Norfolk and Suffolk NHS
NHS Foundation Trust

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

Information request for the Health Overview and Scrutiny Committee

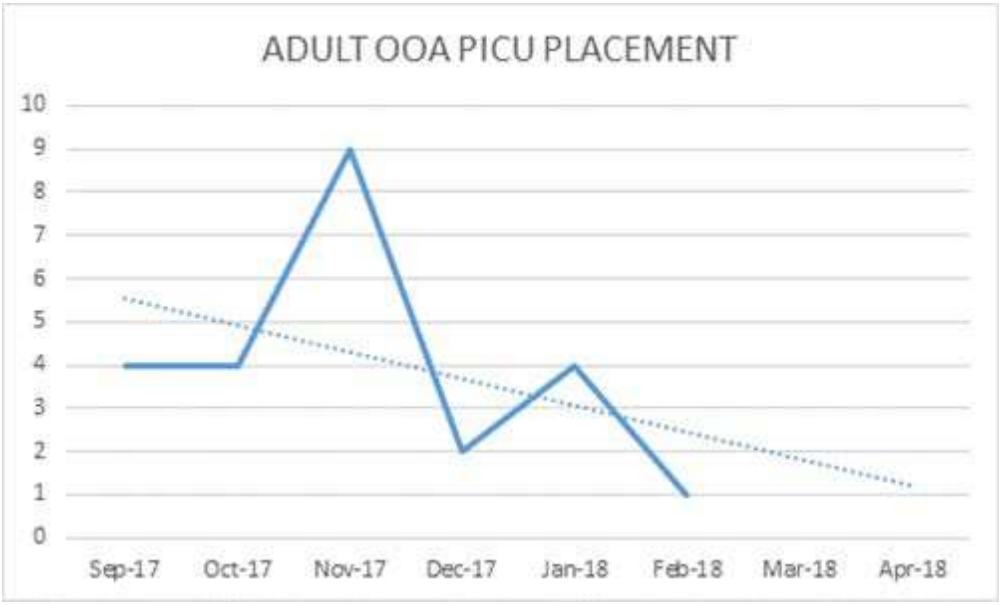
1. The updated Improvement Plan setting out progress in response to the CQC's 'must do' and 'should do' action list and the wider system challenges

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

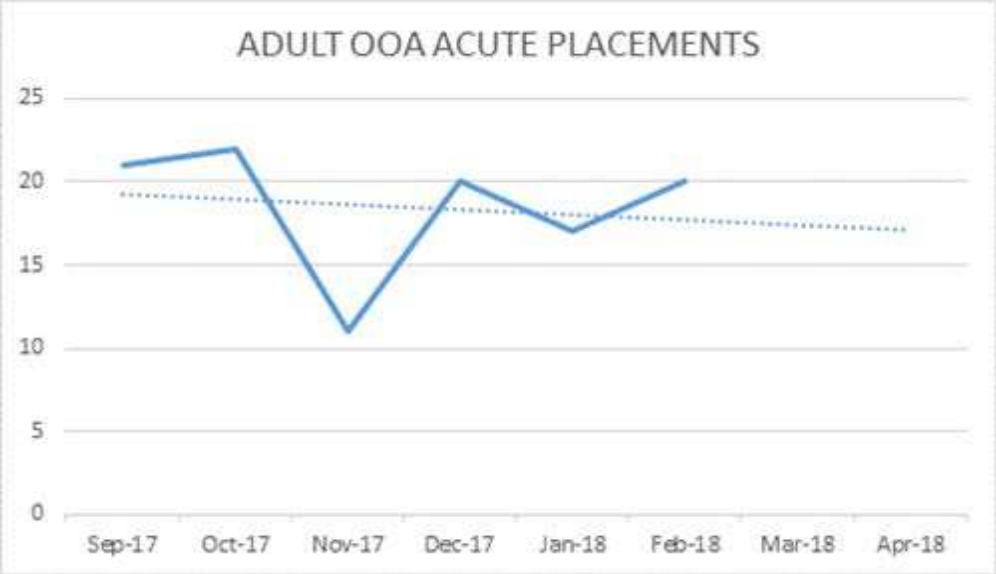
   Appendix 1 - Executive summary of the Section 29A – slide deck shared with the Overview and Assurance Group at it's on the 13th March.

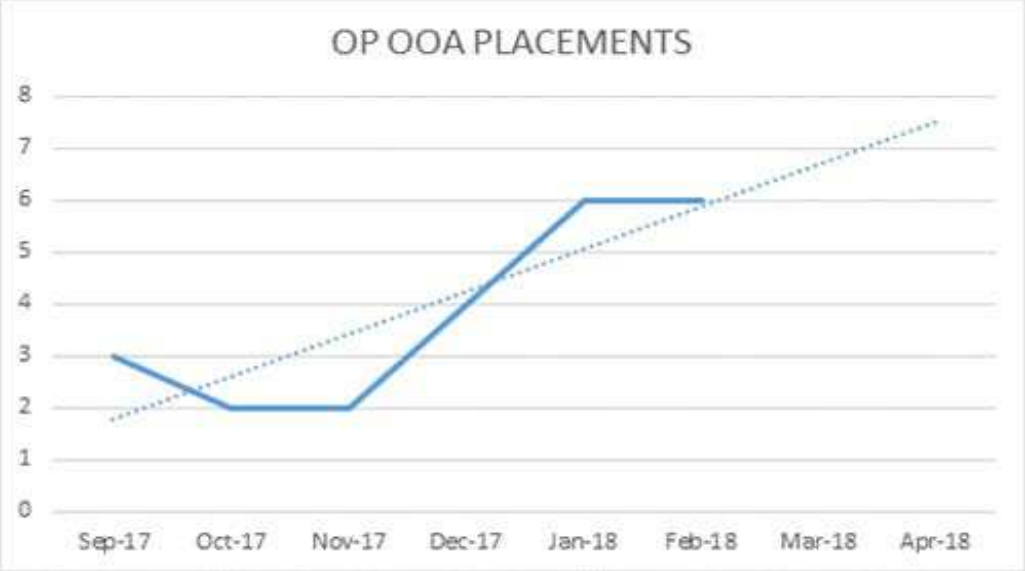
   Appendix 2 – Extract from Summary of the CQC Improvement Plan, 5 February 2018 – showing progress with key actions on leadership, medical engagement, staff engagement and culture.

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



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





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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

S.29a submission summary

Norfolk and Suffolk NHS
NHS Foundation Trust

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

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

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

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

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2. Ligature point management and environmental risks

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

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

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

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3. Seclusion environments and seclusion practice

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

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

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

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4. Accommodation for men and women

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

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

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

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

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

Since November 2017 there have been no reported breaches on Datix

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5. Staffing

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

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

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

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

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

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

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

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7. Access to Services

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

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

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

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8. Risk assessment and care planning

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

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

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

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9. Clinical Records

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

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

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

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Norfolk and Suffolk NHS
NHS Foundation Trust

10. Access to alarms and emergency equipment

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

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

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

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

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

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

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

OUR IMPROVEMENT PLAN - SYSTEMIC ISSUES

Leadership

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

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

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

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

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

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

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

OUR IMPROVEMENT PLAN - SYSTEMIC ISSUES (continued)

Medical Engagement

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

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

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

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

OUR IMPROVEMENT PLAN - SYSTEMIC ISSUES (continued)

Staff Engagement

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

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

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

OUR IMPROVEMENT PLAN - SYSTEMIC ISSUES (continued)

Culture

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

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

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

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