# Great Yarmouth and Waveney Joint Health Scrutiny Committee

**(Quorum 3)**

**Date:** Friday, 15 April 2016

**Venue:** Burrage Centre (Lecture Theatre)
James Paget University Hospital
Lowestoft Rd
Gorleston-on-Sea
Great Yarmouth
Norfolk
NR31 6LA

**Time:** 10:30am

**Membership:**

| | |
|---|---|
| Cllr Colin Aldred | Norfolk County Council |
| Cllr Alison Cackett | Waveney District Council |
| Cllr Michael Carttiss | Norfolk County Council |
| Cllr Michael Ladd | Suffolk County Council (Chairman) |
| Cllr Bert Poole | Suffolk County Council |
| Cllr Shirley Weymouth | Great Yarmouth Borough Council |

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For further information on any of the agenda items, please contact Rebekah Butcher, Democratic Services Officer, on 01473 264371 or rebekah.butcher@suffolk.gov.uk

**Business to be taken in public**

1. **Public Participation Session**

   A member of the public who is resident, or is on the Register of Electors for Norfolk or Suffolk, may speak for up to five minutes on a matter relating to the following agenda.

   A speaker will need to give written notice of their wish to speak at the meeting using the contact details under 'Public Participation in Meetings' by no later than 12 noon on 11 April 2016.

   The public participation session will not exceed 20 minutes to enable the Joint Health Scrutiny Committee to consider its other business.

2. **Apologies for Absence and Substitutions**

   To note and record any apologies for absence or substitutions received.

3. **Declarations of Interest and Dispensations**

   To receive any declarations of interests, and the nature of that interest, in respect of any matter to be considered at this meeting.

4. **Minutes of the Previous Meeting** Pages 5-9

   To approve as a correct record, the minutes of the meeting held on 22 January 2016.

5. **James Paget University Hospital (JPUH) Transformation Plan and CQC Inspection follow-up – a progress update and action plan** Pages 11-36

   JPUH Chief Executive and Senior Management and GY&W CCG Chief Executive will update the Joint Committee on matters relating to the JPUH transformation programme.

6. **Information Bulletin** Pages 37-59

   These items are not intended for discussion at the Committee meeting. Further information may be obtained by contacting the named officer for each item. If there are any matters arising from this information that warrant specific aspects being added to the forward work programme or future information items, Members are invited to make the relevant suggestion at the time that the forward work programme is discussed. Topics include:

   a) Norfolk and Suffolk NHS Foundation Trust staff survey

7. **Forward Work Programme** Pages 61-62

To consider and agree the forward work programme.

8. **Urgent Business**

To consider any other item of business which, in the opinion of the Chairman, should be considered by reason of special circumstances (to be specified in the minutes), as a matter of urgency.

**Date of next scheduled meeting**

Friday, 15 July 2016, 10.30am, Riverside Campus, Lowestoft.

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**Deborah Cadman OBE**
**Chief Executive**
**Suffolk County Council**

**Chris Walton**
**Head of Democratic Services**
**Norfolk County Council**

**Unconfirmed**

Minutes of the Great Yarmouth and Waveney Joint Health Scrutiny Committee Meeting held on 22 January 2016 at 10:30 am in the Conference Room, Riverside Campus, Lowestoft.

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|---|---|
| Present: | Councillors Michael Ladd (Chairman, Suffolk County Council), Alison Cackett (Waveney District Council), Marlene Fairhead (Great Yarmouth Borough Council), Nigel Legg (South Norfolk Council), Bert Poole (Suffolk County Council) and Shirley Weymouth (Great Yarmouth Borough Council). |
| Supporting officers present: | Paul Banjo (Scrutiny Officer, Suffolk County Council), Rebekah Butcher (Democratic Services Officer, Suffolk County Council) and Maureen Orr (Democratic Support and Scrutiny Team Manager, Norfolk County Council). |

**21. Public Participation Session**

The Joint Committee heard from the following members of the public.

Mr Patrick Thompson, a member of the public, spoke in relation to Agenda Item 5: Decision following the 'GP practice premises in Gorleston and Bradwell' consultation. Mr Thompson informed the Joint Committee of his concerns in regards to what was happening within the local GP practices and the community at large. He stated that during consultation phase, the idea that all three practices would combine to one location gave a united approach to the consultation. Mr Thompson did not consider it appropriate that Family Healthcare were now in talks with Central Surgery, which was already struggling to accommodate the needs of patients, with car parking being very difficult and the building not being fit for purpose in the future. Mr Thompson felt that the Shrublands site would enable a complete look at Health, Social, Voluntary and other sectors to develop a site that would be a fully integrated service for a community in an area of high deprivation. Mr Thompson applauded the fact that the proposals were now being taken forwards with target dates. In conclusion, he suggested to the Joint Committee that they support the move to Shrublands as proposed and offer its reservations for the merger of the other two practices at Central Surgery.

Councillor Sonia Barker, Leader of the Labour Group at Waveney District Council, spoke in relation to business continuity at the James Paget University Hospital (JPUH) on 3-4 January 2016 when an unprecedented number of ambulances arrived to the accident and emergency department. Councillor Barker enquired whether dispersal of patients from Lowestoft had put additional pressure on the JPUH and asked what analytical work had been done in order to reassure the residents of Lowestoft in case an incident like this happened again.

The Chairman invited a brief comment from the GY&W CCG Chief Executive who stated that the 3 January event was a freak occurrence, with unprecedented pressure on the hospital. All of the local hospitals had pulled together to assist. Root cause analysis was underway and would reveal more detail but there was not thought to be any connection with the Lowestoft changes. Further information would be provided to the Joint Committee at its meeting in April 2016.

**22. Apologies for Absence and Substitutions**

Apologies for absence were received from Councillor Michael Carttiss (substituted by Councillor Marlene Fairhead) and Councillor Colin Aldred (substituted by Councillor Nigel Legg).

**23. Declarations of Interest and Dispensations**

There were no declarations made or dispensations given.

**24. Minutes of the Previous Meeting**

The minutes of the meeting held on 13 November 2015 were confirmed as a correct record and signed by the Chairman.

**25. Decision following the 'GP practice premises in Gorleston and Bradwell' consultation**

At Agenda Item 5, the Joint Committee received a suggested approach from the Scrutiny Officer (Suffolk County Council) to a report from the Great Yarmouth and Waveney Clinical Commissioning Group (CCG) about the NHS England decision, following the public consultation on 'GP practice premises in Gorleston and Bradwell'.

The Chairman welcomed Andy Evans (Chief Executive, Great Yarmouth and Waveney CCG) to the meeting and invited him to introduce the relevant sections of the report. Mr Evans summarised the consultation, and the decision that Shrublands was the most sensible location for the multi-disciplinary centre. One of the three GP practices involved in the consultation, Family Healthcare Centre, had changed their mind and was proposing to move in with the Central Surgery in Lowestoft; however they would consider a branch surgery in the new building.

Members asked questions about: the ownership of GP premises; whether the GY&W CCG were invited to comment on local authority planning consultations for housing; and how the CCG could encourage Family Healthcare to move to the Shrublands site.

Members noted a correction to the report at page 14, paragraph 3.6, 2nd line, amending 'Lowestoft' to 'Gorleston'.

**Recommendation**: The Joint Committee:

a) Reiterated its commendation of GY&W CCG on the thoroughness of its consultation;

b) Strongly endorsed NHS England's decision that the Shrublands site was the preferred location for the development of a purpose built primary care centre for Gorleston and Bradwell;

c) Recommended that GY&W CCG, whilst not a statutory consultee, should make more publicly visible its views on planning applications for new housing developments and the medical facilities needed; and

d) Confirmed it would not be making a report to the Secretary of State under Section 23 (paragraph 9) of the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) 2013 Regulations.

**Reason for recommendation**: Members were satisfied that NHS England had made a decision that agreed with the GY&W CCG recommendations, which the Joint Committee had supported at its previous meeting on 13 November 2015. The Joint Committee had noted the outline timescale for the project and that GY&W CCG had already submitted the bid to secure the centrally-held capital from NHS England to proceed with implementation as soon as possible.

Members enquired about the joined up working between the GY&W CCG and the local planning authorities with regards to new housing developments and the medical facilities required, and the use of Section 106 or Community Infrastructure Levy (CIL) funds for GP surgeries. The GY&W CCG Chief Executive stated that the CCG was keen to draw on any funding sources and that there were regular meetings of the Infrastructure Group with the councils, so the process was there to ensure that the CCG was aware of new developments. The CCG had built a good, trusting relationship with their Local Government colleagues over the past few years, recognising that much more could be achieved if working together. Mr Evans advised that a number of informal meetings happened with planning authorities outside of the public domain, but confirmed there should be further public visibility.

The GY&W CCG Chief Executive said that ownership of GP premises in the area was a mixture of GP owned, private company owned and rented to the NHS, or NHS owned. It was anticipated that there would be inevitable movement to consolidate practices, with fewer, larger practices in better facilities, however Members' concerns were shared regarding the impact on rural communities and the need to work out ways to address rural transport issues.

**Alternative options**: There were none considered.

**Declarations of interest**: There were none declared.

**Dispensations**: There were none noted.

## 26. Implementation of the Changes to Adult and Dementia Mental Health Services in Great Yarmouth and Waveney

At Agenda Item 6, the Joint Committee received a suggested approach from the Scrutiny Officer (Suffolk County Council) to a report from the Great Yarmouth and Waveney Clinical Commissioning Group (CCG) about its progress with implementation of the changes to adult and dementia mental health services in Great Yarmouth and Waveney.

The Chairman welcomed the following witnesses to the meeting:

Gill Morshead (Locality Manager, Norfolk and Suffolk NHS Foundation Trust (NSFT)); and

Andy Evans (Chief Executive, Great Yarmouth and Waveney CCG).

The Chairman invited Gill Morshead to introduce the report. Consultation had taken place in 2014, and the Joint Committee had received an update in 2015. The implementation was a phased approach, covering the three areas of Adult acute care, Adult dementia and Information Centres, with the general direction being the provision of services closer to those in the community and at home where possible.

Members asked questions about: staffing levels throughout the transition process; the types of care available to patients in their own home; engagement with the voluntary sector; the numbers and cost of patients having to receive treatment outside of their locality; whether the number of new beds at Northgate Hospital accounted for the forecasted population increase; whether the care homes should be paying to train their staff; the long waiting list for counselling in the new Wellbeing Service; and involvement in the transformation plan for Child and Adolescent Mental Health Services (CAMHS).

**Recommendation**: The Joint Committee:

a) Noted the good progress on implementing the changes to adult and dementia mental health services in Great Yarmouth and Waveney, and establishment of the children's service at Carlton Court;

b) Recommended that NSFT and GY&W CCG look into reported concerns regarding capacity and timeliness of referrals for the new 'Wellbeing Service'; and

c) Confirmed it would revisit the projects progress in 6 months to a year.

Members also:

a) Noted that NSFT staff survey results would be available during February/March; and

b) Confirmed a site visit would be arranged for the Joint Committee to visit the new Great Yarmouth Acute Services facility at Northgate Hospital.

**Reason for recommendation**: Members noted that, during the changes to the adult pathway, occupied bed days had remained constant, and there had been no need for any out-of-area bed placements; this was a credit to the teams, including the crisis team. There were now 20 beds available, however the first line of intervention was to see people in their own home.

Members noted that, with regard to dementia and complexity in later life, the early intervention by the Dementia and Intensive Support Team (DIST) had ensured that no more than 40% of the hospital ward capacity had been used.

The GY&W CCG Chief Executive said that NSFT have been excellent partners in taking this project forward, and it was encouraging that evidence has backed

up the estimates of the number of beds required. They would continue to review the assumptions and adapt if needed.

Staff issues were being taken very seriously and the NSFT had worked really hard to support staff. The results of the staff survey were due in February/March.

With regard to the Resource Information Centre, the NSFT was looking to work with schools and Third Sector colleagues to give information and support at an early stage. Patients wanted locations that they already used, eg. libraries.

Members raised some perceived concerns about the capacity and delays in referring people to the Wellbeing Services, whilst recognising it was a new service that was still settling down.

**Alternative options**: There were none considered.

**Declarations of interest**: There were none declared.

**Dispensations**: There were none noted.

**27. Information Bulletin**

The Committee noted the information bulletin at Agenda Item 7.

During a verbal update from the Chief Executive of GY&W CCG regarding the managed list dispersal for former patients of the closed Oulton Medical Practice, the GY&W CCG indicated it could make available to members the 'Estates Strategy' document.

**28. Forward Work Programme**

At Agenda Item 8, the Joint Committee agreed its Forward Work Programme with the inclusion of an additional agenda item at the 15 July 2016 meeting on the GY&W CCG's approach to delivering services to children who have an Autistic Spectrum Disorder, with particular regard to perceived delays in getting assessments.

It was also agreed to include a future item in relation to Learning Disability Services in the Great Yarmouth and Waveney area.

With regard to the topic at the April 2016 meeting regarding services at the James Paget University Hospital, Members requested that it include information on root cause analysis from the 3 January 2016 surge in demand at the Accident and Emergency department.

**29. Urgent Business**

There was no urgent business.

*The meeting closed at 12.35 pm.*

Chairman

Norfolk County Council at your service

Suffolk County Council

**Agenda Item 5**

# Great Yarmouth and Waveney Joint Health Scrutiny Committee

## 15 April 2016

## Covering Report: James Paget University Hospital Transformation Plan and CQC Inspection follow-up – a progress update and action plan

Suggested approach from the Scrutiny Officer.

James Paget University Hospital (JPUH) Chief Executive and Senior Management and Great Yarmouth & Waveney CCG Chief Executive will update the Joint Committee on matters relating to the JPUH transformation programme.

### Background

1. At its meeting on 8 October 2014 the Joint Committee received information about the JPUH 2-year Transformation plan in an Information Bulletin.

2. At its meeting on 6 February 2015 the JPUH Chairman and Chief Executive spoke to the Joint Committee about the James Paget University Hospitals NHS Foundation Trust Transformation Plan. In the course of discussion the following key points were minuted:

   a) David Wright and Christine Allen explained how the transformation plan was about more than how the JPH could make cost savings in order to meet its financial targets, they said the transformation plan was about redesigning services and improving the welfare of patients and in particular the quality of patient care and patient safety.

   b) They said the JPH strived to meet its financial targets but would not compromise on patient care.

   c) Good progress was being made in meeting the challenges set out in the transformation plan.

   d) The JPH had seen a significant increase in demand for its services; in 2014/15 there was £2.8m of additional planned activity and £1m of additional activity related to emergency admissions. The hospital had experienced a 9% increase in A&E attendances and a 7% increase in emergency admissions.

e) The transformation strategy had been refined to focus on planned future activity and to include some pilot work in A&E and ambulatory services.

f) Increased admissions to A&E reflected a reduction in services available outside of the hospital and in community services, as well as increased public awareness of hospital services in general.

g) Seven day services had been achieved, particularly in the services necessary for safe discharge of patients such as consultants, radiology, diagnostics and social care. It was intended that all staff who worked in roles that were considered to be essential to patient safety (including temporary staff) and in the safe discharge of patients, should be employed in a 7 day service. Enhanced work rosters would be introduced for nursing staff to improve the care provided to patients. There was more work to be done on terms and conditions for other staff

h) The hospital was looking to Europe and to the Philippines to meet its need for additional nurses, where it had not been possible to recruit or retrain locally.

i) The service changes that arose from the transformation strategy would inform the way the JPH used its current facilities and the design of buildings on the hospital site and how buildings were used to support high quality services.

j) The hospital was developing a commercial strategy to generate income from rental space, research and in-house services.

k) The hospital's computerised appointment system applied to all JPH departments but the "custom and practice" of how the computer system was used had varied significantly throughout the hospital but was now being streamlined.

l) One of the key aims of the transformation plan was to reduce bed pressures and to improve patient flow. The service changes that arose from the transformation strategy were aimed at achieving a much quicker turnaround of patients from hospital to care at home.

m) There were currently *{ie. as at 6 Feb 2015}* 37 cases of delayed transfers of care at the JPH, 20 cases of patients awaiting their choice of after-care, plus patients with other requirements.

n) The JPH was expected to have an overall deficit of somewhere between £2m and £15m by the end of 2015/16.

The Committee noted the good progress with the transformation plan and requested a further report in one year's time. It was suggested that this report should include an update on progress with the transformation plan, the level of savings achieved and patient feedback about the service.

3. In August 2015 the Care Quality Commission carried out a routine inspection of the JPUH, with a rating of Good overall.

4. On 3-4 January 2016 there was a 'Business Continuity Event' of unprecedented high demand at JPUH A&E department.

## Purpose of today's meeting and Suggested approach

5. The JPUH Chief Executive and Senior Management and the GY&W CCG Chief Executive will attend the meeting to present the reports and to receive any comments or recommendations that the Joint Committee may wish to make.

6. Anticipated attendees:

JPUH:
- Christine Allen, Chief Executive
- Andrew Palmer, Director of Performance & Planning
- Anna Hills, Director of Governance

GY&W CCG:
- Andy Evans, Chief Executive

7. The Joint Committee is asked to consider:

a) The JPUH and GY&W CCG reports.

b) Any recommendations that it wishes to make to JPUH or GY&W CCG

**Key focus areas to cover:**

8. From JPUH perspective:

- Savings achieved/planned:
  - In the 2-yr Transformation Plan
  - Implications of the Lord Carter Review of efficiency / productivity in acute hospitals
- Patient feedback:
  - Different approach
  - Emerging themes
  - Key Performance Indicators (KPI)
- Any changes to the transformation plan
  - Including impact of the 'Norfolk Provider Partnership' launched in Jan 2016
- Action plan following the CQC inspection 11-13 Aug 2015
- Impact of Out-of-Hospital Team(s)
- Root cause analysis of the 'business continuity event' surge in A&E demand on 3 Jan 2016
- Capacity issues, including workforce / recruitment

9. From GY&W CCG / 'system' perspective:

- Impact of the Out-of-Hospital Team(s)
- Root cause analysis of the 'business continuity event' surge in A&E demand on 3 Jan 2016
  - What/who is involved in the system wide root cause analysis?
  - The findings, so far

10. Following the formal meeting, committee members will have a site visit to see the 'Ambulatory' facility and the new 'Day Case Unit'.

## Supporting Information

11. The following documents are attached:

    a) Appendix 1 - JPUH Report

    b) Appendix 2 – JPUH CQC Action Plan

    c) Appendix 3 - GY&W CCG – Impact of the Out-of-Hospital Teams

    d) Appendix 4 - GY&W CCG – Business Continuity Event 3 Jan 2016

## References

(i) The Committee's previous consideration of this topic at its meeting on 6 Feb 2015: http://norfolkcc.cmis.uk.com/norfolkcc/Meetings/tabid/70/ctl/ViewMeetingPublic/mid/397/Meeting/328/Committee/25/Default.aspx

(ii) The Committee's Information Bulletin briefing on this topic at its meeting on 8 Oct 2014: http://norfolkcc.cmis.uk.com/norfolkcc/Meetings/tabid/70/ctl/ViewMeetingPublic/mid/397/Meeting/327/Committee/25/Default.aspx

(iii) JPUH Board papers http://www.jpaget.nhs.uk/about-us/board-of-directors/meetings/

(iv) CQC Report: http://www.cqc.org.uk/sites/default/files/new_reports/AAAE5085.pdf

(v) January 2016 business continuity event: http://www.jpaget.nhs.uk/news-media/news-events/2016/january/pressure-eases-after-unprecedented-demand/

(vi) Lord Carter of Coles' report: Operational productivity and performance in English NHS acute hospitals: http://www.parliament.uk/business/publications/written-questions-answers-statements/written-statement/Commons/2016-02-05/HCWS515/

(vii) Norfolk Provider Partnership: http://www.jpaget.nhs.uk/news-media/news-events/2016/january/norfolk-provider-partnership-launched-by-local-hospitals-and-community-services/

## Contact details

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James Paget University Hospitals NHS
NHS Foundation Trust

# Great Yarmouth & Waveney Joint Health Scrutiny Committee

# 15 April 2016

## 1. Transformation Plan

1.1 The James Paget University Hospitals NHS Foundation Trust (JPUH) is responding to a challenging financial savings target for 2016/17. This can only be met by fundamentally changing the approach to transformation both internally and across the wider health and social care system.

1.2 The on-going challenges faced in the health sector, both financially from a reducing income as well as from the continued pressures of increasing demand, have led to a need to redesign the way health services are provided by the JPUH and its partners. The pace of transformation is increasing both internally and across the wider system. This report provides an insight into how the JPUH is working with partners to deliver system-wide transformation, at pace, and in innovative ways. This work places our patients at the centre of the redesign process, with patient care and safety at the heart of all the transformation processes. This is demonstrated by the Clinical Quality Risk Assessment (CQRA) that is undertaken, and signed off by the Clinical Director and Director of Nursing, for every transformation project impacting the patient. This process is now successfully applied to all joint projects undertaken with partners.

1.3 The Trust has delivered a wide range of successful transformation projects in 2015/16, both internally and with partners. These include;

- The ‘Flo Project’ and ‘Plan for Every Patient’ work, whilst still underway, has resulted in a demonstrable benefit in making more appropriate and timely discharges of patients from hospital. This is helping the hospital meet the challenges of peak demand through patient centred plans from front door to discharge, and has in particular enabled continued elective surgery as planned over the winter period;
- The Day Theatre Upgrade, which was the biggest building project ever undertaken by the Trust, was completed in 2015. The additional theatre capacity is providing modern facilities for patients and enabling the hospital to manage more procedures as day cases, providing benefits to both patients and the Trust;
- Working in partnership with Norfolk and Suffolk Foundation Trust a successful CQUIN (Commissioning for Quality and Innovation) project has focused on providing better support for frequently attending mental health patients;
- The Trust has worked closely with Great Yarmouth and Waveney Clinical Commissioning Group (GYWCCG) to reduce ‘system’ drug spend by a new project to switch patients in a trial area from expensive branded drugs to a generic bio-similar alternative. With the security of a CQRA and full clinical engagement this work is seeing efficiency savings being secured and apportioned through an innovative gain share agreement between JPUH and GYWCCG.

1.4 In the last year a Joint Leadership and Service Development Group has been established between the Trust, East Coast Community Healthcare (ECCH) and GYWCCG. This monthly meeting is enabling a much clearer direction to system wide transformation and the delivery of projects jointly between partners.

1.5 The Trust's determination to work closely with partners is further demonstrated through the Norfolk Provider Partnership. A Memorandum of Understanding has been signed between the Norfolk and Norwich University Hospitals NHS Foundation Trust, Norfolk Community Health and Care NHS Trust and the Queen Elizabeth Hospital King's Lynn NHS Foundation Trust. A number of joint areas are being progressed to ensure greater efficiency savings and improved management of patient care across the providers. The priority areas for review include finding different ways to deliver front line services where there are capacity limitations impacting all three hospitals, such as radiology, and efficiencies that could be realised through sharing capacity.

1.6 In 2015 GYWCCG decided to change the way they commission services associated with a broad range of services related to out of hospital care. The aim is to accelerate progress towards integrated service provision and the establishment of a cohesive integrated care system. The CCG chose to commission these services through the "Most Capable Provider" (MCP) procurement route with the new delivery of services scheduled to commence in January 2017. The MCP offers much greater stability in the local health economy with services being commissioned over a five year contract. As a result the following six provider organisations are working closely to redesign services:

- All Hallows Healthcare Trust
- East Coast Community Healthcare CIC (ECCH)
- James Paget University Hospitals NHS Foundation Trust (JPUH)
- Norfolk and Suffolk Foundation Trust (NSFT)
- Norfolk County Council (NCC), and
- Suffolk Social Care (SSC).

It is the intention that a Joint Venture involving a number of the partners will be established to deliver the services. This is an innovative approach and should see true system transformation across the wider health and social care economy for the benefit of those living in Great Yarmouth and Waveney. This does pose risks to those involved but this is being robustly managed so that an innovative approach can be adopted for the benefit of patients and the local health economy.

1.7 Moving forward, and responding to the financial challenge outlined above, the Trust has refocused its transformation programme. A Savings and Transformation day involving clinicians, managers and other JPUH staff has resulted in a number of Programmes being developed, each with underpinning projects that together support the delivery of the overall savings target for 2016/17. The developing Programmes for 2016/17 include:

- Medicines Management and Pharmacy
- Redesigning Outpatient Services
- Procurement
- Theatres utilisation and efficiency
- Service Line Reporting and Better Business Management
- Workforce
- Patient Flow
- Diagnostics
- Commercial/Corporate Estates and Facilities.

1.8 The Trust is also refocusing its Transformation governance arrangements to better support the delivery of the overarching Programmes. Individual Programme Boards will oversee the supporting projects and report, by exception, to the Trust's Transformation Board. The Transformation Board, chaired by the Chief Executive, meets monthly and will be supported by a new 'Programme Dashboard' highlighting the critical success factors for each of the projects.

1.9 Whilst the scale of transformation required in 2016/17 is extremely challenging, the Trust is putting in place the necessary capacity to maximise the chances of delivering what is required. The full programme of transformation projects is to be finalised in the next few weeks.

## 2. Lord Carter report, Operational productivity and performance in English acute hospitals

2.1 The final report was published on 5 February 2016 and provides information regarding the various streams of work undertaken nationally. The work aims to support the NHS efficiency challenge where the NHS is expected to deliver efficiencies of 2-3% per year, effectively setting a 10-15% real terms cost reduction target for achievement by April 2021.

2.2 An assessment has already been undertaken against the 15 recommendations and is being considered by the Board of Directors, with further work required to develop a full action plan. This includes further reviewing the individual Trust benchmarking reports to ascertain what is achievable as part of the Trust's transformation and savings programme.

2.3 Financial performance, along with all other performance indicators, is monitored through reporting to the Board of Directors in public. The latest reports to the March 2016 meeting are available on the Trust's website:

Quality and Safety Report

Performance Management Report

Operational Report

Finance Report

## 3. How we seek and utilise patient feedback to improve

3.1 The Trust has a Board approved Patient Experience and Engagement Strategy in place. One of the priorities for 2015/16 was to deliver and embed the first year's objectives.

3.2 The Trust strives to ensure that all those who access our services have an experience that 'exceeds their expectations', and to this end we will not become complacent but will work with our patients to make sure we continue to improve based on the feedback we receive. How positive an experience people have on their journey through the NHS can be even more important to the individual than how clinically effective care has been.

3.3 Patient and public involvement and engagement is essential to help us develop and deliver services which are truly patient centred and we require feedback on our services in order to continually improve and refine our hospital in response to what we learn.

3.4 Patient feedback is received into the Trust via many sources including capturing face to face real time feedback using the National Friends and Family Test, patient experience visits and spot check audits, via the Patient Advice and Liaison Services, complaints, social media, NHS Choices, Patient Opinion, national and local surveys.

3.5 At source, all individual feedback is shared with the relevant staff, teams, Divisional patient experience leads and Divisional Management to ensure that they receive timely feedback on their services and the level of care being provided. This provides the ability to address any issues at the earliest opportunity to support local resolution and de-escalation. In addition, where feedback is positive, this supports the Divisional teams to share good practice and disseminate any learning.

3.6 As a Trust, we have a responsibility to ensure all feedback is collated at a corporate level and analysed to enable identification of any emerging themes and trends. Discussions in this regard take place at sub Board level via the Carer and Patient Experience Committee with the Divisional teams. The corporate report presented at this meeting details all Trust level patient experience feedback data to identify areas of good practice and areas requiring improvement. In addition, findings of national surveys are shared at this forum and action plans initiated and monitored to address any areas of improvement required. Noise at night and information and communication at discharge presented as key themes and formed the basis of our key quality priorities for patient experience in 2015/16.

3.7 We are currently considering our quality priorities for 2016/17, including participating in a research opportunity to understand how front line staff use patient experience data for service improvement.

3.8 The Trust encourages a personal approach to dealing with feedback with direct contact being made where possible, offering individuals the opportunity to meet with staff to discuss any concerns and aid resolution. In addition, a Trust representative will respond to all social media feedback/feedback in the public domain. Patient stories are shared at Board and Divisional meetings to bring patients' experiences to life, which also enables time for reflection and key lessons learned to be shared.

## 4. Care Quality Commission Inspection follow up

4.1 The Trust was given an overall rating of "Good," following the Care Quality Commission (CQC) inspection which took place in August. This placed us in the top 30% of acute trusts in the country. It was a tremendous achievement, reflecting the hard work and commitment of our staff who show such dedication each and every day.

4.2 The CQC's report highlighted several areas of outstanding practice, notably the leadership demonstrated in the hospital's Emergency and Urgent Care which was rated as 'outstanding'. It also reflected the culture which exists throughout the organisation. In his letter attached to the report, the Chief Inspector of Hospitals Professor Sir Mike Richards noted that our staff "were exceptionally caring and went the extra mile for their patients."

4.3 There were some areas where improvements were required. An action plan is in place to strengthen those particular areas so that we can further improve the quality of service we offer our patients. This has been considered through our governance structure, and was presented to the Board in public in March 2016 as part of the Quality & Safety Report. The latest version of the action plan is attached for the Committee's attention.

4.4 We have a strong track record in continuous improvement over the last two years and we have already taken action to ensure that the inspectors' recommendations enhance our improvement plans.

## 5. Business continuity event, 4 January 2016

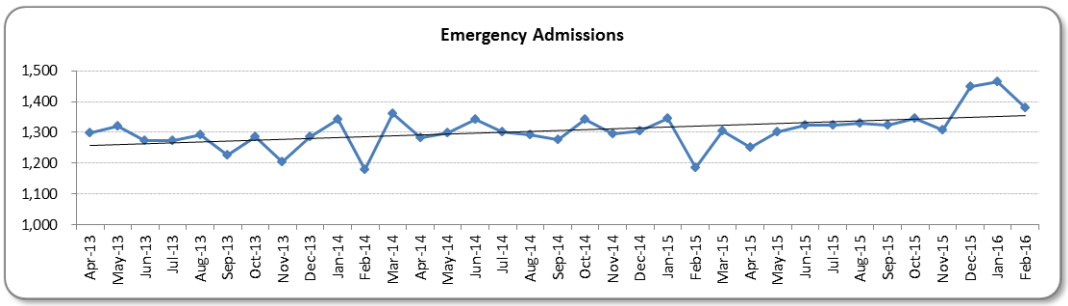
5.1 The internal Root Cause Analysis (RCA) has been drafted based upon statements from all staff involved and a detailed chronology via our Major Incident documentation procedures. This will be reviewed by the Executive led Strategic Risk Group and once finalised will be provided to the CCG via the usual processes for all Serious Incidents. We have identified some learning which has been developed into an action plan and this will be monitored at the Executive level to ensure delivery of the improvement actions. The CCG will then utilise this and the feedback from the system-wide de-brief meeting to formulate the system-wide RCA report to identify any wider learning.

## 6. Performance

6.1 The following tables identify emergency activity and growth over a 3 year period:

**Table 1**

| Year | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 13/14 | 1,297 | 1,320 | 1,273 | 1,273 | 1,292 | 1,226 | 1,286 | 1,204 | 1,287 | 1,341 | 1,180 | 1,362 | 15,341 |
| 14/15 | 1,284 | 1,297 | 1,343 | 1,302 | 1,292 | 1,275 | 1,341 | 1,298 | 1,306 | 1,345 | 1,185 | 1,305 | 15,573 |
| 15/16 | 1,250 | 1,300 | 1,323 | 1,323 | 1,331 | 1,322 | 1,344 | 1,307 | 1,449 | 1,465 | 1,379 | | |




6.2 It is clear that emergency activity has continued to grow year on year without exception. There is some seasonal variation (particularly Q1) but the trend is in an upward trajectory.

6.3 The three new main initiatives' that have been in place to manage emergency admission demand are as follow:

- **Ambulatory Care** (opened August 2013). The evidence clearly shows that this is not increasing demand, for the following reasons: no stepped increase in emergency admissions on that date going forward, other than a continued increased trend in emergency admissions going in an upward trajectory. Ambulatory care has been successful in reducing length of stay of patients within JPUH and therefore a cost reduction to the CCG.
- **Better Care Fund (BCF)** (April 2015 onwards). Apart from Quarter 1 which showed a reduction in emergency admissions, there has not been a reduction in emergency admissions of the predicted 3.5% but an increase of 3.2% (2015/16) suggesting that the Better Care Fund is not having an impact on reducing emergency demand.

- **Out of Hospital Team (OHT).** It is clearly evidenced from table 2 that the biggest increase in emergency admissions comes from the GP practices that sit within this scheme. Please note this does not mean that patients are not getting more timely access to the appropriate services, or that this is not a positive scheme, only that it is not reducing emergency admissions in line with one of the KPIs.

### Table 2: OHT emergency admission data

OHT

| Year | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 13/14 | 466 | 441 | 430 | 465 | 430 | 390 | 476 | 438 | 494 | 480 | 428 | 498 |
| 14/15 | 402 | 481 | 449 | 473 | 440 | 446 | 446 | 456 | 471 | 491 | 447 | 482 |
| 15/16 | 424 | 445 | 474 | 451 | 447 | 464 | 464 | 461 | 517 | 497 | 481 | |

Other 06M

| Year | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 13/14 | 718 | 766 | 720 | 674 | 688 | 698 | 714 | 679 | 698 | 770 | 672 | 787 |
| 14/15 | 766 | 711 | 745 | 688 | 700 | 716 | 774 | 737 | 743 | 786 | 652 | 734 |
| 15/16 | 713 | 736 | 727 | 701 | 726 | 730 | 749 | 750 | 813 | 864 | 813 | - |

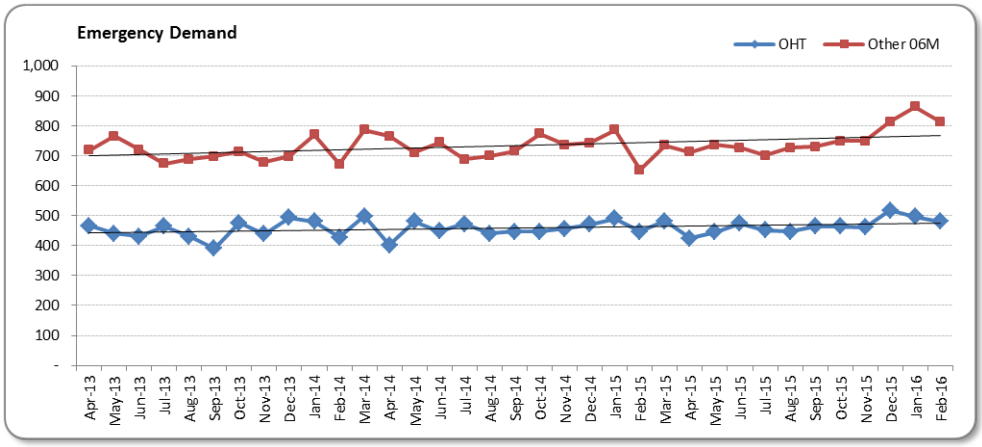



Table 2 shows the increase in emergency demand from the OHT Practices compared with the other GP practices

### Table 3: A&E activity Data

| Year | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 13/14 | 5,708 | 6,102 | 5,664 | 6,425 | 6,298 | 5,651 | 5,548 | 4,989 | 5,090 | 5,204 | 4,964 | 6,085 | 67,728 |
| 14/15 | 5,998 | 6,461 | 6,051 | 6,613 | 6,291 | 5,929 | 5,760 | 5,460 | 5,554 | 5,320 | 4,961 | 5,776 | 70,174 |
| 15/16 | 5,732 | 6,172 | 6,067 | 6,446 | 6,457 | 5,788 | 6,082 | 5,618 | 5,616 | 5,558 | 5,626 | | |

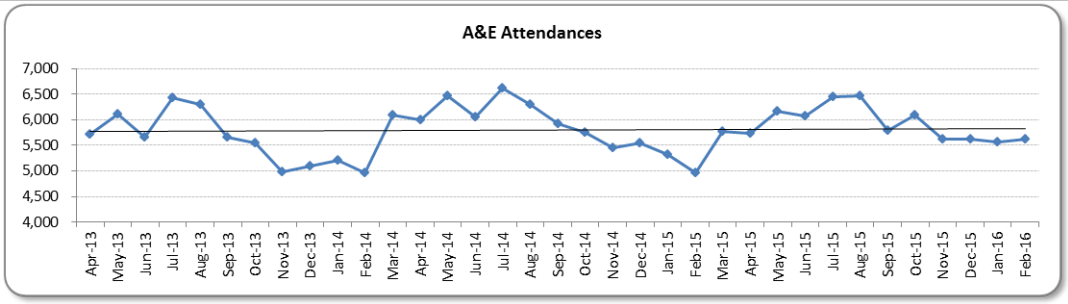
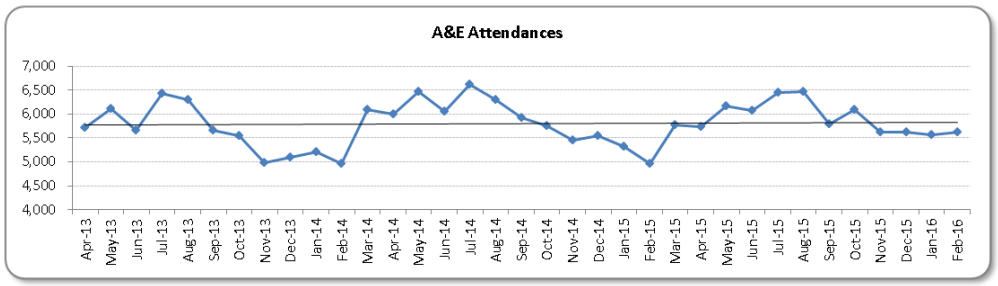
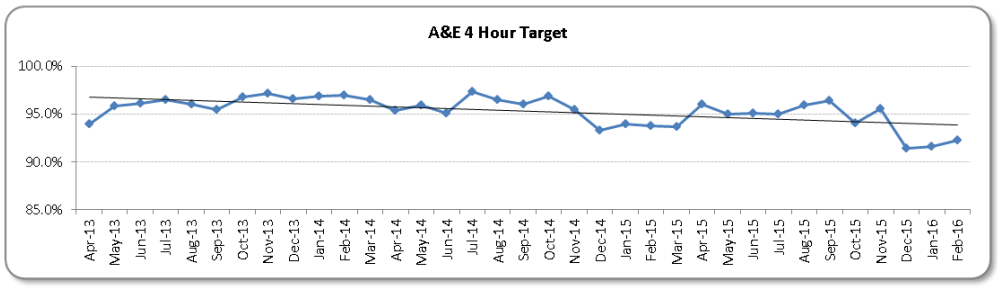


Table 3 clearly demonstrates that the activity levels in A&E continue in an upward trajectory however this is not to the same percentage increase as emergency admissions, in other words, whilst A&E has seen an increase it is not to the same levels as emergency admissions.

### Table 4 and 4a 4b: JPUH A&E performance

| Year | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 13/14 | 93.9% | 95.8% | 96.1% | 96.5% | 96.0% | 95.5% | 96.8% | 97.2% | 96.6% | 96.9% | 97.0% | 96.5% |
| 14/15 | 95.4% | 95.9% | 95.1% | 97.3% | 96.5% | 96.0% | 96.8% | 95.5% | 93.3% | 94.0% | 93.8% | 93.7% |
| 15/16 | 96.0% | 95.0% | 95.1% | 95.0% | 95.9% | 96.4% | 94.0% | 95.6% | 91.5% | 91.6% | 92.2% | |

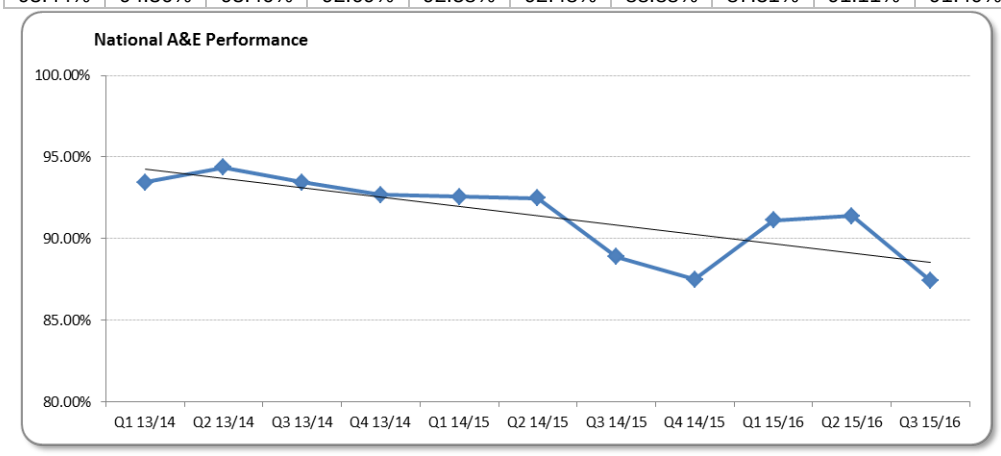



6.4 The above tables clearly demonstrate that the performance at JPUH is deteriorating and based on current activity levels it is prudent to assume that unless there is a significant shift in either A&E attendances or emergency admissions or a large scale system wide transformation, then it is unlikely that JPUH is able to (on its small bed base) achieve the 95% A&E target going forward.

### Table 5: National A&E performance

| 2013/14 | | | | 2014/15 | | | | 2015/16 | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 |
| 93.44% | 94.36% | 93.46% | 92.69% | 92.58% | 92.48% | 88.88% | 87.51% | 91.11% | 91.40% | 87.40% |



6.5 The national picture of A&E performance remains in a downward trajectory, which is reflected in the JPUH current performance. The Sustainability & Transformation (S&T) funding letter clearly states that any improvement trajectory should be realistic and therefore to submit a fully compliant one is both naïve and non-evidence based.

**Table 6: Diagnostic activity over 3 years for 6 week tests.**

| Year | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 13/14 | 7,637 | 7,871 | 7,033 | 7,635 | 7,127 | 6,839 | 7,628 | 7,020 | 6,543 | 7,351 | 6,981 | 7,247 | 86,912 |
| 14/15 | 7,223 | 7,259 | 7,648 | 8,046 | 6,921 | 7,750 | 7,947 | 7,778 | 7,425 | 7,601 | 7,194 | 8,306 | 91,098 |
| 15/16 | 8,183 | 7,280 | 8,424 | 8,698 | 7,653 | 8,472 | 8,613 | 8,369 | 8,123 | 8,260 | | | 82,075 |

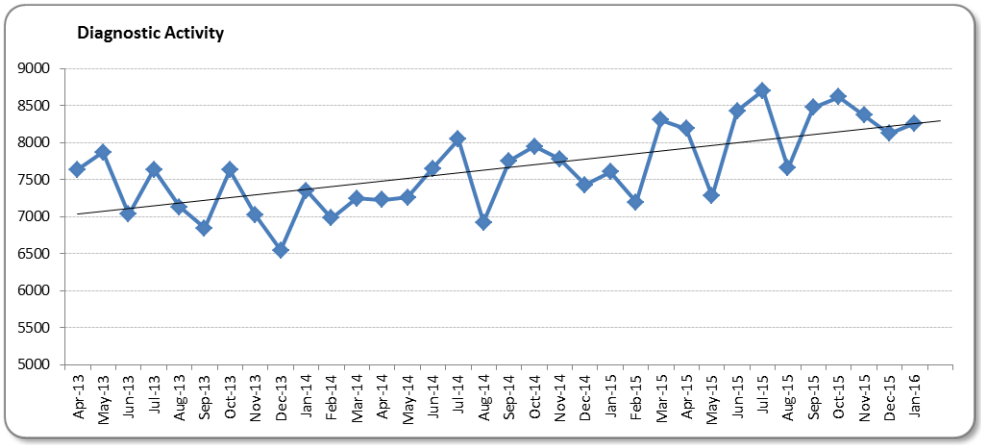
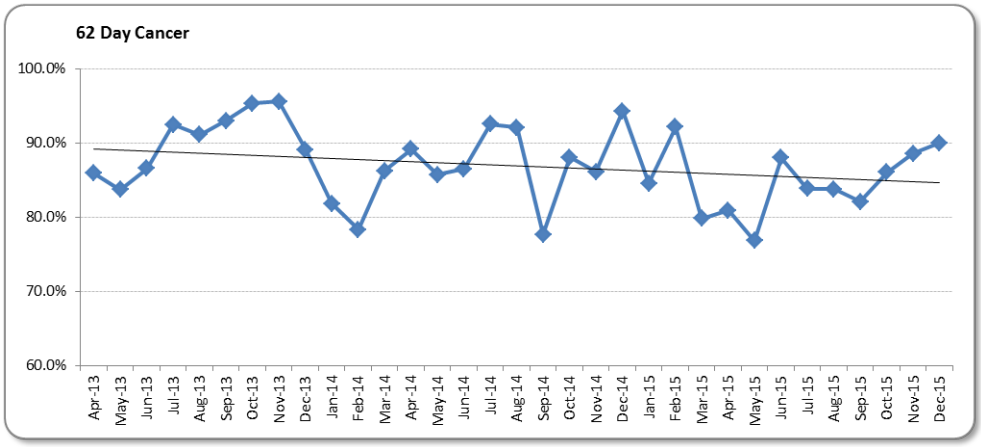



**Table 7: 62 day cancer performance**

| Year | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2013/14 | 85.9% | 83.7% | 86.5% | 92.5% | 91.1% | 92.9% | 95.3% | 95.6% | 89.0% | 81.8% | 78.3% | 86.2% |
| 2014/15 | 89.2% | 85.7% | 86.5% | 92.5% | 92.0% | 77.7% | 88.0% | 86.1% | 94.3% | 84.5% | 92.1% | 79.8% |
| 2015/16 | 80.9% | 76.8% | 87.9% | 83.8% | 83.8% | 82.0% | 86.0% | 88.5% | 90.0% | | | |

6.6 Due to the increase in emergency admissions, the cancer performance has been challenging to achieve.




It is evident from table 8 that the 62 day cancer target has been difficult to achieve at JPUH. There are real capacity issues across the Trust and for tertiary referrals.

## 7. Workforce/recruitment and capacity issues

7.1 The Medical and Nursing Recruitment Strategy focuses on both recruitment and retention and the short, medium and long term objectives of the Trust, in relation to how it attracts, develops and retains its workforce. Whilst the current NHS reforms and uncertain economy may cause some anxiety amongst staff, the Trust recognises that unless we have an appropriately skilled and motivated workforce, we will not be able to deliver our strategic and operational objectives and the best possible care to our patients, their families and the community we serve. Some specialties present particular difficulties and challenges for us with national shortages of medics in these disciplines, in particular radiology, emergency medicine and dermatology making it very difficult to recruit substantively to these positions. Work is ongoing on the overall implementation of the strategies for both medical and nursing staff including the increasing use of recruitment events ensuring appropriate marketing of our achievements i.e. CQC outcome – GOOD, overseas recruitment and utilising social media as part of the recruitment process. Discussions are also continuing with agency and locum medical staff to attract them into substantive posts.

7.2 Overseas Nurses - The Trust's first cohort of overseas nurses arrived on 24 February 2016. There were seven nurses from both the Philippines and India. There are a further 15 nurses arriving from India and the Philippines on 27 April 2016 to commence Trust induction on 3 May 2016. It is anticipated that this will form part of an ongoing recruitment strategy.

7.3 Experienced Nurses - Six experienced nurses started with the Trust in February 2016 along with three newly qualified nurses in February 2016 to include a late qualifier finishing in April 2016. The Trust has recruited five September 2016 qualifiers from interviews in March. Allocations will be as per the rotation programme. There were 22 applications on our specific Newly Qualified advert in March 2016 with 20 shortlisted and 19 appointed.

7.4 Allied Health Professionals (AHPs) - In addition we realise that there are difficulties both locally and nationally with the recruitment of some areas for AHPs. This is an umbrella term for a range of professions and includes registered HCPC (Health and Care Professionals Council) practitioners and a wide range of support staff. The Trust is currently creating a Recruitment Strategy for AHPs to identify the recruitment difficulties and give particular focus to the current shortages and those areas difficult to recruit to and retain staff. The Trust recognises that effective recruitment and retention of staff is based on reputation as a good employer and as an organisation, which acts professionally in all of its activities. These 'hard to recruit' areas will be given priority when running recruitment campaigns/events.

7.5 East of England Streamlining Programme – the Trust signed up to the national programme in 2015 and progress is steadily being made around an improved collaborative approach between NHS trusts. Specifically, the programme focused on four key work streams: Medical Staffing, Occupational Health, Recruitment and Statutory & Mandatory Training. The critical success factors for the programme is that NHS trusts ensure an efficient and smooth transition of staff moving between trusts within our region. Trusts must aim to resolve the issues relating to the rotation of Junior Doctors and increase the amount of time Junior Doctors spend with patients. NHS Trusts must revise and reduce the total amount of time staff take to reach 100% compliance with Statutory & Mandatory Training. In addition they must resolve the problems and overcome obstacles relating to the sharing of Occupational Health data when staff move between NHS trusts.

7.6 There are a number of actions that will be explored and undertaken to enhance the current recruitment process. Systems can be introduced that will better support managers throughout the process, reduce the admin burden and minimise bottlenecks in the system.

## 8. Site Strategy

8.1 Over the last 12 months the Trust has been undertaking significant work to review the Trust's estate requirements over the coming years to ensure that we provide sustainable services that enhance our patients' experience. Our Site Development and Estate Strategy has now been approved by the Board of Directors and sets out our plans for the next 10+ years.

8.2 Engagement with internal stakeholders commenced in 2015 and a number of meetings took place with a wide range of staff and staff groups from all specialties. This included reflecting on patient feedback from a number of sources, such as national surveys, in ensuring that our planning took account of our patients' needs. The information gathered from these meetings has been used to populate the recommendations and 'drivers for change' identified within the strategy.

8.3 The Council of Governors participated in an engagement exercise during January 2016 to prioritise outline plans from a patient and staff perspective. The findings of this exercise have been used to help shape the Master plan priorities and their comments are included with the strategy document itself.

8.4 We are finalising a briefing sheet which sets out our vision, the next steps for this long term strategy and how it fits with our wider Trust priorities. We will be circulating this to all our stakeholders during April to ensure they are briefed on progress. With the current financial constraints, we are keen to manage expectations about what is possible but also to plan for an exciting future.

8.5 Each element of the strategy will be subject to detailed consideration and assessment and further external engagement will take place as elements of the strategy are developed.

## 9. Trust Visit

A tour of the Ambulatory Care Unit, new Day Case Unit and refurbished Central Delivery Suite will be arranged for between 12.30 and 1.30pm, led by our Director of Operations, Sue Watkinson.

**1 April 2016**

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James Paget University Hospitals NHS
NHS Foundation Trust

# TRUST ACTION PLAN FOLLOWING ANNOUNCED CQC INSPECTION AUGUST 2015

Dated: 08/12/2015
Version: 5.01

**Aim:** The aim of this action plan is to ensure that CQC Requirement Notices are fully met
**Content:** This action plan captures all of the requirement notices from the report issued by the CQC in November 2015 and includes responsibilities and timescales for delivery.
**Responsibility for delivery:** Nominated Executive Leads reporting to identified governance committees

**Governance:** The Trust will monitor delivery of this action plan by assigning clear responsibilities and timescales to each action. Each Core Service has been assigned an Executive lead who will have oversight of the plan to ensure delivery to timescale.
The plan will be updated at least monthly and will be presented to the Patient Safety and Effectiveness Committee (Executive Committee). On a bi-monthly basis the Safety and Quality Governance Committee (committee of the Board) will receive a progress report.

Key for RAGBW rating of Actions:

| | | | | |
|---|---|---|---|---|
| (**W**)hite = Not yet started | (**G**)reen = Completed | (**A**)mber = In progress | (**R**)ed = Due but not complete | (**B**)lue = Ongoing monitoring to be assured of continued achievement |

| ID | Ref in Report | Issue Raised in Final Report | Action | Operational lead | Timescale | BARRIERS TO ACHIEVEMENT/PROGRESS UPDATES |
|---|---|---|---|---|---|---|
| **Requirement Notices** | | | | | | |
| 1 | 20 | Regulation 15 (1)(a)(c)(e)<br>The provider was failing to ensure equipment; including emergency equipment was properly checked.<br><br>**Executive Lead: Director of Governance** | Inform all senior nurses and departmental managers of the immediate requirement to abide by checking procedures<br>Take proportionate action if practice does not meet the required standard in any service | Lead Nurses/ Head of Midwifery/Service Managers | 30/11/2015 | |

| ID | Ref in Report | Issue Raised in Final Report | Action | Operational lead | Timescale | BARRIERS TO ACHIEVEMENT/PROGRESS UPDATES |
|---|---|---|---|---|---|---|
| | | | | | | |
| 1.1 | | | Ensure all routine equipment maintenance schedules are fully met for all equipment. | Head of Estates | 01/02/2016 | The Estates Department maintains a schedule for maintaining equipment according to a prioritisation regime. The schedule is monitored and has been met since 2015. |
| 1.2 | | | Routinely monitor compliance to safety systems through internal governance processes | Lead Nurses/Head of Midwifery Service Managers/Head of Estates | 31/12/2015 | 100216<br>Divisions reported their actions back to the PSEC Extraordinary meeting. |
| 1.3 | | | Provide monthly update reports to Patient Safety and Effectiveness Committee to confirm that the risks are being controlled | Lead Nurses/Head of Midwifery/Service Managers | PSEC Dates<br>~~05/01/2016~~<br>~~02/02/2016~~<br>~~08/03/2016~~<br>05/04/2016<br>10/05/2016<br>07/06/2016 | January meeting did not take place<br>100216<br>At the February meeting of PSEC it was decided that a series of Extraordinary Meetings would take place on a fortnightly schedule to allow sufficient time to focus on the progress to actions for CQC improvement. An action log will be the evidence for this.<br>140316<br>Process of reviewing progress at the EPSEC is working. Updated copy of this plan to be sent to PSEC for information and audit purposes. |

| ID | Ref in Report | Issue Raised in Final Report | Action | Operational lead | Timescale | BARRIERS TO ACHIEVEMENT/PROGRESS UPDATES |
|---|---|---|---|---|---|---|
| | | | | | | |
| 1.31 | | | Provide monthly update reports of safety checks to Health and Safety Committees to confirm that the risks are being controlled<br><br>100216<br>After discussion at the PSEC meeting, it was agreed that further work was required to ensure that the H&S Committee was fully sighted on any risks/issues re planned maintenance of safety equipment/medical devices. Head of Clinical Audit and Compliance to contact to help resolve with Head of Risk and Safety. | Head of Estates | H&S Committee dates<br>~~04/01/2016~~<br>04/03/2016<br>05/06/2016<br>01/07/2016 | January meeting did not take place<br><br>The reports to H&S Committee are not yet comprehensive. New Action 100216<br><br>140316<br>Copy of Premises Assurance Model has been provided and this provides documentary evidence of our governance arrangements for Medical Gases and Medical Devices. EPSEC is asked to confirm that the corporate element of this outcome is achieved. |
| 1.4 | | | Divisions to instigate accountability processes which require those responsible to evidence that all checks are taking place and are adequate. | Lead Nurses/Head of Midwifery/Service Managers | 30/11/2015 | 100216<br>Divisions reported their actions back to the PSEC Extraordinary meeting. |
| 1.5 | 20 | The provider failed to ensure in theatres that the environment was properly maintained. | Review plans for phase 2 and provide documented assurance that the intended works will address the environmental risks | Deputy Director of Operations/ Theatre Manager | 31/12/2015 | Confirm completeness May 2016 |

| ID | Ref in Report | Issue Raised in Final Report | Action | Operational lead | Timescale | BARRIERS TO ACHIEVEMENT/PROGRESS UPDATES |
|---|---|---|---|---|---|---|
| | | **Executive Lead:- Director of Finance** | identified in the report. | | | |
| 1.6 | | | Provide monthly update reports to Health and Safety Committee to confirm that the risks in Theatres are being controlled.<br><br><u>100216</u><br>After discussion at the PSEC meeting, it was agreed that further work was required to ensure that the H&S Committee was fully sighted on any risks/issues re planned maintenance of safety equipment/medical devices. Head of Clinical Audit and Compliance to contact to help resolve with Head of Risk and Safety. | Divisional Manager Elective/ Head of Estates | <u>H&S Committee dates</u><br>~~04/01/2016~~<br>04/03/2016<br>05/06/2016<br>01/07/2016 | January meeting did not take place. Review in March.<br><br>140316<br>Evidence seen in Surgery Action plan that the theatres project will deliver the require outcome. <u>EPSEC request to close</u>. |
| 2 | 20 | Regulation 17 (1)(2)(c)<br>The provider was failing to ensure that each service user had an accurate, complete and contemporaneous record of their care.<br>**Executive Lead: Director of Nursing and Workforce** | Issue a one page briefing applicable to all professional groups to remind them of the record keeping standards they must adhere to. | All professional leads (including doctors) | 31/12/2015 | Draft sent for comments 17.12.15<br>Distributed 21.12.15 |

| ID | Ref in Report | Issue Raised in Final Report | Action | Operational lead | Timescale | BARRIERS TO ACHIEVEMENT/PROGRESS UPDATES |
|---|---|---|---|---|---|---|
| | | | | | | |
| 2.1 | | | Identify and make amendments to some nursing record templates to assist compliance to record keeping standards | Lead Nurses/ Head of Midwifery | 31/01/2016<br>11/03/2016 | The Essentials of Care booklet is being reviewed using a collaborative approach which will include reference to Record Keeping Standards. First print draft expected by end of February, |
| 2.2 | | Do Not Attempt Cardio Pulmonary Resuscitation Forms were found to be incomplete and decision making not of consistent quality.<br><br>**Executive Lead: Medical Director** | Ensure that all Do Not Attempt Cardio Pulmonary Resuscitation forms are completed fully and in line with national guidance. | Divisional Directors | 30/06/2016 | The Resuscitation Committee has issued instruction to mandate clinicians to contact relatives to discuss decision making. Our current documentation needs to be amended to reflect this and we expect this to be in place by April 2016.<br>100216<br>Discussed at PSEC EM. Agreed that the issue is best resolved by enabling Trust implementation of revised national plan which will provide revised documentation, improving compliance and outcomes.<br>150316 EOLCG escalating concern re achievement of this action. EPSEC to discuss 290316 |
| 2.3 | | | Medical Director to write to all doctors to require them to improve compliance to standard | Divisional Directors | 31/12/2015 | Draft sent for comments 17.12.15<br>Distribution 21.12.15 |

| ID | Ref in Report | Issue Raised in Final Report | Action | Operational lead | Timescale | BARRIERS TO ACHIEVEMENT/PROGRESS UPDATES |
|---|---|---|---|---|---|---|
| | | | with immediate effect and Clinical Directors/ Consultants to enforce | | | |
| 2.4 | | | Audit DNACPR forms and report by Consultant so as to provide rapid feedback on performance | Clinical Director/End of Life Lead Clinical Audit Team/ Resuscitation Officer | 31/01/2016 | October audit completed. New plan to re-audit February March to measure the impact of distribution of staff Guidance Booklet |
| 2.5 | | Staff on some wards were not clear on guidance they would use or actions they should take, if they were unclear whether a patient had capacity to consent.<br><br>**Executive Lead: Medical Director** | Assure application of the assessment under the Mental Capacity Act 2005 at all stages but particularly end of life, by: | Divisional Directors | 30/06/2016 | Cross reference with EOLC and Safeguarding Action Plans |
| 2.6 | | | Undertaking a review of knowledge and skills of medical staff of the MCA 2005 | Divisional Directors | ~~31/01/2016~~ revised to 31/04/2016 | Cross reference with EOLC and Safeguarding Action Plans<br>100216 Head of Clinical Audit and Compliance to contact Dr Lams for evidence of training.<br>170216 email sent to request/JS 23/02/2016<br>Dr Lams has responded. Also, the Adult Safeguarding Lead updated the EPSEC with detail that a rapid audit tool has been devised and will be implemented – results to follow. Revise timeline to 31/4/2016 |
| 2.7 | | | Providing training and/or information updates as required | Divisional Directors | 28/02/2016 | Cross reference with EOLC and Safeguarding Action Plans |
| 2.8 | | | Auditing medical records after improvement actions embedded. | Divisional Directors | 01/04/2016 | Cross reference with EOLC and Safeguarding Action Plans |

| ID | Ref in Report | Issue Raised in Final Report | Action | Operational lead | Timescale | BARRIERS TO ACHIEVEMENT/PROGRESS UPDATES |
|---|---|---|---|---|---|---|
| | | | | | | 140316<br>See 2.6 |
| 2.9 | | The provider had failed to ensure a consistent approach to end of life care pathway.<br><br>**Executive Lead: Director of Nursing and Workforce** | Appoint senior medical and nursing leadership for end of life care to advise, support and supervise the acceleration of the roll out of the end of life care plan system and advice and enforce standards of practise for end of life decision making and record keeping. | Director of Nursing and Workforce/ Medical Director | 31/01/2016 | Cross reference with EOLC and Safeguarding Action Plans<br>Update Jan 2016<br>Clinical Educator now in place<br>Job description for clinical lead in place recruitment process commenced for secondment (2/52 closing date)<br>Senior nurse discussions re portfolio change due to be completed end January<br>Roll out plan revised and accelerated (monitored through CAEOL group ) |
| 2.10 | | | Revise EOLC Action plan to ensure alignment with the gaps identified in the report. | Director of Nursing and Workforce | 30/11/2015 | Cross reference with EOLC and Safeguarding Action Plans |
| 2.11 | | | Accelerate the implementation of the approved replacement for the Liverpool Care Pathway for people receiving end of life care | Clinical Educator End of Life Care | 31/03/2016 | 14/12/16 Monitored by EOLC Group. Minutes meeting December as evidence of discussion |
| 2.12 | | | Draft an audit programme which will identify key audits as a priority.<br>The results will be reported widely to maximise learning. | SPCT Team and Senior Clinical Audit Facilitator | 31/12/2015 | 31/12/15 Received and awaiting Divisional Sign Off.<br>150316<br>CAEOL Group received a report confirming that Care of the Dying Audit has commenced and the |

| ID | Ref in Report | Issue Raised in Final Report | Action | Operational lead | Timescale | BARRIERS TO ACHIEVEMENT/PROGRESS UPDATES |
|---|---|---|---|---|---|---|
| | | | | | | SPCT phone line audit has a revised start date of 220316 |

NHS
Great Yarmouth and Waveney
Clinical Commissioning Group

HealthEast

# Briefing for Great Yarmouth and Waveney Health Scrutiny Committee on the impact of out of hospital teams

In April 2014 NHS Great Yarmouth and Waveney CCG commissioned an out of hospital team for Lowestoft, the first of its kind in the area.

Since then, the CCG has completed the 'Shape of the System' public consultation aimed at rolling-out across Great Yarmouth and Waveney a model of care based on looking after people in their own homes wherever possible.

The out of hospital teams have been highly successful with some excellent patient feedback to date. It needs to be noted that the teams are up and running currently in Lowestoft and in Great Yarmouth. The new model of care is still in the process of being rolled out across the whole of Great Yarmouth and Waveney and so the full impact is not yet being felt.

**JPUH Emergency Admissions (Great Yarmouth and Waveney patients only)**

The population where we know the out of hospital teams are having the biggest impact is the over 75s. In April to November 2015-16 there was a 4% reduction in the number of emergency admissions from the over 75s when compared to the same months in 2014. Even in the winter months of December to January 2015-16, when there is always an increase in admissions, there was a reduction of 0.1% in December and January when compared to the same two months in 2014/5, the previous year. This group of patients can be those that have more complex discharge needs.

It should be noted that these figures are for GYW patients attending the James Paget University Hospitals NHS Foundation Trust, they do not include the figures for patients attending other acute trusts or for patients attending JPUH from other CCGs.

**Patient Experience**

In its first year the Lowestoft team supported over 1,000 patients. Patient, family and carer satisfaction is very high; over 90% in satisfaction questionnaires.

Patients have told us:

"I can't express how it has helped to restore my confidence…"
"…more realistic consideration of patients actual needs"

Reviews identify a real sense of "team" with all out of hospital team staff encouraged to share views and suggest improvements. Patients are put first and supported in the right place by a relevant professional, and that there is good evidence of integrated working with other public

services.

There are other benefits beginning to show too. Adult social care believes that the number of Lowestoft residents going into long term care has reduced.

**The North Out of Hospital Team**

The North Out of Hospital Team (supporting Bradwell, Gorleston, Great Yarmouth and the Northern Villages) was established by East Coast Community Healthcare and NorfCC Adult Social Care on 1 April 2015. It is a truly integrated service across health and social care, with one team manager leading the entire team, with a single budget to resource the team and with one care assessment and one care plan for all patients.

This service has been developing and growing and on 1 October 2015 the service went 24/7. In its first month of service the team supported 38 patients to remain at home, by August this rose to 107 patients and in September 129 patients. Referrals are being received from GPs, Social Care, the local acute Trust, paramedics and others.

Feedback has been very positive….

“Would have been unable to cope without this team, they were always willing to fit in with our routine to give generously of their time and to go beyond the call of duty. Thank you”

It is too early to have definitive numbers over a whole year given the recent implementation, but between April and September 2015 the North Out of Hospital Team has supported over 460 patients to remain at home when they might previously have been admitted to hospital.

Experience from the Lowestoft Out of Hospital Team suggests that, if the North team had not supported these patients to remain at home, approximately one third of them would have been unnecessarily admitted to the local acute trust.

**Lorraine Rollo**
Head of Communications and Engagement
29 March 2016

NHS
Great Yarmouth and Waveney
Clinical Commissioning Group

HealthEast

# Briefing for Great Yarmouth and Waveney Health Scrutiny Committee on the business continuity event at JPUH on 3 Jan 2016

On Sunday 3 January the Great Yarmouth and Waveney system experienced unprecedented demand with 231 attendances to A&E. This included 93 ambulance arrivals to A&E. Normal activity for a Sunday would be approximately 185 attendances to A&E, of which approximately 50 would be ambulance arrivals.

The ambulance service were also busy with 131 incidents attended, 66% (93) of these being conveyed to an acute hospital.

Of the 231 attendances, 54 patients required an emergency admission. However, capacity issues within the James Paget University Hospital (JPUH), community services and social care meant that the patient flow through the emergency system was compromised, and A&E were unable to move patients to the appropriate area.

The significant increase in demand on Sunday 3 January had an impact on performance on Monday 4 January. Although A&E attendances and ambulance conveyances were back to a normal level for a Monday (192 A&E attendances of which 61 via ambulance) emergency admissions remained a concern and risk for the system given the lack of capacity.

A full business continuity incident was declared on Monday 4 January (following the JPUH Internal Majax policy). Throughout this period system partners worked collaboratively to address capacity issues, for example -

- an additional eight beds were put in place at Beccles Hospital to support discharge from JPUH
- All Hallows Hospital made four spot purchase beds available
- Out of hospital teams in reached to help identify patients suitable for discharge
- The CCG continuing healthcare team worked within the hospital to make sure patients were discharged safely and quickly, often being moved to discharge to assess beds in the community.

An extraordinary system teleconference was held with acute hospital providers from across Norfolk and Suffolk. All agreed to an ambulance divert for three hours to allow the JPUH A&E department some respite. This was managed by front line and ambulance staff.

Unfortunately the lack of capacity within the system at this time led to three 12 hour breaches within A&E on Monday 4 January. As part of the 12 hour breach protocol, these incidents are being investigated and a full root cause analysis completed for each breach.

A debrief session was held on Wednesday 13 January with all system partners to understand the pressures and capacity issues facing the system in the lead up to and during the New Year weekend. This looked for learning opportunities which could be implemented for long term resilience. It also sought areas which need to be strengthened to support the system over the Easter period which is traditionally a time when there is increased demand on services.

An early review of activity showed that the increases in attendances were for the elderly population. The top reasons for attendance were breathing difficulties/COPD, chest pain, fainting, falls and stroke. Anecdotal discussions at the debrief suggested that a number of the admissions were due to the elderly population who tend not to access urgent/emergency primary care, waiting until crisis point before accessing services.

As part of the debrief process, all partners across the system were asked for activity levels running up to this period.

From the responses received from primary care there did not appear to have been a significant rise in demand, although there was varied activity across the practices. Some practices had a number of free appointments in between Christmas and New Year and also on Monday 4 January whilst others were full.

IC24 Out of Hours primary care again did not experience any significant rise in demand. However, Saturday 2 January was particularly busy although Sunday 3 January was comparatively quieter. This was the same for NHS111 who experienced a rise in call volumes on Saturday 2 January. This resulted in a breach against the target for calls answered within 60 seconds. The report from NHS111 noted calls queuing for long periods due to very high volume over a few hours. The call volumes were considerably higher than predicted during morning periods and although significantly increased staffing levels were in place this was not sufficient to meet the high demand which had an impact on all three IC24 call centres at the same time.

Over Christmas and the lead up to New Year's Eve referrals to mental health were relatively quiet. However there were increased referrals on New Year's Eve, almost double usual referrals. Of the 12 referrals, 6 required admission. The service was also affected by staff sickness.

Whilst the New Year period is always busy, the activity on one day, Sunday 4th January, was unprecedented and could not have been predicted in its intensity. It did not follow any trends seen previously. By Tuesday 5 January the system was much improved. The rapid return to normal activity in fact shows the resilience of the system and its ability to recover quickly.

**Lorraine Rollo**
Head of Communications and Engagement
29 March 2016

**Agenda Item 6**

# Great Yarmouth and Waveney Joint Health Scrutiny Committee, 15 April 2016

## Information Bulletin

The Information Bulletin is a document that is made available to the public with the published agenda papers. It can include update information requested by the Committee as well as information that a service considers should be made known to the Committee.

This Information Bulletin covers just the one item: NSFT Staff Survey 2015

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### NSFT Staff Survey 2015

At the Joint Committee's meeting on 22 January 2016 it was noted that the Norfolk and Suffolk NHS Foundation Trust (NSFT) staff survey results would be available during February/March.

The staff survey results are available at the following website: http://www.nhsstaffsurveys.com/Page/1053/Latest-Results/Mental-Health-Learning-Disability-Trusts/

The Summary Report for NSFT is attached as Appendix 1 *[22 pages]*.

# 2015 National NHS staff survey

# Brief summary of results from Norfolk and Suffolk NHS Foundation Trust

## Table of Contents

## 1. Introduction to this report

This report presents the findings of the 2015 national NHS staff survey conducted in Norfolk and Suffolk NHS Foundation Trust.

In section 2 of this report, we present an overall indicator of staff engagement. Full details of how this indicator was created can be found in the document ***Making sense of your staff survey data***, which can be downloaded from www.nhsstaffsurveys.com.

In sections 3 and 4 of this report, the findings of the questionnaire have been summarised and presented in the form of 32 Key Findings.

These sections of the report have been structured around four of the seven pledges to staff in the NHS Constitution which was published in March 2013 (http://www.nhs.uk/choiceintheNHS/Rightsandpledges/NHSConstitution) plus three additional themes:

- Staff Pledge 1: To provide all staff with clear roles and responsibilities and rewarding jobs for teams and individuals that make a difference to patients, their families and carers and communities.
- Staff Pledge 2: To provide all staff with personal development, access to appropriate education and training for their jobs, and line management support to enable them to fulfil their potential.
- Staff Pledge 3: To provide support and opportunities for staff to maintain their health, well-being and safety.
- Staff Pledge 4: To engage staff in decisions that affect them and the services they provide, individually, through representative organisations and through local partnership working arrangements. All staff will be empowered to put forward ways to deliver better and safer services for patients and their families.
- Additional theme: Equality and diversity
- Additional theme: Errors and incidents
- Additional theme: Patient experience measures

Please note, the questionnaire, key findings and benchmarking groups have all undergone substantial revision since the previous staff survey. For more detail on these changes, please see the ***Making sense of your staff survey data*** document.

As in previous years, there are two types of Key Finding:

- percentage scores, i.e. percentage of staff giving a particular response to one, or a series of, survey questions

- scale summary scores, calculated by converting staff responses to particular questions into scores. For each of these scale summary scores, the minimum score is always 1 and the maximum score is 5

A longer and more detailed report of the 2015 survey results for Norfolk and Suffolk NHS Foundation Trust can be downloaded from: www.nhsstaffsurveys.com. This report provides detailed breakdowns of the Key Finding scores by directorate, occupational groups and demographic groups, and details of each question included in the core questionnaire.

## Your Organisation

The scores presented below are un-weighted question level scores for questions Q21a, Q21b, Q21c and Q21d and the un-weighted score for Key Finding 1. The percentages for Q21a – Q21d are created by combining the responses for those who “Agree” and “Strongly Agree” compared to the total number of staff that responded to the question.

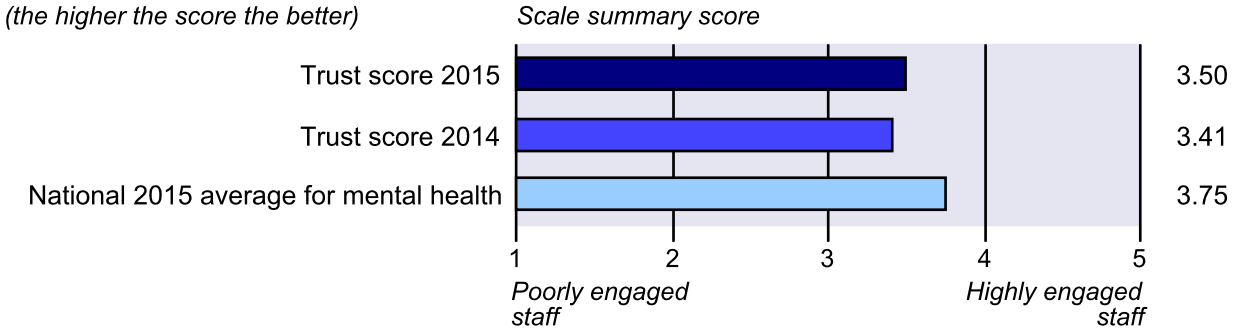
Q21a, Q21c and Q21d feed into Key Finding 1 “Staff recommendation of the organisation as a place to work or receive treatment”.

| | | Your Trust in 2015 | Average (median) for mental health | Your Trust in 2014 |
|---|---|---|---|---|
| Q21a | "Care of patients / service users is my organisation's top priority" | 52% | 70% | 43% |
| Q21b | "My organisation acts on concerns raised by patients / service users" | 57% | 72% | 50% |
| Q21c | "I would recommend my organisation as a place to work" | 34% | 56% | 34% |
| Q21d | "If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation" | 38% | 59% | 36% |
| KF1. | Staff recommendation of the organisation as a place to work or receive treatment (Q21a, 21c-d) | 3.11 | 3.66 | 2.99 |

## 2. Overall indicator of staff engagement for Norfolk and Suffolk NHS Foundation Trust

The figure below shows how Norfolk and Suffolk NHS Foundation Trust compares with other mental health / learning disability trusts on an overall indicator of staff engagement. Possible scores range from 1 to 5, with 1 indicating that staff are poorly engaged (with their work, their team and their trust) and 5 indicating that staff are highly engaged. The trust's score of 3.50 was below (worse than) average when compared with trusts of a similar type.

### OVERALL STAFF ENGAGEMENT




This overall indicator of staff engagement has been calculated using the questions that make up Key Findings 1, 4 and 7. These Key Findings relate to the following aspects of staff engagement: staff members' perceived ability to contribute to improvements at work (Key Finding 7); their willingness to recommend the trust as a place to work or receive treatment (Key Finding 1); and the extent to which they feel motivated and engaged with their work (Key Finding 4).

The table below shows how Norfolk and Suffolk NHS Foundation Trust compares with other mental health / learning disability trusts on each of the sub-dimensions of staff engagement, and whether there has been a change since the 2014 survey.

| | Change since 2014 survey | Ranking, compared with all mental health |
|---|---|---|
| **OVERALL STAFF ENGAGEMENT** | ✓ Increase (better than 14) | ! Below (worse than) average |
| **KF1. Staff recommendation of the trust as a place to work or receive treatment** *(the extent to which staff think care of patients/service users is the trust's top priority, would recommend their trust to others as a place to work, and would be happy with the standard of care provided by the trust if a friend or relative needed treatment.)* | ✓ Increase (better than 14) | ! Below (worse than) average |
| **KF4. Staff motivation at work** *(the extent to which they look forward to going to work, and are enthusiastic about and absorbed in their jobs.)* | ✓ Increase (better than 14) | ! Below (worse than) average |
| **KF7. Staff ability to contribute towards improvements at work** *(the extent to which staff are able to make suggestions to improve the work of their team, have frequent opportunities to show initiative in their role, and are able to make improvements at work.)* | • No change | ! Below (worse than) average |

Full details of how the overall indicator of staff engagement was created can be found in the document ***Making sense of your staff survey data***.

## 3. Summary of 2015 Key Findings for Norfolk and Suffolk NHS Foundation Trust

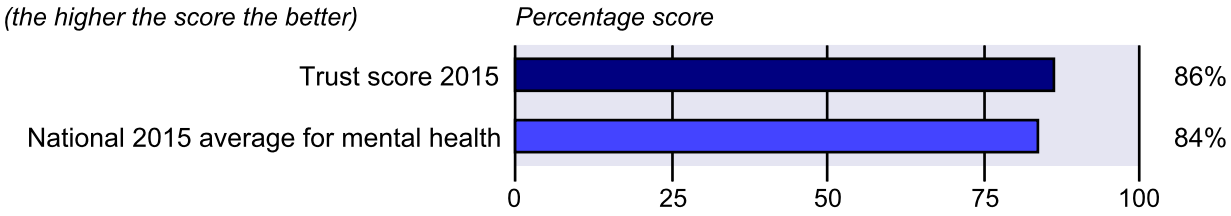
### 3.1 Top and Bottom Ranking Scores

This page highlights the five Key Findings for which Norfolk and Suffolk NHS Foundation Trust compares most favourably with other mental health / learning disability trusts in England.

**TOP FIVE RANKING SCORES**

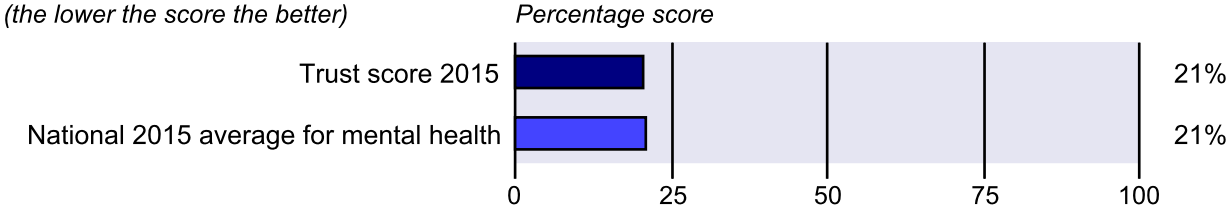
**✓KF24. Percentage of staff / colleagues reporting most recent experience of violence**

*(the higher the score the better)*



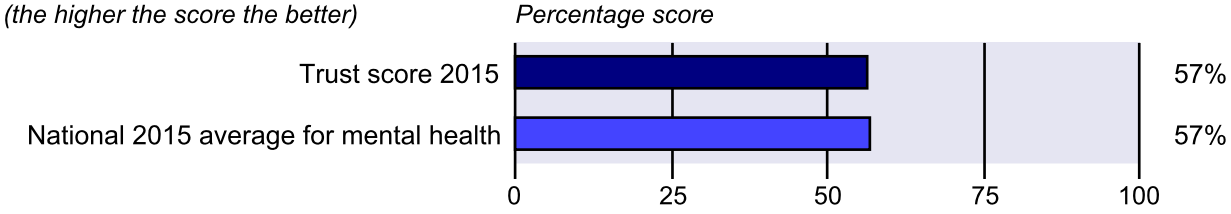

**✓KF22. Percentage of staff experiencing physical violence from patients, relatives or the public in last 12 months**

*(the lower the score the better)*



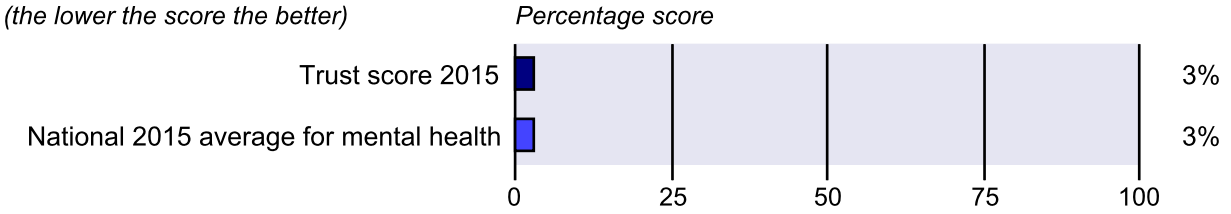

**✓KF15. Percentage of staff satisfied with the opportunities for flexible working patterns**

*(the higher the score the better)*



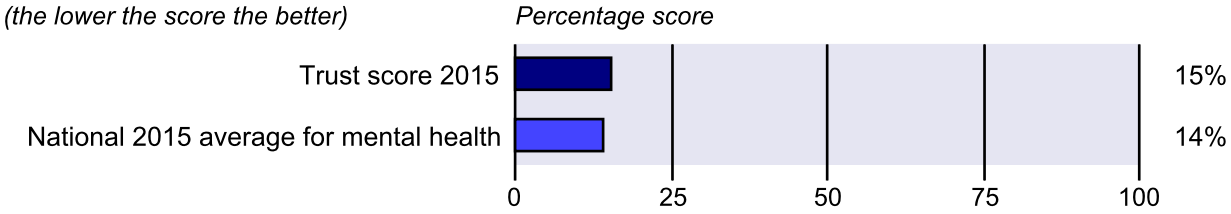

**✓KF23. Percentage of staff experiencing physical violence from staff in last 12 months**

*(the lower the score the better)*




**✓KF20. Percentage of staff experiencing discrimination at work in last 12 months**

*(the lower the score the better)*



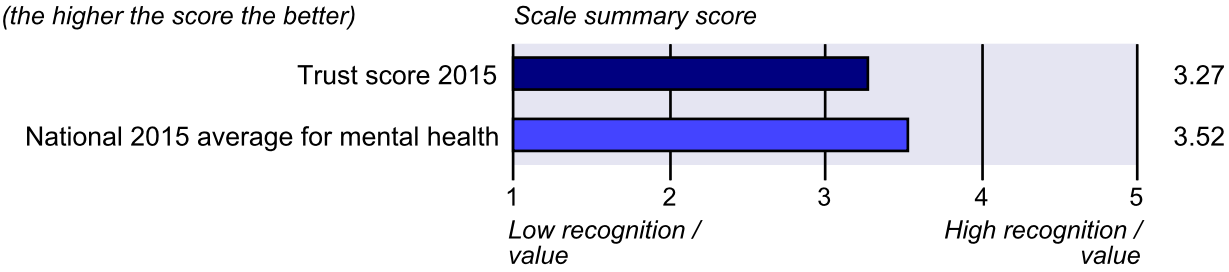

For each of the 32 Key Findings, the mental health / learning disability trusts in England were placed in order from 1 (the top ranking score) to 29 (the bottom ranking score). Norfolk and Suffolk NHS Foundation Trust's five highest ranking scores are presented here, i.e. those for which the trust's Key Finding score is ranked closest to 1. Further details about this can be found in the document ***Making sense of your staff survey data***.

This page highlights the five Key Findings for which Norfolk and Suffolk NHS Foundation Trust compares least favourably with other mental health / learning disability trusts in England. It is suggested that these areas might be seen as a starting point for local action to improve as an employer.

## BOTTOM FIVE RANKING SCORES

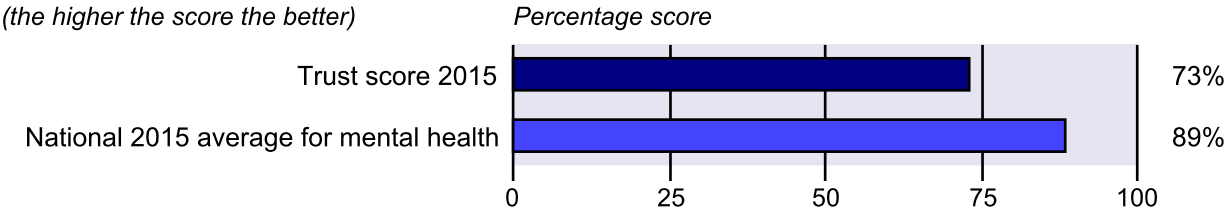
### ! KF5. Recognition and value of staff by managers and the organisation

*(the higher the score the better)*



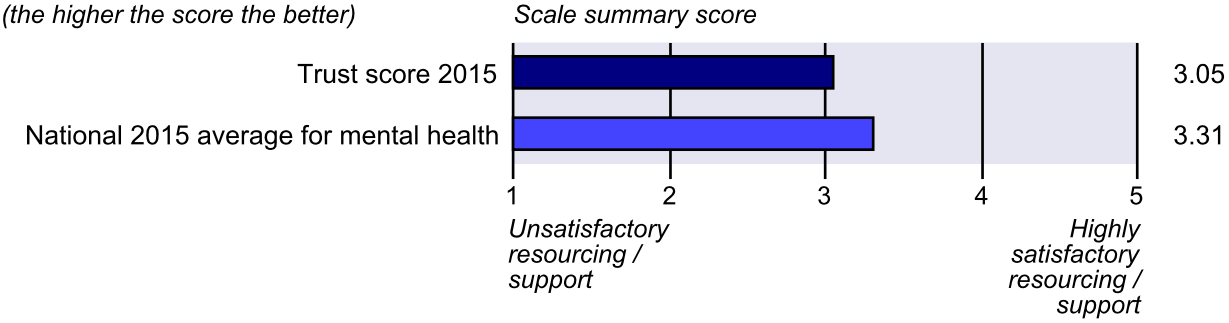

### ! KF11. Percentage of staff appraised in last 12 months

*(the higher the score the better)*



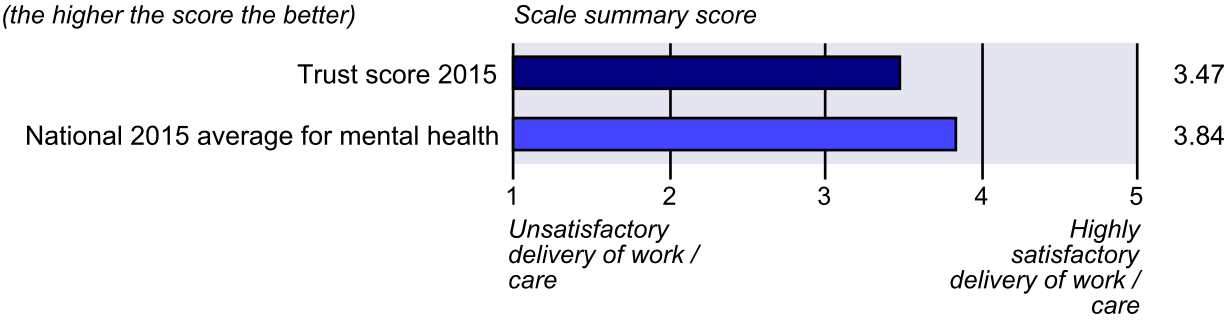

### ! KF14. Staff satisfaction with resourcing and support

*(the higher the score the better)*



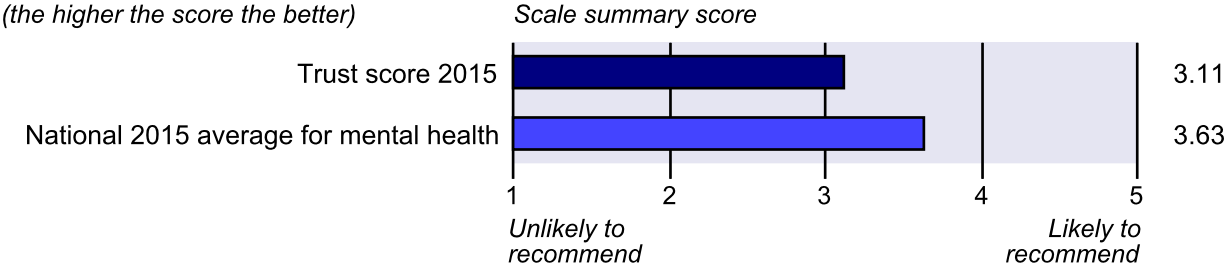

### ! KF2. Staff satisfaction with the quality of work and patient care they are able to deliver

*(the higher the score the better)*




### ! KF1. Staff recommendation of the organisation as a place to work or receive treatment

*(the higher the score the better)*



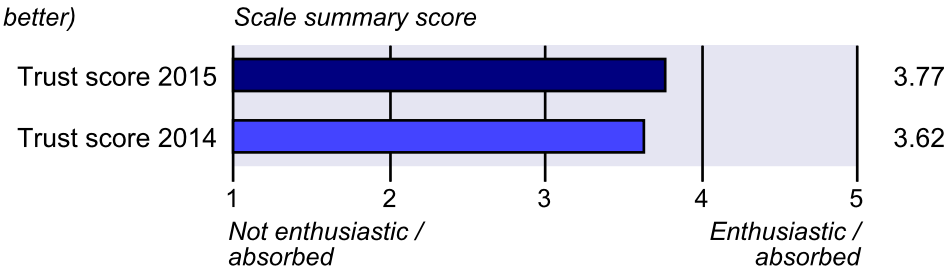
## 3.2 Largest Local Changes since the 2014 Survey

This page highlights the five Key Findings where staff experiences have improved at Norfolk and Suffolk NHS Foundation Trust since the 2014 survey. (This is a positive local result. However, please note that, as shown in section 3.3, when compared with other mental health / learning disability trusts in England, the scores for Key findings KF4, KF11, KF17, and KF28 are worse than average).

### WHERE STAFF EXPERIENCE HAS IMPROVED

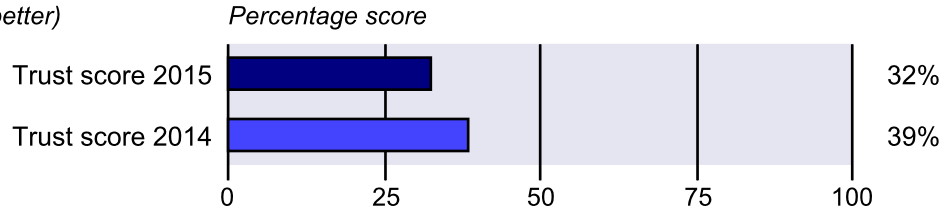
**✓KF4. Staff motivation at work**

*(the higher the score the better)*



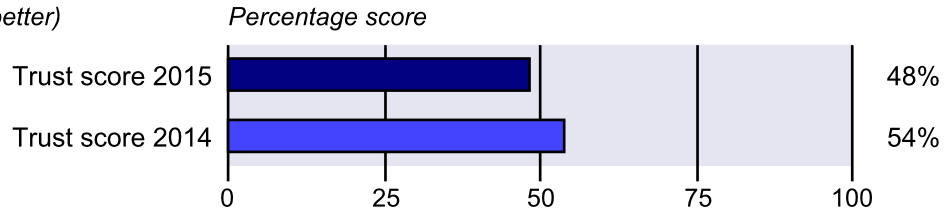

**✓KF28. Percentage of staff witnessing potentially harmful errors, near misses or incidents in last month**

*(the lower the score the better)*



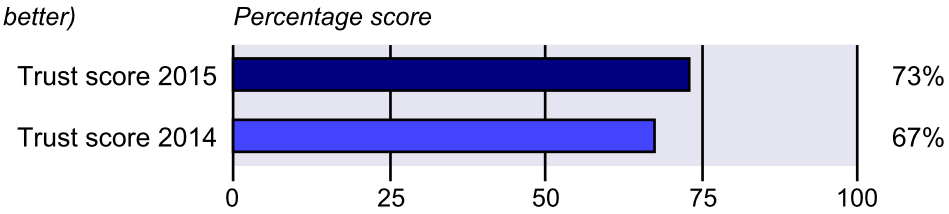

**✓KF17. Percentage of staff suffering work related stress in last 12 months**

*(the lower the score the better)*



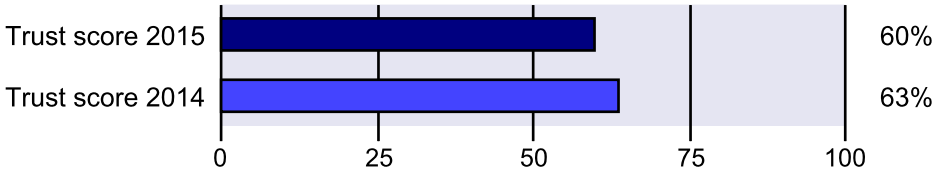

**✓KF11. Percentage of staff appraised in last 12 months**

*(the higher the score the better)*




**✓KF18. Percentage of staff feeling pressure in the last 3 months to attend work when feeling unwell**

*(the lower the score the better)*



## 3.2. Summary of all Key Findings for Norfolk and Suffolk NHS Foundation Trust

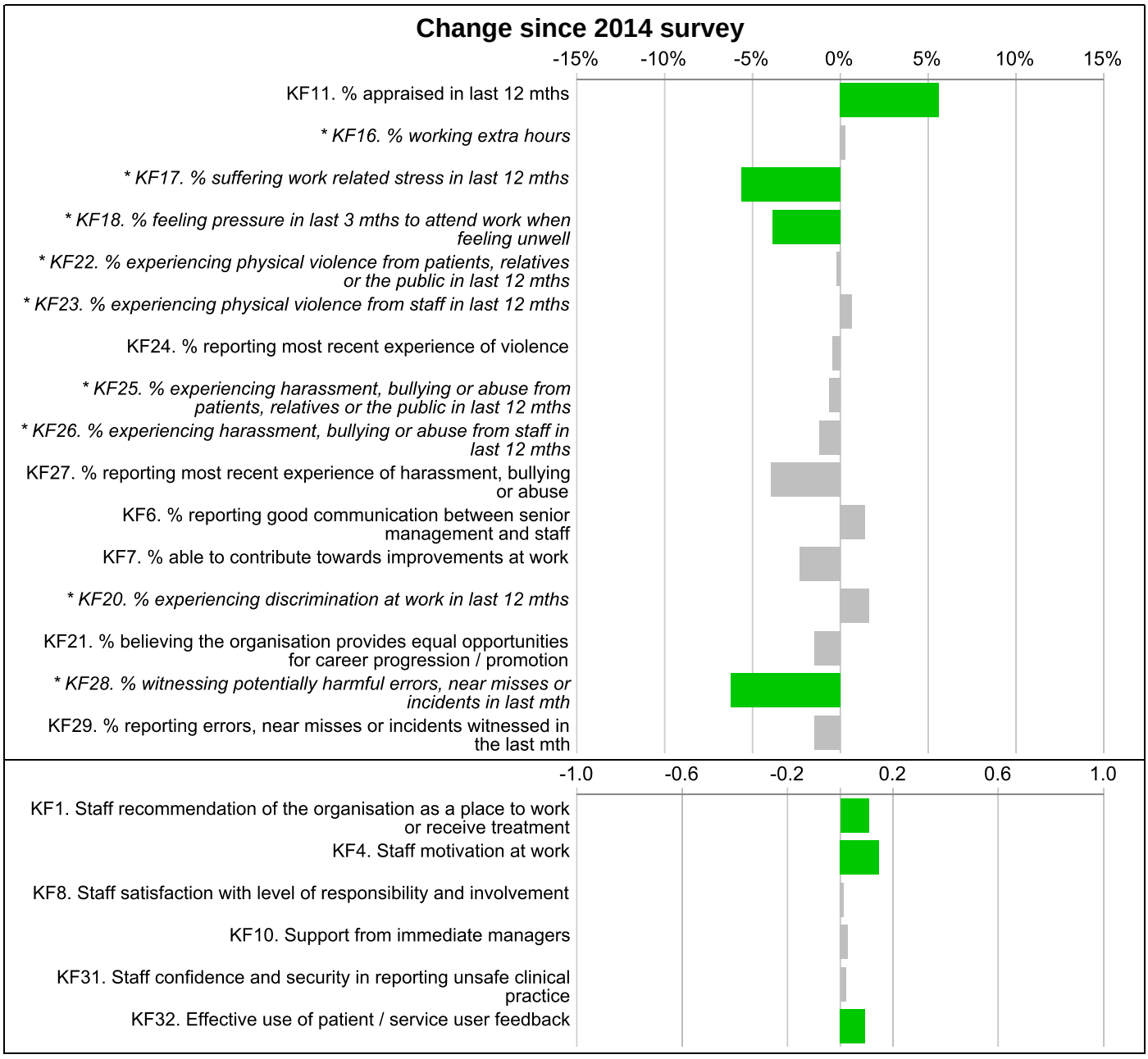
KEY

Green = Positive finding, e.g. there has been a statistically significant positive change in the Key Finding since the 2014 survey.

Red = Negative finding, e.g. there has been a statistically significant negative change in the Key Finding since the 2014 survey.

Grey = No change, e.g. there has been no statistically significant change in this Key Finding since the 2014 survey.

For most of the Key Finding scores in this table, the higher the score the better. However, there are some scores for which a high score would represent a negative finding. For these scores, which are marked with an asterisk and in *italics*, the lower the score the better.



## 3.2. Summary of all Key Findings for Norfolk and Suffolk NHS Foundation Trust

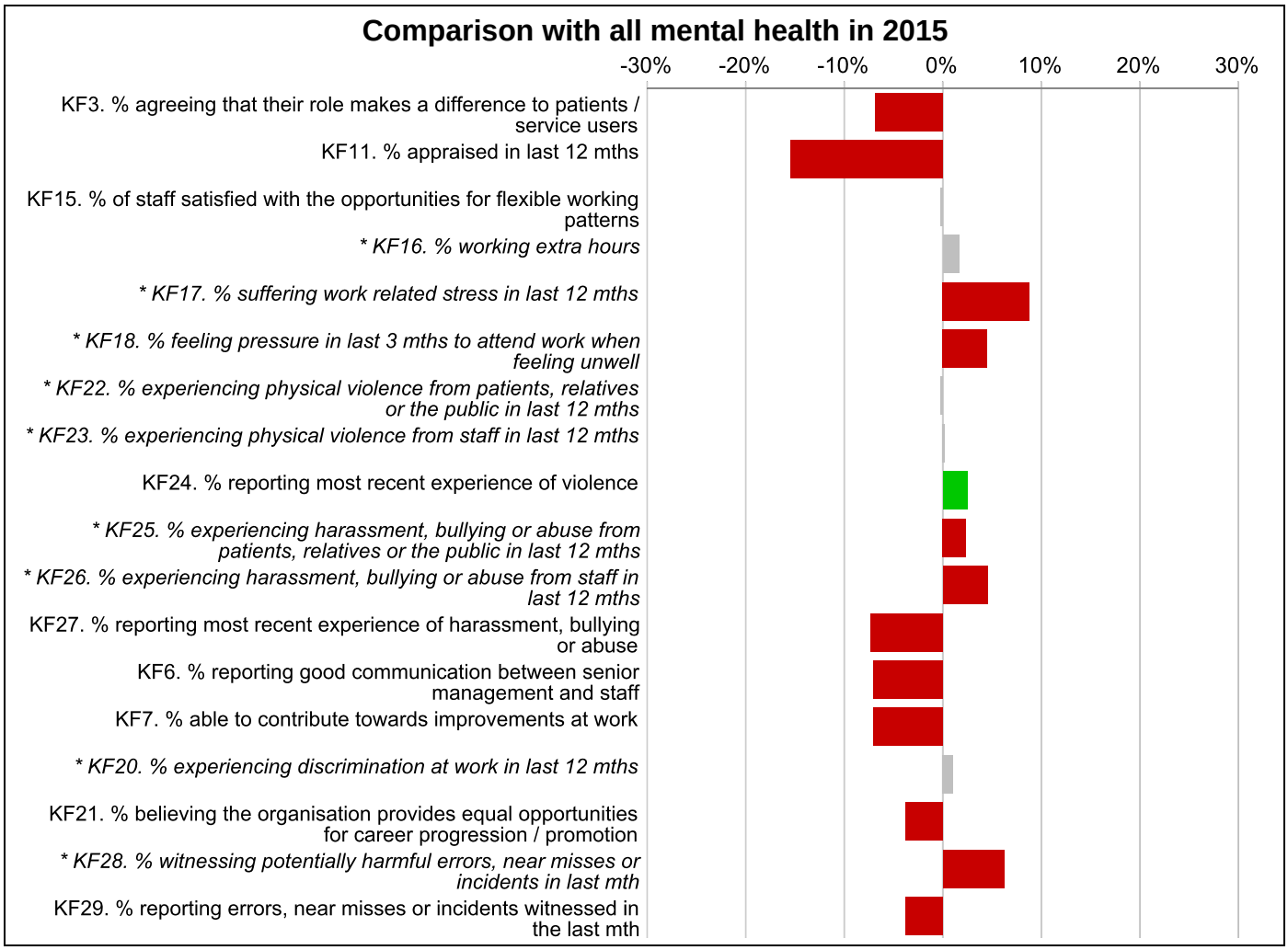
KEY

Green = Positive finding, e.g. better than average.

Red = Negative finding, e.g. worse than average.

Grey = Average.

For most of the Key Finding scores in this table, the higher the score the better. However, there are some scores for which a high score would represent a negative finding. For these scores, which are marked with an asterisk and in *italics*, the lower the score the better.



## 3.2. Summary of all Key Findings for Norfolk and Suffolk NHS Foundation Trust

KEY

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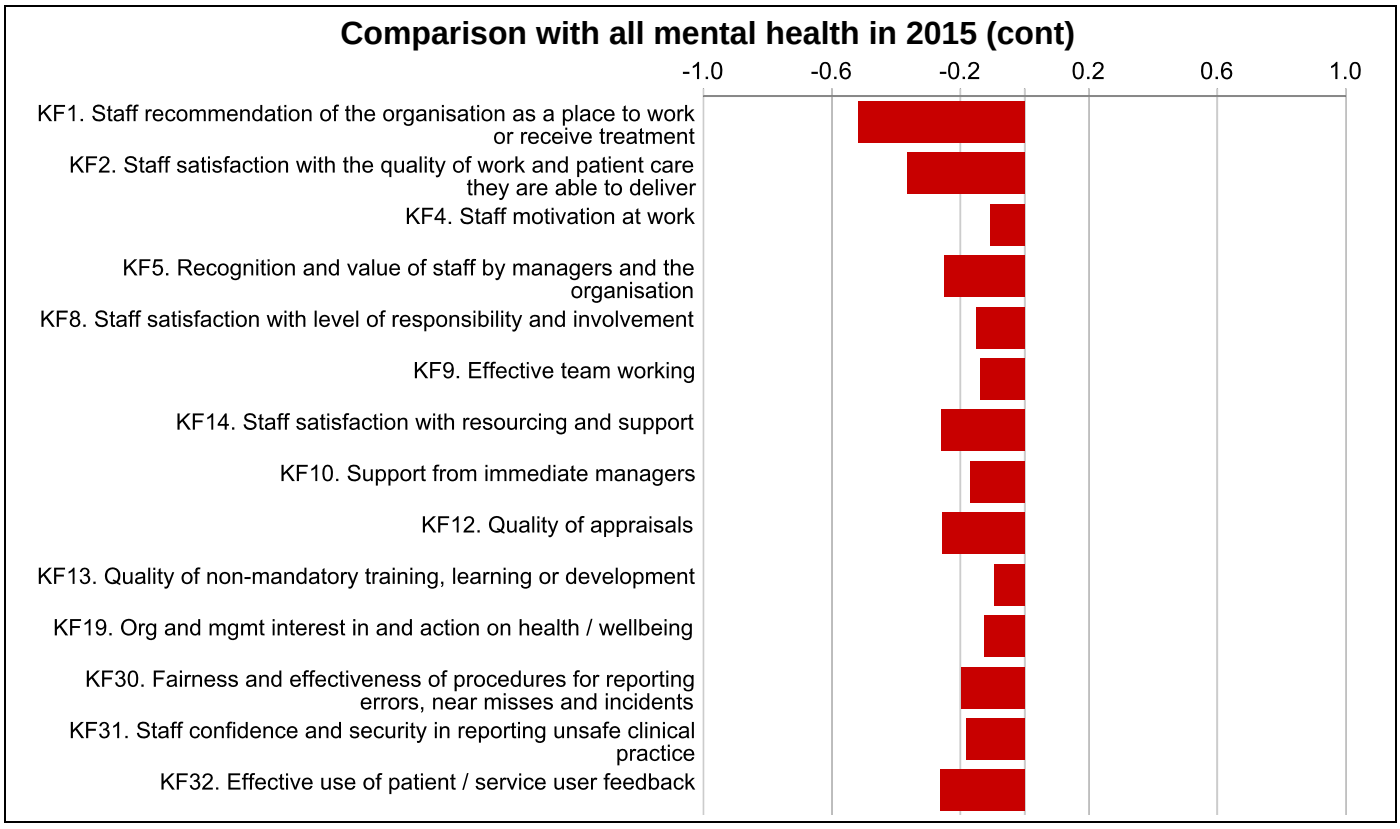


## 3.3. Summary of all Key Findings for Norfolk and Suffolk NHS Foundation Trust

KEY

✓ Green = Positive finding, e.g. better than average, better than 2014.

! Red = Negative finding, e.g. worse than average, worse than 2014.

'Change since 2014 survey' indicates whether there has been a statistically significant change in the Key Finding since the 2014 survey.

-- Because of changes to the format of the survey questions this year, comparisons with the 2014 score are not possible.

* For most of the Key Finding scores in this table, the higher the score the better. However, there are some scores for which a high score would represent a negative finding. For these scores, which are marked with an asterisk and in *italics*, the lower the score the better.

| | Change since 2014 survey | Ranking, compared with all mental health in 2015 |
|---|---|---|
| **STAFF PLEDGE 1: To provide all staff with clear roles, responsibilities and rewarding jobs.** | | |
| KF1. Staff recommendation of the organisation as a place to work or receive treatment | ✓ Increase (better than 14) | ! Below (worse than) average |
| KF2. Staff satisfaction with the quality of work and patient care they are able to deliver | -- | ! Below (worse than) average |
| KF3. % agreeing that their role makes a difference to patients / service users | -- | ! Below (worse than) average |
| KF4. Staff motivation at work | ✓ Increase (better than 14) | ! Below (worse than) average |
| KF5. Recognition and value of staff by managers and the organisation | -- | ! Below (worse than) average |
| KF8. Staff satisfaction with level of responsibility and involvement | • No change | ! Below (worse than) average |
| KF9. Effective team working | -- | ! Below (worse than) average |
| KF14. Staff satisfaction with resourcing and support | -- | ! Below (worse than) average |
| **STAFF PLEDGE 2: To provide all staff with personal development, access to appropriate education and training for their jobs, and line management support to enable them to fulfil their potential.** | | |
| KF10. Support from immediate managers | • No change | ! Below (worse than) average |
| KF11. % appraised in last 12 mths | ✓ Increase (better than 14) | ! Below (worse than) average |
| KF12. Quality of appraisals | -- | ! Below (worse than) average |
| KF13. Quality of non-mandatory training, learning or development | -- | ! Below (worse than) average |
| **STAFF PLEDGE 3: To provide support and opportunities for staff to maintain their health, well-being and safety.** | | |
| **Health and well-being** | | |
| KF15. % of staff satisfied with the opportunities for flexible working patterns | -- | • Average |
| * *KF16. % working extra hours* | • No change | • Average |
| * *KF17. % suffering work related stress in last 12 mths* | ✓ Decrease (better than 14) | ! Above (worse than) average |
| * *KF18. % feeling pressure in last 3 mths to attend work when feeling unwell* | ✓ Decrease (better than 14) | ! Above (worse than) average |
| KF19. Org and mgmt interest in and action on health / wellbeing | -- | ! Below (worse than) average |

## 3.3. Summary of all Key Findings for Norfolk and Suffolk NHS Foundation Trust (cont)

| | Change since 2014 survey | Ranking, compared with all mental health in 2015 |
|---|---|---|
| **Violence and harassment** | | |
| * *KF22. % experiencing physical violence from patients, relatives or the public in last 12 mths* | • No change | • Average |
| * *KF23. % experiencing physical violence from staff in last 12 mths* | • No change | • Average |
| KF24. % reporting most recent experience of violence | • No change | ✓ Above (better than) average |
| * *KF25. % experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 mths* | • No change | ! Above (worse than) average |
| * *KF26. % experiencing harassment, bullying or abuse from staff in last 12 mths* | • No change | ! Above (worse than) average |
| KF27. % reporting most recent experience of harassment, bullying or abuse | • No change | ! Below (worse than) average |
| **STAFF PLEDGE 4: To engage staff in decisions that affect them, the services they provide and empower them to put forward ways to deliver better and safer services.** | | |
| KF6. % reporting good communication between senior management and staff | • No change | ! Below (worse than) average |
| KF7. % able to contribute towards improvements at work | • No change | ! Below (worse than) average |
| **ADDITIONAL THEME: Equality and diversity** | | |
| * *KF20. % experiencing discrimination at work in last 12 mths* | • No change | • Average |
| KF21. % believing the organisation provides equal opportunities for career progression / promotion | • No change | ! Below (worse than) average |
| **ADDITIONAL THEME: Errors and incidents** | | |
| * *KF28. % witnessing potentially harmful errors, near misses or incidents in last mth* | ✓ Decrease (better than 14) | ! Above (worse than) average |
| KF29. % reporting errors, near misses or incidents witnessed in the last mth | • No change | ! Below (worse than) average |
| KF30. Fairness and effectiveness of procedures for reporting errors, near misses and incidents | -- | ! Below (worse than) average |
| KF31. Staff confidence and security in reporting unsafe clinical practice | • No change | ! Below (worse than) average |
| **ADDITIONAL THEME: Patient experience measures** | | |
| KF32. Effective use of patient / service user feedback | ✓ Increase (better than 14) | ! Below (worse than) average |

## 4. Key Findings for Norfolk and Suffolk NHS Foundation Trust

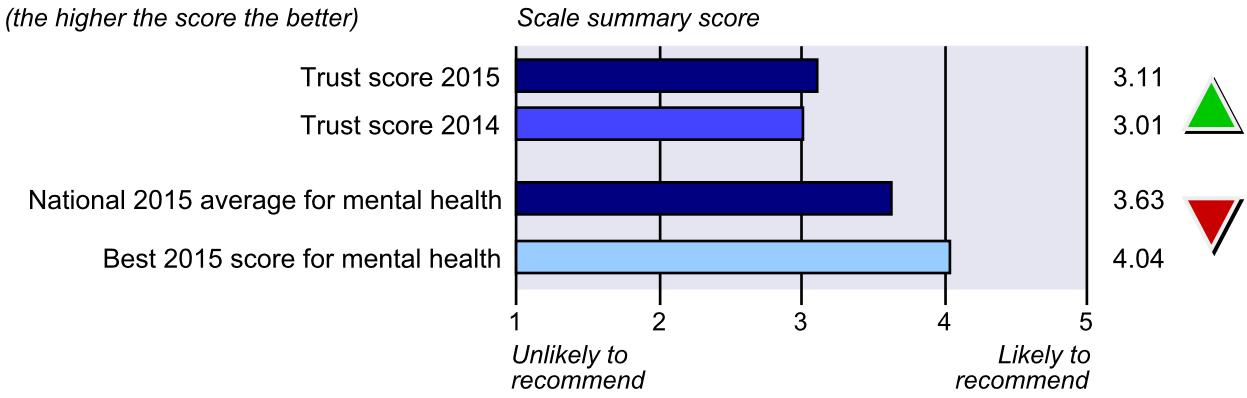
1825 staff at Norfolk and Suffolk NHS Foundation Trust took part in this survey. This is a response rate of 52%[1] which is above average for mental health / learning disability trusts in England, and compares with a response rate of 36% in this trust in the 2014 survey.

This section presents each of the 32 Key Findings, using data from the trust's 2015 survey, and compares these to other mental health / learning disability trusts in England and to the trust's performance in the 2014 survey. The findings are arranged under seven headings – the four staff pledges from the NHS Constitution, and the three additional themes of equality and diversity, errors and incidents, and patient experience measures.

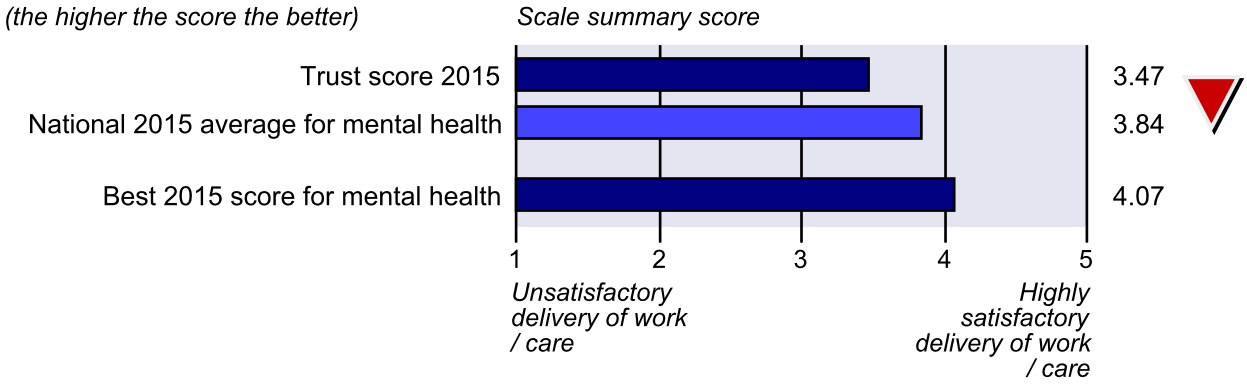
Positive findings are indicated with a green arrow (e.g. where the trust is better than average, or where the score has improved since 2014). Negative findings are highlighted with a red arrow (e.g. where the trust's score is worse than average, or where the score is not as good as 2014). An equals sign indicates that there has been no change.

### STAFF PLEDGE 1: To provide all staff with clear roles, responsibilities and rewarding jobs.

#### KEY FINDING 1. Staff recommendation of the organisation as a place to work or receive treatment



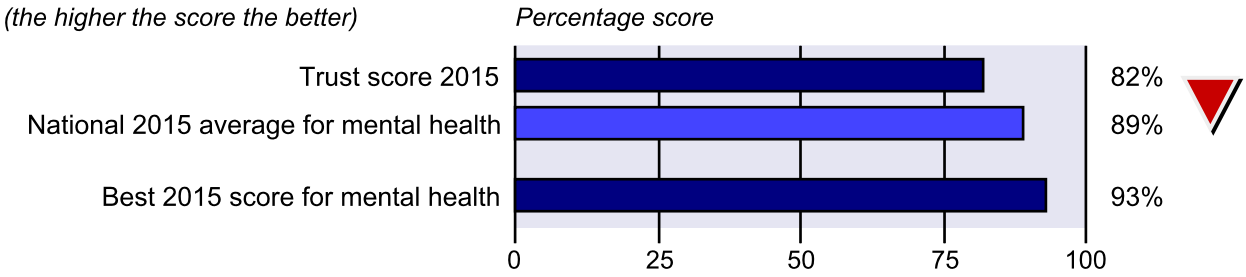

#### KEY FINDING 2. Staff satisfaction with the quality of work and patient care they are able to deliver




[1]Questionnaires were sent to all 3529 staff eligible to receive the survey. This includes only staff employed directly by the trust (i.e. excluding staff working for external contractors). It excludes bank staff unless they are also employed directly elsewhere in the trust. When calculating the response rate, questionnaires could only be counted if they were received with their ID number intact, by the closing date.

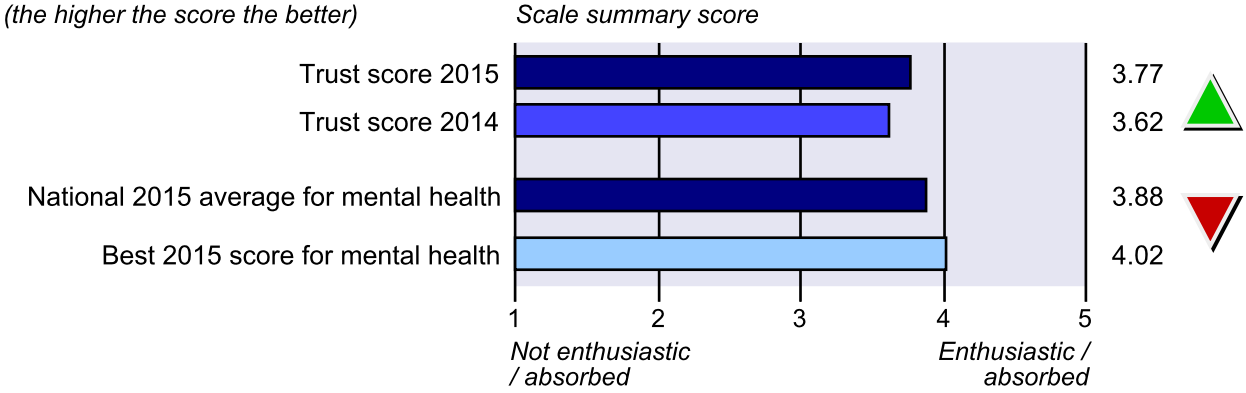
## KEY FINDING 3. Percentage of staff agreeing that their role makes a difference to patients / service users

*(the higher the score the better)*



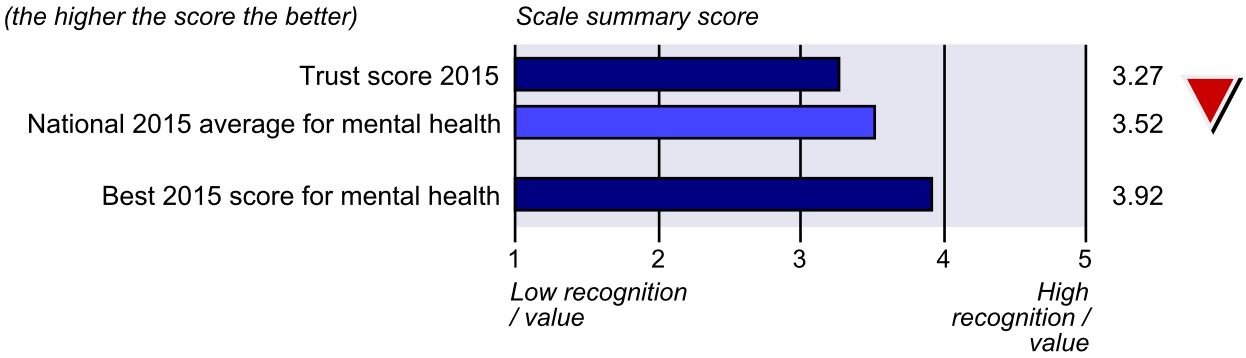

## KEY FINDING 4. Staff motivation at work

*(the higher the score the better)*



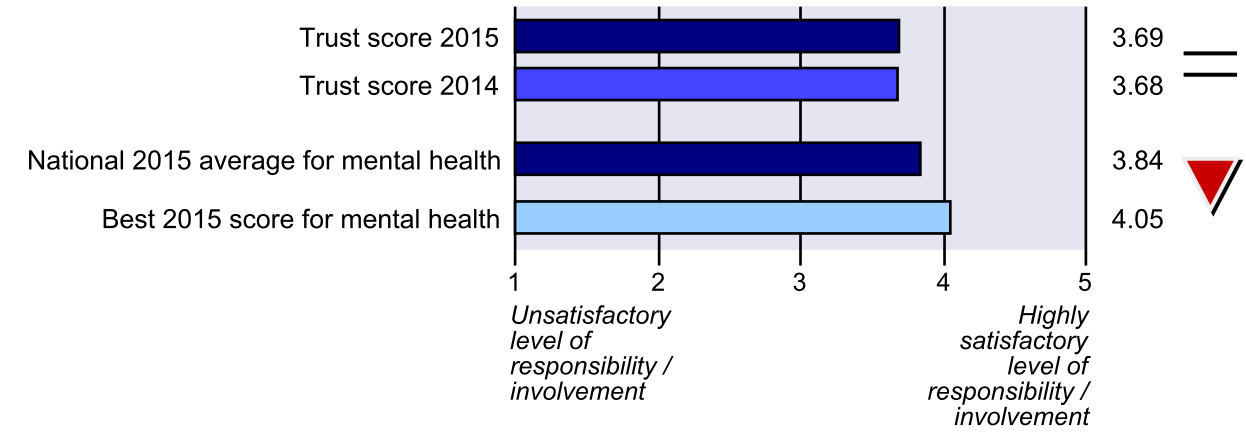

## KEY FINDING 5. Recognition and value of staff by managers and the organisation

*(the higher the score the better)*



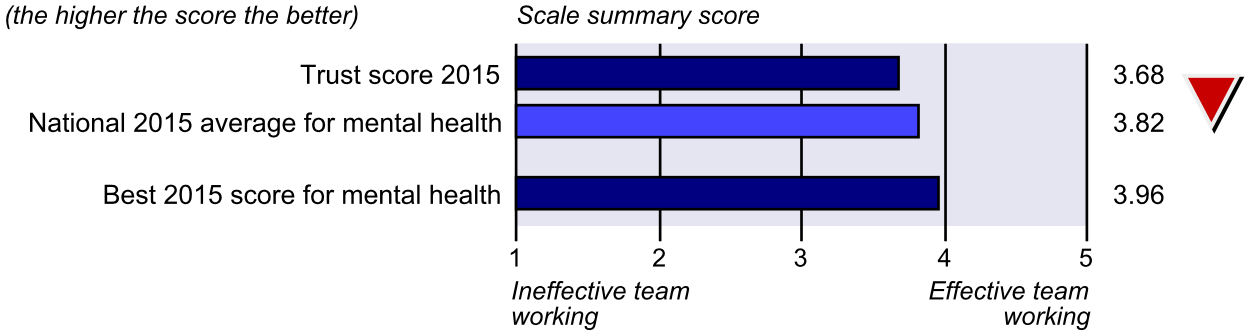

## KEY FINDING 8. Staff satisfaction with level of responsibility and involvement

*(the higher the score the better)*



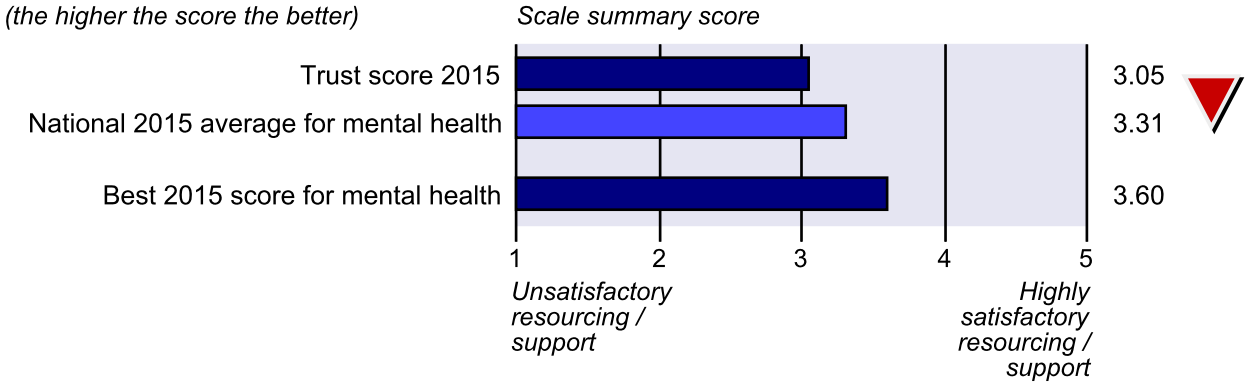
### KEY FINDING 9. Effective team working

*(the higher the score the better)*




### KEY FINDING 14. Staff satisfaction with resourcing and support

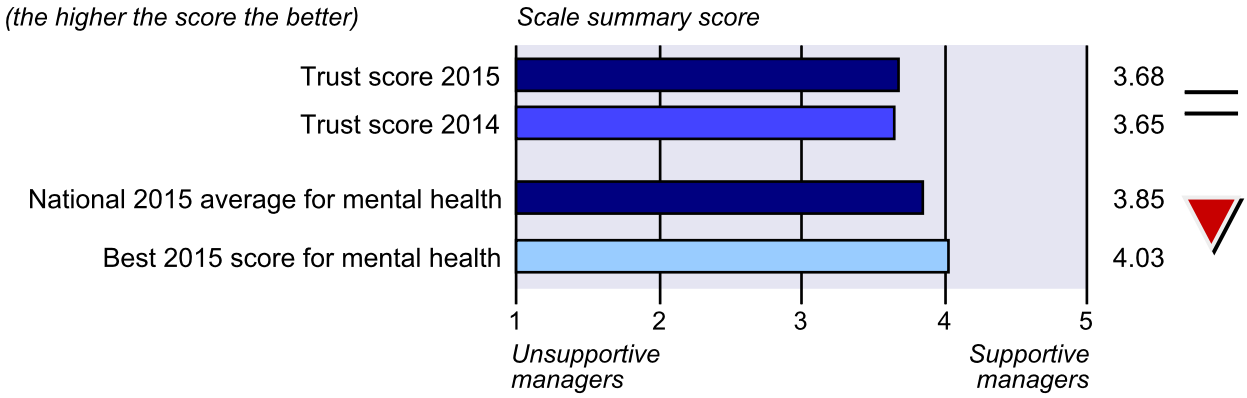
*(the higher the score the better)*




## STAFF PLEDGE 2: To provide all staff with personal development, access to appropriate education and training for their jobs, and line management support to enable them to fulfil their potential.

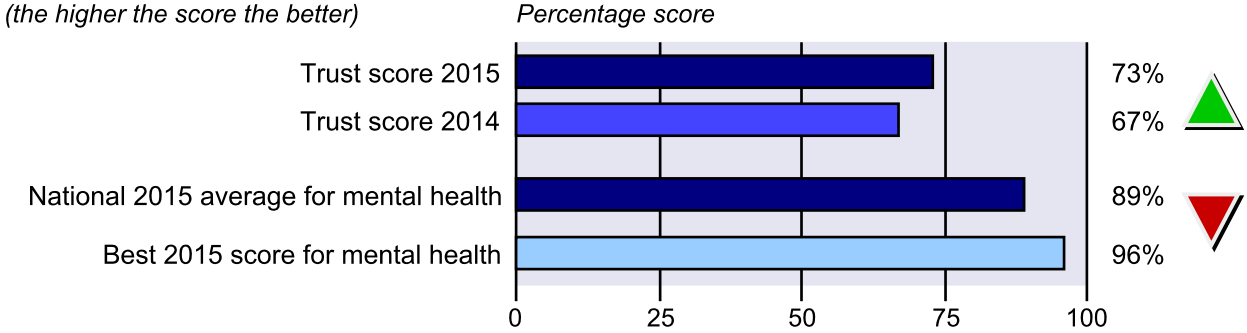
### KEY FINDING 10. Support from immediate managers

*(the higher the score the better)*



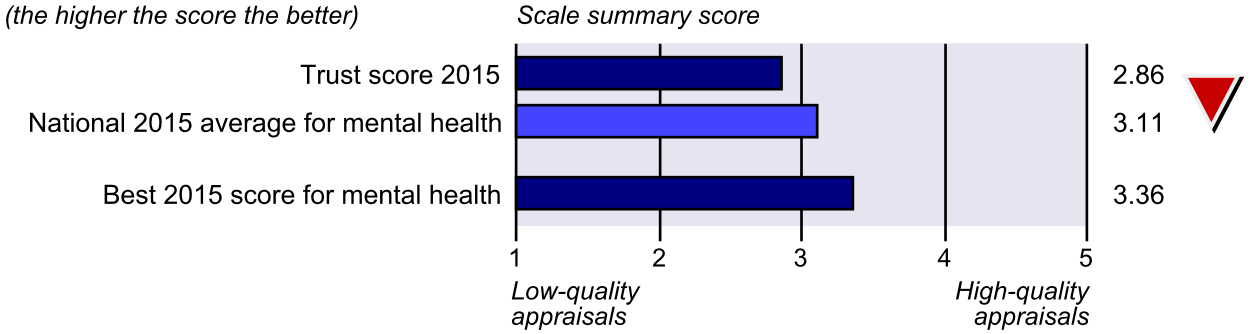

### KEY FINDING 11. Percentage of staff appraised in last 12 months

*(the higher the score the better)*



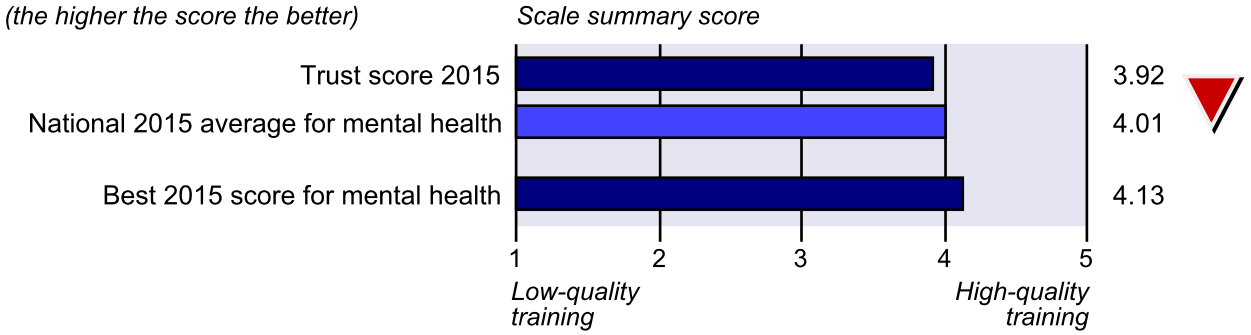
### KEY FINDING 12. Quality of appraisals

*(the higher the score the better)*




### KEY FINDING 13. Quality of non-mandatory training, learning or development

*(the higher the score the better)*

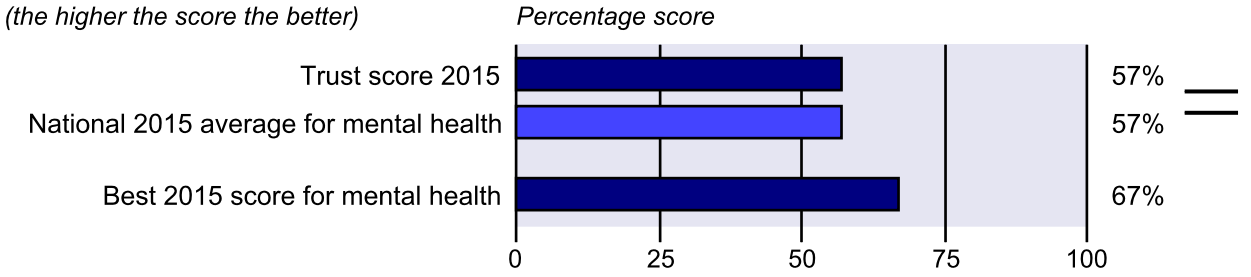



## STAFF PLEDGE 3: To provide support and opportunities for staff to maintain their health, well-being and safety.

### Health and well-being

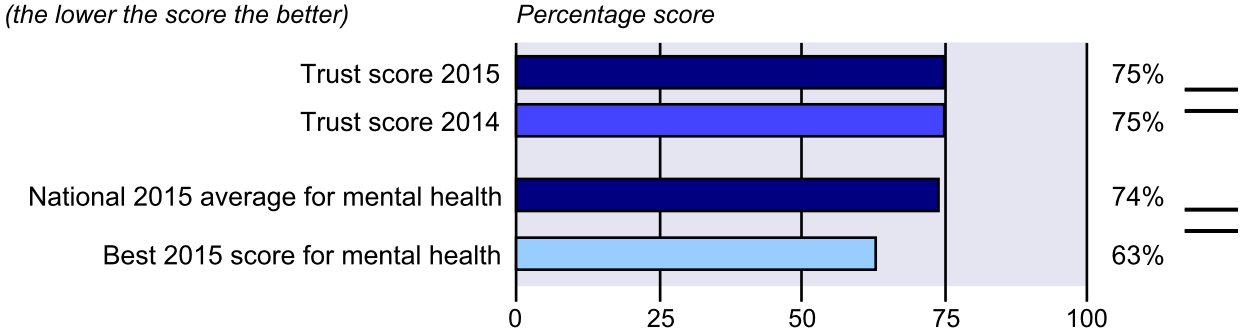
### KEY FINDING 15. Percentage of staff satisfied with the opportunities for flexible working patterns

*(the higher the score the better)*



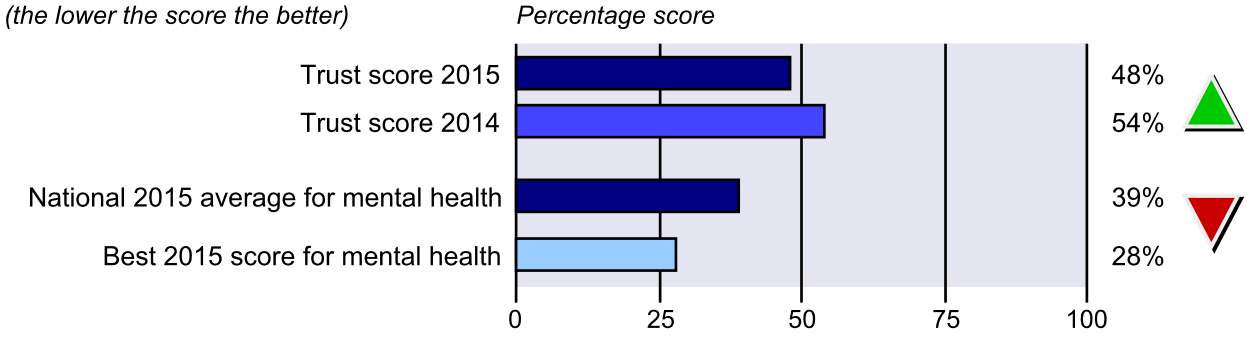

### KEY FINDING 16. Percentage of staff working extra hours

*(the lower the score the better)*



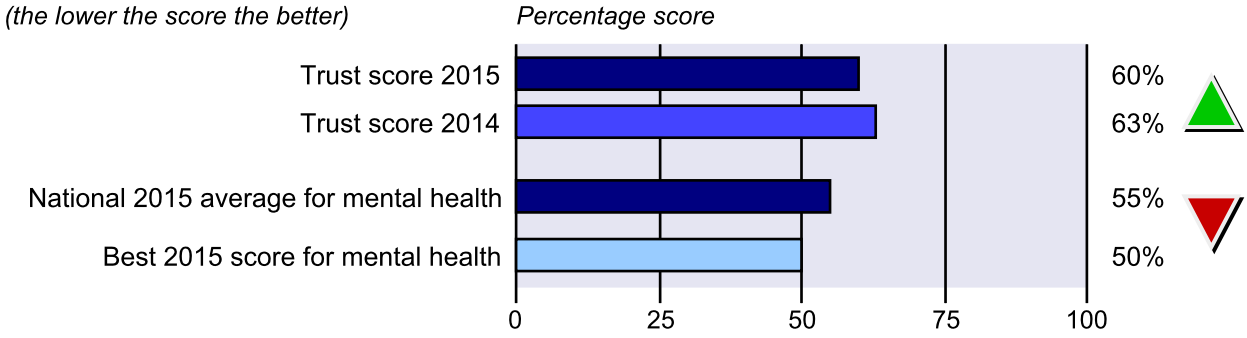
### KEY FINDING 17. Percentage of staff suffering work related stress in last 12 months

*(the lower the score the better)*



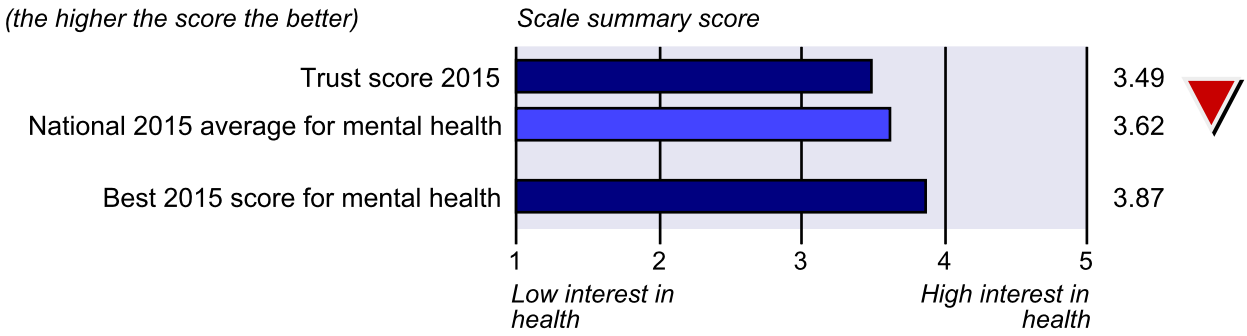

### KEY FINDING 18. Percentage of staff feeling pressure in the last 3 months to attend work when feeling unwell

*(the lower the score the better)*




### KEY FINDING 19. Organisation and management interest in and action on health and wellbeing

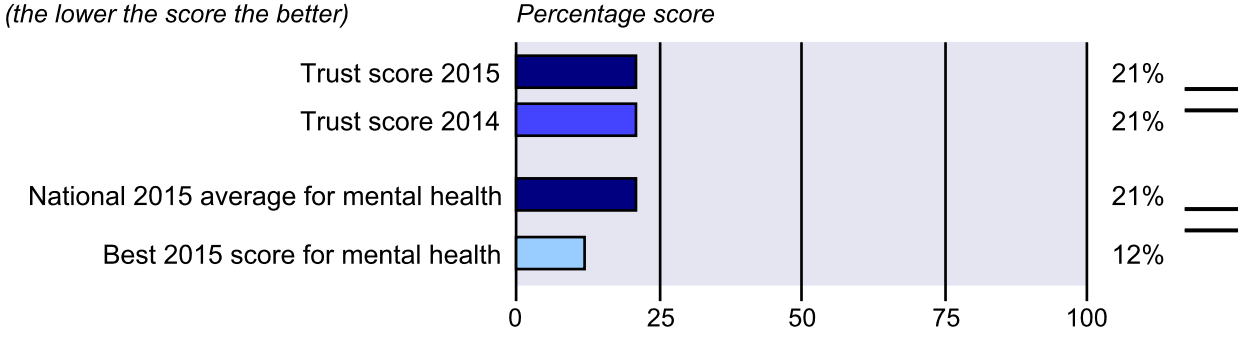
*(the higher the score the better)*




## Violence and harassment

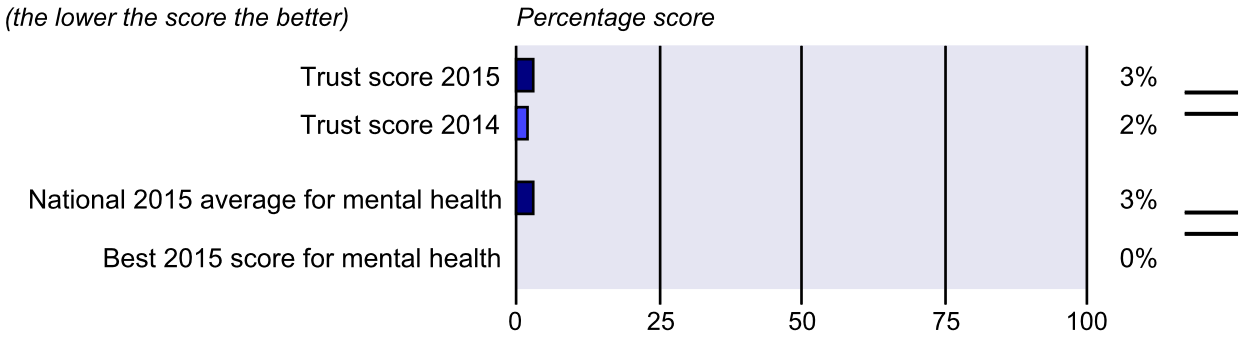
### KEY FINDING 22. Percentage of staff experiencing physical violence from patients, relatives or the public in last 12 months

*(the lower the score the better)*



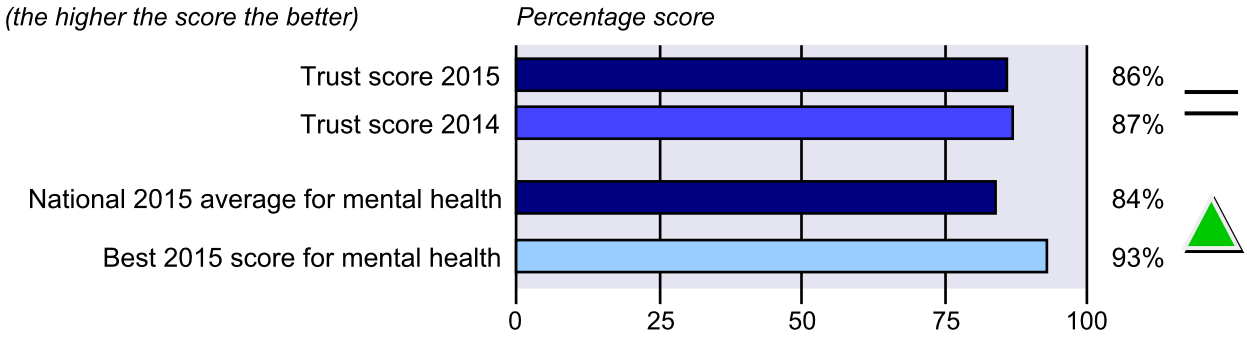
## KEY FINDING 23. Percentage of staff experiencing physical violence from staff in last 12 months

*(the lower the score the better)*



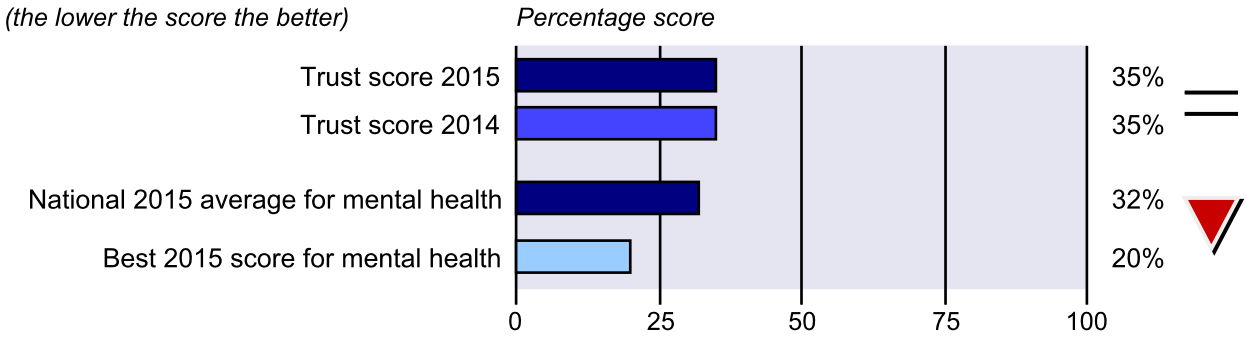

## KEY FINDING 24. Percentage of staff / colleagues reporting most recent experience of violence

*(the higher the score the better)*



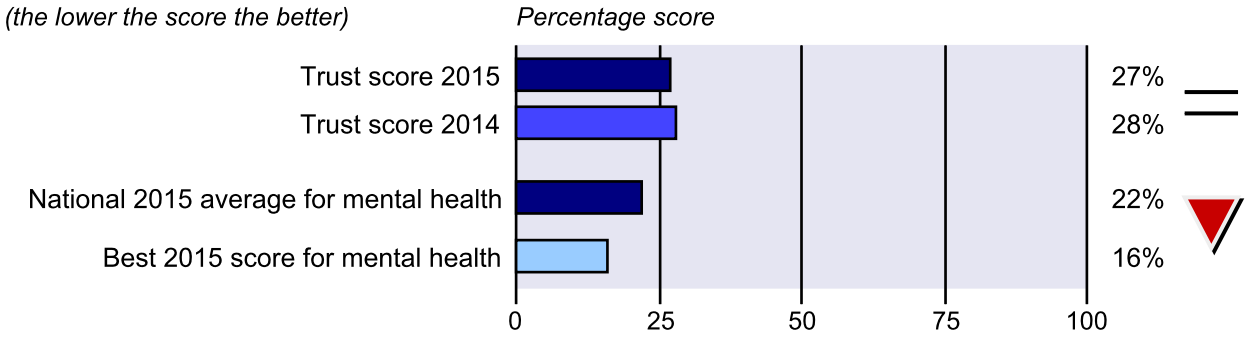

## KEY FINDING 25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months

*(the lower the score the better)*



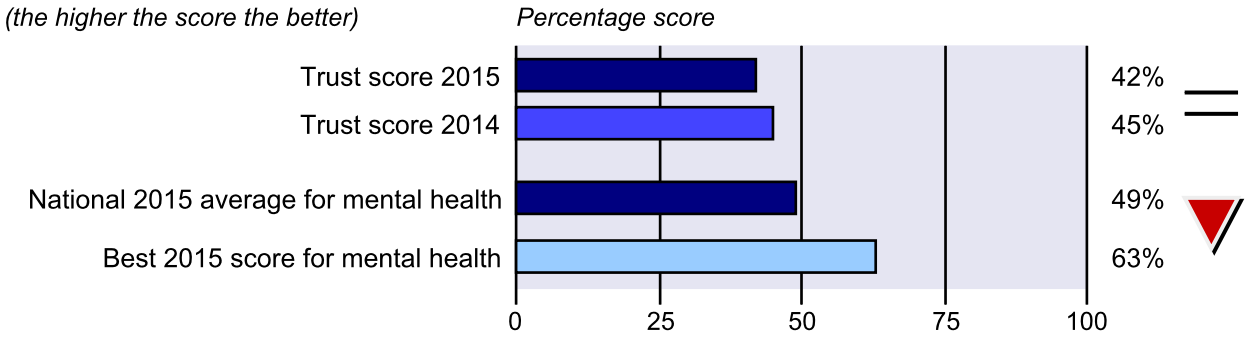

## KEY FINDING 26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months

*(the lower the score the better)*



### KEY FINDING 27. Percentage of staff / colleagues reporting most recent experience of harassment, bullying or abuse

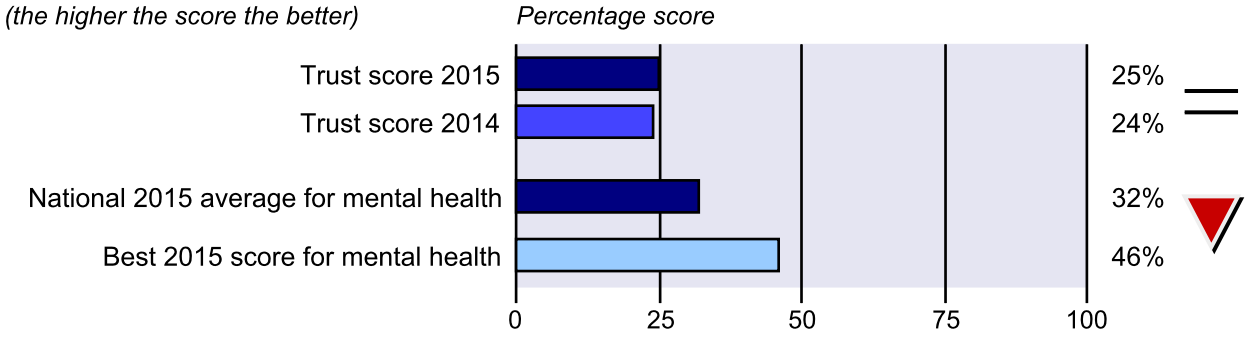
*(the higher the score the better)*




## STAFF PLEDGE 4: To engage staff in decisions that affect them, the services they provide and empower them to put forward ways to deliver better and safer services.

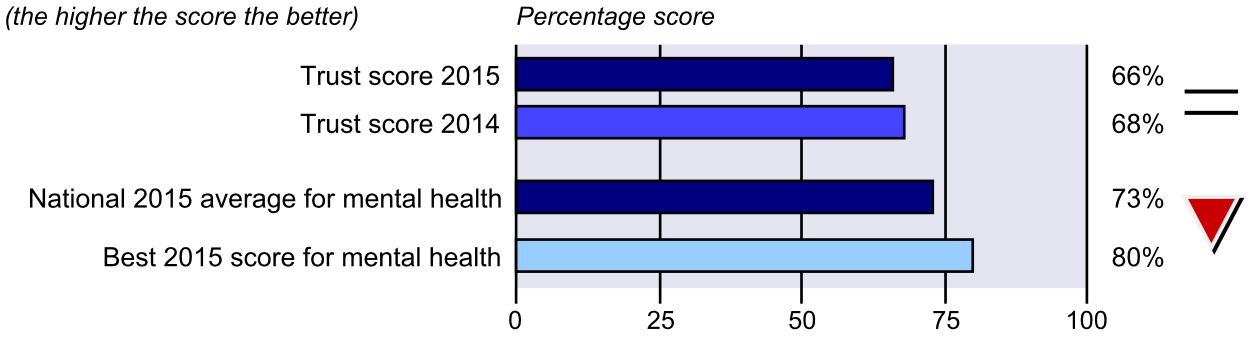
### KEY FINDING 6. Percentage of staff reporting good communication between senior management and staff

*(the higher the score the better)*




### KEY FINDING 7. Percentage of staff able to contribute towards improvements at work

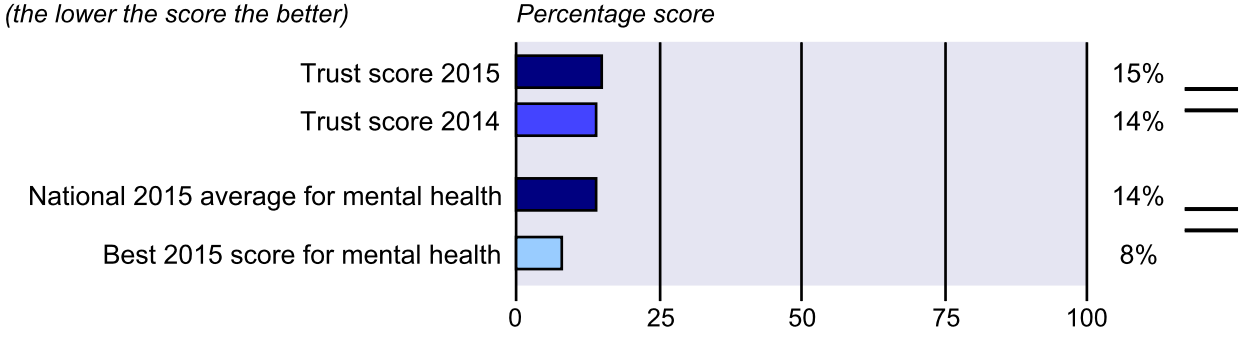
*(the higher the score the better)*




## ADDITIONAL THEME: Equality and diversity

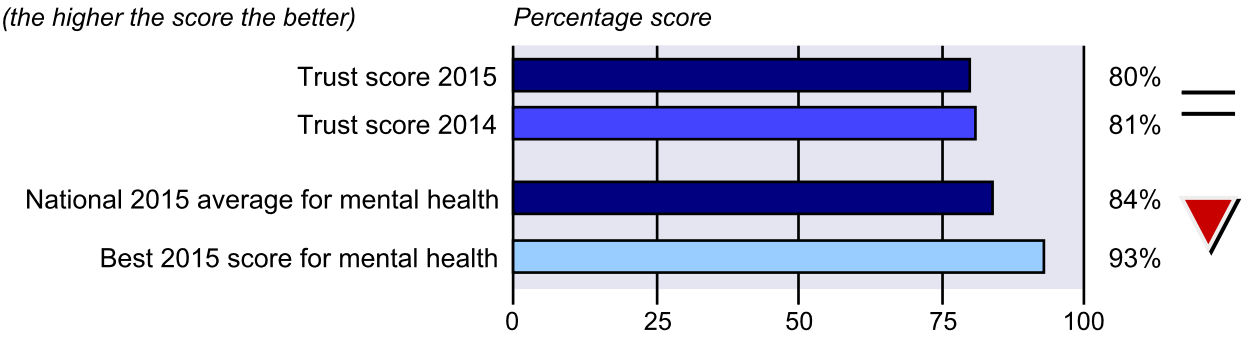
### KEY FINDING 20. Percentage of staff experiencing discrimination at work in last 12 months

*(the lower the score the better)*



### KEY FINDING 21. Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion

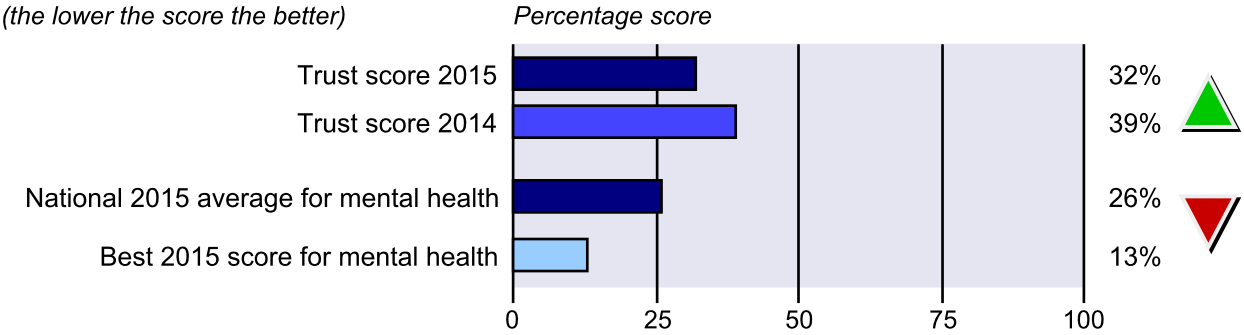
*(the higher the score the better)*




## ADDITIONAL THEME: Errors and incidents

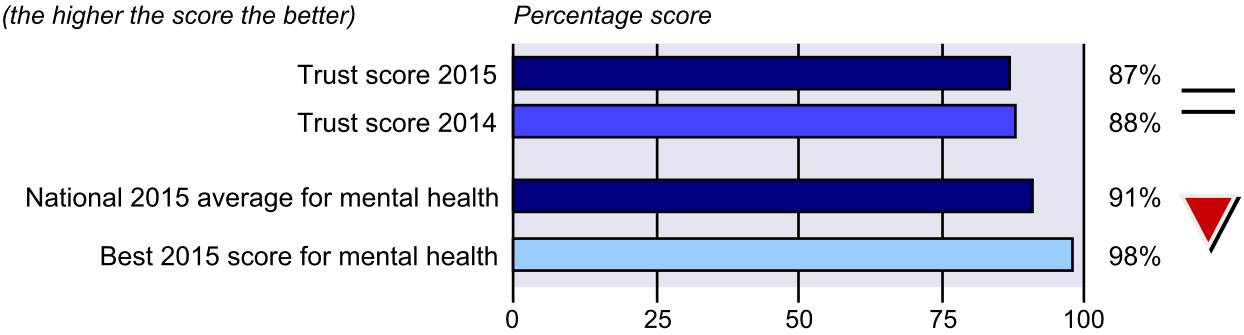
### KEY FINDING 28. Percentage of staff witnessing potentially harmful errors, near misses or incidents in last month

*(the lower the score the better)*



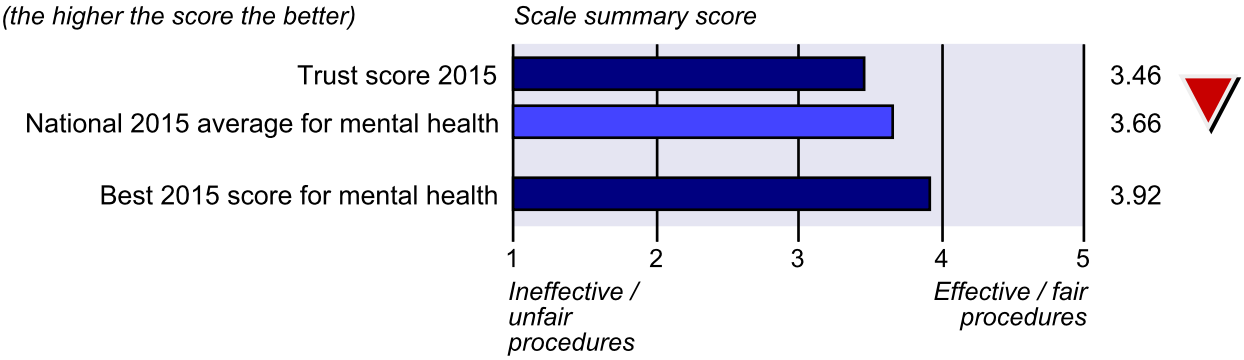

### KEY FINDING 29. Percentage of staff reporting errors, near misses or incidents witnessed in the last month

*(the higher the score the better)*

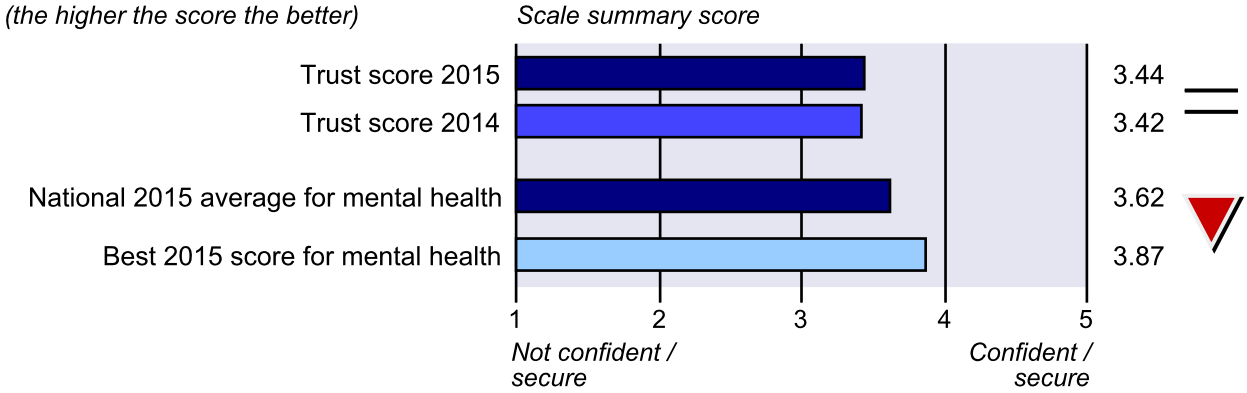



### KEY FINDING 30. Fairness and effectiveness of procedures for reporting errors, near misses and incidents

*(the higher the score the better)*

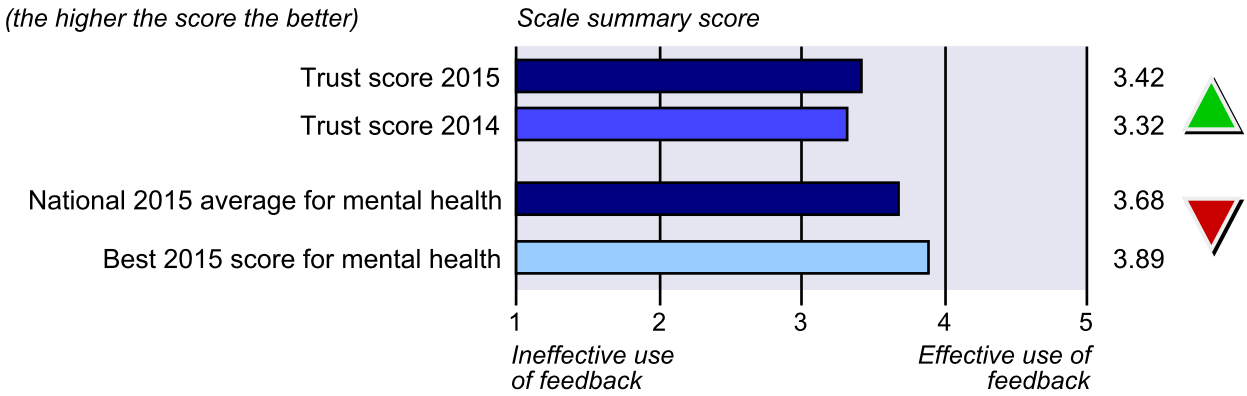


### KEY FINDING 31. Staff confidence and security in reporting unsafe clinical practice




## ADDITIONAL THEME: Patient experience measures

### KEY FINDING 32. Effective use of patient / service user feedback



**Agenda Item 7**

# Great Yarmouth and Waveney Joint Health Scrutiny Committee
# Forward Work Programme

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**Friday 15 July 2016:-**
(Venue: Lowestoft, to be confirmed).

1. 'Shape of the System' implementation – a six-month progress update
2. GP practice premises in Gorleston and Bradwell – a six-month implementation progress update
3. NSFT / Mental Health update – update on the outcomes and impacts for GY&W arising from the CQC inspection of NSFT. *[NB. There is an Information Bulletin item on NSFT quality improvements at Suffolk HSC on 14 April 2016]*
4. GY&W CCG approach to delivering services to children who have an Autistic Spectrum Disorder (ASD). *[This item was added at to the FWP at the meeting on 22/1/16, following member concerns about delays in getting assessments]*
5. (Provisional) A further update on the Implementation of the Changes to Adult and Dementia Mental Health Services.

Information Bulletin – to include the following:
- Policing and Mental Health services – Long term plan for GY&W area. – an update on the longer term budgeted plans for using control room nurse / triage car from 2016/17 onwards.
- Update on Greyfriars Walk-In Centre.

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**[Provisional date] Friday 7 October 2016:-**
(Venue: Great Yarmouth, to be confirmed).

*Agenda items to be confirmed*

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**[Provisional date] Friday 20 January 2017:-**
(Venue: Great Yarmouth, to be confirmed).

*Agenda items to be confirmed*

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**[Provisional date] Tuesday 4 April 2017:-**
(Venue: Great Yarmouth, date to be confirmed).

*Agenda items to be confirmed*

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**[Provisional date] Friday 14 July 2017:-**
(Venue: Great Yarmouth, to be confirmed).

*Agenda items to be confirmed*

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**Potential topics / events / Information items, not yet scheduled:**

- Diabetes care within primary care services in Great Yarmouth and Waveney – Update on the Integrated Model of Diabetes care (ref. the Information Bulletin for the July 2015 meeting) – Possibly look at this in October?
- Changes to treatment criteria for hip and knee replacements – update on the outcome and impact of the policy change (Ref. the Information Bulletin for the April 2015 meeting)
- 'Continuing Healthcare' assessment delays – as raised at the GY&W CCG Board – progress update (NB. There was some information on this issue in Ipswich and East Suffolk CCG and West Suffolk CCG at the Suffolk HSC on 14 Oct 2015)
- Possible site visit to see the Kirkley Mill Out of Hospital Team (OOHT)?
- At the meeting on 22/1/16 it was agreed to include on the FWP a future item regarding Learning Disability Services in the GY&W area.