Norfolk County Council

Norfolk Health Overview and Scrutiny Committee

Date: **Thursday, 17 January 2019**

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
Mr D Fullman	Mr M Fulton-McAlister	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
Ms E Flaxman-Taylor	Mr G Carpenter	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
Mr F O'Neill	Mr R Foulger	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
Mrs A Claussen-Reynolds	Mr M Knowles	North Norfolk District Council
Mrs S Young	Mr S Eyre/Mrs 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 6 December 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, to a greater extent than others in your division

- Your wellbeing or financial position, or
- that of your family or close friends
- Any body -
    - Exercising functions of a public nature.
    - Directed to charitable purposes; or
    - One of whose principal purposes includes the influence of public opinion or policy (including any political party or trade union);

Of which you are in a position of general control or management.

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	**10.10 - 11.15**	**The Queen Elizabeth Hospital NHS Foundation Trust - response to the Care Quality Commission report** **Appendix A** (Page 21) - Queen Elizabeth Hospital NHS Foundation Trust report **Appendix B** (Page 33) - QEH Quality Improvement Programme progress update	**Page 13**
	11.15 - 11.25	**Break at Chairman's discretion**	**Page**
7	**11.25 - 12.30**	**Norfolk and Suffolk NHS Foundation Trust - response to the Care Quality Commission report** **Appendix A** (Page 61) - Norfolk and Suffolk NHS Foundation Trust report **Appendix B** (Page 89) - South Norfolk Clinical Commissioning Group report **Appendix C** (Page 93) - Correspondence regarding travelling costs in relation to out-of-area placements	**Page 55**
8	**12.30 - 12.40**	**Forward work programme**	**Page 103**
		Glossary of terms and abbreviations	**Page 107**

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Norfolk County Council

NORFOLK HEALTH OVERVIEW AND SCRUTINY COMMITTEE
MINUTES OF THE MEETING HELD AT COUNTY HALL, NORWICH
on 6 December 2018

Present:

Michael Chenery of Horsbrugh (Chairman)	Norfolk County Council
Ms E Corlett	Norfolk County Council
Mr F Eagle	Norfolk County Council
Mr M Fulton-McAlister (substitute for Mr D Fullman)	Norwich City Council
Mrs S Fraser	Borough Council of King's Lynn and West Norfolk
Mr D Harrison	Norfolk County Council
Dr N Legg	South Norfolk District Council
Mrs B Jones	Norfolk County Council
Mr G Middleton	Norfolk County Council
Mr R Price	Norfolk County Council
Mrs S Young	Norfolk County Council

Also Present:

Dawn Newman	Head of Quality in Care, Great Yarmouth and Waveney CCG
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
Jo Smithson	Chief Officer, Norwich CCG
Jeanette Patterson	Continuing Healthcare Lead, Norfolk County Council
Rebecca Hulme	Chief Nurse, Great Yarmouth and Waveney CCG
Sam Revill	Business Development Manager, Healthwatch Norfolk
Caroline Fairless-Price	Member of the public (& a CHC service user)
Dr Chris Price	Member of the public and carer
Dr Sue Vaughan	Member of the public
Sarah Taylor	Nurse at the NNUH
Mark Davies	Chief Executive, Norfolk and Norwich University Hospitals NHS Foundation Trust
Professor Nancy Fontaine	Chief Nurse, Norfolk and Norwich University Hospitals NHS Foundation Trust
Richard Parker	Chief Operating Officer, Norfolk and Norwich University Hospitals NHS Foundation Trust
Melanie Craig	Interim Executive Lead for the STP & Chief Officer Great Yarmouth & Waveney CCG
Frank Sims	Chief Officer, North Norfolk CCG (lead commissioners for the N&N)
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 Mrs A Claussen-Reynolds, Ms E Flaxman-Taylor, Mr D Fullman, Mr F O'Neill and Mr P Wilkinson.

2. Minutes

2.1 The minutes of the previous meeting held on 18 October 2018 were confirmed by the Committee and signed by the Chairman.

3. Declarations of Interest

3.1 There were no declarations of interest.

4. Urgent Business

4.1 There were no items of urgent business.

5. Chairman's Announcements

5.1 There were no Chairman's announcements.

6 Continuing Healthcare

6.1 The Committee received a suggested approach by Maureen Orr, Democratic Support and Scrutiny Team Manager, to a report on the management of NHS continuing healthcare by Norfolk Continuing Care Partnership (NCCP) for the four Clinical Commissioning Groups (CCGs) in central and west Norfolk and by Great Yarmouth and Waveney CCG for its area.

6.2 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, Jo Smithson, Chief Officer, Norwich CCG, Jeanette Patterson, Continuing Healthcare Lead, Norfolk County Council, Rebecca Hulme, Chief Nurse, Great Yarmouth and Waveney CCG and Dawn Newman, Head of Quality in Care, Great Yarmouth and Waveney CCG.

6.3 The Committee also heard from Sam Revill, Business Development Manager, Healthwatch Norfolk, and Dr Chris Price, a carer for (and speaking on behalf of) Caroline Fairless-Price, a member of the public and a CHC service user.

6.4 Sam Revill, Business Development Manager, Healthwatch Norfolk, explained how Healthwatch Norfolk had worked with the NCCP since Spring 2018 on the need for timely provision of information and better communication with both patients and carers in the central and west Norfolk area about NHS continuing healthcare issues (CHC). Sam Revill said Healthwatch wanted to see what was described as a 'communications boost' to raise awareness and understanding about CHC amongst the general public. Healthwatch Norfolk had held four workshops with the NCCP and voluntary organisations on this subject. The workshops had come up with recommendations for improving family and patient carer leaflets, for correspondence with family members and next of kin, and for how the public could raise complaints.

One of the key messages from the workshops was that the NHS Continuing Healthcare process had to be communicated clearly and in writing to the individual or their representative, as soon as was reasonably practicable. For those approaching the end of their lives, it was vital that they received appropriate information about their condition and care and for this to be communicated with honesty and sensitivity by professionals who had the expertise to do so.

6.5 Dr Chris Price, speaking on behalf of Caroline Fairless-Price, a member of the public and CHC service user, said that there was a serious problem with staffing levels in care and support and this was getting worse. Wherever the care came from and however it was paid for, the same problem existed: there were not enough carers specifically trained in the care that CHC service users needed and reliably available at the time when that care was needed. People and organisations were taking carers from one another to fill gaps and this was not a solution. Developing a safety net for CHC clients had to be about looking further than the odd occasion when care failed. It had to be about the lack of carers to set up reliable care packages.

6.6 During discussion the following key points were made:

- The four CCGs that made up the Norfolk Continuing Care Partnership (NCCP) had not made any changes to the National Framework for NHS Continuing Healthcare because this was set at the national level and not within the power of local CCGs to change.
- The speakers said that for the foreseeable future integration would continue to be a key theme for both health and social care services.
- The NCCP was moving towards the position on continuing healthcare taken by Great Yarmouth and Waveney CCG.
- The speakers said that for historical reasons a lot of different models for the delivery of continuing healthcare were used in Norfolk that did not provide for equitable treatment throughout all the CCG areas.
- One of the reasons why Great Yarmouth and Waveney CCG had historically developed a different model of care was because they had to work with both Norfolk County Council and Suffolk County Council.
- Each patient at the James Paget Hospital was allocated a named CHC Practitioner. The CHC Practitioner worked with the patient and their representatives throughout the patient's stay, and in so doing provided for continuity and personalisation of care and support throughout the assessment process.
- Members stressed the importance of a consistent decision-making approach for all parties and providers of CHC. They said that the difficulty of individuals experiencing a multiplicity of care workers needed resolving to ensure continuity for the patient and flexibility for service provision.
- The speakers said that the assessment teams made sure that the patient played a full role in the assessment and decision-making process and that the patient knew what to expect and where to get information and advice. This was usually done by the patient asking for a friend or relative to help them explain their views.
- The speakers said that patients could be referred to the advocacy services provided by Beacon, a charitable organisation and an independent NHS continuing healthcare adviser that also provided the CCGs with training, advice and advocacy services.
- The speakers from the Norfolk Continuing Care Partnership (NCCP) and Great Yarmouth and Waveney CCG were asked to provide the take up figures on how many people under assessment for CHC took up advocacy services to help them get through the process.

- The speakers said that the STP System Resilience Group had an overview role when it came to workforce winter planning. They and other planning groups within the NHS recognised that a coordinated approach to staff training, based on minimum standards of quality assured training, was required for everyone involved in the CHC assessment process. In reply to questions, the speakers from the CCGs said that in addition to supporting staff in meeting their training needs they recognised the importance of providing a wide range of staff incentives to raise productivity.
- Members drew attention to the additional NHS and social care funding for 2018-19 to fund winter pressures and support winter resilience, specifically for those activities which reduced the need for people to receive formal social care and support and provided for their safe discharge from hospital. It was pointed out that when this matter was considered at Adult Social Care Committee some concern was expressed that some of this funding might have to be used to bolster short term capacity in the homecare and care home markets and to manage potential market failures, such as that which had occurred with Allied Healthcare.
- The speakers said that the quality standards within service contracts helped to ensure that the CCGs were able to hold providers to account for the quality of continuing health care that they provided.
- The speakers explained how the CCGs had developed local protocols between themselves, other NHS bodies, Norfolk County Council and other relevant partners that set out each organisation's role and how responsibilities were to be exercised in relation to hospital discharge thereby improving contingency planning in the event of service failure.
- Steps were being taken to ensure that the services that providers of NHS Continuing Healthcare were expected to supply was clearly set out in the service specification or contract between provider and CCG.
- It was pointed out that where the patient had a rapidly deteriorating condition and was entering a terminal phase, then the Fast Track Tool could be used.
- The intention of the Fast Track Pathway was that it should identify individuals who needed to access NHS Continuing Healthcare quickly with minimum delay.
- The CCGs accepted all Fast Track referrals that had gone through the correct referral process.
- The significantly lower number of CHC Fast Track referrals in West Norfolk was due to the existence of other commissioned End of Life services which could be accessed without the need for completion of a Fast Track referral.
- The Norfolk Hospice (Tapping House) provided specialist palliative care to people with life shortening illnesses and as such had the effect of reducing the referral rate for continuing health care assessments in West Norfolk.
- It was pointed out that in West Norfolk, approximately 75% of Fast Track referrals came from the QEH, 10% from community hospitals and 15% from the NNUH and other acute hospitals and other sources.
- The detailed breakdown of the number of patients in receipt of CHC and the regional variations in the numbers of patients assessed as eligible for NHS CHC could be found in the report.

6.7 The Committee **noted** that rates of referrals for fast track CHC were lower than the English average in both the Great Yarmouth and Waveney Clinical Commissioning Group area and across the Norfolk Continuing Care Partnership area, and that Great Yarmouth and Waveney CCG intended to provide staff training in the James Paget Hospital on when it was appropriate to make a fast track referral.

6.8 The Committee **recommended**:

- That Norfolk Continuing Care Partnership should consider providing staff training at the Norfolk and Norwich and Queen Elizabeth hospitals on when it was appropriate to refer patients for fast track CHC assessment.

The Committee **agreed**:

- Norfolk Continuing Care Partnership (NCCP) and Great Yarmouth and Waveney CCG should provide the figures on how many people under assessment for CHC took up advocacy to help them with the process.
- Great Yarmouth and Waveney CCG and NCCP should provide a progress update for the NHOSC Briefing including a response to the committee's recommendation and evidence of the trends in referrals and assessment of eligibility for CHC and explanation of those trends (see Forward Work Programme below)
- In noting the effect of a shortage of healthcare workers for CHC patients, and the workforce shortages elsewhere in the local NHS, the Committee agreed to ask the Norfolk & Waveney Sustainability Transformation Partnership (STP) Workforce workstream Lead to report on what was being done to address the shortfalls (see Forward Work Programme below).
- An update on the information provided in the National Audit Office's 'The CHC process' diagram to be provided, if available (the diagram, on p.15 in the agenda papers, was based on 2015-16 data).

7 Norfolk and Norwich University Hospitals NHS Foundation Trust – response to the Care Quality Commission report

7.1 The Committee received a suggested approach by Maureen Orr, Democratic Support and Scrutiny Team Manager, to a report from the Norfolk and Norwich University Hospitals NHS Foundation Trust (NNUH) about the NNUH response to the report of the Care Quality Commission's (CQC) inspection between 10 October 2017 and 28 March 2018, published on 19 June 2018.

7.2 The Committee received evidence from Mark Davies, Chief Executive, Norfolk and Norwich University Hospitals NHS Foundation Trust, Professor Nancy Fontaine, Chief Nurse, Norfolk and Norwich University Hospitals NHS Foundation Trust, Richard Parker, Chief Operating Officer, Norfolk and Norwich University Hospitals NHS Foundation Trust, Melanie Craig, Interim Executive Lead for the STP & Chief Officer Great Yarmouth & Waveney CCG and Frank Sims, Chief Officer, North Norfolk CCG (lead commissioners for the N&N).

7.3 The Committee also received a PowerPoint presentation from the speakers (which can be found at page 77 of the agenda) and heard from Sarah Taylor who had started on a Return to Nursing practice course at the beginning of September 2018.

7.4 Sarah Taylor said that she had previously been a nurse for 22 years and had worked at NNUH in Cardiology, as a Resuscitation Officer, as part of the site operations team and in main theatre recovery. She said that although the NNUH was far busier than when she had last worked at the hospital11 years ago, she was impressed to see the staff provided excellent, compassionate and clinically skilful care every day and that patient satisfaction was high.

7.5 During discussion the following key points were made:

- The speakers said that the NNUH had taken immediate enforcement action in relation to the most significant concerns raised in the Care Quality Commission's (CQC) inspection report.
- There had previously been recognisable divisions within the NNUH executive team and the team had not functioned as effectively and cohesively as they should. Steps had been taken to address these managerial concerns and for the hospital to have a more "clinically led" management structure.
- Since the publication of the CQC report, the NNUH had done a lot more to listen to staff concerns, to encourage staff feedback and to put in place improved mechanisms for staff to report issues to management. Monthly staff get togethers were regularly attended by 200 or more staff and the Chief Executive took a "hands on approach" and regularly attended these meetings.
- A "buddy trust" for the NNUH was expected to be appointed by NHS Improvement shortly.
- The NNUH aimed to be out of special measures by mid-2019 and to be rated as outstanding in the next five years.
- The NNUH had reviewed the forms that were used for the collection of patient data to ensure they were fully compliant with national guidance and met the requirements of NNUH policy. The NNUH had also taken steps to collect more of its key performance data in an electronic form.
- The speakers said that to meet the pressures on the NNUH, hospital services were being delivered in new ways.
- The pressures that the hospital faced included:
    - The capacity constraints of the NNUH building.
    - Finding new ways of working with NHS organisations that were outside of the NNUH's direct control (such as with the Ambulance Service).
    - Devising new methods for incentivising staff which at the same time helped improve hospital productivity.
    - Dealing with a significant increase in the number of patients aged 70-79 years old.
    - Dealing with an ongoing NNUH 8% budget deficit.
- It was pointed out that all NHS organisations were expected to return to a balanced budget position in the next two to three years.
- The NNUH was making representations to Government for help in meeting the hospital's £20m a year in PFI commitments which were for the next 20 years.
- The NNUH had commissioned a virtual ward with a third-party care provider, Homelink Healthcare, who would use their own staff for this purpose.
- In reply to questions from the Chairman, the speakers said that the NNUH had agreed to help the QEH in any way they could to provide hospital services for patients who were waiting to undergo surgery for cancer.
- It was pointed out that some 430 consultants worked at the NNUH and of these some 70 also worked at the QEH.

7.6 The Committee **agreed** that information on the allocation of additional Winter funding (2018-19) for Norfolk and Waveney should be circulated to Members.

7.7 The Committee **noted** the N&N's good progress towards completing the 'must do' and 'should do' actions in the CQC's report and that the CQC was expected to return to the hospital in the new year.

7.8 The Committee **agreed** to await the CQC's follow-up report before deciding if they wished to return to this issue.

8 Forward Work Programme

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

8.2 The Committee **agreed** the forward work programme with the following additions:

11 April 2019 –*Local action to address health and care workforce shortfalls* – a short report by Norfolk & Waveney (STP) Workforce workstream lead.

May 2019 – *Access to palliative and end of life care* – follow-up from the meeting on 18 October 2018

8.3 The Committee **agreed** to add to the NHOSC Briefing (information briefings to enable Members to consider whether to add items to a future agenda):

- Continuing healthcare – response to the committee's recommendation (see item 6 above) and evidence of the trends in referrals and assessment of eligibility for CHC and explanation of those trends.
- Community eating disorder service – capacity, quality and consistency
- Physical health checks for adults with a severe mental illness – process for identifying patients for the register and the numbers of health checks delivered
- GP core services – description of what should be provided under the standard General Medical Services contract

8.4 The Committee **proposed** that a NHOSC Member should be included on the Member Group that had been set up by the Policy and Resources Committee on 29 October 2018 to examine palliative and end of life care. It was **noted** that the Member Group was expected to start its deliberations when NHOSC completed its scrutiny of 'Access to palliative and end of life care' (scheduled for May 2019).

Chairman

The meeting concluded at 1.10 pm

The Queen Elizabeth Hospital NHS Foundation Trust – response to the Care Quality Commission report

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

Examination of the Queen Elizabeth Hospital NHS Foundation Trust's (QEH) response to the report of the Care Quality Commission's (CQC) inspection between 4 April and 21 June 2018, published on 13 September 2018.

1.0 Purpose of today's meeting

1.1 To receive and examine the QEH's action plan to address the issues raised by the CQC inspection report.

The key focus areas are:-

(a) The QEH's progress in addressing the CQC's requirements for improvement.

(b) Capacity of the QEH to manage current and future demand for services.

(c) The commissioners' and wider health and care system's role in supporting the QEH to improve.

1.2 The QEH has been asked to provide the following information:-

1. Details of progress against each of the 'must do' and 'should do' actions set out by the CQC.
2. Details of capacity planning for this year and for the future.
3. Details of staffing including:-
    a. Numbers of vacant posts
    b. Staff sickness levels
    c. Numbers of vacant posts and sickness absences covered by locum / agency / bank staff
    d. Additional steps that have been taken to fill vacant posts and cover staff absences since the CQC inspection.
4. The current situation regarding the reported proposal to transfer patients to other hospitals due to insufficient staffing at the QEH.
5. Details of the QEH's financial position and 2018-19 end of year forecast.

The QEH's report is attached at **Appendix A** and **Appendix B** (details of progress against each of the 'must do' and 'should do' actions set out by the CQC).

1.3 Representatives from the QEH and West Norfolk Clinical Commissioning Group (lead commissioner for the QEH's services) will attend to answer the committee's questions.

2.0 Background

2.1 The CQC report

2.1.1 The CQC inspected specific services at the QEH between 4 April 2018 and 21 June 2018. Services inspected were:-

- Urgent and emergency services
- Medical care (including older people's care)
- Surgery
- Maternity
- End of life care
- Outpatients
- Diagnostic imaging

Critical care and services for children and young people were not inspected.

2.1.2 The report was published on 13 September 2018 and is available on the CQC website:-
https://www.cqc.org.uk/provider/RCX

The CQC rated the QEH as 'Inadequate' overall. It had been previously been in this position and placed in special measures in October 2013. However, it's rating was raised to 'Requires Improvement' in September 2014, where it remained until the 2018 inspection.

The CQC recommended that the QEH be returned to special measures. This means:-

- An improvement director can be appointed to provide assurance of the trust's approach to performance
- NHS Improvement review the capability of the trust's leadership
- A 'buddy' trust may be chosen to offer support in the areas where improvement is needed
- Progress against action plans is published monthly on the trust's website and the NHS website.

NHS Improvement assigned Philippa Slinger as the improvement director with the QEH. Ms Slinger is also the improvement director with Norfolk and Suffolk NHS Foundation Trust and the Norfolk and Norwich NHS Foundation Trust, who are also in special measures.

The QEH's designated 'buddy' trust is Sherwood Forest Hospitals NHS Foundation Trust.

2.1.3 The table below shows the ratings of services within the Trust and whether their position had improved (↑), deteriorated (↓) or stayed the same (→←) since the previous inspection in June 2015 (published on 30 July 2015).

Ratings for The Queen Elizabeth Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Inadequate ↓ Aug 2018	Requires improvement ↓ Aug 2018	Good →← Aug 2018	Requires improvement ↓ Aug 2018	Inadequate ↓↓ Aug 2018	Inadequate ↓↓ Aug 2018
Medical care (including older people's care)	Inadequate ↓ Aug 2018	Requires improvement ↓ Aug 2018	Requires improvement ↓ Aug 2018	Requires improvement ↓ Aug 2018	Inadequate ↓↓ Aug 2018	Inadequate ↓↓ Aug 2018
Surgery	Requires improvement ↓ Aug 2018	Requires improvement ↓ Aug 2018	Good →← Aug 2018	Requires improvement ↓ Aug 2018	Requires improvement ↓ Aug 2018	Requires improvement ↓ Aug 2018
Critical care	Good Jul 2015	Good Jul 2015	Good Jul 2015	Good Jul 2015	Good Jul 2015	Good Jul 2015
Maternity	Inadequate Aug 2018	Requires improvement Aug 2018	Good Aug 2018	Inadequate Aug 2018	Inadequate Aug 2018	Inadequate Aug 2018
Services for children and young people	Good Jul 2015	Good Jul 2014	Good Jul 2014	Good Jul 2014	Good Jul 2014	Good Jul 2015
End of life care	Requires improvement ↓ Aug 2018	Inadequate ↓↓ Aug 2018	Good →← Aug 2018	Good ↑ Aug 2018	Requires improvement →← Aug 2018	Requires improvement →← Aug 2018
Outpatients	Requires improvement Aug 2018	Not rated	Good Aug 2018	Requires improvement Aug 2018	Requires improvement Aug 2018	Requires improvement Aug 2018
Diagnostic imaging	Requires improvement Aug 2018	Not rated	Good Aug 2018	Requires improvement Aug 2018	Requires improvement Aug 2018	Requires improvement Aug 2018
Overall*	Inadequate ↓ Aug 2018	Requires improvement ↓ Aug 2018	Good →← Aug 2018	Requires improvement →← Aug 2018	Inadequate ↓ Aug 2018	Inadequate ↓ Aug 2018

The overall ratings are the same as for the Norfolk and Norwich University Hospitals NHS Trust (NNUH) but the QEH has worse ratings within medical care (including older people's care), maternity and end of life care. It has better ratings within surgery, critical care and services for children and young people.

The QEH was given 94 'must do' and 'should do' actions to complete.

2.1.4 **Staffing levels** were a serious concern. The CQC found a 56% vacancy rate on one medical ward and an overall nurse vacancy rate of 21% in medicine. This impacted on the hospital's ability to consistently deliver safe and effective care.

In autumn 2018 a proposal to close a ward and redeploy staff to reduce and mitigate the vacancy factor in the most challenged wards was one of the options under consideration to mitigate the situation. This would have affected the hospital's programme of elective surgery to a greater or lesser extent (depending on whether the closure was a surgical or medical ward) and patients would have been transferred to the Norfolk and Norwich Hospital (N&N).

On 7 December 2018 the QEH issued a press release making it clear that proposals to move elective cancer surgery to the N&N over the winter period would not go ahead. The trust intended to run as much of its planned surgical programme as possible while at the same time serving its emergency patients.

It should be noted that medical care (including older people's care) received a 'requires improvement' rating for 'caring' where every other service was rated 'good' for caring. The CQC said that although staff displayed a kind, compassionate and dedicated approach to patients and relatives, they did not have the time or capacity to provide the level of support they would like to. Although patients spoke highly of the nursing staff and their experiences of the care received the CQC found there were not always good communications from staff to ensure patients were fully involved and understood decisions. This was due to time and capacity pressures on staff.

2.1.5 **Maternity** at the QEH received particularly poor ratings from the CQC. It found that the leaders within the service, both midwifery and clinician, could not work together and did not demonstrate integrity on an ongoing basis. It said the leadership had broken down, the leaders did not have oversight of risk or quality improvement and the CQC was not sure they understood the challenges to quality and sustainability of high quality patient care.

2.1.6 Since the CQC report was published on 13 September 2013 there have been the following changes in leadership at the Trust:-

- The Chairman stood down on 22 October 2018 and a new Chairman, Professor Steve Barnett, was appointed.
- The departure of the Chief Executive was announced on 5 December 2018 and a new Chief Executive, Caroline Shaw, will start on 14 January 2019.

2.2 **The wider local health and care system**

2.2.1 As noted at NHOSC on 6 December 2018 when the NNUH's response to its CQC report was on the agenda, Norfolk has three 'Inadequate' rated trusts, which is a very high proportion when compared to the rest of the country.

This points to a need to consider the actions of the commissioners and the county's wider health and care system as well as the individual responsibilities of the trusts involved.

As outlined by the Norfolk and Waveney Sustainability Transformation Partnership (STP) Interim Executive Lead at NHOSC on 6 December 2018 the STP recognises the need for the whole system to be enabled to work together, reducing duplication (e.g. in diagnostics) and alleviating pressure on individual organisations as much as possible.

3.0 Suggested approach

3.1 After the QEH representatives have presented their report, the committee may wish to discuss the following areas with them and the West Norfolk CCG representatives:-

For discussion with the QEH

(a) The QEH recalibrated its Quality Improvement Programme towards the end of 2018 to become more rigorous in its self-assessment process. This means that more recent reports are showing less progress against the CQC's 'must do' and 'should do' actions than earlier reports. Is the QEH now fully assured that is taking the required action and gathering evidence to demonstrate it to the CQC's satisfaction?

(b) The QEH's Quality Improvement Plan (Appendix B) notes that three Quality Improvement Managers will be recruited by mid-January 2019. Has the recruitment been successful?

(c) On 6 December 2018 the QEH confirmed that it would not transfer cancer surgery to the N&N but would run as much of its planned surgical programme as possible while at the same time serving its emergency patients. What proportion of planned surgery at the hospital has had to be postponed so far during winter 2018-19 and has this affected cancer patients as well as other patients?

(d) The QEH's report (Appendix A) says that during the first week of January it began to run an extended recovery unit staffed by theatre staff to accommodate the vast majority of the planned elective work. This was instigated as an alternative to transferring urgent and cancer patients to the Norfolk and Norwich Hospital. Does using theatre staff in this way mean that fewer operations can be carried out at the QEH each day and how does it affect waiting times for patients?

(e) The QEH's report (Appendix A) mentions that it will work with independent sector providers (ISPs) to offer routine elective surgery to as many of its patients as possible. What percentage of local patients are receiving surgery from ISPs and where are these

providers located?

(f) How well has the hospital performed so far during winter 2018-19 in relation to 18 week referral to treatment and A&E 4 hour waiting standards and with regard to ambulance turnaround times?

(g) The proposal to transfer surgery to other hospitals was brought forward as a means of maintaining clinical safety of patients due to a shortage of staff at the QEH. Is the QEH currently staffed to a level that ensures clinical safety for emergency and planned patients?

(h) What more can be done locally to ensure sustainable staffing at the hospital?

(i) To what extent is the cost of temporary staffing contributing to the financial deficit at the QEH?

(j) The commissioners across the Norfolk and Waveney STP have been looking to agree 'block contracts' with the with acute hospitals. This means the hospital receives a fixed amount of funding regardless of how many patients it serves. Has the QEH agreed to a block contract and, given the rise in demand in recent years, is the block contract a sustainable funding basis for the hospital?

(k) The QEH's work on future demand and capacity modelling (as described in Appendix A, paragraph 1.2) was due to be completed by 10 January 2019. What were the bottom-line results of that work?

(l) What has been done specifically to address the divisions in leadership within the maternity service to ensure that all the required improvements in that area can be delivered?

(m) In addition to the service improvements required by CQC there are some high-rated risks in the QEH's risk register relating to hospital building; particularly the roof, the fire safety system and the ventilation system. Given the Trust's current financial position, how can these risks to the building, and consequently the service, be further mitigated?

For discussion with commissioners

(n) NHOSC has heard from commissioners over many years that they are working to shift the NHS emphasis towards primary and community services so that more people can be cared for outside of the acute hospital. How are the commissioners planning to speed up this process in west Norfolk?

(o) Even if the measures that the commissioners are planning for prevention of ill health and primary and community services are very successful, will it still be necessary to increase bed numbers (summer and winter) because of overall population growth and rising demand?

(p) With the QEH forecasting a deficit of £34.2m in 2018-19 and health organisations across Norfolk and Waveney facing a combined deficit of at least £66m, where is the scope for reallocation of resources away from acute care and towards preventative, primary and community services?

4.0 Action

4.1 Following the discussions with representatives at today's meeting, Members may wish to consider whether:-

(a) There is further information or progress updates that the committee wishes to receive at a future meeting or in the NHOSC Briefing.

(b) There are comments or recommendations that the committee wishes to make as a result of today's discussions.

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The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust

REPORT TO THE NORFOLK HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Meeting Date: **17th January 2019**

Report Title: Queen Elizabeth Hospital NHS Foundation Trust report in response to specific questions.

Purpose:

To provide updates and assurance in relation to the following areas;

1. Details of progress against each of the 'must do' and 'should do' actions set out by the CQC.

2. Details of capacity planning for this year and for the future.

3. Details of staffing including:-

    a. Numbers of vacant posts
    b. Staff sickness levels
    c. Numbers of vacant posts and sickness absences covered by locum / agency / bank staff
    d. Additional steps that have been taken to fill vacant posts and cover staff absences since the CQC inspection.

4. The current situation regarding the reported proposal to transfer patients to other hospitals due to insufficient staffing at the QEH.

5. Details of the QEH's financial position and 2018-19 end of year forecast.

Author: **Carly West-Burnham, Head of Strategy**
Owner: **Nick Lyons, Acting CEO**
Date: **07/01/19**
Version: **1.6**

1. **Details of progress against each of the 'must do' and 'should do' actions set out by the CQC.**

   Please see attached separate report. **(Appendix B)**

2. **Details of capacity planning for this year and for the future.**

   The first major national deliverable for the 2019/20 planning round is the Initial Plan Submission on 14th January 2019.

   The Trust will have its internal activity plan signed off by 7th January 2019.

   The Trust's plan will be aligned with the commissioner/STP plans by 11th January 2019.

   The plan submission is being used as a regional checkpoint to assess progress against the demand, capacity and efficiency objectives set out in the planning letter. To support this checkpoint commissioners and providers are being asked to complete activity planning templates for submission and review by the regulator's regional team.

   These plans need to be demonstrably aligned across providers and commissioners. System-level planning should take full account of the significant contribution of specialist services, with STPs/ICSs and NHSE regional hubs expected to work together to ensure alignment of plans.

   The Trust therefore met with the commissioners on 11th December to specifically discuss the guidance and submission requirements for the 14th January, and to agree the initial actions to enable successfully delivery of aligned plans to deadline.

   Forecast Outturns (FOTs) will form the basis for the commissioner and provider plans. The Trust's finance team produced revised FOTs based on month 8 data w/c 24th December 2018.

   Due to the forthcoming changes to Identification Rules (IR) for identifying Specialised Commissioning related activity, the commissioner FOTs for the January collection will be provisional. The FOTs will be refreshed for the February submission template.

   Financial planning returns will not be required for the 14th January and therefore the demand and capacity plans should be based on the capacity, both staffing and beds, that is already in place.

   Activity and capacity plans are being requested for the following items:

   - Referrals – GP, Other
   - Outpatients – First and Follow Up attendances, and outpatient procedures
   - Elective Admissions – Day Case and Ordinary
   - Non-elective Admissions – Zero and 1+ Length of Stay
   - A&E attendances – Type 1 and Other

- Bed numbers

The Trust had the referral planning figures completed by 18th December for review and discussion with the commissioners. The remaining items will be populated based on the revised FOT figures once available.

Plans are not being requested for any performance trajectories, or for RTT activity lines.

For all activity lines the regulators will provide provisional 18/19 FOT data, and require organisations to supply the following:

- Any adjustments to the 18/19 FOT
- A total 19/20 plan figure

This information will allow for the calculation of planned growth percentages for 2019/20. The Commissioning Support Unit (CSU) linked to West Norfolk CCG (the Lead Commissioners) have agreed to look at the Office of National Statistic (ONS) population projections by CCG area to estimate levels of demographic growth.

The 14th January submission also requires a further 3 elements:

- Monthly activity profiles
  Organisations are to provide planned activity figures for each month of the year to ensure plans take account of seasonal demand and capacity.

- Waterfall
  Organisations are to break down planned activity by components of change – for example the amount of additional activity they expect to provide due to demographic or counting & coding changes. This will enable the calculation of 'real' growth rates.

- Alignment data
  Providers are to attribute activity across commissioners, including identifying the proportion of activity expected to come from specialised commissioning and other commissioning. Commissioners have been asked to undertake a similar exercise across their providers.

<u>Indicative Activity Plans</u>

A large element of the planning work centres around the formulation and agreement of the Indicative Activity Plans. A suite of models has been developed by the Informatics and Finance teams that cover four key areas to support the determination of a robust activity plan for 2019/20:

- Demand Model
- Capacity Model
- 2018/19 Forecast Out-turn (Actual Performance)

- Performance Delivery (including 18 Week Referral to Treatment and Cancer 62 Day Waits)

The 2018/19 Forecast Out-turn produced by the Finance team forms the basis for the Trust's plans.

The outputs of these models are being triangulated and cross-validated to determine a robust Indicative Activity Plan which will be reviewed and signed off by the Divisional/Clinical Sign Off Group. Financial modelling that takes account of the impact of the 2019/20 proposed national and local tariffs will then be applied to the activity plan to determine the associated finance for the operational income plan.

The final outputs of this work-stream will be Indicative Activity Plans (IAPs) with associated income at a Point of Delivery and Specialty level, split by commissioner.

Demand Model

This model is intended to show the predicted levels of demand for each specialty, by effectively showing the maximum expected levels of activity that could be treated based on the levels of referrals expected to be received by the Trust.

The starting point was an analysis of referral trends over a 24 month period by specialty. Year to date referral numbers were then extrapolated to year end based on referrals per day over the last quarter.

This formed the expected referral baseline for 2019/20. Further work for the 14th January plan submission is currently being undertaken to split the referrals further by source (GP/Other) and commissioner.

Once the predicted referral numbers were determined, the team analysed the current and historic conversion rates of referrals to new outpatient attendances over the same period. These were then applied to the referral figures to determine the expected Outpatient demand. This is currently being reviewed against the current New to Follow Up ratios and nationally observed ratios (using data from the Dr Foster data source) to sense check the expected outpatient demand.

Current and historic conversion rates from new outpatient attendances to elective Daycase and Inpatient spells were then reviewed to determine the rates to be applied to the outpatient figures to give an estimate of the demand for those services.

Year on year referral levels over the same 12 month period were then analysed to identify an expected level of growth to enable the team to predict the likely levels of referrals that will be received going forward into 2019/20. These figures can be plugged into the model to see the resultant expected impact on outpatient and inpatient activity.

As part of the work-stream for the plan submission on 14th January, the CSU agreed to look at the Office of National Statistic (ONS) population projections by CCG area to estimate levels of demographic growth, and their findings are currently being considered by the Technical Information & Finance group.

Demand that currently exists in the system through Appointment Slot Issues (ASIs), waiting lists and backlogs (linked to the Performance Delivery models) has also been included in the triangulation template to ensure that all expected activity has been captured.

The impact of any commissioning intentions proposed by the Trust that will affect demand levels, or commissioner Quality, Innovation, Productivity and Prevention (QIPP) related admission avoidance schemes are being reviewed by the Technical Information and Finance group. Suitable adjustments will be applied to the model where appropriate.

The Demand model is due to be shared with the commissioners by the end of December 2018, and will be finalised via the triangulation process by 10th January 2019.

Capacity Model

The intended function of the Capacity Model is to identify the activity levels that the Trust should be able to achieve based on its actual core capacity, assuming that the full establishment of workforce is in place. The model is based on a specialty level review of items such as clinic templates for Outpatients and Theatre rotas and bed numbers for Inpatients. Lengths of stay and bed numbers are also being considered. The output is subject to ongoing review with the operational and clinical leads for each Clinical Business Unit (CBU) for their feedback and sign off to ensure that any assumptions are appropriate, and that the core capacity figures are accurate and robust. This process is due to be completed by the 4th January when the triangulation exercise is due to be completed.

The information team is also working with the operational and clinical leads to identify any issues that would result in a deviation from the core capacity levels. This includes such items as additional capacity for non-recurrent activity (e.g. waiting list initiatives (WLIs)), out-sourcing of activity to alternative providers (e.g. Independent Sector), current vacancies and cover arrangements, periods of extended annual leave/long term sickness, recruitment, efficiency gains and the impact of known service changes and commissioning intentions.

These figures are being reviewed and refined through an iterative process with the CBU leads to determine expected capacity figures for each point of delivery and specialty for 2019/20.

2018/19 Forecast Out-turn (Actual Performance)

The forecast out-turn model is intended to show the levels of activity that would be expected for 2019/20 based upon what has actually been deliverable during 2018/19 and previous years. The Finance team have developed a model that is based on current year to date performance, out-

sourcing and run rates for each point of delivery and specialty that forecasts an out-turn position for 2018/19.

Growth assumptions would then be applied to the out-turn to determine a baseline.

The FOT model currently includes items such as backlog clearance.

This has resulted in a model for 2019/20 that reflects actual delivery. The Trust's finance team will be producing revised FOTs based on month 8 data by w/c 24th December and these figures have been reflected in the model and used as the basis of the plan submission on 14th January 2019.

Performance Delivery (including 18 Week Referral to Treatment and Cancer 62 Day Waits)

The Trust has produced a number of models to support in the performance management of key national and local quality requirements, such as the 18 Week Referral to Treatment (RTT) 92% threshold. The outputs of these models, such as total waiting list sizes, and their potential impact will need to be considered when determining the final planned activity and finance levels to ensure that they are aligned to the successful delivery of the required quality standards.

Triangulation Exercise

The Information and Finance teams are undertaking a series of reviews and discussions with the operational and clinical divisional leads regarding the triangulation and cross-validation of the outputs. This exercise is due to be completed by 10th January 2019.

This will ultimately result in the determination of a robust Indicative Activity Plan (IAP) at Trust Level anchored to the FOT.

As in the planning round for 2018/19, this work require a series of meetings between divisional leads and executives to discuss any gaps identified between the expected levels of Demand, Capacity and Actual delivery, and what mitigating actions can be taken to close them. These actions and their associated level of risk will be reviewed and signed off by the Divisional/Clinical Sign Off Group.

This process will also include a revisit of the activity levels that were agreed and signed off by the divisional operational and clinical leads for 2018/19 and 2017/18. As those levels were expected to be achievable at the point of sign off, there will need to be clear and detailed understanding of the issues and drivers where those levels have not been realised in-year. The review will need to establish if the remedial actions that were agreed have been implemented, and the barriers where this has not been the case. An assessment of current activity run rates will need to be made to reaffirm if the activity levels are still achievable, or if alternative remedial actions would be required, with clear timescales regarding their planned implementation as appropriate.

Workforce Planning

Upon completion of the Triangulation Exercise, the outputs will be aligned to the planning for Workforce.

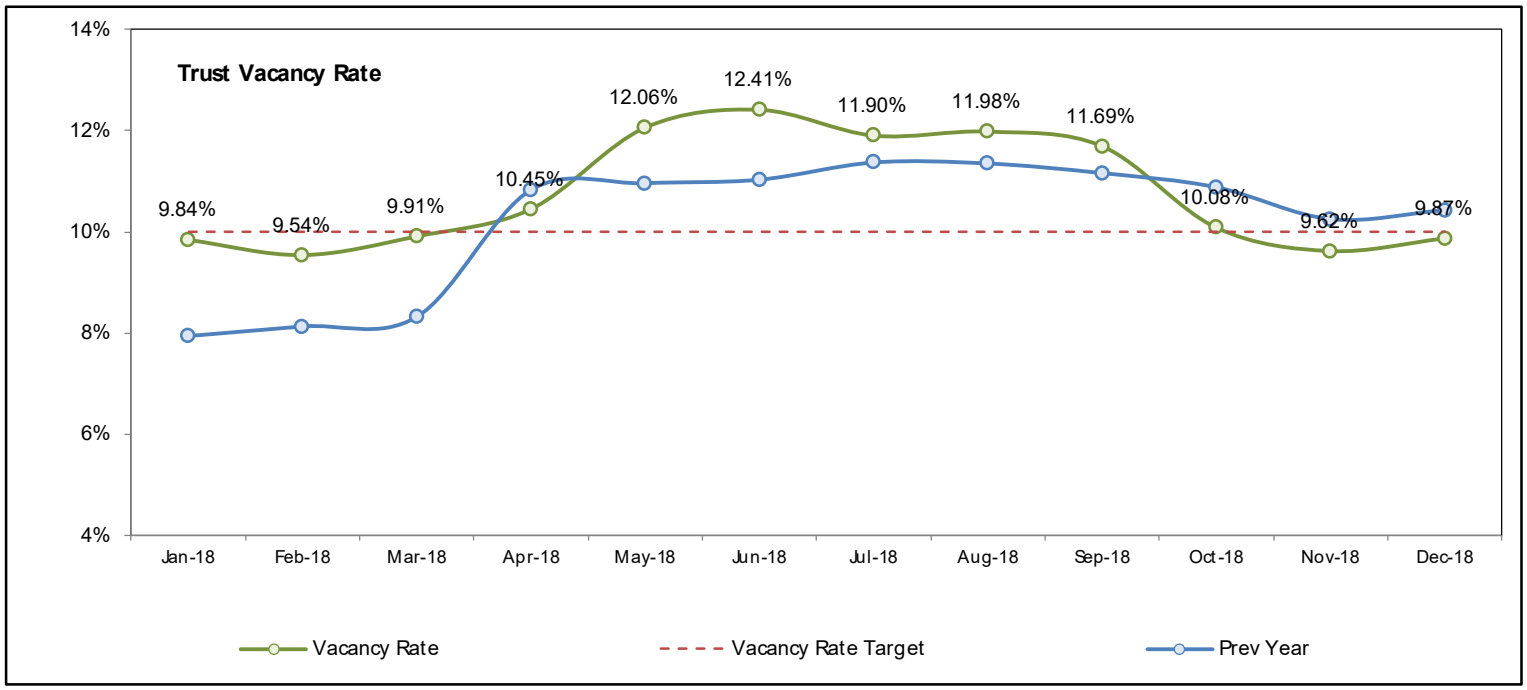
The number of Whole Time Equivalents (WTEs) across all areas that are required to deliver the plans will be modelled, along with all supporting services. This exercise will need to consider the impact of any commissioning intentions and service changes.

Any areas of recruitment and retention risk will be identified, with contingency actions drawn up for each as appropriate. This will enable a full HR Structure to be developed which will also support the production of the Trust's Operational Plan.

3. Details of staffing including:-

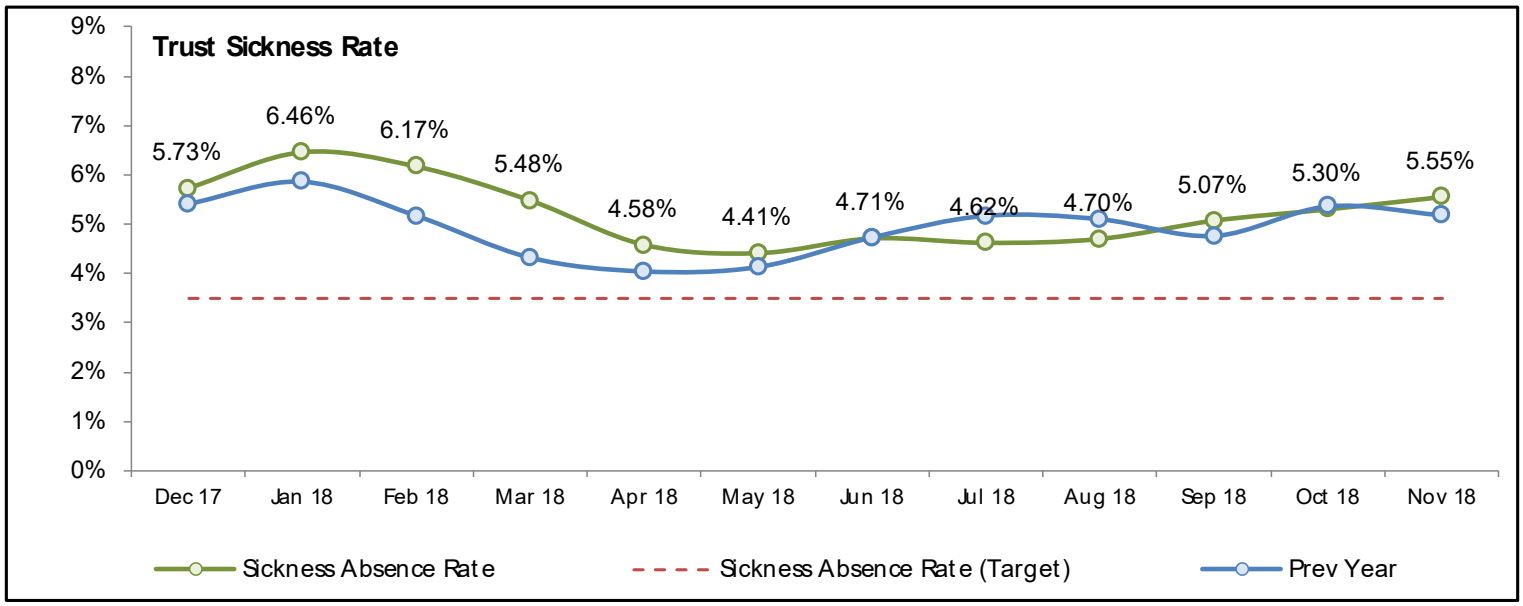
a. Numbers of vacant posts – as at 21st December 2018

Row Labels	Sum of FTE Budgeted	Sum of FTE Actual	Sum of FTE Variance	% FTE Variance
Add Prof Scientific and Technic	109.88	112.72	2.84	2.58%
Additional Clinical Services	577.75	541.30	-36.45	-6.31%
Administrative and Clerical	585.17	546.08	-39.09	-6.68%
Allied Health Professionals	157.10	153.18	-3.92	-2.49%
Estates and Ancillary	348.42	304.15	-44.27	-12.71%
Healthcare Scientists	34.94	28.60	-6.34	-18.15%
Medical and Dental	397.49	369.43	-28.06	-7.06%
Nursing and Midwifery Registered	959.69	801.90	-157.79	-16.44%
Students	2.00	2.00	0.00	0.00%
Grand Total	**3172.44**	**2859.37**	**-313.07**	**-9.87%**



b. **Staff sickness levels –** as at 30th November 2018

Summary Sickness Absence Trust Level	
2017 / 12	5.74%
2018 / 01	6.46%
2018 / 02	6.09%
2018 / 03	5.48%
2018 / 04	4.58%
2018 / 05	4.41%
2018 / 06	4.72%
2018 / 07	4.62%
2018 / 08	4.70%
2018 / 09	5.07%
2018 / 10	5.30%
2018 / 11	5.55%



c. **Numbers of vacant posts and sickness absences covered by locum / agency / bank staff**

Medical – there are currently 42 Locum Doctors within the Trust who are covering vacant posts / sickness.

Nursing – November data. 203 whole time equivalent bank and agency nursing staff utilised to cover sickness and vacancies.

d. **Additional steps that have been taken to fill vacant posts and cover staff absences since the CQC inspection.**

- Increased Registered Nurse (RN) fill rate

- Increased oversight of staffing levels and % of agency use on each ward to allow improved decision-making in relation to staff movement
- Maintained high Friends and Family Test (FFT) scores within all ward areas
- Reduction in recruitment process to a rolling cycle of 7 weeks
- Review of International Recruitment process and agencies (prediction 10 every 6 weeks – 5 joining in January)
- Student nurse fast-track offer process and recruitment incentives
- Recruitment incentives agreed
- Enhanced bank payments over the Christmas period
- Nursing pipeline and vacancy information produced on a weekly basis

Retention initiatives;
A number of initiatives are being developed and implemented that will aid retention. Whilst there are some initiatives that are specific and being piloted within nursing there is an intention to roll these out across all staff groups if appropriate.

Reporting Concerns;
Who can I tell sessions have been held. These sessions covered the outcome of the CQC report and the associated action plan. The session also explained how individuals can raise concerns and the channels that are available for staff to raise these concerns.

Training opportunities;
Leadership development offered to senior managers
360 degree appraisals have been rolled out for band sevens and above in maternity services and outcomes are being provided to these members of staff

Increased Engagement;
Cultural workshops with specific services have been held or are due to be held where the staff survey and staff FFT have raised concerns about the behaviours within the departments

The Trust continues to run Schwartz rounds which focusses on the emotional impact rather than clinical learning

Chief Executive information sessions and briefings with staff continue to take place and allow staff to raise concerns

The new values have been launched and the Trust will be reintroducing values awards for all staff groups

Be Well – Staff Health and Well Being;
The Trust has agreed to pay the fee for the EU settlement scheme to allow staff to apply through the early stage of this process

Health and well-being initiatives including mindfulness training, training for managers in managing mental health in the workplace are being developed.

The Service eye care has been attending the Trust throughout November and this has been well attended.

Health promotion work continues to take place and is centred around national campaigns

Just for You;

- East of England based Credit union in partnership with Joint Strategic Commissioning Committee
- Neyber financial advice to staff
- NHS discounts for staff both locally and nationally

Retention initiatives specifically for nursing staff;

- Local university recruitment programme commenced
- Internal nurse transfer policy and stay conversations
- Band 7 and 6 development programme

Health and Wellbeing Initiatives will be highlighted in the two campaigns “Be Well” and “Just for You” in January 2018.

Following feedback and suggestions from the November Trust Board the HR Division are reviewing how they could utilise the “Why are you staying” question to gather additional ideas from staff to further inform next year’s implementation Plan.

4. The current situation regarding the reported proposal to transfer patients to other hospitals due to insufficient staffing at the QEH.

The Trust has explored the option of the transfer of urgent and cancer patients to NNUH but this is not being taken forward for a number of reasons.

The Trust have put in place an alternative scheme (implemented during the first week of January) to enable the running of an extended recovery unit staffed by theatre staff to accommodate the vast majority of the planned elective work.

In addition the Trust is continuing to work with Independent Sector Providers (ISP) to ensure that we are able to offer routine elective surgery to as many of our patients as possible.

5. Details of the QEH's financial position and 2018-19 end of year forecast.

5.1 Year to date financial position

At the end of November, the year to date, the Trust has made a pre-Provider Sustainability Fund (PSF) loss of **£22.4m**, £10.5m adverse to the pre-PSF plan and **£13.9m** adverse to the NHSI control total (which includes planned receipt of PSF).

The 2018/19 financial plan was finalised prior to the conclusion of pay award negotiations for NHS staff employed under "Agenda for Change" terms and conditions of employment (the majority of NHS staff, excluding the medical workforce).

Additional funding in the form of income has been provided to offset the unplanned cost element of the pay award settlement. The impact of the additional funding and cost is separately identified in the table below in order to show the underlying operational variances.

Subjective	YTD 2018/19 £000	A4C > 1% £000	Variance exc > 1% A4C £000	Variance
Clinical Income	(4,198)	1,440	(5,638)	Adverse
Other Income	(131)		(131)	Adverse
Pay	(3,821)	(1,440)	(2,381)	Adverse
Non Pay	(2,447)		(2,447)	Adverse
Financing Costs	60		60	Favourable
PRE-PROVIDER SUSTAINABILITY FUND VARIANCE	**(10,537)**	**0**	**(10,537)**	**Adverse**
Provider Sustainability Fund	(3,356)		(3,356)	Adverse
CONTROL TOTAL VARIANCE	**(13,893)**	**0**	**(13,893)**	**Adverse**
Other items outside of control total deficit	(49)		(49)	Adverse
Net (Deficit)/Surplus	**(13,942)**	**0**	**(13,942)**	**Adverse**

The year to date adverse to plan financial performance is driven by:

- Planned productivity improvements not being achieved (reflected in the clinical income variance).
- Unplanned costs incurred to improve service quality and
- Failure to deliver the planned level of cash releasing cost savings.

5.2 Forecast outturn financial position

Incorporating all appropriate and known factors, the assessed forecast outturn at the end of September 2018 was for a £34.2m pre-Provider Sustainability Fund

(PSF) deficit. A deficit of £34.2m will be **£18.4m adverse to the pre-PSF plan** and £24.5m adverse to the control total agreed with the Regulator.

The key drivers of the £18.4m adverse position to the original 2018/19 Trust financial plan can be summarised as follows:

- Under delivery of clinical income of £8.1m adverse
- Under delivery of Cost Improvement Programmes (CIPs) £4.9m adverse
- Pay net overspends of £2.6m adverse
- Non Pay overspends of £2.3m adverse
- Under delivery of other income £0.6m adverse
- Underspend in financing costs of £0.1m favourable

Immediate grip & control actions to assist with the delivery of, and potentially improve upon, the 2018/19 £34.2m deficit forecast outturn have been implemented. However, risks to the forecast outturn are though at a greater scale than the currently identified in-year mitigations.

5.3 Risks to forecast outturn

Currently the identified risks to the forecast outturn are:

- Delivery of forecast levels of elective income and the impact of winter pressure
- Out-patient productivity.
- Commissioner claims in relation to 2018/19 and also to 2017/18 are an ongoing point of dispute and negotiation.
- The forecast level of cash releasing cost reductions not being achieved, particularly planned workforce and procurement savings.

Currently the additional mitigations that could improve the forecast are:

- Grip and control measures operationalised.
- Financial Recovery Board (FRB) instituted.
- Developing Service Line Reporting specialty/Clinical Business Unit specific bottom up staged recovery targets aligned to Model Hospital/Reference Cost peer performance.
- Outline brief developed for additional external expertise and capacity to support to delivery of forecast outturn.

The Queen Elizabeth Hospital King's Lynn
NHS Foundation Trust

NHOSC Report
The Quality Improvement Plan Progress Update: January 2019

Quality Improvement Programme

Background and Context

The Care Quality Commission (CQC) report published on 13th September 2018, confirmed the Trust's rating of 'Inadequate' and NHS Improvement (NHSi) placed the Trust in Special Measures, with the appointment of an Improvement Director: Philippa Slinger.

To effectively deliver the 'Must' and 'Should Do' actions outlined in the CQC report, a Quality Improvement Programme was established and a Quality Improvement Plan (QIP) developed. The Trust appointed Louise Notley; Associate Director of Quality Improvement as it's Programme Director.

Quality Improvement Plan (QIP)

The QIP is split into 5 workstreams, each with an Executive Lead, accountable for the delivery of the required improvement actions. The Musts and Shoulds have been aligned to the respective workstreams and themed where duplicate actions have been identified.

Workstreams and Executive Leads

Trust Quality Improvement Plan (QIP)				
People	**Caring Safely**	**Environment**	**Performance**	**Governance & Learning**
Exec Lead Karen Charman	**Exec Lead Emma Hardwick**	**Exec Lead Roy Jackson**	**Exec Lead Jon Wade**	**Exec Lead Nick Lyons**

Based on these workstreams, a 'high level' Quality Improvement Plan (QIP) has been developed which details the actions the Trust has agreed to undertake to address both the immediate actions and some longer term quality improvement actions. The plan also includes the Section 29A Warning Notice from May 2018 and the subsequent actions following the Maternity Section 31 Enforcement Notice.

The need to immediately address regulatory compliance breaches has generated a QIP which is largely transactional in its delivery. Whilst it is recognised this approach is required during the early stages of our improvement journey, it is essential that staff and patients play a central role in the development and delivery of the quality improvement programme going forwards. The QIP therefore recognises the need to develop a Quality Improvement Strategy to support a culture of continual quality improvement and learning in the organisation.

A Quality Improvement Team has been established led by the Associate Director of Quality Improvement and currently supported by an existing Quality Project Manager and three interim Quality Improvement Managers. The Quality Improvement Managers are aligned to specific workstreams and its respective accountable Executive. The Trust is in the process of recruiting three Quality Improvement Managers to replace the interim staff in place, for a

fixed period of eighteen months to support the Trust's immediate and longer-term quality improvements and initiatives and the required cultural change which is an essential component of the Trust's work to engage with staff and sustain change. The aim is to complete the recruitment phase of this process by mid-January 2019 with all three staff in post by March 2019, depending on negotiated notice periods.

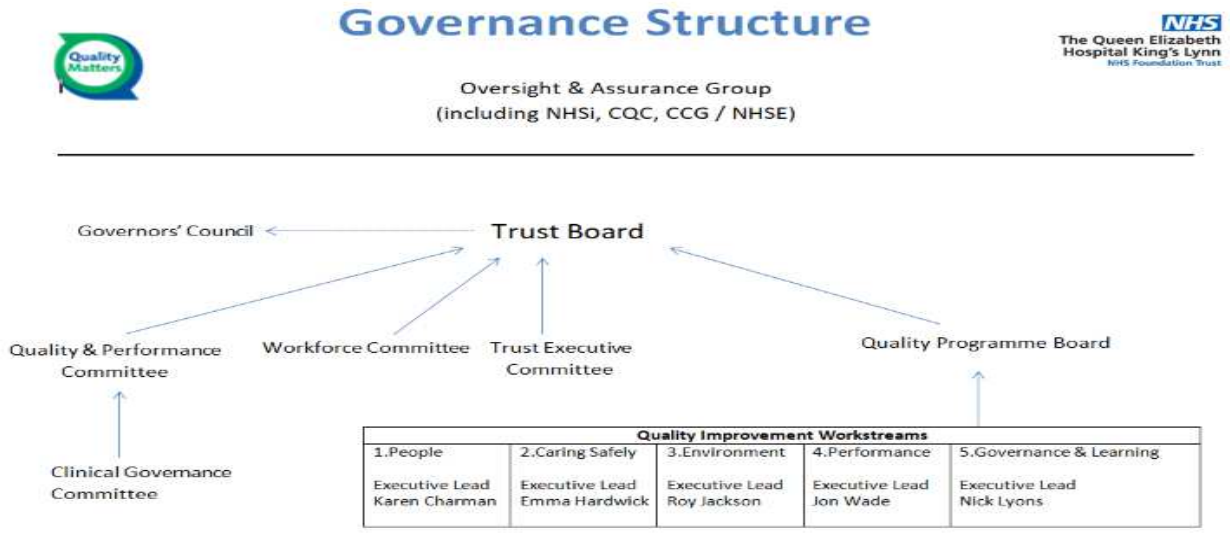
Governance Arrangements

The governance and reporting arrangements for the Quality Improvement Programme have been finalised and are fully operationalised. This includes the establishment of a Quality Improvement Evidence Group with staff, patient and CCG representatives to review the evidence of actions submitted as complete.

As work has commenced progressing the QIP and exploring actions in detail, there has been a need to alter a number of action owners and deadline dates where it has been identified that the issue is more complex than first thought or that more detailed work is required to effectively address the Must or Should action. In turn, it is anticipated that a number of actions will need to be added to ensure that the impact of actions are evaluated. A Change Control Process, adopted from the NNUHT, has been established to ensure there is a clear audit trail of any changes and provides complete transparency of changes to the original QIP.

A Metrics Dashboard is under development which will capture and track the monthly outcome metrics of specific improvement actions such as Mandatory and Cardiotocography (CTG) training (a Section 31 Action). An early draft of this dashboard was presented to the Quality Programme Board (QPB) in December with the launch of the dashboard planned for the January QPB. The dashboard will evolve with the QIP.

Governance Structure for the Quality Improvement Programme.



Unannounced CQC Inspection Maternity December 2018

There was an unannounced CQC Inspection on the 4th December to review the Section 31 conditions and progress against Section 29A for Maternity Services.

The Trust is awaiting formal feedback.

Initial verbal feedback:

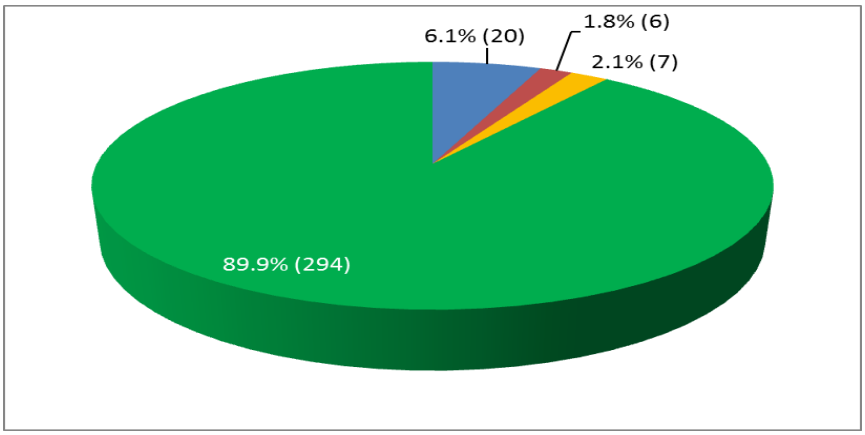
- A positive visit – 'palpable difference'
- Evidence of improvements provided a level of assurance
- The strengthening of leadership within the department is making a difference
- Progress must be sustained to ensure improvements embedded in practice

There remains continued support with onsite visits from NHSI Maternity Advisors and improvement work to progress the actions within the QIP continues.

Combined QIP Workstreams Progress Report as Presented to Quality Programme Board December 2018

ASSURANCE - all workstreams

(December)



ACTION BRAG STATUS (current month)

Red	Amber	Green	Blue
6	7	294	20
1.6 %	2.1%	89.9%	6.1%

BRAG Status and Definitions

A comprehensive and productive discussion was held by members of the QPB on 6th December regarding the BRAG status of actions following recalibration of the QIP. As part of this discussion there was concern that the current workstream highlight reports do not accurately reflect actions with an 'inherent risk', or where there is 'a risk of effective delivery' and that Blue ratings do not accurately reflect improvement actions which are complete, evidenced and where there is assurance that the required outcome has been achieved and embedded.

Following a detailed discussion, the QPB agreed to amend the AMBER and BLUE BRAG definitions, to ensure that they accurately reflect that the progress of quality improvement actions is having the desired impact, addressing both the original concern and providing the required level of assurance that actions have improved the quality of care patients receive.

Clarity to the BLUE and AMBER BRAG definitions agreed:

- AMBER – 'inherent risk or risk to effective delivery'
- BLUE – 'complete, evidenced, required outcome assured / sustained'

It is anticipated that a number of GREEN actions within each workstream will move to BRAG status of AMBER in the January QPB report to accurately reflect the level of inherent risk within the action, or risk of its effective delivery. It is also anticipated that a number of BLUE actions will move to a BRAG status of GREEN to accurately reflect work completed and evidenced, but where evidence that actions are embedded in practice is still required.

BRAG Status Definition Revision

Table 1

Original QIP BRAG Status	
Blue	Completed and Evidenced
Red	Overdue
Amber	At Risk of Delivery
Green	On Track

Table 2

Revised QIP BRAG Status	
Blue	Complete, Evidenced and Required Outcome Assured / Sustained
Red	Overdue
Amber	Inherent Risk or Risk of Effective Delivery
Green	On Track

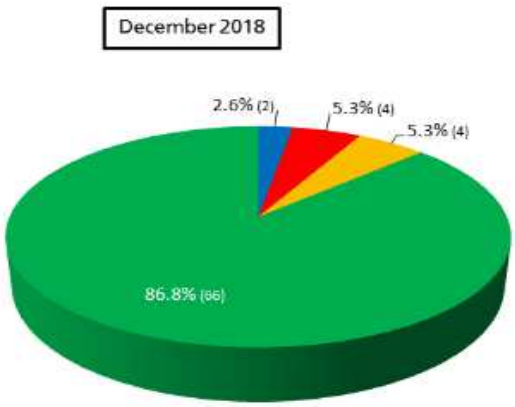
It was agreed at the QPB that these revised BRAG definitions will be applied to individual workstream highlight reports as of **January 2019** for reporting to the January QPB and Oversight and Assurance Groups (OAG). Therefore the workstream highlight reports captured in this report, reflect the action status of the original BRAG definitions as detailed in **Table 1** above.

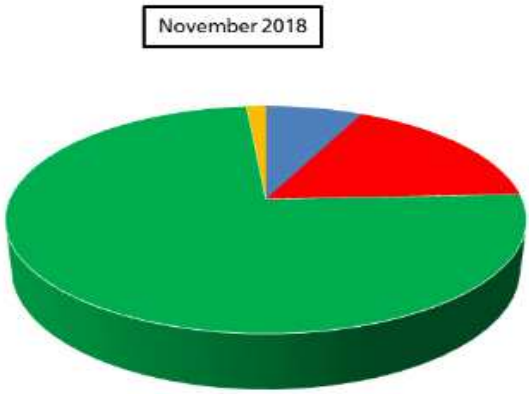
Number of actions by BRAG status in each CQC domain

CQC Domain	Red	Amber	Green	Blue	TOTAL
Safe	**1**	**3**	**146**	**10**	**160**
Safe, previous 6 months	17	29	91	17	Nov-2018
Effective	**0**	**1**	**33**	**3**	**37**
Effective, previous 6 months	3	5	25	3	Nov-2018
Caring	**0**	**0**	**1**	**4**	**5**
Caring, previous 6 months	0	0	1	7	Nov-2018
Responsive	**1**	**1**	**57**	**1**	**60**
Responsive, previous 6 months	5	8	41	6	Nov-2018
Well-led	**4**	**2**	**57**	**2**	**65**
Well-led, previous 6 months	15	4	37	7	Nov-2018

People Workstream

Executive Lead Karen Charman; Director of HR and OD



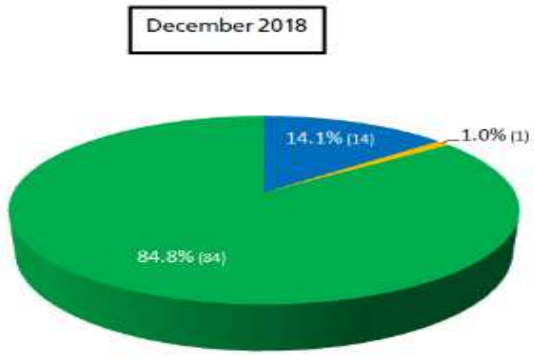


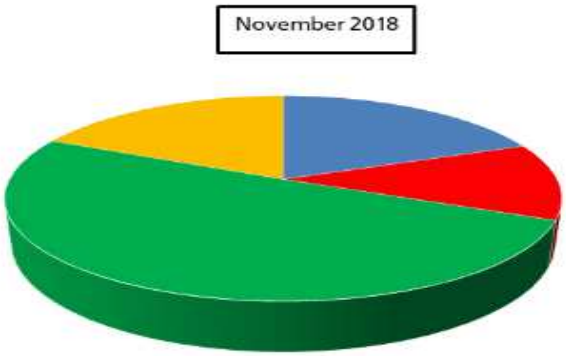
ACTION STATUS (current month)

	Red	Amber	Green	Blue
No.	4	4	66	2
%	5.3	5.3	86.8	2.6

Caring Safely Workstream

Executive Lead Emma Hardwick; Chief Nurse

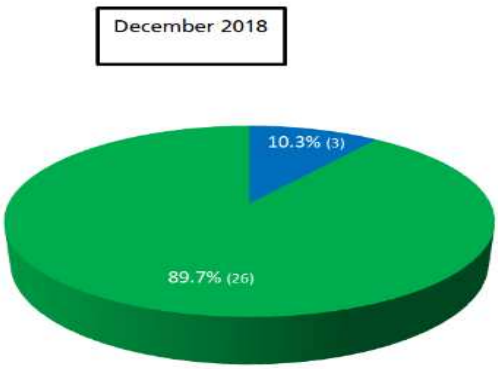


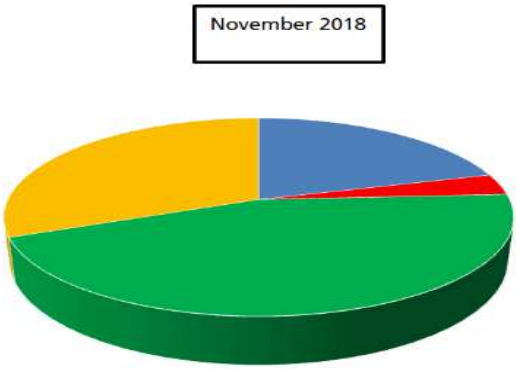


ACTION STATUS (current month)

	Red	Amber	Green	Blue
No.	0	1	84	14
%	0	1	84.8	14.1

Environment Workstream
Executive Lead Roy Jackson; Director of Resources and Finance

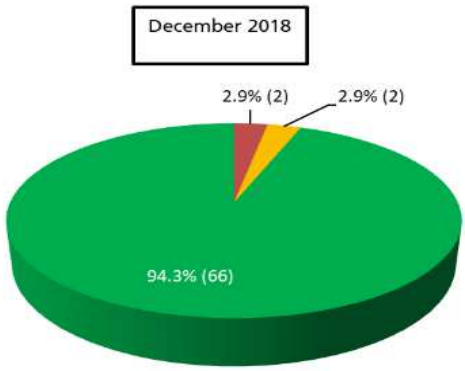


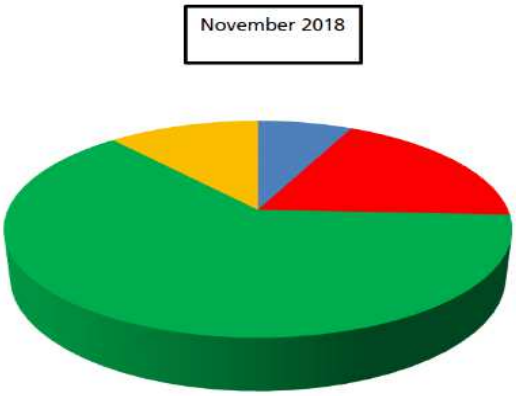


ACTION STATUS (current month)

	Red	Amber	Green	Blue
No.	0	0	26	3
%	0	0	89.7	10.3

Performance Workstream
Executive Lead Jon Wade; Chief Operating Officer

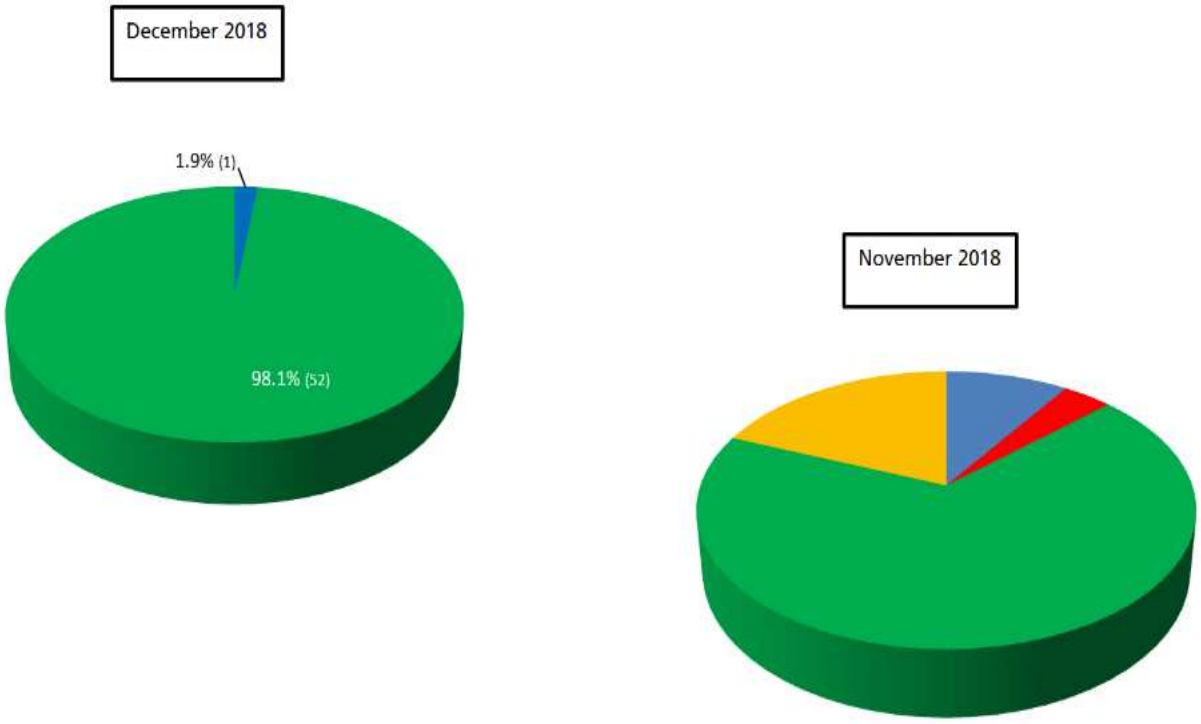




ACTION STATUS (current month)

	Red	Amber	Green	Blue
No.	2	2	66	0
%	2.9	2.9	94.3	0

Governance and Learning Workstream
Executive Lead; Nick Lyons Medical Director



ACTION STATUS (current month)

	Red	Amber	Green	Blue
No.	0	0	52	1
%	0	0	98.1	1.9

The CQC inspection covered 7 core services and stipulated 94 Must and Should Do actions in total. A number of these Musts and Shoulds were identified in more than one core service, these were therefore combined and themed within the overarching QIP.

A varying number of actions have been assigned to each Must and Should, depending on the extent of the issue and work required. The QIP is therefore made up of the 98 Must and Shoulds supported by a total of 327 individual actions. The progress of these individual actions are BRAG rated each month and progress against each is detailed in a highlight report. These detailed workstream reports are presented to the QPB each month where the Workstream Executives Directors are accountable for updating on the progress of their workstreams, focusing on the Red and Blue actions, risks and mitigations.

Two example workstream highlight reports have been included to illustrate the varying number of individual actions and level of information provided to both the QPB and OAG.

Highlight Report to: December QPB

Domain
Safe

Action RAG Rating			
Overdue or not on track	At risk of delivery	On Track	Complete & Evidenced

Workstream	Executive Lead / Senior Responsible Officer (SRO)	Improvement Manager	Completion date submitted to CQC on QIP	
Environment E6	Roy Jackson	José García Escudero	Initial	Revised
			01/10/2018	01/10/2018
MUST DO Recommendation:	**Must 3.30** 30. Surgery - The trust **must** ensure that plans to improve arrangements for disposing of waste on Surgical Assessment Unit (SAU) and Elm ward are implemented, to ensure compliance with infection prevention and control (IPC) procedures.			
We will have achieved GOOD when:	• Installation of new sluice on Elm ward facilities to be undertaken as part of ward cleaning enabling works.			
Issue:	SAU and Elm Ward did not have appropriate facilities for disposal of clinical waste.			
Exec Summary:	Actions completed.			

Actions	Progress update and next Steps	Action RAG
E6.1 Review of facilities and install new sluice which meets IPC standards and ensures the appropriate disposal of waste.	**Progress:** Action completed, new sluice installed **Next steps:** • Action recommended for closure. **Evidence:** • Sluice pictures: IMG_20181123_125936, IMG_20181123_125941, IMG_20181123_125955, IMG_20181123_125959 and IMG_20181123_130016. • Sluice IPC compliance confirmation- email.	

Risks/Issues	Mitigating Actions	Escalation & Decisions for QPB
N/A		

The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust

Highlight Report to: December QPB

Domain
Well-led

Action RAG Rating			
Overdue or not on track	At risk of delivery	On Track	Complete & Evidenced

Workstream	Executive Lead / SRO	Improvement Manager	Completion date submitted to CQC on QIP	
Governance & Learning GL1	Nick Lyons	José García Escudero	Initial	Revised
			31/12/2019	31/03/2019
MUST DO Recommendation:	**Regulation 17, Must 5.4, Must 5.36, Must 5.40, Should 5.86** 4. Trust Overall - The trust **must** ensure that there is an effective process for governance, quality improvement and risk management in all departments. 36. Surgery - The trust **must** ensure there are clear governance processes in place, particularly in relation to the monitoring of safety checks in theatre, identification and management of risk and reporting of performance to the board. 40. Maternity - The trust **must** ensure that there are effective processes in place for quality improvement and risk management. 86. Outpatients - The trust **should** ensure that there is an effective process for quality improvement and risk management.			
We will have achieved GOOD when:	• Updated ToR and Agenda approved and distributed to all Divisional and CBU Triumvirates • 100% of Divisional and CBU Triumvirate attend one of the workshops planned. • Accountability Framework to be introduced with an implementation strategy and support for Divisional and CBUs to work in line with this framework. • Report and recommendations to be submitted to Clinical Governance Committee for consideration and action to ensure effective arrangements for the Divisions are in place. • Divisional organograms will be updated and displayed within ward/depts.			
Issue	Arrangements for governance and performance management do not operate effectively and new Divisional Structure needs to become embedded within the organisation			
Exec Summary:	Although tasks associated to the actions have been completed (ToRs and agendas) or progress is very advanced (training), no impact evaluation has been completed. Initial examination of evidence suggests that implementation requires further efforts so deadlines have been revised. The completion of the Accountability Framework is fundamental for the progress of other actions within the workstream.			

Actions	Progress update and next Steps	Action RAG

Actions	Progress update and next Steps	Action RAG
GL1.1 Review and update the TOR and agendas for the new Divisional Board and CBUs to ensure ward to board quality governance and performance is robust.	**Progress:** ToRs and agendas have been reviewed, updated and made available to be used in relevant meetings (sent out as part of a 'pack' to all Triumvirate teams and available on the intranet). Initial examination of evidence indicated that further work is needed in embedding the templates developed (approved templates are not always used, some items in the agenda are never covered in the meeting, ToRs have been modified from the template and not approved, etc.). **Next steps:** • To implement documents and evaluate impact. • To complete the recruitment of the band 3 administration support role. **Action changes**: • Deadline moved to 28/02/19. • Action status changed from 'Overdue or not on track' (red) to 'On track' (green).	
GL1.2 Divisional Board and CBU Chairs and administrators to attend Governance and Chair / administrator Training Workshops to support the effective working of these meetings.	**Progress:** Training materials for 'Chairs' have been developed and training was provided to some of them on the 09/10/18 and for 'Administrators' on the 18/10/18. N**ext steps:** • Evaluation of the action has not been completed yet, however, when examining the evidence for the action above, it has been found that the effectiveness of these meetings could be improved. • Training to be completed for all identified individuals. **Action changes**: • Deadline (31/12/19, typing error) to be changed to 31/01/19.	
GL1.3 Accountability Framework to be developed and introduced into the organisation with a clear implementation strategy with support and training for the Divisional Boards and CBU leads to ensure this is implemented effectively.	**Progress:** Accountability Framework due to be presented at Trust Executive Committee (TEC) for approval on the 13/12/18 (it was planned for November's meeting, but meeting was cancelled). **Next steps:** • See risks section.	

Actions	Progress update and next Steps	Action RAG
GL1.4 To carry out a review of the Risk and Governance resource and support to the Divisions to ensure they effectively support Divisional ability to work in accordance with the Accountability Framework in respect of risk management, quality improvement and governance.	**Progress:** Review has been carried out. It is in the process of being documented. **Next steps:** • See risks section for GL1.3.	
GL1.5 Divisional organograms to be updated to reflect new divisional structure, CBUs and Specialties to support staffs understanding of where they sit with the new operational and governance structure.	**Progress:** Divisional organigrams have been updated and distributed to the relevant colleagues for displaying in relevant areas and communication to team members. There are plans to make these documents available in the intranet and to formally define the document management arrangements for them. The impact of the action has not been evaluated yet. **Next steps:** • To evaluate the understanding of colleagues in relation to the structure and composition of their senior team and their reporting lines. This evaluation is to be integrated within the current Quality Assurance Visit process. **Action changes**: • Deadline moved to 31/03/19. • Action status changed from 'Completed & evidenced' (blue) to 'On track' (green).	

Risks/Issues	Mitigating Actions	Escalation & Decisions for QPB
GL1.3: Deadline stack for actions GL1.4, GL4.3, GL8.3 and GL13.3 will prevent the completion of actions within their deadline since they all depend of GL1.3 being completed. The deadline for the former is later or the same than the deadline for GL1.3.	Deadline review for all related actions.	Actions GL1.4, GL4.3, GL8.3 and GL13.3 are of high importance. By reviewing the deadlines for these actions, the margin of time for implementation prior to the expected CQC inspection will be reduced significantly.

Must & Should Do Actions
Summary Update as of December 2018

'MUST/SHOULD' Action	Workstream	Update
1. Trust Overall The trust must ensure that mandatory training attendance, including training on infection prevention and control and Safeguarding of vulnerable children and adults, improves to ensure that all staff are aware of current practices.	People ID : P1 / P2 / P3 Actions : 3 / 3 / 3 (see also 56)	An implementation plan for improved access to Mandatory Training via e-learning is being submitted to the November 2018 Workforce Committee. Full promotion and comms to support in early January 2019. Developing mandatory training trajectories by Divisions and CBUs and will be validated by the increased access via e-learning. Dashboards will be presented at Divisional Board Meetings to monitor improvement trajectories to ensure compliance by 31/05/19
2. Trust Overall The trust must ensure patient care records are accurate, complete and contemporaneous. This includes the accurate and consistent completion of weight and nutritional assessments and fluid balance charts.	Caring Safely ID : CS1 / CS20 Actions : 10 / 7 (see also 81)	Nursing Assessment launch delayed at printers and new deadline set for end of December 2018. Following Policy launch in November, proposed to test embedding of Record Keeping Policy over 6 months period. Deadline for full implementation revised to end of April 2019 to measure impact across 3 audit phases.
3. Trust Overall The trust must ensure mental capacity assessments are consistently and competently carried out where required.	Caring Safely ID : CS3 Actions : 9 (see also 51, 56)	Review of Mental Capacity Act / Deprivation of Liberty Safeguards (MCA/DoLS) actions required following appointment of new Action Owner 19/11. Develop new approach to ensure processes and assessments are embedded in practice. This includes the establishment of new MCA/DoLS Group to report directly to Adult Safeguarding Committee. Group will oversee all MCA/DoLS activities Trust-wide. New assessment tool is in place. New actions will be developed to reflect enhanced approach and revised deadlines identified.
4. Trust Overall The trust must ensure that there is an effective process for governance, quality improvement and risk management in all departments.	Governance - Learning ID : GL1 / GL3 Actions : 5 / 9 (see also 36, 40, 86)	Although tasks associated to the actions have been completed (ToRs and agendas) or progress is very advanced (training), no impact evaluation has been completed. Initial examination of evidence suggests that implementation requires further efforts so deadlines have been revised. The completion of the Accountability Framework is fundamental for the progress of other actions within the workstream.
5. Trust Overall The trust must ensure that processes for incident reporting, investigation, actions and learning are embedded across all services. Including effective monitoring of incident categorisation, grading, trend analysis and processes for staff to learn from incidents.	Governance - Learning ID : GL4 / GL5 Actions : 6 / 1 (see also 6, 7)	Although deadlines for most actions are not until 31/12/18 or later, the implementation of some actions has not started. In other cases the full development and implementation of actions depend on the development and implementation of the Accountability Framework, for which deadline is the same or later than the one which relates to these depending actions. The amount of actions that are the responsibility of one individual owner may affect the capacity for delivering actions as planned. Deadline has been extended to allow documenting findings and developing of action plan.
6. Trust Overall The trust must ensure that serious incidents are identified, reported and investigated in a timely manner.	Governance - Learning ID : GL4 Actions : 6 (see also 5, 7)	See Above

'MUST/SHOULD' Action	Workstream	Update
7. Trust Overall The trust must ensure that the duty of candour is carried out as soon as reasonably practicable, in line with national guidance.	Governance - Learning ID : GL4 Actions : 6 (see also 5, 6)	See Above
8. Trust Overall The trust must ensure that recommendations and learnings from regulators, external reviews and local audit are utilised to identify actions for improvement and that these are monitored and reviewed.	Governance - Learning ID : GL9 / GL11 Actions : 3 / 1 (see also 45, 65, 83, 87)	Governance Structure has been reviewed to include a Clinical Audit Committee. ToR for this Committee will be discussed and, if appropriate, approved by the Clinical Governance Committee meeting in second week of January 2019. The first meeting of the formalised Clinical Audit Committee will take place in January 2019. The implementation of the reviewed 'Management of External Agency Inspections, Reviews and Accreditations Visits Framework' requires deadlines to be extended. Evaluation required the extension of the deadline for the completion of the action.
9. Trust Overall The trust must ensure clear processes are in place for sharing learning from incidents, complaints and audits with staff.	Governance - Learning ID : GL7 Actions : 5 (see also 69)	These actions can be linked to GL4.6 although deadlines for them are far more restrictive. No progress has been reported for these actions but reviewed deadlines and consistency of ownership will allow effective implementation. Work on stacking deadlines across different topics within the workstream is being carried out so deadline changes optimise the sequence of actions. New complaints process has been introduced; however compliance with 24hr call back cannot currently be evidenced in all cases.
10. Trust Overall The trust must improve the functionality of the board and ensure formalised processes are in place for the development and support of both current and new executive directors.	People ID : P19 Actions : 1	The review is completing w/e 02/12/18 with the draft report likely in the first half of December. The CEO had thought it might be possible to complete the action, which is the development of a formalised development and support plan for both current and future execs. Whilst in theory, it is possible to have this agreed in December, it is likely this will be late Jan to mid Feb.
11. Trust Overall The trust must ensure that effective processes are in place, and monitored, to ensure clinical policies and guidelines are regularly reviewed and updated in line with national guidance.	Governance - Learning ID : GL12 Actions :3 (see also 22,43)	Extensive work undertaken in Maternity to ensure policies are in date. Reviewed as part of recent CQC unannounced Section 31 visit. Funding has been approved for the Datix document management module and that a project manager for implementation is available. Once the Datix module is implemented, deadline for this action will be more accurate.
12. Trust Overall The trust must ensure that the information used to monitor, manage and report on quality and performance is accurate, valid, reliable, timely and relevant	Performance ID : PF10 Actions : 8	Deadline changed to reflect month end closure report run to provide up to date evidence. Roll out commenced with 30 licenses for Senior Ops Managers with wider roll-out to be confirmed. Deadline will need revisit with IT and SRO.
13. Trust Overall The trust must continue to review the bed management and site management processes within the organisation to increase capacity and flow and ensure effective formalised processes are in place to ensure patient safety in any escalation areas when in use.	Performance ID : PF1 Actions : 7 (See also 62)	Review of all actions has identified original deadlines required review/confirmation. Pathways are in place, evidence for one action to be presented for closure in January. On track for completion for all other actions.
14. Trust Overall The trust must improve the culture, working relationships and engagement of consultant staff across all services.	People ID : P13 Actions : 6	Engagement Survey sent out to all medical staff for three weeks. Results will be assessed and a set of agreed actions will follow. Representatives from QEH FT are fully signed up to participate in the NHSI Leadership and Culture Change programme.

'MUST/SHOULD' Action	Workstream	Update
15. Trust Overall The trust must ensure that effective process for the management of staff grievances and complaints are in place, ensuring timely management in line with trust policy.	People ID : P16 Actions : 9	New Freedom To Speak Up Guardian (FTSUG) appointed on 03/09/19. From staff sessions, an Action Plan will be developed for improving how staff can increase their knowledge on how to raise concerns in different circumstances. A new Trust Whistleblowing Policy is on track for dissemination by 31/01/19. A new reporting system for recording, monitoring and reporting staff complaints is on track for delivery by May 2019.
16. Trust Overall The trust must ensure effective processes are in place to meet all the requirements of the fit and proper person's regulation.	People ID : P20 Actions : 2	Evidence of alignment with current regulatory monitoring and compliance is reported on the Trust website. Evidence of Trust adhering to CQC Report Regualtion5 - Fit and Proper Persons check – evidence of documents signed by all Directors
17. Urgent & Emergency The trust must ensure that resuscitation trolleys are checked in accordance with the trust policy and resuscitation council guidelines.	Caring Safely ID : CS8 / CS9 Actions : 4 / 3 (see also 49, 52, 90)	Progress continues for Resuscitation Trolleys. Further audit evidence required to ensure daily/weekly checks establish improvements. Deadline date revised to 30/4/19 remains on schedule overall for completion to ensure improvements are embedded. Planning to commission external review of Resuscitation Team and equipment across the Trust for further assurance.
18. Urgent & Emergency The trust must review nursing and medical staffing numbers and plan staffing acuity accordingly.	People ID : P10 Actions : 8 (see also 25, 75)	Sustainable workforce programme been developed – a number of projects have been identified as part of the roll out of key projects in the programme. New deadline of 31/05/19 suggested as piloting of new models on certain wards will be completed in March 2019 prior to full roll out to other wards in May.
19. Urgent & Emergency The trust must ensure that the environment within the emergency department is appropriate to provide safe care and treatment.	Environment ID : E1 Actions : 3 (See also 58)	Short term solution and deadline agreed at the ED Review Meeting. However, the proposed solution seemed to affect negatively the department's capacity. Initial option piloted - alternative solution being discussed.
20. Urgent & Emergency The trust must ensure that serious incident action plans are comprehensive and that the completion of actions is monitored.	Governance - Learning ID : GL8 Actions : 3	No issues identified for the implementation of the GL8 actions. Action owner is checking about the possibility of including this within the ToR for the existing Serious Incident Review Panel.
21. Urgent & Emergency The trust must review the arrangements for booking in patients and for the waiting area to ensure that patients at risk of deterioration are identified and escalated appropriately. Non-clinical staff responsible for booking in patients must have clear criteria for escalating patients to clinical staff.	Performance ID : PF6 Actions : 6	Deadline date changed from 31/11/18 to 31/01/19. Evidence of Induction pack and SOP not provided in time for submission to QPB for sign-off. Evidence will be available for closure in January. Streaming for pilot is in place and evidence provided. Need Standard Operating Procedure (SOP) for implementation to confirm full process is in place.
22. Urgent & Emergency The trust must ensure that compliance with new or updated national guidance is regularly assessed and monitored, and improvements made where necessary.	Governance - Learning ID : GL12 Actions : 3 (see also 11, 43)	Funding has been approved for the Datix document management module and that a project manager for implementation is available. Once the Datix module is implemented, deadline for this action will be more accurate.
23. Urgent & Emergency The trust must improve its performance times in relation to ambulance turnaround delays, four-hour target, patients waiting more than four hours from the decision to admit until being admitted and monthly median total time in A&E.	Performance ID : PF2 Actions : 8	Needs to move to a clinical lead to ensure professional standards are met. Original deadline date was not appropriate or sufficient to measure a change in ED delivery. Report from recent Emergency Intensive Care Support Team (ECIST) visit shared with Trust on 28th November 2019. Action plan being developed to address recommendations

'MUST/SHOULD' Action	Workstream	Update
24. Medical The trust must ensure the service has enough nursing staff, on all medical wards, to keep people safe from avoidable harm and to provide appropriate standards of care and treatment.	People ID : P10 Actions : 8 (see also 18, 75)	Immediate Action completed in May 2018, through closing escalation ward. Ward remained closed. The sustainable workforce programme has been developed – a number of projects have been identified as part of the roll out of key projects in the programme. New deadline of 31/05/19 suggested as piloting of new models on certain will be completed in March 2019 prior to full roll out too other wards in May. Associate Medical Directors (AMDs) and Medical staffing have recruited approximately 35 QEH Fellows with a supporting training package to fill the large number of gaps we had. The target was 42. BMA and Royal College of Medicine have issued some new safe staffing guidelines and so a review is underway to check the original assumptions in the Clinical Workforce Strategy.
25. Medical The trust must ensure staff have ready access to required equipment, including resuscitation equipment.	Caring Safely ID : CS10 / E5 Actions : 4 / 3 (see also 90)	Buddy Trust review to be commissioned by Chief Nurse and deadline for full implementation of any recommendations revised to June 2019. Additional resuscitation equipment has been placed in areas identified by the Trust as a concern.
26. Medical The trust must ensure there are sufficient and appropriate induction procedures for agency staff and competency checks for both agency staff and substantive staff who are moved from other areas of the hospital.	People ID : P8 Actions : 10	Gap Analysis and next steps completed. A SOP and skills passport is in the early stages of development and seeking agreement from operational teams to ensure the process is fit for purpose and achievable in all clinical areas. A SOP and skills passport is in the early stages of development and the Action Owner will be seeking agreement form operational teams to ensure the process is fit for purpose and achievable in all clinical areas.
27. Medical The trust must ensure there are processes in place to reduce the risk of medicines errors.	Caring Safely ID : CS12 Actions : 8	Mandatory training review completed and new Handbook launched across Trust. Deadline now confirmed for Electronic Prescribing and Medicines Administration (EPMA) implementation of 1/4/20. Education review complete, however evidence required for next steps
28. Medical The trust must ensure the risk register is reflective of all the risks in the service and includes relevant actions to mitigate risk.	Governance - Learning ID : GL6 Actions : 2	The development of a new Risk Strategy and an Assurance Framework required a deadline review. The review of the risk register is on track. Gaps have been identified. The amount of work involved in completing this action (proposal, consultation and approval) would justify a change of deadline.
29. Surgery The trust must ensure that staff follow infection prevention and control procedures in relation to hand hygiene, disposal of intravenous equipment and clothing in theatres.	Caring Safely ID : CS16 Actions : 2 (see also 53, 91)	Mapping of Hygiene Code is in progress and gap analysis required to provide evidence for variance against Code.
30. Surgery The trust must ensure that plans to improve arrangements for disposing of waste on SAU and Elm ward are implemented, to ensure compliance with infection prevention and control procedures.	Environment ID : E6 Actions : 1	New sluice installed on 21/09/18 and IPC compliance confirmed – Action Completed.
31. Surgery The trust must ensure that staff in theatres have clear guidance, and effective processes are implemented, in relation to the required safety checks for anaesthetic equipment and the malignant hyperthermia trolley.	Caring Safely ID : CS17 Actions : 2 (see also 36)	Requires 6 months audit data to ensure effective process and checks embedded in practice. Auditing commenced. Deadline changed from 30/11/18 to 30/3/19
32. Surgery The trust must ensure that medicines are stored, prescribed and administered safely, in line with trust policy.	Caring Safely ID : CS13 Actions : 5	Audits are in place; however evidence shows inconsistencies in performance. Deadline dates to be extended to 30/03/19 to ensure audits are in place and effective improvements are made.
33. Surgery The trust must ensure that patient care records are stored securely in all areas.	Environment ID : E8 Actions : 5	No issues identified for the completion of actions.

'MUST/SHOULD' Action	Workstream	Update
34. Surgery The trust must review the location of the elective admissions unit to ensure that the needs of patients are met.	Environment ID : E2 Actions : 5	As part of the Winter Plan, it has been approved for Leverington ward to become the admission ward. Proposals for improving the situation for Feltwell have been detailed and awaiting approval. 23h extended recovery unit was approved by the Board on the 18/12/18. This approval is within the context of the Winter Plan.
35. Surgery The trust must ensure that the world health organisation (WHO) and five steps to safer surgery checklist is used consistently in theatres and that effective process is in place for quality audit of all five steps of the checklist.	Caring Safely ID : CS18 Actions : 3 (see also 44)	Actions are scheduled for completion against deadline. No risks identified.
36. Surgery The trust must ensure there are clear governance processes in place, particularly in relation to the monitoring of safety checks in theatre, identification and management of risk and reporting of performance to the board.	Governance - Learning ID : CS17 / GL1 Actions : 2 / 5 (see also 31) (see also 4, 40, 86)	Audit information and minutes of CBU1 Board received as evidence. Requires 6 months audit data to ensure effective process. Deadline changed to 30/3/19. Although tasks associated to the actions have been completed (ToRs and agendas) or progress is very advanced (training), no impact evaluation has been completed. Initial examination of evidence suggests that implementation requires further efforts so deadlines have been revised. The completion of the Accountability Framework is fundamental for the progress of other actions within the workstream.
37. Maternity The trust must monitor medical staff training rates, and improve appraisal rates to meet the trust target.	People ID : P6 / P7 Actions : 4 / 2 (See also 77, 92, 59)	New paperwork, incorporating the new Trust Values and Behaviours, has been launched and staff are being trained on how to use the new system. Appraisal trajectories are being submitted to the Workforce Committee for monitoring.
38. Maternity The trust must improve cardiotocography training rates.	People ID : P5 Actions : 1	Action completed as part of Maternity QIP. Staff training tracked monthly. CTG training is part of induction and Mandatory training. Evidenced reviewed as part of CQC unannounced Maternity Section 31 visit in December.
39. Maternity The trust must ensure that the environment at Wisbech hospital and in the early pregnancy unit is appropriate to provide safe care and treatment.	Environment ID : E3 Actions : 3	Most actions recommended for closing and one on track.
40. Maternity The trust must ensure that there are effective processes in place for quality improvement and risk management.	Governance - Learning ID : GL1 / GL3 Actions : 5 /9 (see also 4, 36, 86)	Although tasks associated to the actions have been completed (ToRs and agendas) or progress is very advanced (training), no impact evaluation has been completed. Initial examination of evidence suggests that implementation requires further efforts so deadlines have been revised. ToRs and agendas have been reviewed, updated and made available to be used in relevant meetings (sent out as part of a 'pack' to all Triumvirate teams and available on the intranet). The completion of the Accountability Framework is fundamental for the progress of other actions within the workstream.
41. Maternity The trust must ensure that effective arrangements are in place for vulnerable service users.	Caring Safely ID : CS5 Actions : 3	Initial MatQIP evidence received. More up to date evidence required to complete action and recommend for closure.
42. Maternity The trust must ensure that service users with high risk care pathways receive consistent care planning and appropriate consultant review.	Caring Safely ID : CS4 Actions : 4	Initial audit of accessible of care plans demonstrated inconsistencies. Further audit required by April 2019 to ensure recommendations are embedded and care plans are available.
43. Maternity The trust must ensure that clinical guidelines are regularly reviewed and contain up-to-date national guidance.	Governance - Learning ID : GL12 Actions : 3 (see also 11,22)	Funding has been approved for the Datix document management module and that a project manager for implementation is available. Once Datix module is implemented, deadline for this action will be more accurate

'MUST/SHOULD' Action	Workstream	Update
44. Maternity The trust must ensure that the world health organisation (WHO) and five steps to safer surgery checklist is used consistently within obstetric theatres.	Caring Safely ID : CS18 Actions : 3 (see also 35)	Actions are scheduled for completion against deadline. No risks identified.
45. Maternity The trust must improve its local audit programme and review national audit outcomes to improve patient outcomes.	Governance - Learning ID : GL9 / GL11 Actions : 3 / 1 (see also 8, 65, 83, 87)	Governance Structure has been reviewed to include a Clinical Audit Committee. ToR for this Committee will be discussed and, if appropriate, approved by the Clinical Governance Committee meeting in second week of January 2019. The first meeting of the formalised Clinical Audit Committee will take place in January 2019. The implementation of the reviewed 'Management of External Agency Inspections, Reviews and Accreditations Visits Framework' requires deadlines to be extended. Evaluation required the extension of the deadline for the completion of the action. Interim additional senior Governance Project resource secured and in place in November with Maternity expertise.
46. Maternity The trust must review the antenatal booking process to ensure that referrals are tracked	Performance ID : PF7 Actions : 2	Badgernet (Electronic system) in place (new process went live 25/6/18) -for all referrals from Community Midwives and nolonger reliant on paper referrals. Initial audit completed with further audit of referrals planned.
47. Maternity The trust must ensure that leaders within the service collaborate to improve the service and that culture and wellbeing of staff is improved.	People ID : P14 Actions : 1	Interim Clinical Director appointed. New Clinical Lead appointed. Support from NHSi Pastoral care enhanced Advancing Change through Transformation (ACT) Workshop took place 22/11/18 Healthcare Leadership Model (360-degree feedback) rolled out across all leadership roles
48. Maternity The trust must ensure that women who have miscarried up to 16 weeks are cared for in a suitable environment.	Environment ID : E4 Actions : 4	Some actions have been carried out but have not been evaluated. Deadlines have been reviewed where necessary to ensure effective implementation and evaluation of actions.
49. Maternity The trust must ensure that resuscitation trolleys are checked daily and that all medicines stored on resuscitation trolleys are in date.	Caring Safely ID : CS8 Actions : 4 (see also 17, 52, 90)	Further audit evidence required to ensure daily/weekly checks to establish improvements are embedded in practice. Deadline revised to 30/4/19.
50. End of Life Care The trust must review 'do not attempt cardio-pulmonary resuscitation' (DNACPR) forms to ensure they are completed fully and in line with trust policy and national guidance.	Caring Safely ID : CS7 Actions : 9	Significant progress made on DNACPR processes and Policy launch. New form developed by Clinicians and implemented into practice. Resus Committee has oversight of audits and improvement made and embedded through audits in September and November. Further audit in February 2019 to ensure improvements are progressing.
51. End of Life Care The trust must review its Mental Capacity Assessment and Deprivation of Liberty Safeguarding process and the way this is documented within patients' notes.	Caring Safely ID : CS3 Actions : 9 (see also 3, 56)	Review of MCA/DoLS actions required following appointment of new Action Owner 19/11 and development of new approach to ensure processes and assessments are embedded in practice. This includes the establishment of new MCA/DoLS Group to report directly to Adult Safeguarding Committee. Group will oversee all MCA/DoLS activities Trust-wide. New assessment tool is in place. New actions will be developed to reflect enhanced approach and revised deadlines identified to complete.
52. Outpatients The trust must ensure resuscitation equipment in the paediatric clinic is checked daily.	Caring Safely ID : CS8 Actions : 4 (see also 17, 49, 90)	New additional resuscitation equipment in place in Paediatric Resuscitation area in ED. Further audit evidence required to ensure daily/weekly checks to establish improvements are embedded in practice. Deadline revised to 30/4/19.

'MUST/SHOULD' Action	Workstream	Update
53. Outpatients The trust must ensure infection prevention and control audits are completed regularly and action taken to address concerns including cleaning of toys in waiting areas.	Caring Safely ID : CS16 Actions : 2 (See also 29, 91)	Mapping of Hygiene Code is in progress and gap analysis required to provide evidence for variance against Code. Then need to map variances into an action plan which will then deliver effective change.
54. Diagnostic Imaging The trust must ensure staff lock computer screens to protect patient information when leaving them unattended in the breast care unit.	Environment ID : E8 Actions : 5	No issues identified for the completion of actions.
55. Diagnostic Imagining The trust must provide all patients with the option of a chaperone when undergoing diagnostic imaging in the cardio respiratory department.	Caring Safely ID : CS6 Actions :3	Revised Chaperone Policy is being consulted on for sign-off in December and deadlines dates revised to reflect timescale for implementation.
56. Trust Overall The trust must review the knowledge, competency and skills of staff in relation to the Mental Capacity Act and Deprivation of Liberty safeguards	People / Caring Safely ID : P3 / CS3 Actions : 3 / 9 (See also 1, 3)	Review of MCA/DoLS actions required following appointment of new Action Owner 19/11 and development of new approach to ensure processes and assessments are embedded in practice. This includes the establishment of new MCA/DoLS Group to report directly to Adult Safeguarding Committee. Group will oversee all MCA/DoLS activities Trust-wide. New assessment tool is in place. New actions will be developed to reflect enhanced approach and revised deadlines identified to complete.
57.Trust Overall The trust should ensure that effective processes are in place to promote and protect the health and wellbeing of all staff.	People ID : P11 Actions : 4	This task is on track for delivery by 30/01/19. Action Plan has identified the need for a staff feedback portal on the intranet. Confident of meeting the correct deadline in Launching the staff 'For You' staff (trade) benefits website.
58. Urgent & Emergency The trust should review the layout of the emergency department to ensure that it supports flow and meets the needs of local people.	Environment ID : E1 Actions : 3 (see also 19)	Short term solution and deadline agreed at the ED Review Meeting. However, the proposed solution seemed to affect negatively the department's capacity. Initial option piloted - alternative solution being discussed.
59. Urgent & Emergency The trust should ensure that staff receive yearly appraisals.	People ID : P6 Actions : 4 (See also 37, 77, 92)	New paperwork, incorporating the new Trust Values and Behaviours, has been launched and staff are being trained on how to use the new system. Appraisal trajectories are being submitted to the Workforce Committee for monitoring.
60. Urgent & Emergency The trust should review the hours that the ambulatory emergency care unit, the paediatric assessment unit and the rapid assessment team are available to maximise admission avoidance.	Performance ID : PF11 Actions : 2	All actions on schedule for delivery. No risks identified.
61. Urgent & Emergency The trust should ensure that internal professional standards are created and monitored.	Performance ID : PF3 Actions : 2	Deadline date extended to 30/04/19. Professional Standards to be embedded and tested.
62. Urgent & Emergency The trust should review the policies and protocols in place to manage escalation and crowding.	Performance ID : PF1 Actions : 7 (See also 13)	Review of all actions has identified original deadlines required review/confirmation. Pathways are in place, evidence for one action to be presented for closure in January. On track for completion for all other actions.
63. Urgent & Emergency The trust should review the service provided for patients with mental health conditions to ensure that they receive timely assessment and treatment.	Performance ID : PF12 Actions : 1	Due to interdependencies, deadline needs to be extended to 31/03/19 to link to renewed contract and embedding in Trust to ensure measurement of performance.
64. Urgent & Emergency The trust should ensure that patients, relatives and carers receive timely emotional support.	Caring Safely ID : CS2 Actions : 1	Action is on track to meet completion deadline, no risks identified.

'MUST/SHOULD' Action	Workstream	Update
65. Urgent & Emergency The trust should ensure the service improves its local audit programme, including audits recommended in national guidance.	Governance - Learning ID : GL9 / GL11 Actions : 3 / 1 (see also 8, 45, 83, 87)	Governance Structure has been reviewed to include a Clinical Audit Committee. ToR for this Committee will be discussed and, if appropriate, approved by the Clinical Governance Committee meeting in second week of January 2019. The first meeting of the formalised Clinical Audit Committee will take place in January 2019. The implementation of the reviewed 'Management of External Agency Inspections, Reviews and Accreditations Visits Framework' requires deadlines to be extended. Evaluation required the extension of the deadline for the completion of the action.
66. Urgent & Emergency The trust should review its communication aids available to assist staff to communicate with patients living with a sensory loss, such as hearing loss.	Environment ID : E7 Actions : 5	Funding required for an external provider to carry out the Equality Impact Assessment. Provider is prepared to act promptly once the approval is completed and an order placed to complete the assessment for ED department (the overall programme will last 5 years).
67. Urgent & Emergency The trust should ensure that regular and minuted mortality and morbidity meetings take place for urgent and emergency services.	Governance - Learning ID : GL2 Actions : 4 (see also 76, 84)	ED mortality review will be included within the Medical Structured Judgement Review (SJR) meeting. Weekly meetings are taking place and learning brought from this meeting to the Surgical Clinical Governance Committee. Escalations are made from this Committee to the Mortality Surveillance Group. End of Life Care (EoLC) Quarterly Mortality Audit is being considered. Results are to be reported within the Trust's Mortality Surveillance Group meetings. Mortality Report template is being developed. This will be used by the different specialties when reporting into the CBU mortality meeting and the Mortality Surveillance Group.
68. Urgent & Emergency The trust should ensure that plans in relation to the development of a strategy for the urgent and emergency service are implemented.	People ID : P17 Actions : 7 (See also 80)	Evidence from the CEO and Governance Office that the vision (and corporate strategy) went and was signed off by Board in September 2018. This has been consulted on with a wide range of stakeholders. The Comms plan has yet to be launched formally and embedded within the organisation.
69. Medical The trust should ensure there are systems in place to ensure the consistent and effective sharing of feedback and learning from complaints and incidents	Governance - Learning ID : GL7 / GL13 Actions : 5 / 7 (see also 9, 72,88)	These actions can be linked to GL4.6 although deadlines for them are far more restrictive. No progress has been reported for these actions but reviewed deadlines and consistency of ownership will allow effective implementation. Work on stacking deadlines across different topics within the workstream is being carried out so deadline changes optimise the sequence of actions. New complaints process has been introduced; however compliance with 24hr call back cannot currently be evidenced in all cases.
70. Medical The trust should ensure there are systems in place to reduce and manage the high number of medical outliers.	Performance ID : PF4 Actions : 8	Consultant cover is in place for medical outliers with weekly patient reviews indicating medical outliers. Bed modelling projection to provide assurance that projections for Winter are viable. Action owners now confirmed and deadline dates agreed in line with realistic timescale for completion.
71. Medical The trust should ensure call bells are answered promptly to respond to patient risk and need.	Caring Safely ID : CS22 Actions : 3	Call bell audits established and monitored across wards to identify issues/concerns. Immediate actions are taken when issues identified and staff reporting is in place. Proposed for closure.
72. Medical The trust should ensure complaints are managed and responded to in a timely manner and in line with trust policy.	Governance - Learning ID : GL13 Actions : 7 (see also 69, 88)	New complaints process has been introduced; however compliance with 24hr call back cannot currently be evidenced in all cases. Some improvements in Datix are being implemented so telephone number of complainant will be easily available.
73. Medical The trust should ensure there is improved communication and multidisciplinary working with external services.	Performance ID : PF13 Actions : 5	Waiting confirmation joint winter discharge room is established with Social Services, CCG, NHSE and NCHC.

'MUST/SHOULD' Action	Workstream	Update
74. Medical The trust should ensure there are appropriate systems to ensure staff feel supported, engaged and listened to.	People ID : P15 Actions : 4	Ask and Act sessions have been established and the follow up actions are with the Executive Directors. Work progressing to ensure complete embedding of Executive Ward/Dept. Buddy system culture change initiative. Post Implementation Evaluation of how well the findings inform the improvement work are to be carried out quarterly.
75. Surgery The trust should continue to implement plans to maintain sufficient nursing staff to meet the needs of patients.	People ID : P10 Actions : 8 (see also 18, 24)	Sustainable workforce programme been developed – a number of projects have been identified as part of the roll out of key projects in the programme. New deadline of 31/05/19 suggested as piloting of new models on certain wards will be completed in March 2019 prior to full roll out to other wards in May.
76. Surgery The trust should ensure that regular and minuted mortality and morbidity meetings take place for surgery services.	Governance - Learning ID : GL2 Actions : 4 (see also 67, 84)	ED mortality review will be included within the Medical SJR meeting. Weekly meetings are taking place and learning brought from this meeting to the Surgical Clinical Governance Committee. Escalations are made from this Committee to the Mortality Surveillance Group. EoLC Quarterly Mortality Audit is being considered. Results are to be reported within the Trust's Mortality Surveillance Group meetings. Mortality Report template is being developed. This will be used by the different specialties when reporting into the CBU mortality meeting and the Mortality Surveillance Group.
77. Surgery The trust should ensure all staff receive an annual appraisal, in line with trust policy.	People ID : P6 Actions : 4 (see also 37, 59, 92)	New paperwork, incorporating the new Trust Values and Behaviours, has been launched and staff are being trained on how to use the new system. Appraisal trajectories are being submitted to the Workforce Committee for monitoring.
78. Surgery The trust should ensure strategies to manage access to the service and patient flow through the service are embedded.	Performance ID : PF5 Actions : 5	Hot Review Clinics are established. Ambulatory area in SAU when in operation.
79. Surgery The trust should ensure there are clear processes in place for sharing information with ward staff.	People/Caring Safely ID : P12 / CS19 Actions : 1 / 6	Initial implementation of safety huddles in place. Audit programme required to monitor effectiveness and to be completed over 4 month period to enable accurate measurement of impact. Major challenge to the review of communication mechanisms and tools to inform design and roll out of Trust communication plan due to the nature of work involved and the pending challenges within the Communications establishment
80. Surgery The trust should ensure that plans in relation to development of a vision and strategy for the surgery service are implemented.	People ID : P17 Actions : 7 (See also 68)	Evidence from the CEO and Governance Office that the vision (and corporate strategy) went and was signed off by Board in September 2018. This has been consulted on with a wide range of stakeholders. The Comms plan has yet to be launched formally and embedded within the organisation.
81. Surgery The trust should ensure that information relating to the individual needs of patients is collected in a timely way.	Caring Safely ID : CS1 Actions : 10 (see also 2)	Nursing Assessment launch delayed at printers and new deadline set for end of December. Following Policy launch in November, proposed to test embedding of Record Keeping Policy over 6 months period.
82. Surgery The trust should ensure all staff have access to relevant information management systems, to meet patients' needs.	People ID : P8 Actions : 10	Gap Analysis and next steps completed. A SOP and skills passport is in the early stages of development and seeking agreement from operational teams to ensure the process is fit for purpose and achievable in all clinical areas. A SOP and skills passport is in the early stages of development and the Action Owner will be seeking agreement form operational teams to ensure the process is fit for purpose and achievable in all clinical areas.

'MUST/SHOULD' Action	Workstream	Update
83. Surgery The trust should review the implementation of the local clinical audit programme for surgery services.	Governance - Learning ID : GL9 / GL11 Actions : 3 / 1 (see also 8, 45, 65, 87)	Governance Structure has been reviewed to include a Clinical Audit Committee. ToR for this Committee will be discussed and, if appropriate, approved by the Clinical Governance Committee meeting in second week of January 2019. The first meeting of the formalised Clinical Audit Committee will take place in January 2019. The implementation of the reviewed 'Management of External Agency Inspections, Reviews and Accreditations Visits Framework' requires deadlines to be extended. Evaluation required the extension of the deadline for the completion of the action.
84. End of life Care The trust should ensure morbidity and mortality meeting need to have a focus on the end of life care journey and how to improve end of life care.	Governance - Learning ID : GL2 Actions : 4 (see also 67, 76)	ED mortality review will be included within the Medical SJR meeting. Weekly meetings are taking place and learning brought from this meeting to the Surgical Clinical Governance Committee. Escalations are made from this Committee to the Mortality Surveillance Group. EoLC Quarterly Mortality Audit is being considered. Results are to be reported within the Trust's Mortality Surveillance Group meetings. Mortality Report template is being developed. This will be used by the different specialties when reporting into the CBU mortality meeting and the Mortality Surveillance Group.
85. Outpatients The trust should ensure that patients commence treatment for cancer within 62 days in line with national guidance.	Performance ID : PF8 Actions : 8	Needs further clarification of evidence from Division that recommendations from Cancer Intensive Support Team (IST) will be taken forward. No Cancer At This Time (NCATT) result evidence required.
86. Outpatients The trust should ensure that there is an effective process for quality improvement and risk management.	Governance - Learning ID : GL1 / GL3 Actions : 5 / 9 (see also 4, 36, 40)	Although tasks associated to the actions have been completed (ToRs and agendas) or progress is very advanced (training), no impact evaluation has been completed. Initial examination of evidence suggests that implementation requires further efforts so deadlines have been revised. The completion of the Accountability Framework is fundamental for the progress of other actions within the workstream.
87. Outpatients The trust should ensure the service improves its local audit programme and review national audit outcomes to improve patient outcomes.	Governance - Learning ID : GL9 / GL11 Actions : 3 / 1 (see also 8, 45, 65, 83)	Governance Structure has been reviewed to include a Clinical Audit Committee. ToR for this Committee will be discussed and, if appropriate, approved by the Clinical Governance Committee meeting in second week of January 2019. The first meeting of the formalised Clinical Audit Committee will take place in January 2019. The implementation of the reviewed 'Management of External Agency Inspections, Reviews and Accreditations Visits Framework' requires deadlines to be extended. Evaluation required the extension of the deadline for the completion of the action.
88. Outpatients The trust should ensure that the service improves the time taken to investigate complaints in line with its complaints policy.	Governance - Learning ID : GL13 Actions : 7 (see also 69, 72)	New complaints process has been introduced; however compliance with 24hr call back cannot currently be evidenced in all cases. Some improvements in Datix are being implemented so telephone number of complainant will be easily available.
89. Diagnostic Imaging The trust should ensure the secure storage, prescription and administration of medicines. This includes ensuring that appropriate patient group directives (PGD) are in place for the safe administration of medicines, including the safe administration of saline.	Caring Safely ID : CS14 / CS15 Actions : 3 / 4	MMI inspection schedule in place and issues with storage of medication resolved via staff meeting. No risks to delivery against schedule identified. PGD list and access guidance now live on Trust website.
90. Diagnostic Imaging The trust should ensure that resuscitation equipment in the breast care unit is easily accessible to all staff.	Caring Safely ID : CS8 / CS10 Actions : 4 / 4 (see also 17, 49, 52)	Equipment available. Further audit evidence required to ensure daily/weekly checks to establish improvements are embedded.

'MUST/SHOULD' Action	Workstream	Update
91. Diagnostic Imaging The trust should ensure effective processes are established for the cleaning of clinical rooms and equipment in the radiology department.	Caring Safely ID : CS16 Actions : 2 (see also 29,53)	Mapping of Hygiene Code is in progress and gap analysis required to provide evidence for variance against Code. Then need to map variances into an action plan which will then deliver effective change.
92. Diagnostic Imaging The trust should ensure all staff receives an annual appraisal, in line with trust policy.	People ID : P6 Actions : 4 (See also 37, 77, 59)	New paperwork, incorporating the new Trust Values and Behaviours, has been launched and staff are being trained on how to use the new system. Appraisal trajectories are being submitted to the Workforce Committee for monitoring.
93. Diagnostic Imaging The trust should ensure effective processes are in place for the timely completion of diagnostic reports.	Performance ID : PF1 Actions : 4	Review of all actions has identified original deadlines required review/confirmation. One action has completed with evidence to be presented for closure in January. On track for completion for all other actions.
94. Diagnostic Imaging The trust should review processes to ensure that patients are able to access diagnostic imaging services in a timely manner.	Performance ID : PF9 Actions : 4	Need further assurance that current performance levels are sustainable. No risk to delivery identified. Deadline date now confirmed as 31/08/19.

Norfolk and Suffolk NHS Foundation Trust – response to the Care Quality Commission report

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

Follow up to previous scrutiny of Norfolk and Suffolk NHS Foundation Trust (NSFT) and examination of the Trust and commissioners' response to the report of the Care Quality Commission's (CQC) inspection between 3 and 27 September 2018, published on 28 November 2018.

1.0 Purpose of today's meeting

1.1 The key focus areas for today's meeting are:-

(a) How NSFT intends to meet the requirements highlighted by the latest CQC inspection.

(b) The commissioners' and wider health and care system's role in supporting NSFT to improve, including the implications of:-
   i. The Norfolk and Waveney Sustainability Transformation Partnership's (N&W STP) review of mental health services for adults (by Boston Consulting Group)
   ii. The similar review of mental health services for adults in Suffolk
   iii. The N&W STP review of mental health services for children and young people (by Rethink Partners)

(c) NSFT's current position in relation to previous scrutiny and recommendations made by Norfolk Health Overview and Scrutiny Committee (NHOSC).

1.2 NSFT and South Norfolk CCG (lead commissioner for mental health services in Norfolk and Waveney) have been asked to provide information reports on the current position and how they intend to improve it. NSFT's report is attached at **Appendix A** and South Norfolk CCG's report is attached at **Appendix B**.

1.3 Representatives from NSFT and South Norfolk CCG will attend the meeting to answer NHOSC's questions about the commissioning of mental health services and action to improve the provision of services.

2.0 Background

2.1 CQC reinspection

2.1.1 The CQC re-inspected NSFT from 3 – 27 September 2018 and its report was published on 28 November 2018:-https://www.cqc.org.uk/provider/RMY The Trust continued to be rated 'Inadequate' overall. The table below shows the ratings of services within the Trust and whether their position had improved (↑), deteriorated (↓) or stayed the same (→←) since the previous inspection in July 2017.

Ratings for mental health services

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

2.1.1 The CQC's rating of the NSFT's overall responsiveness went down from 'Requires Improvement' to 'Inadequate'. It noted that:

'Almost 2400 adult patients across the trust had not been allocated a care coordinator in community mental health services for adults. A further 636 patients were waiting for treatment as of 20 September 2018 in children's and young people's mental health services CAMHs. Waiting lists across services were a serious issue. In July 2018, over 220 people had been waiting more than 18 weeks for treatment.'

The main reasons for the continued rating of 'Inadequate' overall were:-

- Leadership - the Board had not driven effective change as required.
- Safety – not all ward and community environments were safe; not all clinical risks were managed; nursing and medical staff vacancies remained high; there were not enough staff in some community services to meet the needs of patients. All these issues had been raised with the Trust during previous inspections.
- Morale – low across services. This was attributed to a 'do unto' attitude staff felt came from senior management and directors.
- Risk management – key risks that were considered closed or mitigated in the Trust's assurance process had not, in fact, been fully addressed. In some cases, the work undertaken had created new risks.
- Waiting lists – not all services were meeting their target for assessment. Too many referrals were refused or downgraded from urgent to routine without due care. There were many instances of people who had significant needs being denied a service.

It should be noted that the Trust's rating for 'Caring' remained 'Good' with the CQC finding that staff continued to show kindness and compassion.

2.1.2 The CQC has once again given NSFT a list of 'must do' and 'should do' actions. The 'must dos' address 61 breaches of legal requirements across 9 of NSFT's services.

2.1.3 Since NSFT last attended NHOSC on 5 April 2018 there have been the following changes in leadership at the Trust:-

- Antek Lejk took up the post of Chief Executive on 1 May 2018.
- A new Head of Quality Improvement started in May 2018.
- The Chairman, Gary Page, stood down on 20 November 2018
- A new Interim Director of Corporate Affairs and Communications started on 20 November 2018
- A new Chief Nurse started on 21 November 2018

2.2 Review of mental health services in Norfolk and Waveney

2.2.1 On 10 December 2018 Norfolk and Waveney STP published the first draft of its new Adult Mental Health Strategy, which is available to read on the Healthwatch Norfolk website:-
https://www.healthwatchnorfolk.co.uk/ingoodhealth/stp-mental-health/

This follows on from a review by Boston Consulting Group, which the five CCGs commissioned in mid 2018. The pillars of the new draft strategy are:-

- Focus more on prevention and wellbeing
- Ensure clear routes into and through services and make these transparent to all
- Support the management of mental health issues in primary care settings
- Provide appropriate support to those in crisis
- Ensure effective in-patient care for those that really need it
- Ensure the system is focused on working in an integrated way to care for patients

It also says '… *it will be important to examine how organisations work together to deliver the services in future. Key to this is taking a 'whole system' approach to improving mental health and wellbeing, working with schools, police, housing, employers, the voluntary sector and other partners'*.

The draft strategy identifies three key areas that need to be worked on to enable success of mental services within a 'whole system':-

- Workforce – in primary care (i.e. General Practice) and secondary care
- Information technology – harmonisation of systems across a Norfolk and Waveney integrated system
- Estates – resolving current mismatches between demand and capacity and addressing future expected growth.

2.2.2 A separate review focusing on the mental health of children and adolescents across Norfolk and Waveney took place between September and December 2018. The draft Adult Mental Health Strategy says that future work will build on the two documents to shape an all age mental health strategy for Norfolk and Waveney.

2.3 **Previous reports to NHOSC**

2.3.1 The committee has received numerous previous reports from NSFT and the commissioners and has made its own recommendations for improvements. The following links will take you to the reports on Norfolk County Council's website where the recommendations NHOSC made on 7 December 2017 and NSFT and CCG's responses to them before 5 April 2018 can be found (click on 'Reports'):-

5 April 2018
7 December 2017

The report to 7 December 2017 NHOSC also set out the history of the committee's scrutiny of mental health services back to September 2016, including the actions the committee had previously taken.

2.3.2 Following the meeting on 5 April 2018, NHOSC wrote to NHS Improvement (NHSI) on 13 April 2018 to express support for NSFT's bid for £5.2m capital funding from national funds to support improvements. NSFT's report for today's meeting (Appendix A, paragraph 20) confirms that they received approval for the funding, but that it was granted as a loan rather than the public dividend capital for which they applied.

2.3.3 In view of the fact that out-of-area and out-of-Trust placements to non-specialist beds were continuing despite past assurances to NHOSC that they would be stopped, the committee recommended to the CCG and NSFT on 5 April 2018:-

'That the local NHS should reimburse travel costs for families of service users who were placed in out-of-area beds due to unavailability of local beds (i.e. placed out-of-area for non-clinical reasons)'.

The South Norfolk CCG and NSFT did not accept the recommendation and after further correspondence NHOSC raised the matter with NHS England (NHSE). NHSE responded on 8 October 2018 encouraging both the CCG and the Local Authority to review applications for support with travelling costs on a case by case basis and confirming the ambition for out-of-area placements to reduce to zero by March 2021.

The full correspondence is attached at **Appendix C.**

3.0 Suggested approach

3.1 After the NSFT and the CCG have introduced their reports, the committee may wish to discuss the following areas with them:-

For discussion with NSFT

(a) What are the main factors that have prevented NSFT making the changes the CQC required of it in 2014 and 2017?

(b) What more can NSFT do to make the necessary improvements this time around?

(c) The CQC report highlighted low morale at the Trust and staff's impression of a 'do unto' attitude from senior management and directors. Are the NSFT representatives certain that they have staff support for the actions they are now taking to bring about improvements?

(d) The CQC's found that some of the action NSFT had taken since 2017 had actually made matters worse. Is the Trust certain that it is now on the right course?

For discussion with commissioners

(e) What do the commissioners think are the main factors that have prevented improvement of mental health services in Norfolk and Waveney?

(f) What solutions are emerging from the review of adult and children's mental health services?

(g) What solutions are emerging from the commissioners' review of adult mental health services in Suffolk and how do these impact on Norfolk and Waveney?

(h) The review of adult mental health services in Norfolk and Waveney highlighted workforce shortages in primary and secondary care as a significant challenge. What more can be done at local level that has not already been tried?

(i) The review also highlighted harmonisation of information technology across the Norfolk and Waveney care system as essential for improvement of the mental health services. How is this to be achieved in the current financial climate?

4.0 Action

4.1 Following the discussions with representatives at today's meeting, Members may wish to consider whether:-

(a) There is further information or progress updates that the committee wishes to receive at a future meeting or in the NHOSC Briefing.

(b) There are comments or recommendations that the committee wishes to make as a result of today's discussions.

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Norfolk and Suffolk NHS
NHS Foundation Trust

Report To:	Norfolk Health Overview and Scrutiny Committee
Meeting Date:	Thursday 17th January 2019
Title of Report:	NSFT Report to NHOSC
Action Sought:	For Information
Estimated time:	20 minutes
Editor / compiler:	Marcus Hayward, NSFT Senior Operational Team
Director:	Rebecca Driver, Director of Communications & Corporate Affairs

Contents page

Introduction

This report provides Norfolk and Suffolk NHS Foundation Trust's (NSFT or the Trust) response to information requests from the Norfolk Health Overview and Scrutiny Committee (NHOSC). It includes:

- Providing a summary of the CQC findings from the CQC Inspection Report published on 28 November 2018 following the NSFT inspections which took place between 3-27 September, and actions being taken to address the findings;
- Providing updates about queries and actions from previous NSFT reports to NHOSC;
- Responding to information requests in new areas

Report structure

The information requests from the NHOSC are shown framed in blue text and head sections 1 to 20. The corresponding sub-numbed paragraphs provide NSFT's responses in black text. The content page (page 2) has used a summary heading for the NHOSC information requests to help with navigating the report.

Before the main body of the report laying out the NHOSC information requests and the Trust's response, we thought it would be helpful to provide a brief overview of the CQC report as part of this introduction.

A summary of CQC findings

Whilst the Trust's overall Key Line of Enquiry (KLOE) rating for 'caring' remained 'good', the responsiveness of the organisation was judged to have declined to an 'inadequate' rating. The Trust KLOE ratings for 'safe', 'effective' and 'well-led' were unchanged. The overall rating for the Trust remained 'inadequate' and the Trust remains in Special Measures.

The child and adolescent unit was rated 'outstanding', forensic inpatient / secure wards and community services for people with learning disabilities & autism as 'good'. Community-based services for adults of working age, acute wards for adults of working age / psychiatric intensive care units and specialist community services for children and young people were rated 'inadequate' overall. All other services were rated as 'requires improvement'.

The full CQQ report is available via the following link:
https://www.cqc.org.uk/sites/default/files/new_reports/AAAH6627.pdf

1.0 NSFT's updated Improvement Plan setting out progress in response to the CQC's 'must do' and 'should do' action list and the wider system challenges (a link to the updated Improvement Plan on the website will be fine) and commentary on how the Trust intends to deliver CQC requirements that it has so far not delivered on time.

1.1 Status of NSFT's CQC Improvement Plan

At the time of report submission, NSFT's updated and draft improvement plan had been submitted to the CQC for approval. This will be shared with NHOSC once it has been fully approved by the CQC and a link to the online document provided.

1.3 Progress made

A review of required actions between the 2017 and 2018 inspection shows improvements have been made in the following areas:

i. **Mixed sex accommodation and double bedrooms** – actions have been taken to address issues and there are no longer any double bedrooms. Fencing has been fitted at Foxhall House to resolve dignity and privacy issues.

ii. **Alarm systems** – all wards have alarm systems in place and community environments have undergone an extensive work programme

iii. **Reducing restrictive interventions and rapid tranquillisation practice** – although internal methods of assurance indicate that there is more to be done to embed best practice consistently

iv. **Basic Life Support (BLS) equipment and emergency medication** – 37 defibrillators have been issued to all community environments, with equipment already in place in inpatient environments. An anaphylaxis pack is also available in every community team base

v. **Mandatory training and appraisal** – performance is above target in the vast majority of subjects and disciplines

vi. **Seclusion facilities** – predominantly addressed, although some concerns in relation to maintaining service users' privacy and dignity are being reviewed and will be addressed under the leadership of the Chief Nurse

vii. **Usability of the Electronic Patient Care Record (EPR)** – improvements have been made to the speed and performance of the EPR (i.e. Lorenzo)

viii. **Temperature monitoring for storage of medications** - is in place

ix. **Executive Team -** is now substantively in place

1.4 Key actions to address priority themes

1) **Access to services in the community and in crisis**

A senior lead has been appointed to the improvement theme of 'access to services'. The Trust has introduced a risk stratification method and monitors and allocates high risk patients into services as a priority. It has additionally commenced weekly service user Patient Tracker Meetings for all community services and is actively working to standardise and embed a harm review and reduction culture whilst reducing waits.

A new daily report for breach and downgrade analysis has been introduced and weekly crisis access compliance data is reported to the Chief Operating Officer.

A second clinical review has also been introduced for all 4-hour emergency downgrades and breaches falling outside the 4 hours. It is now only permissible to stop the clock of an emergency referral with a face-to-face contact. It is anticipated that this change may initially show as a fall in performance against standard with increased scrutiny of exceptions.

Crisis response services are now provided by two separate teams, co-located with Home Treatment Teams at both east and west Suffolk Adult Acute Services.

The Trust is also to launch a top level Waiting Time Project for routine community referrals consisting of four work-streams: Referral to treatment definitions, business intelligence, operational management and demand capacity.

2) **Staffing levels in community services**

The Trust has made significant additional investment to its crisis teams.

New roles continue to be developed and the Trust has attended recruitment fairs to raise its profile. The Trust also continues to explore methods of retaining its workforce through active engagement events and feedback methods, which are used to help improve the working lives of staff.

Staffing in Children, Families and Young People's Services (CFYP) across both counties and against current capacity requirements is being actively reviewed to inform plans to address any gaps.

Medical job plans are being reviewed with our teams, in the context of demand and capacity, to ensure we have accurate and up-to-date information to inform our baseline medical establishments.

To maintain safety and reduce harm, the Trust's Performance and Review Meetings review referral activity into our community teams and assess and support day-to-day operational management decisions taken in response to changes in demand.

Risk assessment and care planning

A 'Patient Journey Tool' has been introduced, supported by training, to aid and prompt staff in the timely updating of patients' care records and care plans; enabling them to track progress and required care planning actions.

A multi--stakeholder Care Planning Stocktake workshop was held in July 2018, which identified the following initiatives which are being actively supported by service users:

i. A Care Plan Approach (CPA) mobilisation group has been established to drive improvement actions
ii. A Formulation and Dialog+ steering group is working toward improved quality and personalisation of care planning, documentation and co-production. A pilot is being undertaken in the first half of 2019 to inform Trust wide roll out in year
iii. A CPA quality and compliance sub-group has been established which includes identifying and making recommendations about care planning documentation to effect on-going improvement in the quality of care planning
iv. CPA simplification work is underway with the combining of core, risk and physical health information that will be introduced in the first half of 2019

3) **Seclusion environments and seclusion practice**

A Professional lead for Reducing Restrictive Interventions (RRI) was substantively appointed in August 2018 and an additional post will be recruited into.

A RRI Steering Group has been established and is monitoring all episodes of seclusion and compliance against code of practice standards. A standard operating procedure for 1-hour medical reviews was introduced in October 2018 and is resulting in improved performance. Simplified seclusion paperwork that is fully compliant with the code of practice is also now in place.

Facilities have been improved with two new seclusion facilities in King's Lynn and Great Yarmouth. However, the Chief Nurse is overseeing a review of policy to ensure that privacy and dignity is assured for service users at all times.

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1.5 Outstanding areas of concern

Staffing levels and morale, timely access across all services whilst keeping service users safe and in safe environments, appropriate care planning and risk assessments, alongside the development of a robust safety culture, are among the main outstanding areas of concern.

1.6 Actions for sustainable Improvement

The Trust recognises that to deliver sustainable organisational change and quality improvement, it must develop the ability to undergo successful transformation using a proactive and strategic approach rather than implementing more limited 'firefighting' responses to immediate challenges. To that end, a four-year draft strategic plan, with Project Management Office to support its delivery, has been developed. This identifies primary outcomes which have been themed across six-strategic intents. Service user and staff engagement in its development continues.

Within and alongside this, a portfolio of transactional actions to address issues within our latest CQC inspection report for more immediate delivery has been identified. These have been aligned to 14 themes which will have designated leads for each one. The Trust has been instructed to provide these actions to the CQC by the 2nd January 2019. Designated project support has been made available to support delivery and reporting of this work; and both this and the four-year improvement plan will be overseen by the QPB and reported to the Trust Board.

The support of the wider health system will be essential to the success of the improved access to high quality mental health services for all.

1.7 For further information please contact: Diane Hull, Chief Nurse; Email: diane.hull@nsft.nhs.uk Telephone: 01473 266288.

2.0 Waiting times information:-

a) Current waiting times compared to targets for emergency, urgent and routine referrals in each service, including referral to assessment and assessment to treatment

b) Current median and longest waiting times in each service, including referral to assessment and assessment to treatment

c) The numbers of individuals waiting longer than target times in each service, including referral to assessment and assessment to treatment.

2.1 About assessment and treatment contacts

A first assessment contact, identified in Lorenzo as an 'initial assessment', is clearly an assessment only contact. Contacts may also be designated as ongoing assessments in which there is more in-depth exploration about what has happened to the person, their personal circumstances, what may have helped or worsened symptoms in the past, etc. This may well have high therapeutic value but there is varying opinions about whether this constitutes commencement of treatment.

Unfortunately, there is not yet any nationally agreed definition for what constitutes treatment within mental health. This has resulted in most contacts, including 'ongoing assessment' being designated as a treatment contact. Referrals to treatment times only indicate a first contact of a type that has been designated as a treatment contact, and therefore does not measure progress along a clinical pathway.

With the lack of nationally agreed standards, the 18-week referral to treatment measure applied to Acute Trusts is also the default for mental health (with some notable exceptions, including the 14-day referral to treatment standard for first episode psychoses). However, more stringent measures have been locally agreed and used as performance measures within established contract monitoring meetings; this includes most of the standards shown by type in the tables at 2.2 and 2.3.

Establishing meaningful and robust ways to evidence progress following referral is part of the priority theme 'Access to services in the community and in crisis' listed in section 1 of this report (paragraph 1.4).

2.2 (a & c) Referrals to Assessment in Norfolk and Waveney (November 2018)

Pathway	Service Line	Type	Standard	Referrals	Actual % in standard	Actual # not in standard
COMPLETED	CFYP[1]	Emergency	4 hrs	18	72%	5
	CFYP	Urgent	120 hrs	24	88%	3
	CFYP	Routine	28 days	131	91%	12
	Access & Assess.	Emergency	4 hrs	12	100%	0
	Access & Assess.	Urgent	120 hrs	62	95%	3
	Access & Assess.	Routine	28 days	99	88%	12
	MH Liaison[2]	Emergency	4 hrs	173	98%	4
	MH Liaison	Urgent	24 hrs	75	92%	6
	MH Liaison	Routine	3 days	78	83%	13
	DIST[3]	Urgent	120 hours	57	75%	14
	[1]CFYP: Children, Families and Young People [2]MH Liaison: A&E / Acute Trust teams [3]DIST: Dementia Intensive Support Teams					

A 'Completed' assessment pathway means that the assessment contact has actually taken place in the reporting period.

Pathway	Service Line	Type	Standard	Referrals	Actual % in standard	Actual # not in standard
IN PROCESS	CFYP	Urgent	120 hrs	7*	57%	3
	CFYP	Routine	28 days	166	74%	43
	Access & Assess.	Emergency	4 hrs	2*	50%	1
	Access & Assess.	Urgent	120 hrs	18	67%	5
	Access & Assess.	Routine	28 days	188	80%	37
	MH Liaison	Emergency	4 hrs	1*	0%	1
	MH Liaison	Urgent	24 hrs	2*	0%	2
	MH Liaison	Routine	3 days	1*	0%	1

An 'In Process' assessment pathway means that that the assessment contact had not yet occurred by the end of the reporting period. The % in standard show the number of referrals that are still within the standard time at end of the reporting period.

* % in standard is less helpful when numbers of referrals is low. Action will have been taken within standard, and assessment outside of standard will invariably be arrangement due to patient, carer, or referrer choice.

2.3 (a & c) Referrals to Treatment in Norfolk and Waveney (November 2018)

Pathway	Service Line	Type*	Standard	Referrals	Actual % in standard	Actual # not in standard
COMPLETED	Access & Assess.	RTT	84 days	82	99%	1
	CFYP	RTT	84 days	166	100%	0
	Early Intervention	RTT	14 days	6	67%	2
	Eating Disorders	UPRTT	1 week	4	100%	0
	Eating Disorders	RPTT	4 weeks	8	75%	2
	Suffolk IDTs[1]	RTT	84 days	7	100%	0
	Unallocated Service Line	RTT	12 hours	7	29%	5
	Adult Acute	ATT	12 hours	351	87%	47
	Access & Assess.	RTT	28 days	173	93%	12
	Adult Community	RTT	18 weeks	313	100%	1
	Adult Acute Service	RTT	12 hours	6	83%	1
	CFYP	RTT	56 days	120	93%	9
	DCLL	RTT	18 weeks	531	100%	1
	Early Intervention	RTT	14 days	18	94%	1
	Suffolk IDTs	RTT	28 days	3	67%	1
	Unallocated Service Line	RTT	12 hours	10	10%	9
	[1]IDT: Integrated Delivery Team [2]DCLL: Dementia and Complexity in Later Life					

A 'Completed' treatment pathway means that a face-to-face treatment contact has actually taken place in the reporting period.

Pathway	Service Line	Type*	Standard	Referrals	Actual % in standard	Actual # not in standard
IN PROCESS	Access & Assess.	RTT	84 days	87	100%	0
	CFYP	RTT	84 days	180	97%	5
	Early Intervention	RTT	14 days	2	50%	1
	Eating Disorders	UPRTT	1 week	1	0%	1
	Eating Disorders	RPRTT	4 weeks	11	55%	5
	Suffolk IDTs	RTT	84 days	0	-	-
	Unallocated Service Line	RTT	12 hours	14	0%	14
	Adult Acute	ATT	12 hours	3	0%	3
	Access & Assess.	RTT	28 days	208	81%	39
	Adult Community	RTT	18 weeks	243	100%	0
	CFYP	RTT	56 days	168	80%	34
	DCLL	RTT	18 weeks	655	100%	0
	Early Intervention	RTT	14 days	4	25%	3
	Unallocated Service Line	RTT	12 hours	17	6%	16

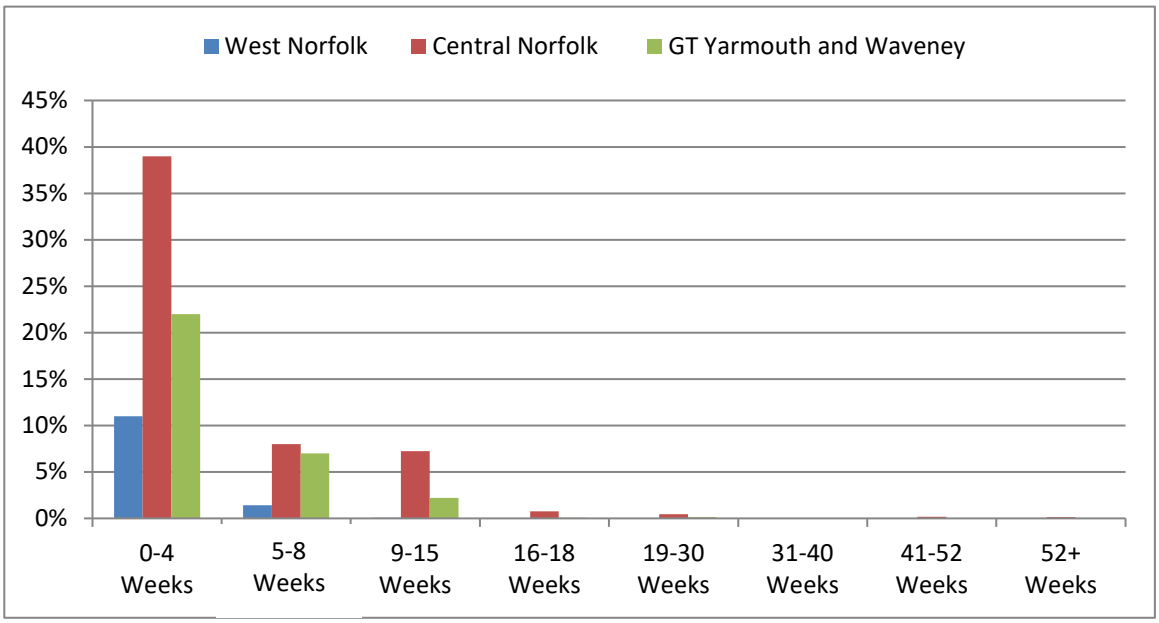
An 'In Process' pathway means that that a treatment contact had not yet commenced by the end of the reporting period. The % in standard shows the number of referrals that are still within the standard time at end of the reporting period.

*Type legend			
RTT	Referral to Treatment	UPRTT	Urgent Priority Referral to Treatment
ATT	Assessment to Treatment	RPRTT	Routine Priority Referral to Treatment
EPRTT	Emergency Priority Referral to Treatment		

2.4 (b) The following table provides a snap shot of the current waiting time status (as at 13 December 2018) for referral to 1st treatment contact (for 'in process' waits).

Locality & Service Line	0-4 Wks	5-8 Wks	9-15 Wks	16-18 Wks	19-30 Wks	31-40 Wks	41-52 Wks	52+ Wks	Grand Total
West Norfolk	**172**	**22**	**1**						**195**
Adult Acute	1	1							2
Adult Community	41	6	1						48
CFYP	51	8							59
DCLL	79	7							86
Central Norfolk	**621**	**132**	**115**	**12**	**7**		**3**	**2**	**892**
Access & Assessment (SPOA)	48	2	1						51
Adult Acute	4								4
Adult Community	118	23	4	1	1				147
CFYP	219	28	21	2	5		3	2	280
DCLL	232	79	89	9	1				410
GT Yarmouth and Waveney	**343**	**117**	**35**	**1**	**2**				**498**
Access & Assessment (SPOA)	200	43	5						248
Adult Acute	2								2
Adult Community	18	7	1	1					27
CFYP	25	21	1		2				49
DCLL	91	46	28						165
Neurodevelopmental	7								7
Total	**1136**	**271**	**151**	**13**	**9**		**3**	**2**	**1585**

This graph shows this information by percentage reduction over time:



The rapid fall by 72% within 4 weeks and 98% within 15 weeks is evidence of the work being done to be as responsive as possible in the face of the growth in demand.

2.5 (a, c & b) The following table provides waiting time information for the Norfolk and Waveney Wellbeing service for November 2018 (see also 4.8).

Standard Definition	Standard	Target	Denom. (Referrals in month)	Actual %	Avg. Wait
Number waiting 3 working days or less for first contact from service following receipt of referral	3 working days	95%	2794	**98.7%**	2
Number awaiting first treatment contact but waiting 15 working days or less	15 working days	**95%**	2571	**63.4%**	13
Number awaiting first treatment contact but waiting less than or equal to 6 weeks	42 calendar days	**75%**	2198	**91.5%**	20
Number awaiting first treatment contact but waiting less than or equal to 18 weeks	126 calendar days	**95%**	2198	**100.0 %**	20
Number awaiting second treatment contact waiting 28 calendar days or less	28 calendar days	**95%**	1977	**54.1%**	40

3.0 The number of patients waiting for first contact from NSFT and a breakdown of how many are in Norfolk & Waveney, and how many are children & young people, adult, older people.

3.1 The overall total number of people waiting for first treatment contact in all Trust services as at 13 December 2018 is 2640, which represents a slight fall of 3.4% compared the number reported in October 2018.

1585 (60%) of these are in Norfolk and Waveney and 1056 (40%) in Suffolk.

3.2 The Norfolk and Waveney waiting time breakdown information is shown in the table at 2.3 above and, by percentage by locality and service line, is as follows:

Locality & Service Line	Grand Total	Percentage
West Norfolk	**195**	**12.3%**
Adult Acute	2	0.1%
Adult Community	48	3.0%
CFYP	59	3.7%
DCLL	86	5.4%
Central Norfolk	**892**	**56.3%**
Access & Assessment (SPOA)	51	3.2%
Adult Acute	4	0.3%
Adult Community	147	9.3%
CFYP	280	17.7%
DCLL	410	25.9%
GT Yarmouth and Waveney	**498**	**31.4%**
Access & Assessment (SPOA)	248	15.6%
Adult Acute	2	0.1%
Adult Community	27	1.7%
CFYP	49	3.1%
DCLL	165	10.4%
Total	**1585**	**100%**

4.0 Access and assessment information:-

Description of how access and assessment is currently managed in each of the N&W localities; including:-

a) the times that the access and assessment teams are available,

b) the numbers and types of staff involved (including the clinical component and the administrative support component);

c) the systems used for initial triage and then for assessment and how these distinguish between emergency, urgent and routine need;

d) the differences between access and assessment teams in terms of:-

i. numbers signposted away from NSFT,

ii. numbers allocated to the Wellbeing service

iii. numbers allocated to the most appropriate NSFT specialist service line. Including explanation of what 'allocated' means in b & c (i.e. what is the process by which an individual who has been assessed as needing the Wellbeing service or a specialised service line gets taken up by those services?)

4.1 **About Access and Assessment**

Following a review of Access and Assessment in secondary services in 2014/15, this function was reduced to Single Points of Access (SPOA). This included moving most of the clinical staffing resource back into clinical teams to improve efficiency and safety, with the SPOA providing only an administrative and clinical triage function.

4.2 (a) The Wellbeing Service has its own fully integrated single point of access and accepts self-referrals as well as referrals from friends, carers and health and social care professionals. The telephone number for referrals as well as general enquiries is **0300 123 1503** and operates from 08:00 to 20:00 Monday to Friday (excluding bank holidays). Referrals can also be made online 24/7 via www.wellbeingnands.co.uk/.

4.3 (a) For secondary service referrals in Norfolk and Waveney, the Trust has two main Single Points of Access (SPOA) as follows:

Admin Base	Telephone Number	Operating hours	Service Lines	Area covered
Hellesdon Hospital, Norwich	0300 790 0371	09:00 to 18:00	All Secondary Service Lines	Central and West Norfolk
Northgate Hospital, Great Yarmouth	01493 337958	09:00 to 18:00	All Secondary Service Lines	Great Yarmouth & Waveney

Some specialist services and teams (e.g. Memory Assessment) still accept direct referrals, and these are registered by a team administrator in the same way as by SPOA. If a team receives a referral that is not considered appropriate for the local team, this is forwarded to the SPOA to action.

4.4 (c) The SPOAs provides an administrative function registering referrals on Lorenzo, our Electronic Patient Record (EPR) System for all service lines. The SPOA also has clinical practitioners who liaise with referrers for more information when required to inform allocation and confirm or regrade referral priority (see section 5).

SPOA	Lorenzo Referral Logging	Liaison with referrer / referral prioritisation
Children, Families and Young People	Yes	Service line
Adult Community	Yes	SPOA
Adult Acute (CRHT)	Yes	Crisis teams
Adult Acute (inpatient)	Yes	Bed Management team
Dementia and Complexity Later Life	Yes	Variable depending on reason for referral
Specialist services*	Yes	Specialist teams
* e.g. Memory assessment, Neurodevelopmental, Early Intervention, Eating Disorders,		

As the administrative registering and allocation of referrals to clinical teams is done electronically, the referral becomes visible to the allocated team immediately the referral has been allocated.

Prior to 2015, all referrals received clinical triage and initial assessment by the Access and Assessment Team and the staffing resource included administrative and clinical staff. However, this approach proved inefficient for a number of reasons, including an increase in repeated assessments when referrals were subsequently allocated to teams.

When the Access and Assessment function was reconfigured in 2015, some clinical members of staff were retained for the reduced SPOA function while others were redeployed within the service lines. The administrative members of staff were retained to provide the SPOA function of registering referrals.

SPOA retains the system name of Access and Assessment, and until a referral has been accepted by another team the referral will show on waiting list reports as a wait within the Access and Assessment team (as show in section 2).

4.5 (b) Single Point of Access staffing

SPOA	Administrative staff	Clinical
Central and West Norfolk	2 WTE Team Administrators 2 WTE Data Technicians	5 WTE (Senior Mental Health Practitioners) 1 WTE (Senior Mental Health Practitioners stationed with the multi-agency Norwich Escalation & Avoidance Team (NEAT) at Lakeside)
	The SPOA is hosted by the Acute Service Line and provides office administrator and MHP line management and business support. Variable additional admin resource is available, as required, to respond to SPOA workload pressures.	
Great Yarmouth & Waveney	1.0 WTE Office Manager 2.34 WTE Team Administrators 3.67 WTE Data Technicians	In reach from service lines – variable (responding to workload)

4.6 (d i & ii) Referral outcomes via SPOA (based on referrals received in 17/18)

The following table shows the movement of referrals through SPOA and into other teams.

From 1st referral to 2nd referral in episode		
1) 1st Referrals to SPOA	**#**	**%**
GP referrals to SPOA to NSFT Community & EIP[1]	2,393	12%
GP referrals to SPOA to Other[2] NSFT Teams	11,059	54%
GP referrals signposted to other (non-NSFT) services or returned to GP	6,925	34%
Total	20,377	100%
2) Referrals from other (excluding A&E):		
GP referrals to SPOA to NSFT Community & EIP[1]	860	28%
Other referrals to SPOA to Other[2] NSFT Teams	1,655	53%
Other referrals signposted to other (non-NSFT) services including GP	596	19%
Total	3,111	100%
3) 1st referrals by A&E		
A&E to NSFT Community & EIP[1]	167	5%
A&E to Other[2] NSFT Teams	868	27%
A&E to Acute MH Beds[3]	30	1%
A&E to signposted to other (non-NSFT) services / care of GP	1,308	40%
Total	3,241	100%
4) 1st Referrals to Crisis care		
GP Referrals to Crisis care to Acute MH Beds[3]	24	
Other Referrals to Crisis care to Acute MH Beds[3]	31	

[1] There are 22 teams in N&W designated in his category that primarily includes adult community and early intervention teams.

[2] There are 84 teams in N&W designated as 'Other NSFT teams' including CFYP and DCLL teams and adult and older persons inpatient wards, as well as other specialist teams like neurodevelopmental and eating disorders.

[3] This designation is for non-NSFT Acute MH Beds and includes Out of Area.

4.7 The table above shows about 1 in 3 of all referrals are signposted / returned to the GP. However, there may be a data quality issues increasing this number above the actual percentage returned to the GP. The referrals shown are all new referrals and this will include people who already have an active referral within a Community or Other NSFT team. A clinical note of the repeat referral will added to the patient's record and the new referral is mostly likely to be closed with a designation of returned to GP.

4.8 (d iii) The SPOA outcome information in the table at 4.6 does not include referral to the Norfolk and Waveney Wellbeing service. Wellbeing has a separate Electronic Records System IAPTus), and comprehensive monthly performance reports are provided for contract monitoring purposes.

The table below provides an example of the relevant measures from the Norfolk and Waveney Wellbeing Service activity for September to November 2018 (see also 2.5).

Description	N&W Aggregate (all CCGs)		
	Sep	Oct	Nov
The number of people who are referred for psychological therapies	2317	2700	2805
Number of people who enter treatment	1135	1552	1779
Number of people referred who subsequently go on to enter treatment (conversion rate)	49.0%	57.5%	63.4%
Number of **self-referrals** received by the service	1727	1956	2072
Number of **GP referrals** received by the service	431	520	485
Number of referrals from **other sources** received by the service	159	224	248
Active caseload - received assessment, on treatment pathway at end of month	7131	7291	7260

5.0 The trend in NSFT downgrading the urgency rating of referrals to the services including the percentage and number downgraded month-by-month since February 2018:-

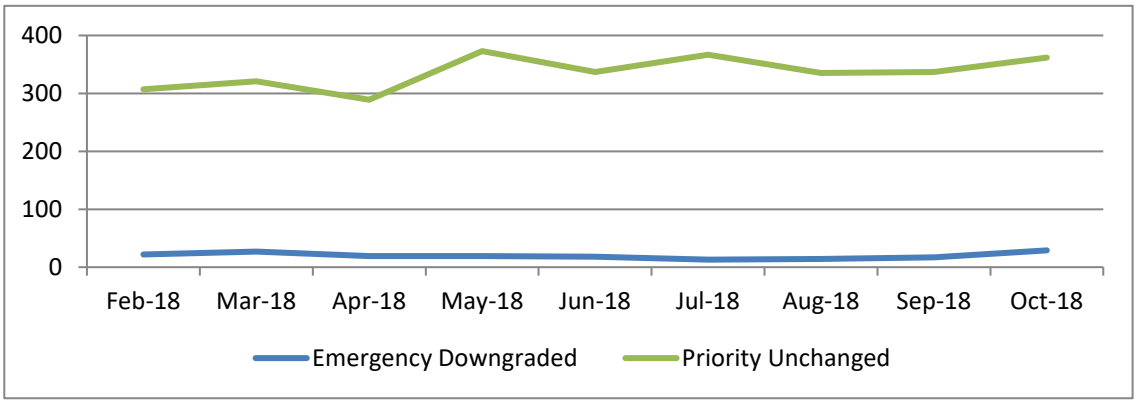
a) Emergency referrals downgraded to urgent or routine

b) **Urgent referrals downgraded to routine**

5.1 (a) Emergency referrals downgraded to urgent or routine, Feb to Oct 2018

Month	Emergency Downgraded	Emergency Upgraded	Priority Unchanged	Grand Total	% downgraded
Feb-18	22	n/a	307	329	6.7%
Mar-18	27	n/a	321	348	7.8%
Apr-18	19	n/a	289	308	6.2%
May-18	19	n/a	373	392	4.8%
Jun-18	18	n/a	337	355	5.1%
Jul-18	13	n/a	367	380	3.4%
Aug-18	14	n/a	335	349	4.0%
Sep-18	17	n/a	337	354	4.8%
Oct-18	29	n/a	362	391	7.4%

Emergency referral priority change trends:



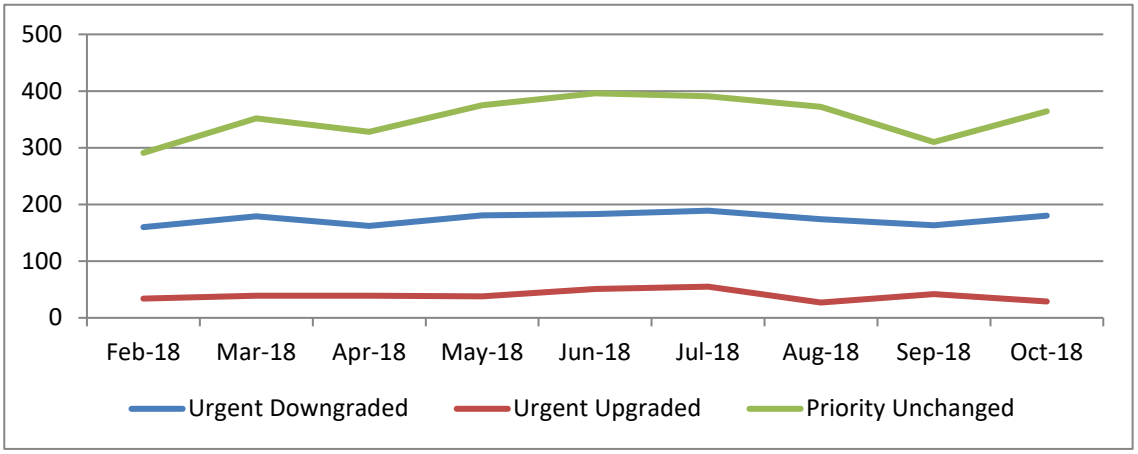
Nearly all emergency referrals that are downgraded are re-graded to urgent and contact scheduled within 5 days / 120 hours. It is rare for an emergency referral to be downgraded to routine.

However, it is important to note that the number of urgent referrals upgraded to emergency shown in the 'Urgent Upgraded' column the table below, is notably higher than the numbers shown in the 'Emergency Downgraded' column above. This provides corroborating evidence that the triage undertaken within SPOA is appropriately clinically driven.

5.2 (b) Urgent referrals downgraded to urgent or routine, Feb to Oct 2018

Month	Urgent Downgraded	Urgent Upgraded	Priority Unchanged	Grand Total	% downgraded
Feb-18	160	34	291	485	33.0%
Mar-18	179	39	352	570	31.4%
Apr-18	162	39	328	529	30.6%
May-18	181	38	375	594	30.5%
Jun-18	183	51	396	630	29.0%
Jul-18	189	55	391	635	29.8%
Aug-18	174	27	372	573	30.4%
Sep-18	163	42	310	515	31.7%
Oct-18	180	29	364	573	31.4%

Urgent referral priority change trends:



5.3 New controls have been introduced from 5 December 2018, that requires:

- A second clinician to review the decision to downgrade
- Emergency referrals require a face-to-face contact with the service users to achieve the 4-hour compliance

6.0 The number of patients currently without a named care co-ordinator

6.1 The table shows the number of people waiting for allocation to a Care Coordinator (CC) or Lead Care Professional (LCP)

	Total Trust-wide	N&W Total	West Norfolk	Central Norfolk	GY&W
Total number of people awaiting allocation to a CC or LCP	7726	4984	726	2842	1416
	100%	64%	(15%)	(57%)	(28%)
People who are unallocated but receiving treatment	2603	1816	376	851	589
	100%	70%	(21%)	(47%)	(32%)
(%) = percentage of N&W only total					

The number of people waiting for allocation to a Care Coordinator or Lead Care Professional is a concern, with Central Norfolk a particular pressure point. A reduction in this number is one of the primary objectives of the Access Improvement Task Force, chaired by our Chief Operating Officer and will be meeting with Commissioners in January. (This is part of the first priority theme listed in paragraph 1.4 above.)

6.2 The safety of those on the waiting list is manged by providing information about how to make contact with the team, and the team's duty worker initiates contact in line with the application of an intervention level as part of Clinical harm Review processes. This helps to prioritise the allocation of any person who is experiencing a worsening of symptoms.

They are also able to access Recovery College courses. Great Yarmouth and Waveney have established a Recovery Information Centre (RIC) at Victoria House in Lowestoft where people on the waiting list can be signposted for information about housing support, finance, citizens advice, etc. A similar resource is being planned at Northgate Hospital in Great Yarmouth. The effectiveness of this initiative will be evaluated in 2019 in considering a similar information resource can be replicated in other parts of the Trust, including in Norwich.

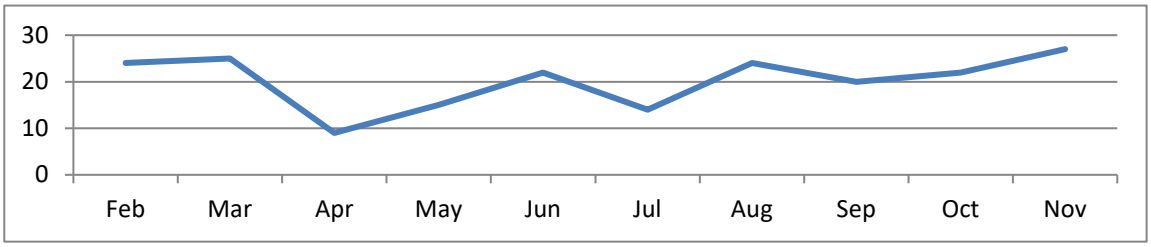
Those in the 'unallocated but receiving treatment group' are 'team held' and in contact with members of the team who are not designated as CCs or LCPs. This includes the team's duty worker (a registered clinical member of the team), assistant practitioners, care support workers and peer support workers.

7.0 The trend in out-of-Trust placements (except for placements in an appropriate tier 4 specialist services not provided within NSFT's area) – figures showing month-by-month out of-Trust (OOT) placements since February 2018 showing both the number of individual placements and the total bed days; showing OOT placements within Norfolk and Suffolk as well as OOT placements outside the two counties; showing the locations of the placements and the organisations with which the patients are placed, showing the category of patients - adult; child and adolescent mental health services (CAMHS); dementia with complexity in later life; complexity in later life; with totals in each category (*i.e. updating the info provided to NHOSC for 5 April 2018, item 6 Appendix C*)

7.1 Norfolk and Waveney patients placed Out Of Trust Area (OOTA), Feb to Nov 2018

Service line	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Total
ADULT ACUTE	16	19	3	9	18	12	18	16	20	23	**154**
ADULT PICU	1	5	2	2	3	0	2	2	1	4	**22**
OP – functional (CLL)	4	0	4	3	1	2	3	2	1	0	**20**
OP – Dementia (DCLL)	3	1	0	1	0	0	1	0	0	0	**6**
TOTAL	**24**	**25**	**9**	**15**	**22**	**14**	**24**	**20**	**22**	**27**	**202**

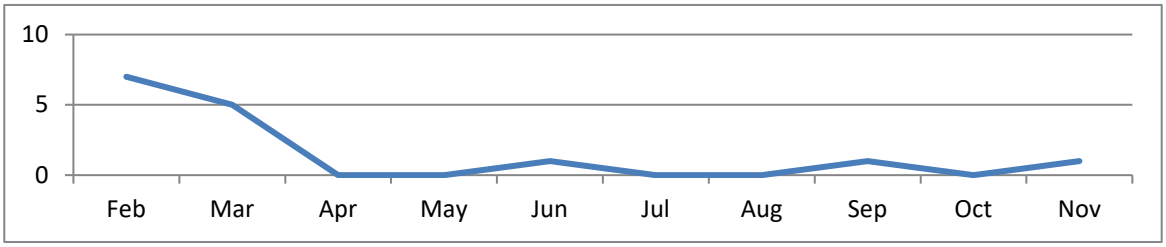
Total OOTA showing trend



7.2 Patients placed Out Of Trust (OOT) but in Norfolk and Suffolk (in area)

OOT IN NORFOLK	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Total
ADULT (Norfolk)	4	5	0	0	1	0	0	1	0	1	**12**
OP – Functional (CLL)	2	0	0	0	0	0	0	0	0	0	**2**
OP – Organic (DCLL)	1	0	0	0	0	0	0	0	0	0	**1**
TOTAL	**7**	**5**	**0**	**0**	**1**	**0**	**0**	**1**	**0**	**1**	**15**

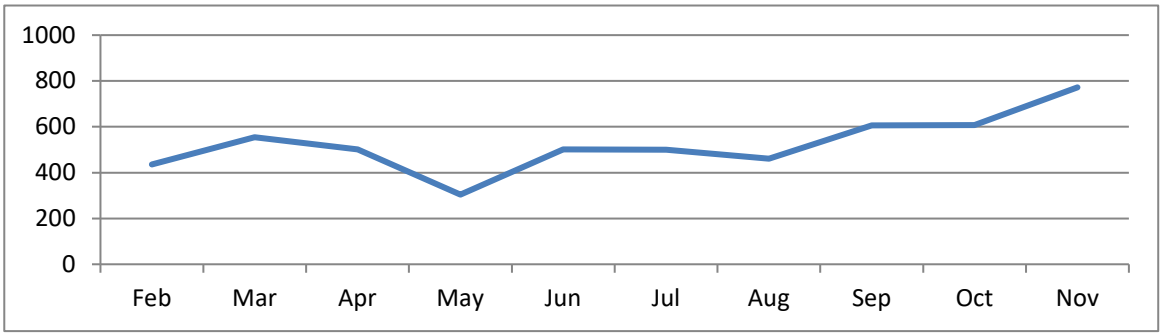
Total OOT, in area, showing trend



7.3 Bed days OOTA, Feb to Nov 2018

OOTA BED DAYS	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Total
TOTAL	**436**	**555**	**502**	**304**	**502**	**500**	**461**	**606**	**608**	**772**	**5246**

Total OOTA bed days showing trend



Local factors contributing to the recent rise in OOTA bed days, include:

- Compliance concerns following CQC inspections of a number of independent care homes in the region resulting in closure or placement restrictions

- Within the Trust we have an example of this with the change of usage of St. Catherine's way (see section 17)

This is causing increasing difficulty finding placements for patients medically fit for discharge but who have ongoing personal care needs.

7.4 OOTA (Feb to Nov) destinations by facility name.

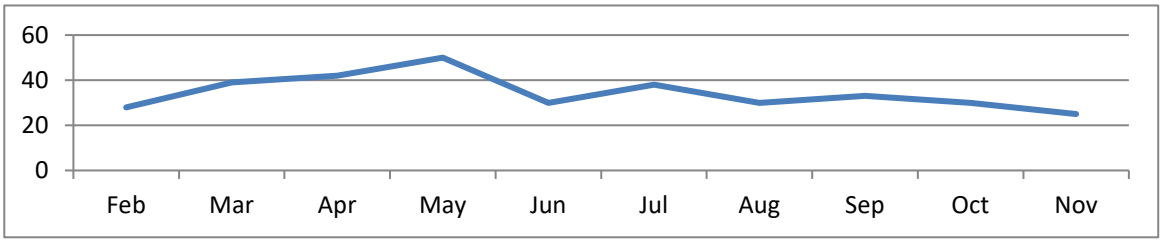
OOTA BED DAYS	Total
PRIORY ELLINGHAM	271
PRIORY CHELMSFORD	820
PRIORY TICEHURST	572
PRIORY MIDDLETON ST GEORGE	106
PRIORY WOKING	202
PRIORY ROEHAMPTON	151
PRIORY LAKESIDE	99
PRIORY CHEADLE	145
PRIORY BRISTOL	152
PRIORY SOUTHAMPTON	47
PRIORY ALTRINCHAM	74
PRIORY POTTERS BAR	49
PRIORY BURGESS HILL	16
PRIORY KNEESWORTH	263
ST.ANDREWS NORTHAMPTON OP	325
ST ANDREWS ESSEX	186
ST ANDREWS NORTHAMPTON (ADULT)	244
CYGNET STEVENAGE	234
CYGNET BIERLEY	148
CYGNET BECKTON	15
CYGNET WYKE	88
CYGNET HARROGATE	414
CYGNET BLACKHEATH	36
CYGNET HARROW	244
CYGNET COLCHESTER	120
CYGNET AUGUSTINES	43
CYGNET CHURCHILL	9
HUNTERCOMBE ROEHAMPTON	28
MUNDESLEY SOUTHERN HILL	44
MILE END HOSP TOWER HAMLET	68
NHS NEWHAM CENTRE, LONDON	28
NHS SWALLOWNEST COURT ROTHERHAM	5
TOTAL	5246

8.0 A similar breakdown of figures showing month-by-month placements of patients in beds within NSFT but outside of their own locality over the past 6 months (i.e. out of home area (OOHA) placements).

8.1 Patients in a Trust bed, but Out Of Home Area (OOHA), February to November 2018

OOHA PLACEMENTS	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Total
OOHA WARD (and Locality)											
SOUTHGATE (West Suffolk)	3	8	9	4	6	5	1	0	1	0	**37**
NORTHGATE (West Suffolk)	2	3	1	1	1	0	0	0	0	0	**8**
AVOCET (East Suffolk)	4	7	2	6	2	5	3	6	2	2	**39**
POPPY (East Suffolk)	2	4	2	4	3	6	2	4	4	3	**34**
GYAS (Gt. Yarmouth & Waveney)	11	6	17	25	9	11	14	17	15	15	**140**
THURNE (Central Norfolk)	0	2	4	1	2	1	1	2	0	0	**13**
GLAVEN (Central Norfolk)	1	0	1	2	1	1	3	0	1	0	**10**
WAVENEY (Central Norfolk)	1	1	0	0	3	4	1	0	1	1	**12**
CHURCHILL (West Norfolk)	3	8	6	7	1	5	5	4	5	4	**48**
PICU											
LARK	1	0	0	0	0	0	0	0	0	0	**1**
CLL/DCLL											
ABBEYGATE	0	0	0	0	1	0	0	0	0	0	**1**
WILLOWS	0	0	0	0	1	0	0	0	1	0	**2**
TOTAL	**28**	**39**	**42**	**50**	**30**	**38**	**30**	**33**	**30**	**25**	**345**

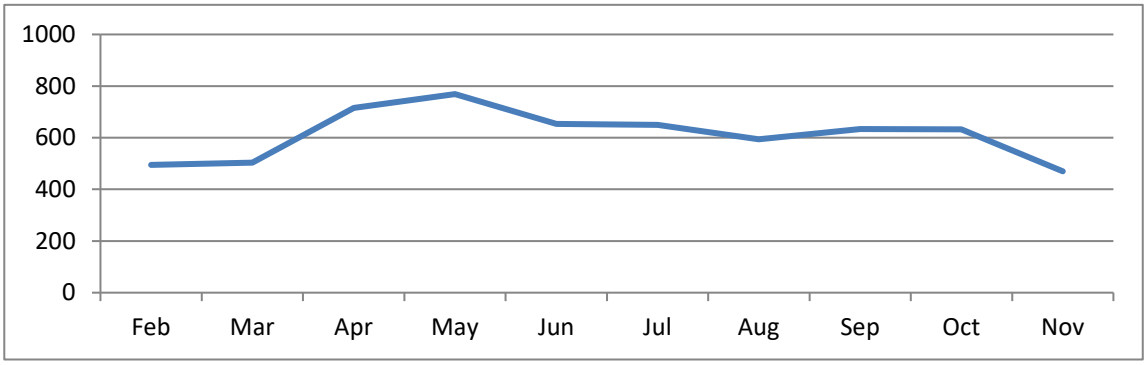
Total placed OOHA showing trend since February 2018



8.2 Patients' bed days OOHA, February to November 2018

OOHA BED DAYS	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Total
ADULT											
SOUTHGATE	15	20	41	50	27	69	11	0	5	0	**238**
NORTHGATE	32	82	85	53	54	41	9	0	14	0	**370**
AVOCET	46	101	110	56	4	46	42	82	92	25	**604**
POPPY	25	69	68	51	64	43	28	35	80	40	**503**
GYAS	264	122	188	290	242	191	224	252	229	257	**2259**
THURNE	0	9	30	62	59	20	31	60	31	30	**332**
GLAVEN	9	0	9	47	47	26	17	40	47	0	**242**
WAVENEY	24	23	30	2	23	65	77	0	2	5	**251**
CHURCHILL	76	78	155	158	111	100	124	135	100	101	**1138**
PICU											
LARK WARD	4	0	0	0	0	0	0	0	0	0	**4**
CLL/DCLL											
ABBEYGATE WARD	0	0	0	0	17	18	0	0	0	0	**35**
WILLOWS	0	0	0	0	5	31	31	30	33	12	**142**
TOTAL	**495**	**504**	**716**	**769**	**653**	**650**	**594**	**634**	**633**	**470**	**6118**

Total bed days OOHA showing trend since February 2018



There is a gradually reducing trend in patients and bed days OOHA that provides evidence that our effort to treat people as close to home as possible is having some effect.

9.0 Within each service line, broken down month-by-month since Feb 2018:-

a) Number of serious untoward incidents

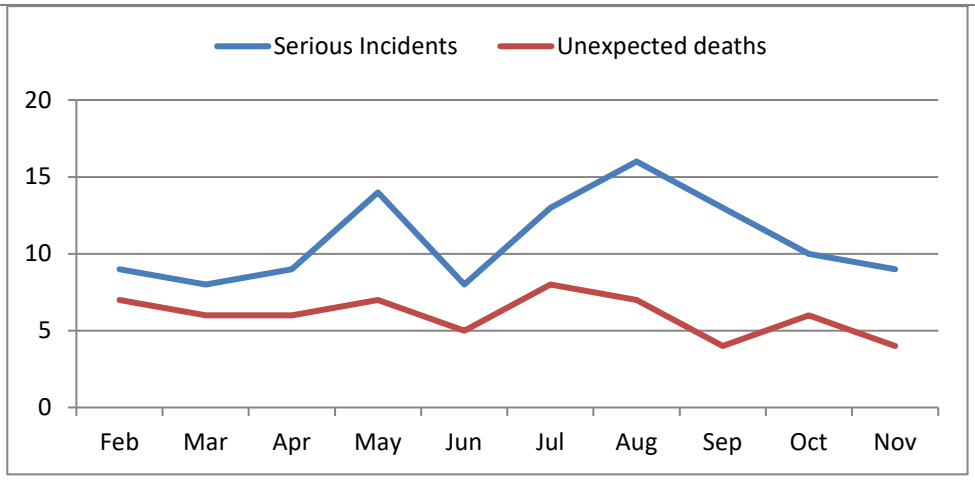
b) Unexpected deaths

c) Pathway status serious incidents and unexpected deaths (e.g. on waiting list, waiting for allocation, in service receiving treatment, discharged.)

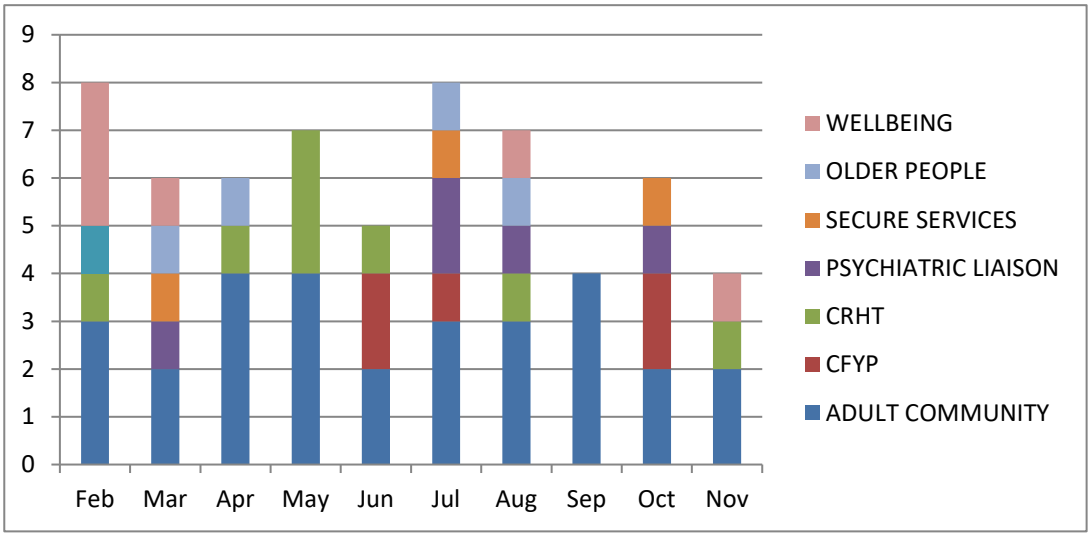
9.1 (a & b) Total reported serious incidents, including number categorised as unexpected deaths by service line in Norfolk and Waveney

Serious Incidents by Service Line	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov
ADULT COMMUNITY										
Serious Incidents	3	2	4	4	2	3	3	4	2	2
Unexpected deaths	3	2	4	4	2	3	3	4	2	2
CFYP										
Serious Incidents	0	0	0	2	5	4	2	1	4	3
Unexpected deaths	0	0	0	0	2	1	0	0	2	0
CRHT										
Serious Incidents	1	0	1	3	1	0	1	0	0	1
Unexpected deaths	1	0	1	3	1	0	1	0	0	1
PSYCHIATRIC LIAISON										
Serious Incidents	0	1	0	0	0	2	1	1	1	0
Unexpected deaths	0	1	0	0	0	2	1	0	1	0
ACUTE INPATIENT										
Serious Incidents	0	0	0	0	0	1	2	3	0	1
Unexpected deaths	0	0	0	0	0	0	0	0	0	0
SECURE SERVICES										
Serious Incidents	2	1	3	3	0	2	4	4	3	1
Unexpected deaths	0	1	0	0	0	1	0	0	1	0
OLDER PEOPLE										
Serious Incidents	0	3	1	2	0	1	2	0	0	0
Unexpected deaths	0	1	1	0	0	1	1	0	0	0
WELLBEING										
Serious Incidents	3	1	0	0	0	0	1	0	0	1
Unexpected deaths	3	1	0	0	0	0	1	0	0	1
TOTAL										
Serious Incidents	9	8	9	14	8	13	16	13	10	9
Unexpected deaths	7	6	6	7	5	8	7	4	6	4

Total by month:



9.2 (a & b) Unexpected deaths by Service Line in Norfolk and Waveney



9.3 (c) Pathway status of serious incidents and unexpected deaths (Feb to Oct only)

The information available at the time of report submission only disaggregates into those with an open or active referral and those who are within 6 months of discharge, as follows:

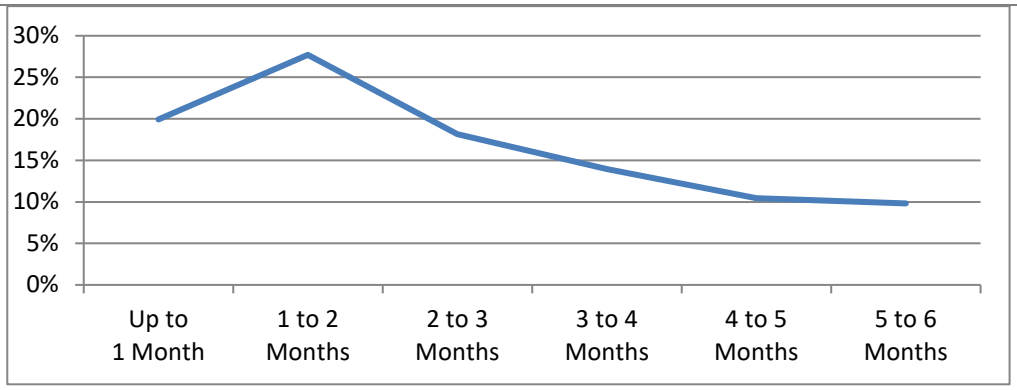
Type	Total	Status	Number
Unexpected Deaths	56	Open	86
		Discharged	14
Other Serious Incidents	100	Open	86
		Discharged	14

10.0 Number of people discharged form services who are re-referred within 6 months.

10.1 Re-referrals in Norfolk and Waveney of people who have been discharged within the previous 0 to 6 months (based on discharges in December 2017 to April 2018).

Measure	Number	Percentage
Total discharged (Dec 17 to April 18)	15,078	100%
Total re-referrals, 0 to 6 months following discharge.	2469	17%

Re-referral trend (based on total re-referrals over 6 months):



11.0 NSFT's income in 2017-18 & 2018-19 and the number of referrals to NSFT in 2017-18 & 2018-19 (*i.e. updating the table provided in NSFT's report to 5 April 2018 NHOSC, paragraph 5*)

11.1 Trust's total yearly income since 2012/13 (All NSFT)
(also showing % change compared with 2012/13 as baseline)

	2012/13 £m	2013/14 £m	2014/15 £m	2015/16 £m	2016/17 £m	2017/18 £m
Income	219	217	213	212	216	227
% change	–	-0.9%	-2.7%	-3.2%	-1.4%	+3.7%

It should be noted that this includes income from a range of commissioning organisations and changes in commissioned services (i.e. ending of the section 75 arrangements in Norfolk and the Norfolk Recovery Partnership).

There has been increased investment in services in Norfolk and Waveney that will be captured in the response to the NHOSC questions to N&W CCGs.

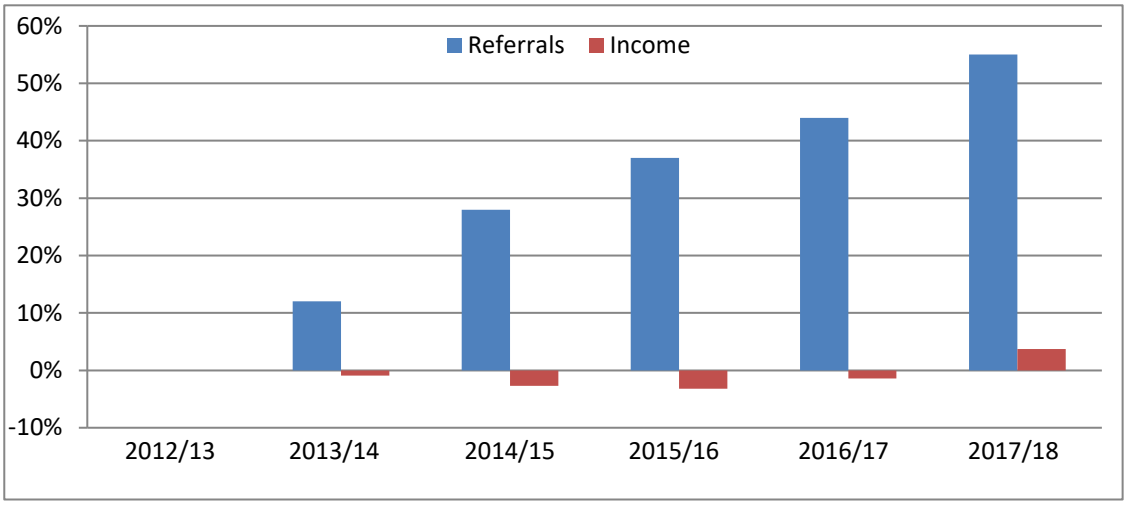
11.2 Trust's total yearly referrals since 2012/13 (All NSFT)
(also showing % change compared with 2012/13 as baseline)

	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
Referrals	65,107	73,248	83,390	89,334	94,085	101,056
% change	–	+12%	+28%	+37%	+44%	+55%

Referrals in the first eight months of this year (18/19) are 68,198. The estimated full year effect is 102,018.

Referrals to Wellbeing services for people with mild to moderate mental health needs account for a large proportion of the growth in referrals.

11.3 Percentage income and referral changes since 2012/13



This graph needs to be treated with caution due to the contractual changes, impact of Wellbeing activity and areas of increased investment referenced in 11.1 and 11.2. Please do not replicate in isolation and without the context of this report. However, it is included here as it does provide an important correlation with some of the other areas of concern identified within this report (i.e. in 4.7 and 6.1).

12.0 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.

12.1 Vacancy status as at 30 November 2018

	Number of Vacancies	Vacancy Rate	Number of staff on maternity leave	Number of staff on long-term sick
Central Norfolk Adult and DCLL	42.61	5.49%	9	21
Great Yarmouth & Waveney Adult & DCLL	23.39	6.88%	8	4
West Norfolk Adult and DCLL	13.75	8.04%	2	4
Norfolk & Waveney Adult and DCLL Total	**79.75**	**6.20%**	**19**	**29**
Central Norfolk CFYP	-1.8	-0.92%	11	3
Great Yarmouth & Waveney CFYP	5.65	2.36%	6	3
West Norfolk CFYP	2.52	5.24%	1	0
Norfolk & Waveney CFYP Total	**6.37**	**1.32%**	**18**	**6**
Norfolk & Waveney Total	**86.12**	**4.87%**	**37**	**35**
Trust Total	**368**	**8.92%**	**75**	**79**

Short term vacancies in community teams are covered within the team. Longer term vacancies, due to unfilled posts, extended sick leave, maternity leave, etc., are frequently covered by temporary staff on longer term contracts.

The most critical vacancies are in our inpatient wards that accounts for most of our agency and bank use.

12.2 Bank / Agency fill rate – Inpatient Wards (October 2018)

	Day		Night	
Ward name	Average fill rate - registered nurses (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses (%)	Average fill rate - care staff (%)
Abbeygate Ward	91.2%	91.1%	94.3%	89.8%
Avocet Ward	93.8%	162.4%	84.5%	222.4%
Beach Ward	80.2%	125.9%	53.1%	151.4%
Catton Ward	119.2%	165.0%	100.2%	259.6%
Churchill Ward	118.8%	93.0%	93.7%	107.4%
Dragonfly Unit	98.6%	88.5%	98.4%	106.4%
Drayton Ward	85.1%	105.1%	100.0%	108.0%
Foxhall House	94.6%	125.4%	60.2%	182.7%
Glaven Ward	101.3%	122.4%	85.4%	188.2%
Great Yarmouth Acute Services	96.3%	93.4%	102.5%	119.1%
Lark Ward	114.5%	93.9%	85.3%	97.7%
Laurel Ward	76.0%	132.0%	100.0%	134.8%
Northgate Ward	95.0%	98.4%	79.1%	118.7%
Poppy Ward	67.8%	117.3%	73.9%	175.1%
Reed Ward	92.4%	100.0%	132.9%	106.4%
Rollesby Ward	72.0%	152.3%	91.0%	123.2%
Rose Ward	63.3%	181.8%	158.5%	200.0%
Sandringham Ward	85.2%	105.9%	97.1%	101.7%
Southgate Ward	109.1%	101.5%	97.0%	100.0%
Suffolk Rehabilitation and Recovery Service	64.1%	124.2%	106.4%	96.3%
Thorpe Ward	105.7%	109.2%	120.2%	128.2%
Thurne Ward	81.3%	153.4%	88.7%	143.4%
Walker Close	80.2%	111.2%	66.2%	144.6%
Waveney Ward	114.1%	125.1%	88.6%	144.9%
Whitlingham Ward	74.1%	105.4%	55.1%	155.4%
Willow Ward	95.7%	145.2%	98.7%	175.4%
Yare Ward	78.2%	108.5%	103.8%	108.8%

The risk from unfilled registered nursing shifts is mitigated through maintaining staffing numbers with an increased number of non-registered care staff as this table clearly shows (see also 12.4).

12.3 Overall Trust vacant shift fill rate January to October 2018

MONTH	Registered nurses by day fill rate	CSWs by day fill rate	Registered nurses by night fill rate	CSWs by night fill rate	Overall fill rate
Jan-18	91.8%	125.5%	86.3%	141.0%	114.0%
Feb-18	90.0%	125.6%	88.5%	140.3%	113.8%
Mar-18	93.5%	126.3%	91.9%	142.2%	116.0%
Apr-18	92.3%	129.4%	90.7%	143.2%	116.9%
May-18	92.3%	126.3%	92.6%	139.4%	115.3%
Jun-18	90.9%	124.0%	96.4%	136.5%	113.8%
Jul-18	88.6%	118.8%	88.7%	133.7%	109.7%
Aug-18	85.8%	119.8%	87.1%	132.1%	108.7%
Sep-18	87.2%	120.5%	86.7%	134.1%	109.7%
Oct-18	89.8%	118.4%	89.6%	135.9%	110.6%

12.4 The shortage of registered nurses is a national problem and has contributed to a reported 10% vacancy rate for mental health nursing posts nationally. To mitigate the impact on our wards and ensure safe staffing numbers are maintained, the shortfall in registered nurses fill rate is offset by an increase in the number of support workers (CSWs).

One-to-one constant observation of acutely unwell patients is another factor for when CSW fill rates exceeds 100%.

13.0 Current staff sickness rates in each service line compared to Feb 2018.

13.1 Sickness rates, February 2018 compared with November 2018

	Feb 2018	Nov 2018	Change
Central Norfolk Adult and DCLL	5.33%	6.13%	0.80%
Great Yarmouth & Waveney Adult & DCLL	5.66%	3.61%	-2.04%
West Norfolk Adult and DCLL	3.81%	5.07%	1.26%
Norfolk and Waveney Adult and DCLL Total	**5.23%**	**5.31%**	**0.08%**
Central Norfolk CFYP	4.42%	3.62%	-0.80%
Great Yarmouth & Waveney CFYP	4.13%	3.98%	-0.15%
West Norfolk CFYP	10.14%	1.25%	-8.89%
Norfolk and Waveney CFYP Total	**4.84%**	**3.60%**	**-1.24%**
Norfolk Total	**5.13%**	**4.83%**	**-0.30%**
Trust Total	**4.89%**	**4.98%**	**0.09%**

At the time of writing this report, the most recently reported sickness absence rates for all mental health Trusts, in August 18, was 4.67%.

14.0 Community care co-ordinator / lead professional and psychiatrist caseloads in each service line.

14.1 Due to data validation issues and risk of a high number of duplications in caseload information the response to this question requires a high degree of information analyst time. It has not been possible to achieve this in time for the report submission deadline. The Trust will aim to submit this ahead of the January HOSC meeting.

15.0 Assessment of the success of NSFT's incentive payment system in those areas where it is hard to recruit in regard to:

a) A one-off premium payment of £10k paid to externally appointed consultants

b) A one-off premium payment of £3k for band 5 and band 6 registered nurses in hotspot areas

***c)* A 'recommend a friend' incentive scheme payment of £200 on successful appointment / probationary period)**

15.1 Whilst there are some areas of variation, overall, our voluntary turnover is fairly stable at about 10%.

15.2 a) & b) The Trust has used recruitment premiums for 'hard to fill' registered nurse band 5 and band 6 posts, and medical posts in 'hot spot' areas. This has supported attracting staff to work in NSFT, including the conversion of bank and agency staff to Trust employment. This has had some success in supporting recruitment, but our experience is that the premiums are not the deciding factors in persuading staff to join us. They do, however, help to maintain our position in a very competitive national market in terms of the package we offer new starters. We have also recently reviewed our relocation package and continuous professional development offerings as further incentives.

15.3 a) A one-off premium payment of £10k paid to externally appointed consultants

b) A one-off premium payment of £3k for band 5 and band 6 registered nurses in hotspot areas. So far, a premium payment has been used for:

i. 15 registered nurse appointments to hotspot areas

ii. 6 medical posts, 5 of which have accepted with 4 start dates agreed. Awaiting response to premium payment from 1

c) A 'Recommend a Friend' incentive scheme payment of £200 on successful appointment / probationary period. So far, this has been applied on two occasions

16.0 The outcome of NSFT and the CCGs' liaison with Local Housing Authorities in Norfolk to identify housing opportunities for incoming staff.

16.1 With the continuing development of effective system-wide working across Norfolk and Waveney, NSFT are working in collaboration on housing connected to workforce matters. Leads from NSFT's Human Resources team from within the Norfolk and Waveney system are now more focused on joined-up recruitment across Norfolk and Waveney instead of each organisation attempting to address recruiting on its own. This includes, for example, looking at a flexible passport for staff to work across organisations more easily. This will encourage innovations which include care coordination following the patient through more integrated physical and mental health pathways.

17.0 The numbers of NSFT's beds across services in Norfolk and Waveney that are currently temporarily closed due to staffing or other issues.

17.1 The closures reported in April 2018 remain in place for CQC compliance and safety reasons, including non-availability of suitably qualified staff. This includes six short-term rehab beds at St. Catherine's Way and Foxglove Ward (that can accommodate between 9-11 beds) at Carlton Court.

17.2 Due to the safety concerns of using St Catherine's Way as a 24/7 service, a full review has been completed and the service has been reconfigured to provide community day treatment.

17.3 The detrimental impact of the removal from a familiar environment can have on a person with progressive cognitive impairment means that the admission of a person with dementia must only ever be considered as a last resort.

The Carlton Court team in collaboration with Gt Yarmouth and Waveney CCG has developed a model to better meet the local need for dementia care sustainably, reduce the numbers of admissions and length of stay, and improve patient and carer experience. A pilot implementation has been approved by the Trust's Executive Team in October, and comprises an outreach and in-reach team working closely with carers and care homes, as well as a day treatment service and a more flexible inpatient unit.

18.0 Details of how staff are now being engaged so that their ideas of changes to make are considered

18.1 A series of engagement events led by the Director of Human Resources & Organisational Development and Chief Executive are being rolled out for staff, which launched in November 2018. Similar events are also being planned for service users and carers.

The focus of these sessions is to discuss the Trust's proposed vision, mission and priority areas.

At the time of preparing this report more than 500 members of staff have attended so far with more events planned over the next few months.

Locality Managers will be supported to run similar events within their own localities throughout 2019 and to ensure that improvements suggestions are developed and implemented.

18.2 We're establishing a Culture Group to steer our work towards organisational cultural improvements. We've had over 100 staff express an interest to be involved in this work and we will ensure that all have the opportunity to be involved.

This work forms part of a wider collaborative programme of work that we're doing in partnership with the Norfolk and Norwich and Queen Elizabeth Hospitals, supported by NHSI and based on an evidence-based model for improving staff engagement and culture.

18.3 Antek Lejk is holding regular webinars to directly engage with staff. Staff can also contact our CEO directly by email – 'Ask Antek' (askantek@nsft.nhs.uk).

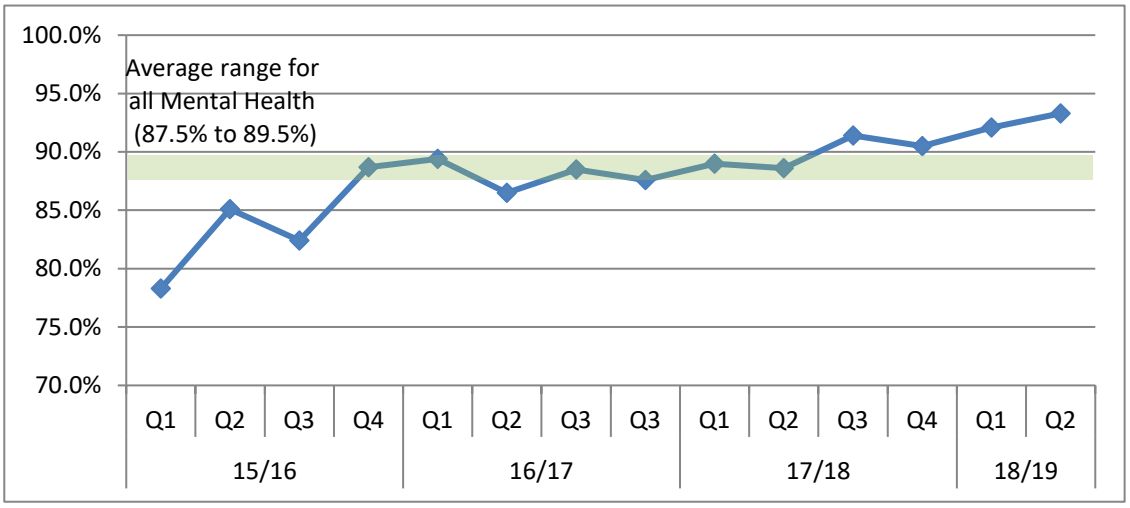
18.4 A Trust Management Board has been reintroduced from December 2018 which involves the senior leadership of the Trust (eg Executives, Locality Managers, Lead Clinicians, Quality Leads, Heads of Corporate departments).

This is enabling direct regular engagement between the Exec and other senior leaders on important issues to increase empowerment and to help ensure decisions are taken at the most appropriate level.

19.0 Any other relevant information that NSFT wishes to provide.

19.1 Friend & Family Test (FFT)

FFT results provide evidence that the percentage of people recommending Trust's services to friends and families has steadily improved over the last 3 ½ years and now exceeds the average % recommending achieved nationally by Mental Health Trusts.



19.2 Mental Health Service Users Survey

The Trust took action in response to poor results in the 2016 survey that rated NSFT in the worse 20% of Trusts nationally.

The results for the 2018 survey were published in November and we have seen the second consecutive year of improvement. All survey sections were in the mid-range for all Mental Health Trusts.

	2016		2018		Trend
Survey Section	Score	Comparison	Score	Comparison	%
Health and social care workers	7.2	About the same	7.2	About the same	0%
Organising care	8.0	Worse 20%	8.7	About the same	+9%
Planning care	6.5	About the same	6.9	About the same	+6%
Reviewing care	6.8	Worse 20%	7.6	About the same	+12%
Changes in who people see	5.2	Worse 20%	6.6	About the same	+27%
Crisis care	5.4	Worse 20%	6.8	About the same	+27%
Treatments	7.1	About the same	7.1	About the same	0%
Support and wellbeing	4.5	About the same	4.4	About the same	-2%
Overall views of care & services	6.8	About the same	7.1	About the same	+4%
Overall experience	6.4	Worse 20%	6.8	About the same	+6%

19.3 **Time to change the conversation?**

The FFT and annual Mental Health Service Users Survey feedback is from a large number of people accessing services. It shows patient experience has improved despite the demand and other pressures the Trust is facing. When in Trust services peoples' experience is comparable with other MH Trusts nationally. This is an important counterbalance, particularly to some of the more extreme negative perceptions of the Trust that have circulated within the media.

The Trust fully accepts there are a number of areas of serious concern that must be addressed with pace. The Trust is totally committed to this challenge. However, the lack of sufficient progress with addressing previously raised CQC concerns, a factor in the inadequate rating, shows the extent of the challenge the Trust is facing.

Following the outcome of the 2017 CQC inspection, the Trust took multiple internally focused actions to address the 'must do' directives. But it's clear from the outcome of the 2018 inspection that this internally focused approach not only failed, but may have actually contributed to a worsening of the external view of the Trust, staff morale and the cultural issues. We have to work in a different way, and this includes changing the conversations we have internally and externally.

The rise in demands on our services has complex external causes. The Trust, therefore, welcomes the Sustainable Transformation Partnership's essential focus on the wider system and the opportunity this provides to systemically address the disparity between growing demands and the finite resources available.

But the cultural challenges within the Trust, including poor staff morale, also have external contributors. It is very evident from conversations with staff that the negative press and social media coverage of the Trust and its senior leadership is a major contributor to low morale, difficulties attracting registered professionals to the area, and the higher turnover of staff within the first year or two of joining the Trust. Underpinning our culture change programme (see 18.2) is a strong evidence base that shows close correlation of staff morale with quality and patient experience.

The Trust's board and our caring staff are totally committed to improving our mental health services. If our pressure groups who also declare this their purpose are true to their word, they also need to recognise how much more difficult it will be to achieve this most essential of outcomes if the negative campaigning of recent years continues into the future.

It's time to change the conversations we have and come together, respectfully and positively, to achieve the best mental health services possible. We must do this for all in our local communities, but most importantly for those most in need of support and treatment from our mental health services.

20.0	**The outcome of NSFT's bid for £5.2m capital funding from national funds to support improvement work.**

20.1 NSFT were successful in that we received approval for the funding, but this was granted as a loan rather than as public dividend capital, which is what had been applied for.

END

South Norfolk CCG's response to the information requests for NHOSC 17 January 2018

(Info requests in bold, with SN CCG's response below each one)

a) An update on the progress of the reviews of mental health services for adults and for children and young people in Norfolk and Waveney including:-

i) Emerging proposals

ii) Timetable for conclusion of the review and subsequent actions (including any consultation with NHOSC about substantial changes to services)

iii) Commentary on how the Norfolk and Waveney reviews align with similar review in Suffolk.

Two reviews of mental health provision within Norfolk and Waveney are in their final stages of completion. Firstly a review focusing on adult mental health provision conducted by the Boston Consulting Group and secondly a review of children's mental health conducted by Rethink Partners. An overview of the scope of both reviews is outlined below:

1) Adult Mental Health Review - adult mental health strategy, containing a future vision over the next 10 years, with an implementation road map and an investment and affordability paper providing detailed analysis of scenario modelling and costed strategies against those models.

   The review has set up a number of Task and Finish Groups, which are due to continue within their current format for at least the next three months. These are as follows:

   - Develop, commission and drive a single integrated mental health framework, which will aim to set the key principles behind a contracting and commissioning approach to an integrated system delivery of population based mental health outcomes.
   - Collective focus on wellbeing and prevention of mental health issues, focusing on public mental health and prevention.
   - Clarify mental health pathways, focusing on the increased standardisation towards best practice treatment pathways.
   - Analyse the future primary care model of mental health provision, based around multi-agency, multi-disciplinary locality teams.
   - Focus on strengthened services for crisis management and urgent care in different settings.
   - Ensure high quality acute inpatient care focused on patients that require it.

2) Children and Young People's Review - The review was undertaken between September and December 2018 and is being overseen by a cross-system Task and Finish Group that has been established for this purpose. There is cross membership with the adult mental health review to ensure that the two pieces of work are appropriately aligned.

The scope of the work is to review all aspects of the planning, commissioning and provision of:

- Universal services where there is a focus on resilience and emotional wellbeing
- Tier 2 CYP mental health services
- Tier 3 CYP mental health services

In addition, the review is considering the interactions between core CYP mental health services and wider children's services, including Special Educational Needs, early intervention in psychosis, safeguarding and tier 4 services.

Following a major cross-system workshop at the end of November, the findings, conclusions and recommendations of the review are being developed.

Both reviews took forward a wide ranging engagement approach, with service users, family and carers, the general public, services and a strategic partners. This coproduction approach will continue to be strengthened within the next stages of both the review work and as the recommendations are turned into implementation programmes for delivery.

Both reviews are presenting their outcomes to the Norfolk and Waveney STP and each of the five Norfolk Clinical Commissioning Groups and Norfolk County Council in January 2019.

There has been cross representation between the adult and children's review work streams and also regular meetings with Suffolk Commissioners to ensure alignment.

b) An update on progress towards the establishment of a Community Wellbeing Hub. (For info - the CCGs had secured £558k approx. for this from a bid to the national Sustainability Transformation Plan capital fund at the time of the report to NHOSC in April 2018. They intended to conduct procurement in 2018 with the hub becoming operational in 2019. This was one of the measures intended to enable NSFT to manage within existing bed numbers and reduce out-of-Trust placements to zero).

The project to develop a Community Wellbeing Hub is progressing. CCGs have secured £558k of capital investment from NHS England to develop a hub venue. The revenue funding for the hub has also been agreed by CCGs.

An engagement workshop was held in October 2018 and was attended by over 50 stakeholders, including service user and carer representatives, Third Sector, Secondary Care Mental Health Services, and other statutory organisations. The event was designed to hear the thoughts and gather knowledge from the system to inform the service specification for the hub model. A report was produced detailing the findings of the day and this has been widely circulated.

A market engagement event is taking place on 11th January 2019 to provide interested provider organisations with information about the hub model, the

procurement timescale and to encourage networking between agencies. Commissioners expect have identified a preferred service provider by autumn 2019.

c) Details of any further discussion / agreement between the CCGs and NSFT to fund additional mental health beds either on an interim or permanent basis. (For info - this info is required in light of the ongoing numbers of out-of-Trust placements and NHOSC's recommendation on 17 December 2017 that the CCGs should provide funding to open 15 additional adult acute beds at Yare Ward, Hellesdon Hospital)

Whilst there has been no formal proposal put forward to the Norfolk and Waveney CCGs to fund additional mental health beds by NSFT, commissioners and the provider have been working closely together to review placements and gain a shared understanding of the demands and possible solutions to the current numbers of acute OOA placements.

Part of the Adult Mental Health Reviews remit was to review the bed capacity levels needed within Adult Acute Mental Health Care. The CCGs will be reviewing the outcomes of this early in 2019.

d) Details of how much NHS England's Mental Health Investment Standard (formerly referred to as Parity of Esteem) required the Norfolk and Waveney CCGs to invest in mental health services in 2018-19, how much was actually invested and how much of this went to NSFT and how much to other mental health spending.

Please find below the breakdown of investment as at month 8 2018/19 forecasted to year end. As is indicated Norfolk CCG's are investing above the Parity of Esteem/ Mental Health Investment Standard benchmarks for 2018/19 in terms of NSFT and other mental health services expenditure

2018/19 Forecast at M8	GYW	North	Norwich	South	West
NSFT	31,706	19,870	32,581	20,133	17,406
Other Core MH	7,210	4,896	4,725	5,226	3,109
Total	38,916	24,766	37,306	25,359	20,515
Total increase	3.3%	5.5%	6.9%	3.9%	8.2%
PoE requirement %	2.8%	2.8%	2.9%	3.6%	3.3%

Norfolk County Council

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Ms H Stratton
Interim Chief Officer
South Norfolk CCG
Lakeside 400, Old Chapel Way
Broadland Business Park
Norwich
NR7 0WG

Letter sent by email

15 June 2018

Dear Ms Stratton

Placements in out-of-area beds – families' travel costs

On 5 April 2018 Norfolk Health Overview and Scrutiny Committee (NHOSC) made a recommendation to Norfolk and Suffolk NHS Foundation Trust (NSFT) and South Norfolk CCG (lead CCG for mental health in Norfolk and Waveney), that:-

'The local NHS should reimburse travel costs for families of service users who are placed in out-of-area beds due to unavailability of local beds (i.e. placed out-of-area for non-clinical reasons).'

South Norfolk CCG responded on 17 May 2018 that it could not accept the recommendation because it would be out of line with NHS protocol. I attach a copy of the CCG's response, for ease of reference. NSFT confirmed by email that same guidance would apply to the trust.

NHOSC discussed the response at its meeting on 24 May 2018 and asked me to write to you on the following matters:-

(a) Equality and Parity of Esteem

The response says 'out-of-area mental health episodes are considered the same as tertiary inpatient episodes for physical health and treated in the same way'. Can you please explain why this is the case when the two are clearly not equivalent.

Mental health patients placed out-of-area for non-clinical reasons are in acute secondary care, not tertiary care. The fact is that physical health patients rarely have to travel out-of-area for acute secondary care and on such occasions as they do (e.g when local maternity units are full) length of stay tends to be short, not the weeks or months that are typical for mental health patients.

Has there been an Equality Impact Assessment in respect of the NHS protocol for treating out-of-area mental health episodes the same as tertiary inpatient episodes for physical health in relation to families / carers travel costs? If so, can you please let us see it?

Locally and nationally the NHS has always acknowledged that placement of mental health patients in out-of-area secondary care should not be happening and until such times as it stops we think that families in this situation should not be subject to a general protocol that does not properly recognise the circumstances.

(b) The interests of the patients, their families and the NHS

On 5 April 2018 NSFT provided NHOSC with information on recent out-of-area placements as far afield as West Sussex, Cheshire and West Yorkshire. There has clearly been potential for families from Norfolk to be financially disadvantaged by travelling large distances to visit loved-ones. There are also likely to be cases where patients have been cut off from their social and emotional support networks at a time of acute distress because family and friends have not had the financial means to visit them. In these circumstances, families are not able to bring in essentials for patients (i.e. clothes, toiletries, etc.) and it is much harder for them to be involved in discharge planning, which is essential for safe care.

In December 2017 NHOSC recommended that the CCGs should provide funding to open 15 adult acute beds at Hellesdon. In April 2018 we were told that any discussion on the commissioning of such beds could only be taken forward in the planning round for 2019-20 but that other initiatives to reduce out-of-area placements were in place and numbers were reducing. Nevertheless, there were still 22 patients placed out-of-area for non-clinical reasons and 11 placed in independent facilities within Norfolk and Suffolk.

NSFT told us that a bed in an out-of-Trust facility costs on average £44 more per day than an NSFT bed. Patient transport costs are on top of that. Aside from the human costs, it has certainly not been in the NHS's economic interests to allow placement of acute mental health patients in out-of-area secondary care to carry on for the years that it has. If it can afford to let this situation continue the NHS can, in our view, also afford to reimburse families' travelling costs.

In any event, we see it as a false economy to deny financial support for visits by the families, friends or carers of patients in out-of-area acute mental health beds. It is likely to lead to slower recovery and less effective discharge planning for some, which is in neither the patient's interest nor the NHS's economic interest.

(c) Local discretion

The CCG response said that they 'must adhere to NHS protocol' but can you please tell us whether or not any scope exists for either the CCG or NSFT to exercise local discretion in this matter. We know that in 2014, following re-structuring of NSFT's inpatient services, financial support was available for travelling costs of carers of West Norfolk patients who were admitted to dementia and complexity in later life wards at the Julian Hospital, Norwich. As a planned out-of-area service, we recognise that these arrangements for West Norfolk patients were not the equivalent of un-planned placements out-of-area due to lack of local beds, but they show that a level of local discretion in relation to carers' travel costs was possible at that time.

NHOSC would like the CCGs and NSFT to reconsider their responses to the recommendation the committee made on 5 April 2018. We recognise that the CCGs

would need to set parameters for the financial support, e.g. regarding the distance travelled / cost / number of visits proportionate to the patient's length of stay out-of-area.

If there is no scope for local variance to NHS policy then NHOSC intends to raise the matter with NHS England and I would be pleased if you could send me the relevant contact details.

Yours sincerely

Michael Chenery of Horsbrugh
Chairman of Norfolk Health Overview and Scrutiny Committee

NHS
North Norfolk
South Norfolk
Clinical Commissioning Groups

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Main switch board Tel: 01603 257000

Sent via email

Monday, 16th July 2018

Dear Michael,

Re: Placements in Out of Area Beds – Families' Travel Costs

Thank you for your letter dated 15th June 2018.

In considering HOSCs request for CCGs to provide financial support to families/carers travelling to visit service users in and out of area placement, the CCGs sought out the most appropriate national guidance.

The guidance NHSE in England: Help with Travel Costs:
https://www.nhs.uk/NHSEngland/Healthcosts/Pages/Travelcosts.aspx

Furthermore, the CCG maintains its position as outlined in previous correspondence with yourselves.

You have requested contact details for NHSE. They are as follows:

Simon Evans-Evans
Locality Director for Cambridgeshire & Peterborough and Norfolk
NHS England - Midlands & East (East)
West Wing | Victoria House | Capital Park | Fulbourn | Cambridge | CB21 5XB

Yours Sincerely,

Helen Stratton
Acting Chief Officer
NHS North Norfolk and South Norfolk Clinical Commissioning Groups

Cc: Norfolk and Suffolk NHS Foundation Trust

Norfolk County Council

Norfolk Health Overview and Scrutiny Committee
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Mr S Evans-Evans
Locality Director for Cambridgeshire,
Peterborough & Norfolk
NHS England – Midlands and East (East)
West Wing, Victoria House, Capital Park
Fulbourn
Cambridge, CB21 5XB
Letter sent by email

8 August 2018

Dear Mr Evans-Evans

Placements in out-of-area beds – families' travel costs

On 5 April 2018 Norfolk Health Overview and Scrutiny Committee (NHOSC) met with Norfolk and Suffolk NHS Foundation Trust (NSFT) and South Norfolk CCG (lead CCG for mental health in Norfolk and Waveney). The Committee was informed about placements of patients as far afield as West Sussex, Cheshire and West Yorkshire for acute secondary mental health care. We made a recommendation to Norfolk and Suffolk NHS Foundation Trust (NSFT) and South Norfolk CCG that:-

'The local NHS should reimburse travel costs for families of service users who are placed in out-of-area beds due to unavailability of local beds (i.e. placed out-of-area for non-clinical reasons).'

South Norfolk CCG responded on 17 May 2018 that it could not accept the recommendation because it would be out of line with NHS protocol. NSFT confirmed that the same protocol applied to it. NHOSC wrote to the CCG and NSFT again on 15 June 2018:-

- asking the CCG and NSFT whether they had scope for local discretion in the matter and asking them to reconsider their response;
- pointing out that these mental health patients are not being treated equally to physical health patients for whom acute secondary care is nearly always provided locally and that families are disadvantaged by it;
- asking if there has been an Equality Impact Assessment in respect of the NHS protocol for treating out-of-area mental health episodes the same as tertiary episodes for physical health in relation to families / carers travel costs;
- asserting that if the NSFT and the CCGs could afford to continue placing patients in out-of-Trust beds, which they told NHOSC cost on average £44 more per day than an NSFT bed, they could in our view afford to reimburse families' travelling costs;
- asserting our view that it is a false economy for the NHS to deny financial support for visits in these circumstances because it's likely to lead to slower recovery and less effective discharge planning for some;
- recognising that parameters for financial support would need to be set; e.g. regarding distance travelled, cost, number of visits proportionate to the patient's length of stay.

Finally, we asked that if there was no scope for local variance to this NHS policy that they send us contact details to raise the matter with NHS England.

South Norfolk CCG replied on 16 July 2018 maintaining its previous position, addressing none of the points in our letter of 15 June and giving us your contact details. NSFT again confirmed that it concurred with the CCG's answer. I attach copies of all our correspondence with the CCG.

I should be pleased if you would address the points made in my previous letters to the CCG. We are aware that NSFT has been working hard to reduce the numbers of out-of-area placements and with some recent success. However, numbers have fluctuated before and placements out-of-area for non-clinical reasons have been going on for many years. NHOSC feels strongly that until this unfortunate and uneconomic situation is completely rectified the NHS should recognise the financial strain it places on families of mental health patients and introduce a policy to reimburse people in these circumstances.

Yours sincerely

Michael Chenery of Horsbrugh
Chairman of Norfolk Health Overview and Scrutiny Committee

By e-mail

Michael Chenery of Horsbrugh
Chairman of Norfolk Health
Overview and Scrutiny Committee.

NHS England, Midlands & East
2 – 4 Victoria House
Capital Park
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Cambridge
CB21 5XB

Tel: 011382 51711

8th October 2018

Dear Michael

Response to your letter 'Placements in out-of-area beds – families' travel costs'

Thank you for your letter dated 8th August 2018 in which you outlined your concerns with regard to the local position concerning reimbursement of travel costs for families of service users placed out of area beds and the response from South Norfolk CCG who have directed you to the NHS England Guidance page 'Help with Travel Costs'.

I have read your letter and the reply from South Norfolk CCG, and have tried to respond to each point you raise below.

Is there scope for local discretion in the matter?

The guidance that South Norfolk CCG directed to you is correct; the availability of support to reimburse families travel expenses is not currently a mandated responsibility for health or social care. However the MHA Code of Practice (Chapter 14, **para 14.85)** whilst not mandatory sets out the expectations of the commissioner in such circumstances:

14.85 *When a patient's carer informs the commissioner of difficulties in visiting the patient because of the distance that they need to travel, the commissioner should consider whether they can provide any assistance to support the patient's carer to visit and maintain contact with the patient. The commissioner should inform the carer that they can request a carer's assessment from the local authority.*

Whilst there is scope for local discretion there is not a mandate for South Norfolk CCG to fund travel expenses and unfortunately I cannot find any local authority support either: https://www.norfolk.gov.uk/care-support-and-health/support-to-stay-at-home/local-assistance-scheme

Patients with mental health conditions are not being treated equally to physical health patients for whom secondary care is nearly always provided locally and that families of patients with mental health conditions are disadvantaged

There are some circumstances where an out of area placement is appropriate if it is driven by patient choice, for instance sometimes mental health professionals may choose to be treated out of area. There are also some circumstances where very specialist services such as specialist eating disorders services, cannot be reasonably commissioned locally and therefore an out of area placement is necessary. This situation also occurs in physical health services, for example specialist paediatric services at great Ormond Street Hospital or Specialist Burns Services in Essex require patients to be placed out of area.

It is widely accepted that sending patients out of area should be minimised whenever possible, recognising that distance from local networks in terms of family, social and known health networks can sometimes have a negative impact on length of stay, continuity of care and recovery outcomes.

The Five Year Forward View for Mental Health sets out the case for transforming mental health care and one of the ambitions is to eliminate inappropriate non-specialist adult acute out of area placements by March 2021. Page 8 of the 2018/19 Delivery Plan includes the following 'asks' which all Sustainability and Transformation Partnership's including the Norfolk and Waveney STP are required to meet in order to demonstrate they are working towards the ambition:

- To adequately invest in core community, crisis, acute and local authority mental health services, including housing, to maintain system capacity
- Review all patients places out of area to ensure appropriate packages of care and provide assurance of a confirm and challenge approach within each STP for reviewing individual inappropriate out of area placement cases
- Focus on reducing length of stay and reduction of prevalence of mental health delayed transfers of care (DTOCs)
- Ensure appropriate governance for inappropriate out of area placement reduction programmes to include senior executive and clinical leadership across CCGs, LAs, and providers
- Reduce average length of stay as a region

As a result of this very specific guidance there is increased scrutiny on CCG's to achieve their trajectories set in March 2018 which will reduce inappropriate out of area placement to zero by March 2021. NHS England Midlands and East is supporting commissioners in Norfolk and the provider Norfolk and Suffolk NHS Foundation Trust (NSFT) to work together to develop a robust plan which my team are monitoring closely to ensure it achieves its aim.

If South Norfolk CCG can afford to continue placing patients in out of area beds which tend to be more expensive then could they, in your view, afford to reimburse families travelling costs?

The CCG as a clinically lead local organisation is formed to make local decisions on priorities within the framework of National guidance and policies. Work is underway locally to ensure that local care pathways change so that investment and capacity increases within services such as Crisis Home Resolution teams meaning people can be supported and treated at home and avoid an inpatient stay where possible. The practice of sending patients out of area for reasons of lack of capacity in commissioned services will stop by March 2021.

Is this likely to lead to slower recovery and less effective discharge planning for some?

It is accepted that length of stay, recovery and discharge planning can be adversely affected by placement out of area. We (NHS England) require the local commissioner and provider to demonstrate an extremely proactive approach in terms of monitoring, communicating with and planning discharge with the out of area provider.

I hope this provides helpful reference as to the position in terms of guidance, and the work underway to ensure that people are placed within area going forward. NHS England and the Norfolk and Waveney STP are working hard to ensure that this practice is eliminated where appropriate. Whilst work is underway to reduce inappropriate out of area placements, in light of the MHA Code of Practice and guided by the national support programme I would encourage the CCG and Local Authority to review applications for support with travelling costs on a case by case basis as outlined above.

Yours sincerely

Simon Evans-Evans
Locality Director for Cambridgeshire & Peterborough and Norfolk

C.C: Frank Sims, Chief Officer, NHS South Norfolk & North Norfolk CCG

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 2019

Meeting dates	*Briefings/Main scrutiny topic/initial review of topics/follow-ups*	*Administrative business*
28 Feb 2019	Ambulance response times and turnaround times – report on progress since May 2018 (when EEAST, NNUH and NNCCG attended). QEH to be invited to attend also. Children's Speech and Language Therapy - to follow up the action plan from the independent review of the central and west Norfolk service and to address with issues raised during Members visit with the SENsational Families Group, 20 September 2018.	
11 Apr 2019	Access to NHS dentistry in Norfolk – follow up to the report to NHOSC on 24 May 2018 on access in West Norfolk, and examination of the situation in the rest of Norfolk. Local action to address health and care workforce shortages – a short report by Norfolk & Waveney STP Workforce Workstream Lead.	
May 2019 (*date tbc)*	Access to palliative and end of life care – follow-up from NHOSC's meeting on 18 October 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 2019

Feb 2019 (in the Briefing)	-	**Community eating disorder service** – capacity, quality and consistency in the central and west Norfolk service. (Information on the Great Yarmouth and Waveney service was included in the January 2019 NHOSC Briefing)
Sept 2019 (on the agenda)	-	**Physical health checks for adults with learning disabilities** – update since Sept 2018
July 2019 (in the Briefing)	-	**Continuing healthcare** – update on trends in referrals and assessment of eligibility for CHC and explanation of those trends.

Other activities

Visits to hospice, hospice at home and other services providing end of life care (as requested by NHOSC 18 Oct 2018)	-	East Coast Hospice, Gorleston (i.e. visit with the charity that is planning a hospice in the Great Yarmouth and Waveney area) – arranged for 11.30am, 28 January 2018. Suffolk Members of Great Yarmouth & Waveney Joint Health
	-	Scrutiny Committee have also been invited.
Visit to be arranged	-	Follow-up visit to the Older People's Emergency Department (OPED), Norfolk and Norwich hospital to be arranged after expansion works are completed in 2019-20.

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	-	Ms E Flaxman-Taylor
West Norfolk	-	M Chenery of Horsbrugh (substitute Mrs S Young)
Norwich	-	Ms E Corlett (substitute Ms B Jones)

Norfolk and Waveney Joint Strategic Commissioning Committee

For meetings held in west and north Norfolk	-	M Chenery of Horsbrugh
For meetings held in east and south Norfolk	-	Dr N Legg

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	-	Ms E Flaxman-Taylor (substitute Mr M Smith-Clare)
Norfolk Community Health and Care NHS Trust	-	Mr G Middleton (substitute Mr D Fullman)

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Glossary of Terms and Abbreviations

#	number
A&E	Accident and emergency
ACT	Advancing Change Through Transformation
AMD	Associate Medical Director
ASI	Appointment slot issue
ATT	Assessment to treatment
BLS	Basic life support
BRAG	Blue, Red, Amber, Green – management dashboard for the Quality Improvement Programme
BMA	British Medical Association
CAMHS	Child and adolescent mental health service
CBU	Clinical Business Unit
CC	Care Co-ordinator
CCG	Clinical Commissioning Group
CEO	Chief Executive Officer
CFYP	Children, families and young people
CIP	Cost Improvement Programme
CLL	Complexity in later life
CPA	Care plan approach
CQC	Care Quality Commission – the independent regulator of health and social care in England. Its purpose is to make sure health and social care services provide people with safe, effective, high quality care and encourage care services to improve.
CRHT	Crisis Resolution Home Treatment
CSU	Commissioning Support Unit
CSW	Clinical Support Worker
CTG	Cardiotocography - a technical means of recording the fetal heartbeat and the uterine contractions during pregnancy
CYP	Children and young people
DCLL	Dementia and complexity in later life
DIST	Dementia Intensive Support Team
DNACPR	Do not attempt cardio-pulmonary resuscitation
DOLS	Deprivation of Liberty Safeguards
ECIST	Emergency Intensive Care Support Team
ED	Emergency Department
EEAST	East of England Ambulance Service NHS Trust
EIP	Early Intervention in Psychosis
EoLC	End of life care
EPMA	Electronic Prescribing and Medicines Administration

EPR	Electronic patient record
EPRTT	Emergency priority referral to treatment
EU	European Union
FFT	Friends and Family Test
FOT	Forecast out-turn
FRB	Financial Recovery Board
FTE	Full time equivalent
FTSUG	Freedom to Speak Up Guardian
GP	General Practitioner
GYW	Great Yarmouth and Waveney
HR	Human Resources
IAP	Indicative activity plan
IAPT	Improving Access to Psychological Services
IDT	Integrated Delivery Team
IPC	Infection prevention & control
ICS	Integrated Care System
IR	Identification Rules
ISP	Independent sector providers
IST	Intensive Support Team
KLOE	Key line of enquiry
LCP	Lead Care Professional
MCA	Mental Capacity Act
MH	Mental health
MHP	Mental health practitioner
NCATT	No Cancer At This Time
NCH&C	Norfolk Community Health and Care NHS Trust
NEAT	Norwich Escalation and Avoidance Team
NHOSC	Norfolk Health Overview and Scrutiny Committee
NNCCG	North Norfolk Clinical Commissioning Group
NHSE	NHS England
NHSI	NHS Improvement – the provider trust regulator
NNUH (N&N, NNUHFT)	Norfolk and Norwich University Hospitals NHS Foundation Trust
N&W	Norfolk & Waveney
N&W STP	Norfolk and Waveney Sustainability & Transformation Plan
NSFT	Norfolk and Suffolk NHS Foundation Trust
OAG	Oversight and Assurance Group
ONS	Office of National Statistics
OOA	Out of area
OOHA	Out of home area
OOT	Out of Trust
OOTA	Out of Trust area
OP	Older people

OPED	Older People's Emergency Department
OSC	Overview and Scrutiny Committee
PGD	Patient Group Directives
PSF	Provider Sustainability Fund
QEH / QEHKL	Queen Elizabeth Hospital, King's Lynn
QIP	Quality Improvement Programme
QIPP	Quality Innovation Productivity and Prevention
QPB	Quality Programme Board
RIC	Recovery Information Centre
RN	Registered Nurse
RPRTT	Routine priority referral to treatment
RRI	Reducing restrictive interventions
RTT	Referral to treatment
SAU	Surgical Assessment Unit
Schwartz rounds	A forum where all staff, clinical and non-clinical, come together to discuss the emotional and social aspects of working in healthcare
SJR	Structured judgement review
SNCCG	South Norfolk Clinical Commissioning Group
SOP	Standard Operating Procedure
SPOA	Single point of access
SRO	Senior Responsible Officer
STP	Sustainability Transformation Plan / Partnership
TEC	Trust Executive Committee
ToR	Terms of reference
UPRTT	Urgent priority referral to treatment
WLI	Waiting list initiative
WTE	Whole time equivalent
YTD	Year to date