
- Work collaboratively with partner organisations to develop new and existing roles across clinical pathways to meet changing service needs, skills shortages and integrated operating models **(Directors of Operations)**
- Work collaboratively with Health Education East, the Deanery and educational providers to identify emerging needs and solutions to meet workforce demands and skills requirements **(Director of Nursing, Patient Safety and Quality / Medical Director)**
- Develop advanced nursing roles (such as Nurse Prescribers, Nurse Consultants) and will explore the role of the Associate Physician to mitigate challenges in recruiting doctors **(Director of Nursing, Patient Safety and Quality / Medical Director)**
- Strengthen our peer support and volunteer workforces and continue to develop effective ways of attracting and retaining them **(Director of Nursing, Patient Safety and Quality)**
- Grow our own workforce by developing clear career pathways across all roles (clinical and non-clinical), clearly identifying progression routes, development and training and education requirements, linking into personal development and succession and talent plans **(Director of Nursing / Director of Strategy and Resources)**
- Research and explore the feasibility of buying education places directly from universities **(Director of Nursing, Patient Safety and Quality)**

Retention

Everything we do links to how engaged staff feel and how committed they are to our Trust. As set out in our Workforce and Organisational Strategy, Putting People First, we want our staff to act as positive ambassadors for the Trust, proud of the work they do and positive about the Trust as a great place to work. Therefore we will:

- Provide opportunities for staff to develop their broader transferable skills and experience (such as involvement in projects, secondments) both within and across partner organisations to ensure we have an identified and ready succession of talented staff **(All Directors)**

- Develop rotational posts and secondment opportunities to broaden experience and knowledge within our clinical areas and, in some circumstances, across our partner organisations **(Director of Nursing, Patient Safety and Quality)**
- Ensure all disciplines of newly qualified clinical Band 5s have access to an Academy during their preceptorship year to support the consolidation of their learning, networking and support **(Director of Nursing, Patient Safety and Quality)**
- Work with our Ward Managers to review expectations of the role and identify development opportunities for current post holders and their successors **(Director of Nursing, Patient Safety and Quality / Director of Strategy and Resources)**
- Develop an innovative, effective and flexible induction process, using technology to best effect and ensuring the corporate and work based elements enhance and add value to the new starter experience; this will include engaging new staff before they start in post through an 'on-boarding' process **(Director of Nursing, Patient Safety and Quality / Director of Strategy and Resources)**
- Review and continually develop our leavers processes to ensure we receive as much effective data and information as possible about why employees are leaving, including those leaving within the first two years of service, using the intelligence to inform our strategic and operational plans **(Director of Strategy and Resources)**
- Work actively with our staff approaching retirement age to encourage and support them to have a more flexible approach to retirement, including returning to practice following retirement **(Director of Strategy and Resources)**

How we will deliver this

Our Trust Strategy 2016 - 21 sets out our operating model and accountability framework. This means that whilst the identified Executive Directors have accountability for implementation of their elements of this strategy; day to day accountability for delivery sits with the Strategic Organisational Development and Human Resources Manager and the Deputy Director of Nursing², with devolved responsibilities for delivery via operational managers led by the Locality and Corporate Services' leadership teams.

However, every member of staff has an essential role to play; as only by working collectively can we achieve this strategy and make our Trust a great place to work and a great place to receive care.

With overall leadership from the Executive Director of Strategy and Resources, the strategy will be managed as a transformational programme of work through the Workforce Mobilisation Board and monitored by the Board of Directors via the Organisational Development and Workforce Committee.

Whilst we will utilise our internal resources for delivery where appropriate and possible, where necessary to support capacity and/or due to specialist skills required, we will procure external support.

We recognise that this is an ambitious strategy and, in recognition of the resource required to deliver it, we have prioritised key areas for delivery across its five year lifetime, aligning them to delivery of our Trust goals of:

- 1: Improving quality and achieving financial sustainability
- 2: Working as One Trust
- 3: Focusing on prevention, early intervention and promoting Recovery

² In relation to the Education and Development elements

Domain	Milestone	Trust Goals*
YEAR 1		
Attraction	Develop an approach and 12 month action plan for utilising social media in alignment with the annual recruitment campaign plan	1,2
	Collaborate approach with bank provider on annual recruitment campaigns	1,2
	Explore and develop sustainable external recruitment routes including: Marketing campaign with schools and colleges. Develop a clinical traineeship programme that offers opportunities of employment at its end, for example Prince's Trust, Veterans Programme	1,2
	Further develop the Newly Qualified Academy, linked to Preceptorship and Edward Jenner Programme	1,2,3
Processes	Review and improve recruitment process using lean methodology	1
	Develop and implement values in all stages of the recruitment process, supported by implementing e-learning and training modules for managers	1,2
	Direct employment of student nurses that have been signed off in placement and who demonstrate our values	1,2
	Develop local workplace induction processes	1,2
Skills Mix and Career Pathways	Continue to develop the Talent for Care pathway	1,2,3
	Develop Apprenticeship Pathway making full use of Apprenticeship Levy	1,2,3
	Continue with engagement with Trailblazer Project, moving to Trailblazer 2 ¹	1,2,3
	Continue with supernumerary Clinical Apprenticeship scheme	1,2,3
	Pilot Nursing Associate Role	1,3
	Develop Flexible Nursing Pathway with further cohorts	1,2,3
	Develop advanced nursing roles, linked to Masters in Mental Health	1,3
	Develop the role of Non-Medical Prescribers	1,3
	Review Clinical Team Leader/Ward manager role	1,2
	Strengthen Volunteer Workforce through the appointment of a Volunteer Manager	1,2,3
Retention	Review, develop and improve leavers' processes	1,2
	Delivery of the revised Induction process involving the Recovery College in co-production	1,2
	Develop plans for rotational posts and secondments across the health and social care system	1,3
YEAR 2		
Attraction	Deliver strategic workforce recruitment plans including links to the Clinical Strategy	1,2
Processes	Review success of values based recruitment processes and explore and develop further values based recruitment initiatives e.g. assessment centres	1,2
Skills Mix and Career Pathways	Clinical Career Pathways developed	1,2

	Embed National Talent for Care Strategy	1,2,3
	Explore and develop buying education places	1,2
	Continue to develop advanced nursing roles and Physicians Associates	1,2,3
	Develop strategic organisational approach to succession planning and talent management and commence implementation	1, 2
Retention	Re-focus on retaining retirees and return to practice initiatives	1,2
	Implement nurse rotation programme	1,2,3
	Implement rotational posts and secondments across the health and social care system	1,3
YEAR 3		
Attraction	Evaluate delivery of strategic led workforce recruitment plans	1,2
Skills Mix and Career Pathways	Develop work experience programme that we market to the schools and colleges with opportunities that we offer	1,2,3
	Clinical Succession Planning established	1,2,3
YEAR 4		
Skills Mix and Career Pathways	Corporate Career Pathways developed	1,2
	Corporate succession planning established	1,2
YEAR 5	Review and develop strategic approach and plans for the next five years	1, 2, 3

Measuring success

In line with the success criteria set out within Workforce and Organisational Development Strategy 2016-21, Putting People First, the following indicators will be used to measure success:

- Vacancy rate stable across service areas and professional groups at 8% by 2021
- Voluntary turnover rate stable across service areas and professional groups at 10% by 2021
- Time to hire (advert to unconditional offer) reduced to 8 weeks (and maintained) by April 2017
- Trainee/student experience improved year on year* measured by survey outcomes and retention rates
- The rate of people leaving the Trust within one year of joining is at 10% or less by 2021
- Our workforce reflects the diversity of the communities we serve
- Our workforce management structure reflects the diversity of our Trust
- We will increase our apprentices to 92 whole time equivalents by 2017 and maintain this year on year at 2.3% of our workforce by 2021
- We will double our volunteers to 64 by April 2017 and then increase year on year to achieve and maintain between 180-200 volunteers by 2021

(FINAL DRAFT V11)
Staff Wellbeing - Our Strategic Approach and Plans 2016-21
'Your Wellbeing First'

Our staff are our most important asset and this document describes our strategic approach to improving their wellbeing for the next five years and beyond. Our ability to retain great people who have the right knowledge, skills, values and behaviours is fundamental to the delivery of our strategic goals set out in our Trust Strategy 2016 – 21 of:

- 1: Improving quality and achieving financial sustainability
- 2: Working as One Trust
- 3: Focusing on prevention, early intervention and promoting Recovery

To achieve this we recognise the importance of supporting our staff to work in healthy work environments, with manageable jobs, and to be as well as they can be, physically, mentally and emotionally, for the benefit of their own welfare and for those they provide care or services to.

We acknowledge the mutual benefits of investing in the health and wellbeing of our staff and the aim of this strategy is that through prioritising staff health and wellbeing we will retain happier, engaged staff which in turn improves patient satisfaction and delivers better outcomes.

Leigh Howlett
Director of Strategy & Resources

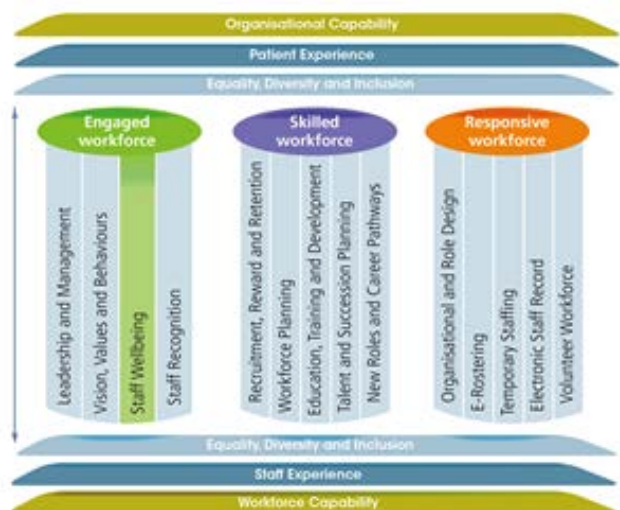
Alison Thomas
Organisational Development Lead

Healthy staff, healthy workplace

The NHS Constitution¹ places wellbeing at the heart of its staff pledges to ‘provide support and opportunities to all staff to maintain their health, wellbeing and safety’. The title of this strategy, Your Wellbeing First, reflects the importance and commitment we place on improving the wellbeing of our staff. It builds upon the progress we have made in the last three years and is informed by national policy and best practice in this area identified by NHS England, NICE Guidelines and the National Workplace Wellbeing Charter.

This strategy has a clear focus on the more direct aspects of staff wellbeing. It also has key interdependencies with other pillars of our Workforce and Organisational Development Strategy, Putting People First 2016-21, in particular, relating to the Engaged Workforce domain of leadership, values and recognition. A number of these pillars are subject to separate existing or emerging strategic approach documents and are therefore not repeated here.

The following diagram shows how this work fits strategically within our overall workforce strategy.



It is a key enabler to the achievement of our strategic Trust goals², as set out below:

Strategic Goal	How this strategy supports this
1. Improving quality and achieving financial sustainability	Through our staff being as physically, mentally and emotionally well as they can be to provide quality services, with increased engagement, reduced absence, turnover and temporary staffing dependency
2. Working as One Trust	With an organisation-wide approach to consistently improving the health and wellbeing of our staff and sharing and implementing best practice;
3. Focussing on prevention, early intervention and promoting Recovery	Through focusing on how we improve wellbeing and prevent ill health, we intervene early when issues arise and we provide appropriate and timely support

¹ (2009)

² Trust Strategy 2016-21

The independent Boorman Review³ into the health and wellbeing of NHS staff stated that “organisations that prioritised staff health and wellbeing performed better, with improved patient satisfaction, stronger quality scores, better outcomes”. We also recognise the following mutual benefits of investing in the health and wellbeing of our staff:

- Improved staff morale
- Increased retention
- Reduced staff turnover
- Improved quality and productivity, impacting financial performance
- Improved reputation as a ‘good employer’
- Reduced sickness absence
- Reduced recruitment and training costs.

In addition, Simon Stevens, Chief Executive of NHS England, identified the following six actions to boost NHS staff health and these are included in our operational plans.

- Provision of NHS Health Checks
- Staff access to physiotherapy and mental health talking therapies, smoking cessation and weight management services
- Provision of healthy eating options in staff restaurants, cafes and vending machines
- Establishing and promoting a local physical activity ‘offer’ to staff and promoting healthy travel to work
- Fully implementing Public Health England’s Workplace Wellbeing Charter and the NICE guidelines on workplace health
- Identify and Board Lead and providing training to all line managers on supporting their staff’s health and wellbeing

As well as being the right thing to do, there is a compelling economic argument for improving the health and wellbeing of our staff. Whilst our sickness absence rate is amongst the lowest in the region for Mental Health Trusts⁴, 61,000 whole time equivalent days are lost within the Trust annually due to staff sickness. This is equivalent to losing 167 full time staff. The direct cost of sickness absence is around £5 million (as at December 2015) at a time when improving quality and achieving financial sustainability is a strategic organisational goal. Our highest cause of absence is due to stress, anxiety and depression. As a mental health Trust, we are committed to doing better in this area.

It is estimated that if, through effective promotion of staff health and wellbeing, we reduced our current absence rate by 1%, we would reduce costs by in excess of £1 million which could be better spent in supporting the delivery of our clinical services. This is better for our staff and is better for our patients.

Our commitment to wellbeing

The Workplace Wellbeing Charter is a statement of intent comprised of a set of standards across eight categories; leadership, absence management, health and safety, mental health, smoking and tobacco, physical activity, healthy eating and alcohol and substance misuse. The key principles of the standards are set out below.

Health and Safety:

- | |
|---|
| <ul style="list-style-type: none">• Demonstrate awareness and compliance with health and safety policies with a clear |
|---|

³ (2009)

⁴ 4.69% to end April 2016

<p>emphasis on ill health prevention.</p> <ul style="list-style-type: none"> • Staff representatives are involved in the development and evaluation of health and safety procedures and all staff and managers have received health and safety training. • The workplace is conducive to health and employee welfare and a risk assessment programme is in place.
<p>Mental Health:</p> <ul style="list-style-type: none"> • Mental health and wellbeing strategies and policies and a stress prevention strategy are in place and being implemented. • Mental health awareness training is available for staff and managers. • Organisational and individual change is accompanied by support, information and targeted interventions. • Social support groups, volunteering and out of work activities are actively encouraged and supported.
<p>Leadership:</p> <ul style="list-style-type: none"> • Senior managers encourage a consistent and positive approach to employee wellbeing. • Managers understand the main issues that impact the health and wellbeing of their team. • Line managers demonstrate regular joint working and shared decision making with employees and empower employees to work in an independent way. • Line managers have relevant leadership and management training including how to have difficult conversations, developing people skills and resolving disputes. • A system is in place that recognises and rewards good work.
<p>Absence Management:</p> <ul style="list-style-type: none"> • Return to work interviews are conducted and recorded with concerns / appropriate support recorded and provided. • Contact is maintained with absent employees to provide support and aid return to work (with appropriate adjustments when necessary). • All managers have participated in absence management training. • Absence trends are monitored and specific programmes are designed and implemented to address the issues and prevent further absence.
<p>Smoking and Tobacco:</p> <ul style="list-style-type: none"> • A working smoke-free policy is in place and staff adhere to it. • 'Stop smoking' services are actively promoted and staff are given time to attend. • All open areas (outdoor) are clearly signposted as smoke-free and steps are taken to prevent smoking in these areas.
<p>Alcohol and Substance Misuse:</p> <ul style="list-style-type: none"> • Employees are aware of the link between alcohol, substance misuse and mental health in the workplace and have access to alcohol awareness training. • Staff representatives are involved in the development and review of the policy which addresses alcohol and other substances. • Managers have access to information on how to identify the signs of alcohol / substance misuse and are aware of where to obtain support or signpost employees.
<p>Healthy Eating:</p> <ul style="list-style-type: none"> • Kitchen facilities or beverage areas are in good condition and conform to the highest possible standards and requirements of food hygiene. • Wherever possible, eating facilities that are clean and user friendly are provided away from work areas. Use of these facilities is promoted to enable regular breaks away from the work area. • All workplaces have access to fresh drinking water. A corporate healthy eating food plan, guidelines or similar has been produced in consultation with staff that covers catering provision, corporate hospitality, local sourcing of food using local providers, vending / in house catering pricing strategy to promote healthy options. Local healthy food availability for staff is considered as part of facilities management. • Tailored programmes to improve understanding and take-up of healthier diets are offered. • Internal or external support is on offer for those who wish to lose weight. • Rolling schedule of planned events to promote the importance of healthy eating are in place.

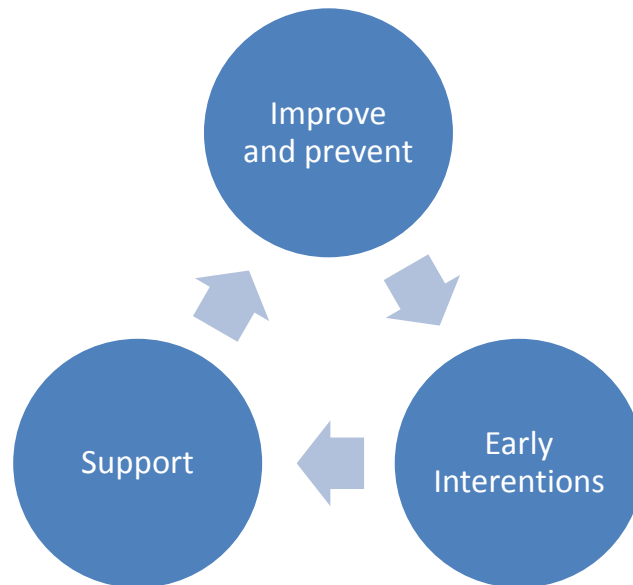
Physical Activity:

- The minimum legally required breaks are taken by all staff.
- Staff are encouraged to take regular breaks.
- Physical activity in the workplace and in the local area is actively encouraged.
- Tailored programmes to improve understanding and take-up of physical activity are offered.
- The organisational travel plan promotes physically active ways of getting to and from work and travelling between meetings.

There are three levels for achievement across each category; commitment, achievement and excellence. Excellence is defined as 'fully engaged leadership with a range of programmes and support mechanisms'. Over the lifetime of this strategy we aim to achieve excellence in each category.

Our Focus

In order we make the right changes, at the right pace, over the lifetime of this strategy we will focus on the three areas shown in the diagram below.

**Improve and Prevent**

We will take a proactive approach to creating a working environment that is conducive to a happy and healthy workforce. We will support our staff to maintain and improve their personal wellbeing and will seek to prevent or reduce issues that can impact their health and wellbeing. Therefore, we will:

- Continue to develop our network of Wellbeing Champions who will raise the profile of health and wellbeing and connect Trust-wide plans and initiatives with local implementation plans that reflect the ideas and needs of staff in their places of work **(All Directors)**
- Support and encourage our staff to access health and wellbeing initiatives including the Healthy Worker programme, resilience training and Mindfulness. This will support the reduction of stress related ill health and provide a supportive environment **(Director of Strategy and Resources)**
- Review workloads and staffing ratios so our staff have manageable jobs; reviewing skill mixes and job roles and working with our commissioners to ensure services are adequately funded **(All Directors)**
- Review our sickness absence policy and reframe this to focus on supporting attendance at work **(Director of Strategy and Resources)**

- Train our managers to support staff, actively promoting wellbeing, and to effectively manage absence **(Director of Strategy and Resources)**
- Increase the profile of our communications to include national and local campaign messages to ensure staff wellbeing remains visible and is at the forefront of management practice **(Director of Strategy and Resources)**
- Make flu vaccinations available to all staff to reduce episodes of related sickness absence and to protect staff and service users **(Director of Nursing, Patient Safety and Quality)**
- We will seek to ensure that staff feel that their job is 'do-able' and that taking a break is actively encouraged to help build resilience and to tackle feelings and reports of work-related stress. We will achieve this through focus/development groups, line manager training, listening events and trust wide campaigns **(All Directors)**
- We will implement the six point action plan of the NHS strategy to improve staff wellbeing **(Director of Strategy and Resources)**
- We will introduce plans to achieve 'excellence' status across all 8 standards in Public Health England's Workplace Wellbeing Charter to ensure we create and promote a healthy workplace **(Director of Strategy and Resources)**
- We will invest an element of the cost avoidance of reducing sickness absence back into supporting staff wellbeing **(Director of Finance)**

Early Intervention

Early intervention involves analysis and research of data, trends and feedback to identify problems and causes for concern. By being aware of problems early we can identify and implement solutions to minimise the negative impacts. Therefore, we will:

- Explore and implement fast-track physical and mental health intervention services for staff to aid wellbeing and reduce sickness absence **(Director of Strategy and Resources / Director of Nursing, Patient Safety and Quality / Medical Director)**
- We will regularly analyse a variety of internal and external qualitative and quantitative data to ensure that we identify trends early and put plans in place to target key areas **(Director of Strategy and Resources)**
- We will regularly benchmark the work we are doing with other organisations to ensure we learn from best practice, also sharing our own good practice amongst the NHS and wider **(Director of Strategy and Resources)**
- Connect the ongoing work of embedding our values and how we have more 'good days' with the impact on staff wellbeing through our Wellbeing Steering Group, wellbeing toolkits and organisational development interventions **(Director of Strategy and Resources)**

Support

Although improvement, prevention and early intervention strategies will reduce the number of reactive situations, there will always be occasions when we need to support staff with new or existing health and wellbeing issues. Therefore, we will:

- Develop an annual calendar of staff wellbeing events to ensuring that there are co-ordinated Trust-wide and local activities and targeted awareness campaigns **(Director of Strategy and Resources)**
- Collaborate with other organisations to support the development and successful implementation our staff health and wellbeing plans **(Director of Strategy and Resources)**
- Ensure that our commitment to staff health and wellbeing is visible and well communicated using a variety of medium including a regular Staff Wellbeing newsletter **(All Directors)**
- Develop and implement a programme of support for staff experiencing mental ill health, including after traumatic or violent incidents at work **(Director of Strategy and Resources / Director of Nursing / Medical Director)**

- Ensure our occupational health services are providing an effective and supportive service to our managers and our staff to not only support the prevention and reduction in absences due to ill health but to also provide timely assessment and advice in the event of a health issues that impacts someone at work (**Director of Finance / Director of Strategy and Resources**)
- Play an active part in challenging and reducing mental health stigma and discrimination by ensuring our Time to Change Pledge action plan is embedded and implemented through our annual operational plans. (**Director of Strategy and Resources/Director of Nursing/ Medical Director**)

Implementation

Our Trust Strategy 2016 - 21 sets out our operating model and accountability framework. This means that whilst the identified Executive Directors have accountability for implementation of their elements of this strategy; day to day accountability for delivery sits with Organisational Development Lead with devolved responsibilities for delivery via the wellbeing champions throughout the organisation.

However every member of staff has an essential role to play as only by taking individual responsibility for our own health and wellbeing, and collectively for the teams and environments we work in, can we achieve this strategy and make our Trust a great place to work and a great place to receive care.

With overall leadership from the Executive Director of Strategy and Resources, the strategy will be managed through the Staff Health and Wellbeing Group who will have responsibility for ensuring that robust annual plans are in place and for monitoring progress. Progress will be monitored by the Board of Directors via the Organisational Development and Workforce Committee.

Whilst we will utilise our internal resources for delivery where appropriate and possible, where necessary to support capacity and/or due to specialist skills required, we will procure external support.

We recognise that this is an ambitious strategy and, in recognition of the resource required to deliver it, we have prioritised key areas for delivery across its five year lifetime, aligning them to delivery of our Trust goals of:

- 1: Improving quality and achieving financial sustainability
- 2: Working as One Trust
- 3: Focusing on prevention, early intervention and promoting Recovery

Domain	Milestone	Trust Goals*
YEAR 1		
Improve & Prevent	Establishment of task and finish working group on supporting staff with mental ill health. Review our sickness absence policy to ensure there is an emphasis on 'Supporting Attendance at Work' and create training for line managers that embeds this approach	1,2,3 1,3
Early Intervention	Implement fast-track access for staff to mental health care Use the results of the trust-wide staff wellbeing survey to target appropriate health interventions	1,2,3 1,3
Support	Workplace Wellbeing Charter: Achieve 'Excellence' standard in Health and Safety and Mental Health Programme of support for staff experiencing mental ill health, including after traumatic or violent incidents at work Prioritise sickness absence training for our managers	1,2,3 1,2,3 1,3

YEAR 2		
Improve & Prevent	Set and achieve objectives in Year 2 plan	1,2,3
	Roll out innovative training programme for line managers on supporting attendance at work trust-wide	1,2,3
	Explore and evaluate options for trust-wide smoking cessation policy	1,2,3
Early Intervention	Analysis of absence data to target specific health interventions to reduce absence and promote wellbeing	1,3
Support	Workplace Wellbeing Charter: Achieve 'Excellence' standard in Leadership and Absence Management	1,2,3
	Tender Occupational Health Services	1,3
YEAR 3		
Improve & Prevent	Set and achieve objectives in Year 3 plan	1,2,3
Support	Workplace Wellbeing Charter: Achieve 'Excellence' standard in Smoking and Tobacco and Alcohol and Substance Misuse	1,2,3
YEAR 4		
Improve & Prevent	Set and achieve objectives in Year 4 plan	1,2,3
Support	Workplace Wellbeing Charter: Achieve 'Excellence' standard in Healthy Eating and Physical Activity	1,2,3
YEAR 5	Review and develop Strategic approach and plans for the next five years	1, 2, 3

Measuring Success

In line with the success criteria set out within Workforce and Organisational Development Strategy 2016-21, Putting People First, the following indicators will be used to measure success:

- Reduction in sickness absence to below 4.5% by April 2017 and to sustain a rate within the lower quartile for Mental Health/Learning Disability Trusts thereon
- To be in the top 20% of Mental Health/Learning Disability Trusts by April 2021 for percentage of staff suffering work related stress in the last 12 months' in the NHS Staff Survey
- Above average scores on key findings associated with staff wellbeing in the NHS Staff Survey for Mental Health/Learning Disability Trusts by 2018, consistently maintaining this by April 2021
- Staff Friends and Family Test results to be consistently above average for Mental Health/Learning Disability Trusts by April 2021
- Achievement of 'Excellence' standard for all 8 standards within the Workplace Wellbeing Charter.

(FINAL DRAFT V12)

**Leadership and Management Development:
Our Strategic Approach and Plans 2016 – 2021**

This document describes our strategic approach to leadership and management development over the next five years and aims to cultivate a leadership climate that makes our Trust a great place to train, work and receive care.

We recognise that strong leadership is key to delivery of our strategic goals set out in our Trust Strategy 2016 – 21 of:

- 1: Improving quality and achieving financial sustainability
- 2: Working as One Trust
- 3: Focusing on prevention, early intervention and promoting Recovery

These goals can only be achieved with an engaged, skilled and responsive workforce that operates within a climate of appropriately skilled, but also supportive, accountable and quality focused leadership.

The aim of this strategy is to develop our managers and leaders of today, supported by a ready pipeline of talented aspiring managers and leaders, with the right skills and behaviours to deliver the transformational change we require to meet the service needs of now and the future.

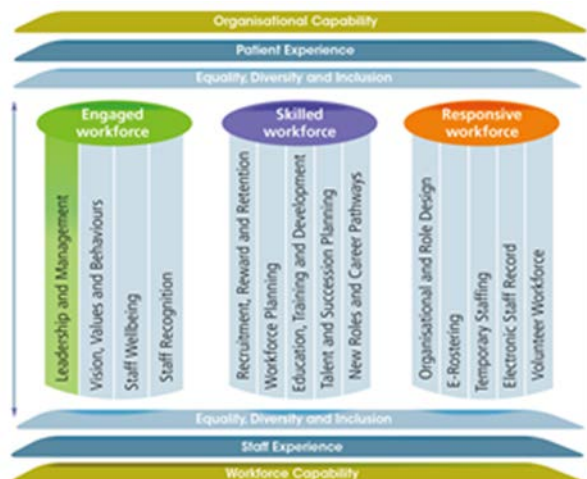
Leigh Howlett
Director of Strategy & Resources

Hannah Edwards
Strategic Organisational Development &
Human Resources Manager

Leadership for our future

Leadership and management are key priorities within the Workforce and Organisational Development Strategy 2016-21 and our aim is to have staff with leadership skills appropriate to their role that encourages innovation, ownership and effective relationships.

Based on research theory and best practice evidence, our Leadership and Management strategy proposes inter-professional leadership development programmes, management development, coaching and mentoring in order to meet our strategic business needs, priorities, vision, values and behaviours. The following diagram shows how this fits strategically within our overall workforce strategy.



We will support a Trust-wide approach, recognising that every individual employed has some responsibility for leadership. The vision is for a culture that values the growth of leaders to enhance patient-focused care at strategic, managerial and individual levels; and sustainable development of appropriate leadership capability and capacity through effective talent management and succession planning.

Our leadership and management development strategy is a key enabler to achievement of our strategic Trust goals¹, as set out below:

Strategic Goal	How this strategy supports this
1. Improving quality and achieving financial sustainability	Through developing a leadership culture of transparency that encourages innovation and openness; accepting responsibility for delivery and outcomes ensuring continuous improvement in all we do, both individually and collectively
2. Working as One Trust	Through alignment of inter-professional leadership development programmes, ensuring understanding at all levels of individual and collective value and one way of working
3. Focussing on prevention, early intervention and promoting Recovery	Through developing a flexible workforce with the right skills to innovate and deliver new clinical pathways and services that involve service users at every stage.

¹ Trust Strategy 2016-21

Listening and Learning

Through independent surveys and listening events, our staff gave us clear direction on what creates a great working environment and demonstrates positive leadership, as shown in the table. Put simply, it is about creating an inspiring environment that is visioning, stretching and encouraging with an inclusive collaborative culture that is trusted and appreciative. These are the themes that will be embedded throughout our leadership and management development.

INSPIRING	
Visioning	<ul style="list-style-type: none"> • Articulate a clear and compelling vision • Engender a feeling of optimism and a positive view of the future • Provide staff with a sense of meaning and purpose to their work • Energise and motivate people to strive for the vision
Stretching	<ul style="list-style-type: none"> • Set challenging but realistic goals • Inspire others to strive for optimal performance • Promote continuous improvement and innovation • Empower people and hold them accountable for performance
Encouraging	<ul style="list-style-type: none"> • Build confidence in those we lead • Provide ongoing constructive feedback • Invest time and resources in developing people • Encourage and reward good performance
INCLUDING	
Collaborative	<ul style="list-style-type: none"> • Invest time in creating and maintaining strong relationships • Encourage openness and sharing of information • Willing to adapt and flex around others • Work collaboratively and seek mutual benefit
Trusted	<ul style="list-style-type: none"> • Do what say will do and keep promises • Honest, genuine and authentic • Open and easy to get to know • Treat others fairly and consistently
Appreciative	<ul style="list-style-type: none"> • Listen and pay attention to others on a personal level • Give praise and appreciation • Show care and consideration to others • Value peoples' strengths and individual differences

Our Focus

We recognise that changing culture and embedding a supportive, inclusive and accountable leadership culture takes time. In order we make the right changes, at the right pace, over the lifetime of this strategy we will focus on the six areas shown in the diagram below.



Leadership Climate

The climate we create as leaders ('how does it feel to be led by me') sets the tone for everything we do as an organisation. We believe that by transforming our leadership climate we can create an environment in which positive change sticks and becomes truly transformational. This is backed by a compelling evidence base which positively links higher levels of emotional intelligence² and higher levels of staff engagement and organisational performance. Therefore, we will:

- Pilot a Leadership Climate Development Programme to increase managers' awareness and understanding of how it feels to be led by them and to support their development to be more inspiring and including (**Director of Strategy and Resources**)
- Review the pilot with a view to delivering this within a workforce wide programme, starting with our leaders (**Director of Strategy and Resources**)
- Ensure that the principles of emotional intelligence and associated behaviours are factored into all of our development programmes (**Director of Strategy and Resources**)

Aspirant Managers and Leaders

Leaders operate at every level of the organisation and do not have to be limited by formal role boundaries. We will develop those who show the talent and commitment to progress into management and leadership roles. Therefore, we will:

- Develop a strategic approach to Talent Management and Succession Planning across the Trust to ensure that we have a pipeline of motivated and capable managers and leaders (**Director of Strategy and Resources**)
- Open up participation in our internal development programmes for aspirant managers and leaders as well as putting identified staff forward to NHS Leadership Academy programmes to support individual development and our succession planning (**Director of Strategy and Resources**)
- Use a values-based 360 feedback model to identify and support individual development needs in line with positive leadership behaviours (**Director of Strategy and Resources**)
- Encourage and enable shadowing of internal or external managers/leaders to benefit the individual's development and to share experiences and learning across the Trust (**All Directors**)
- Develop systems to support and enable opportunities for individuals to take up developmental secondments both within our Trust and across the wider system. This will increase knowledge across departments and organisations, build relationships and support systems leadership (**Director of Strategy and Resources**)
- Develop opportunities for involvement in key project work to support individual development and encourage cross-organisational learning (**All Directors**)
- Encourage attendance at Senior Management Engagement Forum sessions and Annual Leadership Conferences to increase motivation and give individuals opportunities to network and develop their knowledge and skills (**All Directors**)
- Develop an intranet site specifically for management and leadership development which will advertise our offerings, share knowledge and support networking opportunities (**Director of Strategy and Resources**).

Fundamentals for Managers

It is essential we build strong foundations of fundamental management skills to ensure our staff have the knowledge and capability to be effective. This programme will be compulsory for

² For us, emotional intelligence means an individual's ability to recognise their own emotions and the emotions of others and to use this this understanding to guide their thinking and behaviour

everyone in their first management role and will support existing managers who would benefit from some additional or refresher training. Therefore, we will:

- Develop and deliver a modular based fundamentals programme (as shown) to support differing learning styles and mixed capabilities **(Director of Strategy and Resources)**
- Ensure we enhance and embed learning through a variety of opportunities such as action learning sets, coaching and/or group sessions, directed reading and online resources **(Director of Strategy and Resources)**
- Ensure all managers in their first management role attend the Fundamentals Programme and existing managers who would benefit from some additional development **(Director of Strategy and Resources)**
- Set up a bank of trained mentors who have been identified as suitable role models to provide support and guidance to new managers in their first year of management and those managers/leaders who need additional support **(Director of Strategy and Resources)**
- Develop a new managers' induction to set out expectations of our managers and leaders within the Trust, make them aware of the development and tools available and to support their networking and collaboration as a leadership community **(Director of Nursing / Director of Strategy and Resources)**
- Set up networks and forums to support new managers in their first year of management and to encourage relationship building and integrated working and sharing of best practice across the Trust **(Director of Strategy and Resources)**
- Use a values-based 360 feedback model to identify and support individual development needs in line with positive leadership behaviours **(Director of Strategy and Resources)**

Leadership Development Programme

Building on the fundamentals programme and aimed at managers and leaders Band 7 and above, this will be a modular programme based on individual development needs identified through personal development plans and job roles. Therefore, we will:

- Develop and deliver a Leadership Development Programme through a combination of modular workshops, directed reading, on-line tutorials and master classes of the key competencies and behaviours required of a senior leader (clinical and non-clinical) within our Trust. It will focus on leading transformation, delivering an inspiring and inclusive leadership climate. **(Director of Strategy and Resources)**
- Ensure we enhance and embed learning through a variety of opportunities such as action learning sets, coaching and/or group sessions, directed reading and online resources **(Director of Strategy and Resources)**
- Nominate talented staff for NHS Leadership Academy development programmes (supplementing our internal programmes) **(Director of Strategy and Resources)**

Leadership Development Programme Content

- Understanding finance, performance data and using resources effectively
- Leading performance
- Understanding and developing yourself as a leader
- Communicating and influencing with purpose
- Collective leadership
- Commercial awareness
- Innovation
- Clinical leadership
- How to be an effective coach
- How to be an effective mentor

- Deliver a variety of 360 degree leadership feedback tools (including values-based feedback and the Healthcare Leadership Model) to support personal development **(Director of Strategy and Resources)**
- Hold annual Leadership Conferences to support delivery of the collective leadership messages, share good practice and support development **(Director of Strategy and Resources)**

Board Development

Our Board of Directors is responsible for setting the strategic direction of our Trust, inspiring our workforce to strive for this vision and role-modelling supportive, accountable and quality focused leadership. Therefore to support this:

- The Board will ensure annual organisational goals are agreed in time to be cascaded into individual objectives between April and May each year **(All Directors)**
- Personal development needs for Executive and Non-Executive Directors will be identified as an outcome of the annual independent Board review and individual appraisals **(Chair / Chief Executive)**
- We will hold bi-monthly facilitated Board development sessions to increase Board level capability and support strategic planning **(Trust Chair / Chief Executive)**
- Each Executive and Non-Executive Director will have an annual values-based 360 degree review to ensure that the values are driven and role modelled from the top **(Trust Chair and Chief Executive)**
- Healthcare Leadership Model 360 degree reviews will be available to Board members to identify and support development needs and enhance leadership capabilities **(Director of Strategy and Resources)**
- Access to executive coaching and mentoring will be provided as identified through personal development plans **(Director of Strategy and Resources)**
- We will explore and utilise the resources and programmes available through the NHS Leadership Academy and other Director/Board level programmes to increase leadership capabilities **(Director of Strategy and Resources)**

Coaching and Mentoring

We aspire to develop a culture of coaching whereby managers and leaders at all levels of the organisation are equipped with skills to empower staff to explore and resolve issues for themselves, accepting accountability for their own and their teams performance within a supportive framework. Therefore:

- We will develop and deliver coaching methods as a core theme throughout the fundamentals and leadership development programmes **(Director of Strategy and Resources)**
- In addition to tapping into NHS Leadership Academy coaching and mentoring networks, we will develop and train a network of coaches and mentors to provide in-house opportunities to support leadership and management development **(Director of Strategy and Resources)**
- We will provide support, training and facilitate networking opportunities (internal and external) for our in-house coaches and mentors to ensure they are continually supported and developed **(Director of Strategy and Resources and Director of Nursing)**
- We will re-establish the BME coaching and mentoring network, recognising the specific challenges this staff group report to feel **(Director of Strategy and Resources).**

How we will deliver this

Our Trust Strategy 2016 - 21 sets out our operating model and accountability framework. This means that whilst the identified Executive Directors have accountability for implementation of their elements; day to day accountability for delivery sits with the Strategic Organisational Development and Human Resources Manager. However, every member of staff has an essential role to play; as only by working collectively can we achieve this strategy and make our Trust a great place to work and a great place to receive care.

With overall leadership from the Executive Director of Strategy and Resources, the strategy will be managed as a transformational programme of work through the Workforce Mobilisation Board and monitored by the Board of Directors via the Organisational Development and Workforce Committee.

Whilst we will utilise our internal resources for delivery where appropriate and possible, where necessary to support capacity and/or due to specialist skills required, we will procure external support.

To truly support delivery of this strategy, we commit to the continuing development of our Organisational Development (OD) specialists and the broader OD capability within our Trust. This includes increasing the number of staff trained to undertake Healthcare Leadership Model 360 degree assessments as well as other OD tools and interventions.

We recognise that this is an ambitious strategy and, in recognition of the resource required to deliver it, we have prioritised key areas for delivery across its five year lifetime, aligning them to delivery of our Trust goals of:

- 1: Improving quality and achieving financial sustainability
- 2: Working as One Trust
- 3: Focusing on prevention, early intervention and promoting Recovery

Domain	Milestone	Trust Goals
YEAR 1		
Aspirant managers and leaders	Develop and launch a Leadership and Management Development intranet site	1,2
Fundamentals Programme	Implement People Management models from the Fundamentals Programme Prioritise interventions to support the clinical strategy, to include modules from the Fundamentals programmes which support the change process	1,2 1,2,3
Leadership Development	Deliver aspects of the Leadership Programme through Senior Management Engagement Forum as masterclasses Prioritise interventions to support the clinical strategy, to include modules from the Leadership programmes which support transformational change Pilot Leadership Climate Development Programme	1,2,3 1,2,3 1,2
Board Development	Annual review of Board Level development offering	1,2,3
Coaching and Mentoring	Ensure coaching style and approach is integrated into development programmes	1
YEAR 2		
Aspirant Managers and Leaders	Introduction of new managers induction, networks and forums Develop links from the introduction of the Aspiring Managers and Leaders offering through to the plans on talent management and succession planning	1,2 1,2
Fundamentals	Develop and commence the delivery of the remaining modules within	1,2

Domain	Milestone	Trust Goals
Programme	Fundamentals Programme. Introduce Action Learning sets	1,2
Leadership Development	Introduce Action Learning sets	1,2
	Review outcome of pilot and roll out Leadership Climate Development Programme to wider organisation	1,2
	Develop and commence delivery of specialist modules from the Leadership programme e.g. Clinical Leadership, Leading Performance in today's NHS, Finance for Senior Leaders	1,2,3
	Launch of Annual Leadership Conference	1,2
Board Development	Annual review of Board Development offering	1,2,3
YEAR 3		
Aspirant Managers and Leaders	Embed the Aspiring Managers and Leaders offering	1,2
Fundamentals Programme	Full availability of the Fundamentals Programme to all managers	1,2
Leadership Development	Develop and commence delivery of the remaining modules within the Leadership Programme	1,2
	Evaluation of the Leadership climate programme	1,2
Board Development	Annual review of Board Development Offering	1,2,3
Coaching and mentoring	Deliver coaching and mentoring modules from leadership programme and develop internal network.	1,2
	Assignment of a mentor to each new manager	1
YEAR 4		
Fundamentals Programme	Fundamentals Programmes fully available, embedded and evaluated	1,2
	New to Management Support programme fully embedded and evaluated	1,2
Leadership Development	Leadership Programmes fully available, embedded and evaluated	1,2
Board Development	Annual review of Board Development Offering.	1,2,3
Coaching and mentoring	Embed coaching and mentoring culture by developing network (increasing numbers) and increasing use	1,2
YEAR 5	Review and develop Strategic approach and plans for the next five years	1, 2, 3

Measuring Success

We will regularly evaluate and benchmark our management and leadership development programmes to ensure these remain effective and offer value.

Whilst the real success of this strategy will be the successful delivery of our strategic Trust goals, in line with the success criteria set out in Workforce and Organisational Development Strategy 2016-21, the following indicators will also be used to measure the impact of our strategy:

- Our staff engagement score in the NHS Staff Survey to be consistently above average for Mental Health/Learning Disability Trusts by April 2021

- Staff Friends and Family Test net promoter scores to be consistently above average for Mental Health/Learning Disability Trusts by April 2021 with staff recommending the Trust a good place to work and receive and treatment
- A healthy and stable voluntary turnover across service areas and professional groups maintained at 10% by 2021
- Language used by staff at 'Putting People First' listening events will increasingly be in line with our values and behaviours with an improving trend of more positive indicator words than negative indicator words using 'wordles'.
- By April 2021, all senior leaders and managers have accessed leadership and management development support relevant to their needs, with participants and their line managers reporting positive outcomes in terms of the effectiveness of the programmes
- Appraisal rates at 90% by September 2017 and then maintained at 95% and above from September 2018 onwards.

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Norfolk and Suffolk

NHS Foundation Trust

Report To:	Board of Directors – Public
Meeting Date:	23 rd June 2016
Title of Report:	Monitor Self-Certification Statements
Action Sought:	For Approval
Estimated time:	10 mins
Author:	Robert Nesbitt: Company Secretary
Executive:	Robert Nesbitt: Company Secretary

Executive Summary:

Monitor (now NHSI) require FTs to make annual self-certification corporate governance statements. Last month the board made declarations 1 and 2. Declarations 4, 5 and 6 are required by 30.06.16

(Declaration 3 is included in the APR 2016/17 Final Financial Template, which is returned as part of the final operational plan submissions).

1.0 Declarations

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

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

1. Confirmed. (Unchanged from 2015). The risk is that corporate governance standards are not applied consistently. The mitigation is that the Audit and Risk Committee carried out a review of the Trust's corporate governance arrangements against the Monitor Code of Governance Code in 2015/16 and presented the outcomes to the board. A 2015 follow up review by Foresight Partnership provided assurance of progress made in board development following the well-led review in

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	2014.
2. The Board has regard to such guidance on good corporate governance as may be issued by Monitor from time to time	2. Confirmed. (Unchanged from 2015). The risk is that guidance on good governance is not applied. The mitigation is that the Audit and Risk Committee carried out a review of the Trust's corporate governance arrangements against the Monitor Code of Governance Code in 2015/16 and presented the outcomes to the board.
3. The Board is satisfied that the Trust implements:	3. Confirmed (Unchanged from 2015).
(a) Effective board and committee structures;	The Trust regularly reviews the Board and committee terms of references and structures and updates them.
(b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees;	There are clear reporting arrangements for board assurance
and	
(c) Clear reporting lines and accountabilities throughout its organisation.	The Trust has strengthened its operating model to improve organisational accountability.
Overall response for Statement 4(a) to (h): Confirmed (Changed from 2015 on the basis of work on effectiveness over the last year).	
4. The board is satisfied that the Trust effectively implements systems and /or processes:	
(a) To ensure compliance with the Licensee's duty to operate efficiently, economically;	Risks / Mitigating Actions: The Trust improved financial performance in 2015/16 to reduce the forecast deficit from £9.4 to £8.9m and has accepted the control total of £6.1m. The CoSRR is '1' and a FSRR of '2' (in line with plan). For this element the Board therefore declares 'confirmed'.
(b) for timely and effective scrutiny by the Board of the Licensee's operations;	FT4(5)(b) forms part of the Provider Enforcement Undertakings. As a result of changes made to information that comes to the board, changes in Board committee structures, Terms of Reference and committee membership, scrutiny of the Trust's work has improved.

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	For this element the Board therefore declares 'confirmed'. (Changed from 2015 when it was too early to assess impact of changes made).
(c) to ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions;	FT4(5)(c) forms part of the Provider Enforcement Undertakings. The Trust has addressed all of the urgent requirements of the CQC following their inspection in October 2014 and the Trust is licensed to provide services. For this element the Board therefore declares 'confirmed'. (Unchanged from 2015).
(d) for effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern);	FT4(5)(d) does not form part of the Provider Enforcement Undertakings. On the basis of the Board's own scrutiny of the Trust's systems of financial decision-making and controls including the 'going concern' statement and supported by the opinion of the external auditors' report the Board declares 'confirmed' for this undertaking. (Unchanged from 2015).
(e) to obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making;	FT4(5)(e) forms part of the Provider Enforcement Undertakings. This area is addressed by the Trust's Quality Improvement work. Whilst progress has been made it is too early in the process to be able to declare that the progress is sufficient. For this element of the declaration the Board therefore declares 'confirmed'. (Changed from 2015 on the basis of progress made over last year).
(f) to identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence;	FT4(5)(f) forms part of the Provider Enforcement Undertakings. The Board has reviewed the Trust's approach to managing risk, approved a revised risk management strategy and made improvements to these arrangements including the Board Assurance Framework. Internal Audit and has assessed the BAF and risk register assurance as 'Substantial'. For this element the Board therefore declares 'confirmed'. (Changed from 2015 on the basis of progress made over last year).
(g) to generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on	FT4(5)(g) does not form part of the Provider Enforcement Undertakings. However, the financial outturn for 2015/16 was ahead of plan. For this element the board therefore

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such plans and their delivery; and	declares 'confirmed'. (Changed from 2015 on the basis of improvement made over last year).
(h) to ensure compliance with all applicable legal requirements.	FT4(5)(h) does not form part of the Provider Enforcement Undertakings. The Trust has systems in place to identify legal compliance with applicable statute. For this element of the declaration the Board therefore declares 'confirmed'. (Unchanged from 2015).
Overall response for Statement 5(a) to (f) : confirmed (Changed from 2015 on the basis of improvement made over last year).	
5. The systems and/or processes referred to in paragraph 5 should include but not be restricted to systems and/or processes to ensure:	
(a) that there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided;	Risks / Mitigating Actions FT4(6)(a) forms part of the Provider Enforcement Undertakings. The Board has strengthened Board leadership on quality over the past year with new director appointments. For this element the Board therefore declares 'confirmed'. . (Unchanged from 2015).
(b) that the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations;	FT4(6)(b) forms part of the Provider Enforcement Undertakings. There has been significant work on developing the Trust's strategy, planning and discussion making with quality of care as the top priority. For this element the Board therefore declares 'confirmed'. (Changed from 2015 on the basis of improvement made over last year).
(c) the collection of accurate, comprehensive, timely and up to date information on quality of care;	FT4(6)(c) forms part of the Provider Enforcement Undertakings. There has been significant improvement in the availability of information on quality. For this element the Board therefore declares 'confirmed'. (Changed from 2015 on the basis of improvement made over last year).
(d) that the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care;	FT4(6)(d) forms part of the Provider Enforcement Undertakings. As a result of the improvements made in reporting, for this element the Board declares 'confirmed'. (Changed from 2015 on the basis of improvement made over last year).
(e) that the Licensee including its Board actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and	FT4(6)(e) forms part of the Provider Enforcement Undertakings. The Board has put in place a set of actions to improve stakeholder engagement on care quality. These include a new service user and carer involvement strategy and the 'Putting

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	People First' staff engagement work led by the executive director team (both launched in October 2015). For this element of the declaration the Board therefore declares 'confirmed'. (Changed from 2015 on the basis of improvement made over last year).
(f) that there is clear accountability for quality of care throughout the Licensee's organisation including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.	FT4(6)(f) forms part of the Provider Enforcement Undertakings. There has been significant improvement over the last year in the arrangements for escalating quality issues. For this element the Board therefore declares 'confirmed'. (Changed from 2015 on the basis of improvement made over last year).
6. Overall response for Statement 6: Confirmed (Changed from 2015 on the basis of improvement made over last year).	
6. The Licensee shall ensure the existence and effective operation of systems to ensure that it has in place personnel on the Board, reporting to the Board and within the rest of the Licensee's organisation who are sufficient in number and appropriately qualified to ensure compliance with the Conditions of this Licence.	Risks / Mitigating Actions The board has seen significant strengthening of its membership over the last year. The Trust has protected quality and ensured compliance with the licence conditions. For this element the Board therefore declares 'confirmed'. (Changed from 2015 on the basis of improvement made over last year).

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

Gary Page (Chair)	Michael Scott (CEO)
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Other certifications

5 Certification on AHSCs and governance "For NHS foundation trusts: • that are part of a major Joint Venture or Academic Health Science Centre (AHSC); or • whose Boards are considering entering into either a major Joint Venture or an AHSC." "The Board is satisfied it has or continues	Not applicable
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to:

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

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<p>6 Training of Governors</p> <p>The Board is satisfied that during the financial year most recently ended the Trust has provided the necessary training to its Governors, as required in s151(5) of the Health and Social Care Act, to ensure they are equipped with the skills and knowledge they need to undertake their role.</p>	<p>Confirmed. The Trust provides a range of training and development opportunities for governors (overseen by the Education subgroup of the Council of Governors) to enable them to undertake their role.</p>
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Signed on behalf of the Board of Directors and having regard to the views of the governors

Gary Page (Chair)	Michael Scott (CEO)
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2.0 Financial implications (including workforce effects)

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

3.0 Quality implications

3.1 All of the declarations are quality related.

4.0 Equality implications / summary of consultation

4.1 The statements were reviewed with governors at their Planning and Performance Subgroup in May 2016.

5.0 Risks / mitigation in relation to the Trust objectives

5.1 The self-certificate declarations are based on the risks to the Trust objectives as reviewed by the Board in the BAF at its May 2016 meeting.

6.0 Recommendations

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

Robert Nesbitt

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Background Papers / Information

Paragraph 2(b) of licence condition G6

Section 1 – General Conditions

Condition G6 – Systems for compliance with licence conditions and related obligations

1. The Licensee shall take all reasonable precautions against the risk of failure to comply with:
 - (a) the Conditions of this Licence,
 - (b) any requirements imposed on it under the NHS Acts, and
 - (c) the requirement to have regard to the NHS Constitution in providing health care services for the purposes of the NHS.
2. Without prejudice to the generality of paragraph 1, the steps that the Licensee must take pursuant to that paragraph shall include:
 - (a) the establishment and implementation of processes and systems to identify risks and guard against their occurrence; and
 - (b) regular review of whether those processes and systems have been implemented and of their effectiveness.
3. Not later than two months from the end of each Financial Year, the Licensee shall prepare and submit to Monitor a certificate to the effect that, following a review for the purpose of paragraph 2(b) the Directors of the Licensee are or are not satisfied, as the case may be that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with this Condition.
4. The Licensee shall publish each certificate submitted for the purpose of this Condition within one month of its submission to Monitor in such manner as is likely to bring it to the attention of such persons who reasonably can be expected to have an interest in it.

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Report To:	Board of Directors - Public
Meeting Date:	23 rd June 2016
Title of Report:	Annual Report of the Audit & Risk Committee 2015/16
Action Sought:	For approval
Purpose of the Report	To approve the Annual Report on the Committee's work over the 2015/16 year
Author:	Ian Brookman, Non-Executive Director (Chair of the Committee)
Director:	Ian Brookman, NED / Julie Cave, Director of Finance

Executive Summary

The Committee has worked in accordance with and completed its work plan for 2015/16.

Committee membership changed during the year with a new Non-Executive Director and new Finance Directors (Interim for the period August – November and substantive appointment from 1st December).

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

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

1.0 Report Content

1.1 Formal compliance with code of practice

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

1.2 Access to impartial review support and evidence

The Committee has direct access to both external and internal auditors. The Committee's role is to review the control and risk environments, including the Trust's financial systems and annual financial statements. It considers any matters concerning the external auditors, including their value for money reports, and also the adequacy of the Trust's internal audit arrangements. The Committee also has

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responsibility for overseeing the Trust's overall governance arrangements including the Board Assurance Framework (BAF) and Risk Management.

1.3 Committee membership

Membership of this committee is three non-executive directors, and their attendance at meetings is set out below:

	8 Apr 2015	ARA 20 May 2015	10 Jun 2015	12 Aug 2015	14 Oct 2015	9 Dec 2015	12 Feb 2016	8 Apr 2016
John Brierley	✓	✓	✓	✓	✓	✓	✓	✓
Peter Jefferys (Term ended April 2015)	✓							
Marion Saunders	✓	✓	✓	✓	✓	✓	✓	A
Stuart Smith			A	✓	✓	✓	✓	
Ian Brookman						✓	✓	✓
Jill Robinson							✓	✓

1.4 Control Environment

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

Domain	Overall assurance opinion 2015/16	Overall assurance opinion 2014/15	Previous assurance comparison
Finance	Substantial	Substantial	↔
HR / Workforce	Requires Improvement	Requires Improvement	↔
Performance	Requires Improvement	Substantial	↓
Quality	Substantial	Requires Improvement	↑
Governance & Risk	Substantial	Requires Improvement	↑
IT & Information Governance	Substantial	Substantial	↔

The overall opinion is that the Board can take ‘Significant’ assurance from its control environment.

1.5 Committee work during the year

The Committee completed its work plan for 2015/16.

Key aspects of the work the Committee has completed are:

- ❖ Reviewed and recommended the approval of the annual accounts and annual report for 2014/15 to the Board of Directors
- ❖ Self assessment and annual report of the Committee for 2014/15 – which was approved at the June 2015 Committee meeting.
- ❖ Reviewed the accounting policies and timetable for the annual accounts and report for 2015/16
- ❖ Reviewed the Standing Financial Instructions for the Trust.
- ❖ Received the results of the staff counter-fraud survey, and the counter-fraud qualitative assessment and the resulting actions
- ❖ Reviewed the external assurance on the Quality Account for 2014/15.
- ❖ Reviewed the performance of Internal Audit
- ❖ Approved the Internal and External Audit and Counter Fraud plans for 2015/16
- ❖ Approved the Internal and External Audit and Counter Fraud annual reports for 2014/15.
- ❖ Reviewed the Independence letter from the Trust’s external auditors, KPMG, and gained assurance of their independence.
- ❖ Received the Head of Internal Audit Opinion rolling opinion throughout the year
- ❖ Reviewed the Hospitality Register and the Register of Seals
- ❖ Reviewed the redevelopment of the Board Assurance Framework
- ❖ Continued to review the Risk Management Strategy and policies, planning and reporting
- ❖ Continued to monitor losses and special payments
- ❖ Continued to keep under review the IT procurement practices and in particular requested further monitoring reports on the arrangements for replacing photocopiers
- ❖ Received and reviewed regular reports from the head of the Programme Management Office on Quality Improvement progress

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2.0 Conclusion

- 2.1 The Committee has completed its work plan across the 2015/16 financial year. As part of its self-assessment the Committee confirmed its effectiveness in managing and delivering on its terms of reference.
- 2.2 Thanks go to John Brierley for his chairmanship over the year and to the non-executive directors for their work and support to the Committee throughout the year.

3.0 Risk to Trust Objectives

- 3.1 The Audit and Risk Committee has a key role on the oversight of the Trust governance, risk and control environments and seeks to ensure good practices are in place and that actions to address any weaknesses are completed positively and in good time. The follow up of actions and review of controls and best practice are to be continuously reviewed.

4.0 Recommendations

- 4.1 The Board is asked to approve the report.

Ian Brookman

Audit and Risk Committee Chair

31 May 2016

Background Papers / Information

Appendix i: Committee work plan 2015/16

Appendix ii: Terms of Reference 2015/16

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**Norfolk & Suffolk NHS Foundation Trust
Audit & Risk Committee workplan for 2015**

Agenda Item	11 Feb 2015	8 Apr 2015	20 May 2015– Annual Accounts	10 Jun 2015– with Governors	12 Aug 2015	14 Oct 2015	09 Dec 2015
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Pre-meeting		Internal Audit	External Audit	Governors to attend	Clinical Audit		
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Annual Report and Annual Accounts							
Agreement of final accounts and annual report timetable and plans	DoF						
Review of progress on preparation of annual accounts		DoF					
Review and approval of accounting policies		DoF					
Review and approval of audited annual accounts and financial statements (Monitor Code of Governance F3.2)			DoF				
Governance statements			Chief Exec				
Head of internal audit opinion – DRAFT	Chief Internal Auditor (2016)						
Head of internal audit opinion – FINAL			Chief Internal Auditor				
Review and approval of annual report, including: Remuneration report			DoF Trust Sec				
Statement of compliance with Monitor's NHS FT Code of Governance	DoF						
ISA 260 report to those charged with governance			External Audit				

**Norfolk & Suffolk NHS Foundation Trust
Audit & Risk Committee workplan for 2015**

Agenda Item	11 Feb 2015	8 Apr 2015	20 May 2015– Annual Accounts	10 Jun 2015– with Governors	12 Aug 2015	14 Oct 2015	09 Dec 2015
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Governance, Risk Management and Internal Control							
Risk Register exception reporting	Risk Manager	Risk Manager		Risk Manager	Risk Manager	Risk Manager	Risk Manager
BAF development process		Trust Sec					
Review of policies and procedures relating to governance, risk management and internal control. In particular: o Risk Management Strategy & Policy o Risk reporting monitoring and integration (Monitor Code of Governance F3.2)		Risk Manager (2015 only)					Dir of Nursing
Receive the QGC Chair's report	Chair QGC	Chair QGC	Chair QGC	Chair QGC	Chair QGC	Chair QGC	Chair QGC
Legal claims – 6-monthly report				Risk Mgt Coordinator			Risk Mgt Coordinator
Trust Accounts Receivable – 6-monthly report				DoF			DoF
Report on losses and special payments, SFIs / SOs	DoF	DoF		DoF	DoF	DoF	DoF
Counter-fraud							
Approval of Draft Counter Fraud Annual Plan (last approval: Feb 2015)	LCFS						
Approval of Final Counter Fraud Annual Plan (last approval: Jun 2014)				LCFS			
Review of Counter Fraud Progress Updates and Counter Fraud reports • CF interim report	LCFS	LCFS		LCFS	LCFS	LCFS	LCFS

**Norfolk & Suffolk NHS Foundation Trust
Audit & Risk Committee workplan for 2015**

Agenda Item	11 Feb 2015	8 Apr 2015	20 May 2015– Annual Accounts	10 Jun 2015– with Governors	12 Aug 2015	14 Oct 2015	09 Dec 2015
Review of Counter Fraud Performance and Annual Report (last review: Oct 2014)				LCFS			
Results of Annual Counter Fraud survey (last done:)		LCFS					
Report on declaration of interests annual review		Trust Secretary					
Internal Audit							
To receive the draft Internal Audit Plan		Chief Internal Auditor					
To approve the final Internal Audit Plan (last approved: Jun 2014)				Chief Internal Auditor			
Review and approval of Internal Audit Terms of Reference / Charter (last approved: August 2014)					Chief Internal Auditor		
Review of Internal Audit Progress Updates and Internal Audit Reports <ul style="list-style-type: none"> • Interim report • Recommendations follow-up 	Internal Audit	Internal Audit		Internal Audit	Internal Audit	Internal Audit	Internal Audit
Annual Internal Audit report and opinions with an annual review of the internal audit work (last report: Jun 2014)				Chief Internal Auditor			
Draft performance review of Internal Audit (last review: Jun 2014)		A&R Chair / DoF					
Full performance review of Internal Audit				A&R Chair / DoF			

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Audit & Risk Committee workplan for 2015**

Agenda Item	11 Feb 2015	8 Apr 2015	20 May 2015– Annual Accounts	10 Jun 2015– with Governors	12 Aug 2015	14 Oct 2015	09 Dec 2015
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Market testing the IA service from June 2014 – tender spec being developed					DoF		
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External Audit							
External Audit progress report	External Audit	External Audit		External Audit	External Audit	External Audit	External Audit
External Audit reports on Annual Report and Accounts			External Audit				
Agreement of External Audit plans and fees							External Audit
Review performance of External Audit (last review: Jun 2014)				DoF / A&R Chair			
Receive annual statement on non-audit services			External Audit				

Other Assurance Functions							
Review of other reports and policies as appropriate e.g. changes of Standing Orders and Standing Financial Instructions, changes to accounting policies (last review: Feb 2014)	DoF / Trust Sec						

Management							
Declarations of Interest	All	All	All	All	All	All	All
Self-assessment of A&R Committee's effectiveness (last approved: Jun 2014)		A&R Chair (1 st draft)		A&R Chair			

Norfolk & Suffolk NHS Foundation Trust
Audit & Risk Committee workplan for 2015

Agenda Item	11 Feb 2015	8 Apr 2015	20 May 2015– Annual Accounts	10 Jun 2015– with Governors	12 Aug 2015	14 Oct 2015	09 Dec 2015
Review Terms of Reference of the A&R Committee and make publicly available (last review: 12 Feb 2014)	A&R Chair / Trust Sec – to be done every 2 years (next 2016)						
Produce Annual Report of the A&R Committee for BoG and BoD (last approved: Jun 2014)		A&R Chair (1 st draft)		A&R Chair			
Review the Register of Seals (last review: Oct 2014)						A&R Chair / Trust Sec	
Review of the Register of Gifts & Hospitality (last review: Oct 2014)						A&R Chair / Trust Sec	
Produce the attendance report of the Committee members		Deputy Trust Sec					
Review the Committee's work plan	A&R Chair / Trust Sec						
Meeting dates for next year						Deputy Trust Sec	
Last item – “have the most pertinent items of the agenda have been reviewed adequately and at the beginning of the agenda?”	All	All	All	All	All	All	All

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Monitor Code of Governance (March2010) – Section F: Accountability and Audit

F2 Internal Control

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

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

Code provision

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

F3 Audit committee and auditors

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

Monitor's publications, *Audit Code for NHS Foundation Trusts*, *Your Statutory Duties: A Reference Guide for NHS Foundation Trust Governors*, and *Guide for Governors: Audit Code for NHS Foundation Trusts* provide further guidance.

Code provisions

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

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

- ❖ monitor the integrity of the financial statements of the NHS foundation trust, and any formal announcements relating to the trust's financial performance, reviewing significant financial reporting judgements contained in them;
- ❖ review the NHS foundation trust's internal financial controls and, unless expressly addressed by a separate board risk committee composed of independent directors, or by the board itself, review the trust's internal control and risk management systems;
- ❖ monitor and review the effectiveness of the NHS foundation trust's internal audit function;

Norfolk & Suffolk NHS Foundation Trust

Audit & Risk Committee workplan for 2015

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

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

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

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

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

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

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

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

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

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Pre-meeting		Internal Audit	External Audit	Governors to attend			
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Annual Report and Annual Accounts							
Agreement of final accounts and annual report timetable and plans	DoF						
Review of progress on preparation of annual accounts		DoF					
Review and approval of accounting policies		DoF					
Review and approval of audited annual accounts and financial statements			DoF				
Governance statements			Chief Exec				
Head of internal audit opinion – DRAFT	Chief Internal Auditor (2016)						
Head of internal audit opinion – FINAL			Chief Internal Auditor				
Review and approval of annual report, including: Remuneration report			DoF Trust Sec				
Statement of compliance with Monitor's NHS FT Code of Governance	DoF						
ISA 260 report to those charged with governance			External Audit				

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Audit & Risk Committee workplan for 2016 – DUE FOR REVIEW

Agenda Item	12 Feb 2016	8 Apr 2016	17 May 2016– Annual Accounts	10 Jun 2016–	12 Aug 2016 with Governors for external audit	14 Oct 2016	09 Dec 2016
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Governance, Risk Management and Internal Control							
Risk Register exception reporting	Risk Manager	Risk Manager		Risk Manager	Risk Manager	Risk Manager	Risk Manager
BAF development process		Trust Sec					
Review of policies and procedures relating to governance, risk management and internal control (last approved April 2015). In particular: o Risk Management Strategy & Policy o Risk reporting monitoring and integration		Risk Manager					Dir of Nursing
Review risks	A&R Chair	A&R Chair		A&R Chair	A&R Chair	A&R Chair	A&R Chair
Receive the QGC Chair's report	Chair QGC	Chair QGC	Chair QGC	Chair QGC	Chair QGC	Chair QGC	Chair QGC
Legal claims – 6-monthly report				Trust Lawyer			Trust Lawyer
Trust Accounts Receivable – 6-monthly report				DoF			DoF
Report on losses and special payments, SFIs / SOs / Single Tenders	DoF	DoF		DoF	DoF	DoF	DoF
Review QIP Updates	PMO	PMO	PMO	PMO	PMO	PMO	PMO
Review of Fire Policy		Risk Manager					
Receive reports from IG ctte (confirm schedule)		Dir Strat / Res			Dir Strat / Res		Dir Strat / Res

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Emergency Planning Q07 EPRR policy to be reviewed in Oct 17	Resilience Mgr			Resilience Mgr	Resilience Mgr NHS England EPRR Core Standards Submission		Resilience Mgr
Counter-fraud							
Approval of Draft Counter Fraud Annual Plan (last approval: Feb 2015)	LCFS						
Approval of Final Counter Fraud Annual Plan (last approval: Jun 2015)				LCFS			
Review of Counter Fraud Progress Updates and Counter Fraud reports • CF interim report	LCFS	LCFS		LCFS	LCFS	LCFS	LCFS
Review of Counter Fraud Performance and Annual Report (last review: June 2015)				LCFS			
Results of Annual Counter Fraud survey (last done:)		LCFS					
Report on declaration of interests annual review		Trust Secretary					
Internal Audit							
To receive the draft Internal Audit Plan		Chief Internal Auditor					

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Audit & Risk Committee workplan for 2016 – DUE FOR REVIEW

Agenda Item	12 Feb 2016	8 Apr 2016	17 May 2016– Annual Accounts	10 Jun 2016–	12 Aug 2016 with Governors for external audit	14 Oct 2016	09 Dec 2016
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To approve the final Internal Audit Plan (last approved: Jun 2015)				Chief Internal Auditor			
Review and approval of Internal Audit Terms of Reference / Charter (last approved: August 2015)					Chief Internal Auditor		
Review of Internal Audit Progress Updates and Internal Audit Reports <ul style="list-style-type: none"> • Interim report • Recommendations follow-up 	Internal Audit	Internal Audit		Internal Audit	Internal Audit	Internal Audit	Internal Audit
Annual Internal Audit report and opinions with an annual review of the internal audit work (last report: Jun 2015)				Chief Internal Auditor			
Draft performance review of Internal Audit (last review: Jun 2015)		A&R Chair / DoF					
Full performance review of Internal Audit				A&R Chair / DoF			
Market testing the IA service from August 2015 – tender spec being developed					DoF		
External Audit							
External Audit progress report	External Audit	External Audit		External Audit	External Audit	External Audit	External Audit
External Audit reports on Annual Report and Accounts			External Audit				
Agreement of External Audit plans and fees	External Audit						External Audit

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Audit & Risk Committee workplan for 2016 – DUE FOR REVIEW

Agenda Item	12 Feb 2016	8 Apr 2016	17 May 2016– Annual Accounts	10 Jun 2016–	12 Aug 2016 with Governors for external audit	14 Oct 2016	09 Dec 2016
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Review performance of External Audit (last review: August 2015)					DoF / A&R Chair		
Receive annual statement on non-audit services			External Audit				

Other Assurance Functions

Review of other reports and policies as appropriate e.g. changes of Standing Orders and Standing Financial Instructions, changes to accounting policies (last review: Feb 2015)	DoF / Trust Sec						
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Management

Declarations of Interest	All	All	All	All	All	All	All
Self-assessment of A&R Committee's effectiveness (last approved: Jun 2015)		A&R Chair (1 st draft)		A&R Chair			
Review Terms of Reference of the A&R Committee and make publicly available (last review: 12 August 2015)	A&R Chair / Trust Sec – to be done every 2 years (next 2017)						
Produce Annual Report of the A&R Committee for BoG and BoD (last approved: Jun 2015)		A&R Chair (1 st draft)		A&R Chair			

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Audit & Risk Committee workplan for 2016 – DUE FOR REVIEW

Agenda Item	12 Feb 2016	8 Apr 2016	17 May 2016– Annual Accounts	10 Jun 2016–	12 Aug 2016 with Governors for external audit	14 Oct 2016	09 Dec 2016
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Review the Register of Seals (last review: Oct 2015)						A&R Chair / Trust Sec	
Review of the Register of Gifts & Hospitality (last review: Oct 2015)						A&R Chair / Trust Sec	
Produce the attendance report of the Committee members		Deputy Trust Sec					
Review the Committee's work plan	A&R Chair / Trust Sec						
Meeting dates for next year						Deputy Trust Sec	
Last item – “have the most pertinent items of the agenda have been reviewed adequately and at the beginning of the agenda?”	All	All	All	All	All	All	All

Audit & Risk Committee

Terms of Reference – **DUE FOR REVIEW**

Note: The relevant sections of the Monitor Code of Governance are included in brackets and at the end of this document for ease of reference

The NHS LA Monitoring Statement is enclosed at the end of this document for ease of reference

1. Constitution

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

2. Role of the Audit and Risk Committee

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

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- 2.2.2 to provide the Board of Directors with assurance on governance arrangements across the Trust;
- 2.2.3 to ensure the Board Assurance Framework is properly established and monitored;
- 2.2.4 to advise on, and approve, the Annual Governance Statements;
- 2.2.5 to review and monitor Financial Control systems and financial information used by the Trust, including returns to Regulators;
- 2.2.6 to ensure the Annual Accounts are produced in accordance with all relevant legislative and accounting requirements and that sufficient review has been undertaken by management;
- 2.2.7 to ensure the Quality Account is produced in accordance with all relevant legislative and accounting requirements and that sufficient review has been undertaken by management;
- 2.2.8 to ensure both Internal, and External Audit deliver their planned activity, and to review the appropriateness of the planned activity. To ensure recommendations arising from such work are acted on by management. To monitor the joint work of Clinical and Internal Audit; and
- 2.2.9 to provide an Annual Report of the Committee's work to the Board of Directors (see Section 17).
- 2.2.10 to monitor the elements of the Quality Improvement Plan (overseen by the Transformational Project Board) that relates to the Committee and to report on any concerns to the Board of Directors.

3. Membership (F3.1)

- 3.1 Members of the Committee shall be appointed by the Board of Directors, on the recommendation of the Nominations Committee in consultation with the Chair of the Committee. The Committee shall be made up of at least three members. The members will attend at least 50% of meetings during a 12-month period.
- 3.2 All members of the Committee shall be independent Non-Executive Directors at least one of whom shall have recent and relevant financial experience. The Chair of the Board of Directors shall not be a member of the Committee.
- 3.3 Only members of the Committee have the right to attend Committee meetings. However, other individuals such as the Chair, the Chief Executive, the Director of Finance, other Directors, the heads of risk and internal audit and representatives from the finance function will be invited to attend all or part of any meeting, as and when appropriate.
- 3.4 The External Auditors will be invited to attend meetings of the Committee on a regular basis.
- 3.5 Appointments to the Committee shall be for a period of up to three years, which may be extended for two further three-year periods provided the Non-Executive Director remains independent.
- 3.6 The membership of the Committee should be refreshed to ensure that undue reliance is not placed on particular individuals. (A3)

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

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

4. Quorum

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

5. Attendance

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

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

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

6. Authority

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

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

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

7. Frequency of meetings

7.1 The Committee will meet bi-monthly. The Chair's report will be presented at the next full meeting of the Board of Directors highlighting matters requiring the attention of the full Board of Directors. Additional meetings for specific tasks may be arranged with due notice (see paragraph 8).

8 Notice of Meetings

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8.1 Meetings of the Committee shall be summoned by the Secretary of the Committee at the request of any of its members or at the request of the External or Internal Auditors, if they consider it necessary.

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

9. Minutes of Meetings

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

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

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

10. Reporting Responsibilities

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

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

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

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

11. Duties of the Committee

11.1 Governance, Risk Management and Internal Control

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

11.1.2 In particular, the Committee will review the adequacy of:

- ♦ all risk and control-related disclosure statements (in particular the Annual Governance Statements), together with any accompanying Head of Internal Audit opinion, External Audit opinion or other

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appropriate independent assurances, prior to endorsement by the Board of Directors;

- ◆ the underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements;
- ◆ the policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements;
- ◆ the structures, processes and responsibilities for identifying and managing key risks facing the organization, including the Board Assurance Framework;
- ◆ the operational effectiveness of policies and procedures;
- ◆ monitor and review the Risk Register; and
- ◆ review and approve the statements to be included in the Annual Report concerning internal controls and risk management

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

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

11.2 Management

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

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

12 Financial Reporting

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

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

12.1.2 changes in, and compliance with, accounting policies and practices;

12.1.3 unadjusted mis-statements in the financial statements;

12.1.4 major judgemental areas; and

12.1.5 significant adjustments resulting from external audits.

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

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

14. Internal Audit

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

14.1.1 consideration of the provision of the Internal Audit service, the cost of the audit and any questions of resignation and dismissal;

14.1.2 review and approval of the Internal Audit strategy, operational plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the Board Assurance Framework

14.1.3 review and monitor management's responsiveness to the findings and recommendations of the Internal Auditor;

14.1.4 ensuring that the Internal Audit function is adequately resourced and has appropriate standing within the organisation;

14.1.5 annual review of the effectiveness of Internal Audit;

14.1.6 reviewing the annual report of the Head of Internal Audit and reporting relevant matters to the Board of Directors;

14.1.7 to receive from the Director of Finance (annually) an appraisal on the performance of Internal Audit; and

14.1.8 reviewing promptly all reports prepared by Internal Audit.

15. External Audit

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

15.2 The Committee shall develop and implement a policy on the engagement of the external auditor for audit and non-audit services (F3.2, F3.4, F3.6)

15.3 The Committee shall review the work and findings of the External Auditor appointed by the Board of Governors and consider the implications and management's responses to their work. This will be achieved by:

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- 15.3.1 discussion and agreement with the External Auditor, before an audit commences, of the nature and scope of the audit as set out in the Annual Plan, and ensure co-ordination, as appropriate, with other External Auditors in the local health economy;
- 15.3.2 discussion with the External Auditors of their local evaluation of audit risks and assessment of the Trust and associated impact on the audit fee;
- 15.3.3 review all External Audit reports, including agreement of the Annual Audit Letter before submission to the Board of Directors and any work carried outside the annual audit plan, together with the appropriateness of management responses;
- 15.3.4 to assess the extent of the reliance placed on Internal Audit by External Audit;
- 15.3.5 to discuss problems and reservations arising from the External Auditor's work and any matters that the External Auditor may wish to discuss in order to brief the Board of Directors; and
- 15.3.6 to consider the content of any report involving the Trust issued by the Public Accounts Committee or Comptroller and Auditor General and reviewing management's proposed response before presentation to the Board of Directors.

16. Public Disclosure / Whistleblowing (F3.9)

- 16.1 The Committee shall ensure that the Trust's arrangements for its employees to raise concerns, in confidence, about possible improprieties in matters of financial reporting and control, clinical quality, patient safety or other matters are overseen by the Quality Governance Committee.
- 16.2 The Committee shall ensure that these arrangements allow proportionate and independent investigation of such matters and appropriate follow-up action.

17. Other Assurance Functions

- 17.1 The Committee shall review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications to the governance of the organisation. These will include, but will not be limited to, and any reviews by Department of Health Arms Length Bodies or Regulators / Inspectors (e.g., NHS Litigation Authority etc).
- 17.2 The Committee will review the work of other board committees within the organisation, whose work can provide relevant assurance to the Committee's own scope of work. This will particularly include the Service Governance Committee. Minutes from these meetings may form part of the agenda for the Committee.
- 17.3 The Committee will ensure that the Trust has policies and procedures for all work relating to Fraud and Corruption as set out in the Secretary of State's Directions and as required by the NHS Protect.

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- 17.4 The Committee will receive relevant reports from the Trust's Local Counter Fraud Specialist, including their Annual Report.
- 17.5 The Committee will review any proposed changes to Standing Orders and Standing Financial Instructions, and examining circumstances associated with each occasion when Standing Orders are waived.
- 17.6 The Committee will review schedules of losses and compensations.
- 17.7 The Committee will review the Register of Hospitality at least annually.
- 17.8 The Committee will annually review its own performance, constitution and terms of reference to ensure it is operating at maximum effectiveness and recommend any changes it considers to the Board of Directors for approval.

18.0 Annual Report of the Committee

- 18.1 The Committee is required to provide an annual report, which will include (F3.3, F3.5, F3.8):
 - 18.1.1 a specific statement confirming that the draft Annual Governance Statements are consistent with the view of the Committee on the organisation's system of internal control and that it supports the Board of Director's approval of the statement, subject to any reasonable limitations that the Committee may draw attention to;
 - 18.1.2 that the system of risk management in the organisation is adequate in identifying risks and allowing the Board of Directors to understand the appropriate management of those risks;
 - 18.1.3 that the Committee has reviewed and used the Board Assurance Framework and believes that it is fit for purpose;
 - 18.1.4 that there are no areas of significant duplication or omission in the systems of governance in the organisation that have come to the Committee's attention and not been adequately resolved; and
- 18.2 In addition, the report should highlight to the Board of Directors the main areas that the Committee has reviewed and any particular concerns or issues that it has addressed. These should include:
 - 18.2.1 the financial position and financial reporting systems of the organisation;
 - 18.2.2 any major breakdown in internal control that has led to a significant loss in one form or another; and
 - 18.2.3 any major weakness in the governance systems that has exposed, or continues to expose, the organisation to an unacceptable risk.

19. Annual General Meeting of the Trust

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

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20. Other Matters

- 20.1 The Committee shall:
- 20.1.1 have access to sufficient resources in order to carry out its duties, including access to the Trust secretariat for assistance as required;
 - 20.1.2 be provided with appropriate and timely training, both in the form of an induction programme for new members and on an ongoing basis for all members;
 - 20.1.3 give due consideration to the laws and regulations, the provisions of the Combined Code and the regulator, Monitor;
 - 20.1.4 review arrangements for the co-ordination of the Internal and External Auditors;
 - 20.1.5 oversee any investigation of activities which are within its terms of reference and act as a court of last resort.

21. Review of the Terms of Reference

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

Robert Nesbitt

Trust Secretary

03th February 2014

Version Control

Amended to remove Monitor Code of Gov 2013 from Appendix October 2015

Amended to take account of Service Governance Committee becoming Quality Governance Committee September 2015

Amended to take account of creation of Service Governance Committee February 2014

Amended to remove "sub" from Service Governance Committee May 2014

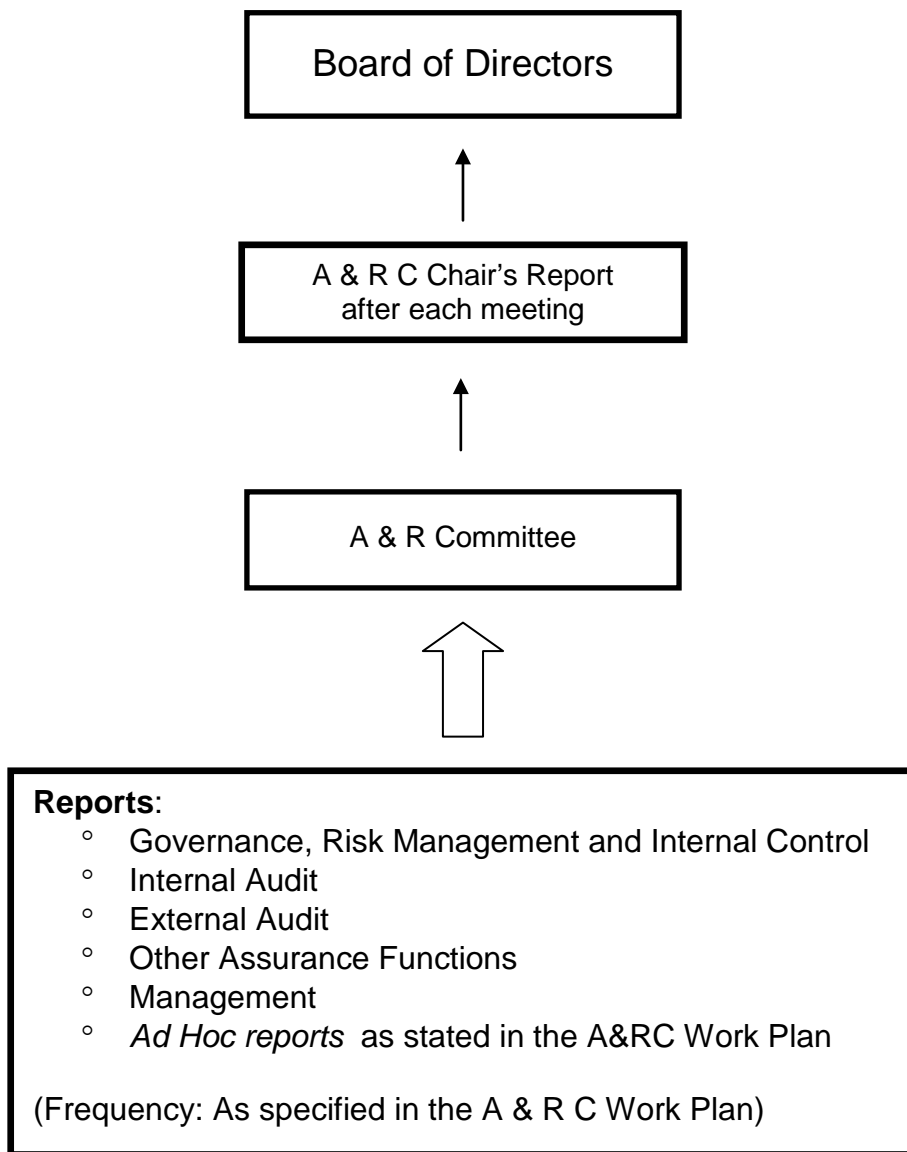
BoD Approved: April 2015, May 2014, Aug 2013, Oct 2011, Aug2010, Aug2009, Apr2008, Oct2006, Aug2006, Jun2006, Nov2004, Oct2003, Jul2002, Jul2001, Apr2000, Jan1998

Original: September 1994

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Monitoring Compliance with this Terms of Reference

Process for Reporting Arrangements to the Audit and Risk Committee (A & RC)



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

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Norfolk and Suffolk

NHS Foundation Trust

Report To:	Board of Directors – Public
Meeting Date:	23 rd June 2016
Title of Report:	Workforce Race Equality Scheme (WRES) Benchmarking
Action Sought:	For Assurance
Estimated time:	5 mins
Author:	Robert Nesbitt: Company Secretary
Director:	Robert Nesbitt: Company Secretary

Executive Summary:

The Workforce Race Equality Scheme (WRES) was introduced in July 2015 and applies to all NHS Trusts. Along with the Equality Delivery System it provides a standardised framework for improving equality in the NHS in line with the public sector equality duties of the Equality Act (2010).

The focus of the WRES is on the experience of black and minority ethnic (BME) staff in relation to racial abuse and in relation fair access to development opportunities in the NHS.

The first benchmarking information is now available for four of the nine indicators, based on the staff survey. The reliability of this first batch of comparative data carries certain caveats.

Overall, NSFT is performing better than most other mental health trusts in the region. However, BME staff still report having worse experiences than White staff on all four indicators.

The report summarises the work undertaken to address these problems.

1.0 Overview of the WRES

1.1 The WRES consists of nine indicators.

The first four are workforce indicators:

- i. Comparison of the percentage of BME staff and White staff in each of the agenda for Change bands 1 – 9 and Very Senior Management (VSM) staffing compared to the percentage of BME and White staff in the overall workforce.

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- ii. Relative likelihood of staff being appointed from shortlisting across all posts.
- iii. Relative likelihood of staff entering formal disciplinary process (two year rolling average).
- iv. Relative likelihood of staff accessing non-mandatory training and continual professional development (CPD).

The second four are NHS staff survey indicators, and is here that we have access to benchmarking information:

- v. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months.
- vi. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months.
- vii. Percentage believing that trust provides equal opportunities for career progression or promotion.
- viii. In the last 12 months have you personally experienced discrimination at work from manager/team leader or other colleagues?

The final indicator is board representation:

- ix. Boards are expected to be broadly representative of the population they serve.

1.2 We have comparative information for indicators v. to viii.

1.3 It should be noted that because the indicators use percentage measures. As the absolute numbers in each sample is relatively small a change of a few points can have a marked effect on the overall percentage. The graphs below should be interpreted in the light of this caveat.

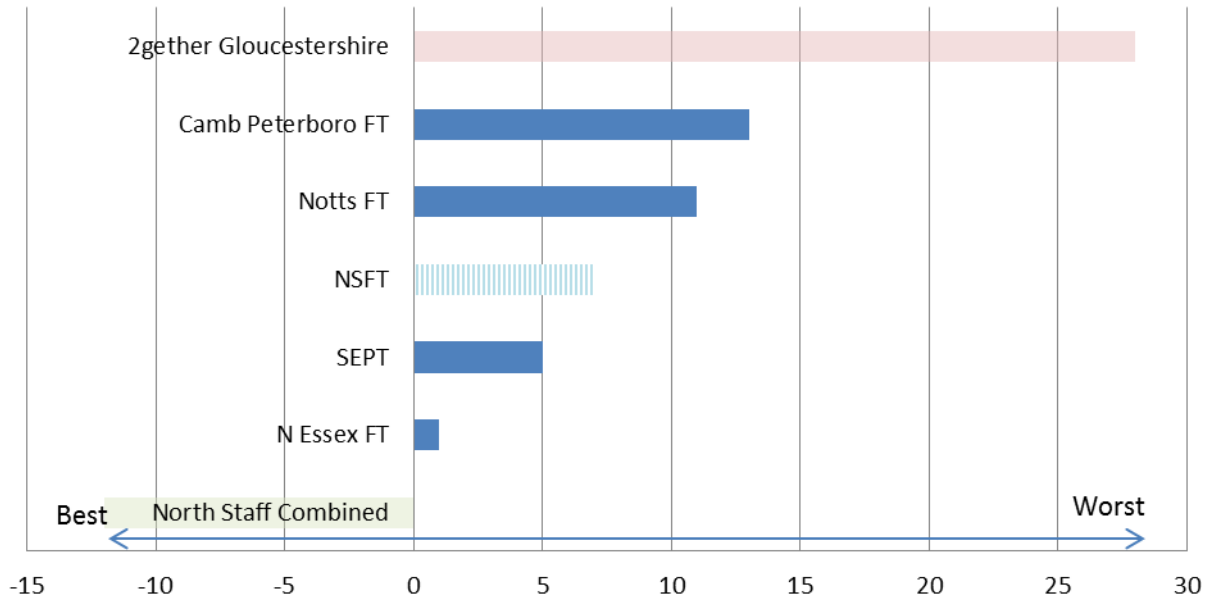
2.0 Benchmarked findings

To help interpret the scores, each graph contains data for seven Trusts including NSFT. These are: the highest and lowest scoring Trusts, NSFT's score and the scores of the mental health trust in the region, and the score for our buddy trust in Nottinghamshire. The x scale measures the gap between BME and white staff self-reported experience.

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2.1 Indicator 5

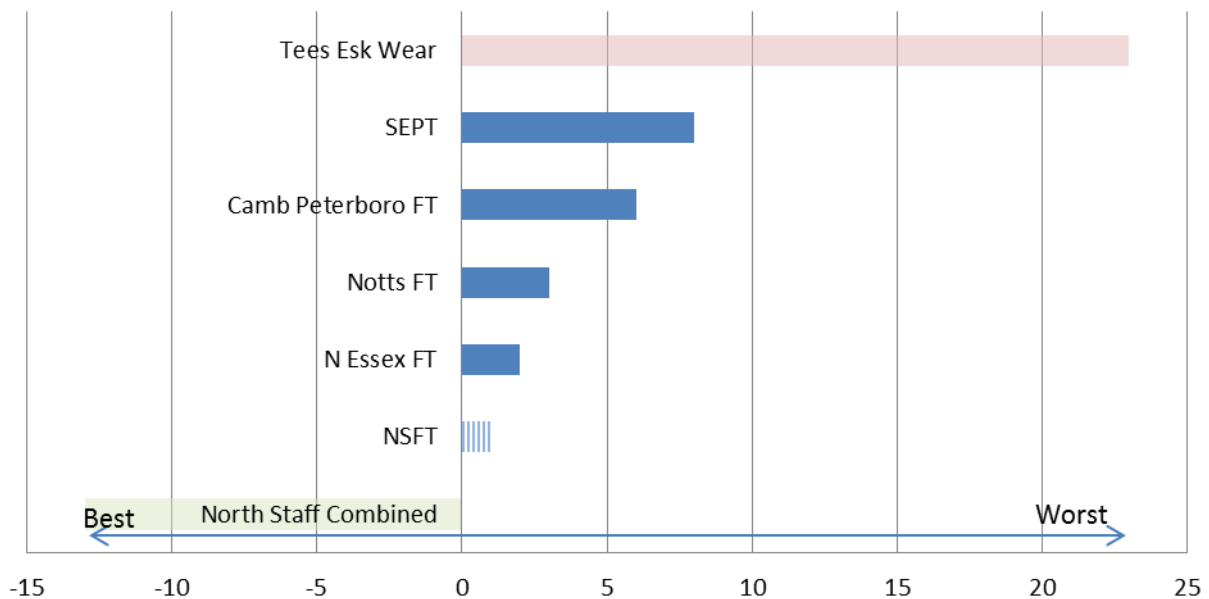
%age of staff who report experiencing harassment, bullying or abuse from patients, relatives or public in last 12 months



Graph 1 - Indicator 5. %age of staff who report experiencing harassment, bullying or abuse from patients, relatives or public in last 12 months

2.2 Indicator 6

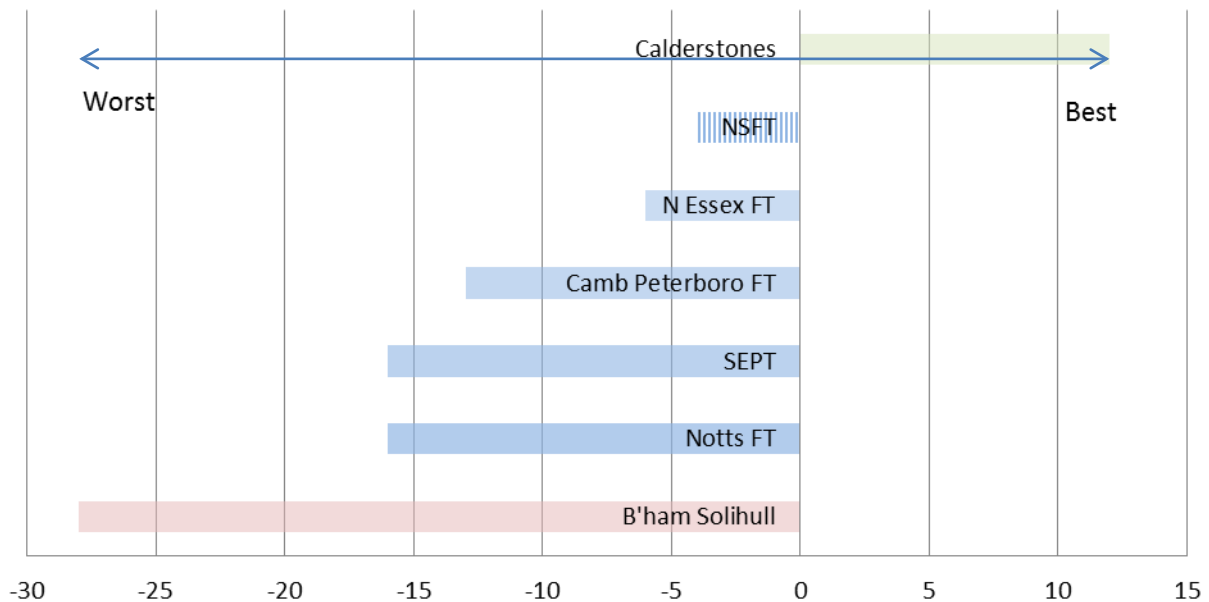
%age of staff who report experiencing harassment, bullying or abuse from staff in last 12 months



Graph 2 - Indicator 6. %age of staff who report experiencing harassment, bullying or abuse from staff in last 12 months

2.3 Indicator 7

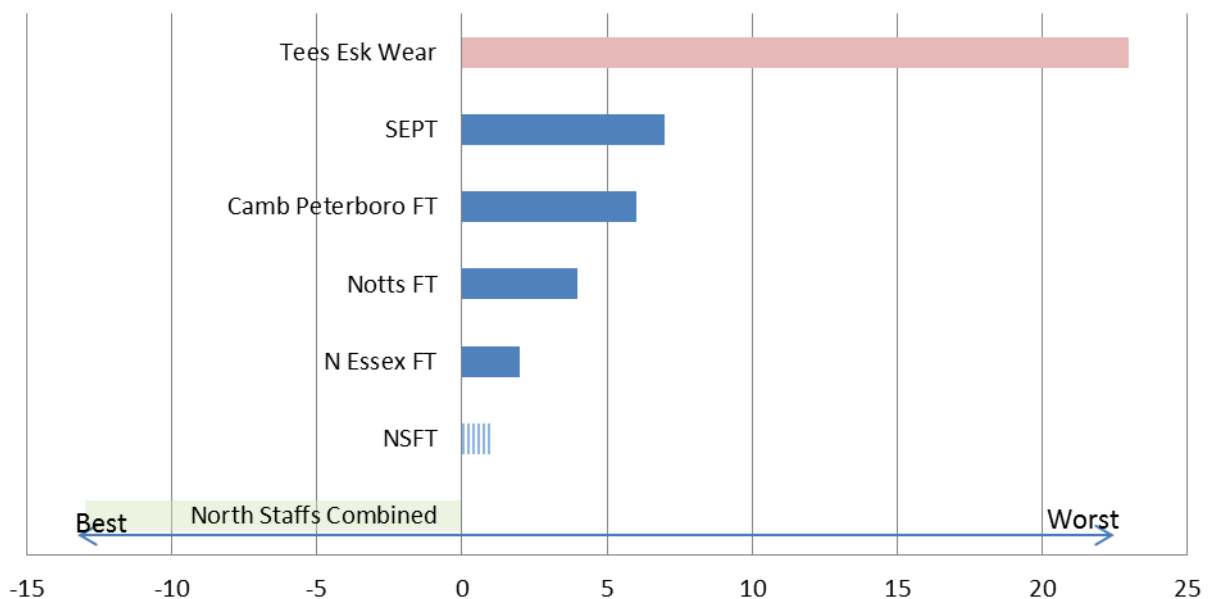
%age of staff who believe that trust provides equal opportunities for career progression or promotion in past 12 months



Graph 3 – Indicator 7. %age of staff who believe that trust provides equal opportunities for career progression or promotion in past 12 months

2.4 Indicator 8

Personal experience of discrimination from manager or colleagues in last 12 months



Graph 4 – Indicator 8. Personal experience of discrimination from manager or colleagues in last 12 months

3.0 Quality implications

- 3.1 The benchmarking graphs show that BME staff report higher levels of abuse and discrimination than White staff. The degree of difference is highest for staff experiencing abuse from patients, carers and the public. The experience of BME staff is less negative in NSFT than in other Trusts but it is still a cause for concern.
- 3.2 We were already aware of this problem through the Trust’s bi-annual staff equality survey which we have been carrying out since 2010 (in SMHPT) and 2012 in NSFT. In response to the issues of racial abuse and discrimination towards staff we have been proactive in introducing several initiatives.
- 3.3 The first step was to improve reporting (Datix reports in 2012 were low – possibly because staff did not think there was any point in reporting an incident).



The “*Spot it – Report it*” campaign improved reporting and was built upon by the next campaign “*Challenge, Educate and Support*” and by the introduction of equality leads across the Trust. Datix reports of abuse are reviewed by the Head of Equalities and Engagement and are followed up by an email to ask if further support would be helpful. The reports are also reviewed by the Equality & Diversity Group (EDG).

The third step was the introduction of face to face equality and diversity training with an emphasis on unconscious bias. The roll out of this training has now begun and there has been a strong take up of the training by staff. Staff will attend this training once every three years.

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3.4 The WRES and EDS are overseen by the bi-monthly Equality and Diversity Group which reports to the Quality Governance Committee in relation to service issues and to the OD and WF committee in relation to workforce issues. Progress on the WRES will be therefore be reported to the ODWF committee.

4.0 Equality implications / summary of consultation

4.1 Although the focus of the WRES is on race, there are transferrable benefits for the whole workforce since a culture that is fair and responsive to individual needs and preferences is one that promotes wider staff engagement.

4.2 The EDG reviewed all the WRES indicators at its meeting on 06.06.16 and a report from this meeting including next steps for improvement will be received by the next ODWF committees

4.2 The next NSFT staff equality survey (which covers all protected characteristics) will take place over the summer and will report in autumn 2016.

5.0 Risks / mitigation in relation to the Trust objectives

5.1 Promoting equality for our workforce supports our goal of improving quality.

6.0 Recommendations

6.1 The board is asked to note the assurance provided in this report on initiatives to address BME staff experience of racial abuse and discrimination.

Robert Nesbitt
Company Secretary

Background Papers / Information

WRES national policy guidance:

<https://www.england.nhs.uk/about/gov/equality-hub/equality-standard/>

Complete benchmarking report:

<https://www.england.nhs.uk/wp-content/uploads/2014/10/WRES-Data-Analysis-Report.pdf>

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Norfolk and Suffolk

NHS Foundation Trust

Report To:	Board of Directors (Public)
Meeting Date:	23 rd May 2016
Title of Report:	Medical Education
Action Sought:	For Assurance
Estimated time:	10 minutes
Author:	Bohdan Solomka Medical Director
Director:	Bohdan Solomka Medical Director

Executive Summary:

The balance between providing leadership and training versus service provision is a significant challenge highlighted in this report.

1.0 Report contents

1.1 Medical Education issues

- 1.1.1 **Director of Medical Education / Core Trust Programme Director.** The Trust appointed Dr Trevor Broughton as DME/Core TPD, who started the role in May 2016.
- 1.1.2 **Junior Doctor Contract.** In May, the BMA and NHS Employers announced an proposed deal regarding the new contract following negotiations. Trainees will be voting on the deal on 6th July 2016.
- 1.1.3 **Releasing trainees to attend MRCPsych course.** Trainees in one part of the Trust have been unable to attend the MRCPsych course in Cambridge due to their on-call commitments and compensatory rest periods intervening in the time available for attendance. The problem developed when their on-call rota changed from a 1:8 to a 1:7 due to a vacancy. A number of attempts have been made to ensure the trainees attend the course, which is a mandatory component of their application to enter for higher qualifications. The DME is assured by the Management Team that they are committed to releasing trainees to attend the MRCPsych Course and it is clear that trainees are not saying that they are being stopped by their Tutors or Supervisors from attending the course. Arrangements for additional medical support to allow trainees to attend courses are being put in place..

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- 1.1.4 **Statutory and Mandatory Training for doctors.** CT and ST Doctors are as a group below 60% in their completion. The target is to achieve 90% by September 2016. One cause is the historical lack of clarity between Educational and Clinical Supervisors and Locality/Service Managers as to who is responsible for ensuring this training is completed. DME, MD and Training Manager to meet to clarify the rules and responsibilities.
- 1.1.5 **Medical Educator's Appraisal.** The Trust is on course to complete the Appraisals of all consultants with responsibilities for supervising doctors in training by end July 2016. Job planning for Medical Educators has been taking place.
- 1.1.6 **On call and doctors in training.** Ending arrangements for new trainees 'shadowing' an established NSFT trainee have been agreed. New rules around on call and rest periods are to come in with the new contract, but we are unable to report the details in this paper. Verbal update will be given at the meeting.
- 1.1.7 **SIFT and provision of medical undergraduate teaching.** On 29th April the UEA wrote to NSFT to highlight the poor performance of teaching for Undergraduates provided by NSFT, the concerns about the length of time it has taken to make changes and the plan by UEA to reduce placements and therefore funding to NSFT for provision of teaching. NSFT acknowledged these difficulties and has a plan to restructure the medical undergraduate teaching structure. This will need greater collaboration between finance, training, operations and MD/UG Lead. Job planning for consultants has been taking place that ensures that medical undergraduate teaching is written in as protected time. 11 job plans are yet to be completed with undergraduate and trainee teaching / supervision written in. This will provide the full picture of teaching provision around the Trust and allow decisions to be made about distribution of funds for teaching time protection.

2.0 Financial implications

- 2.1 A key issue is the release of senior medical staff to fulfil leadership roles: teaching, management and liaison with relevant agencies / stakeholders. Back-fill is not funded from a budget – apart from the DME – so leadership is a cost pressure on the service that has the medical leader. The cost pressure has been agreed. Recruiting into back-fill to protect medical leadership time is not straightforward. Provision of sufficient admin resource to lead clinicians and DMDs has also been a challenge.

3.0 Quality implications

- 3.1 Within the last year, NSFT has been inspected by HEEoE (June 2015) and the GMC (November 2015), and no areas of serious concern were found.

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3.2 A number of recommendations were made by these inspections as well as the UEA for undergraduate training, and Action plans are in place for these three sets of recommendations. An update on the completion of these plans will be provided for the next OD&W meeting and BoD in September.

4.0 Equality

4.2 The GMC will have requirements for Trusts to collect information about the protected characteristics of medical staff. They are interested in such data to measure and understand how protected characteristics impinge on career progression, higher qualification attainment, turnover, complaints and concerns.

4.2 The Trust is developing a database that will capture this information – WRES – which should be compatible with GMC requirements. Medical Director will link up with the E&D lead and HR to ensure this remains compatible with GMC and Trust requirements.

5.0 Risks / mitigation in relation to the Trust objectives

5.1 A key risk to the Trust's finances and reputation is the concern from UEA about the poor performance of NSFT's teaching to medical undergraduates. There is a proposal by UEA to remove students, therefore funding, away from NSFT to other providers. Significant funding and organisational restructure is expected by UEA. NSFT is considering how to undertake this restructure.

5.2 Service delivery pressures are having an impact on trainees accessing training. This is likely to continue, with gaps in rotas caused by CT and ST vacancies.

6.0 Recommendations

6.1 For the committee to note this report.

Name Bohdan Solomka

Title of Author Medical Director

Background Papers / Information

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Norfolk and Suffolk

NHS Foundation Trust

Report To:	Board of Directors
Meeting Date:	23 rd June 2016
Title of Report:	Summary of progress against CQC Quality 'must' and 'should' do's.
Action Sought:	For information
Estimated time:	10 minutes
Author:	Sue Barrett: Head of Governance
Director:	Jane Sayer: Director of Nursing, Quality & Patient Safety

Executive Summary:

Following the comprehensive Care Quality Commission (CQC) inspection of the Trust in October 2014, reports were received for each core service in addition to the Trust overall. They identified a number of actions that the Trust 'must do' or 'should do' and these actions formed the core of the quality improvement plan that was subsequently developed.

This report provides an update against each 'must do' or 'should do' in addition to a summary of actions against the areas where concerns remain.

The report also identifies the top three areas of risk to the Trust compliance with the fundamental standards and therefore a risk to securing a good outcome from the next inspection. These are:

- Staffing: impacts on morale, compliance with policy and process, training, supervision and appraisal
- Weak accountability
- Impact of Lorenzo performance issues.

The Board is asked to note this report.

1.0 Introduction

- 1.1 Following the CQC inspection in October 2014, a further Trust-wide inspection is expected to commence on July 11th and take place over two weeks because of the wide geographic area to be covered. This is required in line with the current inspection model as the Trust is rated as inadequate.
- 1.2 Following the inspection, the Trust received an overall report as well as a further ten reports for the core services we provide and a report for eating disorder services which did not receive a rating as they are not a core service.
- 1.3 Each report identified a number of 'must do' actions and 'should do' actions which were collated to form the quality improvement plan (QIP) which has been actioned by the project management office (PMO).
- 1.4 This report will identify and report progress against the must and should do's. In addition it will identify any risks of non-compliance with the fundamental standards.
- 1.5 It should also be noted that the inspection in July 2016 will also include NRP which was not included in 2014. As guidance has now been issued by the CQC, the service will receive a rating and they have been working closely with the governance team to review the standards, carry out a mock inspection and ensure that the necessary improvements are made.

1.6 The Trust has also been advised that an inspection will be made of the criminal justice liaison teams. These teams are part of a national pilot and as they are not a core service will not receive a rating. The team leader has been working with the head of governance to map the fundamental standards to the team and to identify any urgent action that may need to be taken.

1.7 There is also the possibility that the CQC may, in conjunction with Ofsted, undertake a review of the 'Statement of Educational Need/ Disability' (SEND) arrangements for the Trust and the head of governance and CAMH's lead are working with the lead commissioners to ensure the Trust is prepared if that happens.

2.0 Areas for improvement outlined in the CQC report

2.1 The CQC must and should do's are detailed in Appendix 1 along with the evidence detailing actions and improvement since their visit in October 2014.

3.0 Analysis of progress

3.1 All progress is measured through the Mobilisation Boards, reporting to the Transformation Programme Board. Quality Improvement Plans (QIP) are RAG-rated on milestones, risks, finance, KPIs and an overall rating. Each QIP is assigned to a Board sub-committee where progress is examined, and reported to the Board of Directors monthly.

3.2 For many of the must and should dos, there has been good progress, and although only a small number are signed off as complete (seven), this is because many of the actions require continuous embedding and monitoring.

3.3 There are four QIPs that are currently at red status:

- Supervision and appraisal (QO018): data recording has meant that compliance is not able to be robustly monitored. This is currently being urgently addressed.
- Review of in-patient bed requirement (QO031 and 031a): there are many interdependencies involved, and this QIP is now a priority for the Estates Mobilisation Board. An external review of bed provision is being arranged to inform an options appraisal on bed numbers.
- Management of Section 17 leave (QO048): although risk assessment and recording is in place, completion and sharing of forms remains an issue. The use of ward administrators in this task has been beneficial, and will be replicated across the Trust.

4.0 Main Risks

4.1 Whilst a significant amount of work has been achieved since the last inspection, some underlying risks remain which impact on the ability to embed and sustain improvements. The three highest risks of non-compliance for the Trust (and reported on in the Board Assurance Framework) are:

- Staffing, this impacts on morale, compliance with policy and process, training, supervision and appraisal
- Weak accountability
- Impact of Lorenzo performance issues

4.2 All risks have plans in place to resolve in the medium to long term, and mitigate in the short term, and are monitored regularly.


5.0 Recommendation

5.1 The board is asked to note this report.

Sue Barrett
Head of Governance
1st June 2016


Evidence on areas for improvement outlined in the CQC report

Key: S=Safe
E=Effective
R=Responsive
W/L=Well Led

Key	Area for improvement	Evidence for change	Relevant QIP (if applicable)
1 S	The Trust must have an effective system to share learning from incidents in order to make changes to patients care and reduce the potential for harm to patients	<p>Development and use of 5 key learning points posters</p> <p>Safety bulletin</p> <p>Patient Safety newsletter</p> <p>Standard governance agenda</p> <p>The Trust has a system in place but feedback evidences that there is wide diversity across teams as to how the information is shared at team level. The 5 key learning posters are updated monthly to identify the relevant learning. There have been good examples of sharing learning from incidents, particularly unexpected deaths, however this needs further embedding.</p>	QO014
2 S	The Trust must ensure that medicines prescribed to patients who use the service are stored, administered, recorded and disposed of safely.	 <p>Copy of Medicines Management Monitori</p> <p>The new heatmap is evidencing much improvement in this area.</p>	QO032
3 S	The Trust must ensure that action is taken so that the environment does not increase the risks to patients' safety.	<p>Blickling ward has now moved to Beach and Blickling is no longer in use.</p> <p>Walker Close has had some modification, and the de-escalation rooms are now used appropriately. A capital bid is awaiting approval by NHSE for service transformation.</p> <p>Norvic Clinic redesign plans in place, and steps taken to address immediate concerns.</p> <p>There are now regular meetings between estates department and operational and clinical teams.</p> <p>All in-patient accessible bathroom ligature reduction grab rail installations</p>	QO004 QO035



Key	Area for improvement	Evidence for change	Relevant QIP (if applicable)
		<p>Window modifications made to 14 wards and clinical areas (including Carlton Court, Thurne, Glaven and Waveney Wards Safe Vent window replacement programme)</p> <p>Wedgwood House £1.18m upgrade to mitigate ligature risk</p> <p>Tier 4 acute ward upgrades for Carlton Court</p> <p>All in-patient areas issued with booklet for easy identification of ligature issues that have been agreed with staff and risk management. Booklets are live documents and are updated by estates when new risks identified through assessment programme or removed.</p>	
4 S	The Trust must ensure that action is taken to remove identified ligature risks and to mitigate where there are poor lines of sight.	<p>All immediate concerns addressed.</p> <p>A programme of ligature removal has been implemented and ligature assessments carried out across the Trust. Parabolic mirrors have been used in some areas to improve lines of sight.</p> <p>Ligature booklets for each ward rolled out to identify risks including those to be managed by ward staff.</p>	<p>QO002</p> <p>QO003</p> <p>QO043</p>
5 S	The Trust must ensure there are enough personal alarms for staff and visitors and carry out and document regular checks of emergency equipment.	<p>Personal alarms now in place. Mock inspection showed 97% compliance with one ward having alarms on order, these are now in place.</p> <p>Matrons' checklist shows good compliance with checks of emergency equipment.</p>	QO001
6 S	The Trust must ensure that all mixed sex accommodation meets guidance and promotes safety and dignity.	<p>Poppy and Avocet female only lounges provided.</p> <p>Seclusion area at Wedgwood actively managed (policy in place).</p> <p>Bedroom on Sandringham ward decommissioned.</p> <p>Seclusion area at Norvic actively managed (policy in place)</p>	<p>QO005</p> <p>QO006</p>
7 S	The Trust must ensure that seclusion facilities are safe and appropriate and that seclusion and restraint are managed within the safeguards of national	<p>Monthly seclusion audits demonstrate that the quality of paperwork has shown a modest improvement from 73% to 76% over the course of the year but this has been affected by the implementation of Lorenzo.</p> <p>Seclusion has reduced from an average of 61 to 52 per month (15% reduction).</p> <p>Seclusion remains an area of concern for the Trust. The policy has been reviewed on a</p>	<p>QO007</p> <p>QO008</p>

Key	Area for improvement	Evidence for change	Relevant QIP (if applicable)
	guidance and the MHA Code of Practice.	<p>number of occasions and compared with policies from other Trusts to ensure that it is as simple as possible. Despite coaching sessions provided by the matrons, seclusion remains a complex area which some staff struggle to manage. It is however imperative that this continues to improve to ensure compliance with the MHA code of practice as well as promoting the safety and dignity of patients.</p> <p>The new code of practice (2015) stated that seclusion should only take place in dedicated facilities; this means that some areas which do not have facilities are unable to comply. Work is currently underway to provide additional facilities on Whitlingham and Rollesby wards (for completion end June 2016) but seclusion continues to occur occasionally in other areas. Guidance sent out to CQC inspectors indicates CQC does not expect all services to have dedicated seclusion facilities available as there may be valid reasons why they are not needed. Regardless of location, services must recognise when a patient is being secluded. This is important to make sure that they are following the guiding principles of the Code and this is monitored rigorously by Matrons and governance staff.</p> <p>The Code of Practice changes also brought in a definition of long-term segregation. In the absence of national guidance, the Trust took the decision in June 2015 to classify any seclusion longer than 72 hours as long term segregation. This definition is not used in other Trusts. The policy states that this is not automatic but triggers discussions, and a review of care and treatment plan, with commissioners' involvement. We believe this is an example of good practice.</p> <p>The seclusion facility on Earlham ward was criticised in the last inspection because it is necessary to manage both genders in the same area. Whilst the new plans for the unit address this, an interim management policy is in place to manage the situation.</p>	
8 S	The Trust must ensure there are sufficient staff at all times to provide care to meet patients' needs.	<p>Over the past year we have implemented e-roster across all our inpatient units. Significant support from the e-rostering team has been available, including one unit where they undertook three rounds of centralised rostering to understand all the local rules and their impact on rotas. This has not been easy as some staff felt disadvantaged by this and long standing issues with rosters and working patterns have had to be addressed.</p> <p>However as managers have become familiar with e-roster, the use of temporary staff is starting to reduce as we utilise staff and skill mixes to make sure people are rostered, and work their contracted hours, in the most productive way.</p> <p>Data for the end of 2015-16 shows a vacancy rate of 10.81% against a stretch target of 8%</p>	Recruitment and Retention Strategy

Key	Area for improvement	Evidence for change	Relevant QIP (if applicable)
		<p>(11.41% in March 2015), one of the lowest in mental health.</p> <p>However some areas and geographic locations remain harder to recruit to. We have a new recruitment and retention strategy which outlines our five year plan and are utilising a variety of methods to attract people such as social media and a specialist micro site which shows what a great place to live and work our counties are. We are actively targeting schools and colleges and recognise we will need to do more to 'grow our own' workforce.</p> <p>A safer staffing review in 2015 led to a two million pound investment in additional staff. This led to deterioration in our financial position however the Board supported this investment in quality and safer care. This review has been repeated to ensure the levels reflect any changes to bed numbers or acuity of patients and levels are being reviewed accordingly.</p>	
9 S	The Trust must ensure that there are robust policies and procedures that keep staff and patients safe in the community.	<p>Policies reviewed with staff.</p> <p>Compliance with lone worker policy at mock inspection was 75%</p> <p>Check list introduced to ensure service users are followed up when staff are unwell.</p> <div style="text-align: center;">  <p>Q12a Non-access Visits and Missed or C</p> </div> <p>DNA policy in use.</p>	QO012
10 R	The Trust must ensure that people receive the right care at the right time by placing them in suitable placements that meet their needs and giving them access to 24 hour crisis teams.	<p>Thurne ward opened with 12 beds in use, and a further three beds planned for opening shortly.</p> <p>Alternative to admission beds commissioned.</p> <p>We are currently using beds at Mundesley Hospital, which means that people do not have to travel long distances, and we are able to review care regularly. The governance team has visited and the bed management team routinely check on feedback from service users at the hospital.</p> <p>We continue to have regular meetings each Friday to ensure we use Trust beds more efficiently. We have started to hold a daily Silver Call to check capacity and demand; and to make decisions regarding bringing service users back from Mundesley. Each Locality reviews OOA service users on a weekly basis and this is also discussed at the Silver Call. The number of out of area placements has come down, (11 as at 14/6/16). We have</p>	QO013 QO016

Key	Area for improvement	Evidence for change	Relevant QIP (if applicable)
		<p>noticed an increase in the number of service users admitted to Hellesdon Hospital who are of no fixed abode. Currently 1 ward has 40% occupants of no fixed abode. This is also discussed at our regular Friday meetings, with other agencies including Social Services.</p> <p>24 hour crisis teams remain a commissioning issue for young people and older people.</p> <p>Information has been disseminated to ensure staff are able to articulate that they have mitigating plans in place.</p>	
11 R	The Trust must review the unallocated cases in community services and ensure that there is an allocated care coordinator	<p>There continues to be waiting list pressure due to the ongoing upward trend in referrals. This is currently subject to joint investigation with Central Norfolk commissioners that is breaking down the waiting list into service lines and localities. Central Norfolk's Adult Community Services are implementing a revised operation model, introducing improved collaborative working with primary care, to achieve a more sustainable balance between demand and service capacity in the medium to long term. In the short term, where there are waiting lists, these are being managed through regular contact, risk reviews and prioritisation if there is escalation of needs/risk.</p> <p>To manage unallocated cases (127 cases as at 14/06/16) Norfolk North AFI supporting South AFI on a daily basis with triage phone calls. This is already utilising any available clinical capacity in North. Additional actions are:</p> <ul style="list-style-type: none"> • Band 7 CTL started 13/06/16 in South. Following short period of induction and orientation will be focused on caseloads reviews to increase capacity in wider team. • Band 6 agency member of staff due to start 15/6/16 who will be allocated to AFI function in South/City. Daily contact with NHSP re agency requests. (Only 1 appropriate candidate put forward in last couple of months via agency from NHSP) • 2 x Band 7 Clinical Nurse specialist appointed on 20th May. 1 due to commence 1/8/16. The other is internal candidate current working in NNUH liaison (MH to lobby for early release). These appointments will enable rapid review of service users where there are no complex prescribing needs. Pilot in the North on time to wait for meds review had seen reduction from 3 months to as little as 2 weeks. Pilot in the South not successful due to long term sickness and ultimate resignation of post holder. Issues with Medics in the South have compounded issue. • Locum consultant to extend contract by 4 weeks to provide additional clinic time into AFI to allow reviews and discharge (shared post between North and South and some 	QO016

Key	Area for improvement	Evidence for change	Relevant QIP (if applicable)
		<p>GP practice responsibility in South to backfill consultant colleagues with organisational responsibilities).</p> <ul style="list-style-type: none"> • Rolling programme of recruitment to Band 6 posts however turnover of Band 6 staff has recently peaked with 5 wte equivalent band 6 staff and 2 wte band 5 left the service and Trust in last 3 months in South. Recruitment of new staff currently unable to match demand from leavers (recruitment has been offset by resignations however new staff are still being attracted to South/City). New model will see some role redesign and new posts including Community Pharmacist, Peer Navigator, Clinical Nurse Specialist along with recent consideration of enhanced admin support for senior staff to increase face to face time with service users. Much recruitment is internal which has delayed start dates due to pressure on other service lines. • New model has increased numbers of Clinical Team Leaders from 4 to 7 to enable enhanced team working. • Audit of managed waiting list due at end June 2016. • Ad hoc use of overtime to enhance capacity has been considered but would require a regular commitment over a sustained period of time and case-holding responsibility to be effective and manage risks. • Issues are recorded on risk register • Further locum medic in South Locality would support further risk reduction in South City CCG areas. <p>FACT teams in place</p> <p>Waves pilot in place in Norfolk for people with personality disorder.</p> <p>Crisis line in Norfolk funded on an ongoing basis.</p> <p>Investment in community staffing achieved in 2016/17 commissioning round.</p> <p>The data provided for the quality account shows that there were 280 people waiting over 18 weeks during 2015-16. This is now managed and those waiting are offered support from wellbeing groups or by the ability to contact duty workers who have clinical oversight and can re-prioritise if necessary.</p> <p>This improvement is noted against the year on year increase in referrals to secondary care</p>	

Key	Area for improvement	Evidence for change	Relevant QIP (if applicable)
		and wellbeing services.	
12 E	The Trust must ensure that a 'standard operating procedure' is introduced to manage effectively the interface between the various community services provided.	<p>SOP in place in Suffolk and Norfolk</p> <div style="display: flex; justify-content: space-around; align-items: center;"> <div style="text-align: center;">  <p>Suffolk Operating Framework Mental He</p> </div> <div style="text-align: center;">  <p>Norfolk Pathway v2.pdf</p> </div> </div>	Reviewed and updated in line with Clinical Strategy.
13 E	The Trust must ensure that all risk assessments and care plans are updated consistently in line with multidisciplinary reviews.	<p>An audit in May 2016 demonstrated improved service user and carer engagement in completion of risk and care plans but partial compliance on full data input which required further investigation as to if this was a data collection issue, a performance issue or a combination of both.</p> <p>Subsequent review of the data and discussions by relevant parties have identified that many staff were not authorising documents on the system (as they didn't realise they needed to) and as such more people than identified do have a valid care plan.</p> <p>To address this further work is required (and is underway) by the informatics and operational teams on inclusion of all of clinical note statuses in the data warehouse.</p> <p>In making these additions our compliance figures would be more accurate and would provide a meaningful report with which ongoing DQ of care plans could be monitored by localities. For example, a decision could be made on how long a care plan should be 'draft' and those which fall outside of this could be targeted for completion. You would also be able to see if there were any in other statuses (such as 'incomplete'), or duplicates against a record which need tidying up.</p>	QO012

Key	Area for improvement	Evidence for change	Relevant QIP (if applicable)
		<p>Ultimately all of this will lead to better compliance, improved service user records and more confidence in the report figures. This in turn will enable practice to be reviewed and ensure quality standards are met and continually improved.</p> <p>This quality of the information in care plans would be handled separately via supervision and clinical reviews.</p> <p>To help this further protected time is now in place for teams to complete their care plans and check on the quality.</p>	
14 E	The Trust must carry out assessments of capacity and record these in the care records	<p>Policy updated to provide additional guidance.</p> <p>Awareness week planned for 13/6/16.</p> <p>Mandatory training compliance at the end of April was, Mental Capacity Act, 72.6%. Deprivation of Liberty Safeguards 71.89%</p> <p>Lorenzo documentation / template approved and in place from May 2016.</p> <p>New QIP is in development for 2016/17 quality plan around recording of capacity.</p>	QO048
15 E	The Trust should ensure all staff including bank and agency staff have completed statutory, mandatory and where relevant specialist training	<p>Data for the end of May 2016 shows Trust staff compliance with statutory, mandatory training at 82% against a target of 90%. There is a plan in place to continue the upward positive trend over the past months and achievement of the 90% target in year.</p> <p>The Trust only uses approved framework providers (mostly via NHSP) who ensure that their staff are trained to our specifications. Local inductions take place with bank and agency staff to familiarise them with both Trust policy and local working practices, such as the ligature plan and fire policy. The Trust undertakes monthly spot checks on agency compliance with training in addition to the regular framework audits.</p> <p>NSFT has put together a mental health specific package for NHSP to deliver.</p> <p>Basic LD awareness package to be made available and this will also be shared with partners.</p> <p>Investment in specialist training for staff working with eating disorders has been made.</p>	QO042
16 E	The Trust must ensure all staff receive regular supervision and annual	The appraisal rate at the end of 2015-16 is 61% though due to a data collection system failure a manual audit was undertaken and not all areas have returned their data. As such we know this figure does not reflect every appraisal undertaken. An interim measure is now in place until we fully roll out ESR in Q3 of 2016/17 as the long term solution for all our	QO018

Key	Area for improvement	Evidence for change	Relevant QIP (if applicable)
	appraisals.	<p>workforce data. Corporate areas being used as the pilot for ESR to ensure a smooth roll out to clinical areas.</p> <p>Feedback from the Senior Management Engagement Forum indicates that staff feel the new values-based appraisal paperwork is an improvement, and that objectives are easier to monitor. The new system clearly identifies the things to be discussed at supervision meetings in the year ahead, providing a rolling appraisal record throughout the year. Supervision can only currently be measured through manual data collection. A new data collection process is being put in place from June 2016.</p>	
17 R	The Trust must ensure that they provide people with the right information about services and that this is in the right format for the individual.	<p>Posters in other languages and easy read posters are in place around the Trust.</p> <p>Information can be translated as required via PALS</p> <p>Easy read information available as part of the 'accessible information' standards. This is being led within the Green Light Toolkit project.</p> <p>Communication packs for people with LD/autism being developed.</p> <p>Intranet site http://intranet.nsf.nhs.uk/Trustprogramme/greenlighttoolkit/Pages/Easy-Read.aspx</p>	QO041
18 E	The Trust must ensure that proper procedures are followed for detention under the Mental Health Act and that the required records relating to patient's detention are in order.	<p>Monitored through a monthly heatmap. The heatmap shows some improvement, with targeted action in place to resolve residual issues.</p> <p>Adopted as a quality account priority for 16/17</p>	QO048
19 E	The Trust should ensure that arrangements for patients taking section 17 leave are clear for their safety and that of others.	<p>Monitored through a monthly heatmap. The heatmap demonstrates that compliance with requirements is still partial and this is reflected in the CQC MHA visits. In particular service users and carers are not given copies of the forms, and risk assessments are not consistently reviewed. S.17 compliance is logged as a risk on Datix and managers for non-compliant wards have been asked to put a plan in place to rectify the problem by 30.06.16.</p> <p>Adopted as a quality account priority for 16/17</p>	QO048
20	The Trust should ensure that patients who are detained	Information included in the patient leaflet given to all detained patients.	QO048

Key	Area for improvement	Evidence for change	Relevant QIP (if applicable)
E	under the Mental Health Act have information on how to contact the CQC.	Posters on wards with CQC contact details. Complete.	
21 W/L	The Trust must review the delivery of their vision and values to ensure they are understood and owned by all staff.	<p>In March 2015 the Trust began its journey to identify values and behaviours that all our staff and service users could identify with. The project was called Putting People First (the name chosen by staff) and the consultation involved around 1300 staff and service users and over 2000 hours of listening to develop the values of Positively, Respectfully, Together. These key words are supported by a set of behaviours developed alongside so every member of staff knows what is expected of them, and every service user can know how they should be treated.</p> <p>We launched these at our AGM by the staff and service users involved in developing these, leading to one of the best AGMs we have ever had.</p> <p>The roll out of management training to support these began in November 2015; with the intention that managers cascaded them to their teams so everyone had a clear picture of what this meant to them. By the end of April 16, 125 of 198 teams have their training completed or booked with the rest being planned. A second round of listening event are being planned for September onwards to benchmark the changes in staff perception and impact of the values work when compared to the previous year.</p> <p>This is a significant organisational development and cultural change which will take time to make the difference we know it can, however the values run through everything we do now and we are confident we are already seeing improvement.</p>	Putting People First programme – now in OD & Workforce Strategy
22 W/L	The Trust must ensure that there are systems in place to monitor quality and performance of the teams.	<p>Significant improvement to quality governance process developed through 2015-16, and there is now a standard governance agenda in place from Board to team level, to ensure consistency of information and process.</p> <p>Performance review groups held monthly, these however need to be strengthened with more focus on quality issues. This will be completed by end July 2016.</p> <p>The quality dashboard has been updated, and the framework for a balanced scorecard agreed, with development for implementation in September 2016.</p>	Governance Improvement Plan
23 E	The Trust must review its procedures for maintaining records, storage and	Implementation of Lorenzo in May 2015 has meant all or staff can now access a service users clinical record 24/7. This is a huge improvement on the many disparate IT systems and paper records we had a year ago.	QO019 Lorenzo Programme

Key	Area for improvement	Evidence for change	Relevant QIP (if applicable)
	accessibility including out of hours provision	<p>To support this further, access to historical paper records is provided through the Windip system and the health records team provide a scan on demand service for anyone returning to service. A full programme of scanning is underway for the remaining 200k records we have.</p> <p>We have access to the previous IT systems so historical electronic data can be accessed whenever required so no information has been lost.</p> <p>We recognise that when someone turns up in crisis they cannot always tell our staff if they have been in contact with us previously. To support our clinicians we have developed a patient look up system which draws data from every clinical system that has been/is in operation in the Trust so we can see if someone is known to us and where this information is, leading to safer and more effective care.</p> <p>We have rolled out the summary care record which gives a much fuller picture and assists us in joining the mental and physical health agenda for all our service users.</p> <p>Whilst the implementation has been challenging, staff do acknowledge the benefits of having one clinical system.</p> <p>We recognise that the system has had a number of problems which our outside of the Trust's control and have held CSC robustly to account for this. This has included the European Management team coming to a Trust Board to explain what they were doing to address our concerns.</p> <p>We continue to actively work with the supplier to resolve performance issues and make further improvements to the system.</p> <p>Now that staff are more familiar with the system more bespoke training has been launched.</p>	Board
24 S	The Trust will ensure that all staff working with vulnerable adults and children have a DBS check completed	<p>All new staff have a DBS check and are now signed to the alert system.</p> <p>Peer reviews and mock inspections have not identified staff who report not having received a check.</p> <p>Complete.</p>	Recruitment and Retention Strategy
25 S	The Trust must address the identified environmental health and safety concerns in	<p>Hellesdon 136 suite refurbished.</p> <p>Northgate 136 suite refurbished.</p>	QO034

Key	Area for improvement	Evidence for change	Relevant QIP (if applicable)
	the health-based places of safety	The mock inspection results demonstrated that the 136 suite on Lark ward entrance can still be overlooked from the car park but this is unresolvable given the layout of the site.	
26 R	The Trust will review its procedures for admitting young people to services out of area placement arrangements	Children's transformation plans in place but commissioners yet to agree funding. Plans in Norfolk to move the inpatient unit and create additional bed capacity due to open autumn 2016. For eating disorder services in Suffolk, new services work with people in their homes and a protocol has been agreed with acute providers to help manage eating disorder presentations. In Norfolk, the eating disorder service is in place and staff recruited.	QO029 QO030
27 R	The Trust will review their engagement processes for young people, staff and others for the planning and delivery of specialist community mental health services for children and young people across the Trust	Youth council continues to participate in Trust strategy, recruitment and service development. New youth governors are in place. Involvement in the review and plans for new services in Carlton Court as above.	QO017 QO038
28 R	The Trust will review their engagement processes for staff and others for the planning and delivery of Trust wide services/specialised eating disorder services	In Suffolk, inter-agency stakeholder workshop held with managers and team involvement. Ongoing discussions with commissioners to develop the model. In Norfolk, investment as part of the CAMHs local transformation plan. Partnership working with BEAT and eating matters. Ongoing education programme for primary care and acute colleagues. Strong consultation model of involvement with service users and carers.	CAMHS Transformation Plan
29 R	The Trust will ensure that there is a clear admission criteria for the service	Mock results showed that only 59% of teams had an operational policy. This will be part of the new initiative around the Trust-wide bed management programme, now approved by the Transformation Programme Board. Targeted to start July 2016.	Estates Mobilisation Board
30 R	The Trust should ensure they review the out of hours arrangements with the commissioners for young	Joint multi systems approach with Norfolk County Council and third sector providers. Scoped project to provide 24 hour cover shared between NCC and NSFT. Implementation date to be agreed.	QO037

Key	Area for improvement	Evidence for change	Relevant QIP (if applicable)
	adults age 14-18	Suffolk has demonstrated a reduction in out of area placements as a result of a pathway review meeting targeted objectives.	
31 R	The Trust will look at contingency arrangements in the autism diagnostic service for Suffolk to manage the build-up of the waiting list to this service	The waiting list at the time of inspection had built up because this was a newly commissioned service. A contingency plan is in place but there is no waiting list. Complete.	N/A
32 R	The Trust will review the provision of in-patient beds to ensure that the needs of the local population are met	This work is ongoing and consists of two work-streams, one for general beds and one for PICU beds. This will be part of the new initiative around the Trust-wide bed management programme, approved by the mobilisation board in June 2016. Review of PICU beds being supported by buddy Trust, meeting in July. National benchmarking data to support this work being collated.	QO031 QO031a QO037 QO055
33 R	The Trust will review the provision of their single bedded health based place of safety units in the light of the potential demand for this service.	The data for April to August 2015 was reviewed in October 2015. This identified that no additional beds were required. Complete.	N/A
34 E	Outcome measurement tools will be used to assess appropriateness and effectiveness of care and treatment provided	Outcome tools are used across the Trust and these are being standardised as part of the clinical strategy.	QO022 Clinical Strategy development
35 E	The Trust will ensure that all physical healthcare monitoring forms are completed and acted upon where relevant	Implementation of physiological workbook training. 100% compliance with annual health checks reported March 2016. Annual audit shows 91% compliance with physical healthcare checks on admission. New document developed based on feedback from staff.	QO023 QO024
36	The Trust will review its provision of duty and crisis	Training compliance discussed at supervision.	QO042

Key	Area for improvement	Evidence for change	Relevant QIP (if applicable)
E	services for young people to ensure that staff undertaking assessments have the appropriate skills to ensure this is carried out to an appropriate standard	<p>Specific training needs identified at appraisal.</p> <p>Specific training needs can be raised with the training department and commissioned if required.</p>	
37 E	The Trust will ensure that the good example of health-based place of safety monitoring information seen at one unit is used throughout this service	<p>New form developed and implemented.</p> <p>Complete.</p>	N/A
38 W/L	The Trust will take steps to address the low morale of staff	<p>Specific HR & OD actions in the past 15 months are:</p> <ol style="list-style-type: none"> 1. An approved OD and workforce strategy which has been well received and commended by NHS England stating our workforce and OD plans for the next five year in support of the overarching Trust strategy. 2. Fully recruited to the HR team (from a base line of 60% temporary staff) who have made a significant impact on helping our managers delivering the HR targets: all of which are moving in the right direction. 3. Provided robust monitoring of all HR targets for every level, from Board to ward with clear action plans for places where we know managers are not managing. 4. Delivered a leadership and management strategy and recruitment and retention strategy all scheduled to go to June Board for final approval following Trust wide consultation. 5. Delivered a new wellbeing strategy which has been nationally recognised. This is supported by 70 new volunteer wellbeing champions across the Trust who can access funding to make changes in their areas to support staff wellbeing. 5. Continued improvement in the time to hire reducing it to less than 90 days, a 30 plus day reduction with further improvements expected. 6. Put in place a new medical staffing team to support our medics at whatever stage of their careers. 	Putting People First programme – now in OD & Workforce Strategy

Key	Area for improvement	Evidence for change	Relevant QIP (if applicable)
		<p>7. Undertaken a Trust wide survey on what it is like to be managed within our Trust which, together with the staff survey, has informed our leadership strategy.</p> <p>Our staff survey was disappointing in that we remain in the lower quartile for several areas. However, one positive was that we were the most improved Trust in numbers of staff taking part with a 16% improvement so our staff are now more willing to tell us what we need to change to make the Trust a better place to work. All these now form part of both Trust wide and local service delivery plans.</p>	
39 R	The Trust will ensure that patients and staff are fully informed about the timeline for the closure of the ward and the new model of care at Carlton Court	Complete.	QO033
40 R	The Trust should communicate the future of learning disability services to staff	Complete.	N/A
41 S	The Trust should improve staff understanding of the governance structures	<p>Matron structure reviewed and deputy matrons in place.</p> <p>Governance awareness workshops provided.</p> <p>Governance business partner allocated to each locality to attend governance meetings and performance review groups.</p> <p>Standardised locality governance agenda.</p> <p>Masterclasses in nursing academy for newly qualified staff.</p> <p>Following a mini well-led review by NHSI in May , 2016 further improvements will be delivered by September 2016 to ensure that quality governance improvements from central committee to locality governance teams are also embedded at team level.</p>	QO015
42 W/L	The Trust will improve staff engagement as many staff in mental health community teams felt disconnected from	<p>Over the past 15 months there has been a robust programme of executive and non-executive team visits to services which are reported back on in various forums.</p> <p>Board photos have been put up in all areas so people know who Board members are and</p>	Putting People First programme – now in OD &

Key	Area for improvement	Evidence for change	Relevant QIP (if applicable)
	senior managers and the leadership of the Trust	<p>what they do.</p> <p>There have been new communication channels via Michaels Monday message, directly from the CEO every week and the Board Bulletin directly from the Chair after every Board meeting to tell staff what was discussed/agreed.</p> <p>The CEO has a dedicated 'ask Michael' mailbox which is regularly used and all submissions are personally answered.</p> <p>We have improved our consultation processes with regards change processes or policy development. For example the Trust's new clinical strategy has been driven by the clinical teams and co-produced with service users and carers.</p> <p>All staff have the opportunity to shadow executive team members and managers are encouraged to do this at all levels of the Trust.</p> <p>The Senior management engagement forum was revised and the membership extended all middle managers and clinical leaders. The new format ensures an internal and external focus with speakers and activities to keep the agenda motivating. This has been well received with numbers increasing.</p>	Workforce Strategy

Acle			No response from ward		4		4				N/A	N/A			0	0	81.25%	76.92%
Catton					0		0					6			2	0	85.71%	78.57%
Drayton	No response from ward	No response from ward	No response from ward	No response from ward	No response from ward	No response from ward	No response from ward	No response from ward			No response from ward	No response from ward			0	0	80.00%	70.00%
Thorpe Ward					0		0				N/A	N/A			0	0	55.56%	77.78%
St Clements																		
Suffolk Rehab and Recovery					0		0		N/A			0			1	0	100.00%	90.90%
Chilton House	No response from ward	No response from ward	No response from ward	No response from ward	No response from ward	No response from ward	No response from ward	No response from ward			No response from ward	No response from ward			0	0	100.00%	83.00%
Foxhall House	No response from ward	No response from ward	No response from ward	No response from ward	No response from ward	No response from ward	No response from ward	No response from ward			No response from ward	No response from ward			0	0	54.55%	90.91%
Wedgwood																		
Abbeygate		No response from ward			2		2					3			3	0	87.00%	100.00%
Northgate					0		0		N/A			0			2	0	70.00%	50.00%
Southgate					3		3		N/A			5			5	0	53.85%	41.67%
Woodlands																		
Avocet							1					5			2	0	54.55%	100.00%
Lark					2		2	No response from ward			No response from ward	No response from ward			1	0	62.50%	62.50%
Poppy					4		4					12			5	0	33.33%	60.00%
Willows					0										2	0	82.35%	94.12%
Walker Learning Disability Inpatient Unit					0		1		N/A			62			2	0	87.00%	87.00%

	100%
	75% - 99%
	0 - 74%

Acle	5	5		Plan to include these as tasks in the ward diary for nursing staff	5	Plan to include these as tasks in the ward diary for nursing staff	5				N/A	N/A			0	0	77.78%	71.43%
Catton	8				0		3					2			0	0	85.71%	78.57%
Drayton	eMMA				0		0					0			0	0	80.00%	70.00%
Thorpe Ward	8				0		0				N/A	N/A			0	0	50.00%	62.50%
St Clements																		
Chilton Houses	6				0		0					0			0	0	100.00%	83.00%
Foxhall House	11				0		0		N/A		N/A	0			0	0	66.67%	83.33%
Wedgwood																		
Abbeygate	37				3		3					1			1	0	87.00%	100.00%
Northgate	11				0		0					0			3	0	70.00%	50.00%
Southgate	9				9		3					0			3	2	64.29%	53.85%
Woodlands																		
Avocet	26				1, busy shift and an incident occurred during		1, busy shift and an incident occurred during					0			0	0	50.00%	100.00%
Lark	8	No name printed, patient name not on inside of card			0		0				N/A	0			0	0	76.92%	84.62%
Poppy	24				5		5					4			0	0	38.46%	53.85%
Willows	63				1		1								1	0	82.35%	94.12%
Walker Learning Disability Inpatient Unit	6				0		0		N/A			0			4	0		

	100%
	75% - 99%
	0 - 74%

Monitoring from

	medicine cards			Fridge temp		Ambient temp		Storage						Other				
Ward	Number checked	medicine card complete	allergies noted	Record daily	No of breaches	Record daily	No of breaches	Drug cupboard locked	Trolley locked and secured to wall	Keys held by registered nurse	CD reconciliation / shift	No of breaches	All drugs in date	Drug cupboards have no additional items	Meds related Datix	CD incidents	Compliance with Meds Mgt training	Compliance with Rapid Tranq training
Airey Close																		
Number 5	No response from ward	No response from ward	No response from ward		No response from ward		No response from ward	No response from ward		No response from Technician	No response from ward	No response from ward	No response from Technician	No response from Technician	1	0		
Number 6	No response from ward	No response from ward	No response from ward		No response from ward		No response from ward	No response from ward	N/A	No response from Technician	No response from ward	No response from ward	No response from Technician	No response from Technician	0	0		
Number 7	No response from ward	No response from ward	No response from ward		No response from ward		No response from ward	No response from ward	No response from Technician	No response from Technician	No response from ward	No response from ward	No response from Technician	No response from Technician	0	0		
Carlton Court																		
Foxglove	No response from ward	No response from ward	No response from ward		No response from ward		No response from ward				No response from ward	No response from ward			0	0		
Sweetbriar (Currently Closed)															0	0		
Fernwood	No response from ward	No response from ward	No response from ward		No response from ward		No response from ward				No response from ward	No response from ward			0	0		
Fermoy Unit																		
Churchill												33			5	0		
Hellesdon																		
Glaven	10				1		1					0			0	0		
Rollesby	11				0		0				N/A	N/A			1	0		
Thurne	12				1		1	No response from ward		No response from Technician		0	No response from Technician	No response from Technician	3	2		
Waveney	No response from ward	No response from ward	No response from ward		1		1					2			3	0		
Whitlingham	1				0		0					0	No response from Technician		3	0	89%	89%
Yare	13				No response from ward		8								0	0	low	55.50%
Julian																		
Beach	No response from ward	No response from ward	No response from ward		No response from ward		No response from ward				No response from ward	No response from ward			1	0		
Reed	No response from ward	No response from ward	No response from ward		No response from ward		No response from ward				No response from ward	No response from ward			0	0		
Rose	16				0		1					0			1	1		
Sandringham	No response from ward	No response from ward	No response from ward		No response from ward		No response from ward				No response from ward	No response from ward			1	0		
Northgate																		
GY Acute	11				1		1					3			0	0		
Norvic Clinic																		
Acle					2		2				N/A	No response from ward			1	0	9	7
Catton	8				0		0					8			1	0		

Drayton	No response from ward	No response from ward	No response from ward		No response from ward		No response from ward				No response from ward	No response from ward			0	0		
Thorpe Ward	8				na		N/A				N/A	N/A			0	0		
St Clements																		
Chilton Houses	No response from ward	No response from ward	No response from ward	No response from ward	No response from ward	No response from ward	No response from ward	No response from ward	No response from Technician	No response from Technician	No response from ward	No response from ward	No response from Technician	No response from Technician	0	0		
Foxhall House					0		0				N/A	0			3	0	58%	75%
Wedgwood																		
Abbeygate	No response from ward	No response from ward	No response from ward	No response from ward	No response from ward	No response from ward	No response from ward	No response from ward	No response from Technician	No response from Technician	No response from ward	No response from ward	No response from Technician	No response from Technician	0			
Northgate	No response from ward	No response from ward	No response from ward	No response from ward	No response from ward	No response from ward	No response from ward	No response from ward	No response from Technician	No response from Technician	No response from ward	No response from ward	No response from Technician	No response from Technician	0			
Southgate	No response from ward	No response from ward	No response from ward	No response from ward	No response from ward	No response from ward	No response from ward	No response from ward	No response from Technician	No response from Technician	No response from ward	No response from ward	No response from Technician	No response from Technician	4			
Woodlands																		
Avocet	No response from ward	No response from ward	No response from ward		No response from ward		No response from ward	No response from ward		No response from Technician	No response from ward	No response from ward	No response from Technician	No response from Technician	4			
Lark	No response from ward	No response from ward	No response from ward		No response from ward		No response from ward	No response from ward		No response from Technician	No response from ward	No response from ward	No response from Technician	No response from Technician	0			
Poppy					4		4	No response from ward		No response from Technician			No response from Technician	No response from Technician	0			
Willows	No response from ward	No response from ward	No response from ward	No response from ward	No response from ward	No response from ward	No response from ward	No response from ward	No response from Technician	No response from Technician	No response from ward	No response from ward	No response from Technician	No response from Technician	3			



Monitoring from

	medicine cards			Fridge temp		Ambient temp		Storage						Other				
Ward	Number checked	medicine card complete	allergies noted	Record daily	No of breaches	Record daily	No of breaches	Drug cupboard locked	Trolley locked and secured to wall	Keys held by registered nurse	CD reconciliation / shift	No of breaches	All drugs in date	Drug cupboards have no additional items	Meds related Datix	CD incidents	Compliance with Meds Mgt training	Compliance with Rapid Tranq training
Airey Close																		
Number 5	7				1		1					0			1			
Number 6	1				0		0	No response from Technician	No response from Technician	No response from Technician		7	No response from Technician	No response from Technician				
Number 7	3				0		0	No response from Technician	No response from Technician	No response from Technician		0	No response from Technician	No response from Technician				
Carlton Court																		
Foxglove	No response from ward	No response from ward	No response from ward	No response from ward	No response from ward	No response from ward	No response from ward	No response from Technician	No response from Technician	No response from Technician	No response from ward	No response from ward	No response from Technician	No response from Technician	0			
Sweetbriar															0			
Fernwood	No response from ward	No response from ward	No response from ward	No response from ward	No response from ward	No response from ward	No response from ward			No response from Technician	No response from ward	No response from ward	No response from Technician	No response from Technician	0			
Fermoy Unit															0	0	42.00%	34%
Churchill	2				4		4					44			5			
Hellesdon																		
Glaven	10				0		0					0						
Rollesby	No response from ward	No response from ward	No response from ward	No response from ward	No response from ward	No response from ward	No response from ward	No response from Technician	No response from Technician	No response from Technician	No response from ward	No response from ward	No response from Technician	No response from Technician	3			
Thurne	10				1		1					0			3	0	10	5
Waveney	4				0		0					0			7			
Whitlingham	No response from ward	No response from ward	No response from ward	No response from ward	No response from ward	No response from ward	No response from ward	No response from Technician	No response from Technician	No response from Technician	No response from ward	No response from ward	No response from Technician	No response from Technician	0			
Yare	No response from ward	No response from ward	No response from ward	No response from ward	No response from ward	No response from ward	No response from ward	No response from Technician	No response from Technician	No response from Technician	No response from ward	No response from ward	No response from Technician	No response from Technician	3			
Julian																		
Beach	No response from ward	No response from ward	No response from ward	No response from ward	No response from ward	No response from ward	No response from ward				No response from ward	No response from ward			1			
Reed	No response from ward	No response from ward	No response from ward	No response from ward	No response from ward	No response from ward	No response from ward				No response from ward	No response from ward			1			
Rose	No response from ward	No response from ward	No response from ward	No response from ward	No response from ward	No response from ward	No response from ward				No response from ward	No response from ward			0			
Sandringham	No response from ward	No response from ward	No response from ward	No response from ward	No response from ward	No response from ward	No response from ward				No response from ward	No response from ward			0			
Northgate																		
GY Acute	5				0		0					0			0			
Norvic Clinic																		
Acle	No response from ward	No response from ward	No response from ward	No response from ward	No response from ward	No response from ward	No response from ward				No response from ward	No response from ward			1			
Catton	No response from ward	No response from ward	No response from ward	No response from ward	No response from ward	No response from ward	No response from ward				No response from ward	No response from ward			0			

Drayton	No response from ward	No response from ward	No response from ward	No response from ward	No response from ward	No response from ward	No response from ward				No response from ward	No response from ward			0			
Thorpe Ward	No response from ward	No response from ward	No response from ward	No response from ward	No response from ward	No response from ward	No response from ward				No response from ward	No response from ward			0			
St Clements																		
Chilton Houses	10				1	1						0			2	0		
Foxhall House	No response from ward	No response from ward	No response from ward	No response from ward	No response from ward	No response from ward	No response from ward	No response from Technician	No response from Technician	No response from Technician	No response from ward	No response from ward	No response from Technician	No response from Technician	0			
Wedgwood																		
Abbeygate	No response from ward	No response from ward	No response from ward	No response from ward	No response from ward	No response from ward	No response from ward	No response from Technician	No response from Technician	No response from Technician	No response from ward	No response from ward	No response from Technician	No response from Technician	0			
Northgate	No response from ward	No response from ward	No response from ward	No response from ward	No response from ward	No response from ward	No response from ward	No response from Technician	No response from Technician	No response from Technician	No response from ward	No response from ward	No response from Technician	No response from Technician	0			
Southgate	No response from ward	No response from ward	No response from ward	No response from ward	No response from ward	No response from ward	No response from ward	No response from Technician	No response from Technician	No response from Technician	No response from ward	No response from ward	No response from Technician	No response from Technician	6			
Woodlands																		
Avocet					0		1	No response from Technician	No response from Technician	No response from Technician		2	No response from Technician	No response from Technician	1			
Lark	6	No response from ward	No response from ward		0		0		N/A			0			0	0	73%	71%
Poppy	No response from ward				1		4	No response from Technician	No response from Technician	No response from Technician			No response from Technician	No response from Technician	1			
Willows	63				2		2					2			1	1		15/17 currently no

Trust wide 70%



Title:	Non-access Visits and Missed/Cancelled Appointments
Outcome Statement:	In the event of a non-access visit or missed/cancelled appointment by a service user timely and appropriate action, based on risk assessment will be taken.
Written By:	Sue Barrett – Head of Governance Sue Hudson – Modern Matron
Reviewed By:	Chris Strivens – Deputy Service Manager
In Consultation With:	Norfolk Police
Approved By & Date	Clinical Effectiveness and Policy Group – November 2014
With Reference To:	National Service Framework for Mental Health, Department of Health (1999) Safety First: the National Confidential Enquiry into Suicide and Homicide by People with Mental Illness, Department of Health (2001) The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness. Annual Report. (2013) RCA 696 The following are all National Treatment Agency (NTA) publications: Towards Successful Treatment Completion: a good practice guide (2009) Medications in Recovery: Re-orientating Drug Dependence Treatment (2012) Reducing Drug-related Deaths: guidance for drug treatment providers (2004)
Associated Trust Policies and Documents:	C70b: Discharge from Trust Services C80: Non-concordance with Treatment Regimes by Informal Service Users C82: Clinical Risk Assessment and Management C82b: Application of Alert to Health Records C89: Safeguarding Children C90: Safeguarding Vulnerable Adults C91: Supervised Community Treatment Orders C93: Community Services Clinical Team Meetings C98: Care Programme Approach Q11: Serious Incidents Requiring Investigation Q12: Missing Persons Q17: Lone Working
Applicable To:	Trust wide
For Use By:	All staff offering services to community based service users
Reference No:	Q12a
Version:	05
Published Date:	November 2015
Review Date:	July 2016
Equality Assessment:	August 2013
Implementation:	Trust mandatory Risk Assessment and Management training and updates will assist staff in identifying and managing risks. Clinical Team Meetings will record and monitor service users who disengage.

Review and Amendment Log

Version Number	Reasons for Development/Review	Date	Description of Change(s)
01	Developed/reviewed for use across the merged Trust	February 2012	New policy
02	Early review	September 2013	Reviewed in response to serious incidents and changes to team structures across the Trust
03	Early review	July 2014	Regulation 28 from Coroner regarding systems for welfare checks between the Trust and the Police Revised flowchart for Norfolk recovery Partnership
04	Early review	November 2014	Advised from police that they would not carry out a welfare check unless a home visit has been attempted by NRP.
05	Early review	November 2015	Guidance on chemical exposure added

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1.0 Introduction

Norfolk and Suffolk Mental Health NHS Foundation Trust is committed to maximising the safety and well-being of service users and their relatives/carers and to ensuring that the principles of risk assessment and management are adhered to.

The National Service Framework for Mental Health (DH, 1999) stated that service users must receive care that optimises engagement anticipates or prevents a crisis and reduces risk. Safety First (DH, 2001) showed that non-concordance with treatment programmes and loss of contact with services are associated with suicide and homicide. This was further supported by the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (2013) who highlighted that “suicide is still frequently predicted by missed contact with services” and the role of assertive outreach services in preventing this.

It is recognised that some people may pose a risk to themselves or others if they do not maintain contact with mental health services and it is therefore important that every effort is made to re-engage with the service user service and that there is effective communication amongst professionals, the service user and their family/carer.

The potential significance of a non-access visit or missed/cancelled appointment with mental health services should not be underestimated and actions should be taken to manage clinical risks.

It is also recognised that with the limited resources, incidents of a ‘Did Not Attend’ (DNA) resulted in wasted appointment times that could be used for the benefit of other service users.

2.0 Purpose

This policy provides guidance to all staff offering community services/hospital based services to service users in the community, particularly those who, based on risk assessment, are considered to be at risk of suicide, significant self-harm or harm to others. (E.g. Community Mental Health Teams, Dementia Intensive Support Teams, Crisis Resolution Home Treatment, Alcohol and Drug services and Child, Adolescent and Youth services, Learning Disability services and Wellbeing services).

This may include:

- Those who have been referred for assessment but do not attend/cancel appointment
- Those who have been assessed and accepted by the service but do not attend/cancel appointment
- Those who are known to have experienced recent significant and life-changing events and do not attend/cancel appointments
- Those who disengage from the service without agreement and are considered to be at risk of relapse
- Are non-concordant with or at risk of non-concordance with (psychotropic) medication (see C80: Non-concordance with Treatment Regimes by Informal Service Users policy)

3.0 Definitions

Appointment/visit:

- An arrangement that has been made (in writing, by telephone etc) to see the service user at a certain time and place

Missed Appointment/Did not Attend:

- Any scheduled appointment that is missed without prior notification from the service user

Cancellation

- Where the service user provides notice that they will not be attending a scheduled appointment

4.0 Duties

Ward Managers/Team Leaders

- Ensure that their staff are up-to-date with mandatory training (via PDP) and that all staff are familiar with relevant policies.
- Monitor non-access visits and missed appointments through the electronic system and through

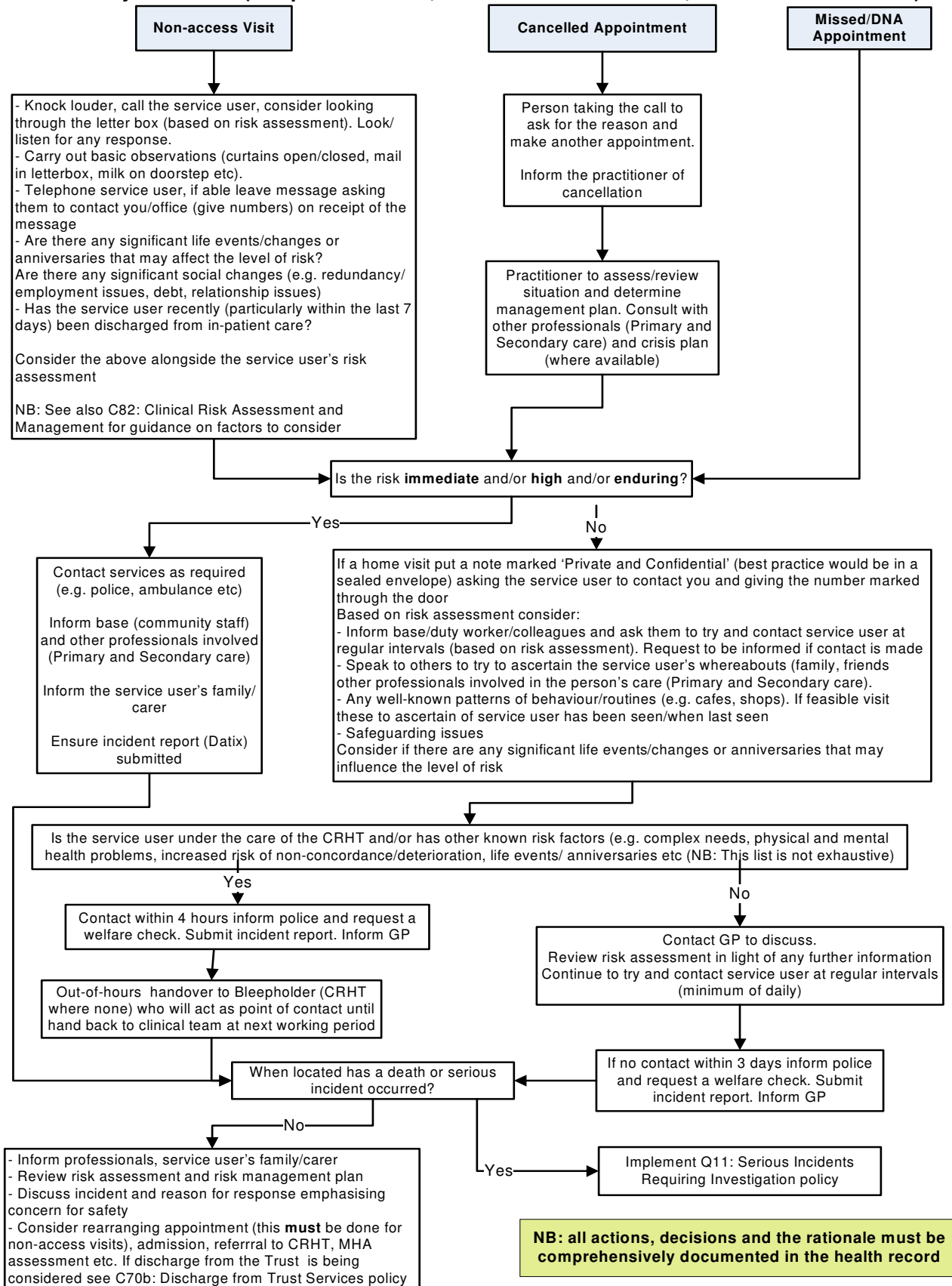
their team meeting documentation (see C93: Community Services Clinical Team Meetings policy).

Clinical Staff

- In the event of non-access visit/missed appointment take appropriate action based on risk assessment (see C82: Clinical Risk Assessment and Management policy) and guidance in this policy.
- Maintain relevant mandatory training and updates, including risk assessment and management and suicide prevention
- Follow to Q17: Lone Working so as to maximise their own safety
- Ensure that all non-access visits and missed/cancelled appointments are entered on the Patient Administration System (iPM/Maracis/ePEX)
- Ensure that all non-access visits and missed/cancelled appointments are identified at team meetings (see C93: Community Services Clinical Team Meetings)
- Maximise the safety of those in their care and to seek to keep service users engaged with services
- Ensure all appropriate personnel are contacted e.g. GP, Social Worker
- Comprehensively document all actions, decisions and the rationale in the health record

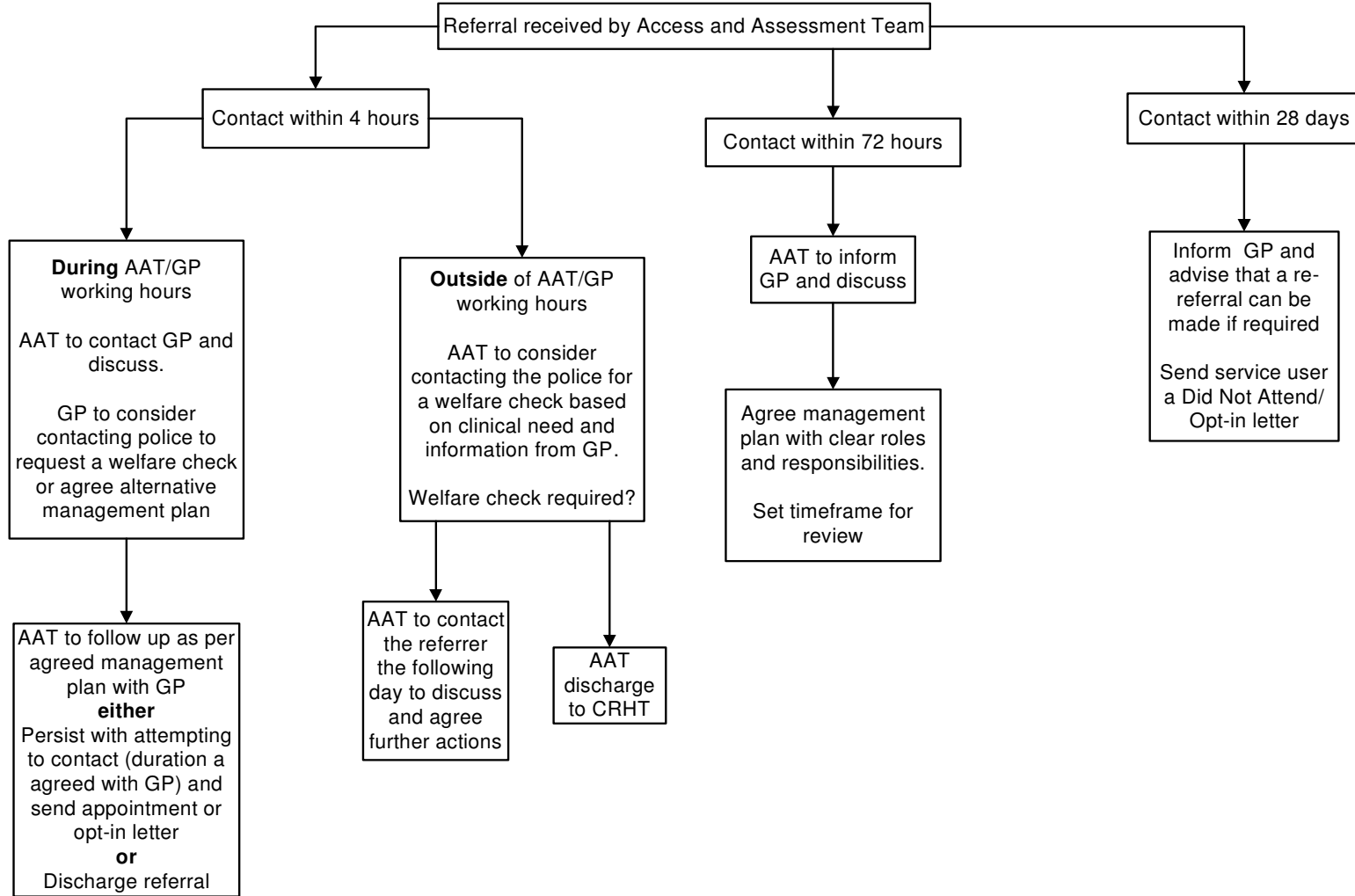
5.0 Non-access Visits and Missed, Cancelled and Did Not Attend Appointments

Summary Flowchart (all apart from AAT, see Section 6.0 and NRP, see Sections 7.0 & 8.0)

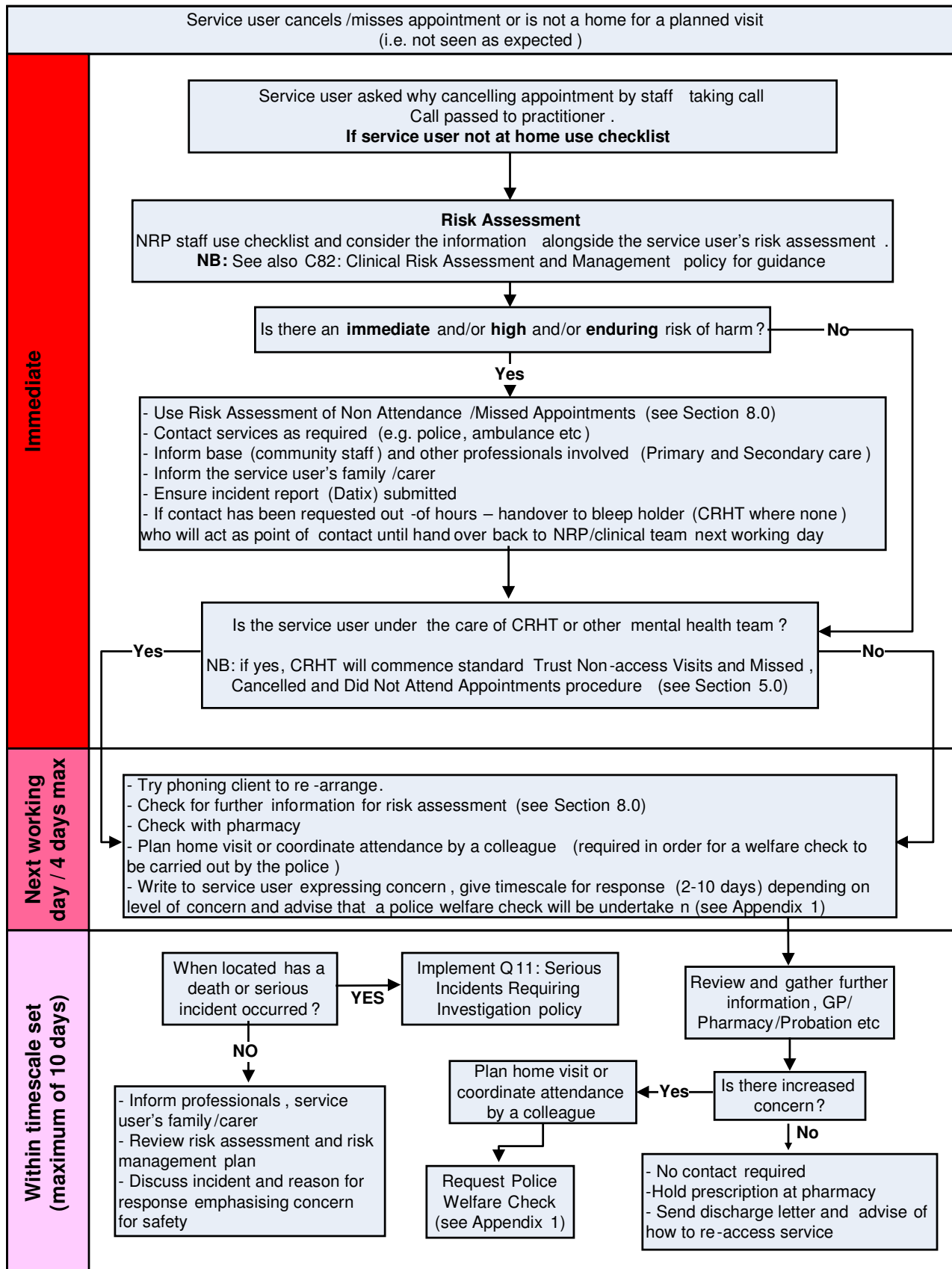


6.0 Non-access Visits and Missed, Cancelled and Did Not Attend Appointments

Summary Flowchart – Access and Assessment Team (AAT) only



Summary Flowchart – Norfolk Recovery Partnership (NRP) only



8.0 Risk Assessment of Did Not Attend/Missed Appointments (NRP only)

IMMEDIATE	<p>RISK ASSESS Practitioner assesses non-attendance – considers client health record and liaises with others if required.</p> <p>Review:</p> <ul style="list-style-type: none"> • Are there any significant life events/changes or anniversaries that may affect the level of risk? • Are there any significant social changes (e.g. redundancy/employment issues, debt, relationship issues) • Has the service user collected community prescriptions as expected? • Has the service user recently (particularly within the last 7 days) been discharged from in-patient care? <p>Consider the above alongside the service user’s risk assessment. (see also C82: Clinical Risk Assessment and Management policy)</p> <ul style="list-style-type: none"> • Is the service user under care of mental health services – inform team? • Are there physical health concerns? <p>If concern:</p> <ul style="list-style-type: none"> • Check GP/Pharmacy for contact • Check Acute hospital liaison team • Consider contact family/friend
Next working day/4 days max	Review any further information / telephone messages etc.
In timescale set (maximum 10 days)	<ul style="list-style-type: none"> • Attempt further phone calls • Write further letter, if no concern offer further appointment and advise that if no contact is received, discharge/Police welfare check may be requested. Copy correspondence to other services (GP etc). • Where concern remains as to their wellbeing, attempt/coordinate home visit by a colleague, write further letter, request contact within a timescale and advise that Police Welfare check would be required. Copy correspondence to other services (GP etc).

Administrators/Reception Staff Checklist

On receiving calls/information that client is not attending appointment:

- Check why?
- Is service user ok?
- Confirm telephone number.
- Pass information to Care Coordinator or a colleague if absent

For staff at home visits and non-access visits

- Knock louder, if possible call the service user through the letter box (be cautious – advice is not look through letter box because of potential injury from object being pushed through).
- Basic observation (curtains open, mail in letterbox, windows open, noise from within property)
- If neighbour approaches accept information they may offer (ok to advise you were visiting (but not disclose who you are or why).
- Telephone service user from doorstep and listen for phone ringing.
- Contact base – any relevant messages.
- Put note through door – request contact you within timescale (4 hour – urgent, 2-10 days – less urgent).

If contact requested within 4 hours and this is outside of service working hours (18.00) handover to bleep holder (CRHT where none) who will act as point of contact until next NRP working period.

Norfolk and Suffolk NHS Foundation Trust

Q12a: Non-access Visits and Missed/Cancelled Appointments. Version 05

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Guidance to Good Practice

9.0 Promoting Concordance

Appointments and visits should, as far as possible, be arranged to accommodate the service user's lifestyle and commitments (see C80: Non-concordance with Treatment Regimes by Informal Service Users). Consideration should also be given to the suitability of the venue. Issues such as disability and cultural or religious beliefs that may impact on the service user accessing services should also be explored.

Staff should also emphasise the importance of letting staff know if they will be unable to keep an appointment and explain the concern this would cause and actions that may be taken in these instances.

10.0 Documentation and Recording

All non-access visits and missed, cancelled and DNA appointments and the action taken must be comprehensively documented in the health record the same working day. This should be updated as required.

Risk assessments and risk management/care plans should be reviewed as indicated throughout the process and when the service user is located. This should be carried out in consultation with the service user (when located) and their family/carer/friends as appropriate.

All non-access visits and missed, cancelled and DNA appointments must also be recorded on the relevant Patient Administration System (iPM, ePEX, Maracis etc) within 1 working day

Incident reports (datix) should be submitted as set out in Sections 5.0, 6.0 and 7.0 Non-access Visits and Missed, Cancelled and Did Not Attend Appointments: Summary Flowcharts

All non-access visits and missed, cancelled and DNA appointments should be discussed, actions agreed and recorded as part of the team meeting (see C93: Community Services Clinical Team Meetings policy)

11.0 New Referrals and Other Appointments

Where the non-access visit or missed, cancelled or DNA appointment is for a new referral, the referrer should be informed as soon as possible so that they can make an up-to-date assessment and decide on the course of action (e.g. cancellation of referral, re-referral, request for an emergency psychiatric assessment etc).

Where the service user is in the process of being assessed by mental health services or does not have an identified Care Coordinator/Lead Professional the assessor has a responsibility to carry out the required processes.

Where a service user has an identified Care Coordinator/Lead Professional, but the visit/appointment is not with them, they should be informed as soon as possible so as to be involved in the risk assessment and risk management planning. Should the Care Coordinator/Lead Professional not be available (e.g. on leave) they must be given a comprehensive handover on return.

12.0 Children and Younger People – additional guidance

Where the non-access visit or missed, cancelled or DNA appointment concerns a child or young person the following should also be taken into account;

- Child Protection concerns/plans
- Safeguarding issues (see C89: Safeguarding Children policy)
- If there is Social Worker involvement they must be informed by telephone and this followed up in writing.
- Where the child is under 5-years the Health Visitor should be contacted, if they are of school age contacting the school nurse (where available) should be considered.

13.0 Wellbeing/IAPT Service – additional guidance

Following a DNA the service user will be discharged and a letter sent to the G.P. Exemptions may be made taking into account the following:

- The nature of the service user's problem/diagnosis
- Condition of the service user at previous appointment
- The length of involvement with the service user
- Any disability that would prevent access
- Any cultural issues that might impact on access

The service will allow two cancelled appointments before speaking to the service user and agree another appointment or discharge, depending on the service user's views. If a further cancellation is then made, the service user would be discharged and a letter sent to the G.P. Any cancellations made without giving the service 24 hours notice will be classed as DNAs.

NB: The Wellbeing/IAPT Service does not routinely offer home visits

14.0 Norfolk Recovery Partnership – additional guidance

Harm from alcohol and drugs

Drug taking is inherently risky, the actual level of risk involved is highly variable and dependent on factors such as the physiology of the person taking the drug, the type of drug used and the method of use. Change in circumstances is a contributory factor, most recognised are the changes in opiate tolerance particularly around times where opiate users have achieved stability such as from a period of stable drug use, residential detoxification or following release from prison.

It is impossible to remove all risk from all drug use, but it is essential that drug treatment services work closely with individuals who are engaging in high-risk drug-taking behaviours to reduce harm (NTA 2004). Interventions offered by NSFT services are needle exchange, information about safer injecting and overdose prevention

The link of alcohol to health harm and death is consistently recognised for example, harm from accidents while intoxicated (e.g 5% of road casualties & 17% of all road fatalities), links of alcohol to medical conditions e.g, over 100% rise in alcohol related hospital related admissions over the last decade and currently the highest levels of liver disease in England (in 2012 had risen by 20% in a decade, with alcoholic liver disease accounting for over a third (37%) of all liver disease deaths).

Engagement with services and non-attendance

National guidance (NTA) of 2009 described the goal of services to improve positive treatment outcome. it described that in 2008 48% of substance misuse service users had an unplanned discharge, with 28 % dropping out of treatment.

Since Jan 2012 the proportion of deaths (in relation to total patients linked with the service was 1.8%, a small number of this figure were unexpectedly found to be deceased through non intentional overdose or acute physical health problem.

As guided by Trust policy, the alcohol and drug services aims to ensure that In the event of a non-access visit or missed/cancelled appointment by a service user, timely and appropriate action, based on risk assessment will be taken.

In considering this NSFT processes, the NSFT substance misuse services considered the guidance of the NTA (2009) which advises that in the event of missed appointments which indicates a service user is dropping out of treatment, the police may be asked in exceptional circumstances to do a welfare check and only if there are sufficient grounds to over-ride the duty of confidentiality

Access to services

NSFT alcohol and drug services offer open access services for service users wishing to access services, where there is a referral (eg from GP) this is screened for additional information to exclude the need of a priority specific appointment or home assessment and the service user and referral are sent a letter

advising them of the open access services for their area. If the service user does not attend the open access service within 21 days the referrer is informed so they may review their referral.

Alcohol and drug services are commissioned to provide services for individuals that have difficulties with substances including dependency. The interventions that they provide should assist mild to moderate severity mental health problems and the more complex, formally diagnosed problems would be managed in partnership with mental health services as part of the dual diagnosis policy.

NSFT services are constantly aiming to improve engagement and retention in effective treatment and to increase the numbers of clients who complete treatment successfully and leave drug misuse treatment services in a planned way in line with the Governments' current drug strategy (NTA 2009).

Because of the common fears of disclosing illegal drug use and negative stigma of addictions, NSFT services offer a confidential treatment service. On entering services, at initial assessment, service users are asked about close family contact, if they live alone, who to contact if there are concerns for their wellbeing. On occasions service users request a confidential service and request special arrangements for contact so family members will not discover their difficulties of substance misuse. Service users are asked to supply details of their next of kin and anyone that has access to their property in the event that contact is unexpectedly lost. Service users are advised that in the event of loss of contact and with sufficient knowledge of risk and concern the police may be asked to undertake a welfare check and that may result in forced access to their property for which the client may be liable for repair.

Where service users miss appointments and stop attending the service the majority do this because of a change in their goals, lapse or relapse into a previous pattern of alcohol or drug use, services will attempt to re-engage them with phone calls, letters inviting them to the drop in to re-engage etc.

Non-attendance of appointments where there is a court order would be routinely reported to the Probation service and follow up by the police may occur immediately.

NRP summary flowchart – see also Section 7.0

The separate process chart for the substance misuse services is provided to recognise the differences faced for these services.

In considering timescales of action 4 days is used as this is the longest allowed period of non attendance for the collection of community opiate substitute treatment (OST). Many service users where there are concerns regarding drug misuse risk will have daily, often supervised doses of medication. For some service users there could be regular occasions where collections are missed. The guidance provided to service users and pharmacists is that if the prescription is not collected for more than 3 days it should be withheld until a reassessment of opiate tolerance can occur.

Where it is known that the service user is a parent and carer for a child, staff will consider any safeguarding concerns and take the relevant course of action.

After two periods of four days where there have been attempts to be in contact by telephone and letter, where there are no other significant risk factors the police may not be asked to undertake a welfare visit. This would be decided by team discussion and agreement with Team Lead / Manager. This would particularly be relevant where there is no mental health history, no concerns of other professionals and the conclusion of the review being that there has been a change in the persons 'Stage of Change' in accessing treatment.

It is felt by the service that routinely requesting welfare checks of the police after a period of non contact and with no other concerns or risks could not be justified in terms of confidentiality and risks the ability for positive future engagement.

Discharge from service would usually occur if contact is lost for more than 21 days.

Staff will use the attached process chart and the service users health record and consultation with colleagues which is documented into the service users record to assess risk in the event of any missed

appointment / access visit.

Where it is identified that in the follow up of a missed appointment a police welfare check may be requested, a home visit should initially be attempted. This may be undertaken by another member of staff if needed and should include leaving a letter stating that in the absence of other assurances of their wellbeing the police will be asked to undertake a welfare check and this may require them breaking into their property.

When a call to the police is later made details of the attempted visit should be supplied.

With Reference to:

- Towards successful treatment completion A good practice guide (NTA 2009)
- Medications in Recovery - Re-orientating Drug Dependence Treatment (NTA 2012)
- Reducing drug-related deaths - Guidance for drug treatment providers (NTA 2004)

15.0 Monitoring

Aspects of compliance or effectiveness being monitored	Monitoring method	Individual/team with responsibility for monitoring	Frequency of the monitoring activity	Group/committee which will receive the findings/monitoring report	Group/committee/individual responsible for ensuring that actions are completed
<p>Service users who miss/cancel/or do not attend appointments and where there is a non-access visit.</p> <p>Identification of follow up action (based on risk assessment)</p>	<p>Audit of C93: Record of Clinical Team Meeting policy appendices and corresponding entry in health record as set out in the audit Terms of Reference</p>	<p>Clinical Audit Team</p>	<p>Annual</p>	<p>Assurance Manager's quarterly report to Service Governance sub-Committee</p>	<p>Service Governance Committee</p>
	<p>Management supervision – completion of 'Audit of record keeping'</p>	<p>Service/Locality manager and Team leaders, staff acting as management supervisors</p>	<p>Monthly</p>	<p>Where problems/issues are identified, to be addressed with the individual by the Service/Locality manager or Team leader</p>	<p>Service/Locality manager or Team leader</p>
<p>NB: See also monitoring statement for C93: Community Services Clinical Team Meetings</p>					

Appendix 1

Mental Health Welfare Checks – Guidance for Staff

Norfolk and Suffolk Constabulary have developed a pathway of response for their Control Room staff, based on their Standard Operating Procedures, when requests are made for them to carry out welfare checks on service users

The police is an emergency response organisation and they will respond to immediate risk, however, staff should be aware that the police have limited knowledge in relation to mental health compared to a mental health professional and also have limited powers unless there is an immediate risk to life, risk of harm to the individual/public or a Section 135 warrant has been obtained. Therefore, based on risk assessment, staff should decide whether they should conduct the welfare check or request police attendance.

When staff contact the Police to request a welfare check they will be expected to be able to provide:

- Clear information about the service user and the situation (see below) to assist the police in establishing the level of threat/risk
- Explanation of what assistance they are requesting and why
- Be able to identify a clear point of contact (e.g. Care Coordinator/Lead Professional) during working hours. Outside of working hours this may be the Emergency Response Clinicians, Access and Assessment Team, Bleepholder or CRHT etc depending on service/availability).

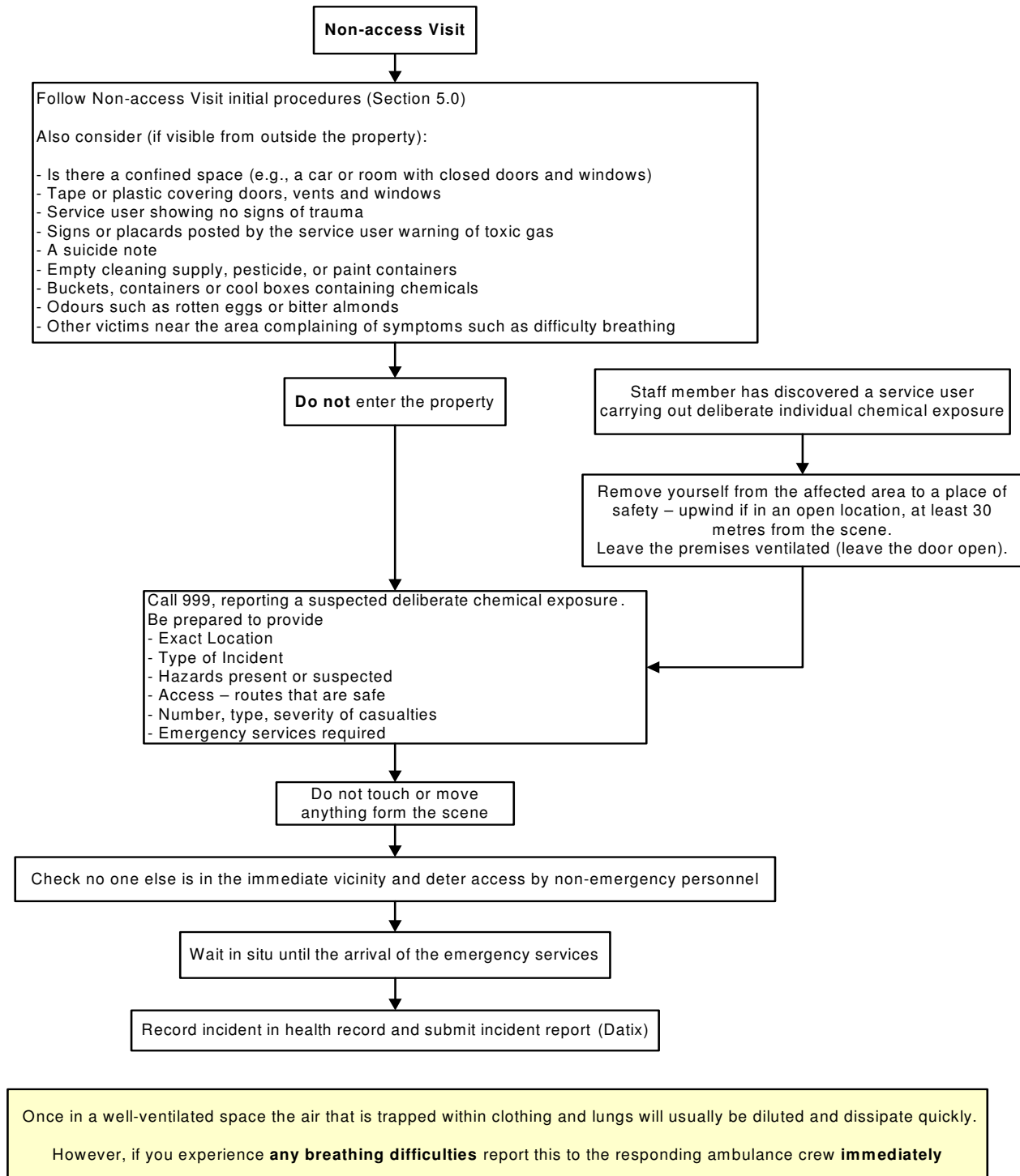
Is there is an immediate threat/risk to life?

Yes	No/Not sure
<p>Details of the individual</p> <p>Any known history of violence</p> <p>Known use or availability of weapons</p> <p>Other relevant clinical information should be discussed as justified based on risk assessment/related to risk (see C10: Confidentiality and Q50: Data Protection Act policies and Information Sharing Agreements)</p> <p>It is the responsibility of Trust staff to request an ambulance if required</p> <p>The response to the request will be coordinated by Police Control room</p>	<p>The Police will then ask a series of questions to determine their response e.g.:</p> <ul style="list-style-type: none"> • Is the person detained under the MHA? • Risk assessment information, in particular any risk to others, history of violent behaviour, self-harm, anti-authority, previous absconding behaviour, use or availability of weapons and/or firearms at the address • Details of any family/carer/partner risk assessment that has been carried out, and date of this being completed • Full name and address of the person you are requesting the check for • Any information you may have about other people who may also be present at the address. • Why has police attendance has been requested • What are the expected actions of the Police if they attend the address • Is an ambulance likely to be required? • Will a mental health professional accompany the police to the address or meet them there <p>This information should be discussed with the Control Room Inspector who will make a decision about the level of response from the police, and discuss this with the member of staff</p>

Appendix 2

Deliberate Individual Chemical Exposure (Chemical Self-harm and Suicide)

There has been a steady increase in chemical self-harm/suicide attempts by using a range of substances to create a chemical reaction either by ingestion or through inhalation, in a partially sealed environment. The chemicals used are often widely available (supermarkets, pharmacies etc.) Due to the complex and unpredictable presentations of some service users, there is the potential for staff to discover someone who is carrying out, or has died as the result of chemical suicide. Aside from the obvious risk to the service user, the vapours generated, especially when trapped in an enclosed space, may exist in concentrations that can be hazardous to others.



Suffolk Operating Framework Mental Health Services

Introduction: This document is the overarching Operational Policy and applies to all mental health services provided in Suffolk and Thetford. There are individual policies detailing role and function in relation to:

- Access and Assessment service
- Integrated Delivery Team pathways
- Home Treatment Team
- Psychiatric Liaison team
- Acute Inpatient
- Psychiatric Intensive Care Unit (PICU)

Overarching principles

2011 The Mental Health Strategy: No health without mental health is an age inclusive strategy. It has six objectives:

- More people will have good mental health
- More people with mental health problems will recover
- More people with mental health problems will have good physical health
- More people will have a positive experience of care and support
- Fewer people will suffer avoidable harm
- Fewer people will experience stigma and discrimination

LOCALLY DEFINED AIMS AND OUTCOMES

- An increase in appropriate supported discharges from the service demonstrating that fewer service users having a long term dependency on the service for their ongoing support.
- Fewer delayed transfers of care from inpatient services
- A reduction in the number of service users who need to re-access the service due to the deterioration in their symptoms
- A reduction in the number of crisis readmissions into mental health services and a reduction in unplanned urgent care attendances in acute hospitals.

- Service user and carer reported outcome measures which compare positively with relevant national indicators
- Work to promote recovery and support Service Users to build satisfying lives and develop a strengths based approach to care for each service user which shall promote access to universal and community resources, support recovery and help each service user to be part of their local community
- Liaise, communicate and work jointly with substance and alcohol support and treatment services in order to effectively support service users with dual diagnosis
- Engage with partners to support the building of capacity in their local communities in order to support Service Users to achieve recovery through being part of the local community.
- Increase the contribution of service users in the delivery of services, including through peer support workers.
- Ensure access for all service users to a wide range of psychological therapies and deliver evidence based interventions which are compliant with NICE guidance and national good practice
- People have a coordinated care and a crisis and contingency plan in place and are able to access the support and care they need to avoid a crisis situation
- Individuals and their families are empowered to manage their own care and support and to make informed choices
- Involve families and carers in development of services.

Community Services:

Introduction: This section relates to services provided by Access and Assessment team and all pathways within the Integrated Delivery Teams and includes standards and process.

Access and Assessment team:

- The majority of referrals into the service are managed through by the team (the exception to this being psychiatric liaison which is covered later in the document)
- Access and Assessment complete the following:
 1. Triage referrals and either refer for assessment or signpost as appropriate
 2. Complete initial assessment to include :
 - Health and Social
 - Risk Screen
 - Clustering
 - Honos
 3. Onward referral to IDT

Clinical:

AAT meetings:

Clinical

Daily MDT meetings:

Frequency is daily

- Review of cases
- Multi-disciplinary feedback
- Duty planning
- Daily co ordination

Team pathway meetings:

Frequency is monthly

- Action log review
- Team working
- Staff availability
- Performance review

Business:

AAT Business meeting occurs monthly

- Feedback from operational management/ governance
- Performance
- Patient safety
- Risk register
- IT
- Service development

Team Clinical supervision:

- Takes place Monthly
- Small groups with trained facilitators
- Reflective Practice

Team training:

Weekly in house training for staff

- Case study reviews on complaints and SI outcomes
- Identified learning needs
- Internal and external speakers

Well Being Service:

Clinical:

Locality meetings:

Frequency is weekly

To discuss assessment outcomes

Groups

Duty cover etc.

Service Governance

Frequency – monthly

3rd Thursday of each month - Stowmarket

Business:

Team meetings

Frequency is monthly

1st Thursday of each month – Ipswich and Bury

Every quarter joint meetings for whole of SWS service – held in Stowmarket

Operational Meeting

2nd Thursday of each month in Stowmarket

All leads plus senior team

Seniors Meeting

Senior Management Team

2nd Thursday of each in Stowmarket – before Ops meeting

East locality lead meetings

Fortnightly (Monday morning)

Business/Clinical Meeting

Every Monday pm

Operational managers and senior clinicians

Wellbeing Network Meeting

Monthly

For all partners

Partnership Meeting

Monthly

Supervision

Managerial supervision

Individual and Monthly

Clinical Supervision

Link workers – monthly group supervision

CBT – monthly group supervision – this includes case management supervision

PWPs – fortnightly supervision skills group supervision and individual weekly case management supervision.

Admin

Monthly group supervision

Autism Diagnostic Service:

All referrals are made to the service via the Access and Assessment Team.

Referrals are accepted from GP's and other professionals within health, social Care and education

Referrers are requested to complete an AQ10 questionnaire for adults referred to the service

The service is a Primary Care Service and cannot accept referrals requiring input for medication management and for individuals with concurrent mental health problems requiring input or where there is evidence of significant risk.

Integrated Delivery Teams:

Introduction: Operating standards are the same for all pathways within the IDTs to ensure a consistent service across Suffolk.

Allocation of Referrals:

- All referrals to pathways are allocated at the Clinical team meetings the frequency of the meetings varies between the pathways and is detailed in the individual operating policies. The minimum the meetings take place is weekly.
- All referrals are allocated on the basis of risk and clinical need using the RAG (red, amber, green) system.

- All pathways will maintain a confidential white board which details the allocations, individual's caseloads and any unallocated cases.
- All referrals must be allocated within two weeks of receiving them with first face to face contact based on the RAG rating of the referral as follows:

Red- 3-5 days

Amber- 10-14 days all for comment

Green- 6-8 weeks

Transfers between IDTS:

- All transfers between IDTS will take place within 28 days of receipt of referral.
- Formal handover will take place between care co-ordinators prior to the transfer taking place.

CPA/NCPA:

- CPA and Non CPA must be applied in line with trust Policy C98 (CPA Non CPA)
- Care co-ordinator has the responsibility to ensure individuals care plans, risk assessments, reviews and crisis/contingency plans are updated on a regular basis and shared with the service user.

Discharge:

- Discharge will take place in line with trust policy C70b Discharge from Trust services.
- In the event the individual is re-referred within three months of discharge the referral will go directly to the IDT in which they were previously receiving treatment and not to AAT.

Reviews:

- As a minimum standard will take place in line with contractual requirements which is a minimum of one every 12 months.
- Comply with CPA/NCPA and Clustering Standards
- Where there is increased clinical risk
- Significant change to clinical presentation

Duty System:

There will be a minimum of two duty workers (Band 5/6 clinicians) in each IDT per day on a rota system undertaking the following duties:

- Review of inward referrals from AAT
- Liaison with AAT
- Respond to urgent clinical phone calls from existing service users
- Telephone contact with service users as part of an agreed care plan
- Co-ordination of lone worker processes

Crisis Situations:

- During the hours between 0900 -1630 crises response to service users open to the service will be via the duty system. A handover and crisis plan will be given to AAT at 1630 for any situations which remain unresolved.

- 1630-0900 crisis calls will be managed by the AAT Emergency function.
- Service Users who are registered with Suffolk Mind Waves Service can access Suffolk Night Owls.

Meetings:

Clinical:

Frequency will vary between pathways but there will be a minimum of one per week the function of the meeting is as follows:

- Allocation of referrals
- Duty feedback
- Case review and discussion
- Access to specialist advice and consultation with colleagues
- Discharge

Business:

Take place monthly within each IDT chaired by the IDT manager

- Feedback from Operational management team/governance issues
- Finance
- Performance
- Patient safety
- Service pressure/risks
- Service development

Reflective Practice groups:

- Reflective practice groups will take place monthly
- Each meeting will have a named chair who will be responsible for facilitating the meeting and taking notes. The chair will rotate six monthly.
- The documentation will be standardised to ensure a consistent format for the meetings.
- One of the functions of the groups will be to review and discuss any Serious Incident (SI) Reports to share learning.

Psychiatric Liaison Team:

- Accepts referral from all inpatient areas of the West Suffolk/ Ipswich Hospitals as part of the liaison role. This may be for assessment, advice, guidance related to management of risk and/or to signpost onto appropriate care/support as identified. The team would take the emergency assessment role for persons attending the Accident and Emergency department within its operating hours.

- Psychiatric Liaison completes the following:
 1. Triage and respond to referrals within the Keogh guidelines
 2. Complete assessment which when indicating secondary care would include:
 - Core assessment
 - Clinical Note
 - Risk Screen
 - Clustering
 - GP Letter
- For those not referred onto secondary care a Core assessment and Clinical note and an assessment letter including risk would be forwarded to GPs

Supervision Managerial

Frequency is monthly

- Individual with line manager

Team Clinical supervision:

Frequency is monthly

- Team with trained facilitator
- Reflective Practice

Team supervision related to Children:

Frequency, as required

- To review child/adolescent referrals in a reflective environment.

- **PLT meetings:**

Daily MDT meetings:

Frequency is daily

- Review of new referral and cases for review
- Multi-disciplinary feedback
- Duty planning
- Daily co ordination

Business/Team pathway meetings:

Frequency is monthly

- Update and discussion related to performance
- Review of pilot clinics
- Team working
- Staff availability
- Feedback from operational management/ governance
- Patient safety
- Risk register – review of SUIs

Acute Services

Introduction: this section relates to Acute Adult Beds, Later Life beds, Psychiatric Intensive Care Unit (PICU) Home Treatment Services, Psychiatric Liaison service. The standards and processes apply across Suffolk the variations to the models are included in the individual operational policies.

Admissions:

- All admissions to the acute beds are managed through a Gatekeeping system in hours this is managed by the Home Treatment Team out of hours by the AAT.
- Admissions are in line with trust Admissions Policy CO1
- Where a bed is not available within the locality the service user will be transferred to the nearest available NHS bed in the first instance, in the event an NHS bed is not available funding for a private bed will need to be requested, within hours this is directly from the CCG, out of hours County Manager on call.

Psychiatric Intensive Care Unit: (PICU)

Lark Ward is a 10 bedded mixed gender adult Psychiatric intensive care unit (PICU). Psychiatric intensive care is for those who are in an acutely disturbed phase of a serious mental health disorder. There is an associated loss of capacity for self-control, with a corresponding increase in risk, which does not allow their safe, therapeutic management, and treatment in a less acute or less secure mental health ward.

Patients referred must be detained under the mental health act and present with behaviour that generally falls under one of the following criteria

- Externally directed aggression. A patient is assessed as posing a significant risk of harm to others, or extreme aggression towards property;

- Internally directed aggression. A patient is assessed as posing a significant risk of suicide and the patient is unresponsive to preventative measures available;
- Absconding. Patients who are detained under the MHA 1983, for whom the consequences of persistent

Absconding is serious enough to warrant treatment in the PICU. The PICU should not provide security

For its own sake, there should always be a primary clinical reason for admission to prevent absconding;

- Unpredictably. Unpredictable patients, potentially posing a significant risk to self or others and requiring further assessment.

Referrals to Lark should be carried out by completing the PICU referral form (available from Lark Ward) along with an up to date core assessment and risk assessment. Indicators for transferring back to the referring environment i.e. Acute Ward should be established prior to admission to PICU and once these have been achieved the patient will be transferred back to the referring team to ensure least restrictive practice is adhered to.”

Adult/Later life Acute inpatient:

Suffolk Acute inpatient services consist of the following wards located in two separate units.

Northgate ward – 21 beds (Adult) – Wedgwood House, Bury St Edmunds

Southgate ward – 16 assessment beds (Adult) – Wedgwood House, Bury St Edmunds

Abbeygate ward – 10 functional & 7 Dementia beds (Later life) – Wedgwood House, Bury St Edmunds

Avocet ward – 20 beds (Adult) – Woodlands unit – Ipswich

Poppy ward – 20 beds (Adult) – Woodlands unit - Ipswich

Willows ward – 10 functional & 10 Dementia beds (Adult) – Woodlands unit - Ipswich

Admission to the Acute inpatient wards:

Admission to the Acute inpatient wards will be ‘gate kept’ via the Home Treatment Team (0730-2100) and the Access and Assessment Team (2100-0730) 7 days a week. Regardless of the source of the admission, these Teams will be contacted by the referrer. Within the home treatment team operating hours, all potential admissions must be discussed to consider home treatment as an alternative to hospital.

Initial management plan/Ongoing Treatment:

Following the initial assessment both the admitting nurse and doctor, will immediately formulate a management plan with the service user. This initial plan forms the basis of an initial care plan for review within the first ‘MDT review meeting’. A multi-disciplinary review meeting takes place on the ward each working day; the purpose of the meeting is to briefly review all new admissions and to outline a treatment plan based on the information gathered through the assessment process using the SBAR handover tool. The meeting will also be used to monitor existing inpatients’ progress of

treatment and to plan discharge/transfer/expected length of stay and ongoing treatment. The wards have full access to an Occupational Therapy programme and Psychology.

Discharge:

Following a successful inpatient stay, the Discharge Checklist/CP5 discharge letter will be completed within 1 working day of discharge. An initial 48 hour telephone follow-up will be completed by the discharging ward. The CP5 will identify the appropriate practitioner completing the 7-day follow up in the community. Key stakeholders who need to be fully informed of aftercare arrangements are the patient themselves, their relatives, community services and the patient's GP.

Meetings:

Clinical:

Daily clinical MDT meeting occur daily which consist of the following:

- New admissions/discharges
- 24 hour patient/ward overview (using SBAR)
- Review/discuss observations
- Identify changes to individual care/treatment plan
- Review individual risk factors.

Business:

Take place monthly within each ward chaired by the ward manager

- Feedback from Operational management team/governance issues
- Finance
- Performance
- Patient safety
- Service pressure/risks
- Service development

Reflective Practice groups:

- Reflective practice groups will take place monthly
- Each meeting will have a named chair who will be responsible for facilitating the meeting and taking notes. The chair will rotate six monthly.
- The documentation will be standardised to ensure a consistent format for the meetings.
- One of the functions of the groups will be to review and discuss any Serious Incident (SI) Reports to share learning.

Home Treatment Team;

The Home Treatment service is an alternative option to an acute psychiatric admission for those aged 18 and above. The patients referred to the team will be experiencing acute mental health issues and will present with associated high risks to themselves or others.

Referrals are received from assessors within the Access and Assessment (AAT), Psychiatric Liaison and Liaison and Diversion teams as well as clinicians within the Integrated Delivery Teams (IDT.) A critical part of the role of the HTT is the ability to offer timely discharge from the acute wards and an emphasis is placed upon regular attendance on the wards.

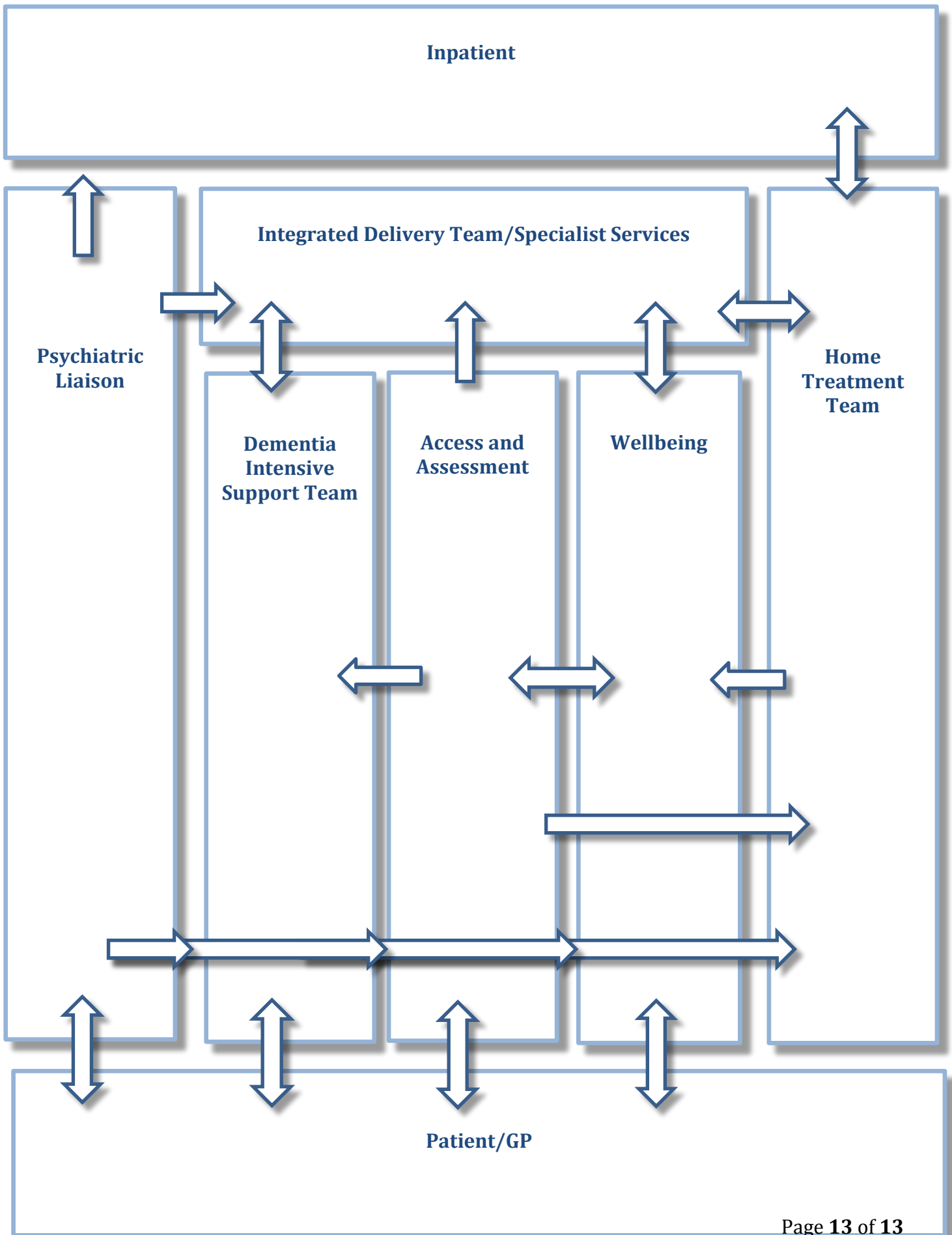
The HTT gate keep all admissions during their working hours.

Patients under the care of the HTT can expect to receive intensive input at home to help manage their difficulties, and support for their family/carers is seen as critical in achieving successful outcomes.

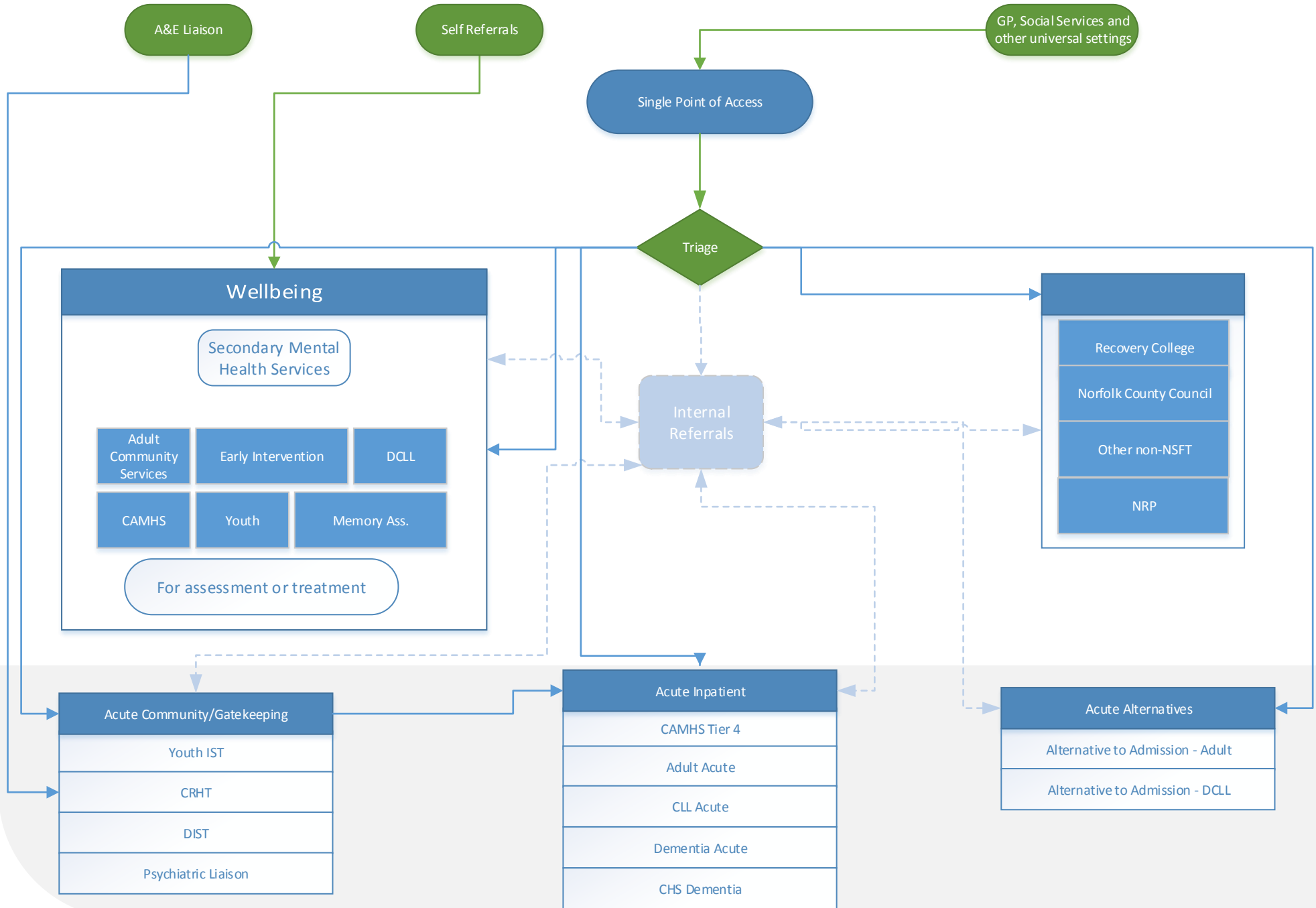
The service operates every day of the week, between 0700hrs- 2200hrs and is multi-disciplinary in its approach. Patients can be visited more than once a day if clinically indicated and twice daily handover meetings allow for a consistent, team approach.

Good relationships with other local mental health teams are key to the success of the home treatment team, and clear pathways (with discharge indicators) are identified to ensure that the patient receives the appropriate input at the required time.

NSFT - SUFFOLK SERVICE MAP



NSFT Norfolk Pathways: Referrers (GPs, A&E, Self etc.)



Date:	23 June 2016	M
Item:	16.108v	

Norfolk and Suffolk

NHS Foundation Trust

Report To:	Trust Public Board
Meeting Date:	23 rd June 2016
Title of Report:	Safe Staffing Update
Action Sought:	For Assurance
Estimated time:	5 minutes
Author:	Dawn Collins, Deputy Director of Nursing and Professional Practice
Director:	Jane Sayer, Director of Nursing and Quality

Executive Summary:

NHS England and the National Quality Board require Trusts to review staffing levels on their in-patient units/wards on a six monthly basis. Following an initial comprehensive review of ward nurse staffing levels in April 2014, there have been two follow up six monthly reviews (excluding this one). This has included a review of staffing following the CQC inspection in October 2014.

The six monthly reviews ensures that the Board is kept abreast of ward staffing levels and assured that safe staffing levels are being maintained. Both monthly Unify data reports and the six monthly reviews are published on NHS Choices and the Trust website. Daily staffing levels are also displayed on wards each day so that patients and the public are aware of the 'real time' situation on that day.

Recruitment to Registered Nursing posts remains difficult, and risks to delivery of clinical quality are mitigated by use of temporary staff, including Care Support Workers when necessary. We continue to work hard to address the reasons why, at times, actual staffing levels do not meet the planned requirement. We are carrying out robust recruitment drives for registered nurses and reviewing issues including staff sickness, vacancies and unavailability of bank or agency staff.

The purpose of this paper is to set out safe staffing levels for each clinical area, ward by ward and to demonstrate review of those staffing levels. Currently there is no agreed national staffing tool for Mental Health, so professional judgement has been applied, and benchmarking where available.

Trust Public Board – Safer Staffing Six Monthly Review	Version 1.1	Author: Dawn Collins Deputy Director of Nursing and Professional Practice Department: Trust Management
Page 1 of 11	Date produced: 1 st June 2016	Retention period: 20 years

1.0 Report contents

- 1.1 Review of staffing levels in Norfolk and Suffolk Foundation Trust (NSFT) within inpatient areas and the process of the review.
- 1.2 Update on information from national pilots regarding evidence-based tools to determine safe staffing levels nationally.

2.0 Update on expectations of Trust Boards following the publication of Hard Truths

- 2.1 From April 2014, NHS Trusts have been required to publish ward level information on whether they are meeting their staffing requirements. Actual versus planned nursing and midwifery fill rates must be published every month. NSFT, in accordance with this requirement, has reported these figures daily on each inpatient area and monthly via the national reporting Unify 2 system and to NSFT Board.
- 2.2 The table below indicates the average fill rates on a month by month basis within NSFT for the last six months. Alongside the reported information on Unify 2 the Board also receives a monthly update on all staffing concerns reported via the datix system within NSFT.

Table 1: Mean staffing, actual against establishment, November 2015-March 2016

	RN % fill against establishment	HCA % fill against establishment
Day shifts		
November 15	89.2%	118.3%
December 15	85.4%	120.9%
January 16	80.8%	122.5%
February 16	85.5%	130.7%
March 16	89.3%	137.5%
Nightshifts		
November 15	89.0%	143.4%
December 15	84.4%	140.9%
January 16	87.2%	148.4%
February 16	85.2%	167.7%
March 16	91.4%	171.2%

- 2.3 This six monthly review has been conducted using professional judgement (a recognised technique in the absence of other tools). To date, there has been

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no publication of National Institute for Health and Care Excellence accredited tools for Mental Health Services.

2.4 The figures in Table 1 show that Registered Nurse cover has often fallen below the safe staffing numbers recommended. On these occasions, additional staff are sought from NHSP and agencies, and if there is no nursing staff available, cover is provided by additional Care Support Workers (CSWs). The elevated numbers for CSWs also include booking of additional staff to cover training, and increased levels of observation. Staff regularly report staffing issues as incidents using Datix, so trends are identified. There is also an escalation process in place when levels of staffing fall below required numbers, and there is no additional staffing availability (Appendix 1)

2.5 The Trust Board will continue to receive updates every six months on staffing levels, which allow for the collection of several data points to inform appropriate staffing.

3.0 New developments to support safe staffing and quality care

3.1 The Deputy Director of Nursing and Professional Practice is taking the lead on future safe staffing reviews and reporting within NSFT.

3.2 E-Rostering is now implemented across all in-patient areas to support safe, fair and efficient rostering practices across NSFT.

4.0 Review of staffing levels across inpatient areas

4.1 During May 2016 the Deputy Director of Nursing and Professional Practice, has undertaken a high level review of the staffing levels across inpatient areas. (Appendix 2)

4.2 Further consultation was sought from locality managers following this review for their sign up and agreement for recommended establishments. Further staffing requirement will be subject to a business case.

4.3 Ward staffing numbers were submitted to the finance team who calculated final establishments using a shift calculator.

5.0 National updates and progress related to evidence-based tools and practice.

5.1 Work continues within the National Mental Health and Learning Disability Forum with regard to developing an evidence-based tool to calculate the required numbers within Mental Health and LD services to ensure not only safe staffing numbers but reflecting skill mix and MDT working. Pilot sites have been identified to trial an adapted existing evidence-based tool (HURST Tool) to evaluate its effectiveness within Mental Health and LD environments. The implementation of the pilot is expected in autumn 2016. Results of the pilot will be shared with forum members as the pilot progresses.

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5.2 The National Clinical Lead for the Lord Carter Review Lyn McIntyre will be visiting NSFT on 20th June to begin work with us to becoming a pilot site going forward.

6.0 Risks / mitigation in relation to the Trust objectives (implications for Board Assurance Framework)

6.1 The provision of safe levels of staffing is a fundamental requirement of the Trust. Although recommended staffing levels are well-developed and resourced, the availability of Registered Nurses remains a risk. On many occasions, cover is available from NHSP and agencies, and on those occasions where this is not possible, Care Support Worker numbers are increased to provide additional numbers of staff. There is a clear escalation process in place and staff are encouraged to report staffing concerns, which are then followed up by the appropriate Locality Manager.

6.2 There have been no reports of harm occurring to service users due to low staffing levels in the past year, but it may be the case that lengths of stay are prolonged by the lack of availability of suitably trained staff, and that those staff who work on shifts with reduced staffing numbers are subject to additional stress. The QuESTT tool (early warning system) measures aspects of this and provides an additional alert to managers, including the ability to track on-going but not acute concerns, and take appropriate action according to an escalation process.

6.3 It should also be noted that reviews of staffing take place outside the formal process, when bed numbers or acuity changes. For example, Thurne's ward staffing will be adjusted when the additional three beds open.

7.0 Recommendations

7.1 The Trust Board is asked to note and approve the contents of this report.

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Safe Staffing Escalation

Standard Operating Protocol (SOP)

The National Quality Board (NQB) Guidance 2013 makes clear the expectation of all NHS organisations around the need for robust escalation processes. This also provides a clear and consistent framework for staff at times of increased pressure and risk around inpatient staffing levels and is included within each inpatient area's operational policy as a SOP.

The NQB guidance states that staff should be aware of the escalation procedures in place, flag where they think staffing capacity and capability fall short of what is required and be able and prepared to use the escalation procedures.

The escalation procedure within this document outlines the actions to be taken, the people who should be involved in decisions in short, medium and long term staffing shortages, and outline the contingency steps where capacity problems cannot be resolved.

The service managers hold responsibility and professional accountability for ensuring that robust escalation procedures are embedded within their respective inpatient areas and that these are followed in line with the RAG rating guidance.

Service managers and on-call managers will be involved in the decision-making/authorisation process and keep a record of contingency actions taken.

All ward/unit managers or, in their absence, the nurse in charge (NIC) should evaluate and risk assess the staffing levels on a shift by shift basis utilising the RAG rating guidance.

On discovering a staffing shortfall, the NIC should refer to the process described here, take the appropriate actions to RAG rate the current situation and advise managers accordingly.

What overarching policy does the procedure link to?
HRP056 – Rostering Policy

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Which services of the Trust does this apply to? **Where** is it in operation?

Division	Inpatients	Locations
Mental Health Services	✓	all
Learning Disabilities' Services	✓	all
Children and Young People's Services	✓	all

Who does the procedure apply to? (staff roles and responsibilities)

- Service/deputy service managers
- Ward/unit managers
- Nurses in charge of inpatient wards/units

When should the procedure be applied? (Context)

- In situations where staffing level is insufficient within an inpatient ward/unit

How to carry out this procedure (step step-by-step information)

Rating	Trigger/Impact	Action	Authorisation
Green	<p>Staffing levels: 'We have' matches 'We planned'.</p> <p>Patient acuity & dependency: is within usual expected range for the area.</p> <p>Situation: "business as usual".</p>	<p>All care and routine tasks will be carried out.</p> <p>Allocation of duties, tasks, breaks etc. by nurse in charge (NIC).</p>	Nurse in charge
Amber	<p>Staffing levels: A shortfall has occurred between 'We have' and 'We planned' e.g. due to staff absence.</p> <p><u>And/or</u></p> <p>Patient acuity & dependency: is increased from that usually expected e.g. requiring increased clinical observation levels or other staff-intensive interventions.</p> <p>Situation: A short term (1 - 2 shifts) increase in activity that can be resolved by short term provision of additional resources.</p>	<p>Some non-essential activities may be postponed or cancelled until situation is resolved as determined by the nurse in charge.</p> <p>NIC seeks redeployment of staff from other areas.</p> <p>Or, where this is unsuccessful, requests additional bank cover as required.</p>	<p>Nurse in charge</p> <p>Advise unit manager or service manager of situation and actions taken.</p> <p>Update the above if/when actions are fruitless or situation is resolved.</p>
Red	<p>Staffing levels: A shortfall has occurred between 'We have' and 'We planned' that</p>	<p>All non-essential tasks are suspended – specifics agreed by service manager</p>	<p>Advise unit manager and service manager (out of hours - manager on call) of</p>

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	<p>cannot be met in the short term by redeployment of staff from other areas or by bank staffing.</p> <p><u>And/or</u></p> <p>Patient acuity & dependency: professional judgement indicates that risks presented are beyond that which can safely be managed without increasing staff numbers.</p> <p>Situation: An urgent situation that requires immediate extra staffing or a longer term staffing shortfall (3 shifts+) that requires continued planned allocation of additional staff.</p>	<p>and unit manager/nurse in charge.</p> <p>Seek redeployment of staff from other areas, request additional bank cover and/or agency cover.</p> <p>Nurse in charge reports on DATIX "Staff & Staffing Issues" incident - sub category: "Cause for concern due to fall in staff levels".</p>	<p>situation and seek authorisation for actions to be taken.</p> <p>Agree frequency of review of situation with above: short term issues may be reviewed a number of times within a day, longer term issues reviewed at least daily and involve general manager.</p> <p>Individual patient acuity/dependency will be reviewed by MDT and care plan amendments or onward referral agreed where required.</p> <p>Update all above as required and advise when situation is resolved.</p>
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Additional guidance to ensure safe staffing and manage the use of agency staff:

- Assessing patient acuity and dependency to see how far the existing nursing skill mix could be flexed to meet patients' needs cost-effectively.
- Considering not filling shifts when there is a short-term staff shortage and only if it is safe to do so.
- Depending on the level of patient risk, engaging on a temporary and fixed basis another member of the MDT who is professionally qualified; staff such as allied health professionals, technical support staff such as activity co-ordinators or nurse therapists or clinical psychologists to supplement the nursing workforce.
- Flexibly deploying existing nursing staff from neighbouring areas to undertake work beyond their usual area (provided they are competent to do so).
- Assessing nursing staff availability on all frameworks that have been approved such as NHSP.

Where do I go for further advice or information?

- Your service/deputy service manager, matron
- Locality manager

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Training

Staff may receive training in relation to this procedure where it is identified in their appraisal as part of the specific development needs for their role and responsibilities.

Please refer to the Trust's Mandatory & Risk Management Training Needs Analysis for further details on training requirements, target audiences and update frequencies.

Monitoring / review of this procedure

In the event of planned changes in the process(es) described within this document or an incident involving the described process(es) within the review cycle, this SOP will be reviewed and revised as necessary to maintain its accuracy and effectiveness.

Equality Impact Assessment

Please refer to overarching policy.

Data Protection Act and Freedom of Information Act

Please refer to overarching policy.

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Appendix 2

		Early	Late	Night	Changes
Gt Yarmouth & Waveney					
GY&W Acute - 32300	Qualified	3	2	2	None
20 beds	Unqualified	2	3	2	
Foxglove - 32401	Qualified	2	1	1	None
11 beds	Unqualified	3	4	3	
Fernwood - 32402	Qualified	2	1	1	None
11 beds	Unqualified	3	4	3	
Tier 4 CAHMS - 32100	Qualified	2	2	1	None
(5 Airey Close)	Unqualified	2	3	2	
Sweetbriar - 32403	Qualified	2	1	1	Ward
Temp closed	Unqualified	3	4	2	Closed
6 & 7 Airey Close closing soon.					
West Norfolk					
Churchill Ward - 34300	Qualified	3	3	2	None
20 beds	Unqualified	2	2	2	
Central Norfolk					
Rose - 33406	Qualified	2	2	1	None
13 beds	Unqualified	3	3	3	
Reed - 33407	Qualified	2	2	1	None
13 beds	Unqualified	3	3	3	
Beach - 33401	Qualified	3	2	2	None
13 beds	Unqualified	3	4	3	
Sandringham - 33402	Qualified	3(3)	2(2)	1(2)	Change to
15 beds (previous in brackets)	Unqualified	3(3)	4(3)	4(2)	Skills mix
Glaven - 33300	Qualified	3	3	2	None
20 beds	Unqualified	2	2	2	
Waveney - 33301	Qualified	3	3	2	None
20 beds	Unqualified	2	2	2	
Rollsby - 33306	Qualified	3	3	2	None
10 beds	Unqualified	3	3	4	

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Thurne - 33315	Qualified	3	3	2	Change to
12 beds	Unqualified	2	2	2(1)	Night CSW
Secure Services					
Acle - 30906	Qualified	2	2	2	None
8 beds	Unqualified	3	3	2	
Catton - 30907	Qualified	2	2	2	None
10 beds	Unqualified	3	3	2	
Drayton - 30908	Qualified	2	2	1	None
16 beds	Unqualified	3	4	2	
Thorpe - 30910	Qualified	1	2	1	None
8 beds	Unqualified	2	3	2	
Yare - 30903	Qualified	2	2	1	None
15 beds	Unqualified	3	3	3	
Whitlingham - 30902	Qualified	2	2	2	
12 beds	Unqualified	2	3	2	
Foxhall House - 30904	Qualified	2	2	2	Bed no
11 (15) beds	Unqualified	2	3	2	changed
Suffolk East					
Poppy	Qualified	3	3	2	None
21 beds	Unqualified	3	3	2	
Avocet	Qualified	3	3	2	None
21 beds	Unqualified	3	3	2	
Lark (PICU)	Qualified	3	3	2	None
10 beds	Unqualified	3	3	4	
Willow	Qualified	3	3	2	None
21 beds	Unqualified	4	4	3	
Walker Close	Qualified	2	2	2	None
11 beds	Unqualified	4	4	3	
Suffolk West					
Northgate	Qualified	3	2	2(1)	Night
21 beds	Unqualified	2	3	2	
Southgate	Qualified	3	3(2)	2	Late inc
20 beds	Unqualified	3	3	2	

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Abbeygate	Qualified	2	2	2	None
17 beds	Unqualified	4	4	2	

Figures in brackets are from the previous review in 2015.

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Norfolk and Suffolk

NHS Foundation Trust

Report To:	Board of Directors – Public
Meeting Date:	23 rd June 2016
Title of Report:	Chair’s report of Audit & Risk Committee on 10 th June 2016
Action Sought:	For Assurance
Estimated time:	10 minutes
Author:	Ian Brookman – Chair of Audit & Risk Committee
Director:	Ian Brookman – Non-Executive Director

Executive Summary:

The report provides assurance on system processes, procedures and controls which operate across the Trust

Assurance review

Issue reviewed by committee	Commentary (including actions where required)	Level of assurance
Legal claims Jan-May 2016	The Committee received an update from the Legal Services Manager on the number of claims against the Trust (Employers Liability: 21 open cases; Public Liability: 6 open cases; Clinical negligence: 21 open cases & 10 funded inquests). The Committee asked for benchmarking information to compare against, but noted our low number of legal claims compared to the number of reported incidents. It was also reported our low claims incidence had seen our contribution to the NHS Litigation Authority reduce over the previous year, which provided assurance on the level of claims.	Green
Internal Audit Annual Plan	The plan for the year was approved. The reduction of 49 days in low risk areas compared to 2015/16 was agreed.	Green
Audit & Risk Committee Annual Report	The Committee reviewed the report which is submitted to the Board for approval.	Green
Risk Register	The Committee received the extract of the risk	Green

Board of Directors – Chair’s report Audit & Risk Committee	Version 1.0	Author Ian Brookman Department: Corporate
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RED = significant gaps and not assured on adequacy of action plans	AMBER = Gaps in assurance but assured appropriate plans in place to address	GREEN = No gaps in assurance

	register (risks of 12 and above). The Committee asked for risks relating to Lorenzo to be split between ICT/system risks and operational practice risks, and for the register to identify trust-wide risks where these were listed as locality risks.	
Losses and special payments	The Committee received on payments up to 31 st May. The Committee asked for some additional information and presentational changes.	Green
QIPs	The Committee received a report on QIPs assigned to A&R. The Committee asked for an update to be circulated on how QIP0016 Community Caseload Management will return to green.	Amber
Internal Audit update	The Committee received a verbal update from Colin Larby, Deputy Head of Internal Audit. An audit of security of the Trust network and systems had been undertaken in March and weaknesses in security of the N3 connection were found. The Director of Strategy and Resources has provided an update on the issue.	Amber
Performance review of Internal Audit	The Committee considered the performance against a number of criteria. 12 month's notice has previously been served on the current provider to enable market testing of the service.	Green

Recommendations

The Board is asked to note the content of this report and support the need to emphasise continued vigilance on application of systems, controls and procedures across the Trust

Ian Brookman
Chair of Audit and Risk Committee
13th June 2016

Board of Directors – Chair's report Audit & Risk Committee	Version 1.0	Author Ian Brookman Department: Corporate
Page 2 of 2	Date produced:	Retention period: 30 years
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Report To:	Board of Directors
Meeting Date:	23rd June 2016
Title of Report:	Chairs Report Quality Governance Committee 24 th May 2016
Action Sought:	For Assurance
Estimated time:	10 minutes
Author:	Gary Page – Chair of Quality Governance Committee
Director:	Gary Page: Chair

Executive Summary:

This report highlights the key issues arising out of the Quality Governance (“QG”) Committee on 24th May 2016.

Assurance review

Issue reviewed by committee	Commentary (including actions where required)	Level of assurance
Care Plans, Crisis Plans, Core Assessments and Risk assessments	The Trust had previously stated that all Service users would have up to date Care Plans etc. loaded onto Lorenzo by 18 th may. Whilst considerable work has been done I was disappointed that we were unable to evidence the extent to which we had met that target because we were unable to carry out automated reporting. A manual audit is underway and I have asked for this to get the urgent attention of the Executive to provide the necessary assurance, identify any gaps and provide the plan to address the gaps.	RED
Restrictive Interventions Annual report	We received the Restrictive interventions annual report. It confirmed a significant year on year reduction in prone restraint (20%) and seclusion (15%) but a small increase (2%) in total restraint. It is clear from the national benchmarking data that comparisons are complex and that there are areas where the Trust is still high relative to our peers. The Committee agreed that we would hold a learning event in September to better understand the benchmarking data and to identify best practice across the trust which we could replicate.	AMBER
Annual Complaints	We received the Annual Complaints report which	GREEN

Board of Directors – 23June2016 Chair’s report on 24May2016	Version 1.0	Author Gary Page Department: Corporate
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report	<p>showed a small reduction year on year from 608 to 592. The number upheld was 59% which is in line with other East of England MH trusts. It was pleasing to see the time to respond showing a significant reduction and it is now below the trust target of 30 days. There has been an increase in the number of complaints being reopened and this will be examined to see if changes to procedures can address this.</p> <p>We examined themes behind complaints and noted the number relating to patients and carers not feeling listened to which resonates with the Verita findings. We also noted the reduction in the number of complaints relating to staff attitude.</p>	
Level of Referrals	Central Norfolk Locality Governance reported they had analysed the high level of referrals and were working with the CCG to work with GPs to improve the understanding of secondary MH services.	GREEN
Serious Incidents	Following concern expressed last month about the wide variation between the number of Serious Incidents in Norfolk (50) and Suffolk (8). NRP had an unusually high number of Sis and when these are stripped out the numbers are broadly consistent with previous quarters.	GREEN
PMO Report	We reviewed the PMO Report for QIPs allocated to QGC. We were advised that a number remained at Amber but there was not the evidence to provide assurance that the QIP had delivered the desired outcomes. This was down to poor drafting of KPIs. I agreed to take this up with the CEO. There was one RED rated QIP relating to MHA Administration and the committee was advised of the remedial action being taken.	AMBER
Mortality review	We received the Terms of reference for the newly formed Mortality review Group and made some small changes. The Group has been set up following NHS Englands recently issued guidance. It will report to the Board via QGC and will be chaired by the Medical Director	GREEN

Forward look

Issue considered by committee	Commentary	Level of assurance
Delayed Transfers of care (DTOCs)	Concern was expressed at the April meeting that the official recording of DTOCs is showing that we are recording very low levels and significantly below "target" yet evidence from staff suggests significant numbers of patients medically fit to be discharged	AMBER

Board of Directors – 23June2016 Chair's report on 24May2016	Version 1.0	Author Gary Page Department: Corporate
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	but prevented from being so because of lack of a suitable place to go. Work is underway to address this reporting issue and this is expected to be resolved in September.	
Clinical Audit Schedule	The schedule was signed off based on assurance that it was the minimum necessary but I was concerned at the widely held view that because of the volume of audits so much effort was spent collecting data that there wasn't the time to learn from the audits and make changes. We were advised that data collection would become increasingly automated such that the burden on the front line would become less. We agreed to review the position when the next report was submitted in 3 months time.	AMBER

Recommendations

Please note the Report.

Gary Page
Chair Quality Governance Committee
31st May 2016

Board of Directors – 23June2016 Chair's report on 24May2016	Version 1.0	Author Gary Page Department: Corporate
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Norfolk and Suffolk

NHS Foundation Trust

Report To:	Board of Directors – Public
Meeting Date:	23 rd June 2016
Title of Report:	Chair’s report of Organisational Development and Workforce Committee 23 rd May 2016
Action Sought:	For Assurance
Estimated time:	10 minutes
Author:	Brian Parrott, OD&W Committee Chair & NED
Director:	Brian Parrott, OD&W Committee Chair & NED

Executive Summary:

This report highlights the key issues arising from the Committee meeting on 23 May 2016. Some of the issues from this meeting were reported verbally to the Board in May 2016. The meeting was well supported by all Director/senior executive colleagues.

Assurance review

Issue reviewed by committee	Commentary (including actions where required)	Level of assurance
OD & Workforce Strategy implementation progress and Performance review of key priorities (not elsewhere on agenda)	The committee considered progress on a number of key measures & welcomed improvements. Focus was on (1) ‘values’ implementation and differential staff attendance and recognition of importance in parts of some localities/services; (2) how far actions required locally as part of staff survey feedback on particular elements and in different places are being focussed and impacting positively; and (3) how appraisal rate performance is being improved in the context of an active performance management culture/expectations in the Trust more generally (and more simplified appraisal reporting)	Amber
Non –medical education	The committee set aside time to understand in some depth the nature and issues relating to our Psychology and OT workforces, including	Amber

Public BoD – 23 rd June 2016, OD&W Chair’s Report	Version 1.0	Author: Brian Parrott Department: NED
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	numbers (need for clarity), professional/clinical leadership, partner education links, and some of the day-to-day experiences and challenges for operational staff. Committee recognised recent increase of time for OT leadership but outstanding need in Psychology. Positive assurance offered on several aspects. It is possible that the Board as a whole may want more time to understand some of these dimensions, including for Physiotherapy, Dietetics and Speech and Language therapies - all key professionals in our multi-disciplinary teams alongside doctors, nurses and social workers.	
Medical education and leadership	Committee welcomed the now nearly complete new directorate staffing structure, but had outstanding assurance concerns about 'back-filling' in order to fully discharge roles, and particular concerns about the recent poor report of undergraduate medical education in the Trust.	Amber
Statutory and Mandatory training format, performance and monitoring OD Strategy	Major discussion given apparent poor performance – not acceptable to Trust or to partners (CCGs). Part of the concern is lack of confidence in data accuracy, whether we are measuring the 'right' things appropriately, and how / when there will be improvement. It is clear that Executives see this as a priority, with more rationalised expectations, and improved compliance and assurance about competency as well as better course attendance. Practical risks remain about improvements being achieved by the target dates set.	Red
Workforce and OD Strategies	<ol style="list-style-type: none"> 1) Leadership and management 2) Recruitment and retention 3) Staff wellbeing, and 4) Temporary Staffing Action Plan <p>All will be coming in one form or other to June 2016 Board for consideration / decision following discussion and observations at the OD&W Committee.</p>	Green

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Recommendations

On behalf of the Trust Board, the Committee meets quarterly and continues to play a rigorous and challenging monitoring, but also supportive role in relation to the wide range of transformational and more immediate practical performance improvements which are required by the Trust. The Board is asked to consider and note this report.

Brian Parrott
Chair, OD & Workforce Committee
31st May 2016

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Norfolk and Suffolk

NHS Foundation Trust

Report To:	Board of Directors
Meeting Date:	23rd June 2016
Title of Report:	Chairs Report Remuneration and Terms of Service Committee 6 th June 2016
Action Sought:	For Assurance
Estimated time:	5 minutes
Author:	Gary Page – Chair of Remuneration and Terms of Service Committee
Director:	Gary Page: Chair

Executive Summary:

This report highlights the key issues arising out of the Remuneration and Terms of Service Committee on 6th June 2016.

Assurance review

Issue reviewed by committee	Commentary (including actions where required)	Level of assurance
Very Senior Manager Pay	The Committee received an update which confirmed that we are compliant with the VSM guidelines. We asked that the VSM guidelines be circulated to the NEDs for information.	GREEN
CEO appraisal	The Committee received a summary of the appraisal process for the CEO and discussed performance against objectives and areas for focus in the forthcoming year. Assurance was received that the appraisal process was robust and the 2016/17 objectives appropriate.	GREEN
Executive Director Appraisals	The Committee reviewed the ED appraisals and objectives. Comment was made that the appraisal paperwork appeared cumbersome and lengthy and asked again for this to be reviewed to streamline the process. Assurance was provided about the robustness of the process .	GREEN
Executive Director Succession Planning	We received an update on ED Succession Planning. Assurance was provided that suitable	AMBER

Board of Directors – 23Jun2016 RemToS report	Version 1.0	Author Stuart Smith Department: Corporate
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RED = significant gaps and not assured on adequacy of action plans	AMBER = Gaps in assurance but assured appropriate plans in place to address	GREEN = No gaps in assurance

	plans existed for interim appointments but it was acknowledged that for substantive appointments we would be predominantly reliant on external appointments. The recently approved OD and Workforce strategy includes plans for talent management which will address this over the medium term. The committee asked for an update on the process for identifying high potential employees for the purposes of talent management and a more detailed succession planning grid at the December meeting	
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Forward look

Issue considered by committee	Commentary	Level of assurance
Terms of Reference	We asked for a review of the Terms of Reference for the Committee to clarify amongst other things the role of the Committee in respect of ED appraisals.	AMBER

Recommendations

Please note the Report.

Gary Page
Chair Remuneration and Terms of Service Committee
6th June 2016

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RED = significant gaps and not assured on adequacy of action plans	AMBER = Gaps in assurance but assured appropriate plans in place to address	GREEN = No gaps in assurance

Date:	23 June 2016	R
Item:	16.108x	

Norfolk and Suffolk 
NHS Foundation Trust

Report To:	Board of Directors – Public
Meeting Date:	23 June 2016
Title of Report:	Annual Report of the MHA Hospital Managers' Committee 2015
Action Sought:	For Assurance on work of committee For Approval of scheme of delegation
Estimated time:	15 minutes
Author:	Gary Page, Chair to the Committee Helen Dewson, Mental Health Legal Practice Advisor
Director:	Gary Page – Chair of the Committee

Executive Summary:

The purpose of this report is:

To provide assurance to the Board that the functions delegated to the Committee are being discharged appropriately.

To provide assurance to the Board that the functions delegated to the Committee adhere to the NHS Constitution Principles, as outlined below:

- The NHS provides a comprehensive service, available to all
- The NHS aspires to the highest standards of excellence and professionalism
- NHS services must reflect the needs and preferences of patients, their families and their carers
- The NHS is committed to providing best value for taxpayers' money and the most effective, fair and sustainable use of finite resources
- The NHS is accountable to the public, communities and patients that it serves

To seek approval for the scheme of delegation for MHA powers and duties (see appendix).

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1. Annual Report

1.1 Introduction

This is the fourth annual report of the Trust's Mental Health Act (MHA) Hospital Managers' Committee. It covers the role of the Hospital Managers and looks at the work they have carried out and progress they have made since the last report of March 2015.

1.2 The Role of the Hospital Managers

The Mental Health Act 1983 (as amended) and its associated Code of Practice define the Hospital Managers (in an NHS Foundation Trust) as the Trust. In practice this means the Board of Directors of the Trust and therefore, in its strictest sense, all of the Trust's Directors are its Hospital Managers. It is the Hospital Managers (collectively) under the MHA who have the authority to detain patients.

In practice, as the Code allows and the Trust's Scheme of Delegation details, most of the functions of the Hospital Managers are delegated to and carried out by staff of the Trust.

Special rules apply to the exercise of hospital managers' power to discharge patients from detention or CTOs. This power may not be delegated.

It is common to use the term "Hospital Manager" to indicate those specially appointed persons mentioned above but it should always be borne in mind that the term does also have a wider meaning encompassing all the members of the Board of Directors. The specially appointed persons operate by virtue of delegated authority from the Board of Directors and only for the purpose of considering discharge from detention or community treatment orders; their role is specifically limited to this function and they do not perform the wider duties assigned to Hospital Managers by the Act and the Code of Practice.

1.3 The Trust's Hospital Managers

The following have acted as Hospital Managers for the Trust during for the period March 2015 to June 2016

Chair and Vice Chairs of Committee	Gary Page. John Brierley March 2015 April 2016
Panel Chairs	
Mr Richard Beck	Ms Elizabeth Harlaar
Mr Robert Bennett (Vice Chair)	Mr John Hume (Vice –Chair)

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Mr Bob Billing	Mrs Tessa Innes
Mr Charles Birch	Mrs Paula Kerr
Mr John Brierley	Mrs Guenever Pachent
Lady Caroline Bunbury	Mr Brian Puplett
Mrs Margaret Cook	Mrs Janet Royce
Mrs Libby Cotton	Mrs Margaret Sparrow
Mr Graham Creelman	
	Total: 17
Panel Members	
Ms Emma Bishton	Dr Sally Haslewood
Ms Sue Brown	Ms Sui McCreadie
Mrs Anne Browning	Ms Carol Palfrey
Mrs Maggie Cowie	Mrs Marion Press
Mrs Penny Creasy	Mrs Angela Ringer
Mrs Joyce Cameron	Sir Sam Roberts
Mr Maurice Curtis	Mrs Mary Rodgers
Mr Sam Earl	Mrs Meryl Rushmere
Lady Kay Fisher	Mrs Marion Saunders
Mrs Angela Grange	Mr Jim Spencer
	Total: 20
Retired Hospital Managers	
Mr Jos Bird	Mrs Elizabeth Spinney
Ms Dawn Broughton	Mrs Maria Temple
Dr K Hugh Davies	Mr Len Wellings
Mrs Sheila Griffiths	Mrs Avery Fraser
Mrs Sheila Kefford	Mrs Fiona Prett
Mrs Josephine Phillips	
	Total: 11

Thanks are recorded to all hospital managers who have retired from the role. Dawn Broughton sadly passed away towards the end of 2015 after serving in the role for a number of years.

Thanks are also recorded to John Brierley and Richard Beck for their respective roles as Chair and Vice Chair. Gary Page has taken over as Chair of the Committee from April 2016. There are two new Vice Chairs, Robert Bennett and John Hume, appointed in April 2016.

1.4 Meetings and training in 2015/16

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The annual reviews for all Hospital Manager are currently taking place. These will be concluded by the end of June 2016.

The Committee held four meetings last year, each of which included a training session.

The training sessions held during the year were:

March 2015	MHA revised Code of Practice update Patient Safety
June 2015	Group discussion on role of Hospital Manager
September 2015	Introduction to Recovery College
December 2015	Equality and Diversity
March 2016	Capacity in Hearings

Attendance at quarterly meetings (details of which are set out in Appendix A) was an issue referred to in last year's report, and was again being highlighted in the appraisal system during 2014. The working group detailed below considered this issue and made revisions relating to mandatory attendance. See below at paragraph 1.7.

For the period March 2016 to June 2016, the MHA Hospital Managers' Committee was attended by Helen Dewson, Mental Health Legal Practice Advisor and Susan O'Hagan, Assistant to the Legal Services Department. Up to March 2016, it was also attended by Lynn Harvey, Mental Health Act Administration Manager.

Lynn Harvey left the Trust in March 2016 and has been replaced by Carol Suthers who commenced her role on 13 June 2016 and will be attending future meetings.

Maeve Sykes, Trust In-House Lawyer will attend as and when necessary.

Susan O'Hagan, Secretary to the Legal Services Department, remains secretary to the Committee.

(See Appendix C for a full list of NSFT staff working in the Trust's Legal and Mental Health Act Departments).

1.5 Patient Hearings in 2015

During 2015 there were a total of 198 Hospital Managers' Hearings held across the Trust at the locations shown in the table below. This is a slight fall on the number for the previous year 2014, which in turn had seen a slight fall in the number of hearings compared with 2013. Naturally numbers will fluctuate from year to year, and it is too early

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to draw any firm conclusions about the pattern of hearings. It may be a result of hospital admissions becoming shorter year on year and closure of beds. This trend will continue to be monitored. All detained patients are informed and reminded about their right to a hearing.

Appendix B shows more detail about these hearings.

Location	Hearings 2015	Hearings 2014	Hearings 2013
Carlton Court, Lowestoft	7	10	8
Fermoy Unit, Norwich	14	14	26
Hellesdon Hospital, Norwich	63	87	116
Julian Hospital, Norwich	2	5	7
Lothingland, Lowestoft	3	2	-
Meadowlands, Norwich	3	1	-
Northgate Hospital, Great Yarmouth	15	22	20
Norvic Clinic, Norwich	5	18	19
Foxhall House and Chilton House	9	3	
Wedgwood House, Bury	27	26	26
Woodlands, Ipswich	49	54	51
Community settings	1	3	1
Total	198	245	274

1.6 Working Group

In March 2015 the Hospital Managers Committee established a working group to review the Hospital Managers' handbook, and a range of related practices. The group consisted of Richard Beck (Chair), Robert Bennett, John Brierley, Helen Dewson (NSFT), Liz Harlaar, Lynn Harvey (NSFT), Janet Royce and Maeve Sykes (NSFT)

The working group met on a number of occasions over a six month period and periodically fed back their findings and suggested amendments to the full Committee. Responses and feedback were taken into account by the working group. Changes included the following:

The Role Description and Personal Specification was amended to include mandatory attendance at three of the four annual Hospital Manager Committees and at training sessions run at the Committees. There is also a minimum number of sittings set (8 per year) to ensure competence.

A Post-Hearing Reflective Feedback form was introduced, which will be used in addition to a self-appraisal, will feed into the paper appraisal and performance review scheme. The Committee is confident that the robust Personal Development Review Scheme will ensure competence and confidence for each Hospital Manager in their role.

Also included is a Statement of Independence to be read to each patient prior to the commencement of the hearing. This is intended to reassure patients of the fact that members of the panel are not employed by the hospital or Trust, will consider the matter

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with fairness and impartiality, and will make their decision entirely independently, and in accordance with the law.

The working group reviewed and amended the process for uncontested hearings to allow for papers hearings. The procedure now mirrors that for the Tribunal Services, but has been enhanced to provide additional safeguards. This will be reviewed December 2016.

As a result of the good work under taken by the working group, the Hospital Manager's Handbook was substantially amended and revised and came into effect on March 2016.

1.7 EU Referendum

All eligible detained patients across all sites in NSFT have been given their rights in relation to voting in the EU Referendum. Patients have either been registered for a postal vote, or alternatively, arrangements will be made for voting in person on the day of the referendum.

1.8 Other matters

Janet Royce is the Hospital Manager Committee representative at the Trust's bi-monthly Mental Health Law Forum (MHLF) which reports to the Quality Governance Committee. The MHLF develops, reviews and approves mental health law related policies and monitors the use of the MHA by the Trust.

A number of additional hospital managers have been appointed to act as panel Chairs. A programme of training is currently being devised to ensure competence in this area.

1.9 HM Safety at Hearings

Following an assault of an RC, and physical interventions of a HM during a CTO hearing, a thorough review of safety was completed. This has resulted in a risk assessment being undertaken for each hearing room across the Trust, and the implementation of a telephone in each room, which can be used to summon urgent assistance via 999 or internal emergency number.

1.10 Going forward

There have been a number of resignations and retirements during the period. This may be due to the introduction of mandatory attendance and minimum sitting numbers. A further recruitment programme is currently being discussed. It is anticipated that this will start in the Autumn 2016.

1.11 Acknowledgements

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The Trust formally acknowledges the very considerable amount of valuable work performed by its Hospital Managers during 2015.

2.0 Financial implications (including workforce effects)

2.1 There are no financial implications of the report.

3.0 Quality implications

3.1 The report provides assurance that the Trust is carrying out its statutory duties appropriately.

4.0 Equality implications / summary of consultation

4.1 National research shows that people from black and minority ethnic backgrounds are disproportionately detained under the MHA. Hospital Managers receive equality and diversity training to mitigate the risk of unconscious bias in decision making.

5.0 Risks / mitigation in relation to the Trust objectives

5.1 The work of the Hospital Managers' Committee supports the Trust's objective to provide quality services.

6.0 Recommendations

6.1 The board is asked to note the assurance provided by the annual report and to approve the Section 5(2) MHA 1983 nominated deputy statement shown in the appendix D.

Gary Page
Chair of MHA Hospital Managers' Committee
June 2016

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Appendix A - Attendance by Hospital Managers during 2015

Hospital Manager	No of Hearings attended 2015	No of Hearings attended 2014	No of quarterly meetings attended 2015	No of quarterly meetings attended 2014
A	15	-	3	-
B	24	28	3	3
C	17	22	3	2
D	18	18	4	4
E	16	22	4	2
F	9	20	3	3
G	16	17	4	0
H	19	21	1	2
I	6	13	3	1
J	7	22	2	2
K	13	13	1	2
L	12	24	3	4
M	12	20	4	2
N	5	12	0	2
O	13	19	2	2
P	20	19	2	3
Q	18	22	2	1
R	14	11	2	3
S	10	-	3	-
T	8	5	2	1
U	8	20	2	3
V	15	15	4	4
W	14	13	3	3
X	11	13	2	3
Y	25	32	4	3
Z	16	10	2	2
AA	10	10	0	0
BB	21	28	0	2
CC	9	18	2	2
DD	10	6	3	-
EE	10	14	2	2
FF	7	-	4	-
GG	17	22	4	4
HH	11	15	4	2
II	18	21	4	2
JJ	16	17	3	3
KK	10	22	2	4
LL	23	28	2	3
MM	10	19	-	3
NN	13	17	4	4
OO	-	6	-	0
PP	11	19	0	1
QQ	25	-	4	
RR	7	-	3	
SS	17	-	2	
TT	12	-	4	

UU	18	-	3	
VV	10	-	3	
WW	4	17	-	

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Appendix B

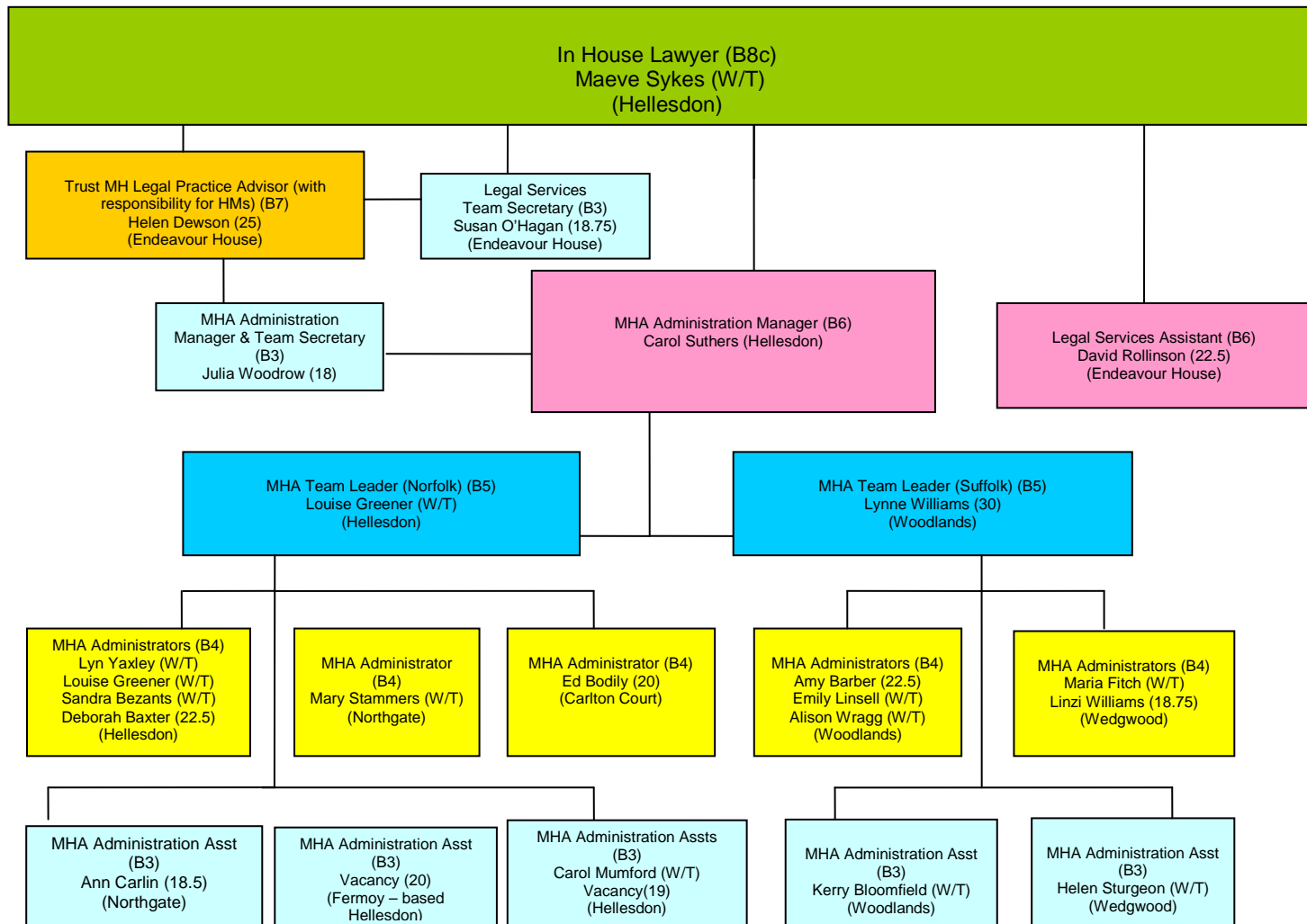
Hospital Manager Hearings 2015

Location	Type of hearing															
	S2 Appeal		S3 Appeal		S3 Renewal		Barring Order		S37 Appeal		S37 renewal		CTO appeal		CTO extension	
	D	ND	D	ND	D	ND	D	ND	D	ND	D	ND	D	ND	D	ND
Carlton Court				1		6										
Fermoy Unit		2		1		3								1	1	6
Hellesdon Hospital			1	11		12						5			1	33
Julian Hospital				1												1
Lothingland				1		2										
Meadowlands																3
Northgate Hospital						2										13
Norvic Clinic						4						1				
Foxhall House and Chilton House						3						6				
Wedgwood House		1		1		3										22
Woodlands		1		7		8									2	31
Community																1
Total		4	1	23		43						12		1	4	110

Notes: D and ND: Discharged/Not Discharged from detention.
 S2 and S3: Section 2 is detained for Assessment and Treatment/ Section 3 is detained for Treatment
 Barring Order: Hearing following decision of Responsible Clinician to bar Nearest Relative discharge (Section 25 MHA)
 S37: Section 37 Hospital Order without Restrictions
 CTO: Section 17A Community Treatment Order

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Appendix C



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Appendix D – Section 5(2) Nominated Deputy responsibility

DECLARATION UNDER THE MENTAL HEALTH ACT 1983

Under the authority of Section 5(3) of The Mental Health Act 1983, the named nominated deputy for the purposes of Section 5(2) of the Mental Health Act 1983 is as follows:

1. During normal working hours (Monday - Friday, 09.00 - 17.00) the RC nominates the most senior doctor in charge of the ward attached to the clinical team for that period of time.

In the event of that doctor being unavailable by reason of annual leave, sick leave, or study leave, he/she should be disregarded, and for the period of his/her absence, the duty falls to the most senior doctor on the ward who is providing clinical cover for the ward at the relevant time.

2. Outside normal working hours (17.00 – 09.00 Monday to Friday weekends) the duty falls to the RC named on the duty list as being the RC on-call at the relevant time.

Those persons carrying out the function of duty doctor, and named on the duty doctor rotas, have received sufficient guidance and training to enable them to carry out the functions under Section 5(2) of the Mental Health Act 1983 in a satisfactory manner.

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