Norfolk County Council

Norfolk Health Overview and Scrutiny Committee

Date: **Thursday, 05 April 2018**

Time: **10:00**

Venue: **Edwards Room, County Hall, Martineau Lane, Norwich, Norfolk, NR1 2DH**

Persons attending the meeting are requested to turn off mobile phones.

Members of the public or interested parties who have indicated to the Committee Administrator, Timothy Shaw (contact details below), before the meeting that they wish to speak will, at the discretion of the Chairman, be given a maximum of five minutes at the microphone. Others may ask to speak and this again is at the discretion of the Chairman.

Membership

Main Member	Substitute Member	Representing
Mrs J Brociek-Coulton	Ms L Grahame	Norwich City Council
Michael Chenery of Horsbrugh	Mr S Eyre/ Ms C Bowes	Norfolk County Council
Ms E Corlett	Miss K Clipsham/Mr M Smith-Clare	Norfolk County Council
Mr F Eagle	Mr S Eyre/Ms C Bowes	Norfolk County Council
Mrs M Fairhead	Vacancy	Great Yarmouth Borough Council
Mrs S Fraser	Mr T Smith	Borough Council of King's Lynn and West Norfolk
Mr G Middleton	Mr S Eyre/Ms C Bowes	Norfolk County Council
Mr D Harrison	Mr T Adams	Norfolk County Council
Mrs L Hempsall	Mr J Emsell	Broadland District Council
Mrs B Jones	Miss K Clipsham/Mr M Smith-Clare	Norfolk County Council
Dr N Legg	Mr C Foulger	South Norfolk District Council
Mr R Price	Mr S Eyre/Ms C Bowes	Norfolk County Council
Mr P Wilkinson	Mr R Richmond	Breckland District Council
Vacancy	Vacancy	North Norfolk District Council
Mrs S Young	Mr S Eyre/Ms C Bowes	Norfolk County Council

For further details and general enquiries about this Agenda please contact the Committee Officer:

Tim Shaw on 01603 222948 or email committees@norfolk.gov.uk

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A g e n d a

1 **To receive apologies and details of any substitute members attending**

2 **NHOSC minutes of 22 February 2018** **Page 5**

3 **Declarations of Interest**

If you have a **Disclosable Pecuniary Interest** in a matter to be considered at the meeting and that interest is on your Register of Interests you must not speak or vote on the matter.

If you have a **Disclosable Pecuniary Interest** in a matter to be considered at the meeting and that interest is not on your Register of Interests you must declare that interest at the meeting and not speak or vote on the matter

In either case you may remain in the room where the meeting is taking place. If you consider that it would be inappropriate in the circumstances to remain in the room, you may leave the room while the matter is dealt with.

If you do not have a Disclosable Pecuniary Interest you may nevertheless have an **Other Interest** in a matter to be discussed if it affects

- your well being or financial position
- that of your family or close friends
- that of a club or society in which you have a management role
- that of another public body of which you are a member to a greater extent than others in your ward.

If that is the case then you must declare such an interest but can speak and vote on the matter.

4 **Any items of business the Chairman decides should be considered as a matter of urgency**

5 **Chairman's Announcements**

6 **Norfolk and Suffolk NHS Foundation Trust - mental health services in Norfolk** **Page 13**

Appendix A (Page 17) - responses to NHOSC's recommendations

Appendix B (Page 27) - CCG response to question about spending levels

Appendix C (Page 29) - Norfolk and Suffolk NHS Foundation Trust report

Appendix D (Page 53) - Clinical Commissioning Group report

	Break at the Chairman's Discretion	Page
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8	Norfolk Health Overview and Scrutiny Committee appointments	Page 65
9	Forward work programme	Page 67

Glossary of terms and abbreviations

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Date Agenda Published: 26 March 2018

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Norfolk County Council

NORFOLK HEALTH OVERVIEW AND SCRUTINY COMMITTEE
MINUTES OF THE MEETING HELD AT COUNTY HALL, NORWICH
on 22 February 2018

Present:

Michael Chenery of Horsbrugh (Chairman)	Norfolk County Council
Mrs J Brociek-Coulton	Norwich City Council
Ms E Corlett	Norfolk County Council
Mrs S Fraser	King's Lynn and West Norfolk Borough Council
Mr D Harrison	Norfolk County Council
Mrs B Jones	Norfolk County Council
Mr G Middleton (substitute for Mr F Eage)	Norfolk County Council
Mr R Price	Norfolk County Council
Mrs S Young	Norfolk County Council

Also Present:

Parveen Mercer	Associate Director of Primary Care (Contracting & Performance), Great Yarmouth & Waveney CCG (lead CCG for primary care)
Alison Leather	Director of Quality Assurance, South Norfolk Clinical Commissioning Group (lead CCG for mental health)
Jill Shattock	Director of Integrated Continuing Care, Norfolk Continuing Care Partnership, Norwich CCG
Rachael Peacock	Head of Adult Continuing Care, Norfolk Continuing Care Partnership, Norwich CCG
Steve Ham	Head of Continuing Care Business Support Services, Norfolk Continuing Care Partnership, Norwich CCG
Jeanette Patterson	Continuing Healthcare Lead, Norfolk County Council
Caroline Fairless-Price	Member of the public & service user
Maureen Orr	Democratic Support and Scrutiny Team Manager
Chris Walton	Head of Democratic Services
Tim Shaw	Committee Officer

1. Apologies for Absence

1.1 Apologies for absence were received from Mr F Eagle, Norfolk County Council, Mrs M Fairhead, Great Yarmouth Borough Council, Mr A Grant, Norfolk County Council, Mrs L Hempsall, Broadland District Council, Dr N Legg, South Norfolk District Council and Mr P Wilkinson, Breckland District Council

1.2 The Committee was informed that the vacancies for main member and substitute member from North Norfolk District Council remained to be filled.

2. Minutes

The minutes of the previous meeting held on 11 January 2018 were confirmed by the Committee and signed by the Chairman.

3. Declarations of Interest

There were no declarations of interest.

4. Urgent Business

There were no items of urgent business.

5. Chairman's Announcements

There were no Chairman announcements.

6 Physical health checks for adults with learning disabilities

6.1 The Committee received a suggested approach by Maureen Orr, Democratic Support and Scrutiny Team Manager, to a report on the take-up of physical health checks for adults with learning disabilities in Norfolk.

6.2 The Committee received evidence from Parveen Mercer, Associate Director of Primary Care (Contracting & Performance), Great Yarmouth & Waveney CCG (lead CCG for primary care) and Alison Leather, Director of Quality Assurance, South Norfolk Clinical Commissioning Group (lead CCG for mental health).

6.3 It was pointed out that South Norfolk CCG was the lead CCG for the Norfolk and Waveney Sustainability Transformation Plan (STP) for learning disabilities. Great Yarmouth and Waveney CCG was the lead for primary care.

6.4 The following key points were noted:

- GP practices were encouraged to identify all patients aged 14 who had moderate, severe or profound learning disabilities, or a mild learning disability with other complex health needs. They were asked to maintain a learning disabilities register and to offer individuals an Annual Health Check.
- The Annual Health Checks for patients with learning disabilities were commissioned by local Clinical Commissioning Groups (CCGs). They were distinct from the NHS Health checks for adults aged 40 – 74 years of age that were commissioned by Public Health and Norfolk County Council.
- Annual health checks were only offered to people with disabilities whose GP had registered them as having a learning disability or associated condition. The speakers accepted that the number of people with a learning disability on GP registers was much smaller than the likely true number of people with a

learning disability, although GP registers should include those with the highest need.

- The uptake of Annual Health Checks was monitored by NHS England who had a national target of 50% of those on a GP's learning disabilities register who were offered a health check as having received one. The speakers said that the national target was also that of the CCGs but that both the CCGs and NHS England were aiming to stretch the target to 65%.
- Although the report showed that in 2016/17 there was a marked increase in the number of people with learning disabilities who had received a health check, and that all the CCGs had achieved above the 50% target (with South Norfolk and Great Yarmouth and Waveney close to the stretched target) clear disparities between different areas of Norfolk in terms of patient uptake suggested that much more needed to be done to help people with learning disabilities to receive health checks and thereby reduce the inequalities they faced.
- Members were of the view that the local target should be 100% and that if the CCGs were to aim for anything less than this figure they would doing a disservice to those who needed the health checks.
- Members asked to be provided with additional information about the take-up rate of learning disabilities annual health checks across Norfolk in 2014-15, 2015-16 and 2016-17. Members asked for this information to show the geographic spread of annual health checks by CCG area and by GP Practice. They also requested evidence to show that the CCGs monitored the uptake of mandatory capacity and consent training and awareness training by provider staff.
- The speakers said that in order to increase confidence in the records of those who were eligible for annual checks the CCGs were taking steps to resolve data quality issues, to ensure patient summary care records were updated and visible to all health care professionals and to provide for a two way flow of information from primary and social care.
- It was important for GPs and other trained health professionals to be involved in the actual screening in terms of quality assurance because this was more likely to lead to appropriate referrals and ultimately health gains.
- The speakers said that while there was an additional administrative and training burden involved in GPs and other health professionals providing annual health checks, and this could be a particular concern for GP practices with a comparatively small number of eligible patients, the financial rewards for GPs practices that provided these checks were significant. GP practices were encouraged to undertake a steady stream of annual health checks throughout the year and to not view them as an additional income stream near the end of a financial year.
- One reason for the poorer health of people with learning disabilities was that they often had difficulty in recognising illness, communicating their needs and making timely use of primary health care services. They were also less likely to proactively seek help to address known health concerns.
- There was a lack of awareness/understanding among people with learning disabilities and their carers about annual health checks. The attitudes and perceptions of carers about health checks were as important as those of the patients themselves. Targeted communications campaigns, designed for people with learning disabilities and carers were therefore needed to increase that awareness.
- Communication guides and information for health professionals about learning difficulties were available from MENCAP and other voluntary organisations.

- Members asked for evidence to show how the CCGs had received and taken on board the views of people with learning difficulties in the Transforming Care work.
- Members recognised that Annual Health Check could lead to the detection of potentially treatable conditions and targeted actions to deal with them.
- In reply, the speakers said that before being asked to undertake their first annual health check patients might have already had their health needs assessed and be in receipt of education health care plans. The CCGs worked closely with schools and social care to identify those in need of support.
- The speakers said that they checked to ensure that after undertaking annual health checks patients were provided with care support plans that were suitable to their specific needs.

6.5 The Committee **agreed** to request:

- Evidence to show how the CCGs received the views of people with learning disabilities and took these views into account in the Transforming Care work.
- A quarterly breakdown of numbers of patients who received a learning disabilities health check in 2014-15, 2015-16 & 2016-17 in:-
    - Each of the 5 CCG areas
    - Each GP practice.
- Evidence of the CCGs' monitoring of the uptake of mandatory capacity and consent training and awareness training by provider staff.

6.6 The Committee **agreed to recommend** to the CCGs that the local target for percentage of patients on the GP Learning Disability register who receive a health check should be 100% of those eligible.

6.7 The Committee **agreed** to:

- Write to NHS England (with a copy to the Secretary of State for Health) to:-
    - seek an explanation of the rationale for setting the national target of patients on the GP Learning Disability register who receive a health check at just 50%
    - Express the opinion that the national target should be 100%.

- Ask the CCG representatives to update NHOSC in 6 months' time (i.e. at 6 Sept 2018 meeting) on progress with the 'next steps' referred to in the report (i.e. data cleansing; audit of practices on Learning Disability register completion; increasing LD health check take up; ensuring practices apply the Accessible Information Standard when communicating with LD patients, etc.)

6.8 The opportunity was offered for a Member to visit the Learning Disabilities Transforming Care Board. (Offered to Cllr J Brociek-Coulton during response to a question).

7 Continuing Healthcare

7.1 The Committee received a suggested approach by Maureen Orr, Democratic Support and Scrutiny Team Manager, to an update report from Norwich, North Norfolk, South Norfolk and West Norfolk Clinical Commissioning Groups (the CCGs) on the action they had taken over the past year in response to the Committee's 2017 recommendations on the delivery of NHS Continuing Healthcare (CHC) to patients who were assessed as eligible for NHS CHC under the National Framework for NHS Continuing Health Care (Department of Health).

7.2 The Committee received evidence from Jill Shattock, Director of Integrated Continuing Care, Norfolk Continuing Care Partnership, Norwich CCG, Rachael Peacock, Head of Adult Continuing Care, Norfolk Continuing Care Partnership, Norwich CCG, Steve Ham, Head of Continuing Care Business Support Services, Norfolk Continuing Care Partnership, Norwich CCG and Jeanette Patterson, Continuing Healthcare Lead, Norfolk County Council. The Committee also heard from Caroline Fairless-Price, a member of the public and service user.

7.3 The following key points were noted:

- Continuing healthcare (CHC) policies in Norfolk remained in line with the national framework, practice guidance and directions.
- On 1st November 2017 the CCGs had set up the Norfolk Continuing Care Partnership (NCCP) which had a Strategic Board with Director level membership from all 5 CCGs and Norfolk County Council. The change to NCCP and how it functioned was published on each CCGs website.
- The Board Members were committed to working together and to the implementation of NHOSC's Feb 2017 recommendations which had not yet progressed as far as might be expected.
- The NCCP was taking early action to reduce waiting times between referral and assessment which remained longer than targeted.
- The NCCP intended to implement a new model of working that ensured patients received a package of care that was reviewed regularly by staff familiar with their case, to ensure the care delivered met the patients' assessed clinical needs.
- The NCCP was developing clear programmes of work and ongoing recruitment was taking place.
- The transition to the NCCP had not resulted in staff redundancies.
- Norfolk Continuing Care Partnership and Norfolk County Council were recruiting additional staff to ensure there was sufficient capacity to undertake assessments within the required timescales and to fortify key areas of the service.
- When the recruitment drive was complete there would be 92 members of staff (excluding Great Yarmouth) providing support for CHC in Norfolk. This represented an increase of an additional 17 posts. One of these posts would provide a co-ordinating role with the Complex Cases Review Board.
- The revised staffing figure would include an additional 6 qualified social worker posts. Each social workers would have no more than the benchmarked standard of 50 patients.
- As a result of the change to a NCCP, and the increased staffing, the robustness and consistency of CHC decision making could be expected to improve.
- The partnership model provided a foundation for future integrated working between the NHS and the County Council.
- In response to anecdotal concerns in relation to the service user experience of the CHC process and the time taken to receive a decision, the NCCP intended to explore with Healthwatch Norfolk new mechanisms to seek patients /relatives' feedback with regard to how well they understood CHC processes, and how well they were explained.
- Members considered that the nationally produced easy read version of the CHC guidance (at 17 pages long) was not up to the task and that the NCCP should look at producing its own local version.

7.4 Caroline Fairless-Price, a member of the public and service user, asked if the NCCP would allow the review process to be led by the standards set out in Harwood Care Charter which she said was a useful tool to draw out patient need and explain to patients what could be achieved. She suggested that real time feedback from Continuing Healthcare service users was essential if progress was to be made. It was important for the NCCP to have the information from patients that allowed it be seen to be developing safety net services for patients rather than just a revolving door emergency service.

7.5 In reply, the speakers said that while the Harwood Care Charter represented an important standard of service it was only one of many such standards to which the NCCP and the County Council aimed to operate.

7.6 The Committee **noted** that in the light of the comments made by the service user the Norfolk Continuing Care Partnership (NCCP) representatives undertook to consider ways of introducing real-time feedback from Continuing Healthcare service users.

7.7 The Committee also **noted** that NCCP was a newly formed partnership and that Healthwatch Norfolk had very recently been asked to work with it to improve communication with service users. The Committee **agreed** to ask the NCCP representatives to update Members on progress in 9 months-time.

7.8 The Committee **agreed** to ask the NCCP representatives to update Members on progress in 9 months-time.

8 Norfolk Health Overview and Scrutiny Committee appointment

8.1 The Committee was asked to fill a vacancy for a link member with Norfolk Community Health and Care NHS Trust.

8.2 The Committee **agreed** to appoint Cllr G Middleton as NHOSC link with Norfolk Community Health NHS Trust.

9 Forward work programme

9.1 The Committee received a report from Maureen Orr, Democratic Support and Scrutiny Team Manager, that set out the current forward work programme.

9.2 The forward work programme was **agreed** as set out in the agenda papers with the addition of:

‘Ambulance performance and turnaround times’ on 24 May 2018

The report for the ‘Norfolk and Suffolk NHS Foundation Trust – mental health services in Norfolk’ on 5 April 2018 agenda to include information from the Royal College of Psychiatrists about funding of services.

Chairman

The meeting concluded at 1 pm

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Norfolk and Suffolk NHS Foundation Trust – mental health services in Norfolk

Suggested approach by Maureen Orr, Democratic Support and Scrutiny Team Manager

The Clinical Commissioning Groups' and Norfolk and Suffolk NHS Foundation Trust's responses to recommendations made by Norfolk Health Overview and Scrutiny Committee in December 2017 and an update on progress with the Improvement Plan to address issues identified by the Care Quality Commission in July 2017.

1. Background

1.1 Representatives of Norfolk and Suffolk NHS Foundation Trust (NSFT) and South Norfolk Clinical Commissioning Group (CCG), the lead CCG for mental health in Norfolk and Waveney, attended Norfolk Health Overview and Scrutiny Committee (NHOSC) on 7 December 2017. NSFT and the CCG reported on the action plan in place following the Care Quality Commission (CQC) inspection in July 2017, which rated NSFT as 'Inadequate'. The report (agenda item 6) and minutes of the meeting are available on the County Council website NHOSC 7 December 2017

1.2 The CQC gave NSFT a list of 'must dos' and 'should dos' to be addressed before a follow-up inspection on these matters, which would occur before July 2018. A full re-inspection of NSFT's services was expected in autumn 2018. Both the CQC and NHS Improvement (NHS I), the regulator of NHS trusts, were monitoring NSFT's progress, the Trust was 'buddied' with the East London NHS Foundation Trust (ELFT) which was rated 'outstanding' by the CQC and an Improvement Director, Philippa Slinger, was in place to assist the Trust.

1.3 NHOSC made 8 recommendations to NSFT and the CCGs regarding service user engagement, oversight of patients in out-sourced beds, service funding and incentives for staff recruitment. Responses were received on 18 January 2018 and included in the NHOSC Briefing for February. An updated version, with progress on accepted recommendations, is attached at **Appendix A**. This includes NSFT's protocol for placement of patients in out-of-Trust care.

1.4 During discussions on 7 December 2017 about levels of spending and the number of referrals to NSFT's services, a point was made about the proportion of funding for NSFT in comparison to other CCG spending. It was agreed that the issue, which involved analysis of figures in NSFT's report, would be put in writing to the CCGs. This and the CCGs' response were circulated to Members in the NHOSC Briefing in January 2018 and are attached at **Appendix B.**

1.5 In December 2017 NSFT agreed to invite Members of NHOSC to visit mental

health services to learn more about progress. Visits took place as follows:-

8 March 2018 – The Fermoy Unit, King's Lynn
26 March 2018 – Hellesdon Hospital and Julian Hospital, Norwich

1.6 At NHOSC on 22 February 2018 a Member referred to research by the Royal College of Psychiatrists (RCP) published on its website on 21 February 2018:- Royal College of Psychiatry - mental health trusts' income 2012 - 2017
The RCP found that mental health trusts in England have less money to spend on patient care in real terms in 2017 than they did in 2012, and it noted increasing demand for services in the same period.

1.7 In the January and February NHOSC Briefings Members received updates on the public engagement process and progress towards provision of a Community Wellbeing Hub in Norwich for people with mental distress and mental ill-health. Establishment of the proposed Hub, which had previously been referred to as a Crisis Café or a Crisis Hub, was part of the action to enable NSFT to manage within existing bed numbers, following a Bed Review at the Trust in early 2017.

It was originally expected that the Hub would be established by December 2017 but the CCGs later agreed to adjust the timeline to include a full procurement process. They had been successful in bidding for capital funding through the Places of Safety fund in 2017 and adjusting the timeline meant that it was not possible to comply with the Place of Safety fund bidding process, so that source of funding was no longer available.

The CCGs second funding route was the national Sustainability Transformation Plan (STP) capital fund. In January 2018 they were informed that their bid for development of the Hub had been shortlisted and were waiting to hear whether it had been successful. There was no firm date for confirmation of the capital funding and the CCGs stated that the Hub project would not be viable unless the funding was received.

The project was expected to take 12 months from its start to the opening of the Hub and CCGs said it would commence as soon as the capital funding was available.

18 On 22 February 2018 NSFT Board of Directors received a progress report on the Trust's improvement plan, which included a full dashboard of 25 'must do' and 'should do' actions and whether or not they were on track to deliver:- http://www.nsft.nhs.uk/Event/Pages/Board-of-Directors-Ipswich.aspx
Item 18.31(E), page 22 – 36.

The areas that were not on track at that point were:-

- Ligatures (i.e. removal of risks)
- Staffing (i.e. sufficient staffing levels)
- Personalised care
- Prescribing (rapid tranquilisation)

2. Purpose of today's meeting

2.1 As well as receiving NSFT and CCG responses to the committee's

recommendations, NHOSC has asked NSFT to set out progress in response to the CQC's 'must do' and 'should do' action list and with the wider systemic challenges that emerged from the CQC inspection, including issues such as leadership, staff engagement, clinical engagement and the culture within NSFT.

2.2 When Mr Antek Lejk attended NHOSC in October 2017 as lead for the Norfolk and Waveney Sustainability Transformation Plan (STP) he spoke of the need for a fundamental review of mental health services. In January 2018 the STP partnership was considering an engagement event to co-create a new vision for mental health services. The CCGs have been asked to update NHOSC on this wider work.

2.3 In addition NSFT and the South Norfolk CCG (lead CCG for mental health commissioning in the Norfolk and Waveney STP area) have been asked to provide specific information about the current situation in local mental health services in regard to out of Trust placements, out of home area placements, demand and income, waiting times, staff vacancy rates, results of the service user and carer review mentioned at NHOSC on 7 December 2017, the Community Wellbeing hub, the Mental Health Investment Standard and potential for additional beds at Yare Ward, Hellesdon Hospital, Norwich.

NSFT's report is attached at **Appendix C** and South Norfolk CCG's report is at **Appendix D** and representatives will attend the meeting to answer Members' questions.

3. Suggested approach

3.1 After the representatives from NSFT and South Norfolk CCG have presented their reports the committee may wish to discuss the following areas:-

(a) On 7 December 2017 NHOSC heard that performance issues with the Lorenzo electronic records system had been escalated and the interim Chief Executive was working with NHS Digital and the system supplier to set a date by which improvements would be made. NSFT's report (Appendix C – Appendix 1) acknowledges that improvements have been made to the system but that progress has not been sufficient. What more can be done to provide reliable access to clinical records?

(b) As at February 2018 NSFT's Improvement Plan was not on track in terms of ensuring sufficient staff, removing ligature risks, providing personalised care and prescribing (rapid tranquilisation). What is holding back progress in these areas and can anything more be done in advance of the CQC re-inspection of 'must do' and 'should do' actions before July 2018?

(c) In December 2017 NHOSC recommended that NSFT should consider use of retention bonuses rewarding length of service and special responsibility payments for hard to recruit areas. The recommendation was partially accepted in that NSFT introduced different kinds of incentive payments in areas where it was hard to recruit (see Appendix A, recommendation 5). Would there be value in introducing the incentives suggested by NHOSC in addition to these?

(d) The CCGs partially accepted NHOSC's recommendation that they should provide funding to enable NSFT to open 15 adult acute beds at Yare Ward, Hellesdon Hospital. The CCGs said they could not side-step due process around consideration of such a proposal and that NSFT had not put forward any formal business case for 15 beds in Yare Ward. Such a proposal could be discussed in the planning round for 2019-20, which starts in July – Sept 2018.

Further step-down beds have been provided, and two dedicated out of area case manager posts have been in place during winter 2017-18 and numbers of out of area (OOA) placements have come down. NHOSC is aware of other times in recent years when OOA placement numbers came down but then went up again.

Given the delay in establishing a Community Wellbeing Hub and the trend of increasing demand for services, are the CCGs and / or NSFT showing enough urgency to consider the case for additional acute beds alongside the other measures?

(e) The CCG's report (Appendix D) mentions that they will shortly be working in the Norfolk and Waveney Sustainability Transformation Plan (STP) Mental Health Workstream to start a period of consultation and engagement to develop a system wide vision and strategy for mental health services, and that it will take year to complete. When will the work begin?

4. Action

4.1 NHOSC may wish to:-

(a) Make comments and / or recommendations to the commissioners and NSFT based on the information received at today's meeting.

(b) Ask for further information for the NHOSC Briefing or to examine specific aspects of the mental health services at a future committee meeting.

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Norfolk and Suffolk NHS Foundation Trust – mental health services in Norfolk

Recommendations made by Norfolk Health Overview and Scrutiny Committee, 7 December 2017

Responses from NSFT and the 5 Norfolk CCGs on 18 January 2018 and updates in March 2018

Recommendations (7 Dec 2018)		**To**	**Responses**
NSFT's overall approach to improvement			
1.	NSFT should ensure that service user participation in NSFT's improvement is genuine co-production, with the broadest range of service users possible and should monitor whether the service user participation is representative of the service user population as a whole.	NSFT	**Jan 2018** **Accepted** Service user and carer Forums have been established in January and February and are being set up on a quarterly basis. This is to enable SU and carer engagement and involvement in our plans and to hear about our progress from executive directors. The Forums are open to all SUs and carers who wish to participate. Following the first round of sessions we will take stock about what has worked and ensure we address any shortcomings to make the sessions as co-produced as possible.
2.	NSFT should give clear, easy to understand feedback to all service users about what service changes or developments have taken place as a result of their feedback, along with information on how to escalate concerns if the feedback is not acted on without reasonable explanation.	NSFT	**Jan 2018** **Accepted** Feedback on developments will be provided at the Forums and we will encourage SUs to be part of the development of services. Any concerns can be discussed with any member of the Exec Team, Governor or Freedom to Speak Up Guardian.
Availability of beds and out of trust / out of area placements			
3.	NSFT should give NHOSC a more detailed account to provide assurance of its oversight of	NSFT	**Jan 2018** **Accepted**

Recommendations (7 Dec 2018)		To	Responses
	the service received by patients in out-sourced beds.		The Trust has a protocol which will be forwarded separately. (See **Appendix 1** attached)
4.	The CCGs should provide funding to enable NSFT to open 15 adult acute beds at Yare Ward, Hellesdon Hospital.	CCGs	**Jan 2018** **Partially accepted** Discussions over the commissioning of services are taken in accordance with the planning round and associated timelines. The planning round for 18/19 commences in quarter 2 2018. Alternative steps may apply in exceptional circumstances however due process and governance must be followed at all times. To include: • Proposals for additional services, including beds, must be evidenced based, clinically appropriate and in accordance with national guidance. • Decisions as to the type of services to be commissioned must adhere to CCG approval processes. • Depending on the material or reputational impact, these decisions may be subject to consultation, or wider scrutiny. • Depending on the material value competitive tender or procurement may apply. Whilst the recommendation to fund additional beds is acknowledged, the CCG cannot side-step due process as outlined above. The HOSC debate on the 7th Dec will recall that the discussion had already been had about whether further beds might be required as an interim step in advance of the forthcoming Crisis Hub. These discussions, in partnership with NSFT are still ongoing and will follow the method and route outlined above. The outcome of this will be known in due course. **March 2018 update**

Recommendations (7 Dec 2018)		To	Responses
			The initial response above should have read "The planning round for **19/20** commenced in Quarter 2 2018". Meaning that any discussions in relation to the commissioning of these beds will be taken forward over this period of time. To date NSFT have not put forward any formal business case in relation to the proposal to open 15 beds in Yare Ward. There have been discussions about further step-down beds and a dedicated out of area / DTOC post to specifically monitor and reduce placements. These initiatives have already begun and the OOA numbers are reducing. See below for further details of step down beds *(i.e. Appendix D)*.
Staffing			
5.	NSFT should consider use of retention bonuses rewarding length of service and special responsibility payments for hard to recruit areas.	NSFT	**Jan 2018** **Partially accepted** We have agreed an incentive payment scheme in those areas where it is hard to recruit. The recruitment incentives are: • A one-off premium payment of £10k is paid to externally appointed consultants (payback arrangements are in place if they leave within 2 years) • A one-off premium payment of £3k for band 5 and band 6 registered nurses in hotspot areas, with payback arrangements within 2 years • A 'Recommend a Friend' incentive scheme payment of £200 on successful appointment/probationary period.
6.	NSFT should consider the business case for 'return to practice' incentives for:-	NSFT	**Jan 2018** **Accepted**

Recommendations (7 Dec 2018)		To	Responses
	i) Those who are out of service that still have valid professional registration ii) Those whose professional registration has lapsed		The Director of Nursing offers £500 incentive payment on commencement and a further £500 on completion of a specified number of hours (depending on circumstances) for return to practice nurses.
7.	NSFT and the CCGs should liaise with all the Local Housing Authorities in Norfolk to identify housing opportunities available for incoming staff.	NSFT & CCGs	**Jan 2018** NSFT - **Accepted** We will investigate whether there is any support Local Housing Authorities can offer to help with recruitment and retention of staff. CCGs - **Accepted** CCGs would welcome the opportunity to investigate this further. (Please can you put us in touch with the HOSC Cllr who made this suggestion? Alternatively please can you signpost us to the named leads in the Districts whom we might liaise with to take this forward?) Note – the relevant District Council contact details were provided to NSFT and the CCGs on 19 January 2018. **March 2018 update** CCGs - Contact has been made with the Chair of the Housing Advice Allocation Liaison Officers (HAALO) group who is liaising with its members to consider what options may be available to incoming NSFT staff with relation to support to obtain housing. It is felt that work in this area could more usefully be taken forward within wider conversations relating to health workforce development across the Norfolk and Waveney STP. The HAALO group are discussing the NSFT elements at their March meeting

Recommendations (7 Dec 2018)		To	Responses
			and a verbal update on the outcomes of this can be provided to HOSC.
Future commissioning strategy and funding			
8.	The CCGs should develop a formula for funding that takes into account increases in referrals to secondary mental health care and demographic variation.	CCGs	**Not accepted** Parity of Esteem is the nationally recognised expectation by which CCGs meeting their funding requirements for mental health provision. It is a requirement that CCGs adhere to this central directive, ignoring this and developing a local alternative would not be permissible. Whilst CCGs can petition regulators to review how their funding is allocated, they cannot insist that changes are made. All the central CCGs have met, and in some instances, exceeded their parity of esteem requirements since the term was defined nationally. **March 2018 update** No update required – recommendation not accepted by CCGs.

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PROTOCOL & FLOWCHART FOR THE PLACEMENT OF SERVICE USERS IN OUT OF AREA / PRIVATE CARE

This flowchart has been developed as a reminder for all staff when considering an out of area or private placement, to ensure that all reasonable considerations have been made. The guidance is issued following learning from an incident in Hertfordshire which can be accessed at http://www.mills-reeve.com/herfordshire_partnership_trust_July2012.

The guidance applies to all services and age groups across the Trust.

All practitioners have a statutory responsibility to recognise and report safeguarding concerns to safeguard children and vulnerable adults. If you are concerned about a placement, or a staff member's behaviour within that placement, a safeguarding referral must be considered alongside any report of a clinical or quality concern. Please contact the NSFT Safeguarding Team for advice; 01603 421311 / 273 / 363 or 01284 755087.

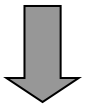
There are four types of out of area placement:

1. Service user to be placed by the specialist commissioning group – see part 1
2. Adults to be placed in beds commissioned by the Trust – see part 2
3. Older people placed in residential care – see part 3
4. Learning Disability placements commissioned by CCGs – see part 4

Part 1

Applies to:

- Tier 4 CAMHS
- Secure Services
- Eating Disorder Services
- Perinatal Services
- Learning Disability Services



Follow the process set out by EoE SCG.

The care co-ordinator remains responsible and must ensure they organise and attend regular CPA reviews.

What happens if concerns are raised about the placement?

The area team monitor the quality of placements but if a member of staff has clinical concerns about the care being given at the home, they should report this to Sue Barrett on 01603 421617 or sue.barrett@nsft.nhs.uk.

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Part 2. The need to find a placement for an adult may arise for two reasons, a) a specialist placement is required to meet their needs and b) when the Trust has no beds available in an emergency situation.

Applies to:
a)Adults to be placed in beds commissioned by the Trust

Need for private placement identified (rationale recorded in patient's records)

↓

Potential placement identified

↓

Is the placement compliant with CQC standards? Check at www.cqc.org.uk

YES ↓

Does the CQC website identify this as a suitable placement, e.g. does it meet the needs of the service user?

YES ↓

Has the placement been used before and found to meet client's needs?

YES ↓

Has a full clinical and contextual risk assessment been completed, and carers consulted where appropriate?

YES ↓

Make application

NO ↓

Ensure this is completed

NO ↓

As part of the risk assessment, the clinician should undertake a visit to the placement

↓

Has a full clinical and contextual risk assessment been completed, and carers consulted where appropriate?

NO ↓

Explore suitable alternative

NO ↓

Placement will not be authorised

b)What happens in an emergency?
If a placement is required in an emergency, e.g. out of hours, the same principles apply. If in **extreme** circumstances a person is placed in a home that has not been used previously, the staff member responsible for the placement must visit the home either at the time of placement or within 24 hours to ensure the patient's needs are met.

What happens if concerns are raised later on?
Some placements may last for many months and if during that time the care co-ordinator has concerns about the placement they should raise them initially with the home manager. Serious concerns that are not addressed can be raised directly with the CQC. If the home receives an inspection and is found to be non compliant, the care co-ordinator should discuss this with the service user and their relatives. If they are happy with the care and the non compliance issues do not affect the treatment received, this should be documented and the situation remain under review. If there are concerns however, then an alternative placement should be considered.

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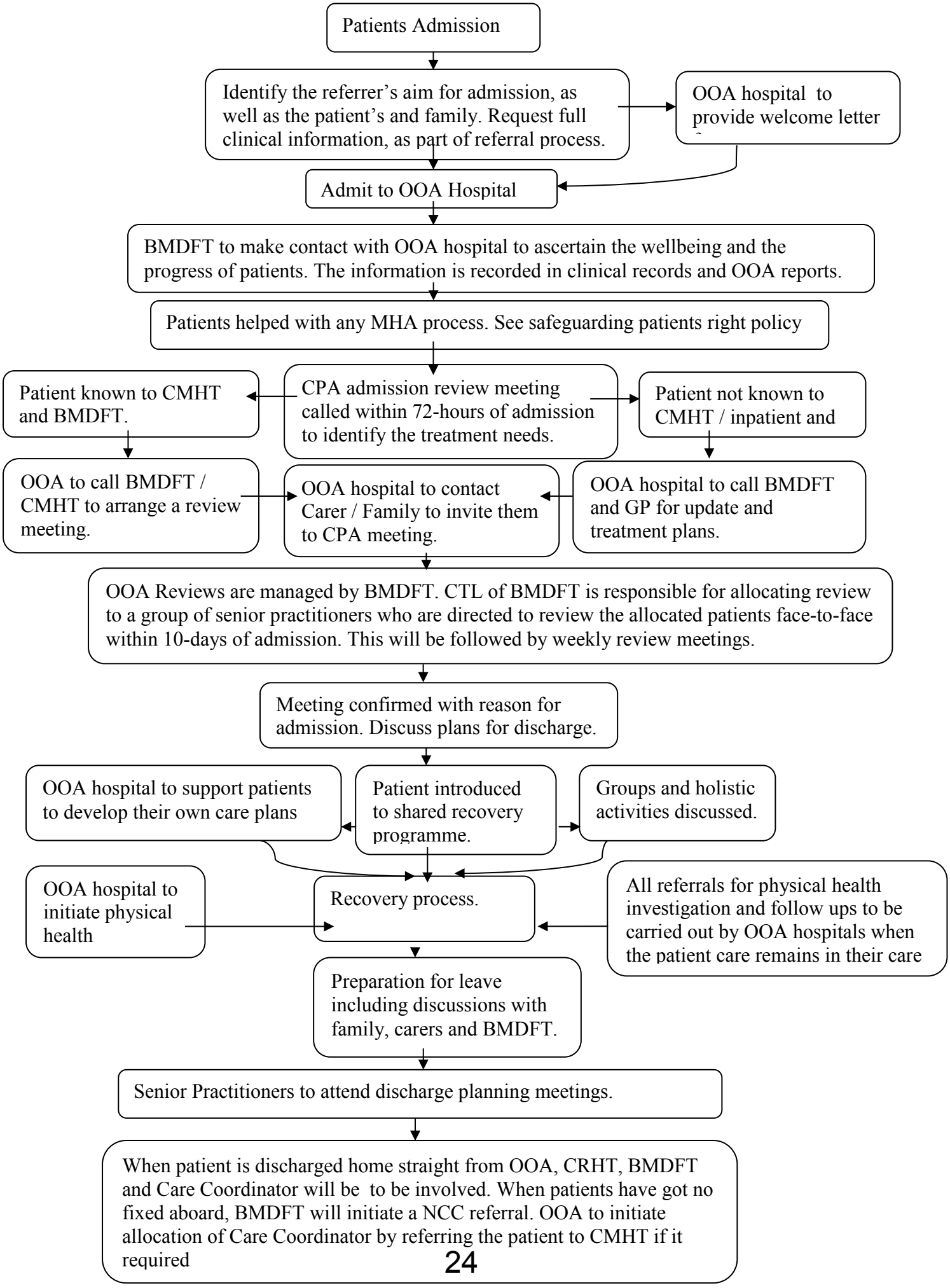

↓

CRHT to be informed by OOA hospital if the patient requires a trial leave before finally discharged from hospital. In that case CRHT will do the discharge process after the trial leave. BMFT to be kept informed..

Part 3

Applies to:
Older people placed in nursing or residential care commissioned by Norfolk or Suffolk social services.

Any concerns with the care in nursing and residential homes should be reported to the active social worker (if available) or directly to the County Council.

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Part 4

Applies to:
Learning Disability placements commissioned by Clinical Commissioning Groups

Need for private placement identified (rationale recorded in patient's records)

↓

Discuss with relevant CCG

↓

Potential placement identified

↓

Is the placement compliant with CQC standards? Check at www.cqc.org.uk

YES ↓

Does the CQC website identify this as a suitable placement, e.g. does it meet the needs of the service user?

YES ↓

Has the placement been used before and found to meet client's needs?

YES ↓

Has a full clinical and contextual risk assessment been completed, and carers consulted where appropriate?

YES ↓

Proceed to place

NO ↓

Ensure this is completed

NO ↓

As part of the risk assessment, the clinician should undertake a visit to the placement

↓

Has a full clinical and contextual risk assessment been completed, and carers consulted where appropriate?

YES ↓

Proceed to place

NO ↓

Ensure this is completed

NO ↓

Explore suitable alternative

NO ↓

Placement will not be authorised

N.B. At any point in the process, if there are clinical concerns that a placement may not be appropriate this should be clearly documented.

What happens in an emergency?
If a placement is required in an emergency, e.g. out of hours, the same principles apply. If in **extreme** circumstances a person is placed in a home that has not been used previously, the staff member responsible for the placement must visit the home either at the time of placement or within 24 hours to ensure the patient's needs are met.

What happens if concerns are raised later on?
Some placements may last for many months and if during that time the care co-ordinator has concerns about the placement they should raise them initially with the home manager. Serious concerns that are not addressed can be raised directly with the CQC and shared with the CCG quality lead. If the home receives an inspection and is found to be non compliant, the care co-ordinator should discuss this with the service user and their relatives. If they are happy with the care and the non compliance issues do not affect the treatment received, this should be documented and the situation remain under review. If there are concerns however, then an alternative placement should be considered.

CCGs' response to a point raised at NHOSC on 7 December 2017 about proportion of CCG funding for Norfolk & Suffolk NHS Foundation Trust

At NHOSC on 7 December 2017 a Member made a point about the figures in CCGs' and Norfolk and Suffolk NHS Foundation Trust's (NSFT) reports to the Committee regarding NSFT's reducing share of CCG expenditure and the increase in referrals to its services in the corresponding period. The representative from the CCG asked for the details, which involved analysis of the figures in the reports, to be put in writing and offered to provide a written response after the meeting. The councillor's point and the CCGs' response were included in the January 2018 NHOSC Briefing and are shown below:-

Point raised at NHOSC on 7 December 2017

NHOSC 7 Dec 2017 agenda document pack , page 70, second column "% of CCG expenditure"

Although it looks as though the reduction in % share isn't that much, it shows a different picture when you compare reduction by CCG area. When we are talking about a £200+ million budget, then small reductions can actually represent a lot in cash terms.

I calculated the reduction as by what % the NSFT share had reduced by

So:
South Norfolk
2013/14 - 7% share of CCG expenditure
2017/18 - 6.5% share of CCG expenditure
% drop of NSFT share 7.1%

Norwich
2013/14 11.3%
2017/18 10.1%
% drop 10.6%

North Norfolk
2013/14 7.5%
2017/18 6.9%
% drop 8 %

GYW
2013/14 9.6%
2017/18 6.9%
% drop 8.3%

West Norfolk
2013/14 6 %
2017/18 5.8%
% drop 5%

So NSFTs reduction in their share of the Norfolk CCG mental health budget is 8.3% overall.

I then compared this with the information provided by NSFT on page 30. Although there has been an increase in actual cash of 3.2%, this is against the backdrop of the above described decrease in NSFTs share of the overall CCG budget. There has been a 48% increase in referrals to NSFT. So by my calculation demand has increased at 15 times the rate that funding has. It's surely unarguable that that is a real terms cut?

The commissioner said that they "have not disinvested from NSFT". I cannot square that statement with the evidence which was presented to us today. The evidence seems clear that NSFT share of CCG budget has reduced in every single CCG area.

There is no evidence that specialist / secondary mental health spend has simply been diverted to other providers meeting the needs of this population. The other columns (Norfolk county council, voluntary sector, other nhs providers) on page 70 so no equivalent uplift.

CCGs' response

Parity of Esteem, and calculating CCG expenditure on NSFT as a % of the CCGs overall budget does not mean CCGs have cut NSFT costs as the email below states. Normally when statistically comparing figures we would not use unrelated percentages.

CCGs have invested considerably in mental health, see below, and have met our parity of esteem requirements. The fact that we are obliged to invest in new services elsewhere doesn't mean there needs to be a corresponding increase in NSFT expenditure.

MH Expenditure - total of core Mental Health Cost Centres £'000s						Year on Year Expenditure Growth				
	1314	1415	1516	1617	1718 FOT	1415	1516	1617	1718 FOT	1314 v 1718
North Norfolk	18,804	19,020	19,926	20,339	21,778	1.1%	4.8%	2.1%	7.1%	15.8%
South Norfolk	20,462	20,656	22,067	23,243	25,309	0.9%	6.8%	5.3%	8.9%	23.7%
Norwich	28,858	29,157	30,810	31,614	32,362	1.0%	5.7%	2.6%	2.4%	12.1%
West Norfolk	16,809	16,731	16,494	17,359	17,843	-0.5%	-1.4%	5.2%	2.8%	6.2%
GYW	34,063	33,878	34,270	35,873	37,268	-0.5%	1.2%	4.7%	3.9%	9.4%
Total	118,996	119,442	123,567	128,428	134,560	0.4%	3.5%	3.9%	4.8%	13.1%

Note £1,300 estimated Roundwell cost transferred from Norwich CCG to South Norfolk CCG in 2017/18 to show a like for like comparison

NSFT Block Contract £'000s						Year on Year Expenditure Growth				
	1314	1415	1516	1617	1718	1415	1516	1617	1718	1314 v 1718
North Norfolk	15,093	15,099	15,081	15,185	16,197	0.0%	-0.1%	0.7%	6.7%	7.3%
South Norfolk	15,958	15,948	16,237	16,267	17,721	-0.1%	1.8%	0.2%	8.9%	11.0%
Norwich	23,803	23,811	24,374	24,470	26,011	0.0%	2.4%	0.4%	6.3%	9.3%
West Norfolk	12,719	12,766	12,321	12,841	13,680	0.4%	-3.5%	4.2%	6.5%	7.6%
GYW	24,761	27,546	27,159	27,613	28,811	11.2%	-1.4%	1.7%	4.3%	16.4%
Total	92,334	95,170	95,172	96,376	102,420	3.1%	0.0%	1.3%	6.3%	10.9%

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Norfolk and Suffolk NHS Foundation Trust – mental health services in Norfolk

Information request for the Health Overview and Scrutiny Committee

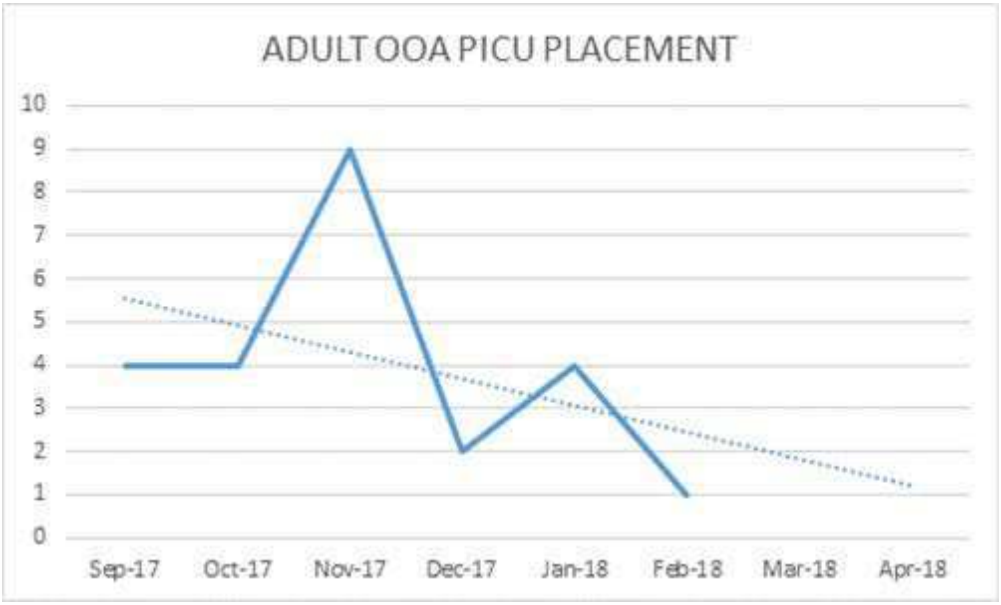
1. The updated Improvement Plan setting out progress in response to the CQC's 'must do' and 'should do' action list and the wider system challenges

   The Care Quality Commission required the Trust to respond to the Section 29A warning notice by the 11th March. The Trust submitted its submission on the 9th March, the submission included a detailed report on the must do' and 'should do' action list supported by an evidence file. The information we have attached for the HOSC is as follows:

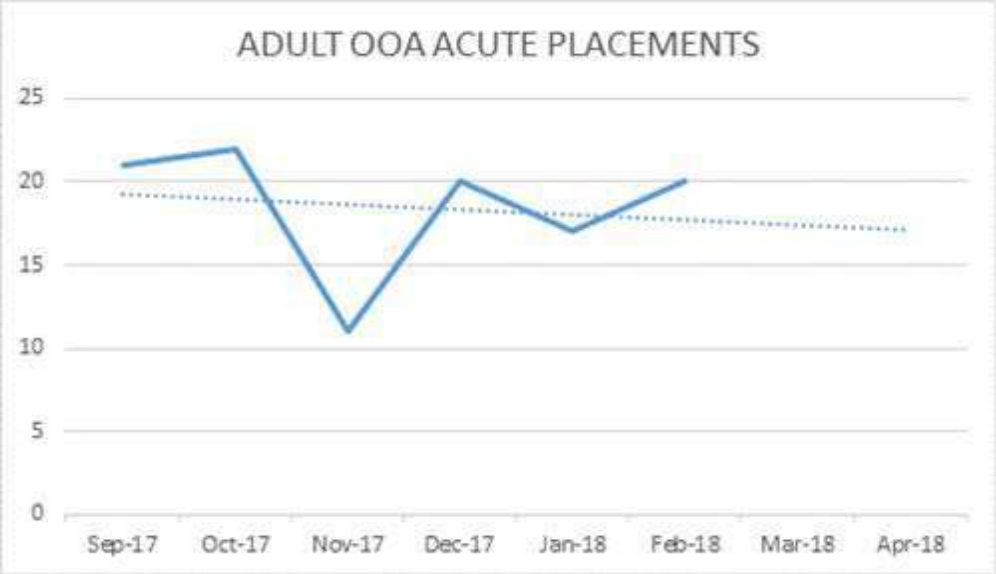
   Appendix 1 - Executive summary of the Section 29A – slide deck shared with the Overview and Assurance Group at it's on the 13th March.

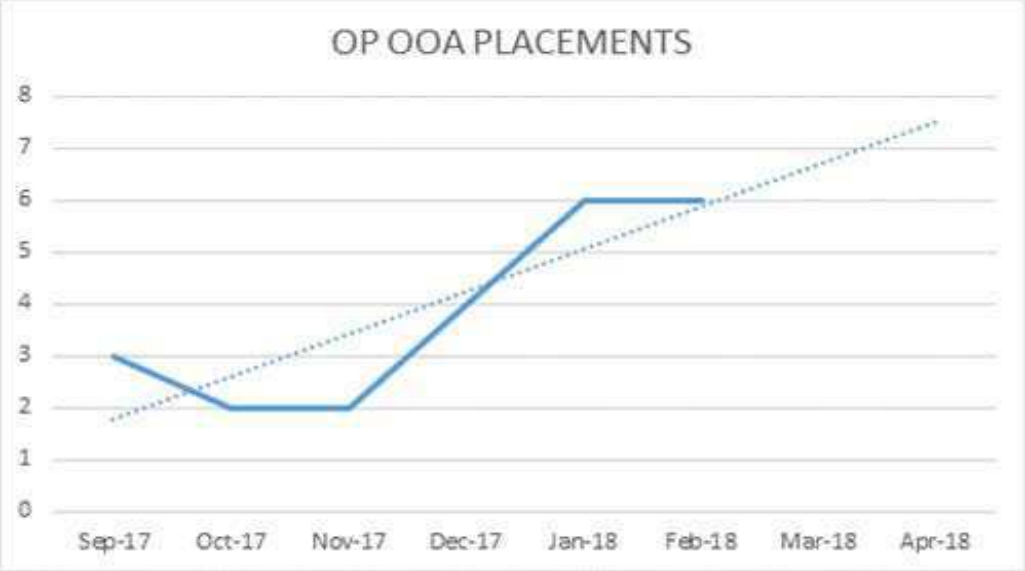
   Appendix 2 – Extract from Summary of the CQC Improvement Plan, 5 February 2018 – showing progress with key actions on leadership, medical engagement, staff engagement and culture.

2. The trend in out-of-Trust placements (except for placements in an appropriate tier 4 specialist services not provided within NSFT's area)



There was an unprecedented demand for PICU beds in November; from Great Yarmouth and Waveney, West Norfolk and Central Norfolk localities. Demand is now at a manageable level.





There has been an increase in demand for older people beds, due to winter pressures. Into March, (not shown on the graph) the pressure is reducing and the trend is coming down. We have had to temporarily close some beds at Carlton Court, due to a shortage of qualified staff. This is adding to pressures at the Julian Hospital in Norwich.

3. Figures showing month-by-month out of-Trust (OOT) placements over the past 6 months showing both the number of individual placements and the total bed days; showing OOT

OOA PLACEMENTS BED DAYS	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18
MUNDESLEY	344	294	0	0	0	0
PRIORY CHEADLE	22	6	5	18	5	0
PRIORY ELLINGHAM	38	162	173	368	218	180
PRIORY TICEHURST	2	44	35	55	84	83
PRIORY ROEHAMPTON	0	19	40	62	46	37
PRIORY CHELMSFORD	0	25	18	52	185	95
PRIORY SOUTHAMPTON	0	12	4	0	7	28
PRIORY WOKING	0	0	18	19	15	0
PRIORY ALTRINCHAM	0	0	8	31	17	0
CYGNET BLACKHEATH	13	0	12	7	0	0
CYGNET BECKTON	10	57	43	4	0	0
CYGNET HARROW	0	19	0	14	0	0
CYGNET STEVENAGE	0	31	7	0	0	11
CYGNET HARROGATE	0	33	7	0	0	0
CYGNET WYKE	0	0	4	11	0	0
CYGNET BIERLEY	0	0	0	0	0	11
ST ANDREWS NORTHAMPTON OLDER PERSONS	77	28	13	0	38	71
THE DENE PIC	0	21	18	62	59	24
KNEESWORTH PIC	0	27	31	63	84	16
ROSEBANK PICU NHS	0	0	0	0	0	0
ST ANDREWS PICU ESSEX AND NORTHAMPTON	2	31	15	53	12	24

This table shows the total bed days. If we have to place a service user in an out of trust bed, we look for a bed that is nearest to their home. The table below shows the locations of the placements and the organisations within which the patients are placed, showing the category of patients with totals (ie number of individual placements) in each category.

PLACEMENTS Sept 17-Feb 18	ADULT	CAMHS	DCLL	CLL
MUNDESLEY	24	0	0	3
PRIORY CHEADLE	4	0	0	0
PRIORY ELLINGHAM	26	2	1	3
PRIORY TICEHURST	7	1	1	3
PRIORY ROEHAMPTON	3	1	0	1
CHELMSFORD PRIORY	19	3	1	0
PRIORY SOUTHAMPTON	1	0	0	1
PRIORY WOKING	3	0	0	0
PRIORY ALTRINCHAM	0	0	0	1
PRIORY POTTERS BAR	0	1	0	0
CYGNET BLACKHEATH	2	0	0	0
CYGNET BECKTON	4	0	0	0
CYGNET HARROW	2	0	0	0
CYGNET STEVENAGE	3	0	0	0
CYGNET HARROGATE	4	0	0	0
CYGNET WYKE	1	0	0	0
CYGNET BIERLEY	1	0	0	0
ST ANDREWS NORTHAMPTON OLDER PERSONS	0	0	8	1
THE DENE PIC	8	0	0	0
KNEESWORTH PIC	11	0	0	0
ROSEBANK PICU NHS	1	0	0	0
ST ANDREWS PICU ESSEX AND NORTHAMPTON	6	0	0	0
CAMBIAN WILLOWS	0	6	0	0
HUNTERCOMBE MAIDENHEAD	0	1	0	0
HUNTERCOMBE STAFFORD	0	1	0	0
LONGVIEW NHS	0	3	0	0
RHODES WOOD	0	1	0	0
THE CROFT	0	1	0	0
COLLINGHAM GARDENS	0	1	0	0
ASH VILLA	0	1	0	0
NEWBRIDGE HOUSE	0	1	0	0
POPLAR ROCHFORD NHS	0	1	0	0
PHOENIX CENTRE	0	1	0	0

4. Figures showing month-by-month placements of patients in beds within NSFT but outside of their own locality over the past 6 months and an explanation of who takes clinical responsibility for patients who are in wards outside of their own locality.

   The table below shows :
   OOT placements ie the number of patients placed in private beds within Norfolk.
   OOHA placements ie the number of patients placed in a bed within NSFT, but not in a bed that is “closest to home”. For example where a patient from West Norfolk is admitted to a Central Norwich bed. (The “closest to home” bed is determined by the patients’ GP surgery)

	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18
OOT PLACEMENTS IN NORFOLK	22	11	4	8	3	5
OOHA PLACEMENTS	19	31	33	34	37	30

NSFT have appointed a dedicated Senior Nurse B 8A Case Manager who takes responsibility for patients who are in wards outside of their own locality. This is a full time post, based at Hellesdon Hospital. The main functions of this role are:

- Reviewing and coordinating the care of patients who are placed in OOA hospitals
- Facilitating more timely decision making and discharge
- Repatriating patients to local care teams as soon as appropriate
- Supporting the family and carers of patients admitted to OOA bed
- Monitoring the quality of gatekeeping by CRHT in order to avoid unnecessary admissions
- Ensuring timely discharge planning is in place

When a patient is sent OOA, the clinical responsibility for managing care overall is with the NSFT Care Coordinator. When a patient is admitted to an OOA bed, the day to day treatment, Responsible Clinician duties, risk management and decisions about leave and discharge lie with the in-patient hospital team that has the patient in their bed. The NSFT Care Coordinator is required to be aware of progress and facilitate discharge planning. NSFT will facilitate the correct discharge pathway to meet the OOA patients' needs – transfer to NSFT bed, step down to Home Treatment team, or direct discharge to CMHT.

5. NSFT's income in 2017-18 and the number of referrals to NSFT in 2017-18 (updating the table provided in NSFT's report to 7 December 2017 NHOSC, paragraph 6)
The increase in income in 2017/18 is due to new service developments such as community perinatal and psychiatric liaison, CAMHS LTP funding and ooa/specialist placement funding.

	2012/13 £m	2013/14 £m	2014/15 £m	2015/16 £m	2016/17 £m	2017/18 £m
Income	219	217	213	212	216	113 (Forecast £227m)
Referrals	65,107	73,248	83,390	89,334	94,085	93,034(up to end of February 2018)

6. Current waiting times compared to targets in each service, including referral to assessment and assessment to treatment

Waiting times performance taken from the KPI report for period Sept 2017 to February 2018

REF	GROUPING	AREA	KEY PERFORMANCE INDICATOR DESCRIPTION	Standard		2017 09	2017 10	2017 11	2017 12	2018 01	2018 02
C010	Wait to Assessment	CFYP	Single point of access: Percentage of Emergency referrals for (under 18 years of age) seen within the service standard RTA of 4 hours	4 Hours	Performance	92%	96%	97%	96%	93%	96%
					Target	95%	95%	95%	95%	95%	95%
C011a	Wait to Assessment	CFYP	Single point of access: Percentage of Urgent referrals for (under 18 years of age) seen within the service standard RTA of 120 hours hours (excludes GY&W)	120 Hours	Performance	83%	78%	88%	78%	82%	83%
					Target	95%	No longer measured as a KPI				
C011b	Wait to Assessment	CFYP	GY&W Access and Assessment: Percentage of Urgent referrals for (under 18 years of age) seen within the service standard RTA of 72 hours	72 Hours	Performance	92%	93%	72%	83%	100%	100%
					Target	80%	No longer measured as a KPI				
C012	Wait to Assessment	CFYP	Single point of access: Percentage of Routine referrals for (under 18 years of age) seen within the service standard RTA of 28 days	28 Days	Performance	77%	83%	78%	84%	78%	84%
					Target	95%	95%	95%	95%	95%	95%
C013	Wait to Assessment	Adult	Single point of access: Percentage of Emergency referrals for (+18 years of age) seen within the service standard RTA of 4 hours	4 Hours	Performance	85%	81%	99%	98%	88%	84%
					Target	95%	95%	95%	95%	95%	95%
C014a	Wait to Assessment	Adult	Single point of access: Percentage of Urgent referrals for (+18 years of age) seen within the service standard RTA of 120 hours hours (excludes GY&W)	120 Hours	Performance	72%	74%	77%	63%	70%	70%
					Target	95%	No longer measured as a KPI				
C014b	Wait to Assessment	Adult	GY&W Access and Assessment: Percentage of Urgent referrals for (+18 years of age) seen within the service standard RTA of 72 hours	72 Hours	Performance	92%	88%	83%	91%	90%	87%
					Target	80%	No longer measured as a KPI				
C015	Wait to Assessment	Adult	Single point of access: Percentage of Routine referrals for (+18 years of age) seen within the service standard RTA of 28 days	28 Days	Performance	73%	72%	83%	83%	67%	78%
					Target	95%	95%	95%	95%	95%	95%
C016	Wait to Treatment	CFYP	Percentage of CAMHS patients (under 18 years of age) being treated within 12 weeks of referral received data (completed pathways)	12 Weeks	Performance	99%	98%	100%	100%	99%	98%
					Target	90%	90%	90%	90%	90%	90%
C017a	Wait to Treatment	Adult	Percentage of adult Community RTT within 18 weeks	18 Weeks	Performance	99%	98%	99%	99%	99%	99%
					Target	95%	95%	95%	95%	95%	95%
C017b	Wait to Treatment	LaterLife	Percentage of dementia and complexity in Later Life RTT within 18 weeks	18 Weeks	Performance	100%	99%	99%	99%	100%	100%
					Target	95%	95%	95%	95%	95%	95%

7. Current NSFT staff vacancy rates, per service line, per locality, along with the numbers of staff on maternity leave or long term sick leave and whether these posts are being covered.

Locality/Service Line	Budget WTE	Actual WTE	Variance WTE	Vacancy Rate	Maternity Leave	Long-term Sick
CFYP	443.09	420.96	22.13	4.99%	18.00	9.00
Gt YARMOUTH & WAVENEY	340.78	319.80	20.98	6.16%	5.00	8.00
NFK & WAV WELLBEING	119.33	112.83	6.50	5.45%	7.00	2.00
Norfolk Central Adult	463.02	447.49	15.53	3.35%	11.00	7.00
Norfolk Central DCLL	287.04	270.97	16.07	5.60%	6.00	12.00
Norfolk West	169.91	149.76	20.15	11.86%	3.00	3.00
	1823.17	1721.81	101.36	5.54%	50.00	41.00

Locality/ Service Line	Staff Group	Budget WTE	Actual WTE	Variance WTE	Vacancy Rate	Maternity Leave	Long-term Sick
CFYP	Admin & Estates	73.59	64.42	9.17	12.46%	2.00	2.00
	Management & Board	10.00	11.00	-1.00	-10.00%	0.00	0.00
	Medical	28.30	32.30	-4.00	-14.13%	1.00	0.00
	Nursing Qualified	129.86	105.87	23.99	18.47%	6.00	2.00
	Nursing unqualified	50.67	54.04	-3.37	-6.65%	1.00	0.00
	S&T/Social Workers	150.67	153.33	-2.66	-1.77%	8.00	5.00
Gt YARMOUTH & WAVENEY	Admin & Estates	47.30	45.31	1.99	4.21%	0.00	0.00
	Management & Board	4.60	6.60	-2.00	-43.48%	0.00	0.00
	Medical	20.40	16.20	4.20	20.59%	0.00	0.00
	Nursing Qualified	126.45	108.75	17.70	14.00%	2.00	4.00
	Nursing unqualified	114.55	115.75	-1.20	-1.05%	2.00	3.00
	S&T/Social Workers	27.48	27.19	0.29	1.06%	1.00	1.00
NFK & WAV WELLBEING	Admin & Estates	22.28	21.11	1.17	5.25%	0.00	0.00
	Management & Board	3.00	4.00	-1.00	-33.33%	0.00	0.00
	Medical	2.45	2.00	0.45	18.37%	0.00	0.00
	Nursing Qualified	30.38	28.64	1.74	5.73%	1.00	0.00
	S&T/Social Workers	61.22	57.08	4.14	6.76%	6.00	2.00
Norfolk Central Adult	Admin & Estates	52.97	54.80	-1.83	-3.45%	1.00	2.00
	Management & Board	8.00	8.00	0.00	0.00%	0.00	0.00

Locality/ Service Line	Staff Group	Budget WTE	Actual WTE	Variance WTE	Vacancy Rate	Maternity Leave	Long-term Sick
	Medical	32.06	22.75	9.31	29.04%	0.00	0.00
	Nursing Qualified	188.19	184.48	3.71	1.97%	6.00	4.00
	Nursing unqualified	147.87	140.95	6.92	4.68%	3.00	1.00
	S&T/Social Workers	33.93	36.51	-2.58	-7.60%	1.00	0.00
Norfolk Central DCLL	Admin & Estates	29.55	27.02	2.53	8.56%	1.00	2.00
	Management & Board	2.00	3.00	-1.00	-50.00%	1.00	0.00
	Medical	19.70	16.40	3.30	16.75%	0.00	2.00
	Nursing Qualified	122.96	113.03	9.93	8.08%	1.00	3.00
	Nursing unqualified	92.90	91.86	1.04	1.12%	2.00	3.00
	S&T/Social Workers	19.93	19.66	0.27	1.35%	1.00	2.00
Norfolk West	Admin & Estates	28.51	27.88	0.63	2.21%	1.00	3.00
	Management & Board	4.00	4.96	-0.96	-24.00%	0.00	0.00
	Medical	21.60	16.40	5.20	24.07%	0.00	0.00
	Nursing Qualified	65.86	49.37	16.49	25.04%	0.00	0.00
	Nursing unqualified	40.70	40.72	-0.02	-0.05%	2.00	0.00
	S&T/Social Workers	9.24	10.43	-1.19	-12.88%	0.00	0.00
		1823.17	1721.81	101.36	5.54%	50.00	41.00

Information about posts being covered is not held centrally, however the majority of vacant posts are routinely covered by bank, agency and locum cover.

8. Results of the service user and carer review that NSFT mentioned at NHOSC on 7 December 2017.

   We are pleased to report that a total of 105 people attended one or other of the 5 Service user and carer improvement plan meetings held in Norwich, Gt Yarmouth, Kings Lynn, Ipswich and Bury St Edmunds throughout January and February. The themes from these meetings are currently being analysed to inform a report with recommendations for next steps.

   We were asked how can someone not able to attend one of these meetings still contribute and make comments, or who have had further thoughts to share since attending. No one method of capturing experiences and ideas is enough. A variety of ways is needed. We have put together a short online questionnaire that can be used to provide further ideas and comments. One of the ideas that we are taking forward is the co-design and co-production of a regular 'Participation News' newsletter, to provide information about activities and involvement opportunities that might interest service users and carers as well as share some of the other actions we have and will be

taking from what people have shared with us. To support this we want to start a participation news mailing list.

S.29a submission summary

1. Systems to monitor and learn for quality and performance information

We recognised that it was vital to improve the accuracy and timeliness of our performance information so that we could understand the risks to patient care and address them effectively. At a Trust-wide level we established the Digital Information Improvement Group (DIIG), led by the Director of Finance. Supported by clinical, technical and staff development work-streams this is a longer term programme that is now bearing fruit and the first of the revised performance dashboards will report to the board of directors on 26.04.18. We have also changed our approach to risk management and our register provides a much better reflection of our risks. Localities bring their top 5 risks to monthly Performance and Accountability Review Meetings (PARMs) for support and challenge so that we start to see risk management as a core tool that supports safe and effective care.

Whilst the DIIG is needed to ensure sustainable governance we also recognised the need to implement an immediate governance structure to deliver the S.29a requirements. The day to day implementation of these changes is driven by the Quality Mobilisation Group, chaired by the Chief Operating Officer, and this reports to the Quality Programme Board, chaired by the Chief Executive and reporting directly to the board of directors. We now have a rolling programme of peer reviews using trained staff and stakeholders that support independent assurance that outcomes are being delivered in front line services. These systems have flagged problems that we need to address and we see this as a strength of our new way of working because where there are gaps or problems we have a system to escalate and address them.

We are looking outside the organisation and our Medical Director has been working with Mazars as part of our learning from incidents and unexpected deaths. Our Mortality Review Group reports to the board and the learning (such as in relation to clinical curiosity) informs our practice development in formulation. We have also prioritised attention to physical healthcare needs and our Trust will be smoke-free from April 2018.

S.29a submission summary

Norfolk and Suffolk NHS
NHS Foundation Trust

2. Ligature point management and environmental risks

We have changed our approach to ligature risk management supported by our Buddy Trust. This is now a clinically led and locally owned approach with corporate services supporting safe care. The Clinical Review provided good assurance that the changes we have made are embedded in our inpatient care. The review also recognised that our work in community settings is less well developed since we have been working on it for a significantly shorter time period. Nonetheless, the same principle of clinically led and owned patient safety is progressing well. We have addressed all community toilet risks a priority (since they are by definition unsupervised) and we are working now on embedding risk mitigation on all other aspects of the assessment analyses that were completed on 08.02.18.

A key part of our approach to 'service to board' risk visibility is the way that we report these matters to the board and our new quality dashboard includes a shift to absolute numbers instead of percentages. Our clinical led and locally owned approach is tested by monthly reviews by matrons and ward managers and supported by online ligature risk assessments that all staff can access.

Our new 16 bed inpatient service in Kings Lynn is scheduled for completion by Q1 2019 and we have also made immediate improvements. We have decommissioned all shared rooms, and the current ward has been re-assessed with support from our Buddy Trust so that all remaining risks identified were resolved by the end of February 2018. We have addressed the safety concerns in the facilities we use at acute hospitals and have made good progress although we continue to have some concerns regarding James Paget Hospital which we are progressing.

S.29a submission summary

Norfolk and Suffolk NHS
NHS Foundation Trust

3. Seclusion environments and seclusion practice

We recognised that we had not taken an effective grip on restrictive interventions including use of seclusion and took a fresh approach to these issues. We have made all the environmental changes required and our Head of Governance has confirmed that all seclusion facilities are compliant. We have decommissioned the seclusion facility at Abbeygate Ward (for older people) and worked with practitioners to bring its clinical practice into line with our other older people's wards.

As well as decommissioning seclusion facilities we identified a clinical need to build seclusion facilities in two wards and these will be complete by May 2018. In the meantime we have introduced clear policies, supported by staff training, to protect patient safety and dignity in these areas.

We recognise the importance of this aspect of our care and we monitor all seclusion practice across the Trust, reporting to the Executive Team and to the board of directors through the quality dashboard.

S.29a submission summary

Norfolk and Suffolk NHS
NHS Foundation Trust

4. Accommodation for men and women

We have changed the use of wards and beds to address gender compliance issues across the Trust.

Beach ward is now all male and Reed Ward is now all female.

In Poppy Ward at Woodlands, we have taken out the swing beds and designated them as male and female and the estates work to make them fully gender compliant is underway.

By April 2018 we will have completed the installation SALTO access controls in Laurel and Sandringham wards.

For Rose Ward (which has a loop layout where SALTO is not workable) we have local interim mitigation plans in place to protect patient safety and dignity and the Executive Team is due to consider an options appraisal paper by the end of March 2018.

Since November 2017 there have been no reported breaches on Datix

S.29a submission summary

Norfolk and Suffolk NHS
NHS Foundation Trust

5. Staffing

Staffing is one of our main challenges and an area which we have prioritised for our collective effort. No matter what national shortages exist, it is our responsibility to ensure the safety of our patients and our staff at all times. Our efforts have been directed at many levels and whilst we have made improvements, and had some successes, this remains one of our main concerns. Our staff tell us that improved staffing and 'do-able jobs' are the most important factors in their ability to provide the quality care and all our efforts are aligned to enable this.

We have funded 40 additional B3 administrators to support team and ward managers and to free up their time to focus on clinical care. By 15.02.18 92% were in post. We have strengthened night time staffing and crisis services. Our top level vacancy percentage figure belies significant localised problems and so we have introduced recruitment premia for registered nurses and doctors. Our data shows that we have not solved this problem and we have increased our focus on community staffing because of the impact on waiting times and on care planning and the resultant stress this places on staff.
We are acutely aware of the risk of acclimatising to unsafe staffing levels and now have systems including safety huddles that escalate staffing (including medical staffing) problems quickly through the organisation so that we can protect our front line staff and our patients. The inspection report brought home to us that we did not have a clear understanding of where our staffing risks sat and so we have improved our reporting, improved our attention to risk information, and ensured that Safer Staffing reports are reviewed at every board.

We recognise that there cultural changes which are fundamental to our improvements. These will form the bedrock for our resolving our longer term staffing problems whilst we maintain a grip on immediate safety issues.

S.29a submission summary

Norfolk and Suffolk NHS
NHS Foundation Trust

6. Management oversight and governance to ensure staff have regular supervision, appraisal and training.

Our appraisal rates at 20.02.18 were 89% (non-medical) and 86% (medical). This is an improvement but we are disappointed not to have improved further and more quickly and are continuing to implement changes to ensure that all staff have meaningful appraisals that support their development.

Management supervision recorded on ESR is at 71% and in response to staff feedback that using ESR can be a barrier to recording we have set up alternative recording arrangements that meet the same end.

At a top level our training compliance was at 90% (non-medical) and 80% (medical) but we know that compliance on specific courses including Basic Life Support is too low. In secure services which had been problematic, some significant improvements have been made (BLS at 100%) but this is not consistent nor Trust-wide and this remains a focus for our attention with clear trajectories for compliance and weekly team reports.

S.29a submission summary

Norfolk and Suffolk NHS
NHS Foundation Trust

7. Access to Services

We recognise the importance of access to the right care in the right place and that bed shortages represent the most visible part of wider care pathway weaknesses. These issues are particularly acute in Norfolk and Waveney. Access to care is a core entitlement and access in a crisis represents an acute risk. As a result we have a multi-faceted approach to improving the whole care pathway working closely with our partners.

We have strengthened our crisis and night time response to support the four hour target of 95% although our current performance falls short of this at 83% and so we are supporting our crisis teams to address this gap. We have strengthened our bed management team with a dedicated B8A manager and B7 support so that placements are carefully reviewed and patients' needs kept at the centre of decision making. We now have access to seven beds for patients who no longer need inpatient care but have no address to go to.

Whilst we have carefully prioritised patient safety and dignity (and so have closed St Catherine's and removed shared bed rooms) we are also investing in new beds and in community services, particular for people with personality based problems, to provide a better fit between our local population's needs and our service design. There is still work to be done to bring the out of area placements to zero and we have submitted a trajectory to do this by March 2019.

S.29a submission summary

Norfolk and Suffolk NHS
NHS Foundation Trust

8. Risk assessment and care planning

We have improved our overall compliance so that at 23.02.18 care plan compliance was at 90% but this is disappointing given the emphasis we have placed not only on ensuring that up to date care plans are in place but also that they are personalised. In adult community services risk assessment compliance is still at only 63% which is unacceptable.

We are working with staff through quality workshops, listening to staff and amending the format, providing care planning tools to help staff and implementing improved tools to monitor compliance.

The Medical Director, supported by the Executive Team, is leading on the improvement plan to address these issues.

S.29a submission summary

Norfolk and Suffolk NHS
NHS Foundation Trust

9. Clinical Records

Although our implementation of Lorenzo addressed the risk we faced in hosting multiple electronic systems that did not link to each other and in having office-based paper records that could not be accessed out of hours, it has brought with it new issues. Our approach recognises that there is no single root cause for the new problems and addresses;

a. performance of the application,
b. support and training for staff, and
c. local infrastructure improvements.

We have emphasised to the suppliers the potential risks to patient care that their product's deficits carry. We have set out as clearly as possible the impact that their product is having on the capacity of our staff to support patients. They have responded and made changes made that have improved speed and reduced crashes. This is positive but not sufficient and we continue to press both the supplier and the contract owner to make further progress without delay. On staff support and training we have put in place an extensive range of supports including visiting every team by 21.03.18. We now have local digital champions and we are seeing improvements in the filing of key documents, correct log-outs to avoid crashes and in positive feedback about on-site support. On local infrastructure, as well as updating local PCs and supplying additional laptops we have a 5 year rolling replacement plan which ensures that our ICT systems remain up to date. By the end of March 2018 all wards will have wifi enabled laptops so that staff can provide more face to face patient support.

S.29a submission summary

Norfolk and Suffolk NHS
NHS Foundation Trust

10. Access to alarms and emergency equipment

The 2017 inspection found that staff at St Catherine's did not carry alarms and there were weaknesses in the arrangements in some community settings. As well as addressing these specific sites, and reflecting on the earlier inspection reports, we have implemented a Trust-wide approach to community environmental risk assessment.

Sufficient alarms are now in place and there are drills which test the response to the sounding of an alarm. Building on this work we have decided to install radio alarms in all bases with sound alarms within the year. We are extending the PinPoint system at Chatterton House Kings Lynn and the PIT system at Great Yarmouth so as to provide comprehensive coverage.

Although St Catherine's is no longer used for inpatient care, it is now included in our community base risk management arrangements.

We have invested in Automated External Defibrillators for our community bases and arranged staff training to support this.

We have reviewed our resuscitation and depot administration policies and practice to ensure that it is appropriate and effectively supported through the issuing of adrenalin to all community bases where service users are seen.

Board assessment that action is on track to deliver outcome Key:
Delivered
On track to deliver
Some issues – narrative disclosure
Not on track to deliver

Extract from NSFT's Summary of the CQC Improvement Plan, 5 February 2018 (version 2.14)

OUR IMPROVEMENT PLAN - SYSTEMIC ISSUES

Leadership

Leadership is a core theme to our improvement. It shapes our culture, promotes engagement and creates an environment open to learning and quality improvement. Whilst some work has started on building emotional intelligence we need to ensure our staff are equipped with the right skills to lead their teams in delivering excellent care to our service users. To do this we need to engage everyone in the organisation so that we have compassionate, inclusive and effective leaders at all levels. To do this we must:

- Agree what good leadership looks like at different levels to include knowledge, skills, attitudes and behaviours.
- Ensure that our staff receive appropriate skills development, including feedback and support.
- Ensure a system is in place to recognize talent and to attract, identify and develop people with good leadership potential.

We will work with East London NHS Foundation Trust to develop some aspects of this core theme, learning from their approach to leadership. Another important feature of our work will be as part of the Norfolk and Waveney and the Suffolk and North East Essex Sustainability and Transformation Plans. This work will focus on the long term sustainability of the health systems across our counties.

Summary of key actions	Oct	Nov	Dec	Jan	Feb	Mar	Apr & beyond
Strategic actions							
Trust Board to review Executive roles and ensure appropriate structure is in place							
Trust Board to develop a revised Organisational Development Strategy and agree an implementation plan							
Trust Board agree and adopt improvement methodology to drive forward a high quality, high performing organisation based on continuous improvement							
Executive Team to adopt the 'Developing People – Improving Care' Framework							
Trust Board to participate in and develop the 'Leadership for Improvement' programme. (See Note 1 below)							
Executive Team to agree and develop leadership programmes for all levels							
CEO to introduce a 'coaching for performance' scheme for managers							
Operational actions							
Executive Team to communicate clear plans for addressing CQC issues and progress. (See Note 2 below)							
Visibility of the Board (Executives and Non-Executive Directors (NEDs)) – to include the CEO monthly broadcast, weekly/monthly planned visits to each area, partnered							

up with corporate heads							
HR lead to introduce a team briefing process							
Chair to lead on substantive appointments to Board vacancies (including recruitment process)							
CEO to ensure regular Senior Leadership Group (SLG) meetings							
HR lead to formalise 360 appraisal process for Senior Leadership Team							
HR lead to introduce mentoring network							
Executive Team to renew approach to Executive oversight and performance management of appraisal, supervision and mandatory training compliance (see separate plan NSFT15)							

Evidence/Assurance
Regular and consistent messaging of plans for addressing CQC issues through a variety of mechanisms (Julie's Monday Message, Team Brief, SLGs) Plan in place for regular Board visits; visits undertaken; feedback from visits shared with Board colleagues Team briefing process implemented Executive positions appointed substantively Regular SLG meetings held Leading in Care Programme delivered Managers held to account for performance at every level Early Intervention (EI) programme for staff cohorts at Bands 4, 5 and 6 completed Staff survey engagement scores for 2018 Note 1: No longer taking forward following advice from programme lead. Decision supported by Interim Director. Note 2: Communications Plan under development. Completion December 2017.

Extract from NSFT's Summary of the CQC Improvement Plan, 5 Feb 2018 (version 2.14)

OUR IMPROVEMENT PLAN - SYSTEMIC ISSUES (continued)

Medical Engagement

The link between doctors and management is an important one and one on which we need to make significant improvement. Medical leaders have a key role in driving quality improvement which is fundamental to our future success. We aim to have a culture whereby managers and clinicians work in partnership to deliver high quality care. To do this we have to be clear on our vision and values, working together to achieve a common objective with an absolute commitment to quality, safety, improvement and engagement. This is not a short term goal: it needs to be embedded and sustainable. We aim to be a Trust with high levels of medical engagement which possesses:

- Understanding, trust and respect between doctors and managers
- Clear expectations, professional behaviour and firm decision-making
- Clarity of roles and responsibilities and empowerment
- A culture focused on quality improvement and safety

We will be supported by East London NHS Foundation Trust in this work.

Summary of key actions	Oct	Nov	Dec	Jan	Feb	Mar	Apr & beyond
Strategic actions							
HR lead to establish a values and competency based selection process for all consultants							
Medical director to develop a leadership programme for consultants							
Medical director and CEO to assess medical engagement through the Medical Engagement Scale, resulting in plans to address the identified issues.							
CEO to establish a programme of learning from other high-performing organisations world-wide							
Medical director to establish key roles for medical leadership							
Operational actions							
Medical director to organise GMC Regional Liaison service workshops							
CEO to meet individual consultants and consultant groups on a regular basis							
HR lead to formalise 360 appraisal process for consultants							
HR lead to introduce mentoring network							
Medical Director to develop the clinical strategy implementation with clinical leads							

OUR IMPROVEMENT PLAN - SYSTEMIC ISSUES (continued)

Staff Engagement

Staff engagement is critical to our approach to improvement. There is evidence to show that engaged staff are more likely to show empathy and compassion. Trusts with engaged staff have higher patient satisfaction levels, with more patients reporting that they are treated with dignity and respect. Staff are more enthusiastic about their work and collaborate more effectively, ultimately delivering better performance. Staff are more engaged if they have responsibility for their work and influence over their working environment. Just as importantly staff must feel able to raise concerns and to identify opportunities for improvement – and for these to be considered fairly.

Our aim is to be inclusive, to promote collaboration, involve staff in decisions, to encourage and coach staff and support staff in addressing organisational challenges. We want to be a learning organisation where staff participate at all levels and feel able to deliver staff-led improvements. The focus must be on developing frontline staff and creating a culture that promotes innovation.

Summary of key actions	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr & beyond**
Strategic actions							
To build on the development of our values in developing our approach to improvement through engagement (e.g. Listening into Action)							
Executive Team to analyse the results from the Staff Survey for 2017 and establish actions to address the issues.							
CEO to promote a more-accessible organisation to deliver a better relationship with the local population and the media							
Operational actions							
CEO-led communications in a variety of channels: live broadcasts, blogs, social media, newsletters, magazines							
Executive/NED walk arounds for visibility and to operate with purpose, with NEDs feedback to impact on changes and opportunities for improvement. All feedback to be included in the programme governance.							
CEO to continue 'You said we did'							
Executives to establish drop in sessions for staff							

OUR IMPROVEMENT PLAN - SYSTEMIC ISSUES (continued)

Culture

Whilst we have worked to develop our vision and values and start to transform the organisational culture we have more to do to ensure that:

- Organisational culture helps to maintain high levels of staff engagement and underpins safe, high quality patient care.
- It is critically important that leaders are seen to act authentically and that organisations live by their values they promote.
- Developing effective procedures to address behaviours that are consistent with our values is a priority. That means addressing negative behaviours of aggression, bullying, harassment and rudeness.
- Staff are more engaged when they feel valued by the organisational leaders and operate within a supportive environment.

We need to build on and progress with the work on our values to ensure that we adopt professional behaviours associated with high-performing organisations in that we take responsibility for our actions, we are accountable and hold people to account for delivery.

Summary of key actions	Oct	Nov	Dec	Jan	Feb	Mar	Apr & beyond
Strategic actions							
The Board to consider its approach to learning with a focus on learning from mistakes and what has worked well.							
The Board to emphasise and re-state a clear direction and priorities based on empowerment/ deliverability/ accountability.							
Operational actions							
HR lead to ensure our values are embedded in our recruitment and appraisal processes							
Executive team to agree on its approach to performance management and the consequences of inappropriate behaviours and performance.							
The Board of Directors to publicly celebrate the success of its staff in delivering results, including against the CQC plan							

Information provided by South Norfolk Clinical Commissioning Group (lead CCG for mental health commissioning in Norfolk & Waveney)

Details of any planning / engagement to create a new vision for mental health services across the STP area.	As part of the Norfolk and Waveney STP Mental Health Workstream, CCGs working with wider partners will shortly commence a period of consultation and engagement to develop a system wide vision and strategy for mental health services. It is envisaged that in order to ensure this is taken forward in the most inclusive way and within a strong coproduced approach this will take a year to complete.
An update on the outcome of the public engagement regarding a Community Wellbeing Hub and progress towards establishment of a Hub (see paragraph 1.6)	The Central Norfolk CCGs conducted an initial consultation relating to the proposed community wellbeing hub. An online survey was open from 11th December 2017 to 12th January 2018. Written responses to the survey questions from individuals and organisations were also encouraged and accepted during this period. A detailed analysis of the survey results is available if required. Some of the key highlights are reflected below: • 123 people participated in the survey, either online or through responding in writing. 5 organisations and individuals corresponded with NHS South Norfolk CCG directly with their feedback on the project. • The general response to the project was positive, with encouragement and enthusiasm towards progress to date. The majority of responses also indicated their individual or organisational willingness to be part of the development of the Community Wellbeing Hub going forward. • There was a general concern regarding the physical and geographical location of the hub in Norwich, particularly for people living in the furthest parts of rural North and South Norfolk. Further information was also required on how transport to and from the hub can be managed for all people in central Norfolk. • The café model was strongly supported, with an emphasis on working with the voluntary sector and involving people with lived experience of mental health conditions in its operation. It was also felt that the Community Hub must work with existing community outreach services, activities and organisations. A project structure is being finalised and invitations to a range of stakeholders will be issued soon. The CCGs intend to operate an engagement process, which will include a workshop to speak with a full range of stakeholders over the course of 2018. Consultation is also ongoing in relation to the hubs development via a monthly service user reference group. Ensuring that people with lived experience are central to the hubs development. CCGs have agreed to conduct a procurement process over the course of 2018 and this will be directly informed by the information gathered as part of the engagement process. The hub is expected to be operational during 2019.
Details of how much NHS England's Mental Health Investment Standard (formerly referred to as Parity of Esteem)	Below are the details of the Parity of Esteem/Mental Health Investment Standard Levels for 2017/18 and 2018/19 across the Norfolk and Waveney CCGs. **2017/18 Parity of Esteem Growth Requirement**

required the Norfolk CCGs to invest in mental health services in 2017-18 and 2018-19, with a breakdown for NSFT services and other mental health spending.

North Norfolk	2.0%
South Norfolk	2.7%
Norwich	2.3%
West Norfolk	2.5%
GYW	2.1%

2017 /18 MH Expenditure and Investment Growth Proportion - total of core Mental Health (excluding expenditure on Mental Health related Prescribing and Continuing Healthcare)

		Growth
North Norfolk	21,778	7.1%
South Norfolk	25,309	8.9%
Norwich	32,362	2.4%
West Norfolk	17,843	2.8%
GYW	37,268	3.9%
Total	134,560	4.8%

Note £1,300 estimated Roundwell cost transferred from Norwich CCG to South Norfolk CCG in 2017/18 to show a like for like comparison

2018/19 Mental Health Investment Standard Growth Requirement (this includes expenditure on Mental Health related Prescribing and Continuing Healthcare which forms part of the Parity of Esteem calculation)

	GYW	North	Norwich	South	West
Total	48,228	35,716	52,731	40,381	35,703
Total increase	2.8%	4.7%	4.3%	3.9%	5.1%
Investment Standard requirement %	2.8%	2.8%	2.9%	3.6%	3.3%

The above shows the total planned increase per CCG against the expected Mental Health Investment Standard. It

<table>
<tr><td></td><td>is not yet possible for CCGs to confirm the breakdown of spend on individual services in 2018/19 as details of contracts are currently being finalised.

These figures highlight that CCGs exceeded the level in investment above the parity of esteem requirement within NSFT services and across the wider mental health care system in 2017/18 and plan to exceed the required level of Mental Health Investment Standard in mental health services in 2018/19.</td></tr>
<tr><td>Details of how much was actually spent on NSFT's services in 2017-18 and how much has been budgeted for 2018-19.</td><td>It is not possible for CCGs to confirm the planned spend on NSFT services in 2018/19 yet. Details of the contract for this year are being worked on currently. In 2017/18 CCGs spent circa £118 million pounds on NSFT services.

How much was spent on NSFT's services in 2017-18 (forecast figures)
<table><tr><th></th><th>GYW</th><th>North</th><th>Norwich</th><th>South</th><th>West</th></tr><tr><td>Block</td><td>28,811</td><td>16,197</td><td>25,982</td><td>17,751</td><td>13,863</td></tr><tr><td>Out of Trust / Secondary Commissioning</td><td>485</td><td>1,015</td><td>1,679</td><td>846</td><td>658</td></tr><tr><td>IAPT</td><td>2,695</td><td>1,807</td><td>2,531</td><td>1,894</td><td>1,679</td></tr><tr><td></td><td>31,991</td><td>19,019</td><td>30,192</td><td>20,491</td><td>16,200</td></tr></table></td></tr>
<tr><td>Outcome of the negotiation with NSFT about funding for 15 additional beds at Yare Ward, Hellesdon Hospital.</td><td>Please see response in previous table (i.e. in Appendix A – response to recommendation 4).</td></tr>
<tr><td>Step Down Bed Overview</td><td>Creating step down beds as an alternative to admission has been adopted as part of the STP mental health work programme.

The service is provided by Evolve, which is an accredited supplier of supported lodgings with NCC. The service provides short say accommodation and support for NSFT adult patients who are deemed 'medically fit' for discharge from the Trust's inpatient units or out of area placements. The service provides a decant service for adults who have temporary problems with accommodation which means that they become a DTOC. Access to the service is managed by NSFT and NCC staff operating at Hellesdon Hospital.

Seven self-contained bed sit flats for placements are provided, plus, support to individuals to facilitate their</td></tr>
</table>

	recovery and move on. Long term commissioning of this type of service will be developed following evaluation during a pilot stage. The service went live at the end of July 2017 and built to full delivery in October 2017. From July 2017 to the end of February the scheme had provided 964 occupied bed days. All tenants have had a housing need eg needing a transfer as their housing exacerbated mental health needs, homeless or awaiting supported accommodation. The support provided has enabled tenants to address benefit issues and to create routines which will support their housing and mental /physical health in the future. At least a quarter had more than one hospital admission in 2017 prior to the admission leading to their placement at Evolve. During their placements only 1 person has had a short admission over a weekend. Over the 2017/18 winter period CCGs were successful in receiving extra money to secure a further 4 beds as part of this provision.
Out of Area Post Case Manager and Support Post Overview.	Funding to support a reduction in out of area beds has been secured to employ 2 posts within NSFT as follows: <u>Band 8A post Out of Area Case Manager (1x w.t.e)</u> This post holder is based at Hellesdon Hospital, but travels to where out of area patients are admitted to conduct regular reviews and to take forward the following: • to improve in patient flow • facilitate more timely decision making and discharge • robust discharge planning including the provision of transport • reduce inpatient length of stay • discuss proposed changes in their care package, eg change of observation level, provision of therapeutic interventions. • repatriate patients to local care team as soon as appropriate • support the family and carers of patients admitted to an out of area bed • ensure that the potential out-of-area facility has access to all relevant information regarding the service user's history, current needs and risks to assist them in their assessment of the service user's suitability for their service. The post holder is also monitoring out of area bed requests by ensuring that trust bed occupancy is checked prior to an out of area admission being made and is monitoring the quality of the Crisis Resolution and Home Treatment (CRHT) gate keeping into adult acute beds to ensure that any potential unnecessary admissions are

	avoided. As part of the post's work in relation to improving patient flow, the post holder is attending ward reviews/board rounds to ensure that prompt discharge planning in in place, creating bed capacity for new admissions and recalls from out of area placements. Also in relation to securing effective patient flow the post holder is working closely with Evolve and other providers of step down beds to ensure that these are utilised in a way that creates capacity within the NSFT adult acute beds. Over the winter 2017/18 period extra Winter Pressures funding was secured to enable the post holder to take forward weekend on call cover to provide support to NSFT bed management and CRHT teams, providing extra oversight during this busy period to ensure that robust bed admissions and bed management processes where supported. During the winter 2017/18 period the Band 8A post was supported in taking forward its roles and responsibilities by a 1x w.t.e. Band 7 post. CCGs are looking at funding this recurrently when the winter pressure monies ends.

The Health and Wellbeing Board and Health Overview and Scrutiny

Report by Maureen Orr, Democratic Support and Scrutiny Team Manager

A briefing on the complementary roles of the Health and Wellbeing Board and Health Overview and Scrutiny.

1. Background

1.1 A document setting out the roles of the Norfolk Health and Wellbeing Board (HWB) and Health Overview and Scrutiny was presented to NHOSC and the HWB in 2013 when the HWB was newly established.

1.2 Since then the system of governance at the County Council has changed from a cabinet and scrutiny system to a committees system and membership of NHOSC, the HWB and the organisations that work with them has substantially changed.

1.3 The HWB requested a briefing to clarify the independent but complementary roles of the HWB and health scrutiny. It was included in the February 2018 NHOSC Briefing and was received and noted by the HWB at its meeting on 6 March 2018.

1.4 The briefing is attached at **Appendix A.** It reflects the roles of health scrutiny and the Health and Wellbeing Board as originally defined but now set within the current system of governance.

2. Action

2.1 The Committee is asked to note the contents of the briefing at Appendix A.

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Norfolk Health & Wellbeing Board and Norfolk Health Overview & Scrutiny Committee Briefing Note

1. Background

1.1 From time to time Members of the Health and Wellbeing Board have discussed the role of the Board and the relationship between it and the role of health scrutiny. This Briefing Note has been prepared for members of the Norfolk Health and Wellbeing Board (HWB) to help address any confusion that may have arisen about the roles of the HWB and health scrutiny.

2. The complementary roles of the HWB and health scrutiny

2.1 The roles of the HWB and health scrutiny are independent, but complementary, with the shared goal of working to improve health, social care and wellbeing outcomes for communities. At its simplest, the key difference between the roles is that the HWB is about developing strategy and health scrutiny is about scrutinising existing practice and proposals to substantially change that practice.

2.2 Two key points worth highlighting are:

- Norfolk Health Overview & Scrutiny Committee (NHOSC) can raise strategic system wide issues with the Norfolk HWB
- Norfolk HWB can commission NHOSC to scrutinise areas of concern

2.3 So, the two work together as part of the whole system accountability. For example, in the light of a report from NHOSC, the HWB might decide to look at the whole system strategic approach to a particular aspect of health and wellbeing in Norfolk. Similarly, in the light of a request from the HWB, NHOSC might decide to look at an issue of concern relating to services and what was happening on the ground.

3. Role of the Health and Wellbeing Board

3.1 The role of the HWB is bring together leaders from across the wider health, care and wellbeing system to better understand their local community's needs, agree priorities and work together in a more joined-up way to improve health and wellbeing outcomes for their area.

3.2 Norfolk HWB provides oversight and strategic systems leadership across many complex organisations and systems, and commissioning across the NHS, social care, public health and wider services. The HWB underpins the shared understanding and joint action that is needed to improve health and wellbeing outcomes for Norfolk.

3.3 The HWB has three main statutory responsibilities:

- **Produce a local, joint health and wellbeing strategy** - the overarching framework within which plans are developed for health services, social care, public health, and other relevant services
- **Assess the needs of their local population** through the joint strategic

needs assessment process (JSNA) and to approve the Pharmaceutical Needs Assessment (PNA)

- **Promote greater integration and partnership** - including joint commissioning, integrated provision, and pooled budgets where appropriate.

4. Role of Health Overview and Scrutiny

4.1 In September 2002, the **Norfolk HOSC** was established to consider matters relating to the needs, health and health related-services of the population of Norfolk. It scrutinises services that have an impact on the health of Norfolk's citizens and challenges the outcomes of interventions designed to support the health of Norfolk people. Local commissioners or service providers **proposing substantial changes to health services in Norfolk** must offer to consult NHOSC unless their proposals cover a wider geographic area, in which case a joint health scrutiny committee of NHOSC Members and health scrutiny Members from other counties may be established to receive the consultation (see 9.& 10. below)

4.2 In 2007, Great Yarmouth & Waveney Joint Health Scrutiny Committee (GY&W JHSC) was established to exercise health scrutiny powers for the **Great Yarmouth & Waveney area only.** This is currently the footprint area for NHS Great Yarmouth & Waveney CCG.

4.3 In April 2017, NHOSC and Suffolk Health Overview and Scrutiny Committee made initial preparations for establishing a joint health scrutiny committee to cover the **Norfolk and Waveney footprint area** on a task & finish basis.

5. What this means in practice

5.1 Norfolk HWB and NHOSC are aware of each other's work and liaise on forward planning to co-ordinate their activity. Below are examples of what the HWB and NHOSC do (and don't do) in relation to commissioning, operational activity and strategic planning.

A. Commissioning

5.2 **The HWB will**:

- Set big context and priorities through the Joint Strategic Needs Assessment (JSNA) and Joint Health and Wellbeing Strategy (JHWBS)
- Challenge health and social care commissioners on priorities
- Give formal opinion on commissioning plans in relation to agreed JHWBS
- Commit to priorities for integration
- Take a patient and resident view, informed by Healthwatch Norfolk
- Ensure that an appropriate balance is struck between 'health' and 'wellbeing' in the JHWBS
- Promote a focus on commissioning for 'wellbeing', as well as for 'health', and make sure that there is a robust evidence-base available on how to improve population wellbeing
- Challenge partners on wider determinants of health
- Challenge national must-do actions if they don't make local sense
- Be a forum where significant changes in commissioning are considered, shaped and tested

5.3 **The HWB won't:**

- Manage commissioning activity
- Arbitrate contract disputes
- Veto' commissioning plans
- Make commissioning decisions

5.4 **NHOSC will**:

- Scrutinise specific health services and integrated health and social care services
- During scrutiny of specific issues, check whether commissioners are acting in line with agreed JHWBS priorities
- Work with Healthwatch Norfolk and other groups to take a patient and resident view (when scrutinising specific topics)
- Scrutinise to ascertain the facts about why local services are being delivered in a certain way and express an opinion on whether it is in the best interests of the local community
- Receive consultation on substantial local reconfiguration plans
- Decide whether to 'call in' local commissioners and/or providers
- Decide whether to seek to influence changes in plans by making recommendations to commissioners or providers, or by making referrals to the Secretary of State for review

5.5 **NHOSC won't**:

- Review the commissioning strategies of each CCG
- Undertake specific scrutiny reviews of wider wellbeing elements outside the health service arena
- Routinely scrutinise individual CCG commissioning plans
- Duplicate the work of Healthwatch Norfolk

B. Operational activity

5.6 **The HWB will:**

- Consider system-wide issues identified through Healthwatch Norfolk and health scrutiny
- Broker action or changes from non-NHS partners eg housing
- Use operational crises to learn and develop wider thinking about underlying causes, including quality issues
- Provide a strategic focus around wellbeing to inform operational activity
- Ask NHOSC to scrutinise an area of concern

5.7 **The HWB won't:**

- Do operational planning or emergency planning in response to events
- Agree operational solutions
- Duplicate the commissioner's role in quality assurance.
- Monitor performance against national targets
- Be the place that "does wellbeing" – letting individual partner organisations and commissioners "off the hook"

5.8 **NHOSC will:**

- Raise system-wide, strategic issues identified through health scrutiny with the

HWB

- Raise strategic issues involving non-NHS partners with the HWB for strategic resolution
- Decide whether to scrutinise one-off operational 'crises' to draw out learning points
- Refer to the evidence in CQC reports in relation to scrutiny of specific subjects
- During scrutiny review of specific subjects, check that commissioners and providers take account of wellbeing in their operational activity
- Consider taking commissions from the HWB to scrutinise specific areas of concern

5.9 **NHOSC won't:**

- Duplicate the commissioner's role in quality assurance

C. Strategic Planning

5.10 **The HWB will:**

- Agree on the big things we all want – for patients and residents
- Challenge itself on keeping wellbeing on the agenda
- Challenge all partners that reductions in funding/de-commissioning decisions are not unduly impacting on the system
- Develop a shared understanding of what 'wellbeing' means in Norfolk and how partners can best work to promote it

5.11 **The HWB won't:**

- Drive the agenda forward with unrealistic expectations

5.12 **NHOSC will:**

- Check that reductions in funding and/or de-commissioning decisions do not impact unduly on the system

Norfolk Health Overview and Scrutiny Committee appointments

Report by Maureen Orr, Democratic Support and Scrutiny Team Manager

The Committee is asked to appoint link members with local Trusts and commissioning bodies.

1. Appointment of link Members

1.1 Norfolk Health Overview and Scrutiny Committee nominates link members to attend local NHS provider (Trusts) and commissioning organisations' meetings held in public in the same way as a member of the public might attend. Their role is to observe the meetings, keep abreast of developments and alert NHOSC to any issues that may require the committee's attention.

1.2 The nominated member or a nominated substitute may attend in the capacity of NHOSC link member.

2. Norfolk and Waveney Joint Strategic Commissioning Committee

2.1 Some months ago the five Clinical Commissioning Groups (CCGs) in Norfolk and Waveney embarked on a process to form a single team for commissioning across the whole system.

2.2 The five separate CCGs (King's Lynn & West Norfolk, Great Yarmouth and Waveney, Norwich, North Norfolk and South Norfolk) are continuing as statutory bodies and their Governing Bodies will continue to meet. However some delegated authority for certain aspects of commissioning decision-making now rests with a Joint Strategic Commissioning Committee (JSCC) for the whole Norfolk and Waveney area.

2.3 The JSCC comprises all five CCGs and has been meeting in shadow form for some months. From June 2018 it will begin to hold meetings in public. The plan is to meet at various locations across Norfolk and Waveney; venues to be confirmed. The JSCC meetings in public are scheduled for the following Tuesdays (all from 2.00 – 4.00pm):-

19 June 2018	16 October 2018
21 August 2018	18 December 2018

2.4 As the JSCC has delegated authority from the CCGs for decision-making which affects the whole county, NHOSC may wish to nominate a link Member and substitute to attend its meetings in public.

3. James Paget University Hospitals NHS Foundation Trust and Great Yarmouth and Waveney CCG

3.1 A vacancy exists for a link Member with James Paget University Hospitals NHS Foundation Trust (JPUH).

The Trust's Board meetings in public are scheduled for the following Fridays (all at 9.30am in the Burrage Centre on the JPUH site).

27 April 2018	28 September 2018
25 May 2018	19 October 2018 (Boardroom)
29 June 2018	30 November 2018
27 July 2018	December- no meeting
August – no meeting	

3.2 The current substitute link Member with JPUH is Mrs M Fairhead.

4. Great Yarmouth and Waveney CCG

4.1 A vacancy exists for a **substitute** link Member with Great Yarmouth and Waveney CCG.

The CCG's Governing Body meetings in public are scheduled for the following Thursdays (all at 1.30 – 5.00pm in Beccles):-

24 May 2018	27 September 2018
19 July 2018	29 November 2018

5. Action

5.1 The Committee is asked to:-

(a) Appoint a link Member and a substitute with the Norfolk and Waveney Joint Strategic Commissioning Committee

(b) Appoint a link Member with the James Paget University Hospitals NHS Foundation Trust

(c) Appoint a substitute link Member with Great Yarmouth and Waveney CCG.

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Norfolk Health Overview and Scrutiny Committee

ACTION REQUIRED
Members are asked to suggest issues for the forward work programme that they would like to bring to the committee's attention. Members are also asked to consider the current forward work programme:-

- whether there are topics to be added or deleted, postponed or brought forward;
- to agree the briefings, scrutiny topics and dates below.

Proposed Forward Work Programme 2018

Meeting dates	*Briefings/Main scrutiny topic/initial review of topics/follow-ups*	*Administrative business*
24 May 2018	Access to NHS dentistry in West Norfolk (including for service personnel's families at RAF Marham) Ambulance performance and turnaround times	
12 July 2018	Maternity services – delivery of maternity reforms by the Local Maternity System Children's speech and language services – progress update since 7 September 2017	*Subject to confirmation by NHOSC*
6 Sept 2018	Physical health checks for adults with learning disabilities – an update on progress since 22 Feb 2018	
18 Oct 2018		

NOTE: These items are provisional only. The OSC reserves the right to reschedule this draft timetable.

Provisional dates for report to the Committee / items in the Briefing 2018

May 2018 Briefing
- evaluation of the District Direct pilot (follow-up to 11/1/18 NHOSC)
- Progress against the trajectory for improvement in waiting times for assessment and diagnosis for autistic spectrum disorders (follow-up to 11/1/18 NHOSC)

6 Dec 2018 – Continuing healthcare – update on progress since 22 February 2018

To be scheduled –Implementation of the Suicide Prevention Action Plan 2016-21 (relating to the county-wide Suicide Prevention Strategy) - progress by service providers. **Note** – Communities Committee received an update on the Action Plan on 7 March 2018. Details were included in the April 2018 NHOSC Briefing. Members may wish to agree the focus for this subject at today's meeting.

Main Committee Members have a formal link with the following local healthcare commissioners and providers:-

Clinical Commissioning Groups

North Norfolk	-	M Chenery of Horsbrugh (substitute Mr D Harrison)
South Norfolk	-	Dr N Legg (substitute Mr P Wilkinson)
Gt Yarmouth and Waveney	-	Mrs M Fairhead (substitute *vacancy*)
West Norfolk	-	M Chenery of Horsbrugh (substitute Mrs S Young)
Norwich	-	Ms E Corlett (substitute Ms B Jones)

NHS Provider Trusts

Queen Elizabeth Hospital, King's Lynn NHS Foundation Trust	-	Mrs S Young (substitute M Chenery of Horsbrugh)
Norfolk and Suffolk NHS Foundation Trust (mental health trust)	-	M Chenery of Horsbrugh (substitute Ms B Jones*)*
Norfolk and Norwich University Hospitals NHS Foundation Trust	-	Dr N Legg (substitute Mr D Harrison)
James Paget University Hospitals NHS Foundation Trust	-	*Vacancy* (substitute Mrs M Fairhead)
Norfolk Community Health and Care NHS Trust	-	Mr G Middleton (substitute Mrs L Hempsall)

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Norfolk Health Overview and Scrutiny Committee 5 April 2018

Glossary of Terms and Abbreviations

B	Band (NHS pay grade)
BLS	Basis Life Support
BMDFT	Bed management and discharge facilitation team
CAMHS	Child and adolescent mental health services
CCG	Clinical Commissioning Group
CEO	Chief Executive Officer
CFYP	Children, Families and Young People
CHC	Continuing Healthcare
CMHT	Crisis Management Home Treatment team
CRHT	Crisis resolution and home treatment
CPA	Care Programme Approach
CQC	Care Quality Commission
CTL	Clinical Team Leader
DCLL	Dementia and complexity in later life
DIIG	Digital Information Improvement Group
DTOC	Delayed transfer of care
EoE SCG	East of England Specialised Commissioning Group
EI	Early intervention
ELFT	East London NHS Foundation Trust
ESR	Electronic staff record
GMC	General Medical Council
GP	General Practitioner
GYW	Great Yarmouth and Waveney
GY&W JHSC	Great Yarmouth and Waveney Joint Health Scrutiny Committee
HAALO	Housing Advice Allocation Liaison Officers group
HOSC	Health Overview and Scrutiny Committee
HR	Human resources
HWB	Health and Wellbeing Board
ICT	Information communication technology
JHWBS	Joint Health and Wellbeing Strategy
JPUH	James Paget University Hospitals NHS Foundation Trust
JSCC	Joint Strategic Commissioning Committee (including the 5 Norfolk CCGs)
JSNA	Joint Strategic Needs Assessment
KPI	Key performance indicator
LD	Learning Difficulties / Disability
MH	Mental health
MHA	Mental Health Act

NCC	Norfolk County Council
NCCP	Norfolk Continuing Care Partnership
NED	Non Executive Director
NHOSC	Norfolk Health Overview and Scrutiny Committee
NSFT	Norfolk and Suffolk NHS Foundation Trust
OOA	Out of area (i.e. outside of the Trust's geographic area)
OOT	Out of Trust (i.e. outside of facilities owned by the Trust)
PARMS	Performance and Accountability Review Meetings
PC	Personal computer
PIC	Psychiatric intensive care
PICU	Psychiatric intensive care unit
PIT	Personal infrared transmitter
PNA	Pharmaceutical Needs Assessment
SALTO	An access control company (i.e. door access)
SLG	Senior Leadership Group (at Norfolk & Suffolk NHS Foundation Trust)
RCP	Royal College of Psychiatrists
RTA	Referral to assessment
RTT	Referral to treatment
Section 29a warning notice	A notice issued by the Care Quality Commission when it decides there is a need for significant improvement in the quality of healthcare
STP	Sustainability & transformation plan / partnership
SU	Service user
WTE	Whole time equivalent