Mental Health Services in Norfolk

Report for the Health Overview and Scrutiny Committee

7th December 2017

A. Introduction

This report provides information for members of the Health Overview and Scrutiny Committee on the current position with Norfolk and Suffolk NHS Foundation Trust, following the CQC reports which were published in October 2017.

B. Response to Questions

1. The action plan to address the CQC recommendations is attached.

The Committee should note that the Trust fully accepts the CQC findings and requirements and the plan addresses systemic themes and the 'must do's' and 'should do's' contained within the overall Provider report. The CQC requires significant improvement by March 2018. A re-inspection of those 'must do's' and 'should do's' will occur before July 2018 and a full inspection is expected within 12 months of entering 'special measures'. It is likely that this will be in the autumn of 2018.

The systemic themes are:

- Leadership
- Staff engagement
- Clinical engagement
- Culture

These issues are longer term and have the support of NHS Improvement and the CQC. As part of the special measures support package, East London NHS Foundation Trust (ELFT) has been appointed as our 'buddy trust'. ELFT has offered their support and advice with regards to the systemic issues having experienced similar issues. ELFT is rated as 'outstanding' by the CQC.

The summary plan is attached for information. Detailed action plans at service line level have been established with dedicated service line leads and project management to deliver the plans.

A Quality Programme Board, chaired by the Chief Executive, meets weekly to review the plans and each service line is reviewed on a fortnightly basis. Progress against the plans will be reported to the Trust Board.

2. The trend in out of Trust placements is as follows:

NORFOLK & WAVENEY										
	JUNE		JULY		AUGUST		SEPTEMBER		OCTOBER	
	Bed Days	Number of Placements	Bed Days	Number of Placements	Bed Days	Number of Placements	Bed Days	Number of Placements	Bed Days	Number of Placements
SERVICE										
Acute	714	44	695	51	756	47	625	43	700	53
CLL acute	0		0		22	1	13	1	64	3
DCLL Acute	52	7	169	7	201	11	79	6	31	1
	766	51	864	58	979	59	717	50	795	57
OOT / OOA										
OOT	583	29	461	34	660	40	608	43	493	38
OOA	183	22	403	24	319	19	109	7	302	19
	766	51	864	58	979	59	717	50	795	57
LOCATION										
Mundesley Hospital	583	29	422	32	533	35	450	36	294	26
Ellingham Hospital	0		39	2	127	5	158	7	199	12
Cygnet - Harrogate	13	2	30	2	0		0		36	3
Cygnet - Harrow	7	2	67	5	10	1	0		20	1
Cygnet - Stevenage									32	2
Kneesworth House - Royston	40	2	43	3	45	2	30	1	26	1
Potters Bar	30	1	38	2	32	2	0			
Priory - Chelmsford	0		11	2	9	2	0		27	3
Priory - Nottingham	0		0		0		0			
Priory - Roehampton	19	4	16	1	0		0		20	1
Priory - Southampton									13	1
Priory - Ticehurst	4	1	25	1	0		0		48	3
Priory - Woking	2	1	0		0		0			
St Andrews - Northampton	52	7	169	7	201	11	79	6	60	2
St Neots	0		0		22	1	0			
The Dene - Sussex	16	2	4	1	0		0		20	2
	766	51	864	58	979	59	717	50	795	57

3. Progress with the actions outlined in the Bed Review

The following actions have been developed from the recommendations in the Bed Review which was jointly commissioned by the Trust and CCGs and undertaken by Mental Health Strategies. The recommendations have been accepted by Norfolk and Waveney STP and are overseen by the STP's Mental Health workstream, chaired by Tony Palframan, General Practitioner.

(i) Clinical variance (both primary and secondary) should be addressed.

Primary Care:
The CCG is leading a piece of work looking at referrals into the crisis team from primary care. Work is ongoing focusing on the number of referrals by practice and of those how many would benefit from alternative signposting.

Secondary Care:
A project has been established, led by the Medical Director to assess clinical variation across the Trust. This is focused on discharge processes and admissions criteria, to ensure that these are consistent within NSFT; and upon any possible efficiencies or improvements within bed management within the Trust. A Trust-wide set of standards of how the Crisis, Home Treatment and In Patient services should function was drafted on 21st November. This is now subject to Service User and Carer review of these standards. The specific ways in which those with Personality Disorder will be managed by Acute pathways was also agreed in the meeting and has been shared with the Personality Disorder strategy project.

(ii) Crisis hub and a small number of additional step down beds would offer the most useful means of alternatives to admission.
A business case has been prepared and accepted to establish a crisis hub in Norwich, based on evidence from Aldershot, Bradford and Leeds which shows that the crisis hub model has been effective in reducing out of area placements and has had a significant impact in improving the options available to service users and to GPs. A city centre location will be the best venue for the crisis hub. The procurement for the service will be undertaken and the expected opening of the service will be October 2018.

Seven step down beds have been procured through Evolve who provide accommodation and integrated services to support people as an intermediary step between hospital care and home. Evolve help to support the patients whose discharge has been delayed.

Patients whose discharge has been delayed for social care reasons are a focus for the STP Mental Health workstream. The Chief Executive for NSFT and the Director of Social Care have discussed the position and the national pressure to reduce the number of delays. In light of Norfolk's deteriorating position with delays progress is expected as a matter of urgency.

(iii) A community personality disorder service would be a useful addition to current services (although it should not be seen as a replacement for any existing services).

NSFT is drafting a Personality Disorder Strategy which has been co-produced with frontline clinicians, service users and carers. The outline strategy and proposals will be presented to the STP in January and will then be considered for implementation under the STP's Mental Health workstream.

(iv) Demand and capacity on community teams is out of balance and should be addressed.

In July 2017 a business case was prepared for additional staff for the community team in Norwich and 10 posts were agreed. The CCG has agreed funding for these posts. Further work is underway

between the Trust and CCGs to assess demand and to consider what else needs to be done to support the staffing capacity available.

4. **The number of complaints raised by NHS patients at Mundesley, either whilst an in-patient or after leaving the facility, and the number of those reported to the police or Local Authority Designated Officer. (Hope Community Healthcare Trust will also be asked to provide this information).**

   NSFT were aware of a total of five patient complaints involving Mundesley Hospital. Of these five, two were reported to the police but did not result in prosecution due to a lack of evidence.

   Two complaints are still under investigation and the outcome of the fifth was that Mundesley hospital was reminded of the importance of 'keeping the nearest relative notified'.

   The Trust stopped admitting any new patients to Mundesley Hospital from 6th October, following the publication of the hospital's CQC inspection report.

   The Trust sought immediate assurances as to remedial safety actions being put in place to ensure the safety of any NSFT patients already placed there.

   The Trust continually monitored the standards of care at the hospital – as with all other providers' we use – with regular visits by senior Trust staff. Patient review meetings were held twice-a-week to ensure that each of our patients was receiving appropriate standards of care.

   Meetings between the hospital's senior management, the CCGs and the Trust's executive were also held.

   When these parties were no longer assured that the hospital's remedial safety actions were being put in place quickly enough or effectively enough, we took action to remove the remaining few NSFT patients.

   By Friday, 20th October the small remaining number of patients still at the hospital all NSFT patients were all safely transferred to beds within our Trust, or beds in a nearby provider (Ellingham Hospital, near Attleborough).

   No incidents were reported in that interim period (6th to 20th October) relating to NSFT patients.

5. **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.**

   To ensure we keep our services users and staff safe, at NSFT we have made recruitment and retaining our existing staff an organisational priority. In the meantime, we make effective use of bank and agency workers to maintain safe staffing levels.

   Of some assurance, is the fact our vacancy rate at the end of October 2017 was 9.95% and below the national average for mental health trusts of 13%, which indicates this is not just an issue for NSFT.

Norfolk and Suffolk NHS
NHS Foundation Trust

Recruiting sufficient staff is a risk for all NHS trusts as we are all managing increasing pressures and demands upon services while coping with a national shortage of qualified staff. Sadly, this is not an issue which is going away in the short or even medium term.

In October, Jeremy Hunt agreed we are facing an 'unprecedented crisis in shortage of nursing staff, with 40,000 posts unfilled in England'

In mental health, recruitment can be even more difficult as there are less and less numbers of people going into this more specialist profession. Last year, the Royal College of Nursing claimed that the number of mental health nurses working in the NHS had dropped by almost a sixth since 2010.

There are plans to recruit more clinical staff that are already very much in action, and have been for the past two years. As of today, we are advertising around 60 clinical posts for our new and existing services. And this rate of recruitment activity has been ongoing for the past two years and will continue.

In response to the national shortage of mental health nurses and doctors in the country, within mental health trusts there has been a strong emphasis on developing new job roles. Therefore, mental health services are provided by a much wider range of multi-disciplinary teams, more so than in most physical health services.

At NSFT a large percentage of our staff are highly qualified and trained NHS staff such as Allied Health Professionals. They are vital in providing appropriate care to our service users and they free up the nurses and doctors for work which specifically requires their skills.

The number of these Allied Health Professionals has significantly increased by 69% between March 2013 and March 2017.

Other initiatives to retain or develop our own staff includes, every student nurse who takes a placement with NSFT is guaranteed to be offered a job on qualifying. In September, we welcomed 20 newly qualified nurses to our Trust under this initiative, and in the summer 14 nurses graduated and joined our teams. A further 54 students were recently welcomed to locally train as mental health nurses. We have also welcomed the first 25 recruits on a joint NHS nursing apprenticeship scheme in west Norfolk which aims to attract nursing students to the area.

As well as recruiting we are looking at keeping and developing our existing staff and have a number of schemes to encourage this, including developing Nurse Specialist Consultant and Nurse Prescriber roles.

A special NSFT academy also offers additional support to newly qualified nurses and therapists, responding to statistics which show a large proportion of nurses across the country leave nursing within two years of qualifying.

Norfolk and Suffolk NHS
NHS Foundation Trust

Locality	Service Line	WTE Staff in Post	Vacancy Rate	Staff on Maternity Leave	Staff on Long-term sickness (28+ days)
CFYP	CAMHS	45.61	11%	3	2
	EARLY INTERVENTION	50.13	11%	2	1
	EATING DISORDERS	18.92	40%	1	0
	INPATIENTS	32.07	5%	3	0
	INTEGRATED SERVICES	42.9	12%	0	0
	LD	14.71	7%	0	0
	MANAGEMENT & ADMIN	42.54	7%	0	3
	OTHER	35.69	13%	0	0
	YOUTH	103.8	-2%	5	5
Gt YARMOUTH & WAVENEY	ADULT COMMUNITY	73.16	-1%	0	1
	ADULT INPATIENT	81.69	8%	1	3
	CONTINUING CARE INPATIENT	57.84	1%	0	4
	DCLL COMMUNITY	44.76	-2%	2	1
	MANAGMENT & ADMIN	55.55	-3%	0	0
	LD COMMUNITY	18.03	-7%	0	0
NFK & WAV WELLBEING	NFK & WAV WELLBEING	111.78	6%	6	4
	OTHER WELLBEING	10.4	5%	0	0
Norfolk Central Adult	ADULT COMMUNITY	145.01	-2%	5	1
	ADULT INPATIENT	209.18	11%	10	4
	MANAGEMENT & ADMIN	58.9	14%	1	0
Norfolk Central DCLL	DCLL MANAGEMENT & ADMIN	30.52	21%	0	0
	CONTINUING CARE INPATIENT	65.14	6%	2	2
	DCLL COMMUNITY	89.56	0%	5	5
	DCLL INPATIENT	76.84	9%	0	0
Norfolk Recovery Partnership	ADULT COMMUNITY	61.81	21%	4	2
	CFYP COMMUNITY	1.84	0%	0	0
	MANAGEMENT & ADMIN	6.8	13%	0	0
Norfolk West	ADULT COMMUNITY	25.73	23%	0	0
	ADULT INPATIENT	48.74	25%	0	0
	DCLL COMMUNITY	25.43	2%	1	0
	MANAGEMENT & ADMIN	46.66	13%	1	4

6. **NSFT's income each year from 2012-13 to 2017-18 (to date) and the number of referrals to NSFT in each year from 2012-13 to 2017-18 (to date).**

	2012/13 £m	2013/14 £m	2014/15 £m	2015/16 £m	2016/17 £m	2017/18 £m
Income	219	217	213	212	216	113 (Forecast £226m)
Referrals	65,107	73,248	83,390	89,334	94,085	48,180

Income reductions from 2012/13 to 2013/14 were due to the decommissioning of beds at Meadowlands and Highlands by NHS England (Specialised Commissioners).
Income reductions from 2013/14 to 2014/15 were due to the national deflator/efficiency (financial savings) requirement and to the Trust ceasing to provide IT services to Suffolk CCGs.

7. **Will delivery of the action plan to address the CQC findings require increased investment by the CCGs over and above the additional investment planned in the STP? (The CCGs will also be asked this question).**

NSFT will seek additional investment to support the demand for crisis and urgent care. The funding for 2018/19 is currently under discussion and investment in capacity to meet demand forms part of that.

8. **Who is the responsible clinician for an NSFT patient when they are placed out-of-Trust and how is the patient's progress reviewed?**

Whilst the person is detained in an OOA hospital the responsible consultant (RC) is the consultant in the treating hospital; this is required by the Mental Health Act. Where someone is treated informally as an inpatient in an OOA hospital, technically they do not have an RC, but their treating consultant is the one in the OOA hospital. This would be the only way to provide safe and coherent medical treatment.

An NSFT psychiatrist would not be responsible for monitoring the patient's care in an OOA bed. The Care Coordinator usually has this responsibility. Psychiatrists will be involved at specific points to make specific decisions about suitability for discharge to the community team, or transfer to the inpatient NSFT bed. The relevant consultant will become involved if a service is planning to receive the patient back.

9. **Is there cause for concern about the quality of any of the independent or NHS mental health providers with which NSFT currently places patients when no beds are available within its own facilities? (Acknowledging that NSFT itself is rated 'inadequate', but that its 'caring' by staff is rated 'good', this means any organisation whose CQC ratings are lower than NSFT's in any of the 5 CQC assessment categories – safe, effective, caring, responsive, well-led).**

NSFT are currently placing people in the following hospitals:

- Priory Ellingham – rated good overall
- Priory Woking – rated good overall

- Priory Ticehurst – rated requires improvement overall, good for caring
- Priory Roehampton – rated requires improvement overall, good for caring
- Cygnet Beckton – rated good overall
- Cygnet Blackheath – rated good overall
- Kneesworth – rated requires improvement overall, good for caring

10. Who decided to stop sending patients to Mundesley Hospital (announced on 20 October) and why was the decision made at that point?

NSFT made the decision to stop admitting patients to Mundesley on 6th October 2017 and the decision to remove patients from Mundesley on 18th October 2017. All patients were safely removed by 20th October 2017.

11. What contingency planning was done after Mundesley Hospital received its consecutive 'inadequate' ratings to allow NSFT patients to stop being placed there?

NSFT met with Priory Ellingham to negotiate block purchasing beds in Redwood unit, their adult acute inpatient ward. Negotiations have been ongoing to work in partnership with this local hospital and the Priory group are in the process of increasing the number of adult beds they provide (currently 10 but due to increase incrementally to 24 by February 2018).

12. With the 27 beds at Mundesley no longer available and the numbers of out-of-Trust placements still required, how does NSFT plan to accommodate in-patients?

At the time of writing there are 11 out of Trust placements for Norfolk and Waveney, of which 5 patients are placed at Priory Ellingham in Attleborough. The outcome from the projects which are underway as part of the Bed Review conclusions will address some of that demand.

13. It is understood from press reports that beds at Priory Group's Ellingham Hospital will be used, but that facility is for patients aged 12 to 25. What are the plans for older patients?

Redwood unit at Ellingham Priory is an adult acute ward and the hospital is currently in the process of refurbishing Woodlands unit which will also be registered as an adult acute unit.

14. Will the cost of out-of-Trust placements increase now that Mundesley Hospital is no longer available? If so, where will the additional funding be found? (The CCGs will also be asked about this issue).

Mundesley Hospital was one of a number of providers where patients were placed outside of the Trust and therefore there is no anticipated cost increase as a result.

15. Were safeguarding concerns raised by patients at Mundesley Hospital shared with NSFT?

Three safeguarding concerns were shared with NSFT.
One concern was raised by a patient in June 2016 following discharge back to the care of NSFT. This incident was investigated by the police and the Multi-Agency Safeguarding Hub for Norfolk. The police found that there was no case to answer.

A safeguarding incident/concern was raised on 14th June 2017 which resulted in NSFT's Director of Operations and Associate Director of Operations making an unannounced visit to Mundesley hospital that day. At the time of the visit there were representatives from Norfolk Police and Norfolk County Council's safeguarding teams present and advice was sought about the safety of keeping patients at the hospital. Neither Norfolk Police nor Norfolk County Council's safeguarding representatives felt that there was a need to remove patients from the hospital. The police fully investigated this safeguarding concern which did not result in any further action.
A concern was raised on 30th June 2017 which was referred to the Multi-Agency Safeguarding Hub for Norfolk and the police. It was found that there was no case to answer.

16. **How can NSFT assure itself that it would be made aware of any problems with safety of care arising at the independent and other out-of-Trust facilities at which patients are placed?**

NSFT proactively review all service users placed in hospitals outside of NSFT. A senior nurse visits Priory Ellingham twice weekly to review patients and care co-ordinators also in reach into the hospital. People placed further afield are regularly reviewed by the NSFT out of area manager and the priority is to repatriate those people placed furthest from Norfolk or Suffolk. The NSFT governance team regularly undertake inspections of independent hospitals and review CQC inspection reports for those hospitals.

17. **How many patients are sent to NSFT in-patient facilities by other mental health trusts and who is responsible for their care?**

It is unusual for non-secure (forensic) patients to be sent to NSFT inpatient facilities by other mental health trusts. On the occasions when this does occur, NSFT would be responsible for their care. But our Trust works closely with teams at the 'referring' trust to ensure the safe and expedient return of that patient to a unit closer to their home, as and when appropriate, and to ensure as much continuity of care as possible.
Patients who require secure (forensic) inpatient placements are referred directly to us form around the country, via the Ministry of Justice commissioning arrangements.

Norfolk and Suffolk NHS
NHS Foundation Trust

Summary of the CQC Improvement Plan

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

Version 1.8

14 Nov 2017

What are we doing?

- The Trust was rated as 'Inadequate' and placed into 'special measures' following an inspection by the Chief Inspector of Hospitals (CQC) in July 2017.
- The Chief Inspector made 25 recommendations in total, 21 of which the Trust must undertake and 4 of which the Trust should undertake. All 25 recommendations are included in our CQC Improvement Plan. The key themes of these recommendations are summarised below:
    - Improving safety
    - Improving staffing
    - Improving service access / capacity
    - Improving data / performance (Quality)
    - Improving compliance
- The plan is iterative and will include a governance review to be commissioned by NHS Improvement which will add to the improvement learning.
- The Trust Board has approved the CQC Improvement Plan which has been designed to deliver the immediate actions required as well as the longer term improvements needed. Support and engagement of our staff and our stakeholders will be fundamental to making the sustainable changes that are required for the benefit of everyone who uses our services.
- A robust system of governance has been established to track and deliver the progress against the plan. The plans have been developed on a service line basis to match the approach taken by the CQC. Service Line Leads have been appointed to implement the plans and Operational Leads have been allocated to ensure actions are implemented quickly and effectively and to unblock any obstacles that might prevent completion of the actions. There is Executive and Non-Executive oversight against all service lines plans and further independent review will be provided through a clinically-led Peer Review and Audit process. Performance will be monitored through our Quality Programme Board and reported to the Quality Governance Committee and to the Trust Board. Further oversight will be provided to our stakeholders through a monthly Oversight and Assurance meeting.
- The improvement plan will be monitored by the Quality Programme Board on a weekly basis, with each service line being reviewed on a fortnightly basis. This document shows our plan for making these improvements and will demonstrate our progression against the plan.
- The CQC Improvement Plan was signed off by the Board on 13 November 2017. The plan ensures that the format and content align to the CQC reporting domains and that there is further clarity of the intended outcomes and key performance indicators across the programme of improvement. This will assist in the process to ensure that improvement actions align with the improvement recommendations.

Who is responsible?

- Our actions to address the recommendations have been agreed by the Trust Board.
- Our Chief Executive, Julie Cave, is ultimately responsible for implementing actions in this document. Other executive directors are responsible for ensuring the plan is implemented as they provide the executive leadership for quality, patient safety and workforce: Debbie White (Director of Ops – Norfolk & Waveney), Pete Devlin (Director of Ops – Suffolk), Dawn Collins (Director of Nursing), Bohdan Solomka (Medical Director), Daryl Chapman (Director of Finance). Mark Gammage is the external advisor to the Board on HR/OD issues. Non-executive directors are responsible for testing and challenging the executive on the robustness of the plan, triangulating board reports with experience of front line staff and service users & carers.
- Philippa Slinger has been appointed as our Improvement Director and she will support our progress by challenging our approach to ensure we deliver the most effective service to our patients. The Improvement Director acts on behalf of NHS Improvement and works with the Trust to ensure delivery of the improvements and to oversee the implementation of the action plan.
- Ultimately, our success in implementing the recommendations of the CQC Improvement Plan will be assessed by the Chief Inspector of Hospitals, who will re-inspect our Trust in 2018.
- If you have any questions about the work we are doing you may contact our Head of Governance, Sue Barrett, sue.barrett@nsft.nhs.uk.

The format of this plan…

- This summary document begins with the longer term changes that we need to make. We recognise that sustainable improvement requires cultural changes which will take longer than our immediate action plans. We need to build a culture that empowers colleagues, that instills ownership and accountability for quality and which ensures that we deliver our promises. We have called these long term themes our systemic issues and they focus on leadership and medical and staff engagement.
- The pages that follow the systemic issues cover our required actions. These are our immediate responses to the Chief Inspector's 25 'must dos' and 'should dos'. Although we have shown these on a calendar going up to April 2018 this does not mean that our work will stop in April. There will be more work to do on some actions and where we have made changes we will continue to check that the improvements have been sustained.
- This is a summary document and behind each of the actions there are detailed service line plans that are not shown here. These include milestones to measure progress and the names of individuals who are accountable for delivering the improvements.
- We have rated the actions as "green" at this stage in our planning. This is because we believe that the plan is realistic and is on track. We recognise that as time goes on, some actions may not go to plan and if this happens they will then change to 'amber' which means that there are reasons to be concerned that the action will not deliver the outcome or timescale or 'red' if we now believe that the action is not on track to deliver. There are some actions where important aspects are not under our control and so we have used 'amber' to show that we have less certainty.
- The "amber" and "red" ratings make sure that we focus our attention on the important actions to get them back on track.

How we will communicate our progress to you?

- We will provide a progress report every month, which will be monitored by the Quality Programme Board and reviewed by the Trust Board.
- The progress report will be published on the Trust website, and subsequent longer term actions may be included as part of a continuous process of improvement. Each month we will let all staff, governors and stakeholders know our progress.
- We will write to all FT members via our newsletters letting them know more about the inspection outcome and describing the improvement plan, where members can access the action plan and how and when we will update it.
- We will present updates on progress at our scheduled Council of Governor meetings which are held in public.
- We will provide staff with an update on progress at our monthly broadcasts and communications to staff.
- We will provide updates to our stakeholders through the oversight and assurance meetings which will be held on a monthly basis.

Chair / Chief Executive Approval (on behalf of the Board):		
Chair Name: Gary Page	Signature:	Date:
Chief Executive Name: Julie Cave	Signature:	Date:

OUR IMPROVEMENT PLAN - SYSTEMIC ISSUES

Leadership

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

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

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

Summary of key actions	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr & beyond**
Strategic actions							
Trust Board to review exec roles and ensure appropriate structure is in place							
Trust Board to develop a revised Organisational Development Strategy and agree an implementation plan							
Trust Board agree and adopt improvement methodology to drive forward a high quality, high performing organisation based on continuous improvement							
Exec Team to adopt the 'Developing People – Improving Care' Framework							
Trust Board to participate in and develop the 'Leadership for Improvement' programme							
Exec Team to agree and develop leadership programmes for all levels							
CEO to introduce a 'coaching for performance' scheme for managers							
Operational actions							
Exec Team to communicate clear plans for addressing CQC issues and progress							
Visibility of the Board (Execs and NEDS) – to include the CEO monthly broadcast, weekly/monthly planned visits to each area, partnered up with corporate heads							
HR lead to introduce a team briefing process							
Chair to lead on substantive appointments to Board vacancies (inc recruitment process)							
CEO to ensure regular Senior Leadership Group meetings							

HR lead to formalise 360 appraisal process for Senior Leadership Team							
HR lead to introduce mentoring network							
Exec Team to renew approach to Executive oversight and performance management of appraisal, supervision and mandatory training compliance (see separate plan NSFT15)							

Evidence/Assurance
Regular and consistent messaging of plans for addressing CQC issues through a variety of mechanisms (Julie's Monday Message, Team Brief, SLGs) Plan in place for regular Board visits; visits undertaken; feedback from visits shared with Board colleagues Team briefing process implemented Executive positions appointed substantively Regular SLG meetings held Leading in Care Programme delivered Managers held to account for performance at every level EI programme for cohorts 4, 5 and 6 completed Staff survey engagement scores for 2018

OUR IMPROVEMENT PLAN - SYSTEMIC ISSUES (continued)

Medical Engagement

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

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

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

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

OUR IMPROVEMENT PLAN - SYSTEMIC ISSUES (continued)

Staff Engagement

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

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

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

OUR IMPROVEMENT PLAN - SYSTEMIC ISSUES (continued)

Culture

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

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

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

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

Our CQC Improvement Plan

to address S29A issues:

required actions

NSFT20	Exec lead: Julie Cave	The Trust must ensure that they fully address all areas of previous breach ofregulation.	PLAN ON TRACK: RAG RATING

Summary of actions	Oct	Nov	Dec	Jan	Feb	Mar	Apr & beyond
The Head of Governance confirms completion of review of 2014/2016/2017 reviews to ensure all must dos/should dos are covered							
The BoD agrees the governance structure to monitor the plan							
The executive team agree leads at all levels							
The QPB agree and implements an escalation process							
The Trust's compliance functions report to the QPB that processes are embedded and sustainable.							
OUTCOME: Regulators are assured that all breaches have been addressed.							

Evidence/Assurance
Governance structure in place Progress is made with the plans and evidence is provided Processes are embedded and sustainable Peer Reviews

NSFT02	Exec lead: Julie Cave	The Trust must ensure that action is taken to remove identified ligature anchor points and to mitigate risks where there are poor lines of sight.	PLAN ON TRACK: RAG RATING

Summary of actions	Oct	Nov	Dec	Jan	Feb	Mar	Apr & beyond

The Head of Estates ensures that site specific risk assessments are published on the intranet. Matrons confirm that risk assessments are accessible to ward staff							
Community toilet area risk assessments complete							
Head of Estates sign off that original work plan complete							
Matrons confirm that they have reviewed risk assessments with ward managers including all relational management arrangements. Ward managers confirm that they have reviewed risk assessments with ward staff including all relational management arrangements. Matrons escalate any issues immediately to locality managers for intervention							
Head of Estates to complete further potential work plan							
Board agrees additional work and funding							
Head of Estates confirms that work plan is in place and has been signed off by ward managers							
Every month, matrons report outcomes of audits to locality governance groups. Locality manager confirms that there are SMART actions in place for all issues identified. Improvements are evidenced and reported via Locality Governance Group minutes. Both environmental and relational aspects covered							
Matron audits confirm that operational policies are complied with in all areas and relational approaches are working							
Head of Estates signs off that work is complete							
OUTCOME: The board is assured that patient safety is protected as ligatures have been removed or the board has agreed that there are robust local arrangements which all local staff work to.							

Evidence/Assurance
Monthly matron audits Peer Review process Exec and Non-Exec visits Photographs of completed work Further reviews of existing areas to check risk assessments are comprehensive and complete

NSFT17	Exec leads: Debbie White /Pete Devlin	The Trust must ensure that people receive the right care at the right time by placing them in suitable placements that meet their needs and give them access to 24 hour crisisservices.	PLAN ON TRACK: RAG RATING

Summary of actions	Oct	Nov	Dec	Jan	Feb	Mar	Apr & beyond
Locality Managers develop capacity business cases where appropriate for discussion with Commissioners							
The Director of Operations N&W confirms that where OOA placements are required then appropriate monitoring is in place to return the patients to the Trust asap (to include LOS)							
The executive team approve acceptable staffing levels for s136 has been agreed or alternative actions taken							
Directors of Operations agree position with Commissioners on crisis services for dementia							
Directors of Operations agree performance and waiting time management plans for all areas that are not delivering waiting time standards							
Head of Estates confirms disabled access assessments have been completed							
Directors of Operations agree DToC plans with local stakeholders							
Directors of Operations N&W confirms that the Crisis Hub has been established							
OUTCOME: Patient safety is protected by access to appropriate services that meet their needs.							

Evidence/Assurance
Service user survey Reduction in complaints S136 compliance monitored through audits/Peer Review Waiting time performance improvement Reduced OOA patients Reduced DToC

NSFT18	Exec leads: Debbie White /Pete Devlin	The Trust must minimise disruption to patients during their episode of care and ensure that discharge arrangements are fully effective.	PLAN ON TRACK: RAG RATING

Summary of actions	Oct	Nov	Dec	Jan	Feb	Mar	Apr & beyond
Directors of Operations confirm that a protocol has been established to minimise risk of out of hours transfers.							
The Patient Safety & Complaints Lead reviews readmissions to identify learning and address review outcomes							
The executive team monitor progress against the OOA Trust/Commissioners action plan							
Directors of Operations confirm implementation of 'Red-to-Green' process and 'Purposeful admission'. This to include all aspects of effective discharge.							
OUTCOME: Patient admission, transfer and discharge arrangements promote recovery.							

Evidence/Assurance
Monitor performance on number of readmissions within 28 days Monitor the number of OOA placements (and bed days) Monitor DToC Monitor LOS for acute wards Peer Review

NSFT07	Exec leads: Pete Devlin/ Debbie White	The Trust must ensure there are enough personal alarms for staff and that patients have a means to summon assistance when required.	PLAN ON TRACK: RAG RATING

Summary of actions	Oct	Nov	Dec	Jan	Feb	Mar	Apr & beyond
Locality managers sign off confirmation that all staff have access to personal alarms							
The Associate Director of Operations (NW) / Chair of Acute Services Forum confirms that procedures on what to do in the event of an alarm have been reviewed (including Lone Worker Policy). Ward managers and community team managers confirm that amended procedures have been communicated to staff							
Ward managers and community team managers confirm that a programme of practice drills is in place.							
Ward managers and community team managers confirm that any malfunctioning alarm systems have been identified by local testing. Ward managers and community team managers confirm that they have tested their local arrangements and that staff know what to do if alarm sounds. Head of Estates confirms that any faulty alarm systems have been repaired							
Peer reviews confirm that alarm systems are effective.							
OUTCOME: Staff and patients can summon effective help if they need it urgently.							

Evidence/Assurance
Sign off by team leaders that sufficient personal alarms are in place and their areas are functioning satisfactorily Peer Reviews Compliance checks Matrons and team leaders monthly checks and reporting Environmental risk assessments

NSFT01	Exec lead: Dr Bohdan Solomka	**The Trust must ensure that all services have access to a defibrillator and that staff are aware of arrangements for life support in the event of an emergency.** The Trust must ensure all clinic rooms are equipped with emergency medication for use on site and in the community. The Trust must ensure that alternative procedures are in place for staff to follow in the event of a medical emergency.	**PLAN ON TRACK: RAG RATING**

Summary of actions	Oct	Nov	Dec	Jan	Feb	Mar	Apr & beyond
Physical health lead to review requirements for access to emergency equipment and provide a case for change.							
Exec decision to purchase defibrillator packs for all community bases (oxygen & adrenalin available in packs).							
Physical health lead signs off that that packs are in place for areas requiring defibrillators. Physical health lead signs off that the protocol is in place and that training has been provided to all areas where defibrillators are not appropriate.							
Senior Maintenance Services Manager signs off that defibrillator calibration and maintenance schedule is in place.							
OUTCOME: Arrangements are in place to minimise risk to people experiencing a medical emergency in that all Trust services either have trained staff with access to a defibrillator or have alternative procedures in place							

Evidence/Assurance
Protocol approved and published on intranet Training sign off by all relevant individuals Compliance checks that equipment is in place Peer review on operational safety Matrons audits

NSFT06	Exec lead: Dawn Collins	The Trust must fully implement guidance in relation to restrictive practices and reduce the number of restrictive interventions.	PLAN ON TRACK: RAG RATING

Summary of actions	Oct	Nov	Dec	Jan	Feb	Mar	Apr & beyond
Trust lead on RIs completes review of Trust practice versus national guidance to identify weaknesses							
Trust lead on RIs identifies best practice organisations and arranges visits/discussions							
Executive team agree revised policy, including performance metrics							
Executive team agrees preventative measures plan including training, Head of Training and PMA lead implements plan							
Assurance & Clinical Effectiveness Manager monitors Trust-wide data weekly and escalates to locality managers poor performing areas to provide agreed actions to address shortcomings.							
OUTCOME: Patient safety and recovery is promoted by minimal use of restrictive interventions.							

Evidence/Assurance
Performance improvement is seen (data shows a reduction in the number of restrictive practices). MDT review of older people restraints, to include RCA and actions to address weaknesses. All patients who have a history of aggression or who have been secluded have a Positive Behavioural Support Plan.

NSFT04	Exec lead: Julie Cave	The Trust must review the continued use of bed bays in the acute wards and work withcommissioners to provide single room accommodation.	PLAN ON TRACK: RAG RATING

Summary of actions	Oct	Nov	Dec	Jan	Feb	Mar	Apr & beyond
Business case to address single room issues at Hellesdon (Glaven and Waveney) agreed by Finance Committee							
Executive team review options for and patient care implications of removing bays.							
If bays continue in short term Matrons review use of management of bed bays with ward managers to maximise privacy and dignity until works completed. Peer reviews confirm effectiveness of measures.							
Head of Estates signs off that work is complete							
Business case for West Norfolk beds agreed in July 2017 and work is underway. Head of Estates signs off works as complete December 2018							
OUTCOME: Patient privacy and dignity is protected by the provision of single room accommodation.							

Evidence/Assurance
New facilities are open and in use No shared rooms available in Trust

NSFT03	Exec leads: Pete Devlin / Debbie White	The Trust must ensure that all mixed sex accommodation meets Department of Health and Mental Health Act code of practice guidance and promotes safety anddignity.	PLAN ON TRACK: RAG RATING

Summary of actions	Oct	Nov	Dec	Jan	Feb	Mar	Apr & beyond
Head of Governance confirms that all ward areas have been assessed against DoH guidelines							
Locality managers confirm that all inpatient areas have zoned sleeping areas so that male/female sleeping areas are clearly boundaried							
Head of Governance confirms that the Single Sex Trust Procedure has been reviewed and updated							
Performance data is reviewed weekly by Directors of Ops and areas of non-compliance escalated to Execs							
Locality Managers sign off that poor performance has been addressed with the local team and plan implemented.							
OUTCOME: Patient safety and dignity are protected because ward areas are gender boundaried.							

Evidence/Assurance
CCG Quality Leads to review areas with Matrons Peer Review Matrons audits Compliance team checks

NSFT05	Exec leads: Pete Devlin / Debbie White	The Trust must ensure that seclusion facilities are safe and appropriate and that seclusion and restraint are managed within the safeguards of national guidance and the Mental Health Act Code of Practice.	PLAN ON TRACK: RAG RATING

Summary of actions	Oct	Nov	Dec	Jan	Feb	Mar	Apr & beyond
Work for seclusion rooms is complete							
Compliance checks against standards complete							
Matrons review areas every month and sign off confirmation of operational compliance, or, if there are issues, makes recommendations to the CTL and Locality Manager to address these. Confirmation that compliance issues have been addressed are signed off by the Locality Manager via the SOT minutes and re-checked the following month by the Matron. Compliance includes physical environment, recording and care planning which promotes wellbeing of patients.							
OUTCOME: Patients' safety and dignity is protected because seclusion and restraint are only used within national standards.							

Evidence/Assurance
Peer Review Compliance Team checks Matrons audits Compliance check against the standards was completed in week commencing 23rd Oct. Operational issues identified e.g.cleaning. Compliance checks to be undertaken at random times.

NSFT16	Exec lead: Robert Nesbitt	The Trust must ensure that patients are only restricted within appropriate legal frameworks.	PLAN ON TRACK: RAG RATING

Summary of actions	Oct	Nov	Dec	Jan	Feb	Mar	Apr & beyond
The Company Secretary identifies those teams that are below training performance standards and locality managers implement a targeted 4-week turnaround process							
Ward managers report progress on a weekly basis to Operational Teams							
Where training performance is <50% teams to be escalated to QPB							
The Company Secretary has strengthened the section reminder system (of date that an authority is due to expire).							
The Company Secretary ensures revised systems are in place to provide clarity on medication chart recording and consent form reporting.							
OUTCOME: Patients' human rights are protected.							

Evidence/Assurance
Peer Reviews Improved CQC MHA assessments Compliance assurance results show documentation is correct Improved performance Random audits to check compliance with documentation and timescales

NSFT10	Exec lead: Dr Bohdan Solomka	The Trust must ensure that all risk assessments, crisis plans and care plans are in place, updated consistently in line with multidisciplinary reviews and incidents and reflect the full and meaningful involvement of patients.	PLAN ON TRACK: RAG RATING

Summary of actions	Oct	Nov	Dec	Jan	Feb	Mar	Apr & beyond
The Medical Director signs off the co-produced work of the CPA Task & Finish Group to include risk assessments as well as care plans and trajectories for monitoring.							
Additional admin resource is in place (NSFT08) to support improvement in recording.							
Locality managers sign off to confirm that their staff are clear on Trust expectations and implement training plans accordingly, including DICES training, Lorenzo training							
BSMs provide monthly or more frequent reporting to team leaders and managers and escalation of implementation issues through to execs for resolution.							
OUTCOME: There is effective care planning including risk management that meaningfully involves service users and carers.							

Evidence/Assurance
Random audit of care plans Peer Review Performance monitoring improvement against trajectory Link with NSFT13

NSFT13	Exec lead: Daryl Chapman	The Trust must ensure that all staff have access to clinical records and should further review the performance of the electronic system.	PLAN ON TRACK: RAG RATING

Summary of actions	Oct	Nov	Dec	Jan	Feb	Mar	Apr & beyond
Locality managers identify any areas where paper records continue to be used and address with ICT.							
Head of ICT confirms that there is on-site support for clinical teams designed to increase the knowledge of staff and the efficiency with which they use the system (clinical teams to identify those that want and require support)							
Head of ICT confirms that there is additional support to 'super-users' (to be identified by clinical teams) so that there is a local resource for clinical teams							
The Head of ICT confirms that system performance issues have escalated to DXC and that there is at least monthly progress chasing: the contract for Lorenzo is between DXC and NHS Digital. High risk of issues at NSFT not being resolved							
OUTCOME: Staff have access to a reliable health records system.							

Evidence/Assurance
Improved staff satisfaction with the system - surveys Link with NSFT10 – improved performance in CPA & risk assessments Faster & accurate reporting from the system Peer Reviews Functional improvements in the system are delivered by DXC/NHS Digital (dashboard)

NSFT21	Exec lead: Daryl Chapman	The Trust must ensure that data is being turned into performance information and used to inform practices and policies that bring about improvement and ensure that lessons are learned.	PLAN ON TRACK: RAG RATING

Summary of actions	Oct	Nov	Dec	Jan	Feb	Mar	Apr & beyond
The Director of Finance establishes the Digital Information Improvement Group with the following work streams: Skills & capability, System performance, Data quality, Reporting,							
Clinical Information Officer appointed							
Quality Programme Board reviews and agrees process for data and information sent to external organisations							
Execs review quality standards and agree set of metrics to improve performance							
The Director of Finance confirms that a work plan is in place for all work streams so that performance against clear milestones to improve data and information can be reported on a monthly basis							
Review performance targets with Commissioners: what's relevant & appropriate							
Director of Finance agrees communication strategy on why data is important for Trust-wide dissemination							
Director of Finance completes a review of performance management processes with Locality Managers and Directors of Ops							
OUTCOME: Reliable data is used to improve quality.							

Evidence/Assurance
Revised set of quality & workforce standards to monitor performance against Performance improves Protocols are in place for how we manage performance standards Workforce performance is recognised and owned Peer Reviews

NSFT22	Exec lead: Dr Bohdan Solomka	The Trust should ensure that the work undertaken in relation to deaths is learnt from to ensure that there are not missed opportunities that would prevent serious incidents.	PLAN ON TRACK: RAG RATING

Summary of actions	Oct	Nov	Dec	Jan	Feb	Mar	Apr & beyond
The Medical Director (through the Mortality Review Group) develops a work plan in relation to deaths with SMART actions							
Patient Safety & Complaints Lead benchmarks position against other organisations							
The Head of Governance ensures all staff are aware of and understand the SI Policy and how it relates to their practice and responsibilities							
Patient Safety & Complaints Lead provides feedback to teams on lessons and learning from incidents to ensure reflective learning and practice change							
Medical Director reports to the Board on learning from the best in the world							
OUTCOME: We can demonstrate that we improve quality by learning from deaths.							

Evidence/Assurance
Team meeting minutes show that learning has been communicated. Staff can describe how they learn from SIs including unexpected deaths Reduction in serious incidents

NSFT08	Exec lead: Dawn Collins	The Trust must ensure there are sufficient staff at all times, including medical staff and other healthcare professionals, to provide care to meet patients' needs.	PLAN ON TRACK: RAG RATING

Summary of actions	Oct	Nov	Dec	Jan	Feb	Mar	Apr & beyond
Exec agreement to increase admin resource to release clinicians for patient care in return for increased performance (specifics agreed with ward managers). HR recruitment team place adverts and organise interviews.							
LMs develop business cases to increase capacity where demand has increased and is evidenced (for CCG support)							
HR lead carries out review of recruitment and retention strategy and leads on executive agreed actions to address shortcomings							
BSMs provide daily roster reporting to local managers so that staff pressure hot spots can be mitigated by CTLs.							
Community team managers confirm that daily 'huddles' in community teams established							
OUTCOME: Patients have their needs met.							

Evidence/Assurance
Time to hire performance is reduced
Level of vacancies is reduced
Reduction in number of Datix incidents for staff shortages
Reduced sickness levels for work-related stress
Peer Review

NSFT19	Exec lead: Pete Devlin / Debbie White	The Trust must ensure that there are clear targets for assessment and that targets for waiting times are met. The Trust must ensure that people have an allocated careco-ordinator.	PLAN ON TRACK: RAG RATING

Summary of actions	Oct	Nov	Dec	Jan	Feb	Mar	Apr & beyond
Directors of Operations confirm that Demand and capacity reviews for services (in conjunction with waiting time performance) have been completed							
Directors of Ops confirm that consistent business approach to record unallocated cases has been agreed and implemented							
Directors of Operations confirm that the Caseload Weighting Tool is in place across the Trust and review current position: agreeing actions to address concerns							
See NSFT17: Directors of Ops agree performance and waiting time management plans for all areas that are not delivering waiting time standards							
Directors of Operations confirm that Standardised documentation is in use across Trust							
Medical Director confirms that referrals from GPs (STP work programme) have been reviewed and learning fed back to STP							
OUTCOME: Patients receive timely care.							

Evidence/Assurance
Peer Review Line management supervision improvement Consistent caseloads in line with agreed thresholds Staff survey improvements Waiting time performance improvements Service User survey feedback shows that people know who their care coordinator is.

NSFT15	Exec leads: Pete Devlin / Debbie White	The Trust must ensure that all staff receive regular supervision and annual appraisals and that the system for recording levels of supervision is effective and provides full assurance to the trust board.	PLAN ON TRACK: RAG RATING

Summary of actions	Oct	Nov	Dec	Jan	Feb	Mar	Apr & beyond
HRBPs ensure that there is monthly reporting to service managers and through to Accountability Review meetings							
Execs agree appropriate performance target %							
Line Managers confirm that 'supervision trees' to ensure everyone is clear who is providing and receiving supervision are in place.							
See NSFT10 additional admin to support recording							
The HR Lead completes a review of appraisal process to ensure it is simple and effective, including recording to demonstrate compliance. HR BPs work with outlier teams. Performance Accountability meetings follow up actions to green.							
OUTCOME: The board is assured that staff receive regular supervision and annual appraisals.							

Evidence/Assurance
Performance improvement Staff satisfaction (survey in 2018) Increased training need identification Peer Reviews

NSFT09	Exec lead: Dawn Collins	The Trust must ensure all relevant staff have completed statutory, mandatory and whererelevant specialist training, particularly in suicide prevention and lifesupport.	PLAN ON TRACK: RAG RATING

Summary of actions	Oct	Nov	Dec	Jan	Feb	Mar	Apr & beyond
HRBPs provide managers and team leaders with compliance reports on a weekly basis							
The Trust Education Lead reviews access to training and increases this where necessary (flexibility in provision of training (e.g. locally) is required).							
The Trust Education Lead Monthly reporting to execs on individuals <50% and executive leads confirm that there are plans in place to reach the compliance targets for each SM training area.							
The Trust Education Lead carries out a review of rationale for mandatory training and targets and reports to the executive team which approves any updated targets based on patient and staff priorities.							
Team leaders report through to Exec directors on reasons why compliance has not improved and provides actions to address at team or individual level as appropriate.							
OUTCOME: Our staff are competent to provide safe and effective care.							

Evidence/Assurance
Performance on mandatory training improves Increased training courses filled Peer review process

NSFT14	Exec lead: Dr Bohdan Solomka	The Trust must ensure that there is full and clear physical healthcare information and that patients physical healthcare needs are met.	PLAN ON TRACK: RAG RATING

Summary of actions	Oct	Nov	Dec	Jan	Feb	Mar	Apr & beyond
Physical Healthcare Lead confirms that the Physical Healthcare Policy review is complete and that the user guide/quick action guide has been developed.							
Physical Healthcare Lead confirms that reporting on compliance system has been established							
Line managers monitor application of the policy through management supervision							
Physical Health Lead attends ward meetings in each locality to assess / address barriers to compliance							
OUTCOME: Patients' physical healthcare needs are appropriately assessed and addressed.							

Evidence/Assurance
Matrons audits Peer Review Line management supervision Compliance reporting improvement

NSFT23	Exec lead: Dr Bohdan Solomka	The Trust should review the audit trail for medicines held at community clinics for administration or supply to service users.	PLAN ON TRACK: RAG RATING

Summary of actions	Oct	Nov	Dec	Jan	Feb	Mar	Apr & beyond
Head of Maintenance confirms Backtraq (medical devices inventory) system is operational							
CTLs to ensure weekly checks on equipment and report issues							
Head of Pharmacy confirms medical competencies check with staff is complete and any shortfalls are addressed							
Head of Pharmacy to confirm pharmacy team provides supervised drug rounds to improve practice							
OUTCOME: Management of medication in community services is consistent with best practice.							

Evidence/Assurance
Peer Review Local audits

NSFT12	Exec lead: Dr Bohdan Solomka	The Trust must ensure that the temperature of medicines storage areas is maintained within a suitable range, and that the impact on medicines subject to temperatures outside the recommended range is assessed and acted on.	PLAN ON TRACK: RAG RATING

Summary of actions	Oct	Nov	Dec	Jan	Feb	Mar	Apr & beyond
Increased resource agreed for Pharmacy to support community teams							
Matrons confirm that electronic system for monitoring fridge temperatures are in place and working and escalate issues to the pharmacy team and maintenance team.							
The Head of Pharmacy reviews medicines management competencies within teams							
Matrons/Pharmacy leads confirm that all staff are clear on the operational procedures to support the system							
OUTCOME: Medication is properly stored.							

Evidence/Assurance
Matrons audits Central fridge monitoring (to Pharmacy) Peer Reviews

NSFT11	Exec lead: Dr Bohdan Solomka	The Trust must ensure that the prescribing, administration and monitoring of vital signs of patients are completed as detailed in the NICE guidelines [NG10] on violence and aggression: short-term management in mental health, health and communitysettings.	PLAN ON TRACK: RAG RATING

Summary of actions	Oct	Nov	Dec	Jan	Feb	Mar	Apr & beyond
Minutes demonstrate that governance meetings in localities consider their local compliance.							
The Lead Clinician establishes a system to ensure that there is team discussion for reflective practice after any event.							
The Physical Health Team Lead reviews Trust procedure against NICE guidelines and makes amendments if necessary							
The head of Training signs off that training is compliant with NICE and training delivered.							
OUTCOME: Violence and aggression is managed effectively in line with NICE guidelines.							

Evidence/Assurance
Performance will improve Matron and clinical audits Datix reporting will reduce Peer review

NSFT24	Exec lead: Dr Bohdan Solomka	The Trust should review the arrangements to support people in the rehabilitation and recovery service to manage their own medicines in preparation for discharge.	PLAN ON TRACK: RAG RATING

Summary of actions	Oct	Nov	Dec	Jan	Feb	Mar	Apr & beyond
Associate Director of Ops/Head of Pharmacy confirm the policy for self-administration of medication is agreed							
Associate Director of Ops establishes protocols for discharge of patients with suitably packaged medication							
OUTCOME: People in rehabilitation services are supported to live independently by promotion of self-management of medication.							

Evidence/Assurance
Peer Review

NSFT25	Exec lead: Dr Bohdan Solomka	The Trust should review the training provided to staff in St Catherine's who handlemedicines.	PLAN ON TRACK: RAG RATING

Summary of actions	Oct	Nov	Dec	Jan	Feb	Mar	Apr & beyond
Associate Director of Ops for Norfolk to provide case on the long term use of St Caths under consideration to Execs							
Local training package to be developed between matron and pharmacy							
OUTCOME: Staff at St Catherine's manage medication safely.							

Evidence/Assurance
Audit of training records Peer Review