Norfolk County Council

Norfolk Health Overview and Scrutiny Committee

Date: **Thursday 10th November 2022**

Time: **10.00am**

Venue: **Council Chamber, County Hall, Martineau Lane, Norwich**

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

Members of the public or interested parties may, at the discretion of the Chair, speak for up to five minutes on a matter relating to the following agenda. A speaker will need to give written notice of their wish to speak to Committee Officer, Jonathan Hall (contact details below) by **no later than 5.00pm on Monday 7th November 2022**. Speaking will be for the purpose of providing the committee with additional information or a different perspective on an item on the agenda, not for the purposes of seeking information from NHS or other organisations that should more properly be pursued through other channels. Relevant NHS or other organisations represented at the meeting will be given an opportunity to respond but will be under no obligation to do so.

Membership

MAIN MEMBER	SUBSTITUTE MEMBER	REPRESENTING
Cllr Daniel Candon	*Vacancy*	Great Yarmouth Borough Council
Cllr Penny Carpenter	Cllr Carl Annison / Cllr Michael Dalby / Cllr Chris Dawson / Cllr Lana Hempsall / Cllr Jane James	Norfolk County Council
Cllr Barry Duffin	Cllr Carl Annison / Cllr Michael Dalby / Cllr Chris Dawson / Cllr Lana Hempsall / Cllr Jane James	Norfolk County Council
Cllr Brenda Jones	Cllr Emma Corlett	Norfolk County Council
Cllr Alexandra Kemp	Cllr Michael de Whalley	Borough Council of King's Lynn and West Norfolk
Cllr Julian Kirk	Cllr Carl Annison / Cllr Michael Dalby / Cllr Chris Dawson / Cllr Lana Hempsall / Cllr Jane James	Norfolk County Council
Cllr Robert Kybird	Cllr Fabian Eagle	Breckland District Council
Cllr Nigel Legg	Cllr David Bills	South Norfolk District Council
Cllr Julie Brociek-Coulton	Cllr Ian Stutely	Norwich City Council

Cllr Richard Price	Cllr Carl Annison / Cllr Michael Dalby / Cllr Chris Dawson / Cllr Lana Hempsall / Cllr Jane James	Norfolk County Council
Cllr Sue Prutton	Cllr Peter Bulman	Broadland District Council
Cllr Robert Savage	Cllr Carl Annison / Cllr Michael Dalby / Cllr Chris Dawson / Cllr Lana Hempsall / Cllr Jane James	Norfolk County Council
Cllr Lucy Shires	Cllr Robert Colwell	Norfolk County Council
Cllr Emma Spagnola	Cllr Victoria Holliday	North Norfolk District Council
Cllr Alison Thomas	Cllr Carl Annison / Cllr Michael Dalby / Cllr Chris Dawson / Cllr Lana Hempsall / Cllr Jane James	Norfolk County Council
CO-OPTED MEMBER (non voting)	**CO-OPTED SUBSTITUTE MEMBER** (non voting)	**REPRESENTING**
Cllr Edward Back	Cllr Colin Hedgley / Cllr Jessica Fleming	Suffolk Health Scrutiny Committee
Cllr Keith Robinson	Cllr Jessica Fleming	Suffolk Health Scrutiny Committee

For further details and general enquiries about this Agenda please contact the Committee Officer:
Jonathan Hall on 01603 223053
or email committees@norfolk.gov.uk

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It will be live streamed on YouTube and members of the public may watch remotely by clicking on the following link: Norfolk County Council YouTube

However, if you wish to attend in person it would be helpful if you could indicate in advance that it is your intention to do so as public seating will be limited. This can be done by emailing committees@norfolk.gov.uk

The Government has removed all COVID 19 restrictions and moved towards living with COVID-19, just as we live with other respiratory infections. However, to ensure that the meeting is safe we are asking everyone attending to practise good public health and safety behaviours (practising good hand and respiratory hygiene, including wearing face coverings in busy areas at times of high prevalence) and to stay at home when they need to (if they have tested positive for COVID 19; if they have symptoms of a respiratory infection; if they are a close contact of a positive COVID 19 case). This will help make the event safe for all those attending and limit the transmission of respiratory infections including COVID-19.

A g e n d a

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

2. Minutes

To confirm the minutes of the meeting of the Norfolk Health Overview and Scrutiny Committee held on 8th September 2022 (Page 5)

3. Members to declare any Interests

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

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

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

If you do not have a Disclosable Pecuniary Interest you may nevertheless have an **Other Interest** in a matter to be discussed if it affects, to a greater extent than others in your division

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

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

4. To receive any items of business which the Chair decides should be considered as a matter of urgency

5. Chair's announcements

6.	**10:10 – 11:00**	**Access to NHS Dentistry in Norfolk and Waveney**	(Page 11)
7.	**11:10 – 11:55**	**Re-examination of the Norfolk & Suffolk NHS Foundation Trust's improvement plan following the Care Quality Commission's inspection from November to December 2021 (report published April 2022)**	(Page 21)
8.	**11:55 – 12:00**	**Forward Work Programme**	(Page 126)

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Date Agenda Published: 2 November 2022

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Norfolk County Council

NORFOLK HEALTH OVERVIEW AND SCRUTINY COMMITTEE
Minutes of the meeting held at County Hall
on 8th September 2022

Members Present:

Cllr Alison Thomas (Chair)	Norfolk County Council
Cllr Julie Brociek-Coulton	Norwich City Council
Cllr Daniel Candon (Vice Chair)	Great Yarmouth Borough Council
Cllr Penny Carpenter	Norfolk County Council
Cllr Barry Duffin	Norfolk County Council
Cllr Alexandra Kemp	Borough Council of King's Lynn and West Norfolk
Cllr Julian Kirk	Norfolk County Council
Cllr Robert Kybird	Breckland District Council
Cllr Nigel Legg	South Norfolk District Council
Cllr Richard Price	Norfolk County Council
Cllr Sue Prutton	Broadland District Council
Cllr Robert Savage	Norfolk County Council
Cllr Lucy Shires	Norfolk County Council
Co-opted Member (non voting):	
Cllr Edward Back	Suffolk Health Scrutiny Committee
Cllr Keith Robinson	Suffolk Health Scrutiny Committee

Substitute Members Present
Cllr Emma Corlett substituting for Cllr Brenda Jones
Cllr Victoria Holliday substituting for Cllr Emma Spagnola

Also Present:

Kathryn Ellis (item 7)	Director of Strategy & Partnership – Norfolk & Suffolk NHS Foundation Trust
Diane Hull (item 7)	Chief nurse – Norfolk & Suffolk NHS Foundation Trust
Cath Byford (item 7)	Deputy Chief Executive Officer and Chief People Officer – Norfolk & Suffolk NHS Foundation Trust
Tricia D'Orsi (all items)	Director of Nursing – Norfolk & Waveney Integrated Care Board
Rebecca Hulme (all items)	Associate Director for Children, Young People and Maternity Services - Norfolk & Waveney Integrated Care Board

Online:

Emma Willey (item 7)	Head of Mental Health - Norfolk & Waveney Integrated Care Board
Heather Roach (item6)	Independent Chair - Norfolk Adult Safeguarding Board

Officers:

Jonathan Hall	Committee Officer
Peter Randall	Democratic Support and Scrutiny Manager

1 Apologies for Absence

1.1 Apologies for absence were received from Cllr Brenda Jones (substitute Cllr Emma Corlett) and Cllr Emma Spagnola (substitute Cllr Victoria Holliday).

2. Minutes

2.1 The minutes of the previous meetings held on 14 July 2022 were agreed as an accurate record of the meetings and signed by the Chair.

3. Declarations of Interest

3.1 The following declarations were made:
Item 6
Cllr Penny Carpenter advised she was a member of the Norfolk Adults Safeguarding Board.
Item 7
Cllr Lucy Shires advised you she a member for the campaign for Mental Services in North Norfolk.
Cllr Emma Corlett advised she was a founder member of the Campaign to Save to Mental Health Services in Suffolk and Norfolk.
Cllr Daniel Candon advised as part of his employment he attends meetings with the minister and other MPs.

4. Urgent Business

4.1 There were no items of urgent business.

5. Chair's Announcements

5.1 The Chair had no announcements.

6 Health and care for adults with learning disabilities / autism: Cawston Park Hospital Safeguarding Adults Review (SAR) – progress update

6.1 The Committee received evidence in person from Heather Roach, the Independent Chair of the Norfolk Safeguarding Adults Board (NSAB) and Tricia D'Orsi, Director of Nursing, Norfolk & Waveney Integrated Care Board

6.2 The Committee received a presentation from Heather Roach, the Independent Chair of the Norfolk Safeguarding Adults Board (NSAB), which highlighted the progress made implementing the recommendations of the review that was published by NSAB in September 2021 following the deaths of Joanna, Jon and Ben, who were patients of Cawston Park, with learning disabilities and/or autism.

6.3 The Chair thanked Heather Roach for her presentation and during the ensuing discussion the following points were noted:

- The progress made in implementing the recommendations was widely accepted by the committee as being very good.
- It was noted that all patients removed from the hospital following the review had experienced good outcomes in their new environments with one success story highlighted of an individual moving into a self-contained flat and engaging in community activities.
- A number of providers looking to set up facilities and provide a service within the sector had been refused as a result of more robust due diligence taking place following the review.

- Difficulties had been experienced in recruiting a coordinator for the Coalition for Change group although progress in that regard was now being made.
- There was a need to ensure the coordination of the work being undertaken was maintained correctly as several stakeholders including the ICB were involved. It was felt this responsibility did not necessarily sit with NSAB but needed careful consideration to ensure all stakeholders within the sector implement the correct changes.
- Reassurances were provided that the measures and safeguards in place currently ensured that the possibility of such an event as Cawston Park Hospital happening again were significantly reduced, although there was a strong desire not to be complacent.
- Tricia D'Orsi confirmed that the recommendations from the review are a priority for the ICB and herself personally. Tricia acknowledged that the capacity for mental health services was a significant challenge particularly with regard to ensuring providers could meet the require standards. Tricia acknowledged that the situation was dire in terms of capacity in health and social care and work was underway to support the flow of patients through the system to make sure people were getting the right support at the right time. Work was also underway with acute hospital trusts and other system partners looking at how to facilitate more timely discharge into the community.
- Following on from the focus on racism at the SAR summit, Tricia D'Orsi acknowledged that racism is an issue throughout health and social care and that there was a need for a collaborative system-wide response to racism.
- Recruitment to roles to increase capacity and ensure a quicker diagnostic pathway were being addressed, but the current situation was challenging. This was against a backdrop of increased demand, especially since the pandemic. Recognised the need for more to be done in regard for the recognition, treatment and care of patients with co-morbidities and the need for a greater focus on physical health needs of people with mental health issues or physical disabilities.
- Discharge to appropriate housing for patients was vital to ensuring hospital stays were reduced and work with the districts councils and others was underway to look at the current housing stock and the issues of supply to a mixed model of housing requirements.
- Tricia D'Orsi also committed to investigating how additional support can be provided for relatives if they feel their concerns regarding a patient's physical health are not being addressed.
- The system currently had 13 adult patients and 2 child patients in a residential setting and robust weekly reviews of care plans were taking place to ensure that discharge into a community placement can happen in a timely fashion.

6.4 The Chair concluded the discussion:

- Thanking Heather Roach for all the hard work of the NSAB to oversee the implementation of the required changes.
- The chair further commented that she was pleased to note that the CQC were robustly applying their support care and culture guidelines and that new providers were being refused permissions to open new private facilities if these could not be met.
- Underlying health conditions were now being correctly identified and treated in addition to a patient's mental health needs.
- Cawston Park Hospital failed to provide care or assessment for patients and that this absence of provision will not be tolerated again in the future.
- Specialist Housing provision provided by district councils was a vital part of the transition for patients and that members of the committee should use their

influence where possible to ensure that a better mix of housing stock was provided.
- The Chair suggested that an update on the item was provided within the December HOSC briefing.

The committee undertook a comfort break and reconvened at 11.10am

7 Examination of the Norfolk & Suffolk NHS Foundation Trust (NSFT) improvement plan following the Care Quality Commission inspection from November – December 2021

7.1 The Chair expressed her disappointment that the papers for the agenda item arrived from NSFT after the legal publication date and as a result a supplementary agenda had to be issued. This had meant that the Chair was unable to review the papers before they were issued and any inaccuracies or omissions would not have been spotted, for which she apologised. The Chair further expressed disappointment in the quality of the papers, with little of the requested information being provided in enough detail to allow for meaningful scrutiny to take place.

7.2 Cath Byford, Deputy Chief Executive NSFT apologised for the lateness of the report and committed to installing a process which she had undertaken in her previous role within the local CCG to ensure the position does not arise again. Cath also advised that Stuart Richardson had been called to an urgent meeting in London of all NHS Chief Executives in the country and he sent his apologises.

7.3 The Committee received the annexed report (7) from Dr Liz Chandler, Scrutiny & Research Officer, which provided an update on the NSFT's improvement plan following the inadequate rating from the CQC inspection that took place in late 2021.

7.4 The Committee received evidence in person from representatives of Norfolk & Suffolk NHS Foundation Trust: Cath Byford, Deputy Chief Executive Officer and Chief People Officer, Kathryn Ellis, Director of Strategy & Partnership and Diane Hull, Chief Nurse. Norfolk & Waveney Integrated Care Board (ICB); Tricia D'Orsi, Director of Nursing, and Emma Willey Head of Mental Health.

7.5 Cath Byford, NSFT Deputy Chief Executive Chief People Officer advised that the Trust had made significant progress and that changes implemented had been designed to ensure these were embedded and sustainable. However, there was still work to do and the Trust needed to work on gaining and building trust amongst service users and the wider community.

7.6 The reports submitted were taken as read and during the ensuing discussion the following points were noted:

- There was a national shortage of consultant psychiatrists and recruitment was an issue. However Alex Lewis the Trust's Medical Director was treating recruitment as a priority to ensure services and treatment could be improved and enhanced and waiting lists reduced.
- The issues at Northgate Hospital were acknowledged as disappointing and the CQC report had identified poor leadership as an issue. Improvements had included a change in leadership, bringing in an experienced senior nurse from another Trust as well as changing policies on training and improving quality safety reviews of patients' care plans. There has also been an external review of observation processes which the CQC requested immediate action and have subsequently been assured with progress.

- Changes following the CQC report were happening at pace and were being embedded within processes and training to ensure these are sustainable.
- Cath Byford, Deputy Chief Executive and Chief People Officer committed to providing data and timely information to the committee and reiterated her early apologies. It was agreed that future reports need to concentrate on how changes are making a difference and what will happen next to improve services further.
- The improvement plan was tackled on three levels. The first was the 'must do's' the CQC asked the Trust to address immediately relating to quality and safety. Root cause issues which prevented sustained improvement were also being addressed within the Trust and other partners. A key part of the plan to ensure that changes were sustainable was to acknowledge how staff, service users and carers were feeling. As an example an evidence group had been created at Queen Elizabeth Hospital in King's Lynn to provide independent check and challenge on how services were received, and this provided evidence that changes were having an effect.
- Numerous changes had taken place within Dragonfly Ward in Lowestoft to improve safety including extensive training and webinars, in addition 120 safety reviews had been undertaken since December 2021. A new consultant psychiatrist had been recruited as well as other team members. The ward had been moved into the Suffolk Children's and Young People's Care Group where there is greater experience and knowledge to provide more resilience and robustness.
- Emma Willey, Head of Mental Health for Norfolk and Waveney ICB advised that NSFT were now more proactive in providing information with regards to business continuity measures, and that at the next Board meeting the Trust will speak about the challenger they face with staff culture issues, including the issues around racism.
- It was acknowledged that the report lacked detail in a number of areas, especially context with data provided around the reported recruitment of 750 new staff.
- The report advised 20% of the Section 29a 'must dos' have not been completed. The 20% related to mandatory training, waiting lists and recording of care plans for service users. Each outstanding area had a clear plan which was being implemented to ensure the 20% was completed in a timely manner.
- The Trust is having issues retaining staff as 41% of new staff leave within two years of starting.
- The balance of recruiting the right leadership staff and clinical staff had been difficult for the Trust and this had exacerbated the void that had appeared for the leadership to support the frontline staff in their day to day activities. It was acknowledged the culture at NSFT had to change and this was being addressed by the Board.
- Both Norfolk and Suffolk ICBs had agreed to an independent review of the mortality data. The number of deaths was known although there was some confusion as to how this data had been collected and recorded. The findings of the review would it is hoped will end the confusion. Members asked whether bereaved families would be included in the discussions around mortality numbers. The trust agreed to explore this.

7.7 The Chair concluded the discussion and thanked all from NSFT for their input.

- It was acknowledged that scrutiny of the item had been difficult as the report did not really provide the detail required.
- It was agreed that NSFT would return to the committee in November 2022 and that a precise list of questions would be provided prior to ensure detailed answers could be provided.

- The Chair advised, with the agreement of the committee, that she would write to the new Secretary of State for Health and express concerns that the committee faced today and that further scrutiny will take place in November 2022.

8 Forward Work Programme

8.1 The Committee received a report from Peter Randall, Democratic Support and Scrutiny Manager which set out the current forward work programme and briefing details that were agreed subject to the following additions:

Meetings
November 2022

- NHS dentistry services – (Access for patients and award of new NHS contracts). The response letter from the Health Secretary in respect of NHS dentistry in Norfolk would be circulated with the papers.

Date TBC

- System approach to hospital discharge
  To review the patient journey from arrival by ambulance at A&E through to discharge into social care placements. To include mental health patients. Duncan Baker MP to be invited to meeting as he served with EEAST during summer recess.

Alison Thomas Chair
Health and Overview Scrutiny Committee

The meeting ended at 12.23pm

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Access to NHS Dentistry in Norfolk and Waveney

Suggested approach from Liz Chandler, Scrutiny and Research Officer

A report on progress regarding **access to NHS dentistry across Norfolk and Waveney since March 2022.**

1.0 Purpose of today's meeting

1.1 To examine the report from commissioners NHS England and NHS Improvement (NHSE&I) regarding access to dentistry services across Norfolk and Waveney. The report is attached at **Appendix A**.

1.2 The report provides an update to that received at the NHOSC meeting in March 2022.

1.3 Representatives of NHSE&I will be in attendance to answer Members questions.

2.0 Background

2.1 Previous reports to NHOSC

2.1.1 In September 2020, NHOSC received a report from the commissioners NHS England and NHS Improvement (NHSE&I) providing an update on progress regarding access to dentistry across Norfolk and Waveney, Covid-19 arrangements and practices in Norfolk and Waveney that were accepting patients. The committee also received a paper from Family Voice on the difficulties that the families of children and young people with special educational needs and/or disability (SEND) experienced when accessing NHS dental services. The full reports and minutes of the meeting are available here.

At this meeting, the committee agreed to write to the Department of Health and Social Care (DHSC) about the national issues, particularly the dental contract and workforce shortage. A reply to this letter was received on 29 September 2020 and was included in the agenda for the NHOSC meeting in March 2022. The letter and the Secretary of State's reply can be viewed here.

2.1.2 In March 2022, NHOSC received a further update on access to NHS dental services in Norfolk and Waveney following a number of ongoing concerns from the meeting in September 2020.

The report provided was collated with input from NHSE&I, the Local Dental Network, Norfolk County Council Public Health, Healthwatch Norfolk and Local Dental Committee. The full reports and minutes of the meeting are available here.

Discussion at the meeting centred on:

- Continued capacity issues due to the Covid pandemic and ongoing infection prevention controls.
- Recruitment and retention of dentists particularly in relation to coastal and rural areas, the effects of Brexit and the Covid lockdown; the provision of a dental school in the region to address workforce issues; and NHS contracting, especially in terms of flexibility, to make NHS work more attractive for dentists in the private sector.
- Support for upskilling of dentists to provide more specialist treatment.
- A prevention strategy to tackle tooth decay and gum disease. The positive effects of fluoridation of the drinking water supply on dental health was highlighted, as was the need for public awareness around this issue.
- Concerns were raised about the inequalities around accessing services for those with limited or no IT provision.
- It was also noted that data around the service was nearly three years old and needed updating.

The committee agreed to write to the Department of Health and Social Care (DHSC) about the need for a dental school in Norfolk and Waveney to address the difficulties in recruiting to a rural area, issues around fluoridation of the water supply and the need for myth-busting, the recruitment and retention of dentists and the contract for dental services.

This letter was sent via email on 29 March 2022; a reply has yet to be received.

2.2 Wider national developments around dentistry

2.2.1 In July 2022, NHS England announced changes to the dental contract in a bid to improve access to dental care. Further details about these changes can be found via this link: NHS England: Better access to NHS dental services under new reforms.

2.2.2 Also in July 2022, a few days after NHS England announced its dental contract reforms, the Health and Social Care inquiry into Workforce: recruitment, training and retention in health and social care branded the currant Unit of Dental Activity (UDA) contract system as ‘not fit for purpose’ and called for urgent reform to boost staff recruitment and retention in NHS dental services. The committee stated it would ‘return to the issue in a forthcoming inquiry into dental services’. Further details available via this link: Workforce: recruitment, training and retention in health and social care - Health and Social Care Committee.

2.2.3 Having criticised the NHS England contractual reforms, claiming they 'do not even begin to address the system's fundamental flaws' (see: British Dental Association: Marginal changes under scrutiny), the British Dental Association welcomed the findings of Health and Social Care Committee's inquiry (see: British Dental Association: Health Committee concludes contract not fit for purpose).

2.2.4 In August 2022, a BBC investigation found that nine in 10 NHS dental practices across the UK were not accepting new adult patients and eight in 10 were not taking on children. Norfolk and Suffolk were among the counties that the BBC could not find a single practice accepting new adult patients. In Norfolk, a total of 66 dental practices with NHS contracts were contacted; in Suffolk 70 dental practices with NHS contracts were contacted. One practice in Norfolk said it had more than 1,700 people on its list. Further details of this investigation can be found via this link: BBC research into NHS dentistry shortage.

2.2.5 In September 2022, the new Health and Social Care secretary and Deputy Prime Minister Thérése Coffey set out the government's new 'Our plan for patients' aimed at improving access to NHS and social care this winter and next. The plan is available via this link: Department of Health and Social Care: Our plan for patients.

2.2.6 Just prior to the Department of Health and Social Care's publication of 'Our plan for patients', 60 MPs signed a letter to the Prime Minister Liz Truss urging her to make good on her campaign pledges on NHS dentistry. The letter is available via this link: NHS Dentistry Letter.

2.2.7 The Suffolk branch of the Toothless in England campaign are among those to criticise Dr Coffey's 'Our Plan for patients' for ignoring the current dentistry crisis. See: Toothless in Suffolk; Dentistry: Health Secretary's statement fails to mention dentistry.

2.2.8 Waveney NP Peter Aldous calls on the government to implement a five point plan to address the current issues in dentistry. See: Waveney MP Peter Aldous pitches five point plan for dentistry.

2.3 Wider developments around dentistry services in Norfolk

2.3.1 According to local media reports, a number of dental surgeries in Norfolk close their doors to NHS patients during August and September 2022, including those at Church Street in Attleborough (see: Church Street dentist Attleborough to close to NHS patients) and Compass Clinic at Kelling Hospital near Holt (see: Holt dental practice to stop seeing NHS patients). In Long Stratton, the dental practice at Manor House closed down completely (see: Manor House dentist in Long Stratton shuts permanently).

2.3.2 In August 2022, Toftwood Dental Practice in Shipdham announced that it would be applying for an NHS contract if planning permission to convert a

house into a second premises is granted. See: Toftwood Dental Practice could convert home for expansion.

2.3.3 Also in August, the difficulties in accessing NHS dental appointments for children inspired Bridge Street Dental Surgery in Fakenham to offer two full days of free children's check-up. See: Norfolk dentist offering free children's check-up days.

2.3.4 On 11 October, Broadland MP Jerome Mayhew secured a debate at the House of Commons about setting up a dental training college at the University of East Anglia (UEA) in a bid to tackling the shortage of dentists in the region. However, the Minister of State at the Department of Health and Social Care, Will Quince, declined to support the idea. See: Jerome Mayhew Speech on the Dental Training College; Blow for calls for UEA dentistry school as minister says no; Norfolk MP Jerome Mayhew vows to continue dental college bid.

3.0 Suggested approach

3.1 The committee may wish to discuss the following areas with NHSE&I representatives:

- Request an explanation about dental band charging particularly in relation to accessing NHS hygienist services. How many NHS dental hygienists are there in Norfolk?
- Under sub-section 3 Recovery and restoration of NHS Dental Services of the report, it cites an increase in the number of patients an NHS dentist can see as having increased due to the relaxation of Covid-19 infection control measures as one of the ways in which NHSE&I has been working closely with dental practices to reduce waiting times for patients. What else is NHSE&I doing to reduce waiting times for patients in Norfolk?
- What evidence is NHSE&I using to support their assertion in sub-section 3.3 that waiting times for NHS funded treatment are reducing?
- Can patients requiring urgent care be guaranteed that they will be able to access a dentist through NHS 111 following the closure of Urgent Dental Care Centres?
- Are the new dental practices fulfilling their contracts of offering an 8am – 8pm 365-day service?
- Request further details regarding access to Special Care Dental Services (Community Dental Services).

The committee may also wish to discuss the following:

3.2
- Revisit plans for a prevention strategy to reduce tooth decay and gum disease with particular emphasis on reducing sugar in the diet and the fluoridation of drinking water.
- Discuss any further action with regard to the letter to the Secretary of State.

4.0 Action

4.1 The committee may wish to consider whether to make comments or recommendations as a result of today's discussion.

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NHS England and NHS Improvement Report for

General Dental Services (Norfolk and Waveney)

Norfolk and Waveney County Council Health and Scrutiny Committee

October 2022

Progress report regarding access to dentistry across Norfolk and Waveney

1. Oral Health Needs Assessment

NHS England – East of England request Needs Assessments to be undertaken as part of the commissioning cycle when a service is close to its contract end date. This is undertaken to ascertain the current need and whether there are any gaps in delivery.

The last Needs Assessment produced, in relation to the Norfolk and Waveney population, was for the 8-8 services procurement that was undertaken. The extracted information was included in the last report that was produced for Norfolk Health Oversight Scrutiny Committee, in February 2022.

2. Dentists per 100,000 population data

This date is published on a yearly basis. The current available data is from the financial year 2021 / 22 in comparison to 2020 / 21:

Population per dentist and the number of dentists providing NHS dentistry
Table 1. Number of dentists with NHS activity, for years 2021 / 22 and 2020/ 21 ending 31 March, England – NHS England region geography and Sub ICB

			2021/22 [note 3]			2020/21 [note 3]		
Org Name	Dentists difference 2020/21 to 2021/22	Percentage difference 2020/21 to 2021/22	Total dentists	Population per dentist[2]	Dentists per 100,000 population[2]	Total dentists	Population per dentist[2]	Dentists per 100,000 population[2]
England	**539**	**2.3**	**24,272**	**2,330**	**43**	**23,733**	**2,372**	**42**
NHS Norfolk and Waveney ICB - 26A	19	4.9	410	2,519	40	391	2,625	38

Source: NHS Dental Statistics for England - 2021-22 Annual Report

There are fewer dentists per 100,000 of population in the Norfolk and Waveney CCG than East of England.

Please note that the information published within the report has been provided by Sub ICS area only, therefore it has not been possible to compare this to the data published previous reports.

3. Recovery and restoration of NHS Dental Services

Provision of dental services have slowly recovered and restored, through a scaling of minimum activity to be delivered, following national guidance; 20%, 45%, 60%, 65%, 85%, 95% since 1 June 2020. As of 1 July 2022, all dental practices are back to delivering 100% of their contracted activity.

Covid presents several difficulties for dental practices such as the workforce working close to a patient's airway as well as some dental procedures generating aerosols from water vapour. These aerosol generating procedures may facilitate the spread of Covid and so longer gaps between patients are needed on some occasions resulting in fewer patients being able to be treated in some clinical environments. This further increases the pressures on NHS dental services as fewer patients can be seen within a set timescale.

This, combined with a lack of dentists, has led to increased waiting lists to access NHS dentists and with the Covid related requirements to dental practices has resulted in reduced access for non-urgent NHS dental care.

NHS England is working closely with dental practices to reduce waiting times for patients. Most helpfully, the number of patients that an NHS dentist is allowed to see and treat each day is now increasing as infection control requirements change to reflect the latest Covid 19 infection and transmission rates.

Patients can approach any NHS dental practice and request care; however, it is important to note that many NHS dental practices now have a waiting list of patients who require dental care.

3.1 Urgent Dental Care Centres in Norfolk and Waveney

Following the publication of the latest letter from the National Team, titled *Dental Services year end arrangement and 2022/23*, dated 5 April 2022, NHS England – East of England, we formally stood down Urgent Dental Care Centres, with effect from 30 June 2022.

If a patient believes that their condition is deteriorating into an urgent problem or changing, they should contact NHS 111, who will be able to direct them to a dentist who does have capacity to see patients who need urgent care.

3.2 Current capacity, clinical staff rates, waiting times and accepting new patients; general dental services in Norfolk and Waveney

Dental practices are independent providers who hold a contract to provide NHS dental services. Dental providers manage their own practice including capacity and determine whether they are able to accept additional/new patients and therefore their lists can open and close on a frequent basis. This is not information that NHS England – East of England holds for each contract.

3.3 Of all the general dental care available in Norfolk and Waveney, what percentage is private care and what percentage is NHS?

Many practices who deliver NHS funded dentistry also see private or independent patients and this would be a matter of patient choice. As dental services continue to restore post Covid-19 many more patients are able to be seen and waiting times for NHS funded treatment are reducing. NHS England commissions NHS services, therefore, we are not in a position to comment about private treatment provided.

Dental practices are independent providers who hold a contract to provide NHS dental services. Dental providers manage their own practice including capacity and determine whether they are able to accept additional/new patients and therefore their lists can open and close on a frequent basis. This is not information that NHS England – East of England holds for each contract.

4. Update regarding the transfer of commissioning responsibility from NHS England to Integrated Care Boards

NHS England is in a transition year during 2022 / 23. The commissioning of service delivery is being aligned and we are working very closely with ICS colleagues to ensure that they have a good understanding about the commissioning of these services, to prepare them for the transfer of this responsibility from 1 April 2023.

5. Commissioning additional NHS dental practices in Norfolk & Waveney.

As previously advised, NHS England – East of England, completed a procurement process aimed at providing access to 8am-8pm dental services across Norfolk and Suffolk, 365 days a year, including all Bank Holidays. These services were funded from various terminating contracts.

The following practices are now providing routine general dental services with unscheduled care slots throughout each operational day to all patient groups which includes the homeless, asylum seekers and those that do not have access to financial support.:

Lot 1, King's Lynn, Norfolk – Smile Care Norfolk Limited
Lot 2, King's Lynn, Norfolk – Smile Care Norfolk Limited
Lot 3, Norwich, Norfolk – Smile Care Norfolk Limited
Lot 6, Lowestoft, Suffolk – Following discussions with Apps Smiles Limited, the contract was subsequently awarded to the Dental Design Studio Limited.

Each of the practices has confirmed that following commencing provision of the service, they have been contacted by a large number of patients seeking assistance, both urgent and non-urgent, future appointments for the latter being scheduled for a number of months to come. Urgent slots are booked on a first come basis with patients being requested to call again where no further appointments are available that day.

Following, seeking further expressions of interest from the market, discussions are currently taking place with providers in respect of Lots 4 and 5 covering Fakenham (Norfolk) and Thetford (Norfolk), respectively. It is hoped that these services will be mobilised during the winter period.

6. Special Care Dental Services (Community Dental Services) in Norfolk and Waveney

CDS;CIC provide a Special Care Dental Service (Community Dental Service) to vulnerable people of all ages to ensure that there is access for all patients. It intends to treat patients of any age whose care cannot be met by other local general dental practitioners due to their special needs, whether that is medical, physical or behavioural. The service provision is back to delivering 100% of contract as outlined in item 3.

7. Prevention strategy to reduce tooth decay, with particular emphasis on fluoridation of drinking water

The statutory duty to deliver the prevention strategy sits with the Local Authority, therefore, we do not have an update regarding the fluoridation of drinking water.

8. Dental Transformational Strategy

NHS England – East of England developed a Transformational Dental Strategy. The aim of which is to support a model that delivers universal access to urgent dental care and patient-focused preventative care to improve oral health and quality of life and reduced health inequalities across the life course and in all communities including our more vulnerable populations. This is underpinned by building a resilient and effective dental workforce better suited to meeting our patient needs, in line with Health Education England's, programme of Advancing Dental Care which develops a wider skill mix of dental professionals.

Out of the 8 programmes to be launched, to date *Programme 1A: In-hours urgent dental care* is the only programme currently being delivered. The uptake for this programme has not been as good across the region as we would have liked by this stage in the Strategy's implementation.

Following discussion at a senior level, within NHS England – East of England, it was agreed that the best course of action at this time would be to focus on developing a hybrid model of Programme 1A (In-hours urgent dental care) and Programme 1B (Oral Health and Stabilisation), with an agreed number of practices, through a selection criteria process, within the region, to test this concept and ensure patients with an urgent care need are seen and treated in a timely manner, addressing health inequalities and providing a firm foundation for improvements in oral health.

Through an Expression of Interest exercise, it is proposed that an agreed number of practices, via a selection criteria process across the East of England Region will be chosen, using agreed criteria and overseen by clinical and commissioning leads, to take part in this initiative. Where possible, this will be in areas of greatest need based on social demographics, availability of NHS services and other

epidemiological data based on advice sought from the Consultant in Dental Public Health, alongside primary care settings with the appropriate workforce. The model will be evaluated to understand the impact that this model has had with patients, which the regional team will use to support Integrated Care Systems when the commissioning of dental services moves to them from April 2023.

9. Progress on the primary care pilots to improving oral health care for residents of care homes

The Pilot was completed in April 2022. An evaluation is currently being undertaken which will be shared with the ICB's, to support their future planning of work regarding dental commissioning for this cohort of patients.

10. Dental School development

There is no further update to provide at the present time with regards to the development of a dental school in this area.

11. Clinical workforce

Recruitment and retention of dentists onto the Performers List remains a limiting factor in large parts of East Anglia, including Norfolk and Waveney. NHS England – East of England alongside the Local Dental Network are working closely with Health Education England to improve the retention of Foundation Dentists in this region.

The Dental Therapist Trainee programme is in its third year. There are currently 4 students working in 2 Norfolk and Waveney practices**.**

12. Re-location of Out of Hours dental service

At present NHS England – East of England has not received a request to relocate the Out of Hours Service, currently provided from the premises from which the new 8-8 service in Norwich is provided and will consider the request upon receipt.

Norfolk and Suffolk NHS Foundation Trust

Suggested approach from Liz Chandler, Scrutiny and Research Officer

Re-examination of the NSFT's improvement plan following the Care Quality Commission's (CQC) inspection from November – December 2021 (report published April 2022).

1.0 Purpose of today's meeting

1.1 To re-examine NSFT's improvement plan following the latest CQC inspection. is attached at **appendix A.**

1.2 An accompanying report on the Norfolk and Waveney Mental Health Programme Overview submitted by Norfolk and Waveney Integrated Care Board (ICB) is also attached at **appendix B.**

1.3 Representatives from NSFT and the Integrated Care Board (ICB) will attend the meeting to answer NHOSC's questions about NSFT's action to improve the provision of services.

2.0 Background

2.1 NHOSC September meeting

2.1.1 Following the CQC inspection (November – December 2021), NSFT attended NHOSC's meeting on 8 September 2022 to update Members on its improvement plan. The committee received a report from NSFT entitled 'Working together for better mental health – approach to improvement for mental health services in Norfolk and Suffolk'. The full report can be viewed here.

2.1.2 At the September meeting, the Chair expressed her disappointment that the papers for the agenda item had arrived from NSFT after the legal publication date. Concern was further expressed by the Chair about the quality of the papers, which were deemed to lack the level of detail required to allow for meaningful scrutiny to take place. Full details of this meeting can be viewed here.

2.1.3 It was, therefore, agreed that NSFT would return to the committee in November 2022. In order to ensure that detailed answers to the committee's questions could be provided, it was also agreed that a precise list of questions

would be provided to NSFT prior to the November meeting. These questions were as follows:

- The CQC's S29A notice raised 14 thematic concerns. These were:
  1. staffing
  2. mandatory training
  3. supervisions
  4. appraisals
  5. ligatures
  6. risk assessments
  7. incidents
  8. observations
  9. care and treatment
  10. outcomes
  11. privacy and dignity
  12. medicines' management
  13. culture
  14. governance

  In relation to each of the thematic concerns and S29A 'must dos', request NSFT provide the following:

  - Outline the major issues relating to each theme.
  - Provide evidence of what progress has been made to address these concerns.
  - Identify what progress still needs to be made and provide a timeline for this progress.
  - Describe how NSFT intends to continue to mitigate these concerns moving forward.

- Request NSFT provide clarity on the number of legal requirements against which the CQC told NSFT it must take action. This is variously stated as 108 and 109.

- Request NSFT provide the following specific information regarding some of the thematic concerns/ 'must dos' cited above and additional questions raised during the NHOSC September meeting:

  - **Staffing**
    The CQC stated in its report to the September NHOSC meeting that it had increased its recruitment of staff 'with 750 new starters since January 2022'. Request NSFT provides information in relation to staffing/recruitment with reference to the areas:

    - Breakdown of these positions according to professional area (ie psychology / medical / nursing / support work)?
    - How many members of staff left in the same period?
    - What is the current vacancy rate?
    - What is NSFT's staff retention programme?

- To what extent is overtime and/or bank/agency staff used to meet safest minimum defined staffing levels?
- What are the current levels of sickness absence?
- Are staff surveys conducted and can this information be provided to NHOSC?
- Are exit interviews conducted and is that information gathered centrally?

- **System-wide working**

Who are NSFT's stakeholders and how are these partnerships working together to improve patient pathways?

- **Engagement**

Request NSFT provide an update on the Annual Member Engagement Event that was held in July and August.

- **Mortality data review**

Request an update on the start date of the independent mortality data review.

- **Evidence group**

Request an update on the establishment of an evidence group made up of service users, family members and carers to test that there is quantifiable evidence that things are changing.

- **Quality assurance**

How does NSFT intend to measure the progress of its improvement plan and ensure that this improvement is sustained in the future?

At the NHOSC meeting in September, NSFT offered to supply the following information:

- Information on waiting lists and demand for services.
- Information on housing and its impact on safe and effective discharge.
- Previous board papers addressing NSFT's KPIs.
- Information about the transformation plan into how people are supported in the mental health system.

2.1.4 It was also agreed that the Chair would write to the new Secretary of State for Health and express concerns that the committee faced today and that further scrutiny will take place in November 2022. A copy of the letter is attached at **appendix C.**

2.2 CQC inspection

2.2.1 The CQC carried out an inspection of NSFT from 2 November – 29 December 2021 and published its report on 28 April 2022. The full inspection report can be viewed here.

2.2.2 During this inspection, the CQC found that the Trust had deteriorated since the last full inspection in November – December 2019 and downgraded its overall rating from 'requires improvement' to inadequate.

2.2.3 The Trust was required to take action to bring services into line with 109 legal requirements relating to the seven core services inspected.

2.2.4 On 24 December 2021 the CQC issued a Section 29A Warning Notice relating to five registered locations: Trust Headquarters, Julian Hospital, St Clements Hospital, Northgate Hospital, Carlton Court. The Warning Notice set out a legally set timescale for the provider to become compliant.

2.2.5 The CQC returned to NSFT in September 2022 to review progress against the Section 29A notice and a 'well led' inspection is expected in November 2022. Reports from both inspections are likely to be published in late January 2023.

3.0 Other developments at NSFT

3.1 A £1.1 million revamp of Blickling Ward at the Julian Hospital in Norwich will begin on 14 November 2022. The ward provides specialist care for older mental health patients. Blickling ward will partially close during the renovation works, although seven beds will remain in use. To mitigate for the ward's partial closure during the works, additional bed space will be provided on Sandringham Ward and by Carlton Court care home in Lowestoft. For further details see: Julian Hospital ward in Norwich set for £1.1m revamp.

4.0 Suggested approach

4.1 The committee may wish to discuss the following areas with the NSFT representatives:

- For the purpose of clarity, what does a clinical pathway look like to a service user entering the service? How is NSFT working with system partners to develop these pathways?
- Members to explore what accountability looks like for NSFT moving forward and how they will be held to account over the improvement journey.
- To what extent are current pressures on social care contributing to delayed discharges?
- What are the main differences that staff and service users have experienced since NSFT's improvement plan was implemented?
- Are exit interviews mandatory and do the digital ones have prescribed questions/responses or are staff able to fully express their individual experiences?

5.0 Action

5.1 The committee may wish to consider whether to make comments or recommendations as a result of today's discussion.

IN TRAN communication for all	If you need this report in large print, audio, Braille, alternative format or in a different language please contact Customer Services on 0344 800 8020 or Text Relay on 18001 0344 800 8020 (textphone) and we will do our best to help.

Norfolk Health Scrutiny Committee

Norfolk and Suffolk NHS Foundation Trust (NSFT) – Update for November HOSC meeting

This paper provides an update to Norfolk Health Scrutiny Committee (NHOSC) as to theTrust's delivery of our Improvement Programme.

This paper focusses on answering the specific questions raised in September's NHOSC in relation to the thematic review and must dos. In addition, this paper includes an update on some of the other key challenges the Trust is currently facing including: culture, staff engagement and medical engagement, and the work undertaken to try and solve these challenges.

The Trust welcomes the opportunity to discuss the impact and ongoing work regarding the improvement programme and some of the other key challenges.

1. Areas of concern

The Care Quality Commission's (CQC) findings require improvement in 14 specific areas of concern across our inpatient and community services set out in the Section 29a notice received in December 2021.

The table below provides a summary position, setting out each overarching CQC concern, the areas of focus to address each of the CQC's concerns, the progress made to-date and future planned activities. Underneath the table we set out our timetable for this work, and the approach we are taking to mitigate the CQC's concerns moving forward.

Fuller detail is set out in the attached Improvement Programme report that was shared at our Trust Board in September.

Staffing	**CQC concern:** The Trust did not consistently maintain safe staffing levels or ensure there are enough suitably qualified staff to meet the needs of people using services. **Our focus:** • To strengthen oversight and scrutiny of staffing levels in line with patient need on a daily, weekly, monthly, and annual basis. • Trust-wide roll out of SafeCare digital tool, ensuring staffing levels match patient need and acuity. • Trust-wide recruitment activities targeted for areas of workforce challenge to deliver safe staffing levels sustainably. • Heightened focus to support leaders and staff on safety matters relating to staffing and safe care. • Heightened focus on retention and induction to retain and develop our staff. **Summary of progress made and evidence:** • Daily assurance that acute wards are working to safest staffing levels, with safest staffing met on all shifts through the roll out of SafeCare.

	• Significant progress recruiting to nursing and medical vacancies with a net staffing increase of 170 since November 2021, including recruitment to, or mitigation of, specific staffing concerns raised by the CQC. **Planned further activities:** • Following the completed roll-out of SafeCare we will review its functionality to continually improve staff utilisation levels. • The Trust will continue to ensure that it maximises the utilisation of medical staff and looking to commission specialist support for job planning. • Sustaining and building on activities that have demonstrated benefits in terms of promoting best practice and support job satisfaction and retention including, peer support and wider rollout of welcome packs, further away days and safety summits and iterative improvements to induction.
Mandatory training	**Summary of concerns:** The Trust did not ensure staff had the mandatory and specialist training (MAST) to undertake safe care and treatment of patients. **Our focus:** • Strengthened leadership, focus, oversight, and controls to increase MAST training levels across the Trust. • Benchmarking and adopting optimum practice approaches to MAST delivery. • Targeted support and increased capacity of Prevention of Management and Aggression (PMA) training as a key area of safepractice. • New Trust induction approach to ensure 80% coverage of MAST for new starters. • Increased support available to managers, to improve our leadership and management capability. • Increasing ease, benefit, and experience of MAST training. • Focused efforts on addressing specific areas highlighted by the CQC, while ensuring that all teams improve trajectories to compliance to target. **Summary of progress made:** • **Training compliance is at 88% in September 2022 (up from 83% in November 2021).** • **Revised induction programme includes completion of 80% of MAST training modules to support our longer-term position.** • PMA training rates have improved significantly through delivery of a targeted action plan with further work to achieve and sustain compliance rates. **Planned further activities:** • Targeted support will continue to be provided to challenged teams i.e., Northgate Ward who have not made improvements in areas such as PMA compliance and Great Yarmouth Acute who are 74% in their MAST compliance. • Improved induction programme delivered, and to be further expanded to include additional training modules (such as Personal Safety Training) to further boost compliance rates for new starters. • Suicide Presentation and Self-Harm Mitigation (STORM) training to be rolled out across the Trust to all clinical staff.
Supervision	**Summary of concerns:** The Trust did not ensure staff receive supervision to support the development of staff in their roles and to support safe and effective care. **Our focus:** • Enhanced scrutiny and targeted support to increase supervision rates across all services within the Trust. • Heightened visibility of timely, immediate data on supervision rates. • Heightened support to increase recording on supervision app as a tool to make recording and capture easier for staff.

	• Work to improve the quality and experience of supervision to ensure staff and patients benefit. **Summary of progress made:** • Programme of work delivered to increase Trust-wide compliance and improve data quality. • **Supervision rates have increased from 62% in November 2021, to 89% at the end of September 2022.** **Planned further activities:** • Introduction of automatic alert processes when teams are below target supervision levels. This will ensure that automated, visible, and timely data is available at team and Trust level. • A QI group has already been established focusing on improving the quality of supervision. This group has undertaken some early actions such as a review of online education resources. They will now develop and deliver a fuller improvement programme. • Shifting focus to support ongoing improvement in the quality and impact of supervision conversations.
Appraisals	**Summary of concerns:** The Trust did not ensure staff receive appraisals to support the development of staff in their roles and to support safe and effective care. **Our focus:** • Enhanced scrutiny and targeted support to increase appraisal rates across all services within the Trust. • Heightened visibility of timely, immediate data on appraisal rates. • Work to improve the quality and experience of supervision to ensure staff and patients benefit. **Summary of progress made:** • Programme of work delivered to increase Trust-wide compliance and improve data quality. • **Appraisal rates have increased from 79% in November 2021, to 87% at the end of September.** **Planned further activities:** • Introduction of automatic alert processes when teams are below target supervision levels. This will ensure that automated, visible, and timely data is available at team and Trust level. • Shifting focus to support ongoing improvement in the quality and impact of appraisal conversations.
Ligatures	**Summary of concerns:** The Trust did not ensure staff were aware of ligature assessments or that ligature points were mitigated or removed to maintain patient safety. **Our focus:** • Immediate mitigation or resolution of ligature points identified by the CQC in our Adult Rehabilitation Ward and Blickling Ward. • Staff training to develop and promote effective ligature management competence and understanding of processes. • Increased controls to heighten oversight of effective ligature management. • Procurement of digital app to digitise assessment and actions relating to ligatures. • Documented, accelerated forward plan for environmental work, prioritised by risk. **Summary of progress made:**

	• Remedial works have been completed or are on the accelerated forward plan for Estates work, with mitigations in place to keep patients safe. • **Ligature compliance processes strengthened, with 100% compliance for completion of ligature walk arounds in August 2022.** **Planned further activities:** • Where mitigations have been put in place, plans developed on our adult rehab ward (SRRS) and Blickling Ward to complete further works. • Controls to be further strengthened through roll-out of the ligature digital app to provide centralised information. • Continue to review and monitor the risk profile at sites changes, changes to guidance, and national safety alerts.
Risk assessment	**Summary of concerns:** The Trust did not ensure patients had up to date risk assessments and risk management plans to manage risks and ensure patient safety. **Our focus:** • Clarification of policies and processes, so that staff understand their responsibilities regarding risk assessment and care planning. • Comprehensive and absolute measures to evidence compliance, and areas requiring further support and challenge. • Specific support and actions to assess and address environmental risks. **Summary of progress made:** • Our Quality Safety Reviews show improvements in the regular review of assessments. • **Our inpatient Care Process Audit shows improved compliance with the regular revision of risk assessments from 87% in March 2022 to 95% in July 2022.** **Planned further activities:** • Further work required through business-as-usual governance to ensure improvements are sustained and embedded, and revisions to risk assessments are made in a timely fashion.
Incidents	**Summary of concerns:** The Trust did not ensure staff report, manage, and learn from incidents to protect patients and staff from harm. **Our focus:** • More timely review of open incidents to ensure incidents are swiftly acted on and learnt from. • Datix training to improve ease and accuracy of recording and capture of incidents. • Heightened controls to promote oversight and review and learning from incidents. • Quality audits to check effective learning from incidents. **Summary of progress made:** • All incidents identified by the CQC have been reviewed and acted on. • **Through a targeted programme of work, we have reduced our backlog of overdue incidents from 1,300 to 150.** • Strengthened escalation processes to ensure that this improvement can be sustained. **Planned further activities:**

	• Future project work with Power BI Team is planned to enable us to capture protected characteristics within the reporting of incidents to help identify trends and support future learning. • Through improved controls and audit, we will continue to monitor and sustain this improvement.
Observations	**Summary of concerns:** The Trust is not ensuring staff carry out patient observations in accordance with Trust policy and NICE guidance to protect people from harm. **Our focus:** • Evidenced improvement in audited observations in accordance with Trust policy and guidance. • Improved processes and protocols to support compliance. **Summary of progress made:** • Revised processes for conducting and recording observations in a timely way. • **Quality Management System (QMS) introduced in February 2022, including monthly ward level audit.** • Audit and CCTV evidence shows improved practice when delivering and recording observations. **Planned further activities:** • Introduction of monthly inter-rater reliability (validation) governance checks to support learning and provide additional assurance. • Testing and implementation of a re-designed audit tool to enable greater understanding of safe practice. • Development of a Patient Safety Pocket Guide with focus on therapeutic observations. • QI project on 2 wards testing a new hourly/general observation form to improve compliance.
Care & treatment	**Summary of concerns:** The trust did not ensure staff had access to patient records or maintain accurate records regarding patient care, physical health checks and nutrition. **Our focus:** • Consistent delivery policies and processes, including care planning, put in place to support service users. • Heightened review and assurance processes to support continuous improvement. • Programme to reduce waiting lists for community services and ensure appropriate risk stratification and support for those on waiting lists. • Responsive to patient need as well as to improve patient experience understanding of their care. • Promotion of physical health alongside mental health. • Focused efforts to safely manage seclusions, ensure that when they do happen, they are delivered and recorded consistently and improve learning. **Summary of progress made:** • **Sustained improvement with the inpatient Care Process Audit showing improved compliance with agreed processes regarding assessment and care planning, from 81% in March 2022 to 90% in July 2022.** • Quality Safety Reviews show that patients report feeling more involved in their care planning. • Waiting times for Adult Community services have reduced, with revision to and strengthened application of our Clinical Harm Policy to support those who are waiting.

	Planned further activities: • Moorhouse Waiting List review recommendations to be implemented. • New care plan template to be uploaded to Lorenzo and launched, to support consistent but comprehensive care planning across teams. • Ongoing review of care plan compliance data, physical health dashboards, and waiting list reports to ensure that initial improvements in practice are sustained. • **Additional updates have been made to the Clinical Harm Review Policy, which will go to the Quality Committee for review and ratification October 2022.**
Outcomes	**Summary of concerns:** The Trust did not ensure patient outcomes were measured to demonstrate progress being made. **Our focus:** • Embedding Dialog+ as the Trust Wide outcomes rating scale. • Robust monitoring and assurance to ensure that outcomes are being recorded and reviewed to demonstrate progress being made. • Joint ownership of outcomes with service users. • Enabling better access to improve outcomes and tackle health inequalities. **Summary of progress made:** • **Further progress made to embed use of the Dialog+ outcomes measurement tool with 2,500 staff trained.** • Evidenced increase in staff use of Dialog+. **Planned further activities:** • The Dialog+ team will be in-reaching into teams to offer additional support, advice and guidance where it is identified that Dialog+ is not fully embedded. • Away days on care planning and Dialog+ scale implementation are scheduled at Great Yarmouth & Waveney to further support take-up. • The training team have developed a new package of training, roll out of this started from September 2022 with an e-learning module and a one-day classroom module. • The Dialog+ team will initiate next round of evaluation for both staff and service users in October 2022, so that we can further improve the way in which we use outcomes measures. • Rolling out the new PowerBI report in October 2022. • We also need to improve service user engagement and ownership of their scores and are developing the specification and timeline for an ICT project to enable service users to access their scores and understand their progress. • We will continue our 3-year collaborative on tackling inequalities and improving outcomes for disadvantaged groups.
Privacy & dignity	**Summary of concerns:** The Trust did not ensure patients were introduced to the ward area, privacy was respected in both the environment and by knocking on doors or through patient involvement in their care. **Our focus:** • Immediate resolution of CQC identified environmental concerns, or appropriate mitigations. • Heightened oversight and scrutiny of compliance with mixed sex accommodation, privacy, and dignity standards. • New service user welcome pack implemented for patients on admission to wards to improve Service User experience of being introduced to wards. • Additional privacy and dignity considerations improved. • Additional environmental improvements to enhance privacy and dignity.

	Summary of progress made: • **Immediate concerns identified by the CQC regarding privacy/being overlooked resolved, with privacy film installed in relevant areas within Blickling and Poppy Ward.** • CQC concerns regarding mixed sex accommodation on Sandringham Ward addressed. • Further works completed to improve privacy and dignity in our 136 Suites and Adult Rehabilitation Ward (SRRS). **Planned further activities:** • New anti-barricade doors with observation panels ordered, and to be installed, with work due to commence on SRRS November 2022. • Ongoing review through QSR process to identify and resolve any further issues.
Medicines management	**Summary of concerns:** The trust did not ensure effective medicine management was taking place effectively to maintain patient safety. **Our focus:** • Updating policies and protocols to prioritise patient safety and ensure that NICE guidance, and best practice, is followed across the Trust. • Development of strategy, plan, and clarity of expectations. • Heightened oversight and controls to scrutinise compliance levels. • Development of our electronic systems to support compliance. • Capacity building across pharmacy team, and the clinical teams we support. **Summary of progress made:** • **Immediate concerns identified by the CQC have been addressed.** • Additional staff have been recruited into the pharmacy team with strengthened support through supervision and training. • The Medicines Management strategy and plan has been developed to address the findings of the external review commissioned by the Trust and deliver sustained improvement. **Planned further activities:** • Exploring the opportunity to increase pharmacy team capacity and allow pharmacists to focus their efforts on supporting teams. • Implementation of PowerBI to improve medicines optimisation ensuring the medicines management team access to real-time medicines data, expected to be implemented end Q4 2022.
Culture	**Summary of concerns:** The trust did not ensure that cultures were supportive of staff to work in to provide care. **Our focus:** • Improved mechanisms to actively engage with staff and service users, through a wider variety of channels. • Improved processes to encourage openness and learn from concerns and complaints. • Initiatives put in place to foster a supportive culture. • Initiatives to improve equality, diversity, and inclusion. **Summary of progress made:** • **Immediate actions undertaken to improve communication and support staff wellbeing with targeted engagement sessions held with specific teams where concerns were identified.** • Important long-term focus as a Strategic Improvement Theme, with the launch of a new Culture Programme in September 2022.

	• Recruited 60 culture change agents and 100 wellbeing champions to support staff wellbeing across the organisation. **Planned further activities:** • Delivery of a long-term Culture Transformation programme centered aroundactively standing up to discriminatory and marginalising behaviour and developing a culture of acceptance, respect, and safety. • Focus on communication and engagement, developing a series of mechanisms to better engage, listen and respond to staff including via listening sessions, the change agent role, commissioning of Clever Together and Hear to Listen events.
Governance	**Summary of concerns:** The trust did not provide support to teams to maintain good governance in providing high quality care. **Our focus:** • Revised oversight processes at all levels to provide supportive review and challenge to services. • Robust audit and risk management processes. • Access to meaningful information for decision making and improvement. • Development of management and leadership competencies for leaders across the organisation. • Leadership Visibility. **Summary of progress made:** • **Immediate strengthening of governance processes, with QPMs reestablished, a new Board Assurance Framework and monthly audit schedule in place.** • Moorhouse review of local governance completed, with recommendations now to be implemented. • Governance is an important long-term focus as a Strategic Improvement Theme covering Board, Local and Quality governance. **Planned further activities:** • Strengthening Business Intelligence function. • Work to improve data availability and data quality to ensure robust assurance.

Timeline to deliver areas that require further progress:
Phase 1 of our Improvement Programme ran until October 2022. In Phase 1 the Trust focused on making immediate quality and safety related improvements to address the CQC's areas of concern across all services including specific concerns related to inpatient and community service lines. During this time, we also put in place the programme infrastructure to sustain these improvements, while establishing five Strategic Improvement Themes to deliver longer-term improvement.

Phase 2 will run until October 2023. We are currently planning our priorities for Phase 2 by reviewing progress made in Phase 1, as well as learning and reflections from various internal and external stakeholders. At the same time, we have continued to engage with the CQC – with the CQC revisiting the Trust in September to review progress against the Section 29a Notice, followed by a Well Led inspection in November. We expect the CQC's full report of these visits to be published in late January, and we will ensure that our programme of work reflects and responds to the CQC's findings.

Mitigations to address the identified concerns:
The Trust recognises that it has been in a similar position before and has not previously been able to sustain improvement. To address this, our programme of work is based on the principles of the NHS England Sustainability Model to deliver long-lasting positive change.

This includes establishing robust programme management arrangements supported by dedicated improvement governance through the Improvement Board, and evidence assurance process. We have also strengthened our business-as-usual governance through the re-establishment of our Quality Performance Meetings (QPMs), to make sure that improvement is considered part of our daily work at central and local levels.

We have developed Strategic Improvement Themes to address the root cause issues that have been perennial challenges, going beyond the concerns identified by the CQC to address the systemic and cultural challenges that we face.

We have leveraged the learning and experience of others, working closely with NHS England, with an Improvement Director assigned to the Trust and input from the NHS England Making Data Count team. We have also sought to learn from system partners, basing our evidence assurance process on the model developed successfully by Queen Elizabeth's Hospital King's Lynn NHS Foundation Trust.

As we plan for Phase 2 of the Improvement Programme, we are learning from our experience in Phase 1 to identify the themes that we now need to focus on. We recognise that some of the CQC's areas of concern will take longer to fully address, due to the complexity or scale of the challenge, or requirement for a joined-up response with partners. These areas include culture, waiting lists and access – which will all remain priorities in Phase 2.

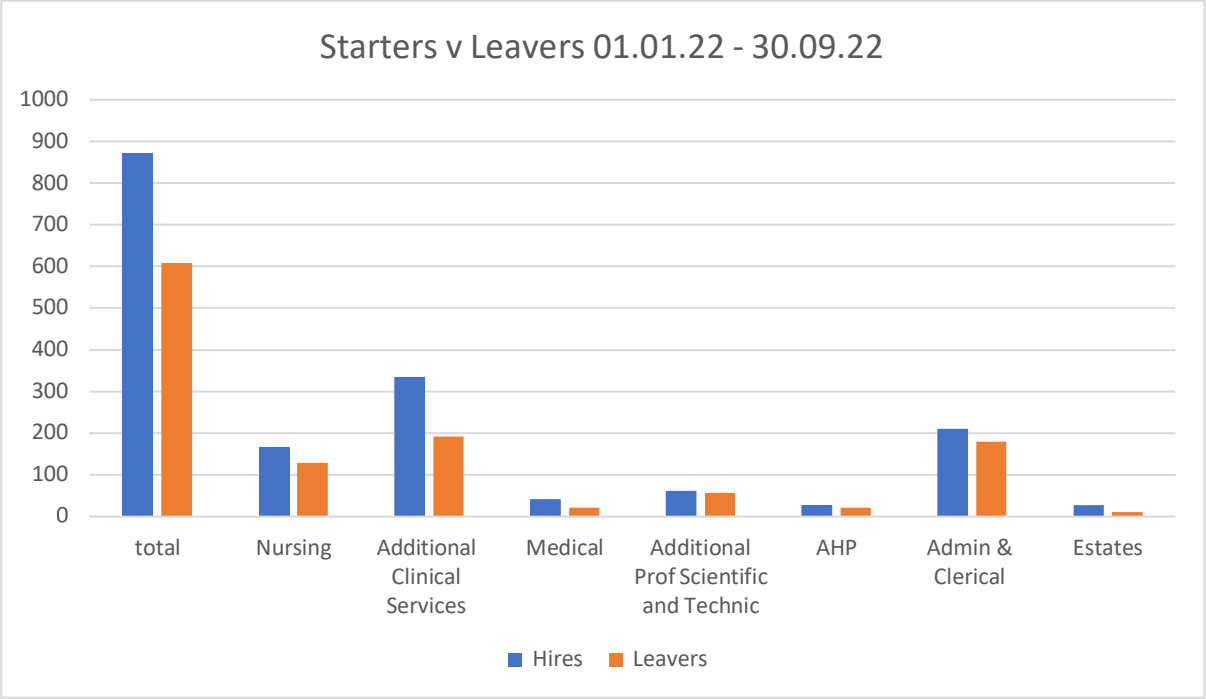
2. NHOSC September meeting: information requests

During the NHOSC September meeting there were requests from NSFT to provide the following specific information in relation to the thematic concerns cited above. NSFT have worked within the Trust and with the ICB to provide further information on each of these requests as set out below.

A) Staffing

Recruitment
The chart below sets out the number of new starters and leavers from 1 January 2022 to 30 September 2022 by professional area.

While recruitment activity has been strong, with a significant number of new starters are joining the Trust, we still have a high number of people leaving the Trust. While the net impact during this time is 262 additional staff, the scale of recruitment including the use of resources and the potential need for temporary staffing during that time is an area of concern. The clear area of focus for us is to improve staff retention, which we can do by first focusing on the reasons why people are leaving.



NSFT's Retention Programmme
To improve our retention of staff, we have developed a Trust Retention Plan with the ambition to improve our retention within 2 years of starting within the Trust from 43% to 30%. While 30% is our current target, we have asked NHS England for benchmarking information to understand the national picture and refine our target accordingly.

The key elements of our Retention Plan include:

- Transforming the induction process to best set up new starters to make a successful start working for the Trust.
- Staff have regular 1-2-1 access to a senior leader for support, feedback,and learning.
- Staff have an opportunity to discuss their career aspirations and development with dedicated career coaches who can support and advise.
- Any staff considering their resignation have an opportunity to discuss their thoughts via "stay conversations" with another staff member and they are offered support and guidance to help inform their decision.
- Flexible working offer to offer greater opportunity for staff to stay within the Trust.
- When staff do leave, we will have a greater understanding of the reasons why people leave.
- Clinical development and nursing programmes are available for those new in role.

The following sets out the detailed actions being undertaken:

- **Updated induction** - Since July the Trust runs a new corporate induction programme in which every person that starts in the Trust attends a face-to-face day which is protected time away from the workplace. New starters have a thorough induction process followed by regular check ins and access to network groups to nurture and increase their sense of belonging within the Trust. During the first induction day, the staff can get their IT equipment, log in details, ID badges etc. For clinical staff, a comprehensive training package is also provided so that all clinical staff start in the clinical workplace with their training completed.
- **Structured check ins** for new starters during the first 12 months of employment.
- **Full review of exit interview policy** and process has been undertaken. The new process was launched on 1st October. Whilst 1:1 exit interviews can still take place; we have an additional method where a person can undertake the exit feedback process without having to discuss with anyone. This new electronic exit interview process which allows us to capture and theme reasons for leaving. The roll out includes coaching and training for line managers. Importantly, previously the data wasn't available centrally to allow themes, trends to be identified and acted on. This will now be addressed in a much more meaningful way than before.
- **Review and update of flexible working policy** and practice completed.
- Introduction of **trained career coaching** within the Trust which can be available via virtual workshops.
- Improved **staff wellbeing offer** including TRIM, staff support service, wellbeing support, staff benefits packages reviewed and updated. A staff wellbeing coordinator has been appointed and is now in post.
- **Financial hardship support package introduced** and continues to be developed.
- **Clinical development and nursing programmes** are being developed and enhanced to enable career pathways such as nursing apprenticeships, advanced clinical practitioner, nurse consultants amongst others.
- **Staff feedback mechanisms** have been reviewed, including the commissioning of an external independent guardian service (in place of our current Freedom to Speak Up Guardian); the use of Clever Together to support engagement via an online platform; weekly Hear to Listen events with members of the Executive Team.
- Non-financial **staff recognition programme** in development.
- **Supervision and appraisal schemes reviewed** with training required for both appraisals and supervision.

Sickness absence rates
The Trust's sickness rates are set out below.

Annualised sickness absence	6.10%
In month total sickness rate	5.74%

Of which is short term	2.44%
Of which is long term	3.33%

Vacancy rate
Our vacancy rates for August 2022 are set out below.

Overall	**10.01%**
Medical	7.68%
Nursing	18.95%
Support to Clinical Roles	5.56%
AHP	5.96%

Extent that overtime and/or bank/agency staff used to meet safest minimum defined starring levels?
The following sets out the total daily staffing demand from our inpatient teams on bank/agency and overtime to meet the need for Registered Nurses (RNs) and Clinical Support Workers (CSWs). These rates are comparatively low, which is a positive sign.

These figures include our Safer Staffing numbers as well as additional daily demand which incorporates reasons such as high patient acuity, special/enhanced observations & escorts. Additional demand can be requested with limited lead times and by this nature will be worked by our temporary workforce. Part of our temporary workforce will be our own staff working additional hours via NHS Professionals.

	Bank Agency %		**Overtime %**	
	RN	**CSW**	**RN**	**CSW**
Jul-22	32.38%	51.44%	1.70%	1.10%
Aug-22	31.11%	51.94%	1.70%	0.95%
Sep-22	31.99%	52.40%	1.66%	0.68%

Are staff surveys conducted and can this information be provided to NHOSC?
Staff surveys are conducted and are in the public domain, the link for the 2021 NHS Staff Survey for the Trust can be found below:

https://cms.nhsstaffsurveys.com/app/reports/2021/RMY-benchmark-2021.pdf

B) Engagement

Annual member feedback
Each year the Trust's governors host a formal series of members engagement events to listen to a wide range of feedback from members, staff members, and the public. This year we held two events in public as well as two online events, at varying times of day and over the weekend so as to reach out to as many people as possible.

The feedback was synthesised into key theme areas, linked to the Trust improvement areas, and governors are now to agree their priority focus areas for the coming year. These priority areas will be used to set agendas for Council of Governance (CoG) meetings, andcraft challenging questions of senior managers,

and the Trust Board.

In turn, the feedback collected by governors will be used to inform the Trust strategic objectives and annual plan, to ensure that the Trust both works to address member feedback and is held to account in addressing it.

Medical Engagement
In early August our Trust Chair received a letter from the Medical Staffing Committee setting out a number of concerns regarding medical staffing and engagement. We share and fully acknowledge the concerns raised by our medical colleagues. We value their views and are committed to working closely with them as we continue to make improvements on behalf of our service users and their families. One of our new Chief Medical Officer's top priorities is to engage fully with our medical staff to make sure they are given every opportunity to make a valuable contribution to these improvements.

What has been done to address medical engagement concerns?
An initial meeting took place between our Chair, a Non-Executive Director and a small group of representatives from the Medical Staff Committee on 23 August where a number of initial actions were agreed. A further meeting took place on 27 September, which will be followed by an all medical staff meeting to share an update on discussions, progress and provide a forum for further feedback and reflection. The Trust are committed to positively engaging with our medical colleagues to ensure improvements are made and felt by staff and service users and therefore there will be continued work within this area, to further engage with our medical staff.

Culture
There is a recognised direct association between staff experience and service user outcomes. The more engaged and supported staff feel, the better service user outcomes are. Metrics including those reflecting bullying, harassment and discrimination within the Trust clearly show the need for a culture transformation programme that requires Board level ownership and commitment to lead the scale and ambition required. Ongoing and historical issues are contributing to an unhealthy culture in the Trust. These include:

- Pockets of discriminatory and marginalising behaviour across the organisation
    - In 2020 **20% of BME compared to 8% of white staff** reported personally **experiencing discrimination** from a manager, team leader or colleagues in the previous 12 months
- Track record of sustained poor staff satisfaction
    - In 2021 **39% of Trust staff** report **teams work well together** to achieve their objectives compared to a **national average of 53%**
- Bullying and harassment takes place across the organisation
    - In 2021 **32% of Trust staff** reported personally experiencing **harassment, bullying or abuse** at work from patients, service users and relatives compared to a **national average of 27%**
- Staff have low confidence in the Trust leadership addressing their concerns.

- In 2021 **51% of Trust staff** reported they **felt confident the Trust would address their concerns** compared to a **national average of 64%**

Our Improvement Programme Strategic Improvement Theme of 'Making Your Voice Count (Culture)' will deliver our planned cultural transformation, further detail is set out below in Section D.

What has been done to address the culture concerns?
The Care Quality Commission reported in April that they observed 'green shoots' of improvement because of work over the last eighteen months to develop our culture. At our Trust Board in public in September we articulated our strengthened resolve to tackle our cultural challenges and deliver an ambitious programme of cultural change as one of our Strategic Improvement Themes in our Improvement Programme.

To ensure we successfully respond to the culture issues we have diagnosed in our organisation, we will work with stakeholders and national experts to find sustainable solutions. We will develop a long-term culture strategy with equality, diversity, and inclusion (EDI) at the heart of it. In embarking on this journey, our immediate priorities are to:

1. Deliver a 'Big Conversation' with our staff that will be facilitated by Clever Together, an independent and specialist large scale engagement provider. They have a successful track record and have helped NHS England and over 50 NHS Trusts to improve culture by helping them to put people's voices at the forefront of change and helping leaders to listen and act on what they hear. This launched Monday 26th September.
2. Commission an external and independent Freedom to Speak Up (FTSU) service, to complement and work together with our FTSU Guardian,to improve and enhance access to a service that supports staff to speak up whilst feeling safe and confident. The start date will be confirmed, however it will be this, Autumn.
3. Prioritise culture improvement interventions with increased investment in addressing discriminatory and marginalising behaviour in the Trust and improving cultural competence.

The Culture and Remuneration Committee has been appointed by the Board to address these concerns and ensure immediate and long-term actions are delivered. The Committee is made of the following members:

- Four Non-Executive Directors, one of whom will be the Committee Chair
- Trust Chair
- Chief Executive
- Other Non-Executive Directors shall be invited to the Part 2 meeting

The Committee will meet on a bi-monthly basis with an annual meeting to review strategic issues and commercial changes, review leadership and structure across the Trust and review Trust adherence to national terms and conditions.

C) Evidence Assurance Group

We have established an Evidence Assurance Group (EAG) as a sub-group of our Improvement Board to review evidence of delivery of the Trust's Improvement Programme.

The role of EAG is to:

- Receive evidence from the relevant team in support of the CQC Must Dos and Section 29a Notice.
- Promote open, supportive conversations on quality of evidence and what it is telling us and how we can improve further.
- Provide an independent view of the strength of evidence back to the teams and to the Improvement Board. This will include any gaps, risks issues and concerns.

Our meetings are chaired by Norfolk and Waveney ICB Medical Director Dr Frankie Swords, who has previously set up evidence assurance meetings at the Queen Elizabeth Hospital, Kings Lynn. Core membership includes senior NSFT Clinical, Care Group and Quality Leaders, the Trust's People Participation Lead, and Experts by Experience. We also welcome colleagues from Norfolk and Suffolk ICBs, Norfolk and Suffolk Healthwatch organisations and NHS England.

During the first meeting, we reviewed evidence submitted by the Dragonfly Tier 4 Children and Adolescent Service, which demonstrated considerable improvements had been made since the initial CQC visit in late 2021. We looked at evidence against several Must Do actions, with some of these signed off by the panel. Further Must Dos will be brought back next month for sign off, with further evidence supplied to show that these actions have been delivered and sustained.

D) Quality Assurance

With support from our NHS England Improvement Director, the Trust has developed an Improvement Programme based on NHS England's Sustainability Model, and Tool for Improvement. This methodology, shared with Norfolk HOSC in September, is designed to create the environment for wholescale, organisation-wide change including quality assurance and evidence assurance processes to check and challenge the improvement being delivered.

Our Quality Assurance model operates on several levels, to provide multiple opportunities for check and challenge. Our refreshed Quality and Performance meetings at Care Group level are the primary forum for assurance as part of our business as usual. These meetings are informed by thorough and holistic reports covering quality, safety, performance and workforce themes. QPM meeting agendas focus on the information presented in these reports to make sure that discussions are focused, and data informed. From here, our Service Delivery Board is the organisation-wide operational forum for review and assurance across Care Groups.

Quality and Safety Reviews (QSRs) provide a further level of review. These reviews are undertaken by a dedicated multidisciplinary corporate team to compare what is being reported with compliance on the ground. Feedback is given to the team under review and also reported to the Quality Committee chaired by the Chief Nurse and Chief Medical Officer.

As set out above, the Evidence Assurance Group, established as a sub-group of the Improvement Board is a key assurance mechanism – with multistakeholder independent review and challenge of our improvement efforts.

3. Information NSFT offered to supply in the NHOSC meeting in September

In the September NHOSC meeting, NSFT offered to supply information in relation to the following:

A) Information on waiting lists and demand for services

Referral numbers
As the charts below show, over the past year there has been a minor non-significant reduction in referral numbers for under and over 18's across Norfolk and Waveney.

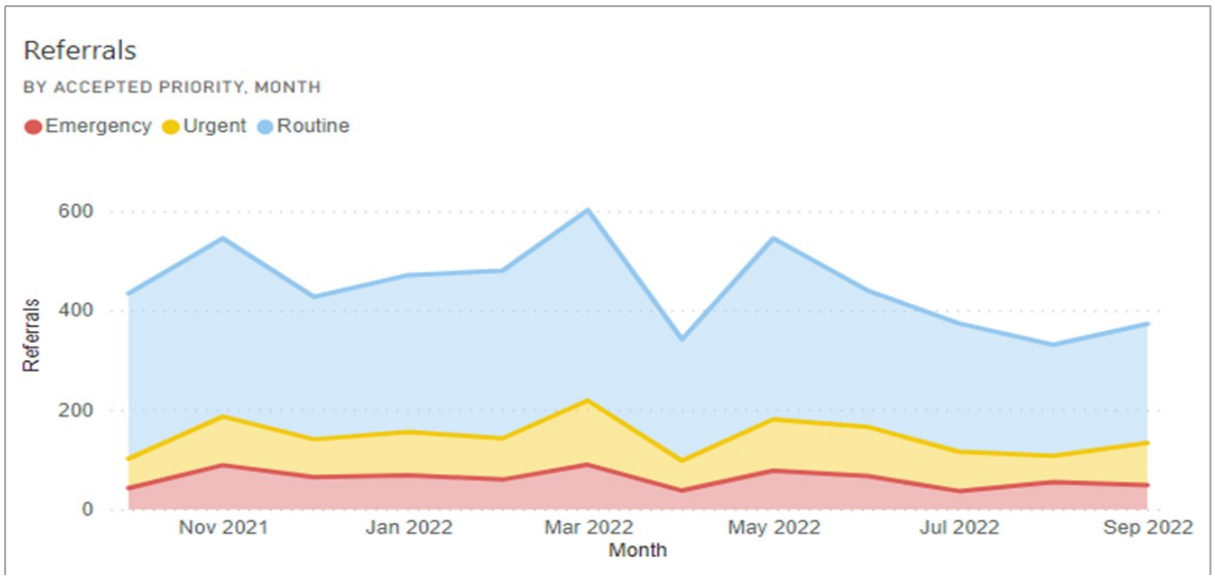


Chart 1a - The number of new external referrals received by community teams between 1st October 2021 and 30th September 2022, for service users aged under 18 at referral

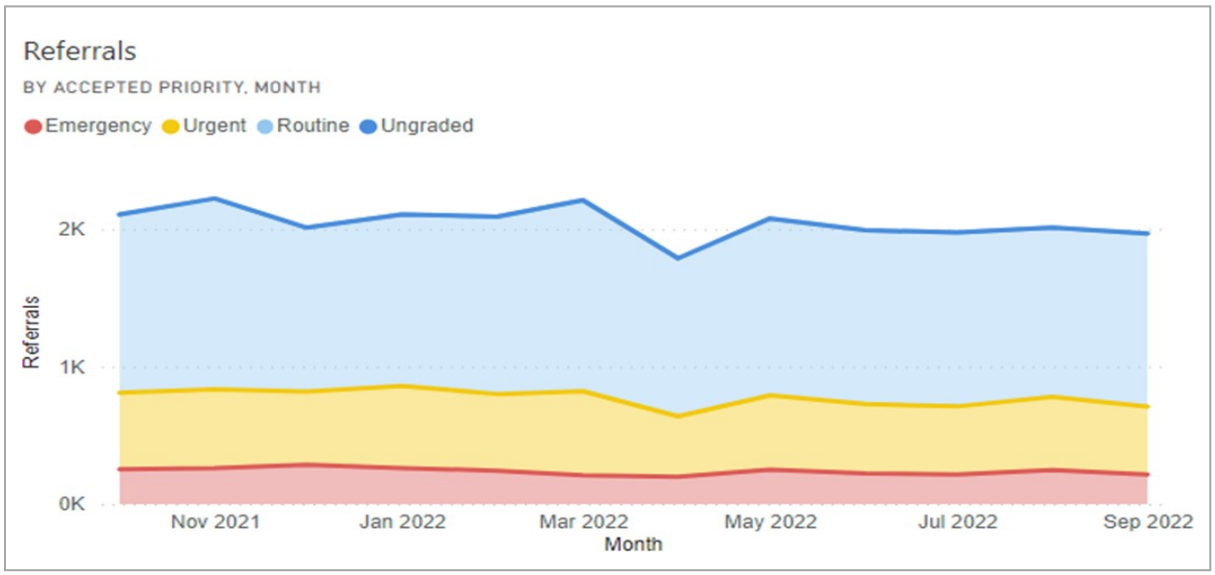


Chart 1b - The number of new external referrals received by community teams between 1st October 2021 and 30th September 2022, for service users aged 18 and over at referral

Referral rates to NSFT remain high in comparison to other Trusts.

Total referrals received by Children's Young Person's Mental Health Service (CYPMHS) community teams were also higher than average at 455 compared with a national average of 379 per 100,000 resident population. In addition, in June 2022 referral acceptance rates across CYPMHS community teams were higher than average at 98% compared with a national average of 77%.

In June 2022 NSFT adult and older adult community mental health services received 565 referrals compared to a national average of 376 per 100,000 resident population. Referral acceptance rates were also above average at 95% compared to an average of 86% per 100,000 resident population.

Waits for assessment

Waits for assessment have progressively increased for under 18's, including the number of waits above 40 weeks and 52 weeks waits those services. This is set out in the graph below.

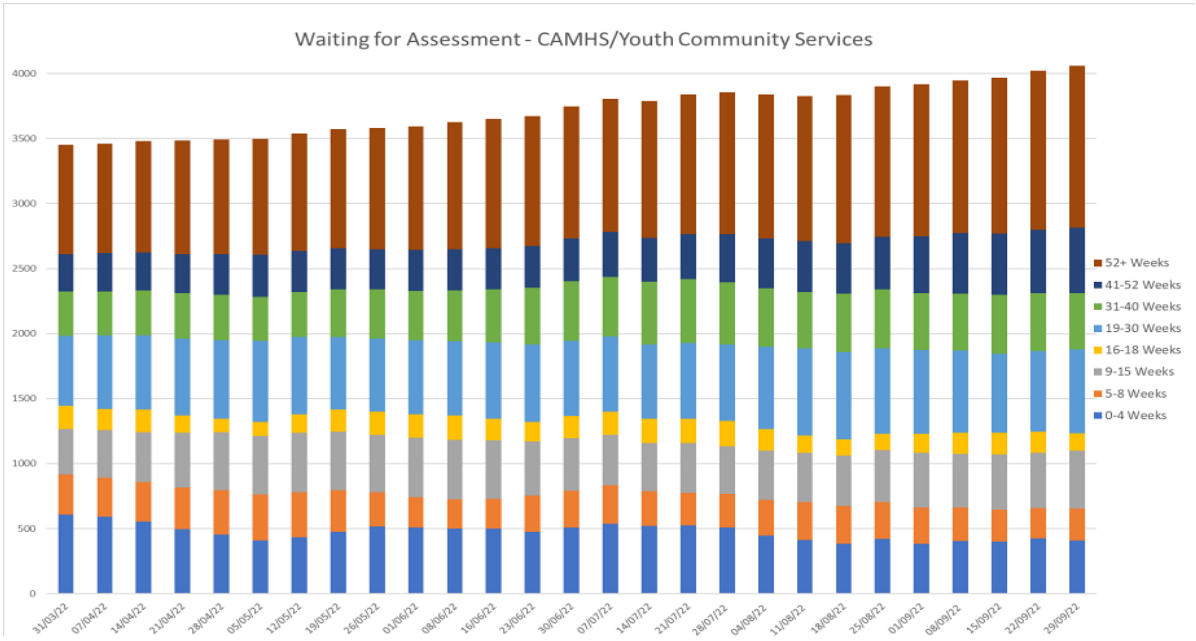


Chart 2a - The number of service users that were awaiting assessment with CAMHS/Youth Services at weekly points between 31st March and 29th September 2022

This increase in waiting times for assessment is due to a number of factors, with services continuing to report an increased number of children and young people presenting in the urgent care pathways and a higher proportion of young people with autism and learning disabilities. Therefore, there has been an increase in the number of complex cases with higher levels of risk, requiring liaison work with social care, schools and partner agencies and taking longer to assess.

The above has impacted capacity and waiting times within services, although improvement work is underway to address these challenges through the Children and Young People's Transformation Programme. We are working with partners to implementing multi-agency approaches to improving access and care delivery. Recruitment remains a barrier to mobilising new investment and improvements, with our recruitment and induction programmes developed as part of our improvement work to address this.

In adults services, waiting times for assessment have remained broadly stable as set out in the chart below. We are working to bring these waits down and are working with the ICB on an Adult Community Transformation Programme.

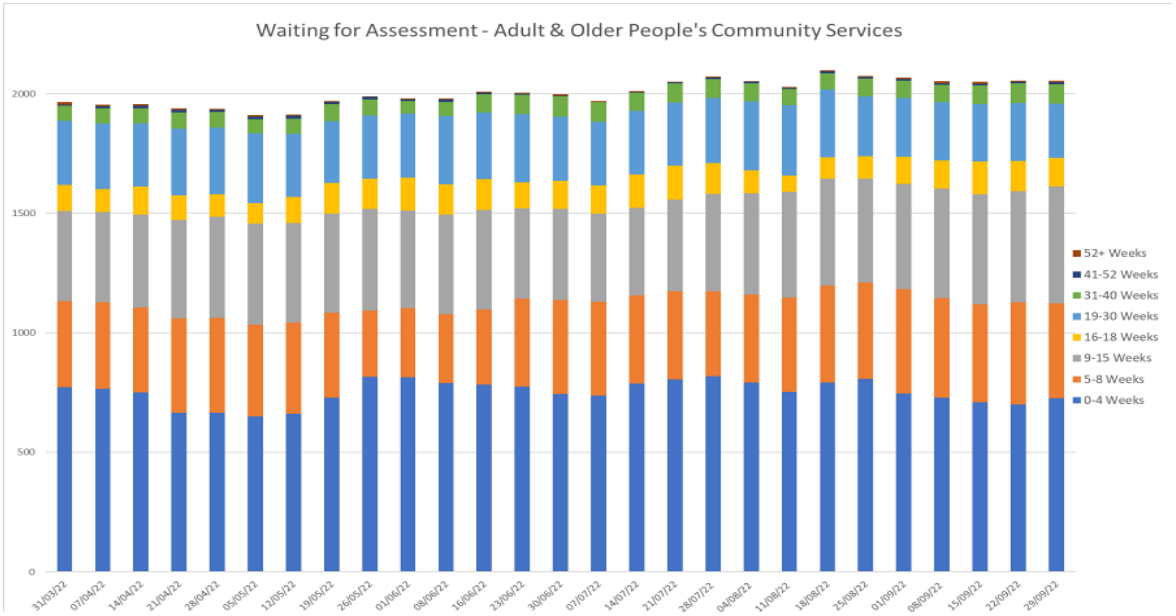


Chart 2b - The number of service users that were awaiting assessment with Adult & Older People's Community Services at weekly points between 31st March and 29th September 2022

Waits for treatment

Waiting times for treatment remain relatively stable for those under 18 despite the Trust supporting an increased number of complex presentations. Work is underway to improve this position by ensuring that treatment pathways are better defined with the aim of reducing waits.

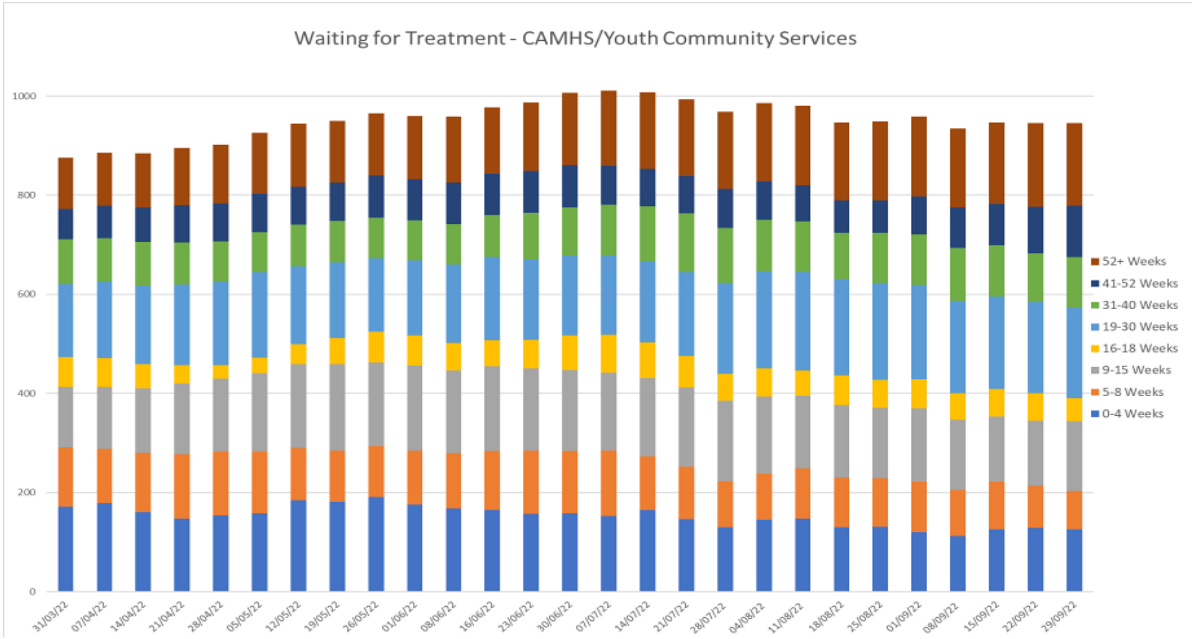


Chart 3a - The number of service users that were awaiting treatment (where assessment already complete) with CAMHS/Youth Services at weekly points between 31st March and 29th September 2022

For Over 18's services, waiting times for treatment are increasing slightly.

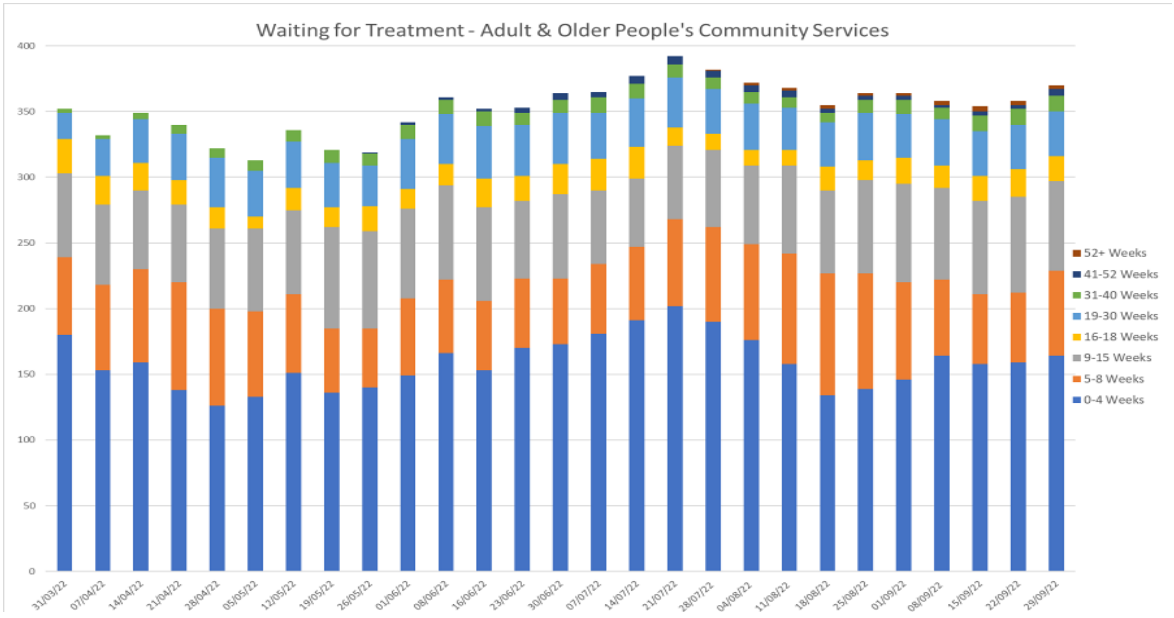


Chart 3b - The number of service users that were awaiting treatment (where assessment already complete) with Adult & Older People's Community Services at weekly points between 31st March and 29th September 2022

For Under and Over 18's the Trust continues to be challenged in meeting 28-day routine referral-to-assessment targets. Over-18s are closer to the target, at 75%, whereas under-18s are critically below the target at 50%. In West and South Norfolk (over 18's), performance is at 60%, due to significant shortages of Senior Band 6 staff who complete assessments. Recruitment is a priority to these teams, to build the capacity to address these targets. At the same time, we are working with system partners to develop clinical pathways across the Norfolk and Waveney system to better support those who require mental health support.

Safety planning for those awaiting assessment or treatment

NSFT's Clinical Harm Review policy sets arrangements for supporting people who are waiting for an assessment or treatment. This was reviewed in January 2022 taking account of feedback from staff and patients.

At the point of receipt of the referral, triage takes place which determines the most suitable response based upon the information contained within the referral. In most cases this involves arranging an assessment but for some, it may be more suitable for the person to be signposted to a more appropriate service. For those requiring an urgent assessment arrangements are made for these to be undertaken. In all cases, a letter detailing next steps is sent to the person concerned and the referrer. The letter includes information on when the person is likely to be seen for assessment and details of who to contact if circumstances change.

The Assessment involves completing a combined assessment which includes a risk assessment and a safety plan. People with the most complex needs and those requiring intensive support are allocated to a practitioner as a priority. If this is not possible for them to allocated immediately, they will be contacted a minimum of weekly unless otherwise agreed with the patient. The contact may include a one-off review eg. medication or short-term interventions along with a review of how the person is progressing and a review of their safety plan.

For people with less complex needs requiring less intensive intervention, the level of support will be determined in the safety plan whilst they await allocation.

Waiting lists are monitored very closely with each service having a Service User Tracker List alongside the service/team wait list. The Trust's Quality and Performance reports include people with an assessment and care plan which is monitored by the Clinical Team Managers/Leads.

In addition to the Trust's internal improvement work, Moorhouse – an external consultancy firm, have been engaged to advise and assist in addressing waiting lists. This work is overseen by the Chief Operating Officer

Eating Disorders

Our partnership with the ICS CYP team for service users under 19 has been a significant contributing factor in reducing referrals, caseload and wait for treatment as shown in the charts below. This work has been supported by the opening of Lighthouse Centre Eating Disorders Day Service. Leadership across the ED team in Norfolk and Waveney is strong and it is anticipated the improvements will continue.

	10 2021	11 2021	12 2021	01 2022	02 2022	03 2022	04 2022	05 2022	06 2022	07 2022	08 2022	09 2022
Active Referrals	221	206	207	209	205	195	188	184	170	158	158	146
New Referrals	39	28	32	29	23	30	28	36	29	16	30	21

Chart 4a - The number of referrals received and active referrals per month, between 1st October 2021 and 30th September 2022, for service users aged under 19 at referral

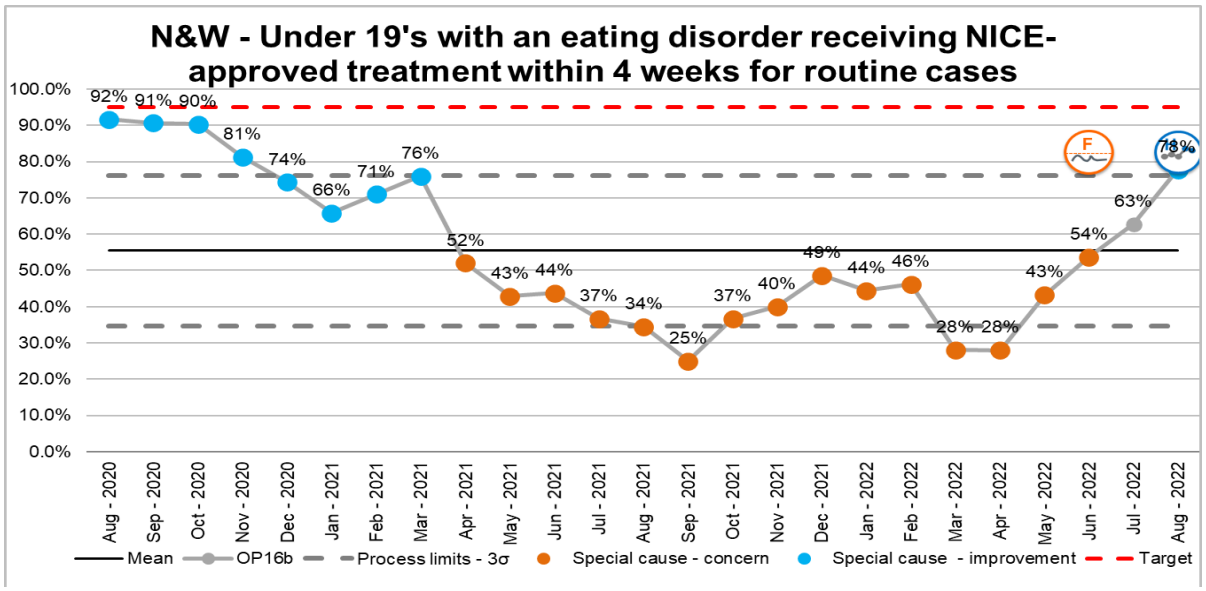


Chart 4b - Under 19's with an eating disorder receiving NICE-approved treatment within 4 weeks for routine cases

B) Delays to safe and effective discharge

In the last two years, whilst there has been an apparent decrease in overall demand for adult inpatient beds there has been an increase in the complexity of individuals admitted. In that same period, we have also seen a significant decrease in discharges (albeit more static in the past few months), indicating that some patients are not being discharged in a timely way to more appropriate settings following their inpatient stay.

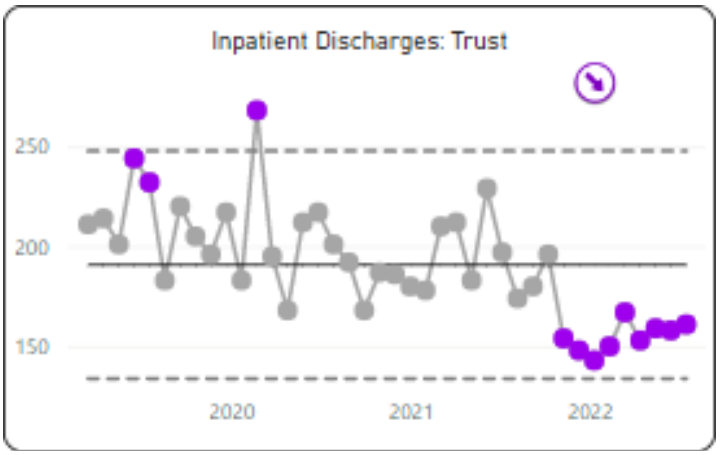


Chart 5a – Inpatient discharges

In the last two years, our DTOC position has remained under the 8% target as shown in the chart below. However, we recognise that DTOC is a narrow measure, which does not include all patients ready for discharge and this metric does not reflect the level of occupancy of patients who no longer require inpatient care. Delayed discharges create a mismatch between inpatient capacity and local need for bedded care.

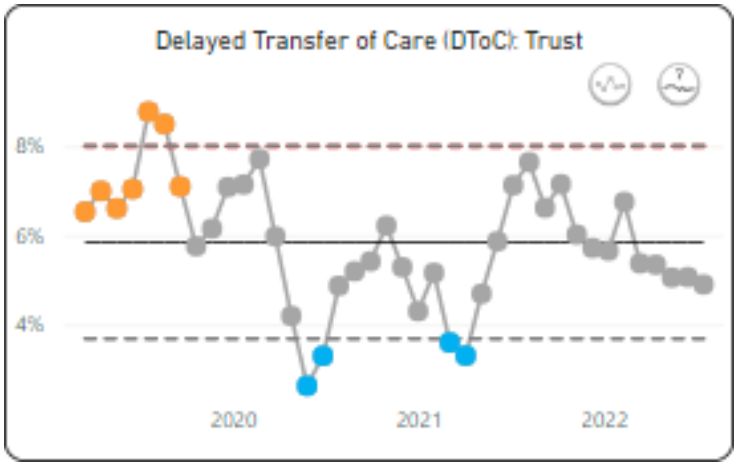


Chart 5b – Delayed Transfer of Care

Change in criteria
NHS England have updated the term and definition used for delayed discharges from mental health, learning disability or autism inpatient settings (formerly known as delayed transfers of care or DTOCs) to the new term **'clinically ready for discharge'.**

This will enable more accurate reporting of delayed discharges and the ability to demonstrate pressures locally and nationally. It should also support efforts to ensure people are only staying in hospital for as long as they need to, as well as the national ambitions to eliminate out of area placements, reduce avoidable long lengths of stay and unsafe levels of bed occupancy.

There are three key criteria which need to be met before the Multi-Disciplinary Team can make this decision.

- There must be a clear plan for the ongoing care and support that the person requires after discharge, **which covers their pharmacological, physical health, psychological, social, cultural, housing and finances, and any other individual needs or wishes.**
- The MDT must have explicitly considered the person and their chosen carer/s' views and needs about discharge and involved them in co-developing the discharge plan.
- The MDT must also have involved any services external to the trust in their decision making, e.g. social care teams, where these services will play a key role in the person's ongoing care.

This new definition provides the following fundamental changes:

1. It signals a move away from the old DTOC definition, which was originally developed for the acute sector, and replaces it with a more tailored definition for mental health, learning disability and autism services
2. It covers both delays caused by internal Trust issues and external factors
3. It is more explicitly person-centred by ensuring that the MDT has considered the individual's and carer's views and needs, when deciding whether someone is clinically ready for discharge

Local systems and Mental Health Trusts must implement this by 1st January 2023 at the latest.

Detailed review of inpatients whose discharge is delayed
In response our ongoing challenges with delayed discharges and wider system flow pressures, in October 2022 we undertook ward level reviews of every inpatient who had a delayed transfer of care (DToC) and those medically optimised and fit for discharge. Our primary objective was to identify any delayed patients who could be expedited to aid flow and create capacity, while also identifying the main reasons for delays to identify and highlight any areas for system escalation and improvement.

The charts below show the numbers of delayed discharges each month for our Older People's and Adults inpatient services.

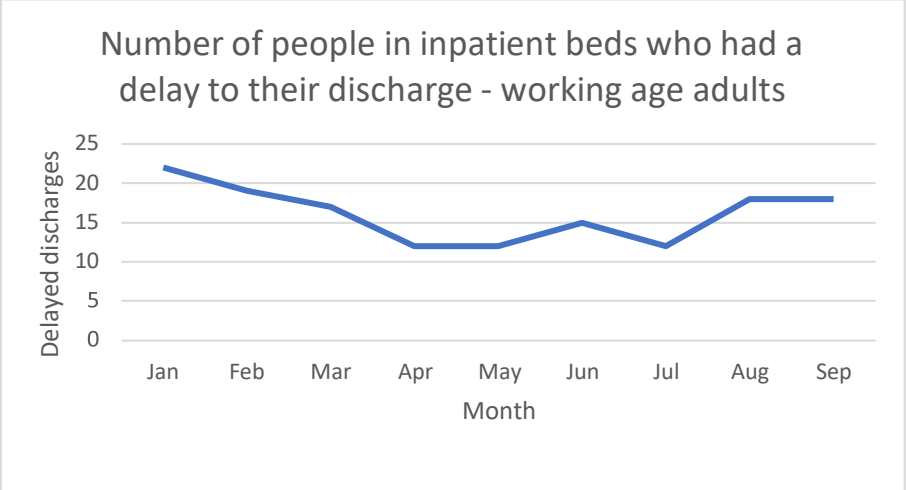


Chart 6a – Number of people in inpatient beds who had a delay to their discharge - working age adults

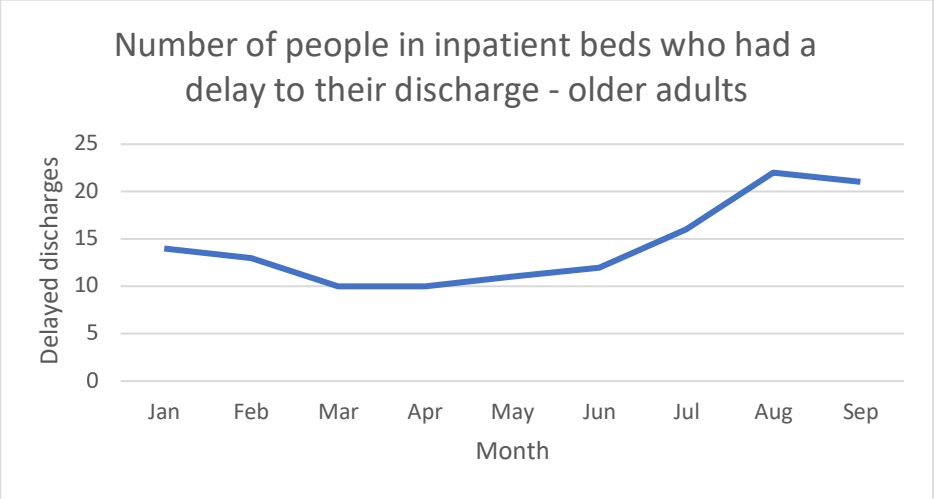


Chart 6b – Number of people in inpatient beds who had a delay to their discharge – older adults

The reviews showed several common themes that cause current delays, including:

- General needs for housing and access for people who are known to MH services but without Social Care needs
- Court dates being moved and creating uncertainty about outcomes
- Placement breakdowns and subsequent difficulty identifying suitable accommodation
- Demand for MH Support accommodation outstripping capacity

We are continuing to work with system partners to review and address these findings through the Norfolk and Waveney Steering Group, via a DToC work stream, reporting into the Norfolk and Waveney ICB Programme Board.

Inappropriate Out of Area placements
People who are placed outside of Norfolk and Suffolk because they need inpatient care that could be provided locally if there was an available bed.

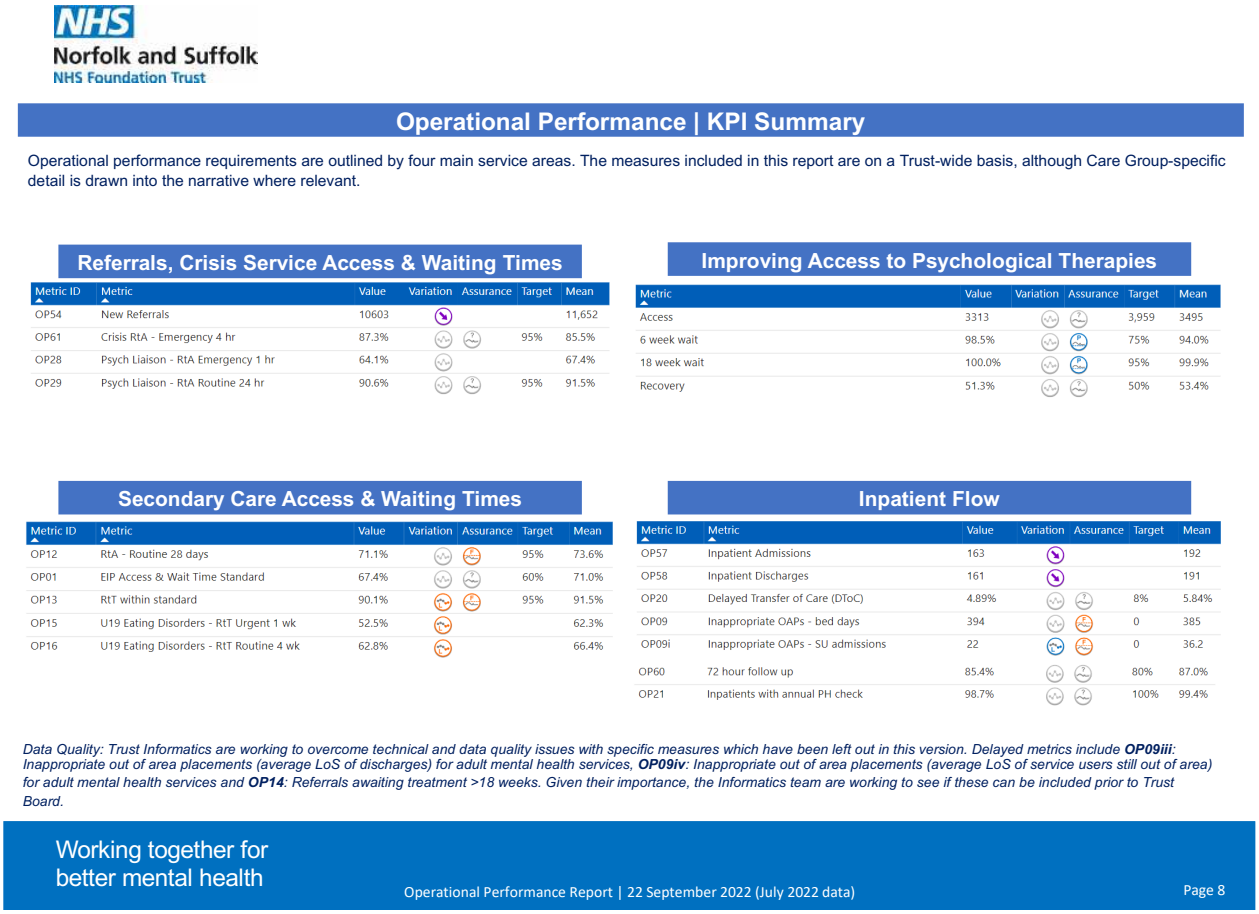
The impact that this has on our service users is that it can isolate them from their families, friends and communities – often by significant distance. In addition, it can be a barrier to timely discharge due to the lack of interface between the inpatient unit and the local community mental health team that will provide the care on discharge.

The table below sets out the scale of this challenge and the total number of bed days that these placements make up.

	Q4 21/22			**Q1 22/23**			**Q2 22/23**	
	Jan	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**
Number of Individuals in Inappropriate OAPs in month	13	14	12	4	15	26	17	15
Number of Individuals in Inappropriate OAPs at month end	7	8	5	2	13	16	12	14
Total bed days in month for Inappropriate OAPs	178	230	207	111	238	541	393	386

C) September Board Paper setting out NSFT's Key Performance Indicators (KPIs)

The following sets out a summary of NSFT's KPIs and operational performance as shared at our September Board. We are working with the NHS England Making Data Count team to refine our reporting further.



NHS
Norfolk and Suffolk
NHS Foundation Trust

Operational Performance | KPI Summary

Operational performance requirements are outlined by four main service areas. The measures included in this report are on a Trust-wide basis, although Care Group-specific detail is drawn into the narrative where relevant.

Referrals, Crisis Service Access & Waiting Times

Metric ID	Metric	Value	Variation	Assurance	Target	Mean
OP54	New Referrals	10603				11,652
OP61	Crisis RtA - Emergency 4 hr	87.3%			95%	85.5%
OP28	Psych Liaison - RtA Emergency 1 hr	64.1%				67.4%
OP29	Psych Liaison - RtA Routine 24 hr	90.6%			95%	91.5%

Improving Access to Psychological Therapies

Metric	Value	Variation	Assurance	Target	Mean
Access	3313			3,959	3495
6 week wait	98.5%			75%	94.0%
18 week wait	100.0%			95%	99.9%
Recovery	51.3%			50%	53.4%

Secondary Care Access & Waiting Times

Metric ID	Metric	Value	Variation	Assurance	Target	Mean
OP12	RtA - Routine 28 days	71.1%			95%	73.6%
OP01	EIP Access & Wait Time Standard	67.4%			60%	71.0%
OP13	RtT within standard	90.1%			95%	91.5%
OP15	U19 Eating Disorders - RtT Urgent 1 wk	52.5%				62.3%
OP16	U19 Eating Disorders - RtT Routine 4 wk	62.8%				66.4%

Inpatient Flow

Metric ID	Metric	Value	Variation	Assurance	Target	Mean
OP57	Inpatient Admissions	163				192
OP58	Inpatient Discharges	161				191
OP20	Delayed Transfer of Care (DToC)	4.89%			8%	5.84%
OP09	Inappropriate OAPs - bed days	394			0	385
OP09i	Inappropriate OAPs - SU admissions	22			0	36.2
OP60	72 hour follow up	85.4%			80%	87.0%
OP21	Inpatients with annual PH check	98.7%			100%	99.4%

*Data Quality: Trust Informatics are working to overcome technical and data quality issues with specific measures which have been left out in this version. Delayed metrics include **OP09iii**: Inappropriate out of area placements (average LoS of discharges) for adult mental health services, **OP09iv**: Inappropriate out of area placements (average LoS of service users still out of area) for adult mental health services and **OP14**: Referrals awaiting treatment >18 weeks. Given their importance, the Informatics team are working to see if these can be included prior to Trust Board.*

Working together for better mental health

Operational Performance Report | 22 September 2022 (July 2022 data)

Page 8

The full September Operational Performance Report has been supplied alongside this paper.

D) ICB commissioned mortality data review

Norfolk and Waveney and Suffolk and North East Essex ICBs and NHSE have agreed to undertake a review of the systems and processes in place at the Norfolk and Suffolk NHS Foundation Trust (NSFT) for collecting, processing and reporting on data relating to patient deaths. The aim is to undertake an independent review, conducted by an independent auditor, to assist NSFT and key stakeholders in understanding NSFT's data management, and to also receive any applicable recommendations for improvement with regard to these processes. A further benefit of this review will be the comparison of NSFT's approach to the definition, attribution and reporting of patient death data with other organisations and national best practice, in order to provide a view on the relative consistency with which this data is represented.

The scope of the mortality data review does not extend to reviewing or providing

opinions relating to individual patients, beyond ensuring that source data and subsequent processingand reporting of this data are accurate.

The review has formally commenced the week of the 10 October 2022 and is expected to take between 4 and 6 weeks to complete. The resulting report will be taken through the governance processes of the ICBs and NSFT as appropriate.

4. Conclusion

The Trust's commitment to sustainable improvement is underpinned by the principles of openness and transparency in order to build the trust of our service users, our staff and stakeholders. The involvement of system partners and service users in our improvement programme evidences that the past approach to 'fix' problems without sufficient assurance and sustainability will not be replicated.

We will continue to work in partnership with colleagues within our system and region to address demand for services, not all of which are or should be delivered by NSFT. The focus on mental health and wellbeing is not only an NSFT issue but a matter that all partners across the public and voluntary sector can influence; improvements in areas such as housing, social care, education and voluntary sector services are key to prevention, early intervention and timely access to services for people when they need it.

Norfolk and Suffolk
NHS Foundation Trust

Working together for better mental health

NSFT Improvement Programme

Trust Board – 22 September 2022

Contents:

What will this paper cover?

Section 1:

How have we approached our Improvement Programme?

This section sets out:

Our Improvement Programme approach

A summary of our phased approach to prioritising delivery of our Improvement Programme

At a glance...

- Our immediate improvements have been focused on key safety-related issues about each area of concern set out in the Section 29A notice and must dos.
- We are working on five Strategic Improvement Themes. These are our long-term initiatives to embed sustained improvement.
- In September 2022, we invited our Internal Auditors to review our Improvement Programme approach. We received a positive rating of 'reasonable assurance'. Auditors noted good practice in the breadth of our planned Improvement Programme, prioritisation of our activities and how closely we are monitoring delivery.

1. Our Improvement Programme approach

Our Improvement Programme approach

We have developed a wholescale programme of improvement, addressing a series of concerns identified by the CQC and the Trust itself to fundamentally improve the safety and quality of the care we provide. Specifically, our Improvement programme addresses the following:

Section 29A notice and CQC must dos – our immediate quality and safety actions

- On 24 December 2021, the CQC issued the Trust with a Section 29A (S29A) warning notice. The notice raised 14 thematic concerns: staffing, mandatory training, supervisions, appraisals, ligatures, risk assessments, incidents, observations, care and treatment, outcomes, privacy and dignity, medicines management, culture and governance.
- In April 2022, the full CQC report followed, including 108 must do actions linked to those core service areas inspected by the CQC.
- We welcomed CQC inspectors back to the Trust on 13 September 2022 to assess our progress against the S29A notice.

Strategic Improvement Themes – our initiatives to deliver sustainable, long-term improvement

- As part of our work to address quality concerns, we undertook a thorough root cause analysis to identify fundamental issues we need to tackle to deliver sustainable improvement. We identified five areas of strategic improvement we must focus with our system partners to effect and embed improvement in the long term.
- Our five Strategic Improvement Theme areas cover culture, governance and leadership, safety, our service offer and timely access to services to balance demand and capacity to deliver.

Positive assurance from our Internal Auditors

We have received an internal audit independent review of our Improvement Programme approach and governance. This review has determined a positive rating of 'Reasonable Assurance' with noted aspects of good practice commending the breadth of scope of our programme work, our prioritised and phased approach and how closely we are monitoring delivery.

1. Our Improvement Programme phasing

Our phased approach to improvement

Our primary focus for Phase 1 has been to address the concerns set out in S29A and the CQC must dos. We have also started work on our five Strategic Improvement Themes.

As we move into Phase 2, we will increase our focus on developing our Strategic Improvement Theme work to further address some of the key underlying challenges facing the Trust.

Phase 1: Addressing the basics
to August 2022

- Delivery of actions to address S29A and CQC must dos
- Establishing our five Strategic Improvement Themes covering culture, governance and leadership, safety, our service offer and timely access
- Completing the first tasks in our Strategic Improvement Themes, particularly those which would have an immediate impact

Phase 2: Sustaining improvement
to October 2023

- Review and learn from Improvement Programme work in Phase 1 and feedback following CQC review of progress
- Sustaining and embedding delivery of our response to S29A and CQC must dos
- Delivery of Strategic Improvement Theme initiatives
- Continue to build the leadership, capacity and infrastructure to deliver
- Finalise Recovery Support Programme (RSP) Exit Criteria with NHS England (NHSE) to deliver improvements

Phase 3: Continuous improvement and innovation
October 2023 onwards

- Review and learn from Improvement Programme work in Phase 2, CQC feedback and progress in delivering RSP Exit Criteria
- Ensure our approach to improvement is sustainable and embedded for the long term
- Enhance innovation in practice and delivery in the Trust and with system partners across our Integrated Care Systems and Regional Provider Collaborative

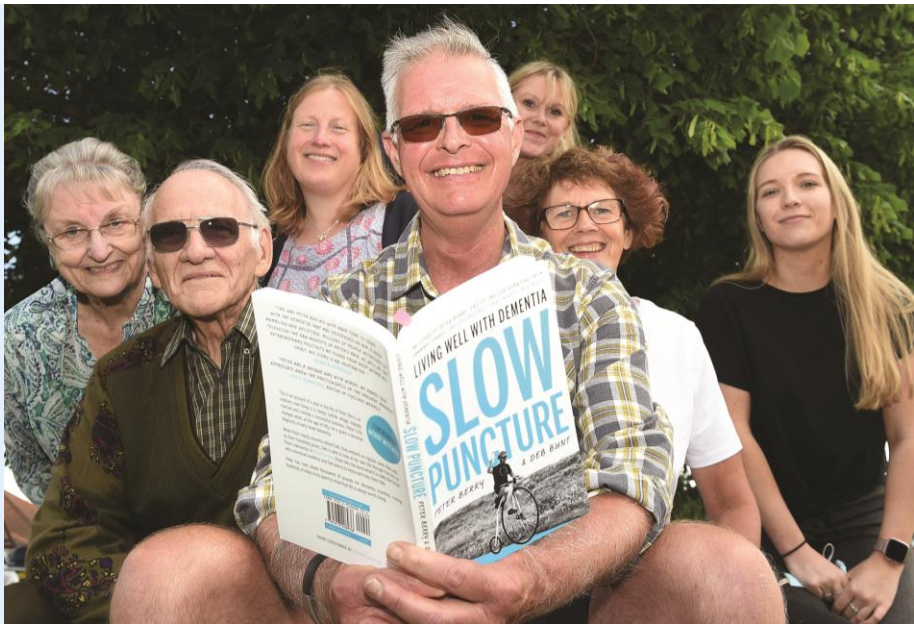
Section 2:
What progress have we made?

Norfolk and Suffolk NHS Foundation Trust

This section sets out:

Our progress to address the CQC S29A concerns, lists each area, what action we have taken, the evidence we have of improvement and where we have more to do.

Our five Strategic Improvement Themes which describe our approach to addressing those root cause issues that prevent sustained improvement, the scope of work in each and what we have achieved to date.



At a glance...

- We can demonstrate that we have addressed specific CQC concerns and improved services.
- By working together, we have delivered beyond the specific examples or services identified by the CQC to ensure we reduce service variation and embed change Trust-wide. We have more to do.
- An Evidence Assurance Group, starting formally in October, means we can test how far we have come with the support and scrutiny of partners.

2a What progress have we made to address S29A concerns?

Theme	Summary
Staffing	• Daily assurance that safest staffing is met on all inpatient shifts. • Significant progress recruiting to nursing and medical vacancies with a net staffing increase of 170 since November 2021, including recruitment to, or mitigation of, specific staffing concerns raised by the CQC. • Further initiatives to support recruitment and retention planned, including staff support and culture development work.
Mandatory training	• Training compliance has improved to 89% in August 2022 from 83% in November 2021. • Revised induction programme includes completion of 80% of mandatory and statutory training modules for all new starters. • PMA training rates have improved significantly however there is more to do to achieve Trust set target.
Supervision	• Programme to increase Trust-wide compliance and improve data quality delivered. • Supervision rates have increased to 89% at the end of August 2022 from 62% in November 2021.
Appraisals	• Programme to increase Trust-wide compliance and improve data quality delivered. • Appraisal rates have increased to 87% at the end of August 2022 from 79% in November 2021.
Ligatures	• Remedial works have been completed or are on an accelerated forward plan for Estates work, with mitigations in place to keep service users safe. • Ligature compliance processes strengthened, including regular audits.

2a What progress have we made to address S29A concerns?

Theme	Summary
Risk assessment	• Our Quality Safety Reviews show assessments are regularly reviewed. Our inpatient Care Process Audit shows risk assessments are more regularly reviewed from 87% in March 2022 to 95% in July 2022. Work in progress to develop our assurance process and provide Trust-wide reporting of risk assessments and care plans, as well as local reporting.
Incidents	• All incidents identified by the CQC have been reviewed and responded to. Through a targeted programme of work, we have reduced our backlog of overdue incidents from 1,300 to 150. We have strengthened escalation processes to ensure that this improvement can be sustained.
Observations	• Revised processes for conducting and recording observations in a timely way. Audit and CCTV evidence shows improved practice when delivering and recording observations.
Care & treatment	• Sustained improvement with the inpatient Care Process Audit showing more compliance with processes for assessment and care planning from 81% in March 2022 to 90% in July 2022. • Service users report feeling more involved in their care planning. • Waiting times for Adult Community services have reduced, with revision to and strengthened application of our Clinical Harm Policy to support those who are waiting. However, we are working with commissioners and partners on more timely access.
Outcomes	• There has been increased use of the DIALOG+ outcomes measurement tool. Around 2,500 staff have been trained this year.

2a What progress have we made to address S29A concerns?

Theme	Summary
Privacy & dignity	• All privacy and dignity related concerns addressed. This includes completion of environmental works in Blickling, Poppy and SRRS wards. • We have reviewed protocols at our mixed sex ward (Sandringham) which adhere to Trust Policy, with practice being monitored to ensure ongoing compliance.
Medicines management	• Immediate concerns have been addressed with policies updated with additional compliance checks, with evidenced improvement in areas such as rapid tranquilization. • Additional staff have been recruited with strengthened support through supervision and training. • The Medicines Management strategy has been developed to address the findings of the external review commissioned by the Trust and deliver sustained improvement.
Culture	• Immediate actions undertaken to improve communication and support staff wellbeing with targeted engagement sessions held with specific teams. • More will be done to transform culture from September 2022. We have recruited 60 culture change agents and 100 wellbeing champions to support staff wellbeing.
Governance	• Immediate strengthening of governance processes, with QPMs re-established, a new Board Assurance Framework and monthly audit schedule in place. • External review of local governance completed, with recommendations set to be implemented. • Governance is an important long-term focus as a Strategic Improvement Theme covering Board, Local and Quality governance.

2a What progress have we made? Where have we more to do?

Theme 1: Staffing

CQC said: "The Trust did not consistently maintain safe staffing levels or ensure there are enough suitably qualified staff to meet the needs of people using services. We found this was impacting on the level of safety staff and service users felt, the governance within teams and multidisciplinary team effectiveness and patient safety."

We took action to:

- Strengthen oversight and scrutiny of staffing levels in line with service user need on a daily, weekly, monthly and annual basis.
- Deliver Trust-wide roll out of our SafeCare digital tool, ensuring staffing levels match patient need and acuity.
- Deliver Trust-wide recruitment activities targeting areas of identified workforce challenge.
- Heighten focus to support leaders and staff on safety matters relating to staffing and safe care.
- Heighten focus on induction and retention to develop and retain our staff.

A summary of where we are now:

- Concerns raised by the CQC about staffing levels, recruitment and retention have been addressed, with relevant Must Dos completed. We have ensured that safest staffing levels are being fully met and have recruited to challenged areas.
- Revision and relaunch of new Trust induction programme amongst initiatives to support recruitment and retention.
- Improved oversight and controls of staffing and recruitment through SafeCare and workforce heatmaps.
- We continue, as other Trusts, to face challenges in terms of staff recruitment and retention and will work to review staffing pressures through prioritising recruitment to identified areas of challenge and mitigating vacancies. Our longer-term workforce and cultural transformation initiatives will support us to sustain and develop our workforce for the future.

Theme 1: Staffing continued...

Safest staffing has been met for all shifts since March 2022

716 new starters recruited since November 2021

Where we have more to do:

- Following roll-out of SafeCare we will review its functionality to continually improve its usage.
- We will commission specialist support to improve job planning for medical staff.
- We will build on initiatives to improve job satisfaction and retention including peer support, improved welcome information, support to staff on joining the Trust and further staff development.

Evidence of our improvements:

Staffing levels:

- Safest staffing has been met for all shifts since March 2022, with no breaches in this period
- Annual safe staffing reviews complete for all wards by April 2022, setting baselines for required staffing levels
- SafeCare Tool rolled out across the Trust (August 2022)
- Staffing heatmaps developed (August 2022)

Recruitment:

- 716 new starters recruited since November 2021, with a net staffing increase of 170
  - Clinical Support vacancies have decreased from 11.6% in December 22 to 5.9% in July 22.
  - 140 nurses have started since November 2021 with 26 more starting in August 2022 and 19 more with a start date for September or October 22.
  - Reduction in Consultant vacancies from 26% in February 2020 to 8% in February 2022
- Refreshed induction programme launched (July 2022).

2a What progress have we made? Where have we more to do?

Theme 2: Mandatory Training

CQC said: "The Trust did not ensure staff had the mandatory training and specialist training to undertake safe care and treatment of service users."

We took action to:

- Strengthen leadership, focus, oversight and controls to increase MAST training levels.
- Benchmark and adopt optimum practice approaches to MAST delivery.
- Target support and increase capacity of PMA training as a key area of safe practice.
- Introduce a new Trust induction programme which ensures 80% coverage of MAST.
- Increase support to managers to improve our leadership and management capability.
- Increase ease, benefit, and experience of MAST training.
- Focus efforts on improving MAST compliance in those specific teams highlighted by the CQC alongside Trust-wide compliance.

A summary of where we are now:

- Material improvement to improve compliance rates on a Trust-wide basis, reduce variability, and address areas of concern such as PMA training. Relevant must dos have been completed or are close to completion for all teams.
- We have developed and implemented specific training programmes for clinical teams, including:
  - Dedicated senior nurse training – bespoke training already rolled out to 150 clinicians.
  - Shift coordinator training provided for all staff who manage shifts.
- We recognise that targeted and intensive support will need to continue to maintain and sustain Mandatory Training improvements, particularly given staffing pressures, staff turnover and the Trust's own ambitious compliance targets.

Theme 2: Mandatory training
continued...

Mandatory training compliance has increased from 83% in November '21 to 89% in August '22.

New staff undertake 80% of MAST training as a result of new Trust induction programme

Where we have more to do:

- Targeted support will continue to be provided to challenged teams that have not yet met the Trust target.
- Improved Trust induction programme to be expanded to include additional training modules.
- Continued roll out of STORM (Suicide Presentation & Self-Harm Mitigation) training to all clinical staff.

Evidence of our improvements:

- Training compliance levels improved:
  - Trust-wide mandatory training compliance has increased from 83% in November 2021 to 89% in August 2022.
  - Physical Intervention training compliance has increased from 58% in November 2021 to 75% in August 2022.
  - Personal Safety training compliance has increased from 54% in November 2021 to 72% in August 2022.
- New Trust induction programme ensures new staff starting undertake 80% of MAST training.

2a What progress have we made? Where have we more to do?

Themes 3 & 4: Supervision and Appraisals

CQC said: "The Trust did not ensure staff receive supervision and appraisals to support the development of staff in their roles and to support safe and effective care."

We took action to:

- Enhance scrutiny and target support to increase supervision and appraisal rates .
- Heighten visibility of timely, immediate data on supervision and appraisal rates.
- Heighten support to increase recording on supervision app as a tool to make recording and capture easier for staff.
- Work to improve the quality and experience of supervision and appraisals to ensure staff and service users benefit.

A summary of where we are now:

- Significant improvement in Trust-wide rates of supervision and appraisals, supported by improved reporting and escalation of compliance levels. Data quality issues raised by teams have been addressed. Relevant must dos completed for all teams.
- We recognise the immediate staffing pressures mean staff and managers risk being unable to carry out supervision and appraisals. To mitigate this, we will continue to demonstrate the value of supervision and appraisals and ensure staff time is protected to prioritise these activities to support staff and their development.

Themes 3 & 4: Supervisions and Appraisals continued...

Where we have more to do:

- We need to continue to work to monitor and improve compliance Trust-wide, and in our targeted support to teams where levels are lower. To improve our monitoring process, we are planning to automate alerts to provide visible, timely data and prompts on compliance levels.
- Our focus will broaden to support ongoing improvement in the quality and impact of supervision and appraisal conversations. We have established a QI group focused on improving the quality of supervision.

Evidence of our improvements:

Trust-wide supervision rates up from 62% in November 2021 to 89% in September 2022

Trust-wide appraisal rates up from 79% in November 2021 to 87% in August 2022

2a What progress have we made? Where have we more to do?

Theme 5: Ligatures

CQC said: "The Trust did not ensure staff were aware of ligature assessments or mitigate or remove ligature points effectively to maintain patient safety."

We took action to:

- Immediately mitigate or resolve ligature points identified by the CQC.
- Undertake staff training to develop and promote effective ligature management competence and understanding of processes.
- Increase controls to heighten oversight of effective ligature management.
- Procure a digital app to digitise assessment and actions relating to ligatures.
- Document and accelerate environmental improvements, prioritised by risk.

A summary of where we are now:

- Immediate areas of concern identified by the CQC have been addressed and have either been resolved or mitigated, with relevant Must Dos completed.
- Controls strengthened to ensure compliance and appropriate escalation.
- There remains outstanding environmental improvement work on our adult rehab ward (SRRS) and Blickling Ward. Works have been prioritised on our estates forward work programme. Interim mitigations have been put in place pending work completion and will be monitored closely at team and Trust level.

Theme 5: Ligatures further information

100%
of ligature checks completed
(August 2022)

Where we have more to do:

- Controls to be further strengthened through roll-out of the ligature digital app to provide centralised information to oversee ligature management Trust-wide.
- Review and management of ligature risks is an ongoing process recognising that safe practice evolves with developing service user need, ligature guidance and national safety alerts. We will continue to manage ligature risks through full risk assessment and development and implementation of appropriate mitigations.

Evidence of our improvements:

- Adult Rehab Ward (SRRS) - Phase 1 ligature removal works completed.
- Adult Rehab Ward (SRRS) – ligature competencies completed with all staff (100% compliance).
- Blickling Ward – risk assessments updated, ligature anchor points removed or mitigated where removal is not possible. CCTV installed.
- Updated ligature identification guidance developed and shared (July 2022).
- Ligature and Self-Harm Reduction Lead role created and appointed.
- 100% of ligature checks completed (August 2022).

2a What progress have we made? Where have we more to do?

Theme 6: Risk Assessment

CQC said: "The Trust did not ensure service users had up to date risk assessments and risk management plans to manage risks and ensure patient safety."

We took action to:

- Clarify policies and processes so that staff understand their responsibilities regarding risk assessment and care planning.
- Ensure comprehensive and absolute measures were in place to evidence compliance and target support.
- Provide specific support and actions to assess and address environmental risks.

A summary of where we are now:

- The Care Process Audit (CPA) shows that sustained improvement has been made with risk assessment compliance and review in inpatient settings, addressing the CQC's overarching S29A concerns and Must Dos.
- Improvements in the number of overdue environmental risk assessment reviews, with further work to make sure that all overdue assessments are reviewed to time.

Theme 6: Risk Assessment
continued…

Where we have more to do:

- Further work required to make sure that this improvement is sustained and embedded, and revisions to risk assessments are made in a timely fashion.
- As of August 2022, a total of 15 environmental risk assessments are overdue, down from 39 in March 2022. Outstanding environmental assessments will be completed as a priority and their completion ensured.

Evidence of our improvements:

The Care Process Audit shows that compliance with the regular revision of risk assessments has improved from 87% in March 2022 to 94% in August 2022.

2a What progress have we made? Where have we more to do?

Theme 7: Incidents

CQC said: "The Trust did not ensure staff report, manage and learn from incidents to protect service users and staff from harm."

We took action to:

- Ensure open incidents are swiftly addressed and learned from.
- Provide further Datix training to improve ease and accuracy of recording and capture of incidents.
- Heighten controls to promote oversight and review and learning from incidents
- Ensure quality audits check effective learning from incidents.

A summary of where we are now:

- Significant improvement has been made to review outstanding incidents including strengthened controls and audit, with relevant must dos addressed.
- While we are closing incidents more quickly, we need to ensure we spend enough time and effort to learn from incidents and share this learning. Our future continuous improvement work seeks to address this.

Theme 7: Incidents continued…

Where we have more to do:

- We will continue to monitor and sustain this improvement.
- To support and maintain improved compliance our Trust-wide induction has been revised, and we will incorporate sessions related to reporting incidents into induction.
- Future project work with Power BI Team is planned to enable us to capture protected characteristics within the reporting of incidents to help identify trends and support future learning.

Evidence of our improvements:

- Reduction in overdue incidents from 1,300 in November 2021 to 150 in July 2022.
- Datix refresher training has been provided for 38 teams and services between November 2021 and July 2022.

2a What progress have we made? Where have we more to do?

Theme 8: Observations

CQC said: "The Trust is not ensuring staff carry out patient observations in accordance with Trust policy and NICE guidance to protect people from harm."

We took action to:

- Evidence improvement in audited observations in accordance with Trust policy and guidance.
- Improve processes and protocols to support compliance.

A summary of where we are now:

- Improvements have been made to address this area of concern, with a new Quality Management System and audit process which demonstrates positive compliance and completion of relevant Must Dos.
- Our focus is now on addressing variation in compliance and ensuring consistent and embedded delivery of observations across services, Trust-wide.

Theme 8: Observations
continued…

Where we have more to do:

- Introduction of monthly validation checks to support learning and provide additional assurance.
- Testing and implementation of a re-designed audit tool to enable greater understanding of safe practice.
- Introduction of a new Patient Safety Pocket Guide with focus on therapeutic observations.
- Work started on the doors in SRRS ward in September to enable hourly observations to take place without disturbing service users.
- QI project on two wards testing a new hourly/general observation form to improve compliance.

New Quality Management System introduced in February 2022 and monthly audits demonstrating positive compliance

Evidence of our improvements:

- Quality Management System (QMS) introduced in February 2022, including monthly ward level audit.
- Findings from this monthly audit for July show strong compliance with best practice:
  - 94% of the audit sample (46 of 49 records) showed staff were completing observations for no more than two hours at a time, in line with best practice.
  - Of the 18 wards recording in the audit, CCTV checks showed 99% compliance in respect of timeliness of observations and actions.

2a What progress have we made? Where have we more to do?

Theme 9: Care and Treatment

CQC said: "The Trust did not manage long waiting lists or monitor the risk within the waiting lists effectively. The Trust did not ensure staff had access to patient records or maintain accurate records regarding patient care, physical health checks and nutrition to meet or demonstrate patient needs have been met."

We took action to:

- Ensure consistent delivery policies and processes, including care planning, were put in place to support service users.
- Heighten review and assurance processes to support continuous improvement.
- Reduce waiting lists for community services and ensure appropriate risk stratification and support for those on waiting lists.
- Ensure we are responsive to patient need as well as improving patient experience and understanding of their care.
- Promote physical health alongside mental health.
- Focus efforts to safely manage seclusions. When they happen, they are delivered and recorded consistently and improve learning.

A summary of where we are now:

- Progress has been made in all areas, as set out here, with the Care Process Audit showing improved compliance, and a new programme of work to reduce waiting lists and better support those on waiting lists.
- We carry ongoing risks for care and treatment with notable, but reduced, waiting lists remaining an issue.

Theme 9: Care and Treatment
continued…

Where we have more to do:

- Focus on physical health assessment monitoring and ensuring consistent compliance with Trust-wide processes especially with regards to care planning and waiting lists.
- New care plan template to be uploaded to Lorenzo and support consistent but comprehensive care planning across teams.
- Ongoing review of care plan compliance data, physical health dashboards, and waiting list reports to ensure that initial improvements in practice are sustained.
- Further work with commissioners and system partners to review how we best support those waiting for services and make appropriate use of a broader range of community alternatives.

Audit shows Trust-wide compliance at 91% for Care Processes

Evidence of progress:

Care Process Audit shows Trust-wide compliance at 91% for Care Processes in August 2022 up from 81% in March 2022

- Compliance with assessment up from 88% to 94%.
- Physical Health Assessment up from 85% to 90%.
- Care Planning up from 79% to 90%.

Work to address waiting lists (adult community services), showing:

- Reductions in the number of people waiting for assessment (from 1106 in November 2021 to 760 in August 2022).
- Reductions in the number of people waiting for treatment (from 212 in November 2021 to 167 in August 2022).

Improved patient engagement, evidenced by the inpatient survey:

- In August 2022 98% of service users felt involved in their care planning, (78% in February 2022).
- 98% of service users believe they were offered a copy of their care plan, up from 62%.
- 93% of service users believed that their recovery plan addressed their needs, up from 81%.
- 85% of service users stated that their recovery plan started within 24hrs of admission, up from 63%.

2a What progress have we made? Where have we more to do?

Theme 10: Outcomes

CQC said: "The Trust did not ensure patient outcomes were measured to demonstrate progress being made."

We took action to:

- Embed DIALOG+ as the Trust-wide outcomes rating scale.
- Ensure robust monitoring and assurance to ensure that outcomes are being recorded and reviewed to demonstrate progress being made.
- Further develop joint ownership of outcome measures with service users.
- Enable better access to improve outcomes and tackle health inequalities.

A summary of where we are now:

- We have made positive progress in increasing the use of DIALOG+ across teams, increasing its use throughout the organisation.

Theme 10: Outcomes continued…

2,500 staff trained in DIALOG+

Where we have more to do:

- Ongoing work to increase the use of DIALOG+ and embed its use throughout the organisation:
    - The DIALOG+ team will be in-reaching into teams to offer additional support, advice and guidance where it is identified that DIALOG+ is not fully embedded.
    - Away days on care planning and DIALOG+ scale implementation
    - A new package of training with an e-learning module and a one-day classroom module.
    - A round of evaluation for both staff and service users to further improve the way in which we use outcomes measures.
- Improving reporting through the introduction of PowerBI.
- We are developing the specification and timeline for an ICT project to enable service users to access their scores and understand their progress. Without this, outcomes reported may not be fully embraced and recognised by our service users.

Evidence of our improvements:

- 2,500 staff trained in DIALOG+
    - DIALOG+ training included within induction
    - Further 'mop-up' training sessions planned for September.
- Increase in the number of DIALOG+ entries between April (10,975), June (12,175) and July (14,736).
- Paired outcome scales for DIALOG+ are at 18% (July 2022), and on an upward trajectory.

2a What progress have we made? Where have we more to do?

Theme 11: Privacy and Dignity

CQC said: "The Trust did not ensure service users were introduced to the ward area, privacy was respected in both the environment and by knocking on doors or through patient involvement in their care."

We took action to:

- Ensure immediate resolution of CQC identified environmental concerns, or ensure appropriate mitigations.
- Heighten oversight and scrutiny of compliance with mixed sex accommodation, privacy and dignity standards.
- Introduce a new service user welcome pack for service users on admission to wards to improve service user experience of being introduced to wards.
- Improve privacy and dignity through environmental and clinical improvements.

A summary of where we are now:

- Immediate concerns identified by the CQC regarding privacy/being overlooked resolved, with privacy film installed in relevant areas within Blickling and Poppy Ward.
- CQC concerns regarding mixed sex accommodation on Sandringham Ward addressed.

Theme 11: Privacy and dignity
continued…

Privacy film and personal alarms installed

Where we have more to do:

- Further works completed to improve privacy and dignity in our 136 Suites and Adult Rehabilitation Ward (SRRS).
- New anti-barricade doors with observation panels ordered, and to be installed, with work commencing on SRRS in September 2022.
- Ongoing review through QSR process to identify and resolve any further issues.

Evidence of our improvements:

- Privacy film applied to windows in Blickling and Poppy Ward identified by CQC.
- Personal alarms installed for SRRS.
- Section 136 interagency protocol produced.
- Standard Operating Procedures produced for all NSFT health-based places of safety.
- Operating protocols reviewed for mixed sex accommodation.
- Wristbands allowing access to certain areas are issued to service users on arrival.

2a What progress have we made? Where have we more to do?

Theme 12: Medicines Management

CQC said: "The Trust did not ensure effective medicine management was taking place effectively to maintain patient safety."

We took action to:

- Update policies and protocols to prioritise patient safety and ensure that NICE guidance, and best practice, is followed across the Trust.
- Develop our Medicines Management strategy and action plan.
- Heighten oversight and controls to scrutinise compliance levels with expected medicines practice.
- Develop our electronic systems to support compliance monitoring and reporting.
- Build capacity across our pharmacy team, and the clinical teams we support.

A summary of where we are now:

- Significant and immediate improvements have been made to policies, protocols and prescribing practice to ensure the safety of service users and address CQC must dos. Particular progress in PRN medication reviews, T2/T3 and HDAT compliance.
- Weekly checklists have been used as an immediate measure to check compliance and safety, as have pharmacy team review of Datix incidents to identify trends and learning, to target support/resource where required and support improved patient safety.
- Training and supervision rates have been improved, to make sure that staff have required competencies, feel supported and are confident in delivering their role.
- Worked to establish sustainable processes and practices to maintain safety. These include:
  - The full roll out of the EPMA system.
  - Formation of the Medicines Optimisation Committee to discuss audit data and policy reviews and ensure that key messages and learning is cascaded to teams.
- We continue our work to ensure consistency of medicines management across the Trust. In September 2022, all teams had information sharing expectations and best practice.
- Levels of staffing in the pharmacy team remain under review. Work is ongoing to look at options available to increase resource and prioritise tasks, with recent successes hiring dispensary technicians.

Theme 12: Medicines Management continued…

Supervision compliance has improved from 38% (February 2022) to 91.7% (July 2022)

Where we have more to do:

- Plans to explore options to increase pharmacy team capacity and allow pharmacists to focus their efforts on supporting teams. This includes opportunities to increase the pharmacy team resource and automating some of the tasks, for example moving to electronic prescriptions.
- Implementation of PowerBI to improve medicines optimisation.

Evidence of our improvements:

- Rapid Tranquilisation compliance – in July 2022, rapid tranquilisation monitoring compliance was 98% after the first hour (89% in February 2022) and 94% after four hours (78% in February 2022).
- Resourcing – Three new dispensary technician posts established; recruited a clinical pharmacist for West Suffolk CRHT.
- Support – Supervision compliance has improved from 38% (February 2022) to 91.7% (July 2022).
- Training – Medicines management training compliance increased to 86.5% (July 2022).

2a What progress have we made? Where have we more to do?

Theme 13: Culture

CQC said: "The Trust did not ensure that cultures were supportive of staff to work in to provide care."

We took action to:

- Improve mechanisms to actively engage with staff and service users, through a wider variety of channels.
- Improve processes to encourage openness and learning from concerns and complaints.
- Refocus initiatives to foster a supportive culture.
- Refocus initiatives to improve equality, diversity and inclusion.

A summary of where we are now:

- Initial focus has been on communication and engagement, developing a series of mechanisms to better engage with staff including holding listening sessions (with particular focus on those teams where the CQC raised concerns), development of the change agent role and commissioning Clever Together to introduce more innovative approaches to improve staff engagement.
- We have continued our work to develop new roles, training tools and mechanisms to promote and embed an open and engaging culture and staff wellbeing.
- Using insight from our staff engagement sessions we have developed a new Cultural Transformation programme, to be launched in September 2022. Whilst we are taking immediate action to address aspects of our culture, we recognise that cultural change will take time to embed and sustain, and will need to be part of a longer-term plan for improvement.

Theme 13: Culture continued…

60
culture change agents recruited and trained in 2022

Where we have more to do:

- We will launch our new Cultural Transformation programme in September '22. This programme will identify and challenge discriminatory and marginalising behaviour and support our development of a culture of acceptance, respect and psychological safety.
- Further cultural improvement work will continue, including initiatives such as the introduction of Schwartz Rounds which are designed to help staff reflect on the emotional aspects of their work, Star Awards to celebrate our staff and Equality Diversity and Inclusion Board Development sessions to learn from best practice.

Evidence of our improvements:

- 60 culture change agents recruited and trained in 2022.
- Further Wellbeing Champions have been recruited (with 76 recruited by March, and more than 100 by July).
- We have piloted a Healthy and Effective team programme to promote team working and a supportive culture.
- We have piloted a new mentoring scheme for frontline managers.
- Staff Wellbeing Toolkit developed, with ongoing month-on-month increase in the numbers of staff viewing the page and downloading materials on staff wellbeing.
- Procured a new independent Freedom to Speak Up service, with extended 24/7 opening times.
- Seven Schwartz Rounds facilitators appointed.
- Team management training for three service management teams and individual coaching for 10 group managers.

2a What progress have we made? Where have we more to do?

Theme 14: Governance

CQC said: "The Trust did not provide support to teams to maintain good governance in providing high quality care."

We took action to:

- Revise governance oversight processes at all levels to provide supportive review and challenge to services.
- Strengthen robustness of audit and risk management processes.
- Improve access to meaningful information for decision making and improvement.
- Develop management and leadership competencies for leaders across the organisation.
- Increase visibility of leaders to promote quality, improvement and oversight.

A summary of where we are now:

- In Phase 1 of our Improvement Programme, we have balanced immediate changes to improve governance, escalation and reporting, with longer-term structural changes. Efforts have been focused on reviewing and strengthening local governance, Board governance and safety and quality. This includes immediate improvements such as revised Care Process Audits, refreshed Quality and Performance Meetings (QPMs), development of a new Board Assurance Framework (BAF) and delivery of a Board development programme.
- We want to improve the process by which we escalate, review and mitigate risks before they become issues, with changes to be made to systems and processes, including reporting. These are being developed and will be delivered in Phase 2.

Theme 14: Governance
continued…

Where we have more to do:

- We will embed our revised Accountability Framework in Phase 2.
- We have procured specialist external expertise to support us with our Ward to Board governance review (NHSE and Moorhouse). Recommendations from their reviews will be implemented in Phase 2.
- We will implement an Integrated Performance Report to provide robust Ward to Board reporting.

Evidence of our improvements:

- New Board Assurance Framework
- Board Development Programme established
- Revised workplan for Quality Assurance Committee
- External review of local governance completed
- New format and agenda for QPM meetings
- Revised Accountability Framework
- Monthly audit schedule in place, with consistent tools
- Revised Trust Leadership Programme - leadership summit involved more than 250 staff attendees
- Phase 1 of our Serious Incident review completed

2a What progress have we made? Where have we more to do?

CQC Must Do actions delivery at the beginning of September

As set out in previous slides significant improvements have been made across the Trust, addressing both the findings of the Section 29A notice and completing Must Do actions set by the CQC.

Since our report to July Board, we have delivered further improvements to address our must do actions, including:

- Further increasing our Trust-wide mandatory training compliance rate to 89% (from 83% November 2021).
- Further increasing PMA training compliance - at end of August Physical intervention compliance is at 75% (from 58% in November 2021), Personal Safety 72% (from 54% in November 2021) with appropriate mitigations where compliance is not yet at Trust target.
- Roll out of a new, enhanced welcome pack to support service user induction to our wards. Positive feedback has been received, with service users reporting that they feel more involved in their care planning.
- Roll out of a new Trust induction programme for all new staff starters from July.
- Completion of rollout of SafeCare across the Trust in August, to support better allocation of staff in response to service user need.
- Development and delivery of training on therapeutic interventions for staff working on adult inpatient wards.
- Ward Managers and Matrons away days held over July and August to enhance training and support.
- Development and distribution of an aide memoire to all teams to support consistency of prescribing practice and medicines management.
- Must do actions completed for our CAMHS ward (Dragonfly) and Adult Rehabilitation unit (SRRS).

At the time of writing 87% of must dos identified by the CQC have been completed. For those remaining 14 we have made significant improvements in addressing concerns but have further work to do to fully embed and sustain delivery

We continue to review and scrutinise our progress at Quality and Performance Meetings, must do groups focused on the completion of Must Dos for each service, Executive Team meetings, Quality and Assurance Committee and Improvement Board. We will also further test this through our planned Evidence Assurance Group.

Following feedback from the CQC visit in September 2022 we will review our progress against both the Section 29A and must dos. We will incorporate follow on, timed actions and deliverables as part of our Phase 2 plan and activities

2b Strategic Improvement Theme 1 - Making Your Voice Count (Culture)

SRO: Cath Byford, Deputy Chief Executive Officer & Chief People Officer

Where we were:

Communications and engagement activities were not sufficient nor consistent at all levels of the Trust, leading to a loss of trust and confidence both internally and externally. There were pockets of unsupportive, psychologically unsafe and discriminatory behaviour experienced by individuals or as part of a team culture and the Trust was not systematically addressing this

Where we want to be:

We will communicate and interact with staff, service users, partners and other stakeholders in a way that builds trust and confidence, and exhibits behaviours that are psychologically safe, inclusive and aligned with Trust values.

Work Area	Objective	Our initial actions
Communicating Effectively	Our formal and informal communications will be timely, relevant, inclusive, transparent and honest to all stakeholders	• Delivery of our initial communications plan for Phase 1 **[C]** • Specialist support commissioned to expand communications capacity and engagement approach (Hood and Woolf) **[C]** • Continued roll out of Improvement communications **[IP]**
Engaging to Act	Our engagement work seeks to 1) build staff trust and confidence and 2) support, facilitate and empower staff to unblock issues that they face	• External support selected and commissioned to support with Trust-wide engagement (Clever Together) **[C]** • Delivery of response and action plan with respect to existing feedback **[P]**
Feeling Safe, Valued and Supported	We will create the conditions and develop systemic enablers for staff to feel safe, valued and supported.	• New freedom to speak up guardian service established **[C]** • Preparation for Cultural Transformation programme launch **[C]** • Launch of our new culture programme **[P]** • Roll out of staff survey around recognition ideas **[P]** • Review of grievances and appeals **[P]** • Review of recruitment process bias **[P]** • Review of best practice around EDI/tackling marginalisation in other Trusts completed **[P]** • A tackling marginalisation plan developed based on best practice and experience of other Trusts **[P]** • Phased rollout of Schwartz Rounds **[P]**
Inspiring Positive Behaviour	We will develop and spread practical ways to manifest the values and behaviours that are important to a positive Trust culture	• Action plan developed for facilitating the spread of values and behaviour modelling **[P]**

KEY: **[C]** Complete | **[IP]** In Progress | **[P]** Planned

2b Strategic Improvement Theme 2 - Improving Governance and Leadership

SRO: Daryl Chapman, Chief Finance Officer

Where we were:

Governance structures and processes were in place but were not always clear or consistent and were not being used effectively to provide robust assurance and manage performance.
Leadership and management behaviours and capabilities were inconsistent across the Trust and staff are not always confident or equipped to navigate challenges.

Where we want to be:

We will have clear and consistent governance structures from ward to Board, aligned to an understood and accepted accountability framework, and provide leaders at all levels with the appropriate skills and information to allow us to report, monitor and improve the services we provide.

Work Area	Objective	Our initial actions
Leadership Capability	We have competent leaders board to floor and systems which enable people's ability to lead well and with pace	• Leadership summit held in July 2022 focusing on accountability - 250 person attendance across 10 sessions **[C]** • New NSFT leadership and management behaviour framework in place **[C]** • Coaching and OD support (such as mentoring) in place for local leaders in struggling services **[C]** • Leadership development roadshow to promote opportunities and engage "hard to reach" local managers **[P]**
Governance, Assurance and Risk	To have systems of governance which allow risks to delivering our goals to be identified, mitigated and escalated, ensuring safe, effective services and a culture of no surprises	• Board development sessions established **[C]** • Quality Performance Meetings (QPMs) reinstated, with focus on S29a concerns **[C]** • Initial findings from quality review and initial mapping of quality committees completed **[C]** • Local governance initial external review completed to inform co-designed action plan **[IP]** • Delivery of recommendations made by NHSE and Moorhouse governance reviews **[P]**
Integrated Performance Reporting	We have reliable information to guide decision making and improvement and provide assurance	• Delivery of NHSE Making Data Count training **[C]** • Integrated Performance Reporting delivery timeline developed **[C]** • Initial engagement sessions with internal and external stakeholders about measures and information held, with findings shared **[P]**
Accountability Framework	We have a clear understanding of the accountability which exists at every level, and authority to act is matched to accountability	• Findings from accountability survey collected **[C]** • Delivery of accountability sessions within the Leadership Summit **[C]** • Refreshed Performance Accountability Framework launched **[IP]** • Delivery of Performance Accountability comms and engagement to support take up **[P]**

KEY: **[C]** Complete | **[IP]** In Progress | **[P]** Planned

2b Strategic Improvement Theme 3 - Safety For All

SRO: Diane Hull, Chief Nurse

Where we were:

There was not one Trust-wide safety culture which everyone recognised, understood and adhered to. There was variation across the Trust in the application of safety processes which weren't always adhered to, or without sufficient governance and reporting to provide assurance.

Where we want to be:

To identify, understand and address the root cause issues which may impact on safety within the organisation. To create a safety culture which is sustainable and allows and enables safe practice and process to be fully embedded and part of everything we do.

Work Area	Objective	Our initial actions
Staffing, Supervision and Training	To ensure we have a workforce with the right, skills, training, experience and support who can deliver safe, compassionate care. This includes staffing numbers, skill mix, governance, new roles and different ways of working	• Improvements to the recruitment campaign **[C]** • Retention action plan developed **[C]** • New staff induction developed with clinical days and greater focus on safety **[C]** • Programme of work to increase Mandatory Training compliance **[IP]** • Updated template and policy for supervision/appraisals **[IP]**
Safety Culture	To create a safety culture within the Trust embedding a narrative and behaviours supported by robust processes and governance which promote the value and importance of safety for all (safety 2)	• Welcome packs with safety information and material embedded **[C]** • Safety away days with matrons and managers **[C]** • Rollout of patient safety roadshows **[C]** • Initial roll out of Storm risk training **[IP]** • Engagement and comms plan delivered for safety culture **[IP]** • Rollout of trial Safety Summits **[P]**
Physical Health	We will ensure people's physical health needs are both identified and met ensuring early detection, early intervention and promotion of good health	• Physical Health policy on a page developed **[C]** • Physical Health Education Programmes delivered **[C]** • Structure for physical health reporting established **[IP]** • Physical Health draft dashboard developed using Power BI **[P]** • Co-production of physical health care plans **[P]**
Medicines Improvement	We will ensure a consistent standard of adherence to medicines and pharmacy processes that optimise their use in a consistently safe way	• Establishment of a new medicines optimisation committee **[C]** • Creation of the 3 aligned plans (for medicines management, medicines governance and pharmacy) and programme team **[C]** • Alignment of pharmacy teams to clinical teams **[C]** • Further delivery of the medicines improvement plans **[IP]**

KEY: [C] Complete | **[IP]** In Progress | **[P]** Planned

2b Strategic Improvement Theme 4 - Changing Services to Meet People's Needs

SRO: Alex Lewis, Interim Chief Medical Officer

Where we were

The Trust had no overarching Model of Care to inform patient pathways or Standard Operating Procedures (SOPs) and there were inconsistencies across Care Groups on the level of support and information service users receive and how they were communicated with. The Trust needed to redefine and map the services it delivered and understand the gaps where other partners could support.

Where we want to be:

To develop a high level Model of Care across the Trust, which can be tailored for individual place requirements. To ensure consistency of service offer and access for service users is provided through generation of SOPs using the new Model of Care.

Work Area	Objective	Our initial actions
Model of Care	Develop a high-level Model of Care, co-produced alongside system partners, users, staff and carers	• Set up working group with defined membership and representation from relevant areas (PPL, DIALOG+, Formulation, Recovery/Safety Planning, SNOMED, QI, IT) **[C]** • Review of current transformation work to support the development of a high-level Model of Care **[IP]** • Agree with commissioners the review process for service specifications **[IP]** • Scope and catalogue specifications and SOPs, identify redundant and out of date Specs/SOPs and identify areas of duplication that could be streamlined where appropriate **[IP]** • Establish clear governance and review process to reduce inconsistency and reduce duplication **[IP]** • Reshape a vision and Model of Care for the Trust's services **IP]**
CMHT and CRHT Model Review	Reset the Community Mental Health Team (CMHT) and Crisis Resolution Home Treatment (CRHT) service models	• Identification whether we have the right services in the right places. Focusing on existing data sources about people with severe mental illness, those falling through gaps, wider sociodemographic indicators and outcomes **[IP]** • Identification and description of the range of services offered, which statutory services have a mental health offer in each PCN, including relevant services offered by other NHS providers and VCSEs **[IP]** • Mapping of information obtained from data sources. In addition to existing "know-do" gaps (i.e. gaps between what we know and what we do in practice), identify and describe social care assets in each PCN **[IP]** • Co-production of a working strategy, which is data-driven, serving as a road-map to monitor change/desired impacts and reinforce areas that are working well **[IP]**

KEY: [C] Complete | **[IP]** In Progress | **[P]** Planned

2b Strategic Improvement Theme 5 - Timely Access

SRO: Thandie Matambanadzo, Chief Operations Officer

Where we were:

Teams did not have a recognised or standardised approach to analyse data on demand and capacity to support decision making. A lack of consistent practice made analysis of productivity and delivery data more challenging. Variation in resourcing and waiting list management impacted on the optimum management and reporting of those waiting for services.

Where we want to be:

To ensure the Trust can adequately manage and reduce demand, match demand with capacity and increase capacity where necessary, all underpinned by timely, accurate data. To refresh processes so staff are in the right place at the right time and clear on their roles to enable effective waiting list management and patient flow.

Work Area	Objective	Our initial actions
Demand and Capacity	To develop demand and capacity models and Power BI dashboards as a key tool to aid decision making	• Joint work with Norfolk CFYP demand and capacity team to continue communication links and support **[C]** • Attendance at Mental Health Improvement System Support Team (MHISST) programme of support for Elective Recovery webinars **[IP]** • Validation of activity data and further communication with additional interested teams **[IP]** • Data dictionary definitions developed and agreed **[IP]** • Development of demand and capacity training/support package, demand and capacity model and dashboard **[IP]** • Training event dates to be released when Power BI is live alongside further developing D&C training page to support uptake **[P]**
Rostering	Ensure right staff are in the right place at the right time	• Revised annual leave policy **[C]** • SafeCare fully rolled out **[C]** • Roll out of e-roster, with 80% of clinical staff on e-roster in September **[IP]** • To improve compliance with recording of unavailability to reduce 'working day unavailability' **[IP]**
Job Planning	Ensure that staff have job plans so that they are clear around role expectations	• Meeting with clinical directors to set Trust target for job planning informed by benchmarking exercise of local providers **[C]** • Train the trainer programme for the medic-on-duty system **[C]** • Programme of work to review, complete and sign off job plans for all staff groups, including specific support for clinical directors to improve capacity and reduce variation **[IP]**

KEY: **[C]** Complete | **[IP]** In Progress | **[P]** Planned

Section 3:
How do we know we are making a difference?

This section sets out:

Feedback from staff and service users participating in our Quality and Safety Reviews (QSRs), highlighting both improvements made and areas for further work building on what we are already doing.

At a glance...

- Our Improvement Programme approach means that we are working differently to assure ourselves that our improvements are impactful and have positive benefit for staff and service users.
- Following the CQC visit in December 2021 our QSR process has been enhanced to test how we have addressed the concerns set out in the S29A notice. We have undertaken over 100 QSRs since the CQC visit, with broadened multi-professional and stakeholder engagement. We have targeted our focus particularly on service areas of concern, undertaking rapid review cycles to ensure opportunities for improvement have been identified and delivered.
- Our work will continue in Phase 2 of our Improvement Programme from October 2022, building on the improvements we have delivered to date in response to staff and service user feedback.

3a Staff feedback from our QSRs

Areas of good practice

- Staff felt well supported and valued, receive support to complete mandatory training, and can access development opportunities.
- Governance - Staff feel comfortable raising concerns and receive immediate managerial support.
- Risk management - staff describe there being good risk management, escalation and debrief processes.
- Strengthened ligature management and mitigation processes.
- Staff receive LMS and clinical supervision and appraisal.
- Staff understand the value and process of therapeutic observations.

3a Staff feedback from our QSRs

Areas for improvement

Some staff reported inconsistent experience of induction when joining the Trust
Our action: We have completely refreshed our induction processes, which launched on 4 July with 182 new starters attending by the end of August 22. The programme has had positive feedback and will be enhanced through the addition of further training modules.

Staff queried whether our ESR data accurately reflected those appraisals undertaken
Our action: We have cleansed ESR data including correcting of hierarchies, to improve the accuracy of compliance reports. Weekly reports are provided via the intranet to give a team and Trust-level view of appraisal rates, including live information for all supervisors of the compliance for their direct reports.

Staff were concerned about staffing levels and staff retention, including that for medical staff
Our action: We have ensured that safest staffing levels are met for all shifts. We have increased recruitment, with 170 further staff in post than last year. We have recruited into medical vacancies, with mitigations in place for especially hard to recruit to posts – for example in medical support to the Crisis Team in West Suffolk. We have developed staffing heatmaps to monitor of areas of concern.

Staff in community teams were concerned about their caseload numbers and the size of waiting lists
Our action: We have developed a Trust-wide Adult Community Services Waits Improvement Programme, supporting teams to take actions to reduce waiting list numbers, decrease pressure on caseloads and improve support to service users waiting for treatment. We have increased our recruitment to community teams and will continue to work to reduce vacancies and improve staff retention.

3a Service User feedback from our QSRs

Areas of good practice

- Service users and carers in the main explained that staff are compassionate, kind and caring in their approach.
- Most service users and carers knew who to contact in the case of an emergency.
- Service users spoke positively about activities programmes on the wards.
- Service users generally felt that their physical health needs were being addressed on inpatient wards.
- Service users thought there was infrastructure in place to capture service user and carer feedback.

3a Service User feedback from our QSRs

Areas for improvement

Service users had varied experiences with regards to care planning
Our action: Consistency is assured via the Care Process Audit (CPA) which is carried out monthly on inpatient wards with ward staff and Governance teams. Consistency has improved, with overall Trust-wide compliance at 90% for Care Processes (July 2022) an increase from 81% in March 2022. Further work is required in this area which will include a focus on our community teams.

Service users were concerned about waiting times for treatment for Adult Community services
Our action: We have reviewed our Clinical Harm Policy to ensure we are safely supporting people on waiting lists. This revision has taken into account staff and patient feedback. Our programme to reduce waits in Adult Community services will reduce waiting list times, as well as improve triage so that those requiring the most immediate support receive it. This is a significant programme of work.

Service users had varied experiences with regards to signposting to local support groups
Our action: Within the Community Transformation Programme asset mapping has begun to determine what is on offer outside of NSFT services and the approach to signposting to these organisations. We are working with commissioners to develop a directory of organisations across Norfolk and Suffolk to raise awareness of these alternative services and how best to signpost to them.

Service users receiving inpatient care requested more 1:1 time with staff
Our action: We ensure that we work to, and exceed where possible, safest staffing levels in all inpatient settings. This has been improved through recruitment of 170 additional staff compared to last year to support improved patient to staff ratios. We recognise that we have more to do, and are continuing with our recruitment and retention programme to reduce vacancies further.

Glossary of terms

CQC – The Care Quality Commission is the independent regulator of health and adult social care in England

Datix – A system for recording incidents

DIALOG+ – An outcomes measure to support structured conversation between service users and clinicians, focusing on the servicer users' views of quality of life, needs for care and treatment satisfaction.

EDI – Equality, Diversity and Inclusion

ePMA – Electronic Prescribing and Medication Administration

Evidence Assurance Group – Learning from best practice, the group is made up of partners to test the strength of evidenced from NSFT

HDAT – High Dose Antipsychotic Therapy

ICT – Information and Communication Technology

MAST – Mandatory and Statutory Training

NICE – National Institute of Clinical Excellence

NHS England – NHS England leads the National Health Service (NHS) in England

PCN – Primary Care Network

PMA – Prevention of Management and Aggression training

PowerBI – Software designed to enable data to be better used and understood

PRN medication – As-needed medication.

QI – Quality Improvement interventions focus on patients and are driven by developing truly service user-centred care.

QPMs – Quality and Performance Meetings, held with each Care Group

RSP – The Recovery Support Programme is intensive and targeted help from NHS England.

SafeCare – Daily staffing software, used widely throughout the NHS, matches staffing levels to patient acuity

Schwartz rounds – Facilitated meetings for healthcare staff to reflect on emotional aspects of their work.

Section 29A – The CQC serve a warning notice under Section 29A of the Health and Social Care Act 2008 when concerns are identified across either the whole or part of an NHS trust or NHS foundation trust. It means there is a need for significant improvements in the quality of healthcare.

SNOMED – Systematized Nomenclature of Medicine is a standardised, multilingual vocabulary of clinical terminology used by physicians and other healthcare providers for the electronic exchange of clinical health information.

SOP – Standard Operating Procedures

SRRS – Suffolk Rehabilitation and Recovery Service

T2/T3 – These list all the psychiatric medication that can be given either on a form T2 (patient consents) or on form T3 (no consent)

NHS
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Operational Performance Report

22 September 2022

NHS
Norfolk and Suffolk
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Developing an Integrated Quality and Performance Report

NSFT is integrating its quality and performance reporting. The aim is to have the new report fully in place by January 2023.

Background

Norfolk and Suffolk NHS Foundation Trust is working with NHS England to create an integrated quality and performance reporting system. Previously, Trust reporting had not been robust enough to support executive and non-executive directors in scrutinising service quality. The aim of integrating quality and performance reporting is to create a single version of the truth which is used to inform improvements at all levels of the organisation and within the two integrated care systems in which we operate.

Report Structure and Use

The integrated quality and performance report will be presented to the Trust Board on a bi-monthly basis and will include key measures across the four domains of Quality & Safety, Operational Performance, Workforce and Finance/Use of Resources. The measures will reflect those included in the Care Quality Commission's Intelligent Monitoring System and Insight Model alongside other measures that are important to the Trust and its service users. The accompanying narrative will transition to focus on exception reporting which will enable the Board to quickly determine areas of challenge, excellence and improvement as well as identifying where working groups are required to address areas of concern.

The same integrated reporting structure will be mirrored at all levels of the organisation, representing a significant change to the current reporting systems that are in place.

April 2022 – June 2022

Phase 1: Initiate

- Care Quality Commission report published
- Roll-out Board and wider education programme on Making Data Count approach using Statistical Process Control (SPC)
- Develop plan for integrating quality and performance (Q&P) reporting
- Develop prototype Integrated Quality and Performance Report (IQPR)
- Evidence scan of best practice

July – August 2022

Phase 2: Design

- Continue education programme
- External review and recommendations on use of exceptions-based and integrated reporting from "Floor to Board"
- Identify core measures for **Operational Performance** & **Workforce** domains and develop SPC charts
- Develop IQPR format
- Develop new reporting cycle

September - October 2022

Phase 3: Test

- Develop and recruit to Q&P improvement function
- Identify core measures for **Quality and Safety** & **Finance** domain and develop SPC charts
- 1st iteration of IQPR submitted to FBIC (14/09) and Board (22/09)
- Roll-out new Q&P reporting cycle

1st iteration delivered to Trust Board

November - December 2022

Phase 4: Implement

- 2nd iteration of IQPR submitted to Trust Committees and Board (inclusive of all domains)
- Making data count format/style by November
- NHSE to NSFT transition plan enacted

2nd iteration delivered to Trust Board

January 2023

Phase 5: Outcome

- 3rd iteration of IQPR submitted to Trust Committees and Board
- IQPR stable, though subject to continuous improvement with annual review and KPI refresh
- Transition to NSFT ownership
- Decommissioning of other reports

3rd iteration delivered to Trust Board

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Contents

Operational Performance | Overview | September 2022 *(July 2022 data)*

Introduction

- The operational performance section of the report provides a strategic overview of performance across key service areas. Each service area includes a small number of Trust-wide measures, together with a narrative to describe performance, challenges and actions. Where especially relevant to overall performance, we have drawn attention to areas of underperformance or exceptional achievement within specific Care Groups. The appendices contain information on using Statistical Process Control (SPC). Narrative to explain performance is contained in the overview under each measure within the relevant section.

Operational service updates

- **Crisis response:** The Trust continues to not meet the overall 4-hour crisis referral to assessment (RtA) target. The Psychiatric Liaison RtA targets are also not being met across the Trust, although performance is at 90.6% for the 24-hour target for referrals outside of the emergency department (ED). More significant challenges are being seen for the 1-hour target for referrals from the ED, where performance is consistently low across the trust (64.1% in July) but especially in Norfolk & Waveney (55.6% in July). This is as a direct result of high demand for the service, recruitment and retention issues, and site challenges around assessment space. Work is urgently needed to further analyse the underlying issues and redesign services to better meet patient need.
- **Inpatient flow:** Inpatient bed occupancy across the Trust is high, with an average of 94.1% in July 2022. This is due to several factors including high levels of service users with complex needs. To manage admissions and length of stay as effectively as possible in the approach to winter, all Care Groups will be reviewing long stay inpatients to establish if there are more appropriate care environments available to meet their needs.
- **Community waiting lists:** The overall community waiting lists for assessment and treatment are increasing and performance against community waiting list targets continues to be challenged. Based on a snapshot of data on 31/07, the total number of service users that were waiting more than 18 weeks for treatment across the Trust was 2,407 (34% of all people waiting at this time). Based on an analysis of the data since January 2021, there has been a statistically significant increase in the number of service users breaching the 18-week RTT target. There is however variation across Care Groups; 58.9% of breaches were caused by Youth/CAMHS and Memory Assessment teams in Norfolk & Waveney. There are known data quality issues which, once addressed, are expected to improve the position.
- **72-hour follow-up:** The percentage of service users being followed up within 72 hours of discharge from an inpatient ward continues to be favourable, with the Trust consistently exceeding the national 80% target. This reflects continued work across all Care Groups to sustain improvements and ensure reliable follow-up and contact.
- **Improving Access to Psychological Therapies (IAPT):** IAPT services continue to see fluctuating referral numbers. Performance against the national access standard is inconsistent on a month-to-month basis although the cumulative in year target is being met by the Trust. In Norfolk & Waveney, an improvement approach is being developed to increase flow through services with the aim of reducing overall waiting list size. An intervention being tested is the development and targeting of marketing to increase awareness of the full IAPT service offer. In Suffolk, an access strategy group has been convened with regular reporting/challenge sessions in place with the ICB. IAPT services in Norfolk & Waveney and Suffolk services are consistently achieving recovery targets. Recovery rates and rates of non-recovery are reviewed throughout the month and all targets compared against national benchmarks monthly to ensure any issues are picked up proactively.

Operational Performance | Overview | September 2022 *(July 2022 data)*

- **Children's, Young Person's and Families Services (CYFPS):** The Trust's CYFPS continue to see a rise in the number of crisis and community referrals across Norfolk & Waveney and Suffolk services. Services continue to report increases in children and young people presenting in the urgent care pathways and a higher proportion of young people with autism and learning disabilities. These service users are more complex cases with higher levels of risk, requiring liaison work with social care, schools and partner agencies and therefore take longer to assess. This has impacted capacity and waiting times within services although improvement work is underway to address these challenges, implementing multi-agency approaches to improving access and care delivery. Recruitment remains a barrier to mobilising new investment and improvements. The Trust continues to see underperformance across its Eating Disorder services and a high DNA rate among service users. Average waiting times for urgent and routine referrals have increased over the past year, although there has been a recent decrease which will be monitored. Work is underway to diagnose the issues driving underperformance which will be reviewed at quality and performance meetings. An improvement plan will be developed for CYPFS in the next reporting period and submitted to FBIC for review.

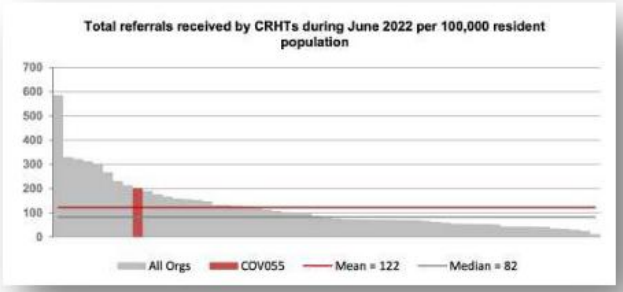
Cross-cutting operational improvement priorities:

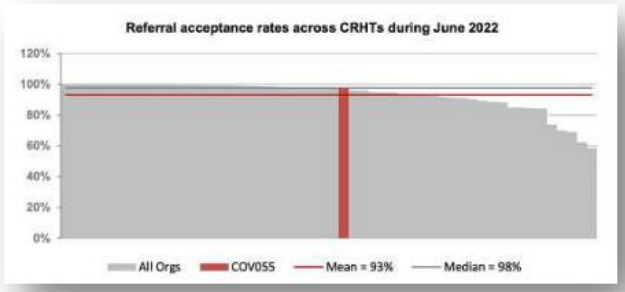
Improvement area	Current state	Planned actions
Winter planning	Winter planning has commenced within the Norfolk & Waveney and Suffolk systems for 2022/23. the Trust has an established understanding of staffing level requirements for services during busy winter periods. However, sickness levels have varied within accepted tolerance levels in recent years.	As part of our planning, we are commencing work to plan for seasonal sickness levels, ensure executive cover is always provided 24/7 on site or via the Trust's On Call system and ensure contingency plans are in place to manage short term sickness absence in services. Staff and service users will also be encouraged to participate in vaccination campaigns.
Strengthening Care Group governance	A review has been completed of governance arrangements within and across Care Groups.	Work is now underway to strengthen governance at Care Group level, including through development and deployment of a "Care Group Governance Toolkit" and education programme. A redesigned set of quality and performance review meetings and reporting mechanisms will also be rolled out in September to reflect plans to develop its integrated quality and performance reporting infrastructure.
Performance improvement team	A review of the Operations Directorate is being completed to ensure that the right resources and infrastructure are in place to drive quality and performance improvements.	Using existing resources, recruitment is underway to 4 x posts to create a small performance improvement function. The purpose of this team is to act as a vehicle to support data driven change across Care Groups, working closely with informatics to develop and maintain quality and performance reporting arrangements to enable strong lines of accountability.
Waiting list improvement	A review has been completed of community waiting lists, identifying areas of underperformance driven by variability in processes, systems and practices within and across Care Groups.	The Trust will be taking forward recommendations through a task and finish group. There has been progress in reducing waiting lists and backlogs across several services including East and West Suffolk's adult and older people's services and work is underway to share and spread best practice. An improvement programme on flow is needed to support improvements on waiting lists, including through better management of demand and redesign of pathways.
Demand and capacity	Benchmarking analysis shows Trust referrals continue to be above the national average for adult and older adult patients. Data from June gives 565 per 100k population against a national average of 376.	The following benchmarking slides contain more information on benchmarking analysis available to the Trust and identifies key action areas. Support is being secured from NHSE to enable demand and capacity analysis to be undertaken across services.

Operational Performance | NHS Benchmarking Network (June 2022)

These two slides provide an extract of NSFT's information from the NHS Benchmarking Network which details an analysis of demand, capacity and activity within mental health services, refreshed with the latest data from April to June 2022.

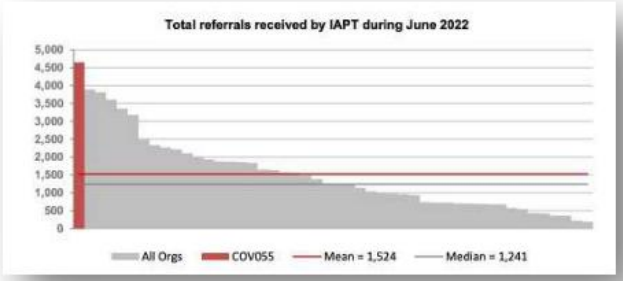
Crisis Resolution and Home Treatment

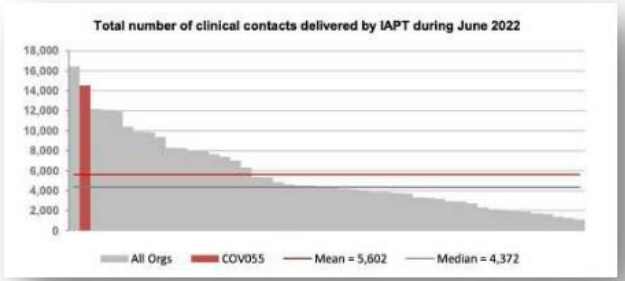




Crisis Resolution and Home Treatment (CRHT) teams have seen referral rates rising, although levels of demand continue to remain below pre Covid rates. Total referrals received by CRHTs during June 2022 were relatively high at 201 compared to a national average of 122 per 100,000 resident population. Referral acceptance rates across CRHTs during June 2022 were 97% compared with a national average of 93% per 100,000 resident population.

Improving Access to Psychological Therapies (IAPT)



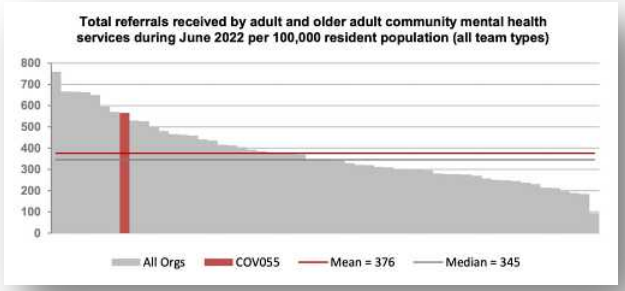


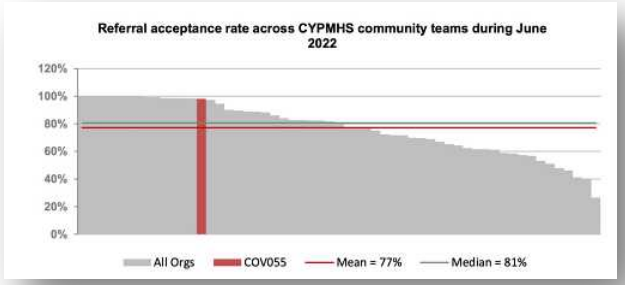
The total number of referrals received by IAPT during June 2022 remains positive and was the highest of participating MH providers. Total number of clinical contacts delivered by IAPT during June 2022 were the second highest.

Source: NHS Benchmarking Network - Mental Health, Learning Disability & Autism Services Tracker April to June 2022

Operational Performance | NHS Benchmarking Network (June 2022)

Community mental health services

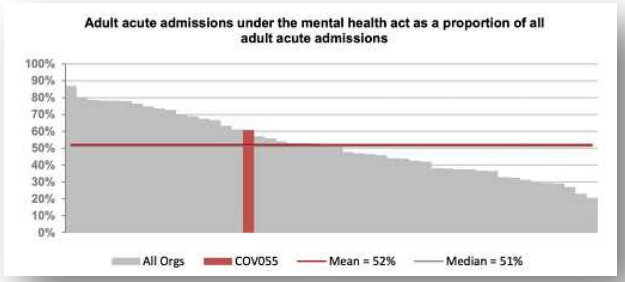




Total referrals received by NSFT adult and older adult community mental health services during June 2022 were high at 565 compared to a national average of 376 per 100,000 resident population. Referral acceptance rates were also above average at 95% compared to an average of 86% per 100,000 resident population. Total referrals received by Children's Young Person's Mental Health Service (CYPMHS) community teams were also high at 455 compared with a national average of 379 per 100,000 resident population. Referral acceptance rates across CYPMHS community teams were high at 98% compared with a national average of 77% during June 2022.

Inpatient flow

Overall admission rates to adult acute inpatient units remained below historic levels, although demand has gradually been recovering. Increased levels of patient acuity are highlighted by the proportion of patients detained under the Mental Health Act (as a % of all admissions to services), which accounted for more than half (61%) of admission numbers within the Trust in June 2022.



The number of adult acute beds were at 21.6 against an average of 20.4 per 100,000 resident population. Bed occupancy was low during June 2022 at 79% although latest information from informatics suggests this has recovered to a high occupancy rate. Benchmarking information on admissions and discharges was incomplete although more current information is available in this report.

Source: NHS Benchmarking Network - Mental Health, Learning Disability & Autism Services Tracker April to June 2022

Next Steps

- **IQPR/Benchmarking**: the NHS Benchmarking Network's second return is being completed for Q2. Consideration should be given to including benchmarking information as part of future IQPRs. While data is largely focused on operational performance, benchmarking information is also available in other areas – for example, annual cost per inpatient bed and sickness rates.
- **Demand and capacity**: benchmarking analysis suggests that Trust referrals continues to track above the national average of total referrals for adult and older adult patients and children and young people. Demand also remains high for crisis and other core mental health services suggesting that urgent work may be needed to analyse current demand levels with system partners and model future demand to ensure services are right sized for patients and service users.
- **Care Group reviews**: Work is underway to compare different approaches to referral acceptance with a view to adopting a standard approach. A long LoS analysis will also be undertaken to identify flow improvement opportunities.

Operational Performance | KPI Summary

Operational performance requirements are outlined by four main service areas. The measures included in this report are on a Trust-wide basis, although Care Group-specific detail is drawn into the narrative where relevant.

Referrals, Crisis Service Access & Waiting Times

Metric ID	Metric	Value	Variation	Assurance	Target	Mean
OP54	New Referrals	10603				11,652
OP61	Crisis RtA - Emergency 4 hr	87.3%			95%	85.5%
OP28	Psych Liaison - RtA Emergency 1 hr	64.1%				67.4%
OP29	Psych Liaison - RtA Routine 24 hr	90.6%			95%	91.5%

Improving Access to Psychological Therapies

Metric	Value	Variation	Assurance	Target	Mean
Access	3313			3,959	3495
6 week wait	98.5%			75%	94.0%
18 week wait	100.0%			95%	99.9%
Recovery	51.3%			50%	53.4%

Secondary Care Access & Waiting Times

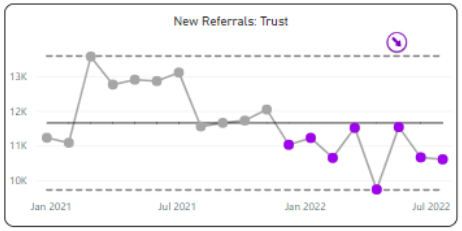
Metric ID	Metric	Value	Variation	Assurance	Target	Mean
OP12	RtA - Routine 28 days	71.1%			95%	73.6%
OP01	EIP Access & Wait Time Standard	67.4%			60%	71.0%
OP13	RtT within standard	90.1%			95%	91.5%
OP15	U19 Eating Disorders - RtT Urgent 1 wk	52.5%				62.3%
OP16	U19 Eating Disorders - RtT Routine 4 wk	62.8%				66.4%

Inpatient Flow

Metric ID	Metric	Value	Variation	Assurance	Target	Mean
OP57	Inpatient Admissions	163				192
OP58	Inpatient Discharges	161				191
OP20	Delayed Transfer of Care (DToC)	4.89%			8%	5.84%
OP09	Inappropriate OAPs - bed days	394			0	385
OP09i	Inappropriate OAPs - SU admissions	22			0	36.2
OP60	72 hour follow up	85.4%			80%	87.0%
OP21	Inpatients with annual PH check	98.7%			100%	99.4%

*Data Quality: Trust Informatics are working to overcome technical and data quality issues with specific measures which have been left out in this version. Delayed metrics include **OP09iii**: Inappropriate out of area placements (average LoS of discharges) for adult mental health services, **OP09iv**: Inappropriate out of area placements (average LoS of service users still out of area) for adult mental health services and **OP14**: Referrals awaiting treatment >18 weeks. Given their importance, the Informatics team are working to see if these can be included prior to Trust Board.*

Operational Performance | Community Services | Referrals, Crisis Service Access & Waiting Times



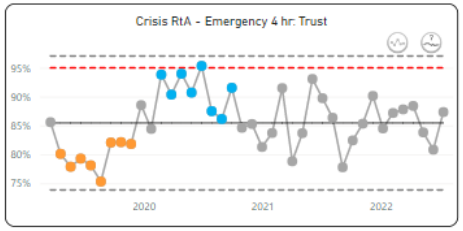
Grouping	Value	Var.	Ass.	Target
Trust	10603			
Norfolk & Waveney	6513			
Suffolk	3259			

Metric Definition & Context
Internal and external referrals are included within the New Referrals figures.

Summary
Following a year of heightened referral numbers in 2021, new referrals maintained their lower trend.

In spite of this trend, benchmarking analysis suggests that NSFT referrals continue to track above the national average of total referrals for adult and older adult patients as well as having a higher acceptance rate than the national average. The June 2022 position is 565 per 100k health population against a national average of 376 per 100k.

Urgent work is needed with system partners to analyse current demand and model future demand to ensure services have capacity for patients and service users.



Metric	Grouping	Value	Var.	Ass.	Target
Crisis RtA - Emergency 4 hr	Trust	87.3%			95%
U18 Crisis RtA - Emergency 4 hr	Trust	100%			95%
18+ Crisis RtA - Emergency 4 hr	Trust	86.8%			95%

Metric Definition & Context
'RtA' denotes the waiting time between referral and assessment.
Crisis RtA - Crisis team 'referral to treatment' eligible episodes which were classed as emergency by NSFT when they first attended assessment contact.

Summary
The Trust continues to not meet the overall 4-hour crisis referral to assessment (RtA) target. Although data shows performance of 100% for U18 in July 2022, performance for 18+ is below the target at 87%.

Performance in East Suffolk (79%) and Great Yarmouth and Waveney (85%) was below average.

In East Suffolk, this was caused by data errors, which are being mitigated by the introduction of a data analyst in September.

In Great Yarmouth and Waveney, only 2 of the 5 breaches were due to lack of capacity to assess, with the other 3 due to patient choice in situations where it was safe and clinically appropriate.

Grouping	Value	Var.	Ass.	Target
Trust	64.1%			
Norfolk & Waveney	55.6%			90%
Suffolk	77.7%			95%

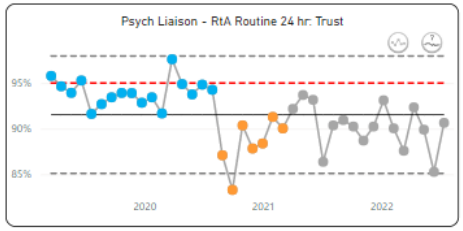
Metric Definition & Context
'RtA' denotes the waiting time between referral and assessment.

Psych Liaison – Attended contacts to a Psychiatric Liaison team where Emergency refers to referrals from an A&E department and Routine as from any other source.

Summary
Significant challenges are being seen for the 1-hour target for referrals from the ED, where performance is consistently low across the Trust (64% in July) but especially in Norfolk & Waveney (56% in July).

A critical problem area was North Norfolk and Norwich, with a performance of 31% in July. Causes of this low performance include a number of process challenges – for example, inappropriately timed referrals. An issue with referrals prior to patients being ready to assess was also raised in Great Yarmouth and Waveney, where patients are referred early to alert the team to upcoming demand.

West Suffolk (72%) and East Suffolk (83%) also performed below target, with contributory factors including high demand across the area, and a lack of assessing space in East Suffolk meaning that only one person can be assessed per hour.



Grouping	Value	Var.	Ass.	Target
Trust	90.6%			95%
Norfolk & Waveney	88.0%			95%
Suffolk	96.9%			95%

Metric Definition & Context
'RtA' denotes the waiting time between referral and assessment.

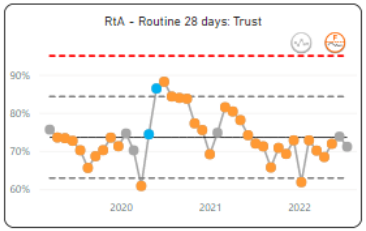
Psych Liaison – Attended contacts to a Psychiatric Liaison team where Emergency refers to referrals from an A&E department and Routine as from any other source.

Summary
The Psychiatric Liaison RtA targets are not being met across the Trust, although performance is at 90.6% for the 24-hour target for referrals outside of the Emergency Department.

Performance remains static with the Trust not meeting the 95% target. Performance is consistently challenged within North Norfolk and Norwich, which in July assessed 81% of routine cases within 24 hours. The two main contributory factors to this were a lack of staffing capacity within the team and a lack of physical fitness from service users.

NHS
Norfolk and Suffolk
NHS Foundation Trust

Operational Performance | Community Services | Secondary Care Access & Waiting Times

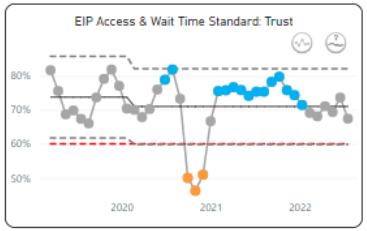


Metric	Value	Var.	Ass.	Target
RtA - Routine 28 days	71.1%			95%
U18 RtA - Routine 28 days	49.8%			95%
18+ RtA - Routine 28 days	75.3%			95%

Metric Definition & Context
RtA Routine 28 days - referral to assessment eligible episodes which were classed as non emergency (Urgent & Routine) by NSFT on the first attended assessment contact.

Summary
28-day routine referral-to-assessment targets in the Trust continues a long-term trend of underperformance. Over-18s are closer to the target, at 75%, whereas under-18s are critically below the target at 50%.

In West and South Norfolk, where performance is at 60%, this is due to significant shortages of Senior Band 6 staff who complete assessments. Recruitment is a priority and is ongoing.

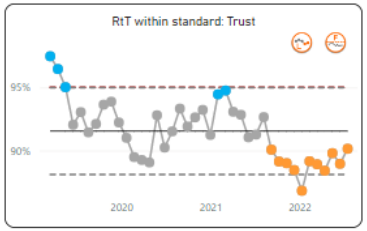


Grouping	Value	Var.	Ass.	Target
Trust	67.4%			60%
Norfolk & Waveney	56.7%			60%
Suffolk	87.5%			60%

Metric Definition & Context
EIP – Early Intervention in Psychosis. This metric is reported as a rolling 3-months performance showing patients who begin treatment within 2 weeks of referral.

Summary
Early Intervention in Psychosis standards continue to be met at Trust level.

In Norfolk and Waveney, there has been a slight downturn in performance against the 60% standard. Difficulty engaging service users has led to a high number of DNAs. As mitigation, deep dives are undertaken for areas of underperformance and work is being undertaken to improve service user contact and use of data. Teams have started assigning experienced staff to the triage role, decreasing referrals accepted for assessment by 50%.

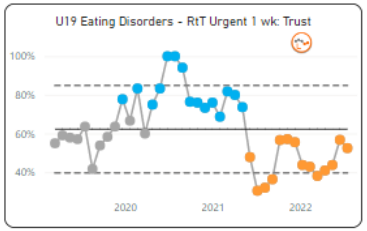


Metric	Value	Var.	Ass.	Target
RtT within standard	90.1%			95%
U18 RtT within standard	66.2%			95%
18+ RtT within standard	94.5%			95%
Adult Community	95.9%			95%
Dementia/Later Life	96.4%			95%
CFYP	78.0%			95%

Metric Definition & Context
RtT – Referrals to Treatment within Standard. Where Standard means; 15 weeks or less in Suffolk, 18 weeks or less for 18 and Over in Norfolk & Waveney and 12 weeks or less for Under 18s in Norfolk & Waveney.

Summary
Referral-to-treatment within standard timeframes remains below the target. The under-18 target has a particularly low performance of 66%, although over-18s have a much more positive picture, being on-track with 95%.

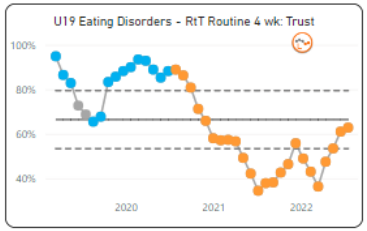
In Norfolk and Waveney CFYP, the target has not been met at any point within the last 24 months and current performance is at 56%. Waiting list initiatives are in place with various partners currently providing input to over 200 waiting young people.



Grouping	Value	Var.	Ass.	Target
Trust	52.5%			
Norfolk & Waveney	76.9%			95%
Suffolk	40.7%			86%

Metric Definition & Context
RtT – Referrals to Treatment within Standard. Where Standard means; 15 weeks or less in Suffolk, 18 weeks or less for 18 and Over in Norfolk & Waveney and 12 weeks or less for Under 18s in Norfolk & Waveney.

The Eating Disorder metrics are reported as rolling 3-month performance.



Grouping	Value	Var.	Ass.	Target
Trust	62.8%			
Norfolk & Waveney	60.5%			95%
Suffolk	65.7%			91%

Metric Definition & Context
RtT – Referrals to Treatment within Standard. Where Standard means; 15 weeks or less in Suffolk, 18 weeks or less for 18 and Over in Norfolk & Waveney and 12 weeks or less for Under 18s in Norfolk & Waveney.

The Eating Disorder metrics are reported as rolling 3-month performance.

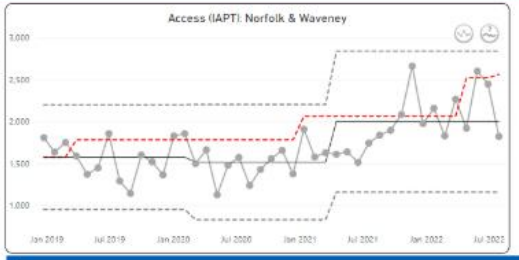
Summary
The Trust continues to see underperformance across its Eating Disorder services. Average waiting times for urgent and routine referrals have increased over the past year, although there has been a recent decrease which will continue to be monitored.

In Suffolk, performance is low among both urgent (31%) and routine (66%) cases. Numbers receiving active treatment remains high, directly impacting available assessment capacity with team members offering both clinical assessment and treatment. Suffolk is working with commissioners to review progress against access targets as all parties recognise a lack of resource to meet current and increasing demand. Suffolk have raised issues with data quality / capture which may be impacting their performance metrics, and work is being undertaken to ensure this is resolved.

Norfolk's performance is generally higher, although still below target. Both systems find patient availability to be a problem with waiting time breaches most often being due to DNAs, cancellations or appointments within timeframe being declined by patients.

Operational Performance | Community Services | IAPT

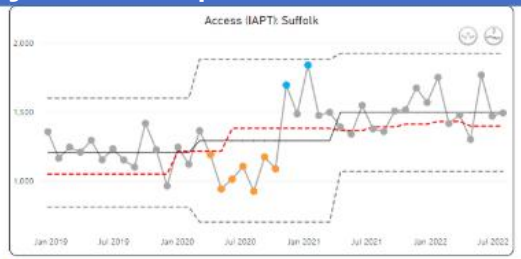
Jul 2022
1822
Variance
Common cause variation, NO SIGNIFICANT CHANGE.
Target
2563
Assurance
This process will not consistently HIT OR MISS the target as the target lies between the process limits.



Summary
The service is not consistently meeting the national KPI on a month-by-month basis. Performance in July 2022 was significantly below target (1822 against a target of 2563). There are concerns that the low referral rate in July 2022 will have a negative impact on August targets.

A QI approach is being used to increase flow through the service to reduce waits as this may impact referrals and service perception, consultant also brought in to also focus on flow, targeted marketing to increase awareness of full IAPT offer.

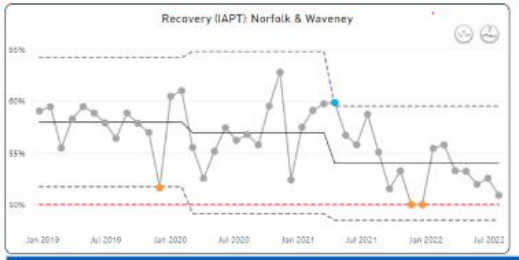
Jul 2022
1491
Variance
Common cause variation, NO SIGNIFICANT CHANGE.
Target
1,396
Assurance
This process will not consistently HIT OR MISS the target as the target lies between the process limits.



Summary
The service is not consistently meeting the national KPI on a month-on-month basis although the cumulative in year target is being achieved. Concerns raised that there is a risk of unintended reduced access with the movement of the mental health linkworkers from Wellbeing.

An Access strategy group has restarted in the service. Close working with adult community services in Suffolk to ensure accountability for enabling access is included in performance meetings with the ICB.

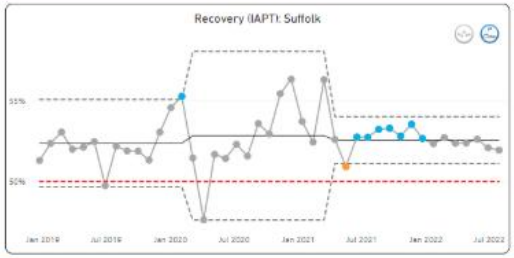
Jul 2022
50.9%
Variance
Common cause variation, NO SIGNIFICANT CHANGE.
Target
50%
Assurance
This process will not consistently HIT OR MISS the target as the target lies between the process limits.



Summary
Although the service has consistently achieved the recovery target, the target is now within process limits making it likely that there will be some underperformance over time.

Recovery rates are reviewed throughout the month and all targets compared against national benchmarks on a monthly basis to ensure any issues are picked up proactively.

Jul 2022
51.9%
Variance
Common cause variation, NO SIGNIFICANT CHANGE.
Target
50%
Assurance
This process is capable and will consistently PASS the target if nothing changes.

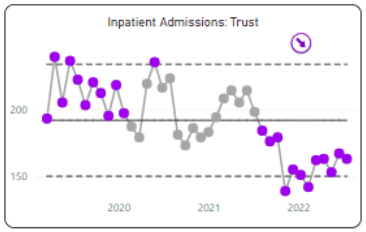


Summary
The service consistently exceeds the recovery target. The recovery rates are reviewed throughout the month and all service metrics are compared with national benchmarks on a monthly basis to ensure any variations to national performance is picked up proactively.

Metric Definition & Context
Metric definitions are being sought and will be included in the next iteration of this report.

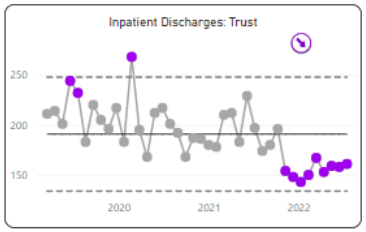
Metric Definition & Context
Metric definitions are being sought and will be included in the next iteration of this report.

Operational Performance | Inpatient Flow



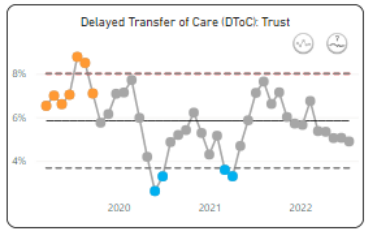
Group	Value	Var.	Ass.	Target
Trust	163			
Norfolk & Waveney	83			
Suffolk	77			

Metric Definition & Context
Inpatient admission in monthly period.



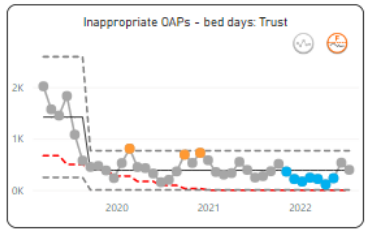
Group	Value	Var.	Ass.	Target
Trust	161			
Norfolk & Waveney	83			
Suffolk	76			

Metric Definition & Context
Inpatient discharges in monthly period.



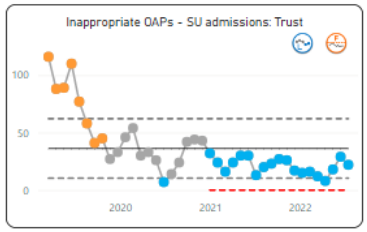
Group	Value	Var.	Ass.	Target
Trust	4.89%			8%
Norfolk & Waveney	7.72%			8%
Suffolk	2.28%			8%

Metric Definition & Context
DToC - A patient is defined as being ready for transfer when a clinical decision and multidisciplinary team have both deemed the patient ready for transfer and when the patient is safe to discharge/transfer. A patient becomes delayed when these conditions are met yet remains in hospital. The DToC metric measure the number of bed days rather than the number of patients.



Group	Value	Var.	Ass.	Target
Trust	394			0
Norfolk & Waveney	249			0
Suffolk	142			0

Metric Definition & Context
OAP – The number of inappropriate Out of Area placements, shown from a bed days and service user perspective.



Group	Value	Var.	Ass.	Target
Trust	22			0
Norfolk & Waveney	13			0
Suffolk	8			0

Metric Definition & Context
OAP – The number of inappropriate Out of Area placements, shown from a service user admissions perspective.

Summary
Despite an apparent decrease in overall demand for inpatient beds over the last two years, there has been an increase in the complexity of individuals admitted. The number of inpatient discharges has remained relatively static in recent months however there has been a significant decrease in discharges over the last two years. Suffolk have been impacted by the end of S75 agreement. The Trust also went into critical incident on 31 August 2022.

A number of priority actions and mitigations are underway:

- Central crisis response medics started to support MDT working and decision making, anticipated to reduce number of informal admission referrals.
- Work to be completed with the W Suffolk MH Liaison Team around difficult conversations for individuals where NICE guidelines recommend community support. Discussions through winter planning to look at Suffolk alternative to admission resource
- Work to be completed to understand the impact of S75 ending on patient flow using data and qualitative feedback.
- As of 1.9.22 daily flow meetings on Hellesdon site to support MDT decision making and improved flow. Part of CI response but likely to remain.

Summary
DToC figures across the Trust remain under the 8% target, however internal NSFT work has identified that DToCs are not always recorded in a timely manner which may cause an under reporting of the figures.

There is a specific system wide working group looking at DToC challenges resulting in improved systems and communications therefore reducing DToCs and their impact.

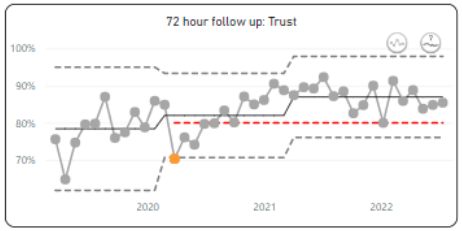
Summary
Inappropriate OAP bed days continue to fluctuate, although within the parameters of common cause variation. Due to a critical incident in the NW system, and NSFT's own internal pressures on flow, more challenged performance is anticipated for August 2022.

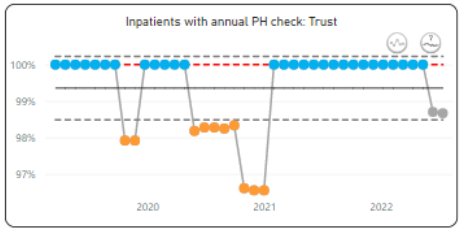
Female PICU beds and Norwich Priory (PN) for NW are not included in the inappropriate OAP figures due to the closure of Rollesby ward and PN as continuity of care principles are in situ by agreement with the ICB and NHSEI. The same agreement is not in place for SNEE.

A number of priority actions and mitigations are underway:

- Introduction of OOA protocol to support consistent and senior decision making, particularly for out of hours, as agreed by the Trust Executive team
- Joint working with Community Transformation (NSFT and system level) to understand the wider influencing factors on the increased demand and therefore increase in OOA use to maintain clinical safety. Including deep dive of UEC pathway presentations and sharing of key themes to support the prioritisation of the Community Progamme
- QSR process in place to ensure quality of placements and service user feedback is gained.

Operational Performance | Inpatient Flow





Metric ID	Group	Value	Var.	Ass.	Target
OP60	Trust	85.4%			80%
OP60	Norfolk & Waveney	88%			80%
OP60	Suffolk	82.9%			80%

Metric ID	Group	Value	Var.	Ass.	Target
OP21	Trust	98.7%			100%
OP21	Norfolk & Waveney	100%			100%
OP21	Suffolk	85.7%			100%

Metric Definition & Context
72 hour follow up – Follow up contact after being discharged from adult psychiatric inpatient care must occur within 72 hours either face-to-face or by telephone.

Metric Definition & Context
PH Check - Receiving an annual physical health check is defined by the presence of a finalised annual health check form within the previous 12 months as per the assessment date recorded.

Summary
72-hour follow up is performing well in the Trust, with both areas and all Care Groups performing at or above the target of 80%.

It was noted in West and East Suffolk that there can be difficulties in engaging service users which they are continue to monitor for assurance purposes.

Summary
Performance was at 100% for all Care Groups other than East Suffolk. Here, under performance is linked to specialist placements where NSFT aren't able to record placement PH checks as they have not been completed by NSFT staff.

Appendix 1 - What is an SPC Chart?

A statistical process control (SPC) chart shows data over time. Process limits show how much variability there is in the data to the chart and patterns are highlighted to show where a change is statistically significant. If there is a target, this variability can be used to provide assurance on whether the target is likely to be met in future.

XmR chart
The most common SPC chart type is the XmR chart. Each data point is shown as a grey dot on a grey line. From this data, the mean is calculated and added between the dots as a solid line, and process limits are added as grey dashed lines. If there is a target, it is shown as a red dashed line.

Process limits
In a stable process, over 99% of data points are expected to lie between the process limits. For reporting, the upper and lower process limit values are usually given as the range of expected values going forward.

Special cause variation & common cause variation
Data naturally varies but if this variation is statistically significant, this is called special cause variation and the grey dots are instead shown as blue or orange, depending on whether a higher value is better or worse – blue is used for improving performance, orange for concerning performance. If not significant, the dots stay grey and this is called common cause variation.

The four rules used to trigger special cause variation on the chart, as advised by the Making Data Count team at NHS England, are:

- a point beyond the process limits
- a run of points all above or all below the mean
- a run of points all increasing or all decreasing
- two out of three points close to a process limit as an early warning indicator

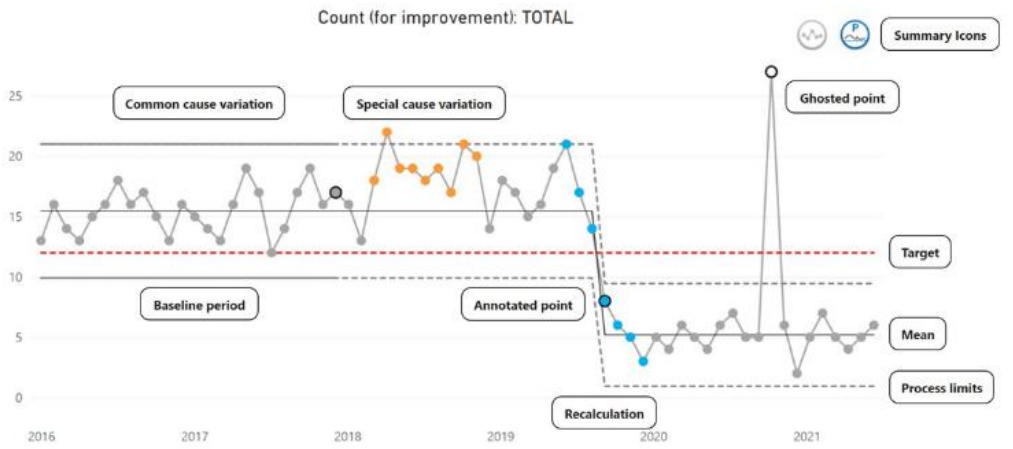
Recalculations
After a sustained change, a recalculation may be added. This splits the chart with the mean and process limits calculated separately using the data before and after. This gives a more accurate reflection on the system as it currently stands.

Baselines
Baselines are commonly set as part of an improvement project, which are shown with solid line process limits. The mean and process limits are calculated from the data in this period and fixed in place for the data points afterwards. This will more easily show if a change has occurred. If a recalculation is later added, the fixed mean and process limits end and are recalculated from the data starting at this point.

Summary icons
Summary icons are shown in the top-right of the chart and explained on the *Icon Descriptions* page.

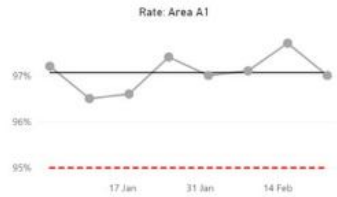
Ghosting
There is sometimes a need to remove a data point from the chart because it is a known anomaly – for example, a high referral count after a one-off migration – and will skew the data to render the chart meaningless. An alternative is to ghost the data point. The data point remains visible on the chart as a white dot but is excluded from all calculations.

Annotations
If a dot has a black circle around it, there is an annotation that can be viewed in a tooltip by placing the mouse cursor over it in the interactive version of the report.



Not enough data points?
An SPC chart requires enough data for a robust analysis. If there are too few data points, the SPC elements are not displayed.

Purple dots
It is not always possible to say that higher values are better or worse, for which purple is used instead of blue and orange.



Appendix 2 - SPC Chart Icons

Variation	Assurance: P	Assurance: ?	Assurance: F	Assurance: (blank)
H	Special cause variation of an **IMPROVING** nature where the measure is significantly **HIGHER**. This process is capable and will consistently **PASS** the target if nothing changes.	Special cause variation of an **IMPROVING** nature where the measure is significantly **HIGHER**. This process will not consistently HIT OR MISS the target as the target lies between process limits.	Special cause variation of an **IMPROVING** nature where the measure is significantly **HIGHER**. This process is not capable and will **FAIL** the target without process redesign.	Special cause variation of an **IMPROVING** nature where the measure is significantly **HIGHER**. Assurance cannot be given as there is no target.
L	Special cause variation of an **IMPROVING** nature where the measure is significantly **LOWER**. This process is capable and will consistently **PASS** the target if nothing changes.	Special cause variation of an **IMPROVING** nature where the measure is significantly **LOWER**. This process will not consistently HIT OR MISS the target as the target lies between process limits.	Special cause variation of an **IMPROVING** nature where the measure is significantly **LOWER**. This process is not capable and will **FAIL** the target without process redesign.	Special cause variation of an **IMPROVING** nature where the measure is significantly **LOWER**. Assurance cannot be given as there is no target.
(none)	Common cause variation, NO SIGNIFICANT CHANGE. This process is capable and will consistently **PASS** the target if nothing changes.	Common cause variation, NO SIGNIFICANT CHANGE. This process will not consistently HIT OR MISS the target as the target lies between process limits.	Common cause variation, NO SIGNIFICANT CHANGE. This process is not capable and will **FAIL** the target without process redesign.	Common cause variation, NO SIGNIFICANT CHANGE. Assurance cannot be given as there is no target.
H	Special cause variation of a **CONCERNING** nature where the measure is significantly **HIGHER**. This process is capable and will consistently **PASS** the target if nothing changes.	Special cause variation of a **CONCERNING** nature where the measure is significantly **HIGHER**. This process will not consistently HIT OR MISS the target as the target lies between process limits.	Special cause variation of a **CONCERNING** nature where the measure is significantly **HIGHER**. This process is not capable and will **FAIL** the target without process redesign.	Special cause variation of a **CONCERNING** nature where the measure is significantly **HIGHER**. Assurance cannot be given as there is no target.
L	Special cause variation of a **CONCERNING** nature where the measure is significantly **LOWER**. This process is capable and will consistently **PASS** the target if nothing changes.	Special cause variation of a **CONCERNING** nature where the measure is significantly **LOWER**. This process will not consistently HIT OR MISS the target as the target lies between process limits.	Special cause variation of a **CONCERNING** nature where the measure is significantly **LOWER**. This process is not capable and will **FAIL** the target without process redesign.	Special cause variation of a **CONCERNING** nature where the measure is significantly **LOWER**. Assurance cannot be given as there is no target.
↗				Special cause variation of an increasing nature where **UP** is not necessarily improving or concerning. Assurance cannot be given as there is no target.
↘				Special cause variation of an increasing nature where **DOWN** is not necessarily improving or concerning. Assurance cannot be given as there is no target.
(none)				There is insufficient data to determine either special cause or common cause variation. Assurance cannot be given as there is no target.

Appendix 3 – Metadata (Operational Performance)

Metric ID	Metric	Definition	Methodology/Exclusions	Data source
OP54	New Referrals	New internal and external referrals into NSFT in monthly	The number of new referrals into the trust during the reported period split then by priority.	Lorenzo
OP61	Crisis RtA - Emergency 4 hr	Percentage of crisis team referral-to-treatment eligible emergency episodes with first attended assessment contact in monthly period that were assessed within four hours, split by age (under 18 and 18 and over)	• Referral priority used is that recorded by NSFT post triage (accepting priority) - emergency only • An attended Assessment must be a F:F or telephone contact with a SU or Proxy where the contact purposes indicates an assessment has occurred. • Must be an emergency referral to a team designated as a Crisis team. • Pass: first contact is less than or equal to 4 hrs from the date and time the referral is received. • Breach: first contact is more than 4 hrs from the date and time the referral is received. • WaitTimeInHours and BreachTimeinHours are calculated in decimals.	
OP61a	U18 Crisis RtA - Emergency 4 hr			
OP61b	18+ Crisis RtA - Emergency 4 hr			
OP28	Psych Liaison - RtA Emergency 1 hr	Percentage of emergency referrals to the psychiatric liaison service with first face-to-face attended contact in monthly period that were within one hour of the referral start time	• Clock stopped by assessment and treatment, triage is excluded • Waiting time clock starts on the receipt of referral by NSFT • An attended assessment must be either a telephone or face-to-face contact with a service user or service users' proxy where the contact purpose indicates assessment and/or treatment has occured	
OP29	Psych Liaison - RtA Routine 24 hr	Percentage of routine referrals to the psychiatric liaison service with first face-to-face contact in monthly period that were within 24 hours of the referral start time	• Includes all external and internal referrals to the service • Referral source ID must be one of the following to be included as 'emergency'; 'AE', 'A&E', 'H1', 'ES', 'EMERG' • Referral source ID must not be one of the following to be included as 'routine'; 'AE', 'A&E', 'H1', 'ES', 'EMERG'	
OP12	RtA - Routine 28 days	Percentage of referral-to-treatment eligible non-emergency episodes with first attended assessment contact in monthly period that were assessed within 28 days, split by age (under 18 and 18 and over) at the date of the RTT eligible spell commencing	• Referral priority used is that recorded by NSFT post triage (accepting priority) • An attended assessment must be either a telephone or face-to-face contact with a service user or service users' proxy where the contact purpose indicates an assessment has occurred • Excluding assessments completed by the following services; Psychiatric Liaison, Memory Assessment/DIST, Autism, ECT, Connect and LAC, Mental Health Police Triage, Compass/PIMHAP/PIMHS, LD. • Excluding assessments where the episode start team was Memory Assessment/DIST Services • Excluding episodes containing National EIP and CFYP ED Clockstops	
OP12a	U18 RtA - Routine 28 days			
OP12b	18+ RtA - Routine 28 days			
OP01	EIP Access & Wait Time Standard	Percentage of referrals into and within NSFT with suspected first episode psychosis or at 'risk mental state' that start a NICE-recommended care package in monthly period that were within two weeks of referral	• Received referral with suspected first episode psychosis starts the clock. • Recieving an initial assessment, being accepted on to the caseload of an accredited EIP service capable of providing a full package of NICE-recommended care, and being allocated to, and engaged with, an EIP care coordinator will stop the clock. •If a service user chooses to delay treatment, cancels or DNAs an appointment this will not stop the clock. • Excluding the waiting times clock stops for non-treatment by EIP services e.g. discharge from trust, or referral to another NSFT service. • Excluding referrals of people who are experiencing psychotic symptoms with a confirmed organic cause, for example brain diseases such as Huntington's and Parkinson's disease, HIV or syphilis, dementia or brain tumours or cysts.	
OP13	RtT within standard	Percentage of referral-to-treatment eligible episodes with first attended treatment contact in monthly period that were treated within the standard (Norfolk & Waveney = 18 weeks, Suffolk = 15 weeks), split by age (under 18 and 18 and over) at the date of the RTT eligible spell commencing and service line (Adult Community Service Team, DCLL Service Team, and CFYP Service Team)	• Referral priority used is that recorded by NSFT post triage (accepting priority) - emergency only • An attended assessment must be either a telephone or face-to-face contact with a service user or service users' proxy where the contact purpose indicates an assessment has occurred • OP13b(i) - Where the serviceline is either Adult Community or Adult Acute only. • OP13b(ii) - Where the serviceline is Older Person only. • OP13b(iii) - Where the serviceline is; 'Central Norfolk CFYP','Suffolk CFYP West','Suffolk CFYP East','West Norfolk CFYP','Suffolk CFYP Specialist','Suffolk CFYP Wellbeing','Great Yarmouth & Waveney CFYP' • Excludes episodes commencing with a referral to any of the following services: Psychiatric Liaison, Memory Assessment/DIST, LD • Excludes episodes containing National EIP and CFYP ED Clockstops	
OP13a	U18 RtT within standard			
OP13b	18+ RtT within standard			
OP13b(i)	Adult Community - 18+ RtT within standard			
OP13b(ii)	Dementia/Later Life - 18+ RtT within standard			
OP13b(iii)	CFYP - 18+ RtT within standard			

Appendix 3 – Metadata (Operational Performance)

Metric ID	Metric	Definition	Methodology/Exclusions	Data source
OP15	U19 Eating Disorders - RtT Urgent 1 wk	Percentage of CYP with a suspected eating disorder for urgent cases starting teatment in monthly period that started treatment within one week of referral	• For single point of access services the clock start date will be the date of the original referral. • For interal referrals the clock starts on the date the internal referral is made. • The waiting time clock starts when the referral is first received even if it is not fully completed, it is the responsibility of the service to follow-up and ensure all necessary information is obtained. • A re-referral will be a new episode of care and a new clock will start even though clinically it may be a continuation of previous clinical care. • A reason for referral of 'Eating Disorder ' must be recorded to initiate a clock start.	Lorenzo
OP16	U19 Eating Disorders - RtT Routine 4 wk	Percentage of CYP with a suspected eating disorder for routine cases starting teatment in monthly period that started treatment within four weeks of referral	• The clock stops when the referral is confirmed as having an ED or suspected ED and the first definitive treatment starts. • Treatment can be delivered by community eating disorder service (CED-CYP), generic CAMHS, general psychiatric in-patient unit or paediatric unit. • A clock Stop must be either face-to-face (or a telephone contact on or after 16/03/2020) • If a service user chooses to delay treatment, cancels or DNAs an appointment this will not stop the clock. • Service users aged 19 and over are excluded.	
OP10	Access	Total access to IAPT services		
OP07	6 week wait	Number of patients who waited less than or equal to 6 weeks for their first treatment contact		
OP08	18 week wait	Number of patients who waited less than or equal to 18 weeks for their first treatment contact		
OP06	Recovery	The proportion of people who are moving to recovery		
OP57	Inpatient Admissions	Inpatient admission in monthly period	The number of patients admitted to an inpatient ward during reported period.	Lorenzo
OP58	Inpatient Discharges	Inpatient discharges in monthly period	The number of patients discharged from an inpatient ward during reported period.	
OP20	Delayed Transfer of Care (DToC)	Percentage of consultant-led and non-consultant-led occupied bed days in monthly period including delayed transfers of care attributable to social care services that were non-acute patients aged 18 and over on admission whose transfer of care was delayed	DToC Clock start: As soon as an adult patient meets these three conditions and remains in hospital • a clinical decision has been made that the patient is ready for transfer, and • a multidisciplinary team has decided that the patient is ready for transfer, and • the patient is safe to discharge/transfer. • Exlusions: Patients who aged under 18 on admission	
OP09	Inappropriate OAPs - bed days	Total number of inappropriate out of area placement bed days in adult mental health services.	An OAP will be inappropriate if the reason is non-availability of a local bed. An out of area placement may be appropriate when, e.g. (not an exhaustive list): • The person becomes acutely unwell when they are away from home. • There are safeguarding reasons such as gang related issues, violence and domestic abuse. • The person is a member of the local service's staff or has had contact with the service in the course of their employment. • There are offending restrictions. • The decision to treat out of area is the individual's choice e.g. where a patient is not from the local area but wants to be near their family and networks.	Lorenzo

Appendix 3 – Metadata (Operational Performance)

Metric ID	Metric	Definition	Methodology/Exclusions	Data source
OP60	72 hour follow up	Percentage of people under adult mental illness specialties discharged from psychiatric inpatient care that were followed up within 72 hours	• Must be a patient discharged from a ward speciality of 710 or 715. • 72 hour time starts on the day after discharge (midnight following the discharge date). • The first contact is the the first attended face to face or telephone contact with the patient following the clock start. The follow-up should aim to be a face-to-face meeting. • A pass is quantified as either receiving a follow up contact within 72 hours or being followed up within 72 hours due to an readmission. • A breach is quantified as either; a follow up contact does not occur within 72 hours or where no contacts have been made within the 72 hour period post discharge. • The contact may be made by the Inpatient Team, Community Mental Health Team/Recovery Team, the Crisis Resolution/Home Treatment Team, Dementia Intensive Support Team, or other identified appropriate health professional. The following excludes from the metric; • Patients who die within 72 hours of discharge. • Where the period between discharge and present is less than 72 hours. • Patients transferred to another NHS psychiatric inpatient ward or a non-NHS hospital - this would be classed as a transfer of care, not a discharge. • Patient discharged from CAMHS (Child and Adolescent Mental Health Services). • Patients discharged to prison.	Lorenzo
OP21	Inpatients with annual PH check	Percentage of inpatients with a length of stay exceeding 12 months at the end of the monthly period that received an annual health check within the previous 12 months	Presence of a finalised annual health check form with assessment date within the previous 12 months. **Exclusions** • Inpatient user stays < 12 months • Physical health check forms with an outcome of pending, not specified, cancelled by NHS, provided information or in progress. • Service users whose latest ward is one of the test, decant, migration or out of area wards • Service users whose latest ward is a Secure Services or CAMHS Tier 4 ward at reporting end date	

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Norfolk and Waveney Integrated Care System

NHS
Norfolk and Waveney
Integrated Care Board

Subject:	**Norfolk & Waveney Mental Health (MH) Programme Overview**
Prepared by:	**Emma Willey, Head of Adult MH Commissioning, ICB Rebecca Mann, Head of Integration and Alliance, Children's Mental Health Norfolk & Waveney**
Submitted to:	**Norfolk Heath Overview and Scrutiny Committee**
Date:	**13 October 2022**

Purpose of paper:

This paper accompanies the report prepared by NSFT to share progress in response to CQC feedback and describe development of the NSFT improvement plan. The wider context of system wide mental health transformation is detailed, which involves NSFT as a key partner within the partnership.

Executive Summary:

22/23 is year 4 of delivery of the Long Term Plan (LTP) which builds on earlier work 'The Five Year Forward View' and provides vision, policy guidance and funding to modernise MH services (see p.5 for links to key documents). The Norfolk & Waveney (N&W) MH Transformation programme utilises dedicated MH transformation funding (£22M additional investment in 22/23) to deliver the LTP ambition and meet long standing capacity short falls and address pathway gaps so that people experiencing mental health difficulties can access information and support quickly, helping to support individuals and families and avoiding escalation of need where possible. The LTP ambition pre-dates the pandemic and work underway has helped to meet additional pandemic related need though need continues to challenge capacity in many areas.

The MH Transformation programme is delivering new locality and community infrastructure and expanding services to support people proactively to maintain their emotional wellbeing and prevent worsening mental health, supporting suicide surveillance and prevention, developing a resilient place-based community model to support a range of MH need and embedding a new Housing Support model for people with complex MH need, enabling them to live their lives and access support close to home. This paper describes strategic priorities and deliverables designed to improve mental health and well-being of the N&W population.

Report

The N&W MH Transformation programme is a system-wide collaboration delivering the following Mental Health Transformation Priorities in 22/23:

1. **Support NSFT to deliver MH Improvement Plan** through integrated planning and programme delivery
2. **Deliver new enhanced support for Primary Care:** Primary Care Network (PCN) Mental Health Practitioners, Recovery workers and Link psychiatrists supporting GP Practices to guide patients to the right support and services
3. **Improving access to CYP mental health provision and emotional wellbeing support** through the development of an integrated front door for 0-25 year olds.
4. **Increasing early access to CYP emotional wellbeing and mental health support:** Roll out of Mental Health Support Teams in schools
5. **Increase Access in Psychological Therapies (IAPT) – N&W Well-being service**
6. **Enhanced support in the community:** Establish 5 Wellbeing Hubs (achieved September 2022) in Norwich, Gorleston, King's Lynn, Thetford and Alysham. As well as 3 Crisis Houses (one in Norwich currently, additional two to be implemented by April 2023)
7. **Improve community services for people living with Severe Mental Illness (SMI):** whole system health, social care, VCSE and adopting a neighbourhood approach to improve physical and mental health (focus on personality disorder, eating disorder and rehab) services for users with serious mental health issues (SMI), working with Community MH and Primary Care teams.
8. **Improve flow, reduce waits, and develop alternatives for crisis support:** building on acute trust mental health Liaison through - extension of Joint Response Ambulance Car, new VCSE led initiatives to support people experiencing MH crisis, supporting new Welling Hubs to provide alternative places of safety, de-escalation, and recovery for those with acute mental distress, Intensive Day Unit (The Lighthouse) for CYP with eating disorders as an alternative to admission, developed an integrated practice model for complex CYP presenting in crisis working jointly with Norfolk Children's Services and other system partners.
9. **Involve experts to develop strategic 'enablers', necessary to drive the above work programmes:** Digital Transformation, Coproduction with experts by experience, Health Inequalities, VCSE partnership, Workforce, Communications, Estate/facilities Development, Pathway Development & Re-engineering and monitoring and evaluation.

Transformation/ improvement work in progress (Long Term Plan ambition):
There are three main delivery themes within the MH Transformation programme currently:

- Prevention & well-being; this focus aims to boost prevention and early intervention through the Well-being service (Improved Access to Psychological Therapies) Improvement plan that supports people with anxiety and depression, increasing Physical Health Assessment for people with complex MH need, provide drop in hubs that offer well-being & crisis and the roll out of mental health support teams in schools.
- Increased community capacity; modernising Community MH Team provision (pilot underway in south Norfolk) and standardising treatment pathways in Childrens & Adolescent MH Services (CAMHS) and Youth teams, introducing new roles such as MH Practitioners/ team in primary care and launching a new MH rehabilitation team (July) plus much needed eating disorder service expansion. Improving the community pathway and expanding community capacity will reduce the need for out of area placements.
- Improving the MH Crisis pathway through increased capacity in community-based Crisis Response Home Treatment (CRHT) and acute hospital based MH Liaison teams (MHLT) in the Emergency Dept. New infrastructure includes the MH ambulance car which is helping avoid ambulance conveyance and support people in

their homes, well-being/ crisis hubs x5 providing an evening sanctuary service for people experiencing MH crisis. Also, short stay recovery houses (1 currently, additional two by end Q4), which provide a focused 5-day admission as an alternative to hospital to help people step out of stressful home life and recover with support. Roll out of a CYP Home Treatment Team as an alternative to admission and the development of an Intensive Day Service and 72 hour respite facility for CYP with complex crisis presentations requiring a multi-agency response. Work on improving the Inpatient pathway to ensure admissions are planned, purposeful and people are discharged with a plan for onward support.

Guiding principles

- Collaboration
- Increased focus on prevention & well-being
- Trauma informed approach – tackling the root of mental health difficulties
- People telling their story once, and 'no wrong door' to enable quicker access to support
- Self-referral and flexibility to accommodate changing need
- Needs led and enabling individuals to identify their own goals and support better outcomes for individuals, children, and families

National and local trends mean there is an increasing need for MH support which presents challenges with capacity:

1. An increasing number of people (new and existing MH need) required support during the pandemic. The complexity of presentation also increased which continues to present a combined challenge for service capacity, with individuals requiring longer to assess and treat
2. Added impact of growing cost-of-living crisis evident in last 12 months resulting in continued increase in demand
3. NSFT, an already challenged MH provider overwhelmed by increased demand for Adult and CYP services (community MH, Eating Disorder and Crisis teams in particular)
4. Diminished social care provider market - poor flow within and between care providers
5. Availability of workforce to meet the demand and skillset to manage the complexity is a national challenge.

MH Pathway issue indicators:

- 12hr Decision to Admit (DTA) and Out of area placement are indicators of capacity and demand issues in the pathway, impacting on quality of care and patient safety
- 12 hr DTA is a focus for SOF4 improvement in N&W for this reason; pathway transformation and service improvement is underway
- Working groups for each report into MH UEC steering group and the N&W Integrated Care System MH Partnership Board

Improvement challenges:

- System culture and ownership regarding mental health being 'everyone's business', responsibility is not limited to 'mental health' providers – development of the Integrated Care Board and Health & Well-being Partnerships is positive, especially as all five Places and 8 Health & Well-being partnerships are prioritising MH improvement at locality level
- NSFT CQC improvement timeline and plan; there is a high risk of distraction if a separate plan is developed - aiming instead to integrate CQC improvement with pre-existing Transformation plan to achieve service improvement and Long Term Plan ambition jointly

Mental Health Transformation timeline (key deliverables)

Key risks and mitigations

Risk	Mitigation
Workforce. There is not enough registered and medical workforce to meet requirements (national as well as local N&W issue). The Well-being Service (IAPT) is fully funded however the Service cannot recruit into training posts for counsellors which is affecting wait times. Capacity within the existing CYP workforce to supervise a range of trainees, reducing senior clinical time to focus on more complex presentations	• N&W MH Workforce Strategy developed. 4 strategic workstreams set up; Upskilling, New Opportunities, Staff Health & Well-being, and Culture & Leadership. • MH Workforce Dashboard developed, focussing on workforce retention as a priority. • Focus on innovation and introduction of range of new roles • Plans in place to develop a CYP specific workforce strategy
Digital. There is a risk that the lack of access to shared digital records and patient management systems will impede ability of primary care facing MH team to deliver safe and effective care, and achieve patient flow for patient tracking and so that information flows with the patient	• Mental Health modules in primary care systems to be implemented to enable effective reporting and improve patient management, flow and tracking. • Shared care record (data warehouse) roll-out. • Electronic Record System Advice and Guidance service.

	• Single trusted assessment (all age) to be embedded through digital systems plus agreed PROM quality measure (Dialog+). • Improvements to NSFT patient management processes (Lorenzo Access Plans project) to facilitate improved patient flow, case management, quality, safety and system-wide communication. • Roll out of integrated front door for 0-25 yrs. and development of interoperable solutions to sharing information
NSFT. Widespread impact of CQC rating and preparation for CQC re - visit in September 2022 and well-led inspection due early Nov 2022: • Organisational capacity stretched to accommodate additional scrutiny as well as transform and modernise • Staff recruitment, retention and workforce culture • Confidence in services (Public/ Providers)	• ICB and partners supporting development of CQC improvement plan focused on five pillars: Culture, Leadership & Governance, Safety, Demand & capacity, Service offer • MH Governance structure providing support and oversight through MH Programme Assurance and integrated -ICS partnership working • Regional NHSE support
Seasonal Pressures. MH Demand is expected to be high this winter following unprecedented summer demand and the increasing cost of living. Demand on the physical acutes is also likely to impact on MH services.	• NHSE has provided MH specific funding to support Winter Schemes (£181K). • Schemes have also been submitted to NHSE for consideration drawing upon System Winter Monies. This funding is focussed on reducing admissions, improving flow, and supporting timely discharges. A pilot for GP Streaming for MH and a pre-assessment unit are being considered. • X6 N&W bids successfully achieved MH UEC capital funding and will be implemented

Links to key guidance:

The NHS Long Term Plan
NHS Long Term Plan » The NHS Long Term Plan

The MH Implementation plan (5 year plan)
NHS Mental Health Implementation Plan 2019/20 – 2023/24 (longtermplan.nhs.uk)

The Community MH Framework 2019
NHS England » The community mental health framework for adults and older adults

FLOURISH – Norfolk partnership strategy for children and young people
Flourishing in Norfolk: A Children and Young People Partnership Strategy - Norfolk County Council

Norfolk County Council

Norfolk Health Overview and Scrutiny Committee
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The Rt Hon Steve Barclay MP
Secretary of State for Health and Social Care
Department of Health and Social Care

Letter sent by email to: mb-sofs@dhsc.gov.uk

27 October 2022

Dear Mr Barclay

Norfolk Health Overview and Scrutiny Committee – Norfolk and Suffolk NHS Foundation Trust

I'm writing to you in my capacity as Chair of the Norfolk Health Overview and Scrutiny Committee (NHOSC) to outline ongoing concerns raised by members of the committee with regards to Norfolk and Suffolk NHS Foundation Trust. For some time now our residents have faced difficulties in terms of both accessing mental health services across the two counties and the quality of services provided.

As you are no doubt aware, during its latest inspection in November – December 2021, the Care Quality Commission (CQC) found that NSFT had deteriorated since the last full inspection in November – December 2019 and downgraded its overall rating from 'requires improvement' to inadequate. Consequently, NSFT was invited to attend NHOSC's meeting in September 2022 to provide an update regarding its progress and activity towards improvement.

The committee had some serious concerns about NSFT's lack of positive engagement with NHOSC and the scrutiny process. NSFT's papers arrived late and beyond the legal publication for NHOSC's agenda. Furthermore, the quality of the reports provided by NSFT was poor and many questions the committee had were left unanswered. This lack of engagement has made it impossible for NHOSC to carry it its role and effectively scrutinise NSFT's improvement plans. Therefore, NHOSC requested a further update from NSFT at its next meeting in November.

Since the October meeting NSFT's new Deputy Chief Executive has adhered to her pledge to provide more quality and timely engagement with NHOSC moving forward. I am, therefore, hopeful that the committee will be able to undertake more effective scrutiny of NSFT's improvement plan at the November meeting.

However, the committee has wider concerns about the pace of progress NSFT has made not just in responding to the requirements and recommendations laid out in the latest CQC inspection report, but also in addressing its historic failings: this is the

fifth time in seven years that the NSFT has been rated inadequate by the CQC. The detrimental effect on the mental health of Norfolk residents that NSFT's continued failure to implement robust improvement measures represents, is an issue of grave concern to NHOSC Members.

Due to the engagement problems outlined above, it has been difficult to discern exactly what progress NSFT has made since its last CQC inspection. The committee is also aware that the CQC is also in the process of carrying out a follow-up inspection.

The NHOSC will continue to provide challenge to the improvement journey for NSFT, highlighting where appropriate concerns with the quality of services provided to Norfolk and Suffolk residents.

I am more than happy to discuss this matter with you further and provide insight where appropriate.

Yours sincerely,

Alison Thomas
Chair of the Norfolk Health Overview and Scrutiny Committee.

Norfolk Health Overview and Scrutiny Committee

Proposed Forward Work Programme 2022/23

ACTION REQUIRED

Members are asked to consider the current forward work programme:-

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

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

Meeting dates	*Main agenda items*	*Notes*
19 January 2023	Menopause services - an overview of menopause services in Norfolk	
23 March 2023	TBC	

Information to be provided in the NHOSC Briefing 2022/23

Dec 2022
- **Winter planning update** – a more indepth update from ICB following October briefing.
- **Cawston Park Hospital Safeguarding Adults Review** – update from Norfolk Safeguarding Adults Board on action underway to address the recommendations.
- **Patient flow/discharge** – an overview of the patient flow through the system until discharge.
- **NSFT new wards** – an update on The Rivers Centre project at Hellesdon Hospital.

Date TBC (Feb 23?)
- **Prisoner healthcare services** -update on recovery of services from the pandemic.

- **Primary Care Estates** – an update on the primary care estate across Norfolk and Waveney

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

Norfolk and Waveney ICB	-	Chair of NHOSC (substitute Vice Chair of NHOSC)
Queen Elizabeth Hospital, King's Lynn NHS Foundation Trust	-	Julian Kirk (substitute Alexandra Kemp)
Norfolk and Suffolk NHS Foundation Trust (mental health trust)	-	Brenda Jones (substitute Lucy Shires)
Norfolk and Norwich University Hospitals NHS Foundation Trust	-	Dr Nigel Legg
James Paget University Hospitals NHS Foundation Trust	-	Daniel Candon
Norfolk Community Health and Care NHS Trust	-	Emma Spagnola

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