# Board of Directors – session in public
Meeting to be held on Thursday 24th November 2016 from 09:30 to 12:30 at the Elisabeth Room, Endeavour House, Russell Road, Ipswich, IP1 2BX

## AGENDA

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<td>09:30</td>
<td>16.190</td>
<td>Chair’s welcome, apologies for absence and notification of any urgent business</td>
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<td></td>
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<td>Apologies: Leigh Howlett</td>
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<td>09:35</td>
<td>16.191</td>
<td><strong>Standing Item:</strong> Declarations of Interest</td>
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<tr>
<td>09:40</td>
<td>16.192</td>
<td>To approve the minutes of the previous meeting in public, held on 27th October 2016</td>
<td>Attachment A</td>
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<tr>
<td></td>
<td></td>
<td>i. To approve the release of the minutes under the Freedom of Information Act</td>
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<td>ii. To note the minutes of the AGM held on 20th October 2016</td>
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<td>09:50</td>
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<td>Matters arising from the meeting in public held on 27th October 2016</td>
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<td>09:55</td>
<td>16.194</td>
<td>Chair’s Report <em>(Gary Page)</em></td>
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<td>10:00</td>
<td>16.195</td>
<td>CEO’s Report <em>(Michael Scott)</em></td>
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<td>10:10</td>
<td>i.</td>
<td>Quality Improvement Plan Progress Report <em>(Michael Scott)</em></td>
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<td>ii.</td>
<td>Quarterly Patient Safety and Quality report <em>(Jane Sayer)</em></td>
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<td>10:35</td>
<td>iii.</td>
<td>Quality Governance Chair’s Report for 25th October 2016 <em>(Gary Page)</em></td>
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<td>10:40</td>
<td>iv.</td>
<td>Finance Report M07 <em>(Julie Cave)</em></td>
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<td>v.</td>
<td>Business Performance Report M06 <em>(Julie Cave)</em></td>
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<td><strong>BREAK</strong></td>
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<td>11:20</td>
<td>vi.</td>
<td>Finance Committee Chair’s Report for 15th November 2016 (Tim Newcomb)</td>
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<td>11:25</td>
<td>vii.</td>
<td>CoG/BoD joint working agreement (Robert Nesbitt)</td>
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**16.197 Items for Assurance**

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<td>11:35</td>
<td>i.</td>
<td>Board Assurance Framework and Risk Register Report (Robert Nesbitt)</td>
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<td>ii.</td>
<td>Review committee structure (Robert Nesbitt)</td>
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<td>11:55</td>
<td>iii.</td>
<td>Committee Meeting Chairs’ Reports</td>
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<td>iv.</td>
<td>Charitable Funds Committee Chair’s Report for 25th October 2016 (Brian Parrott)</td>
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<td>vi.</td>
<td>Organisational Development and Workforce Committee Chair’s Report for 21st November 2016</td>
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<td>Service User and Carer Trust Partnership Chair’s Report for 28th October 2016</td>
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12:10  **16.198 Questions from the public in relation to the papers**

12:20  **16.199 Any other urgent business, previously notified to the Chair**

12:25  **16.200 Date, time and location of next meeting**

The next meeting of the Board of Directors will be held in public on Thursday 26th January 2017 at the King’s Centre, 63-67 King Street, Norwich NR1 1PH.

12:30  **16.201 Motion to exclude public and press from confidential part of the meeting**

CLOSE
Minutes of the Board of Directors – Public Session
Held on Thursday 27th October 2016 from 09:30
at Conference Room 2, King Centre, 63–67 Kings Street, Norwich NR1 1PH

Present:

Julie Cave: Director of Finance
Leigh Howlett: Director of Strategy and Resources
Gary Page (Chair)
Michael Scott: CEO
Jane Sayer: Director of Nursing, Quality and Patient Safety
Bohdan Solomka: Medical Director
Debbie White: Director of Operations – Norfolk

Ian Brookman: Non-Executive Director
Tim Newcomb: Non-Executive Director
Jill Robinson: Non-Executive Director
Marion Saunders: Non-Executive Director
Tim Stevens: Non-Executive Director

In attendance:

Kate Hope: Assistant Company Secretary
Lisa Mungham-Gray: Head of Communications

There were 6 governors, 2 members of the public and 1 member of staff present.

Meeting commenced at: 9.28am

16.171 Chair’s welcome, apologies for absence and notification of any urgent business

The Chair (Gary Page) welcomed the Board of Directors, Governors, staff and the public. Apologies were received from Robert Nesbitt, Alison Armstrong and Brian Parrott.
The Chair informed those present that questions from the public gallery would be taken at the middle and the end of the agenda.

16.172 **Standing Item:** Declarations of Interest

There were no additional declarations of interest reported.

16.173 **To approve the minutes of the previous meeting in public, held on 22 September 2016**

The minutes were approved, by the Board as an accurate record of the meeting of 22nd September 2016 subject to the following amendments:-

1. Item 16.151i on page should refer to a learning event taking place in October 2016.

Subject to the above amendments, the Board approved the release of the minutes under the Freedom of Information Act.

16.174 **Matters arising from the meeting in public held on 23rd June 2016**

It was clarified that information on 16.151iiid was contained within the Business Performance Report for this meeting.

All other matters were noted as complete.

16.175 **Chair’s Report**

The Chair’s report was noted.

Gary Page confirmed that a verbal Chair’s report would be provided to the private session of the Board meeting each month as from 24th November 2016.

16.176 **CEO’s Report**

The report was taken as read and Michael Scott updated the Board as follows:-

1. The Board attended the CQC Quality Summit on Friday 21st October 2016. The event was positive with the CQC providing a supportive and complimentary commentary about the Trust, its leadership and staff morale. The CQC also outlined those areas where the Trust requires improvement.

A query was raised in relation to the ‘requires improvement’ category the Trust is now in. 60% of NHS Trusts are currently in this category and is the Board aware where NSFT sits in that category? It was confirmed that
this category was very broad and it was impossible to say where NSFT is place with that category. However, the Trust’s next priority is to achieve a ‘good’ rating overall and to be ‘outstanding’ in some areas. The Trust is already rated as ‘good’ for caring and this can be developed. The CQC will be back within the next six to twelve months and work needs to continue with a view to achieving a good rating.

2. The action plan formulated following the early indications from the CQC visit in July 2016 is well under way and a formal copy of the plan is to be presented to the Board on 24th November 2016.

3. On 19th October 2016 Kathy McClean, Medical Director of NHS Improvement (NHSI) visited the Trust and was positive about the progress of improvements made at NSFT.

4. Attendance at the Eastern Academic Health Sciences Network discussion provided a good opportunity to form connections with mental health leaders such as Clare Murdoch, who made some positive comments about NSFT on Twitter. This has helped to raise NSFTs profile on a national level.

5. A visit took place to the Dragonfly Centre, which provides beds for young people in Lowestoft. Michael Scott was impressed to see how hard the staff had worked in relocating the unit and how seamless the transfer had appeared and extended the Board’s thanks to the unit’s staff for all their hard work.

6. The Compass Service, which provides healthcare, social care and education services for service users has been shortlisted for an HSJ award. Michael Scott will be accompanying the team to the awards on 23rd November 2016 and will provide an update to the Board at the next meeting on 24th November 2016.

7. The visit to the launch of the National Suicide Audit was discussed. It is 20 years since the audit started and so it is a rich database. Themes emerging are that deaths through inpatient ligatures have radically declined. This is something that has been addressed nationally and the focus has now shifted to the community.

Information provided by the audit showed that figures for suicides throughout the Country are broadly static. The key learning from the information is what the Trust can do to reduce the figures. The post discharge period remains a high-risk period with day 3 being an absolute peak for risk. NSFT ensures that service users are contacted post discharge to monitor this vital period and intervene if necessary.
The report was noted.

**Action 16.176**

a. CQC Action Plan to be added to the agenda for the meeting on 24th November 2016 *(Kate Hope)*

b. The Board’s thanks are to be extended to the staff at Dragonfly unit for all their hard work on the recent move *(Debbie White)*

c. Update to be provided on the Compass Service and the HSJ awards at the Board meeting on 24th November 2016 *(Michael Scott)*

**16.177 Items for Approval**

i. **Quality Improvement Plan Progress Report**

Michael Scott presented the report to the Board and highlighted the Cost Improvement Plans (CIPs). None of the projects are rated as red and the Trust is on target. This is a significantly better position than in previous years.

Of particular note is E-Rostering. This has been monitored by the Workforce Mobilisation Board (WMB). Whilst initially there was some controversy around the introduction of the technology, it is now working throughout the Trust and has been nominated for a national award.

Skype for Business is seeing increased use. The Executive Directors use it for their meetings and it is increasingly being used by clinical staff.

In relation to estates, Whitlingham Ward is about to start the first phase of the secure services rebuild.

In relation to Quality Improvement Plans (QIPs) three of these are currently rated as red:-

- **External placements** – Work is taking place to actively review all placements and bring service users home where we can secure the specialist services locally to meet their needs.

  It was noted that the proposed three month pilot scheme referred to has been delayed whilst the appropriate people to carry out the work are identified.

- **Management of Section 17 leave** – a workshop on this issue is due to take place on 3rd November 2016. The Trust is aware of where the problem lies and immediate steps will be taken to improve the current process.
- Statutory and mandatory training – the Trust is close to achieving its target on this particular issue and will continue to focus on key training elements in the future.

An update was requested on the upgrading of the Trust's broadband. Leigh Howlett confirmed that work was underway to update the current broadband to fibre broadband. The lines and upgrades for 80 St Stephens were ordered back in April 2016 and despite liaising with BT Openreach on a weekly basis, the upgrade has not yet taken place. The Trust is communicating with BT Openreach every other day to get the situation resolved. BT Openreach are now liaising with Highways and have promised that the work will be done by the end of October 2016. If the work is not carried out by Monday 31st October 2016, the issue will be escalated to a chair to chair letter.

Temporary staffing and nursing hours were discussed and it was requested that in future reports, some context was provided in relation to broader Trust performance to aid understanding. It was noted that when comparing agency spend for this and last year, the reports show that the expenditure on temporary staff has almost halved. However the pressure remains. The Trust will always have a need for temporary staff and must ensure that good control is taken of what we pay for our temporary staff. This remains a national issue.

### Action 16.177i

Future QIP reports should include more context about the Trust’s overall performance when reporting on WMB for temporary staffing and nursing hours (Leigh Howlett)

### ii. Finance Report

Julie Cave introduced the report to the Board and highlighted the good performance for NSFT as at 30th September 2016 with a positive variance against plan of £180k. However, the Trust still has a deficit position of £4.8m.

Two key risk areas continue to be monitored closely, Out of Trust (OOT) placements and agency staffing. There are plans in place for both areas to help reduce the cost pressures.

The 2015/2016 CIP forecast is on target to deliver the plan of £10m. In addition, cash held by the Trust is in line with the financial plan.

Gary Page asked for assurance that there is capital available to address the ligature risks that have been identified for remedy and that an escalation process is in place to ensure that this is done in a timely fashion?

Julie Cave confirmed that work identified by the CQC is a priority for the finance team and £50k has been allocated for immediate actions this week.
Any larger pieces of work that are identified and will produce a larger spend will be brought before the Executive Directors for approval. All less expensive actions identified will be remedied immediately.

It had been identified in the recent Quality Governance meeting that where risks were identified, signoff had not been done quickly and staff were having to escalate their requests. It was confirmed that the Head of Estates has been seconded purely to focus on ligature risks throughout the Trust and this work has already started and is ongoing.

Leigh Howlett confirmed that the business change team are already investigating this issue and will take steps to ensure processes are clearly understood. They will work with estates and risk management teams to design a business process which operational staff will have input into. This work started yesterday.

In terms of escalation, this should be through managers. However this will be reviewed with locality teams and the Executive Directors when they meet on Monday 31st October 2016 and steps will be taken to ensure that all matrons know what the escalation process is.

The ability to raise concerns effectively is vital. ICT are in the process of launching Marvel a new service desk system. Leigh Howlett will review this to see if it could be used to track ligature risks raised so matrons can view progress on an application on a smartphone/tablet.

**Action 16.177ii**

The applications of Marvel will be reviewed to see if the system can be used to track ligature risks raised through to their conclusion (Leigh Howlett)

### iii. Business Performance Report

Julie Cave confirmed that the Summary Workforce Performance dashboard for August 2016 shows good progress against national targets.

It was noted the Trust is not required to submit compliance statements for September 2016 as NHSI have said that this is not necessary.

Waiting times are still a concern and staff are working hard to reduce these. Work has been undertaken jointly with the CCGs in Central Norfolk to try and address waiting times. In addition there is some funding available for waiting lists for under 18s. NSFT have submitted a bid for some of this funding and have been successful. It is envisaged that further funding will be made available in November 2016.
In relation to workforce, it was noted that the detailed explanation on stress and anxiety related sickness absence was helpful. It was agreed that it would be valuable to have information to compare other similar Trust’s statistics with our own.

It was noted that nationally, stress is the number one reason people go off sick regardless of the type of organisation. It was queried whether stress should be placed in the same category as anxiety and depression. The Health and Safety Executive separate these conditions out very clearly and it would be helpful to see a separate breakdown for each of these.

The vacancy rate was examined which was rated at green. However discussions had taken place at the Audit and Risk Committee meeting on 14th October 2016 about the Risk Register and how so many of the risks on the register are risks presented by low staffing levels. It was asked how the Trust reconciles having good performance in vacancy rates with the Risk Register identifying many risks associated with low staffing levels? In addition, is the Board therefore receiving false assurance if the vacancy rates are rated as green? It was confirmed that reports can be run at locality and ward levels which is crucial to identifying hotspots. As a result the Trust can identify exactly where to focus attention and where the hotspots lie. This work is being scrutinised by the Organisational and Development Workforce Committee and the mobilisation boards. It was agreed that the potential misalignment on these ratings would be reviewed and that the vacancy rate figure should be split to differentiate between clinical and non-clinical staff.

Figures for sickness absence were reviewed. Short term sickness is reducing however long term sickness is increasing. HR Business Partners are reviewing sickness statistics and are working with locality and service managers to ensure the Trust is doing all it can to reduce these figures where possible. One factor identified is that the increased focus on performance management and accountability means that some staff are subject to investigations and performance management reviews and in some cases the response is to be signed off sick. It was agreed that further scrutiny of these figures is required together with an analysis of the findings to be presented to the OD&W Committee.

**Action 16.177iii**

- a. Future BPRs to include an analysis of reasons for absence for other Trusts for comparison *(Leigh Howlett)*
- b. A separate breakdown is to be provided of figures for absence for stress, anxiety and depression *(Leigh Howlett)*
- c. Vacancy rates to be examined to ensure reporting is not misaligned with non-clinical and clinical staff vacancy rates to be split in future reports *(Leigh Howlett)*
d. Further information and analysis is required on sickness absence rates to be presented to the OD&W Committee for review (Leigh Howlett)

iv. Finance Committee Chair’s Report for 18th October 2016

Tim Newcomb reported that the meeting on 18th October 2016 was the first Finance Committee meeting where both the Finance and Business Performance Report were reviewed in detail. The meeting was positive and effective despite the wide range of material to cover.

OOT placements, specialist placements and the associated costs pressures are examined every month to provide reassurance to the Board that these issues are given scrupulous attention.

The Early Intervention in Psychosis target was raised as an example of an area where the Trust is measured but receives no funding. Funding will be proactively pursued but it is important to note that if no funding is forthcoming this will affect the activity around this target.

The Board noted the report and the recommendations.

v. Operational Plan Q2 Update

Leigh Howlett presented the update and asked the Board to note that all planned activity was achieved to target.

The Board agreed it was positive to note the progress achieved on the Operational Plan. It was also noted that the Clinical Strategy would need to be examined carefully to ensure it focused on fewer projects to deliver rather than trying to deliver on numerous projects and not delivering. In addition, it was requested that more precision was provided around the milestones detailed in the appendix to provide a measure of success.

It was confirmed that the new QIP in relation to the Recovery College would be added to the prevention action plan for 2017/2018 and rolled forward. This particular report was a retrospective review.

The meeting took a break from the Agenda to take questions from members of the public and the following questions were put to the Board:-

a. It was queried whether, on reviewing sickness levels the Trust had taken into account that women in their early 60s have effectively had a further 6 years added to their working life before getting their state pension? People are now having to work for longer and may not be in perfect health.

Michael Scott confirmed that an analysis of previous figures suggested that it was younger people who were off sick however a review could be done to see whether
this trend was changing. Debbie White confirmed that Susan Bissmire of 80 St Stephens was involved in a local campaign around this issue. If the NHS is paying out to a large proportion of this category of staff on long term sick pay this needs to be flagged up as it is not a saving to the government.

b. Is there a correlation between temporary staffing rates and the safety concerns identified by the CQC, particularly in the Psychiatric Intensive Care Unit (PICU)?

Jane Sayer confirmed that a great deal of attention is focused on whether there is a correlation between temporary staffing and any incidents that occur. With the PICU, Rollesby Ward, the majority of temporary staff there are employed continuously and therefore receive the same training as permanent staff.

The PICU (Lark) in Suffolk is being reviewed at the current time as there are a number of concerns identified which require resolution.

c. When referring to suicide are we referring to coroner verdicts or unexpected deaths?

It was confirmed that these verdicts are confirmed by coroners. However the Trust attempts to extract any learning it can from every single serious incident that takes place to understand how best to avoid similar situations occurring in the future.

d. How much does the Trust assist families in helping them to understand mental health issues?

Jane Sayer confirmed that part of the Trust’s strategy is how we engage families differently and what resources we can make available to a family to help them to better understand mental health conditions, how to support people at home and how they can keep family members safe.

Evidence suggests that if work can be done with families to change the way in which they communicate, you can reduce levels of stress and pathology. The Trust’s plan is to offer families a care package that they can draw on in terms of what they can do for themselves. This does not replace the service that we provide. The Trust is shortly to advertise for a lead on suicide prevention as it is recognised that we need dedicated resources to support this project and we will be asking commissioners to make this a priority for next year’s funding.

e. What process is in place to check that recommendations are actioned following place inspection?

Julie Cave will check with the Estates team and will provide an answer to this question.

f. A paper on co-production was presented to the Board at the private session last month, was this co-produced? Should the Trust attach a Non-Executive Director (NED) to the co-production project to ensure it is done?
It was confirmed that the co-production paper was co-produced. However, attempts are being made to ensure every opportunity is taken to co-produce work to add value and consideration is being given as to how this is built into internal practices to ensure it consistently happens.

It is not proposed to allocate a NED to this project as it is not their role to oversee operational issues. However following some NED interim appraisals, a number of them will be on recovery college courses as part of their development.

g. The discrepancy in funding for mental health was raised. It is understood that 23% of the burden of illness in the NHS is mental health. Conversely only 13% of the funding is provided for mental health. Last year, CCGs were advised to put more funding into mental health and at Prime Minister’s Question Time on 26th October 2016 is was stated that 59% of CCGs throughout the Country were paying less than last year. What percentage of the funds that are available to CCGs are they paying to mental health?

Michael Scott confirmed that the data quoted at Prime Minister’s Question Time was taken from the Kings Fund Report. Figures provided by KPMG show that the difference in growth between commissioner spend for NSFT and acute hospitals is 20% less. CCGs have reported that they have spent this money on mental health but not with NSFT but currently there is no way of checking this information. However, CCGs are going to be compelled to produce information on where they spend their resources in the future.

h. Is there any funding coming through for adult long-term schizophrenia?

Michael Scott confirmed that there was not currently any funding available for this but the Five Year Forward View specifically references crisis and acute care. In addition funding for wellbeing has been confirmed.

### Action 16.177

The process for checking that recommendations from Place inspections are actioned is to be circulated *(Julie Cave)*

### vi. Reappointment of Hospital Managers

Gary Page took paper as read and the Board approved the reappointment of the hospital managers.

### vii. Changes to Constitution

The Board approved the proposed changes to the Constitution.

### 16.178 Items for Assurance
i. **Quality Account Report**

The report was taken as read and Jane Sayer provided the following update:-

1. For quarter 2 progress on achieving the quality priorities in the Annual account are on track. More work is required on patient experience and the patient survey results will be brought before the Board as soon as they are available.

2. Lots of work has taken place on care planning and compliance rates and central to that is the experience of those planning their own care. Work will continue on this issue. A query was raised as to whether the care planning training has a recovery-focused approach and it was confirmed that the training has been co-produced.

The Board noted the report.

ii **Equality Delivery Scheme (EDS) Objectives Update**

Michael Scott outlined the contents of the report to the Board and highlighted the graph on page five and the improvement of staff perceptions in how the Trust is promoting equality. However, there is still work to be done on this issue.

The Board discussed the equality leads group and noted the membership’s positive motivation for the important work that they do.

Equality and Diversity Level 2 compliance has declined and a request has been made that this is put back on Lara to ensure the training is carried out. This is being monitored to see whether this is a compliance issue or a capacity issue as it is often difficult for staff members to release themselves for a half day of training. However, it appears that some training sessions have been cancelled due to lack of attendance. It was also suggested that we carry out a pilot project to have BME staff on interview panels. It was agreed that Gary Page would meet with Leigh Howlett and Ravi Seenan to investigate this further.

E&D Training figures will then be reviewed once the Oracle Learning Management system is in place.

It was noted that the EDS model should be reflected throughout the Trust and this is not the case in the Trust’s senior management and Board. It was confirmed that this will be a focus for NED recruitment next year with proactive planning with minority groups in Ipswich and Norwich. This issue has been discussed at Nominations Committee and it was agreed that some learning and advice could be taken from local constabularies and councils on this issue.
It was agreed that it was also important to recognise other protected characteristics as part of this work such as the disability and spirituality groups too. NSFT is planning an equality conference for 2017 to help to celebrate what has been done so far and to identify what can be done in the future.

The Board noted the report.

**Action 16.178ii**

A meeting is to be arranged between Gary Page, Leigh Howlett and Ravi Seenan to investigate why E&D Level 2 compliance is falling and to discuss a pilot project to have BME staff on interview panels (Gary Page)

**Committee Chair’s Reports**

**iii. Audit and Risk Committee Chair’s Report**

Ian Brookman commented that the meeting on 14th October 2016 examined the Risk Register which, whilst rated green, can still be built and improved on. This is being taken forward with the risk team.

The tender process is underway for Internal Audit. Much of the work will take place in November/December 2016 and there will be Governor involvement with the panel.

The report was noted.

**iv. Quality Governance Committee Chair’s Report**

Gary Page highlighted that the Terms of Reference were not attached and these will be circulated separately via email.

The most recent Quality Governance Committee (QGC) meeting took place on 25th October 2016 and the key issues covered were ligature points, care plans and Lorenzo. There is an element of frustration emerging from clinicians that much of their time is being taken up by entering information into Lorenzo and are therefore not as productive as they were before Lorenzo was introduced. A request has been made for more administration staff to be made available to assist with this. Work is therefore taking place as to business processes and whether administration staff can help to alleviate this problem. A report will be brought before the Board in January 2017 on what can be done to improve productivity post Lorenzo.

The Serious Incident annual report was examined and analysis showed that there had been an increase in unexpected deaths. The underlying causes show that this increase is largely due to physical health conditions. There has not been an increase in suicides. This does mean that more work needs to
be done around physical health checks and identifying issues that require
management and treatment and passing these on to the most appropriate
experts to provide the care required.

The Board noted the report.

**Action 16.178iv**

QGC Terms of Reference to be circulated to the Board of Directors via email
(Kate Hope)

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v. **Charitable Funds Committee Chair's Report**

Brian Parrott was unavailable to present this report and it was agreed that
this item would be placed on the agenda for 24th November 2016.

16.179 **Any other urgent business, previously notified to the Chair**

There had been no notifications of urgent business.

16.180 **Questions from the public**

The meeting took further questions from members of the public and the
following questions were put to the Board:-

1. Assurance was requested that all services users throughout NSFT have a
care plan. In addition, assurance that the relevant people are being
copied in to care plans such as carers and advocates.

   It was confirmed that with the introduction of Lorenzo, it is possible to
   identify where care plans are missing. A great deal of work is taking
   place to ensure that all plans are in place and service users have input
   into these plans. More work is taking place around the quality of each
   service user's care plan and that they are co-produced with NRP.

2. Discharge letters to general practitioners were discussed and it was
raised that at times these letters were too long and cumbersome. It
would be worthwhile liaising with GP practices to ensure discharge letters
are succinct and only provide the information required.

   Leigh Howlett confirmed that work is already taking place with a number
   of practices in central Norwich to get the balance right for the Trust and
   for GPs.

3. The importance of continuity of care was raised and how, if you are
suffering from ill health, referrals to numerous clinics can be unsettling.
Debbie White confirmed that some changes were being made to support this. The Access and Assessment Team has been disbanded so patients are now assessed by the staff that are going to treat them. This change took place on 24th October 2016 and so will take a little time to become embedded throughout NSFT.

4. Concern was raised as to those unexpected deaths that occur as a result of self-neglect. In the past, care coordinators were often social workers who were able to see when things were going wrong and raise the alarm accordingly. Has there been a loss of that skill and is the Trust focused on this particular group of highly vulnerable service users?

Debbie White confirmed that the introduction of the STPs will be bringing organisations and their working practices together and nurses and occupational therapists often provide these skills. The Trust does employ some social workers but a campaign is being planned to attract more into the Trust.

5. The reduction of funding by 20% for the Norfolk Recovery Partnership was raised and whether jobs would be lost as a result?

It was confirmed that a plan has been developed with the Matthew Project and this was submitted for approval on Monday 24th October 2016 and the Trust is waiting for feedback on the plan from commissioners. As less funding is available, the model has been changed to feature more group work and less one to one work. NSFT is confident that the change in model will not compromise quality or safety. If staff changes have to be made, there are enough vacancies available throughout the Trust to ensure that staff can be re-deployed.

16.181 Date, time and location of next meeting

The next meeting of the Board of Directors will be held in public on Thursday 24th November 2016 at the Elisabeth Room, Endeavour House, Russell Road, Ipswich IP1 2BX.

16.182 Motion to exclude the public and press from confidential part of the meeting

The meeting closed at 12.06.

Chair: .................................

Date: .................................
Minutes of the Annual General Members’ Meeting
held on Thursday 20th October 2016
IP-City Centre, 1 Bath Street, Ipswich IP2 8SD

Present:

Gary Page: Chair
Tim Newcomb: Non-Executive Director
Brian Parrott: Non-Executive Director
Michael Scott: CEO
Leigh Howlett: Director of Strategy and Performance
Dr Jane Sayer, Director of Nursing, Governance and Performance
Julie Cave: Director of Finance
Debbie White: Director of Operations – Norfolk and Waveney
Dr Bohdan Solomka: Medical Director
Tim Newcomb: Non-Executive Director
Brian Parrott: Non-Executive Director
Ian Brookman: Non-Executive Director
Tim Stevens: Non-Executive Director
Jill Robinson: Non-Executive Director
Marion Saunders: Non-Executive Director (SID)

In attendance
Kate Hope: Assistant Company Secretary
(minutes)

There were 48 members of the public, staff and press were present.

Meeting commenced at: 14:32

A16.01 Chair’s welcome, notification of any urgent business and apologies for absence

Gary Page welcomed everyone to the meeting and thanked members of the public and staff for their continued interest in the Trust’s work.

Apologies were received from:

Guenever Pachent: Public Governor – Suffolk (Lead Governor)
Kathleen Ben Rabha: Public Governor - Suffolk
Ron French: Norfolk Public Governor
Kevin James: Norfolk SU Governor
Sheila Preston: Norfolk Public Governor
Jane Millar: Suffolk Public Governor
Sue Whitaker: Partner Governor
Anne Humphrys: Carer Governor
Nigel Boldero: Norfolk Public Governor
A16.02 To approve the minutes of the Norfolk & Suffolk NHS Foundation Trust Annual General Meeting held on 8th October 2015

The minutes were approved as accurate.

i. To approve the release of the minutes in accordance with the Freedom of Information Act

The minutes were approved for release in accordance with the Freedom of Information Act.

A16.03 To address any Matters Arising from the minutes of the previous meeting, not covered by the Agenda

There were no matters arising.

A16.04 To receive the 2015-2016 Annual Report

Michael Scott presented the 2015-2016 Annual Report.

The Trust has worked hard to listen, learn and improve following the Care Quality Commission (CQC) inspection in October 2014. Following the re-inspection in July 2016, the CQC confirmed that the Trust had made significant progress and recommended that NSFT are taken out of Special Measures which was subsequently confirmed by NHSI on 14th October 2016. Rather than waiting for the final CQC report, immediate action was taken on the early indications and recommendations made by the CQC after the inspection in July 2016. There is an action plan in place which aims to take the Trust forward to good and then subsequently to an outstanding rating.

During 2015/2016, the Board of Directors engaged with staff, service users and carers to define the values of the Trust. 2,000 people engaged with this exercise and the new Trust values were officially launched at the AGM last year. Since then staff have been living the values, embedding them in all they do and this has was recognised by the CQC in their report as was the marked improvement in staff morale. In addition sickness absence figures for staff are the lowest they have ever been since the merger. As part of the ongoing work to support staff, a regular staff survey takes place which now has a response rate of 54%.

The implementation of an electronic patient record Lorenzo has provided real benefits for the storage and sharing of clinical information. It has been a challenge to implement the new system but it is already providing both safety and quality benefits.
To improve quality and to achieve financial stability NSFT has concentrated on working as one Trust, focusing on prevention, early intervention and promoting recovery.

Significant investments have been made in fifteen new beds on Thurne Ward at the Hellesdon site. In addition £3.6m has been spent on recruiting more staff for safer ward staffing.

A clinical Strategy has been created and co-produced with service users, carers and our commissioners with a view to raising the quality of the services provided and establishing a culture of continuous improvement.

Further work has been taking place on improving service user and carer experiences with the Trust. NSFT invested £257,000 into service user and carer involvement. The Trust’s values were co-developed with the input of service users and carers and NSFT is one of only 18 Trusts who have achieved a gold star in the Triangle of care.

There has been a positive move in improved access for service users to have physical health checks. In addition a bed review has been commissioned to assist in reducing the amount of out of Trust placements in the future.

The Trust currently has more peer support workers than anywhere else in the country. They will be presenting a piece later in the afternoon about the excellent work they are doing throughout NSFT.

It has been a challenging year for the NHS as a whole with all trusts striving to raise quality and balance finances as effectively as possible. However NSFT has managed to meet all financial targets that it has been set. Further work is being done by the Board of Directors in campaigning hard for more investment to combat the chronic underfunding of mental health services.

The Trust has worked extremely hard to build strong foundations during a challenging time for the NHS. This has been successful and plans are in place to build on those foundations for our services in the future.

A16.05 To receive the 2015-2016 Annual Accounts

Julie Cave (Director of Finance) presented the accounts and provided a summary of the Trust’s financial position for 2015/2016.

They year 2015/2016 had closed with a £8.9m deficit. This was lower than the planned deficit of £9.5m. The cash balance forecast for 31st March 2016 was £4m but £8.5m was achieved. Capital expenditure for the last year was £4.3m.

The Trust has a Financial Sustainability Risk Rating (FSRR) of 2. This rating is calculated by the Trust regulators and at the current time this is probably what we would expect to receive.

Julie Cave set out the main sources of income from Clinical Commissioning Groups and NHS England.

Challenges during 2015/2016 were out of Trust placements, agency spend (which remains a problem for Trusts nationally), continued financial efficiency for the NHS as a whole and parity of esteem for mental health services.
During the year NSFT has invested capital into improvements to its patient care facilities, IT infrastructure and maintenance of estates. A large part of this maintenance is to ensure continued security and fire safety compliance.

Looking to the future, all Trusts have been issued with control total figures to achieve in 2016/2017. NSFT has been asked to achieve a £4.8m deficit for 2016/2017, £1.1m deficit for 2017/2018 and a surplus for 2018/2019.

One of the Trust’s main priorities for the coming year is to achieve parity of esteem for mental health services and the Trust is working hard to hold CCGs to account for that. Sustainability and Transformation Plans are being developed for Norfolk and Suffolk in partnership with other organisations and it is hoped that by 2021 much more investment will be made in mental health to improve the level of care for service users and patients across the counties.

A16.06 Motion to approve the Annual Report and Accounts 2015-2016
Sue Whitaker (Norfolk Partner Governor) proposed the motion.
Marcus Hayward (Staff Governor) seconded the motion.

The motion was approved.

A16.07 Quality Update

Jane Sayer provided an update to the AGM on Quality. The last year has not just been spent preparing for the CQC inspection and our quality journey does not end after the inspection. Quality is a continuous journey and has to be embedded through our passion for delivering excellent mental health care.

In November and December of 2015 the Trust undertook a mock inspection. This provided staff with an opportunity of taking control of their environment together with service users, carers, governors and CCGs. The findings of the mock inspection mirrored that of the recent CQC findings and the process of inspection is something the Trust will continue.

A summary of improvements throughout the Trust were provided and these have improved considerably. A majority of the work required to be done as a result is on inpatient services and in particular seclusion, ligature points, medication processes and improvements to the environment.

One of the main challenges ahead is to ensure the Trust has a full compliment of qualified nurses and the Trust is engaged in dialogue with acute and community services about how we can be more flexible with our nurses in the future.

Work is already taking place on recommendations made by the CQC during initial post inspection feedback. The Trust is not complacent and is taking steps to ensure that the quality improvement journey is a continuous process in every service, every day with a view to move from good to outstanding ratings in the future.
A question was raised as to who, on the Board of Directors, had made the decision to remove the number of unexpected deaths from the Annual Report for 2015/2016.

Michael Scott responded by confirming that NSFT complies with national guidance when compiling information for the Annual Report and this information was indeed included in the Quality Report. In addition the Trust had commissioned an independent report into unexpected deaths by Verita who concluded that the figures were not higher than average for Norfolk and Suffolk and that the Trust had a culture of early reporting of serious incidents. This report has been published and is available on the Trust’s website.

NSFT’s approach to service user and carer involvement was queried. Does the Trust engage service users and carers at every level?

Jane Sayer confirmed that the Trust had tried over the last year to increase the number of people it engages with. There is still more work to be done. The Trust is increasingly looking at other ways of engagement. There is a presentation during the afternoon on recovery by the Recovery College and the work they do. However more work is to be carried out on overcoming unconscious barriers and on sharing responsibility and coproducing practice.

It was stated that if a trust fails to treat borderline personality disorder, 10% of those people will die. It was suggested that NSFT does not treat those with borderline personality disorder and 157 unexpected deaths in a year are too many.

Michael Scott confirmed that these issues are taken very seriously indeed and one death is one death too many. The Trust is doing all it can to learn about what it can change in the future to reduce unexpected deaths.

Bohdan Solomka also responded to corroborate this. The Trust has set up a serious incident review group. These already take place in Suffolk and are now taking place in Norfolk. The group reviews the detail behind every single death including the decisions made and the thought processes behind each decision. This information is fed into the Mortality Review group for the whole Trust to learn lessons and change the practice on the front line of services.

It was queried that most people in Norfolk do not agree things have improved at NSFT. The service that helps people with obesity has been closed, the Trust does not have enough beds, there is no day hospital available which would keep people safe during the day. What is the Trust’s plan for physical health and the risk to service users of suicide?

Bohdan Solomka confirmed that the Trust is developing a physical health strategy. As part of this strategy the Trust’s care coordinators have active conversations with General Practitioners to establish a physical health plan as an ongoing collaboration to work together in keeping service users safe and as healthy as possible and to find the most appropriate service to deliver that care.
It was noted by a governor that children and young people’s services require improvement. This issue has been raised for the last three years. Are these services now a priority for the Trust and will it involve service users and their families in planning for the improvement of these services?

Alison Armstrong confirmed that it is a priority for the Trust and in Suffolk the Trust is working together with CCGs and Suffolk County Council to improve these. Gary Page recently wrote to the CCGs expressing concern at the pace of the proposed improvement work. A member of senior staff in Suffolk has been seconded to Suffolk County Council to get the single point of access services up and running. The involvement of service users and carers in these types of decisions is championed in Suffolk all the time. Further investment has also been requested for these services to enable the employment of more staff.

Debbie White confirmed that she too shares concerns about children and young people services for Norfolk. She has a meeting on 21st October 2016 at 80 St Stephens, Norwich to discuss the concerns outlined in the CQC report. This is being taken very seriously and she invited the governor to be part of the solution forming process.

Jane Basham had a number of specific questions raised by Councillor Emma Corlett who was unable to attend the AGM. It was agreed that these would be submitted by email to Jane Sayer to allow the Trust to provide a full response to all her questions. Specifically she raised a query in relation to children being admitted to adult wards, why this has happened, what the total number of days were for children held on adult wards, how many children were admitted to out of area beds and what support is given to parents to visit their children when placed out of area?

Michael Scott confirmed that more children’s services are required locally. In Norfolk and Suffolk a total of £3m has been released through local transformation plans. NSFT has opened five new beds for young people in Lowestoft to ease pressure on services. Unfortunately, commissioning of services has to wait for confirmation from commissioners that they will buy them. in the meantime children are having to be placed out of area.

A member of the audience, who is also a carer welcomed a further analysis of the findings of the CQC report, especially with a response from carers. It is concerning that areas in the Trust remain unsafe especially the Psychiatric Intensive Care Unit (PICU).

Jane Sayer confirmed that the Trust has two PICUs and the CQC have not identified which unit they are referring to specifically in their report therefore the Trust is reviewing them together. Work is required on the environment and on ligature points. A rapid review of the units and the areas identified by the CQC is underway.

A further query was raised in relation to student nurses. The government are taking away bursaries for student nurses and therefore more information is required as to what representations NSFT has made to the government about this decision and whether it actually argued for reversal of that decision?

Jane Sayer confirmed that when the decision was announced it was done so without consultation. It is already a challenge to recruit student nurses into
mental health. The Trust sent back representations through the Royal College of Nursing and NHS England. Unfortunately we have to assume that this decision is not going to change. Therefore the Trust is in detailed negotiations with both local universities about increasing the number of placements we have. In addition the Trust is supporting people who want to train but who are not in a position to do so and this is being done via care apprentices and flexible nursing pathways. The Trust is taking this issue very seriously and it is very concerning.

A query was raised as to whether service users who required a medication change could be brought in to hospital to monitor medication changes? In addition will the Trust take responsibility for the helping those with physical health challenges such as obesity?

Bohdan Solomka confirmed that this was unlikely to happen unless it was a specialist medication change which required admission. Beds that are being used are being used for emergency situations. It is therefore much harder to bring people in for a planned admission. In relation to physical health, it is not just NSFT’s role to play a part in that but also for GPs, public health, the leisure industry and food manufacturers.

There were no further questions or comments.

Meeting closed at: 15:30

Chair: ………………………………………

Date: ……………………………………….

Following the meeting there were presentations on the following topics:

- Service User Video
- Recovery College
- Wellbeing Suffolk
- Newly Qualified Academy Graduation
### Matters arising from Board of Directors’ meeting – 27 October 2016

#### 16.175 – CEO’s Report

| a. CQC Action Plan to be added to the agenda for the meeting on 24th November 2016 (Kate Hope) | Completed. On agenda for private session. |
| b. The Board’s thanks are to be extended to the staff at Dragonfly unit for all their hard work on the recent move (Debbie White) | Completed. 14/11/2106 |
| c. Update to be provided on the Compass Service and the HSJ awards at the Board meeting on 24th November 2016 (Michael Scott) | Verbal update to be provided on 24/11/2016 |

#### 16.177i – Programme Management Office Progress Report

Future PMO reports should include more context about the Trust’s overall performance when reporting on WMB for temporary staffing and nursing hours (Leigh Howlett)

Completed. A top level summary on Temporary staffing breakdown as part of the standard reporting for the Workforce Mobilisation Board [WMB]. This will be included in the next reporting period

#### 16.177ii – Finance Report

The applications of Marvel will be reviewed to see if the system can be used to track ligature risks raised through to their conclusion (Leigh Howlett)

Currently under review by IT before any roll out begins.

#### 16.177iii – Business Performance Report

| a. Future BPRs to include an analysis of reasons for absence for other Trusts for comparison (Leigh Howlett) | Completed. Will be effective from January 2017 |
| b. A separate breakdown is to be provided of figures for absence for stress, anxiety and depression (Leigh Howlett) | Completed. Will be effective from January 2017 |
| c. Vacancy rates to be examined to ensure reporting is not misaligned with non-clinical and clinical staff vacancy rates to be split in future reports (Leigh Howlett) | Completed. Will be effective from January 2017 |
| d. Further information and analysis is required on sickness absence rates to be presented to the OD&W Committee for review (Leigh Howlett) | Completed. On agenda for forthcoming OD&W meeting |
### Questions from members of the public

The process for checking that recommendations from PLACE inspections are actioned is to be circulated *(Julie Cave)*

An action plan is compiled following the PLACE inspection with named responsibilities and timescales. Improvements have been made to the process so this is more visible to all.

<table>
<thead>
<tr>
<th>16. 178ii – Equality Delivery Scheme</th>
</tr>
</thead>
<tbody>
<tr>
<td>A meeting is to be arranged between Gary Page, Leigh Howlett and Ravi Seenan to investigate why E&amp;D Level 2 compliance is falling and a pilot project having BME staff on some interview panels <em>(Gary Page)</em></td>
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<tr>
<td><strong>Completed.</strong> Meeting arranged for 05/12/2016.</td>
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<table>
<thead>
<tr>
<th>16.178iv – Quality Governance Committee Chair’s Report</th>
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<tbody>
<tr>
<td>QGC Terms of Reference to be circulated to the Board of Directors via email <em>(Kate Hope)</em></td>
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<tr>
<td><strong>Completed.</strong> Circulated 17/11/2016</td>
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Executive Summary:

This report highlights some key observations following the meetings that have taken place over the last month and includes a list of the key meetings that I have had.

1.0 Key observations from the month:

I spent an evening at the A & E unit in the QE hospital in Kings Lynn where my father was being admitted into hospital and the next morning had a scheduled visit to the Psychiatric Liaison Service at the N and N the morning after. I saw first hand the enormous pressure the A and E units are under and how the experiences of patients with MH conditions varies depending on the Psych Liaison services commissioned. We have an excellent team in Norwich fully integrated into the acute hospital with a 24/7 service. I was really taken aback by the number of patients with MH conditions going through A and E. I contrast that with what I saw in Kings Lynn and the knowledge that there is no night-time provision at all in Suffolk. We are continuing to lobby commissioners and the acute hospitals for a more consistent service across our Trust.

It was wonderful to visit the new Dragonfly Facility and to see a motivated and dedicated workforce. BBC Look East have highlighted the fact that we have 5 beds which, with the appropriate staffing, could be opened up at a time when children from East Anglia are being sent out of area.

These two visits showcased some of the excellent work being done in the Trust and the importance of continuing to stand up for mental health to ensure commissioning better meets the demand for services in the region.

2.0 Key Meetings

2.1 Staff and Services:

- I conducted the interim appraisal for CEO, Michael Scott.
- I visited the Psychiatric Liaison Team at the Norfolk and Norwich University Hospital.
I completed the interim appraisal for the Non-Executive Directors.
I had my Interim Appraisal with Senior independent Director, Marion Saunders.
I visited and met with members of Stowmarket IDT together with representatives from Mid Suffolk District Council
I attended the Equality Lead Network meeting in Diss.
I visited the new childrens in-patient facility, the Dragonfly Unit at Carlton Court.
I attended the monthly Finance Committee.
I had a one to one meeting with Michael Scott.
I met with Emma Townsend to review the progress on the development of a revised discharge letter for Service Users
I chaired the November Quality Governance Committee meeting.
I participated in a Q and A session as part of the Consultants Development Programme.
I participated in the Board Development Day on the STP process
I participated in the shortlisting meeting for the recruitment of 15 new Hospital Managers.
I chaired a teleconference with the Non-Executive Directors.
I participated in a Terms of Reference setting meeting for a Serious Incident Review together with Debbie White, Director of Operations Norfolk

2.2 Service Users and Carers and Governors:

I participated in the Membership Strategy event in Diss organised by Governors.
I had a one to one with the Lead Governor, Guenever Pachent.
Together with Andrew Good, Governor I hosted the NSFT governor special event, Dementia in Perspective held in Ipswich.
I chaired the Service User and Carer Trust Partnership meeting which monitors the progress made on implementing the Service user and carer Strategy
I met with a service user in Mariner House to discuss a complaint he had made about our services
I gave a presentation in Ipswich to members of the public interested in standing as Governors in the upcoming election
I met with Kevin James, Service user Governor
I participated in the Planning and Performance Committee meeting
I participated in an informal Governor meeting re co-production and the CQC Report Action Plan
I met with Luke Woodley to discuss the Veterans Stabilisation Programme

2.3 External Organisations:

I attended an STP and Governance meeting of the East Suffolk and North Essex STP
I participated in the steering committee for the development of a Youth Hub in Bury St Edmunds with West Suffolk College and the Mayor of Bury.
I attended the meeting of the Norfolk NHS Provider Chairs.
I attended the Mental Health Provider meeting in Lowestoft.
I held my last conference call with Dean Fathers Chair of Nottinghamshire MH Trust who were our Buddy trust.
I met with Suffolk Mind and were given a tour of their new Meeting Rooms at Quay Place in Ipswich.

3.0 Recommendations

3.1 The Board is asked to note the report.

Gary Page
Chair

Background Papers / Information
None
Executive Summary:

This report provides an update on the main issues, insights, observations and activities undertaken by the Chief Executive over the past month.

1.0 Leadership development:

1.1 We have had a number of development days as part of our new leadership development strategy:

**Senior Management Team** - Directors, locality managers, clinical leads and matrons met for the day to improve the way we work together and deliver key objectives for the Trust.

**Senior Management Engagement Forum** – this is a regular meeting and this month we met to discuss 2020 visioning, building our future workforce.

2.0 Joint Development with Norfolk Community Health Care:

2.1 We met with the executive Team of the community trust which runs services in Norfolk and Suffolk. We were looking for areas where we can better work together in the service of our patients. We found obvious areas of synergy including children’s’ services and those for older people. We went away with a number of actions to see how we can better work together.

3.0 Health and Wellbeing Board:

3.1 I addressed the Norfolk H&Wb Board in relation to STPs and the position of Mental Health

4.0 STP:

4.1 Both plans were submitted; for Norfolk and Waveney and Suffolk with North East Essex.
5.0 **HSJ Awards:**

5.1 Our work with children and young people has been shortlisted for an HSJ award. As these are being held on the 23rd November a verbal report of the event will be reported.

5.2 We also have a short-listed team from the Central Norfolk Eating Disorder service for the East of England Leadership awards. Our Liaison and Diversion service is also nominated for a national award which is the Howard League for Penal reform’s community awards.

6.0 **Chief Executive visits and meetings:**

6.1 I met with my linked governor, Dr Wyn to discuss various aspect of the Trust and keep him up to date.

6.2 I met with Abdul Razaq who is the new Public Health & Protection at Suffolk County Council.

6.3 I attended the inaugural lecture of Professor Mioshi who is one of our new dementia professors. Professor Mioshi who has a therapist background and Professor Michael Hornberger are both dementia Professors. I also helped host a dementia evening at the Julian Hospital with Professor Hornberger.

6.4 I attended a national leadership of NHS Improvement and NHS England about the way forward which was a useful meeting.

6.5 I joined the stake-holder group for the post of Director of Adult Services in Suffolk but unfortunately no appointment was made. In Norfolk, James Bullion has been appointed to the equivalent role.

Michael Scott  
Chief Executive
Executive Summary:
The tables below give a summary of current activity reference to CIPs and QIPs.

**CIPs:** There are currently 6 active and 15 inactive CIP projects

<table>
<thead>
<tr>
<th>CIP Schemes</th>
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<tr>
<td>Red</td>
<td>0</td>
</tr>
<tr>
<td>Amber</td>
<td>2</td>
</tr>
<tr>
<td>Green</td>
<td>4</td>
</tr>
<tr>
<td>On Hold</td>
<td>0</td>
</tr>
<tr>
<td>Closed</td>
<td>15</td>
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**QIPs:** There are currently 22 active and 29 inactive QIP projects:

<table>
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<th>No.</th>
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<tbody>
<tr>
<td>Red</td>
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</tr>
<tr>
<td>Amber</td>
<td>7</td>
</tr>
<tr>
<td>Green</td>
<td>10</td>
</tr>
<tr>
<td>On Hold</td>
<td>1</td>
</tr>
<tr>
<td>Closed</td>
<td>28</td>
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**Red schemes:**
- QIP022 - Clinical Strategy Development and Implementation.
- QIP024 - Physical Health Monitoring
- QIP042 - Statutory / Mandatory Training
- QIP048 - Management of Section 17 Leave
- QIP053 - External Specialist Placements
1.0 Overview of Progress

Workforce Mobilisation Board (WMB):

Temporary staffing: The Trust is meeting its year-to-date target for agency spends, however, pressure is building as we fill vital clinical roles with Locums. Figures from NHS Improvement show we are amongst the best performers in the region.

Temporary staffing Task and Finish Group to focus on key areas: Locums, Specialising, Non-medical, non-clinical and NHSp Grow the Bank. New Suffolk AD of Operations agreed to be a member of the Task and Finish Group.

Skills gap in West Norfolk: this may be addressed by the proposed remodelling of NRP driven by the reduction in the funding envelop. Any migration of staff will need to be carefully managed as NRP changes will not take place until September 2017. Local discussions have made good progress on the reduction of Locums.

e-Rostering: project implementation review will be undertaken January 2017 focusing on the in-patient implementation. Detail of review to be developed by project team. It was recognised that there remains some dissatisfaction with e-Rostering in some areas and that these views should be taken in to account as part of the review alongside the more positive experiences. Financial impact (benefit analysis) will also be considered as part of the review.


Clinical Strategy: It was recognised that anything outside of business as usual would have resource implications. It was agreed that a small group including the Director of Operations for both Norfolk and Suffolk meet to discuss priorities. Any identified resource and/or associated costs with the rollout of clinical strategy elements would need to be identified by early December 2016 to be included within the business planning cycle. There is a real risk that due to timing pressures, limited clinical strategy elements would be funded 2017/18.

Technology Mobilisation Board (TMB):

Update on CIP053 Skype for Business: Rollout of Skype for Business to clinical teams continues. Skype for Business was presented at the Acute Services Forum (ASF) and was well received, with the presentation being delivered by Skype. A similar presentation is being planned for the Senior Operational Team meeting. A service user has also been identified/volunteered to be the first non-Wellbeing service user to receive treatment by Skype.

Data Warehouse 2: The purpose of this project was to scope the Trust’s requirements for a replacement data warehouse. This was to include development of a service specification that could be used for ITT, and indicative costs. For this purpose an external business analyst was brought in. All targets have been achieved, and a project closure document will be submitted next month. Before the CF1 is raised, the indicative costings are to be checked by forwarding the specification as means of “Requests for Information” to one or two prospective suppliers.

eMMa: Phase 1 handover of system support into BAU has now been completed meaning that the unfunded cost pressure resolved. eMMa phase 2 scoping is underway (QIP056) and will report in January 2017

Core switch replacement timeline: The core switch is the central driver of the NSFT network. The current core switch is nearing the end of its life. A replacement CF1 was approved in July 2016, and the installation of the replacement will take place on 19 and 20 November. This may result in some downtime over that weekend, which will be communicated to Operational and Clinical teams. There are no expected on-going impacts from this replacement
Estates and Bed Mobilisation Board (EBMB)

HQ Project Initiation Document and approach: It was agreed that a new PID will be developed for the creation of a detailed specification. Once the specification has been approved this will inform future work streams, Quality Impact Assessment and implementation/ communication planning.

Secure Services Update (CIP066): The estates construction plan is on target with both Whitlingham and Foxhall House contractors on site. Whitlingham is due for completion by the end of the current financial year and Foxhall House will complete April/May 2017. The Norvic works is out for tender April 2017 with a build start date of July 2017 and a completion of April 2018.

West Norfolk Acute Adult Pathway (QIP051): It has come to our attention that the Chasserton House site has been classified as a Flood Risk Level 2 Area; as a result we are seeking clarification from the Environment Agency regarding the potential defence requirements for any new build. This complexity and uncertainty around build standards may have an impact on overall capital needs with the fully worked up options paper now being targeted for the December16 Finance Committee.

Hammerton Court Continuing Care: After a promising start, temporary staffing costs are seen to be rising. The Locality Operations Manager - Norwich, Central DCLL, supported by Deputy Nursing Director are actively reviewing the local approval process and reasons for extra staffing needs to control and to mitigate the wards negative cost variance.

Long-term, it has been agreed by the executive team to develop a business case to review the configuration and purpose of the bed stock on the site with greater focus on assessment and treatment.

2.0 Red RAG status QIP and CIP updates:

QIP022: Clinical Strategy Development and Implementation: projects that can be started within this financial year have been identified by lead clinicians; with PD pathway review now underway (QO062). These projects need review by executive and operational senior management team to set and agree prioritisation. Difficulties encountered in timing / scoping of projects not fitting with the annual planning process. It is recognised that anything outside of business as usual would have resource implications, the resource gap will be better understood after the prioritisation process. Overall rating moved to Red due to increased concerns about ability to deliver change in 16/17 and 17/18. Route to Green will come from executive agreement on prioritisation, funding envelop and timings of key elements of the clinical strategy implementation.

QIP024: Physical Healthcare monitoring: Scheme has moved from amber to red. It was observed that all aspects of the project are in place and that the RAG status is due to compliance issue. Going forward, the recommendation is to close the project as the QIP has delivered the necessary processes and procedures which now need to be enforced through BAU operations management.

QIP042: Statutory / Mandatory Training: although the overall Statutory/ Mandatory Training is approaching 85%, the Project remains at a red RAG status due to poor compliance against the nominated 6 key elements. Throughout October 2016, staff who were not compliant with their Stat / Mand training have been contacted directly, and brought to the attention of their line managers to prioritise release for training. Further solutions (subject to the outcome of a
formal risk assessment) are being considered such as frequency of refreshers, the use of e-Learning and technology solutions and working with other organisation to increase flexibility for the staff. In addition, the Director of Nursing has made an initial approach to the QEH and NCHC about joining together mandatory training needs in the West Norfolk Locality, with a follow up meeting planned for end of November 2016.

QIP048: Management of Section 17 leave: although the general compliance levels have improved significantly from project baseline, project RAG status remains Red due to compliance targets not being achieved. A multi-disciplined workshop has reviewed, agreed and approved the process going forward. A flow chart detailing the process will be disseminated by the Medical Director to all Clinical Team Leaders, Matrons, and in-patient services Operational Managers. A project closure document will be prepared for the December 2016 Workforce Mobilisation Board approval. Oversight and management will sit with local operational managers within BAU, with compliance monitoring by the existing bi-monthly MHA heat map.

QIP053: External Specialist Placements: At the current trajectory the full year planned budget is forecasted to be £1.2m overspent. This relates to Norfolk & Waveney only as Suffolk has a different funding arrangement with their commissioners. It has been agreed that a multi-disciplined caseload “Review Team Approach” is undertaken for 3 months trial / pilot. The review team will be led by the PICU Rollesby Consultant, and consist of three experienced Mental Health Practitioners drawn from central acute services. The pilot team will review of all patients currently in specialist placements. The review will prioritise actions needed for each placement based on available information and face-to-face interviews/assessments.

The team will provide a report for each placement, to include: a) Effectiveness of the placement with regard to achievement of clinical progress b) Clear pathway recommendations c) What needs to be put in place for the safe return to NSFT services, alternative agency/provider, discharge, etc. d) identification of potential ‘blocks’ to progressing recommendations e) The pilot team will engage with existing care co-ordinators concerning future pathway planning. The review team will be seen as having a ‘doing’ role to take immediate steps to implement identified actions. Members of the Norfolk & Waveney pilot team will meet with Suffolk External Placement Team to understand their systems/processes and apply any learning where appropriate. Based on their experiences during the pilot period, the pilot team will produce a report to include lessons learnt and recommendations for managing external placements going forward e.g. possible establishment of a permanent team, links with PD strategy etc.

3.0 New Mobilisation Boards identified Risks:

There is a risk that capital funding for Data Warehouse 2 and other technology projects in 17/18 may not be forthcoming, owing to competing requirements.

The Datacentre and Disaster Recovery projects require physical locations to house the equipment (with specific power and cooling requirements) – until these locations have been identified there is a risk to the timely delivery of the project, the quality or the cost.

4.0 PMO Communication Update:

“Growing the bank” campaign will commence this month. Focus will be on recruiting existing multi-post holders to the bank and attracting agency staff. New band 5 registered nurse bank rate will take effect from beginning of December 2016. In support of this initiative there needs to be a consistent message that overtime is banned and bank should be used instead.
The Secure Services project team have received a written message of thanks and support from Union Representation on the consultation process so far.

6.0 **Recommendations:**

The Board is asked to note this report.

Stuart Clifton  
**Head of Programme Management Office.**
Report To: Board of Directors
Meeting Date: 24th November 2016
Title of Report: Quality Report, Quarter 2, July - September 2016
Action Sought: For Assurance
Estimated time: 15 Minutes
Author: Michele Allott. Deputy Director of Nursing
Director: Dr Jane Sayer, Director of Nursing and Quality

Executive Summary:

This report summarises Trust-wide information regarding patient safety activity in Quarter 2 (Q2), July to September 2016, for the Board of Directors' assurance.

This report aims to provide the Trust Board with quantitative and qualitative data in order to provide a rounded and consistent way of tracking improvement in the quality of care we offer. Data within this report was presented to the Quality Governance Committee in October 2016 and this report provides focus and analysis on those areas of concerns identified by the committee for assurance.

A glossary of terms is included within this report for information.

The data within this report indicates that while there are spikes in activity over the course of the quarter, there have been no exceptions within natural variation and, as such, the spikes in activity noted should not present a cause for concern to the Board but should be recognised as accepted variations within reporting.

The National Reporting Learning System (NRLS) report covering the period October 2015 to March 2016 (appendix 1) was published during the Q2 reporting period and is included as an appendix within this report. The report highlights that during the 6 month reporting period NSFT reported 77% of all incidents as ‘no harm’ in comparison to 63% nationally. NRLS highlights that high reporting organisations with low levels of harm demonstrate a positive safety culture of openness and transparency.

A number of system pressures are emerging within NSFT that have the potential to impact on the safety of services. The pressures around staffing and capacity within services were highlighted in the recently published CQC report and actions are in progress to address these concerns as part of NSFT’s response to the report.
1.0 Introduction

Safety is at the core of providing an effective and high quality healthcare service. Whilst a tenet of all professions is ‘to do no harm’, events of harm can occur for service users whilst in the care of health services. There can be multiple causes for these events including through direct (i.e. action resulting in harm) and indirect (i.e. omission to act influencing circumstances leading to harm) causes. This report provides assurance to the Norfolk and Suffolk Foundation Trust (NSFT) Board on key patient safety indicators and activity. As part of the changes in reporting the information within this report introduces the use of statistical process control charts (SPC). SPC helps to define the variation of past events offering statistical analysis to assist the identification of special events and trends. The benefit of using SPC is that it assists in defining where there are events of significant change.

2.0 Contents

2.1 Process of analysis and key sources of information

Monitoring safety in complex healthcare systems relies on a range of indicators which can be grouped into broad classes. Singly they provide critical information but when considered as a group they allow examination of actual and potential matters related to patient safety. The content of this report has been divided into the categories below.

Past Harm: Using information on past events assists in the monitoring of trends and outcomes of harm. Such indicators include the Incident Reporting System (Datix), complaints and serious incidents.

Are clinical systems and processes reliable: Organisation of healthcare relies on resources, structures, systems and processes to provide safe care on a reliable basis. A range of factors can influence reliability. Measurement and recording of reliability can include indicators such as the Incident Reporting System (Datix), Risk Register, complaints, audit and soft intelligence.

Anticipation and preparedness: Healthcare is a constantly changing environment with complex external and internal influences. Adapting to change whilst maintaining and improving safety is a significant challenge. Early identification of change allows the best opportunity to plan and implement suitable interventions. Indicators include the risk register and national and local directives.

Integration and learning: The ability to respond to and improve from safety information is a key patient safety activity. Safety information may be received from external sources (i.e. Central Alerting System, Serious Case Reviews, inquests) and internal sources (i.e. serious incidents).

Summary Analysis: Triangulates and brings together key trends or patterns emerging that require the Board’s attention. The performance of the monitoring indicators referred to above is reported to the Quality Governance Committee. Challenges in their application will be reported to the Board on an exception basis.
3.0 Past Harm

3.1 National Reporting Learning System Report

The National Reporting Learning System (NRLS) report covering the period October 2015 to March 2016 (Appendix 1) was published during the Q2 reporting period. The report covers the reporting period October 2015 - March 2016. During the 6-month period covered within the report NSFT recorded a total of 4,620 incidents. The NRLS report provides NSFT with a national benchmarking process regarding the number and categories of incidents reported and level of harm. NSFT reported 77% of all incidents as ‘no harm’ in comparison with 63% nationally. NRLS highlights that high reporting organisations with low levels of harm demonstrate a positive safety culture of openness and transparency.

The NRLS report highlights the top 10 reporting categories within all organisations reported per 1,000 occupied bed days. In all but two categories, (disruptive and aggressive behaviour and infrastructure which includes staffing and environment) NSFT has reported lower than all other mental health organisations.

With regard to the infrastructure category, NSFT is an outlier reporting 21.9% (a decrease from 27% in the previous report) of its incidents within this category compared to 6% of all other mental health organisations. The risk register reflects the impact of high levels of staffing vacancies, ongoing challenges with recruitment and excess demand on the provision of services (27 risks related to individual/team services).

Disruptive and aggressive incidents, while above the national average, are only marginally higher at 17.1% (a decrease from the previous report of 17.8%) compared to 15.1% nationally. Work continues regarding the reduction of restrictive interventions. The Quality Governance Committee received a presentation in October outlining all of the work carried out to date in reducing restrictive interventions and plans for future improvements.

3.2 Internal Benchmarking and data

Incidents are recorded using an electronic record system called Datix. During the period July to September 2016, 3,836 incidents were recorded. Of those reported incidents, 2,964 (77 %) of incidents resulted in no harm.

The graph below demonstrates the total number of incidents reported within NSFT from April 2015, with the incidents shown by the level of harm reported. To support consistency, the level of harm by which incidents are coded is defined by the NRLS. All submitted incident reports are quality checked by Datix administrators (within the Risk Management Team) to ensure that incidents are reported and coded in line with the definitions of harm. This ensures that accurate, consistent, and reliable reporting systems are in place within the Trust, providing comparable data to benchmark both locally and nationally. A breakdown of how levels of harm are defined is contained within Appendix 2, Glossary of Terms.
During July to September 2016, 38 incidents were recorded with moderate harm (mainly in inpatient services) and three incidents recorded as severe harm, all involving service users in the community. There has been an increasing trend of service users admitted to NSFT with existing pressure ulcers (PU) or transferred back to NSFT from acute trusts having sustained PU while in the care of the acute Trust. This seems to reflect pressures across the whole system of health care within the region. The Safeguarding Team has been involved in discussion with clinical services and work is in progress with both operational and Governance teams to establish clear protocols for transfers to and from acute trusts. The NSFT Safeguarding Lead will also escalate this trend to the Health Executive Safeguarding Board to raise awareness.

The charts in Appendix 3 relate to NSFT’s inpatient services and report past harm events recorded as low harm or above using statistical process control methodology to identify where statistically significant changes occur. None of the indicators are showing special cause events at this time. Observation will be made on the slips, trips and falls chart as to whether future months continue a trend towards a special cause (increasing pattern of six points).

Analysis of incidents by wards provides comparable data by 1,000 bed days (appendix 3). Thurne and Southgate wards report higher levels of incidents and deliberate self harm but analysis of their monthly data shows a fluctuating incident range (from high to low numbers), indicating that acute monthly changes are likely a result of changes in service user admissions and needs. Both wards are of comparable size and perform the same service function of a triage ward, and provide care to acutely unwell people.

Southgate Ward reported higher incidents of seclusion, with an average of 17.57 incidents per thousand bed days in comparison to the next highest reporter, Avocet Ward, at 11.75. In comparison Thurne Ward, which provides a comparable service function and size to Southgate Ward, reports an average of 0.93 incidents of seclusion per 1,000 bed days. Feedback from Southgate Ward indicates that a service user with a complex presentation, who has been in the service for a longer period than usual due to her level of acuity, has contributed to the spike in the use of seclusion.
These data have been shared with both matrons and the PMA lead via the Patient Safety Group and to the QGC via the Patient Safety report. The PMA lead will visit Suffolk to support teams in reviewing practice and previous incidents to support and facilitate learning.

Thurne Ward is noted to have the highest level of complaints within acute services. Activity within Thurne regarding key safety indicators will be monitored closely following the opening of three additional beds to monitor for any emerging trends or themes.

3.3 Reducing Restrictive Interventions

The Quality Governance Committee received a learning event outlining the ongoing work in reducing restrictive interventions. The section below covers key highlights for the Board’s information.

The graphs below uses SPC charts to demonstrate the use of restraint within NSFT during the reporting period April 2015 – August 2016.

**Use of Restraint per 1000 bed days**

![Graph of Restraint per 1000 bed days]

**Use of Prone Restraint per 1000 bed days**

![Graph of Prone Restraint per 1000 bed days]

A recent Positive Champion Network meeting in London highlighted that there has been an upward trend in the reporting of restraints nationally. This has been attributed to
heightened awareness and education in the use of restrictive practices amongst clinical teams.

Tertiary interventions such as prone restraint and seclusion should only be used to prevent immediate harm. The charts below demonstrate the percentage of incidents within NSFT that resulted in the use of tertiary interventions related to all violent incidents, including those related to security such as damage to property, during this reporting period.

<table>
<thead>
<tr>
<th>Restraint Used &amp; Position</th>
<th>Seclusion Used</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supine</td>
<td>Yes 5%</td>
</tr>
<tr>
<td>Prone</td>
<td>No 95%</td>
</tr>
<tr>
<td>Both</td>
<td></td>
</tr>
<tr>
<td>Prone &amp; Supine</td>
<td></td>
</tr>
<tr>
<td>Neither position</td>
<td></td>
</tr>
<tr>
<td>14%</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td></td>
</tr>
<tr>
<td>80%</td>
<td></td>
</tr>
</tbody>
</table>

Out of 18,236 recorded violent incidents during the reporting period from April 2015, 3,724 resulted in restraint and 897 in seclusion, demonstrating low conversion rates from violence to prone restraint (24%). The 14% who were not restrained in either position were mainly incidents where a person was held, usually in later life services, to provide care and maintain safety.

High levels of assault reports continue within later life services. Of the 518 incidents recorded in the top 20 reporting areas, 187 were attributed to later life services with only four of the 187 leading to prone restraint.

Spikes in activity are usually related to a small number of individuals making analysis of the data difficult, e.g. increasing rates of self-harm.

3.4 Serious Incidents

Serious incidents in health care are events where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant that they warrant our particular attention to ensure that these incidents are identified correctly, investigated thoroughly and, most importantly, trigger actions that will prevent them from happening again. Whilst there is no set criteria for a serious incident, events will include unexpected or avoidable death, severe harm such as fractures, pressure ulcers grade 3 and above.

During quarter 2, 60 serious incidents were reported. This compares with previous quarter numbers of 47, 47 and 64. Using Statistical Process Control (SPC) charts to analyse for statistical significance of the data over a longer time period, the chart shows
monthly variation around the mean (red line) but no special cause events, indicating no trends.

3.5 Unexpected Deaths

The definition of an unexpected death is the death of a patient who was not expected to die and who was either open to service or within six months post discharge.

The data points from November 2015 show more than eight data points above the mean, demonstrating a significant change in reporting. A notable influencing factor has been the increase in unexpected deaths within the Norfolk Recovery Service over this 10-month period (52) against the previous 10 months (37). This correlates with national data showing an increase in drug-related deaths year on year from 2012.

During this 10-month period, 20 cases have been confirmed as due to a natural/physical cause against 8 in the previous period. A discussion at October’s QGC highlighted that a number of SIs reviewed within localities has identified a number of cases where natural causes such as bronchopneumonia, diabetes or other chronic conditions were identified as the cause of death. While the physical health care of service users within community services should be provided by GPs, the learning from these cases and the Mortality Review Group should be shared with commissioners as a way of ensuring system wide
learning takes place and that services outside NSFT are responsive to learning identified within our internal reviews. During the year 2015, there was a 5.6% increase in mortality at a population level, an unusual increase for which there is no reliable explanation for at this point. From mental health services’ perspective there has also been a rise in total unexpected deaths over the corresponding 10-month period from 89 to 109.

The table below provides a breakdown of data in relation to the increased number of deaths reported attributed to natural causes. These numbers should be treated with caution as they are relatively low, so variations in totals year on year may not indicate true trends. Not all verdicts have been concluded, particularly for 2015/16.

<table>
<thead>
<tr>
<th></th>
<th>No. of unique people seen</th>
<th>No. Sts</th>
<th>No. Unexpected Deaths</th>
<th>No. UDs in MH Services</th>
<th>No. UDs in NRP</th>
<th>Suicide Verdict</th>
<th>Natural Cause Verdict</th>
<th>Drug-related Verdict</th>
<th>Open/narrative Verdict</th>
<th>Accidental</th>
<th>Not concluded</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>2014/15</strong></td>
<td>103,206</td>
<td>228</td>
<td>139</td>
<td>100</td>
<td>39</td>
<td>44</td>
<td>26</td>
<td>38</td>
<td>20</td>
<td>6</td>
<td>5</td>
</tr>
<tr>
<td><strong>2015/16</strong></td>
<td>112,399</td>
<td>216</td>
<td>158</td>
<td>110</td>
<td>48</td>
<td>42</td>
<td>37</td>
<td>34</td>
<td>19</td>
<td>10</td>
<td>16</td>
</tr>
<tr>
<td>% increase/decrease</td>
<td>8.9%</td>
<td>-5.3%</td>
<td>13.7%</td>
<td>10%</td>
<td>23%</td>
<td>-4.5%</td>
<td>42%</td>
<td>-10.5%</td>
<td>-5%</td>
<td>67%</td>
<td>220%</td>
</tr>
</tbody>
</table>

3.6 **Suicide/Took Own Life Verdict**

Incidents coded to this include those where the verdict specifically states suicide or the verdict states that the person took their own life but their intention is not known (undetermined intent).

The chart is presented up to December 2015 because after this point coroners’ investigation completion drops below 75%. The chart shows a range from zero per month
to seven with a mean of 3.38 per month over this period. In respect of statistical analysis, the chart shows variation but no specific increase or decrease.

3.7 Complaints

The previous quarter noted a four point rising trend in the number of complaints received each month. This quarter shows that trend has not continued with the numbers remaining within the expected variation range.

As part of the complaints’ process, analysis of trends is monitored to support learning across the organisation and for recurring themes.

Complaints across services currently reflect service users' and carers' dissatisfaction and concerns regarding the following:

- Access to services - length of time to access is noted in Wellbeing, CAMHS and youth pathways.
- Allocation and changing of care co-ordinators, specifically in those community teams undergoing changes.
- Attitude of staff and lack of support offered to both service users and carers at times of distress.
- Responsiveness of services in that phone calls are not returned or staff/teams are difficult to contact.
- Care and services not provided to meet service users' needs.
- Standard of care provided such as lack of care plans, medication supply following discharge also noted.

The above themes have been noted in services and teams across localities and counties. It is likely that the trend is linked to capacity of services to deliver and inconsistent staffing levels; for example, one acute ward has experienced a 100% rise in complaints in comparison to the same reporting period last year, and the ward is currently on the risk register for staff vacancies and regularly reports low staffing levels via Datix. Teams undergoing periods of change and restructure are also subject to patterns of complaints related to the changes.
Themes from complaints are fed back to services locally and via the patient safety newsletter to discuss locally at locality and team meetings. Learning from complaints is identified within teams and fed into their five key learning points posters.

3.8 Safety Thermometer

The National Safety Thermometer tool provides monthly point prevalence data, which measures the proportion of patients who are free from harm and who were residing on later life wards within NSFT.

During quarter 2, the Trust did not meet compliance with the 95% target in July and August 2016 at 92.92% and 92.37% respectively. In September 89.83% was recorded. The chart illustrates the number and types of harm recorded in Q2.

![Safety Thermometer Numbers and Types of Harm Quarter 2](chart)

Q2 results demonstrated that a total of 12 harms were recorded as new VTEs of which 9 were recorded as new harms. All later life wards recorded 100% completion of VTE assessments.

A total of two pressure ulcers were reported as new harms and were classified as grade 2. A review of the Trust’s Waterlow Risk Assessment has been undertaken resulting in a weekly review for all patients. To support learning, the development of a wound management modular programme is in progress and will focus more on practical learning. The purchase of simulation aids will aid staff to practise wound management, which includes skin inspections, classification of wounds, aseptic procedure and methods of dressing wounds.

Falls reported during Q2 via the safety thermometer were recorded as low harm. Root causes factors include: physical health problems affecting mobility (gait and balance), lack of spatial awareness and elevation of mood, therefore lowered perception of risk to safety. There is evidence from records that falls screening and assessment of risk were carried out and, where relevant, additional observations for patients who experienced multiple falls has been implemented.

A ‘Safe Care Pathway’ project has been taking place at Hammerton Court, which includes the introduction of a new Occupational Therapy Model of Care. It is envisaged that, with an increase in therapeutic interventions, a reduction in falls within the unit will result.

4.0 Are clinical systems and processes reliable

4.1 Friends and Family Test (FFT)
There have been 657 responses from 1st July – 30th September 2016 with an overall rating for the quarter of 83% of respondents reporting that they would be likely or extremely likely to recommend NSFT services.

The score indicates that the majority of comments received are positive regarding the services and support they receive. Amongst the more critical comments, themes were reflective of complaints such as capacity of services and access to treatment, communication and responsiveness of services are noted. Localities discuss FFT results and feedback as a standing item within the locality governance meetings to monitor feedback and trends and act on those comments that require improvement.

4.2 QuESTT

QuESTT provides an early warning system for teams. It is designed to be a supportive tool that enables clinical teams to provide safe and effective care. Appendix 4 reports results for Q2, where submitted. Non-submission is reviewed at monthly accountability meetings. The scoring produces an overall rating. Wards that score red require immediate support to improve.

Trends to note are an increase in the number of inpatient areas reporting amber scores from green during the last six months (1, 3, 4, 3, 5, 6). Analysis of the indicators is that vacancies and staff sickness continue to be the factors for the increase in scores. Areas consistently reporting amber level are Glaven, Waveney and Churchill wards. Limited frequencies of returns are noted in the last six months for 3 & 4 Walker Close and Acle Ward.

From review of key safety indicators of those wards consistently reporting amber no immediate concerns are noted. Waveney Ward has seen a slight upward trend in incident reporting; from discussion with the matron and review of the data a small number of individuals with high levels of acuity can be linked to the increase in reporting levels.
4.3 Risk Register
During the reporting period (July – September 2016) 27 new risks were added. The chart below outlines their initial risk score.

The new risks graded 16 and above reflect performance and capacity issues. Actions are in place and in progress.

One new risk relates to inaccurate or inappropriate re-clustering of patients within secondary care leading to patients outside of cluster 4 being cared for by the Wellbeing Service (ID1328). It should be noted that the Wellbeing Service has carried out a deep dive review of recent SIs to establish any trends. This will be presented to QGC in November 2016.

The register continues to be dominated by risks related to capacity of services to meet demand. This is linked to single or combined factors of sickness, general vacancies, specialist vacancies or over demand beyond the current team capacity. These categories of risk are reflected within themes in complaints as previous referenced in this report in section 3.

4.4 Safe Staffing
In line with the Government’s requirements, the Trust continues to submit data via the national reporting system Unify 2. The table below shows the percentages of shifts filled across the Trust during the reporting period Q2 (July to September 2016). The fill rates are based on actual shift fill numbers and do not reflect the breakdown of substantive staff against temporary staff.

Continuing from Q1, Trust-wide fill rates of registered nurses did not fall below the reportable level of 80%. A number of services continue to have trouble in recruiting
qualified nurses and, in areas experiencing significant shortages, long term booking of agency staff is in place to ensure consistency in care.

The trend continues with mitigation against reduced numbers of qualified staff through the increase in clinical support worker (CSW) hours. Additionally it demonstrates the increased level of staffing in clinical areas for additional observations and complexity of care. Temporary staffing and recruitment are monitored via the Organisational Development and Workforce Sub-Committee, but this evidence alongside that included within the risk register continues to highlight this live issue for service user care, substantive staff and managers.

5.0 Anticipation and Preparedness

The previous Patient Safety Board Report noted the following actions were underway.

- Opening of the new Tier 4 unit at Carlton Court.

The unit has now opened (September 2016). To date no significant events have been reported, though a risk was identified after the opening relating to the resource of medical staffing which has since been resolved.

- The opening of an additional three beds on Thurne Ward at Hellesdon occurred on September 9th 2016.

The incident section within appendix 3 provides data on the activity within Thurne Ward. In comparison with other acute inpatient wards standardised rates (per 1,000 bed days) the ward is at the upper end of incidents reported with low harm and above but remains comparable with Southgate Ward which is of a similar size and provides the same function as a triage ward.

Contributing to the high levels of reporting on Thurne are reports linked to deliberate self-harm with assaults and restraint at the lower end of reporting. Complaints on Thurne sit at the higher end with an average of 4.51 per 1,000 bed days over the last six months. The ward had two clear months with no complaints during July and August but has increased to 7.41 complaints per 1,000 bed days since the opening of the three additional beds in September in comparison to 4.4 on Southgate Ward. Ongoing monitoring will continue via the patient safety group as part of the normal surveillance around incidents.

- Norfolk Central Community teams (CMHTs) will begin their changes to service provision during October 2016. The teams will move to a seven team model from the existing four teams. Environmental changes to support the process have not been completed which could contribute to an increased level of risk in the short term. Plans are in place within the service to mitigate against this. Key safety indicators will continue to be monitored within the Patient Safety Meeting following the implementation of the changes to monitor for any early emerging trends, themes or concerns. As part of this process the deputy matron for community services has been added to the group.
6.0 Integration and Learning

6.1 Service Improvements

The previous Patient Safety Board Report (September 2016) noted the following actions were underway. Each of these remain in progress with no substantive update to provide at this time.

- Dedicated director-led workstream review of CPA/Non CPA Policy and process. Recorded on the risk register this workstream intends to address discrepancies in the CPA level allocation within service lines. The review will also have a focus on care planning, risk assessment and crisis planning rates.

- Service line (Norfolk Wellbeing Service) conducting thematic reviews and deep dive into reported SIs during past six months. The review is in the final draft stages and will be presented to the QGC in November 2016.

- Central Norfolk Community and NRP services are conducting a series of workshops starting with a planning meeting in September 2016 to review trends in SIs related to dual diagnosis. The workshops are due to run until the new year when findings will be reported back to the QGC.

- Capacity pressures impacting on waiting times within Norfolk Central Youth Service resulting in the creation of a plan to remedy influencing factors. The plan was aimed at reducing waiting times, but in essence is a quality and patient safety improvement plan. This plan runs alongside a joint investigation requested by CCGs which will be presented on 31st October and the Local Transformation Plan improvement which has additional resource. The CQC report also identified some of the same issues, such as care plans, waits for treatment and appointment letters. Subsequently plans to address these issues will be superseded by the CQC action plan. This will be an integrated aligned plan to address all of the improvements the service wishes to make.

6.2 Applying learning from Serious Incidents.

At 3rd October 2016, 284 recommendations from serious incident investigations were in action. The recommendations range in scale and depth of activity required for completion. Through monitoring it is identified that some localities are experiencing pressures in meeting the stated timeframe. To support localities the Patient Safety Team offer assistance and guidance on the evidence required to meet completion.

7.0 Summary Analysis

Summary of the key patient safety issues within this report:

- A number of service users are being admitted with pressure ulcers. Initial analysis indicates this is in all areas and crosses both adult and older people’s services. The Trust reports admitted pressure ulcers, grade 3 and above, to CCGs for their information and monitoring. Initial analysis indicates possible lack of understanding by acute providers regarding services provided by NSFT and we will have further analysis in order to establish if there is a trend requiring specific action by the Trust. Feedback from older people’s services indicates that they are experiencing higher levels of admissions from acute providers where service users are not medically fit to return to
NSFT impatient areas, possibly reflecting wider system capacity issues. Work is also in progress with both clinical and governance input to agree shared protocols with NSFT and acute providers regarding transfer between services.

- During this period nine incident reports were completed by Norfolk Central Dementia Intensive Support Team (DIST) in relation to the unavailability of a bed when a service user is assessed as requiring one (and in most cases having a recommendation for detention under the Mental Health Act). Reporting of this nature has not been restricted to this quarter, indicating an ongoing challenge in the pathway of care when admission to hospital is required. The provision of older people’s inpatient beds will form part of NSFT’s review of its number of beds. As indicated, service users admitted to older people’s beds are becoming increasingly physically frail with physical health care in some cases the underlying cause for admission. The pathway into the service and admission criteria will also form part of the above bed review to ensure that those admitted to NSFT wards require our service and that we can meet their needs in a safe and caring environment.

- During this period two risks within Norfolk have been added to the risk register, highlighting the issue of service users being inappropriately clustered and diverted to a service which then assesses it to be an incorrect referral or internal transfer. The risks indicate that the effects are that the patient may have a delay in accessing the appropriate treatment, time and resource is spent responding to and rectifying the issue, and there is a potential for safety to be affected. The recorded risks do not quantify the scale of the problem. At this stage, actions are in early stages and therefore cannot provide assurance that the issue has been addressed at this point.

- Capacity levels continue to dominate the risk register with a spread of risks across services and locations (both inpatient and community). Factors continue to be linked to over-demand, sickness, and vacancies.

- Meeting timescales to implement recommendations has been a challenge for a number of areas, which will be monitored to check it improves over the coming months.

8.0 Risks / Mitigation in Relation to Trust Objectives

Mitigations to risks identified are described above. Quality improvement plans are in place and are largely delivering against outcomes for safety improvement objectives. Further plans have been developed to address emerging concerns.

The ongoing staff shortages within some clinical areas continue to present a risk both clinically and financially, including meeting QIP objectives, due to limited capacity within teams.

9.0 Recommendation

The Board of Directors is asked to note the contents of this report.

Michele Allott

Deputy Director of Nursing
Appendix 1: NRLS report

Organisation Patient Safety Incident Report
Reported incidents between 01 October 2015 to 31 March 2016

NORFOLK AND SUFFOLK FOUNDATION NHS TRUST
Organisation type: Mental health organisation

Are you actively encouraging reporting of incidents?
The comparative reporting rate summary shown below provides an overview of incidents reported by NHS organisations to the National Reporting and Learning System (NRLS) occurring between 01 October 2015 to 31 March 2016. Your organisation reported 4,220 incidents (rate of 55.51) during this period.

Figure 1: Comparative reporting rate, per 1,000 bed days, for 56 Mental health organisations.

The median reporting rate for this cluster is 37.54 incidents per 1,000 bed days.
Organisations that report more incidents usually have a better and more effective safety culture. You can't learn and improve if you don't know what the problems are.

How regularly do you report?
Your organisation reported incidents to the National Reporting and Learning System (NRLS) in 6 out of the 6 months between 01 October 2015 to 31 March 2016.

Report regularly: Incident reports should be submitted to the NRLS at least monthly.

Fifty per cent of all incidents were submitted to the NRLS more than 20 days after the incident occurred. In your organisation, 50% of incidents were submitted more than 40 days after the incident occurred.

Report serious incidents quickly: It is vital that staff report serious safety risks promptly both locally and to the NRLS, so that lessons can be learned and action can be taken to prevent harm to others.
What types of incidents are reported in your organisation?

Figure 2: Top 10 incident types

If your reporting profile looks different from similar organisations, this could reflect differences in reporting culture, the type of services provided or patients cared for. It could also be pointing you to high risk areas. The response system is more important than the reporting system.

Do you understand harm?

Nationally, 73 per cent of incidents are reported as no harm, and just under 1 per cent as severe harm or death.

However, not all organisations apply the national coding of degree of harm in a consistent way, which can make comparison of harm profiles of organisations difficult.

Organisations should record actual harm to patients rather than potential degree of harm.

Recognising and reporting incidents resulting in severe harm or death is an important sign of an organisation’s reporting culture. If the numbers of incidents reported as severe harm or death are low compared with others you should check that your reports reflect all incidents you are aware of through sources such as mortality review, inquests, litigation or complaints.

For further information on the reporting of serious incidents please see NPSA England’s guidance:

Further information for you

The NPSA helps the NHS to understand why, what and how patient safety incidents happen, learn from these experiences and take action to prevent future harm to patients. Alerts and other learning resources can be found at: www.england.nhs.uk/commission/patient-safety/alerts and national data can be found at: www.england.nhs.uk/organisation/learning-data.

Reviewing the results of the NHS staff survey relating to incident reporting alongside this report will provide an important indicator of your reporting culture.
Appendix 2
Glossary of Terms

Incident reporting system (Datix): The Trust uses an online system called Datix for the reporting of incidents across services by all levels of staff. The system allows the immediate cascade of incident information to nominated persons depending on type and level of harm. The system allows live monitoring using dashboards and creates both local and system wide reports.

National Reporting and Learning System (NRLS): The National Reporting and Learning System is a central database hosted by NHS Improvement to which NHS Trusts upload incidents that meet defined patient safety codes. Therefore not all incidents reported to the Trust's incident system will be uploaded to the NRLS system.

The NRLS, and therefore the Trust's incident reporting system, rely on a coding system determining the level of harm experienced per each event. The following are the definitions:

No harm: Impact prevented – any patient safety incident that had the potential to cause harm but was prevented, resulting in no harm to people receiving NHS-funded care.

Impact not prevented - any patient safety incident that ran to completion but no harm occurred to people receiving NHS-funded care.

Low: Any patient safety incident that required extra observation or minor treatment and caused minimal harm, to one or more persons receiving NHS-funded care.

Moderate: Any patient safety incident that resulted in a moderate increase in treatment and which caused significant but not permanent harm, to one or more persons receiving NHS-funded care.

Severe: Any patient safety incident that appears to have resulted in permanent harm to one or more persons receiving NHS-funded care.

Death: Any patient safety incident that directly resulted in the death of one or more persons receiving NHS-funded care.

Statistical Process Control (SPC) Charts: Statistical Process Control (SPC) was pioneered in the 1920's as a way to measure and monitor quality in industrial manufacturing processes. Using statistical methodology to measure outcomes and processes, SPC is increasingly being used within health care.

The principle is that any outcome or process experiences variation. The two causes of variation we need to consider are:

Common causes those random causes that are inherent in the system (processes) over time, affect everyone working in the system, and affect all outcomes of the system.

Special causes those non-random causes that are not part of the system (process or product) all the time, or do not affect everyone, but arise because of specific circumstances.

The following charts provide details of seven rules which assist the reader to identify where a 'special cause' may be indicated. Where a 'special cause' is indicated, the report will provide an
analysis on what the possible causes were.

Tests for Special Causes --- Process Out of Control Conditions

Rule 1
1 point outside either of the control limit lines

Rule 2
2 out of 3 points beyond two-sigma on same side of center line

Rule 3
4 out of 5 points beyond one-sigma on same side of center line

Rule 4
8 consecutive points on either side of the center line

Rule 5
Steadily increasing or decreasing pattern of 6 points

Rule 6
14 consecutive points alternating up and down

Rule 7
15 consecutive points within one-sigma of the center line
Appendix 3 – In-patient incident rates

- **Physical Assaults** - Low harm and above by 1,000 occupied bed days, excluding leave

- **Deliberate Self Harm** - Low harm and above by 1,000 occupied bed days, excluding leave

- **Administration of medication error** - Low harm and above by 1,000 occupied bed days, excluding leave

- **Absconding from ward** - Low harm and above by 1,000 occupied bed days, excluding leave
Absent without leave - Low harm and above by 1,000 occupied bed days, including leave

Low harm and above sustained during applied physical intervention by 1,000 occupied bed days, excluding leave

Slips, trips and falls - Low harm and above by 1,000 occupied bed days, excluding leave

Seclusion events by 1,000 occupied bed days, excluding leave

Prone Restraint by 1,000 occupied bed days, excluding leave
Appendix 4 QuESTT Submissions
Executive Summary:

NHS England and the National Quality Board require Trusts to review staffing levels on their in-patient units/wards on a six monthly basis. Following an initial comprehensive review of ward nurse staffing levels in April 2014, there have been three follow up six monthly reviews (excluding this one).

The six monthly reviews ensures that the Board is kept abreast of ward staffing levels and assured that safe staffing levels are being maintained. Both monthly Unify data reports and the six monthly reviews are published on NHS Choices and the Trust website. Daily staffing levels are also displayed on wards each day so that patients and the public are aware of the ‘real time’ situation on that day.

Recruitment to Registered Nursing posts remains difficult, and risks to delivery of clinical quality are mitigated by use of temporary staff, including Care Support Workers when necessary. We continue to work hard to address the reasons why, at times, actual staffing levels do not meet the planned requirement. We are carrying out robust recruitment drives for registered nurses and reviewing issues including staff sickness, vacancies and unavailability of bank or agency staff.

The purpose of this paper is to set out safe staffing levels for each clinical area, ward by ward and to demonstrate review of those staffing levels.

1.0 Report contents

1.1 Review of staffing levels in Norfolk and Suffolk Foundation Trust (NSFT) within inpatient areas and the process of the review.

1.2 Update on information from national pilots regarding evidence-based tools to determine safe staffing levels nationally.
2.0 Update on expectations of Trust Boards following the publication of Hard Truths

2.1 From April 2014, NHS Trusts have been required to publish ward level information on whether they are meeting their staffing requirements. Actual versus planned nursing and midwifery fill rates must be published every month. NSFT, in accordance with this requirement, has reported these figures daily on each inpatient area and monthly via the national reporting Unify 2 system and to NSFT Board.

2.2 The table below indicates the average fill rates on a month by month basis within NSFT for the last six months. Alongside the reported information on Unify 2 the Board also receives a monthly update on all staffing concerns reported via the Datix system within NSFT.

Table 1: Mean staffing, actual against establishment, May 2016-October 2016

<table>
<thead>
<tr>
<th></th>
<th>RN % fill against establishment</th>
<th>HCA % fill against establishment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Day shifts</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>May 16</td>
<td>88.8%</td>
<td>102.0%</td>
</tr>
<tr>
<td>June 16</td>
<td>87.0%</td>
<td>107.3%</td>
</tr>
<tr>
<td>July 16</td>
<td>86.8%</td>
<td>111.3%</td>
</tr>
<tr>
<td>August 16</td>
<td>84.4%</td>
<td>116.5%</td>
</tr>
<tr>
<td>September 16</td>
<td>87.6%</td>
<td>122.4%</td>
</tr>
<tr>
<td>October 16</td>
<td>91.3%</td>
<td>125.6%</td>
</tr>
<tr>
<td><strong>Nightshifts</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>May 16</td>
<td>91.8%</td>
<td>115.4%</td>
</tr>
<tr>
<td>June 16</td>
<td>89.1%</td>
<td>120.3%</td>
</tr>
<tr>
<td>July 16</td>
<td>87.2%</td>
<td>117.2%</td>
</tr>
<tr>
<td>August 16</td>
<td>87%</td>
<td>120.8%</td>
</tr>
<tr>
<td>September 16</td>
<td>96.1%</td>
<td>127.9%</td>
</tr>
<tr>
<td>October 16</td>
<td>101.6%</td>
<td>129.8%</td>
</tr>
</tbody>
</table>

2.3 This six monthly review has been conducted using professional judgement (a recognised technique in the absence of other tools). To date, there has been no publication of National Institute for Health and Care Excellence accredited tools for Mental Health Services. However, the Keith Hurst tool has been piloted across a number of Mental Health providers, but this does not include Allied Health Professionals (AHP’s) such as Occupational Therapists and Psychologists.
2.4 The figures in Table 1 show that Registered Nurse cover has often fallen below the safe staffing numbers recommended. On these occasions, additional staff are sought from NHSP and agencies, and if there is no nursing staff available, cover is provided by additional Care Support Workers (CSWs). The elevated numbers for CSWs also include booking of additional staff to cover training, and increased levels of observation. Pilot work at Hammerton Court has commenced to review our approach to 1:1 observation, and the potential to establish a pool of staff from base line establishments. Staff regularly report staffing issues as incidents using Datix, so trends are identified. There is also an escalation process in place when levels of staffing fall below required numbers, and there is no additional staffing availability (Appendix 1).

2.5 The Trust Board will continue to receive updates every six months on staffing levels, which allow for the collection of several data points to inform appropriate staffing.

3.0 New developments to support safe staffing and quality care

3.1 The Deputy Director of Nursing and Professional Practice is taking the lead on future safe staffing reviews and reporting within NSFT.

3.2 E-Rostering is now implemented across all in-patient areas to support safe, fair and efficient rostering practices across NSFT.

3.3 Recruitment and Retention Strategy 2016-2021 is underway, with Year 1 plans in progress, supported by a Project group to progress plans and develop opportunities for innovation.

3.4 Proposals for new recruitment system (TRAC) and a more collaborative approach to recruitment were approved by the Transformational Programme Board in October 2016.

3.5 Senior Management Engagement Forum on 8th November 2016, focused on Building our Future Workforce. With plans to co-deliver with Health Education England further workshops within the Fundamentals programme.

3.6 Corporate functions are working closely to review skill mix opportunities across all localities, specific work is underway in West Norfolk and Secure Services.

3.7 Educational funded Advanced Mental Health practitioner roles are being advertised across the Trust in partnership with University of Suffolk and Health Education England.

4.0 Review of staffing levels across inpatient areas
4.1 During October 2016 the Deputy Director of Nursing and Professional Practice, has undertaken a high level review of the staffing levels across inpatient areas. (Appendix 2)

4.2 Further consultation was sought from locality managers following this review for their sign up and agreement for recommended establishments. Further staffing requirement will be subject to a business case.

4.3 Ward staffing numbers were submitted to the finance team who calculated final establishments using a shift calculator.

4.4 Consideration is being given to exchanging the second or third Registered Nursing requirement where appropriate with Band 4 Assistant Practitioner inpatient areas.

4.5 The E-rostering team are continuing to work with managers to improve the rostering efficiency, for example, through better planning of annual leave, and reviewing flexible working patterns.

5.0 National updates and progress related to evidence-based tools and practice.

5.1 Work continues within the National Mental Health and Learning Disability Forum with regard to developing an evidence-based tool to calculate the required numbers within Mental Health and LD services to ensure not only safe staffing numbers but reflecting skill mix and MDT working. Pilot sites have been identified to trial an adapted existing evidence-based tool (HURST Tool) to evaluate its effectiveness within Mental Health and LD environments.

6.0 Risks / mitigation in relation to the Trust objectives (implications for Board Assurance Framework)

6.1 The provision of safe levels of staffing is a fundamental requirement of the Trust. Although recommended staffing levels are well-developed and resourced, the availability of Registered Nurses remains a risk. On many occasions, cover is available from NHSP and agencies, and on those occasions where this is not possible, Care Support Worker numbers are increased to provide additional numbers of staff. There is a clear escalation process in place and staff are encouraged to report staffing concerns, which are then followed up by the appropriate Locality Manager.

6.2 There have been no reports of harm occurring to service users due to low staffing levels in the past year, but it may be the case that lengths of stay are prolonged by the lack of availability of suitably trained staff, and that those staff who work on shifts with reduced staffing numbers are subject to additional stress. The QuESTTT tool (early warning system) measures aspects of this and provides an additional alert to managers, including the ability to
track on-going but not acute concerns, and take appropriate action according to an escalation process.

7.0 Recommendations

7.1 The Trust Board is asked to note and approve the contents of this report.
Appendix 1

Safe Staffing Escalation

Standard Operating Protocol (SOP)

The National Quality Board (NQB) Guidance 2013 makes clear the expectation of all NHS organisations around the need for robust escalation processes. This also provides a clear and consistent framework for staff at times of increased pressure and risk around inpatient staffing levels and is included within each inpatient area’s operational policy as a SOP.

The NQB guidance states that staff should be aware of the escalation procedures in place, flag where they think staffing capacity and capability fall short of what is required and be able and prepared to use the escalation procedures.

The escalation procedure within this document outlines the actions to be taken; the people who should be involved in decisions in short, medium and long term staffing shortages, and outline the contingency steps where capacity problems cannot be resolved.

The service managers hold responsibility and professional accountability for ensuring that robust escalation procedures are embedded within their respective inpatient areas and that these are followed in line with the RAG rating guidance.

Service managers and on-call managers will be involved in the decision-making/authorisation process and keep a record of contingency actions taken.

All ward/unit managers or, in their absence, the nurse in charge (NIC) should evaluate and risk assess the staffing levels on a shift by shift basis utilising the RAG rating guidance.

On discovering a staffing shortfall, the NIC should refer to the process described here, take the appropriate actions to RAG rate the current situation and advise managers accordingly.

**What** overarching policy does the procedure link to?
HRP056 – Rostering Policy

**Which** services of the Trust does this apply to? **Where** is it in operation?

Trust Public Board – Safer Staffing Six Monthly Review
Version 1.0
Date produced: 9th November 2016
Retention period: 30 years

Author: Dawn Collins Deputy Director of Nursing and Professional Practice
Department: Trust Management
<table>
<thead>
<tr>
<th>Division</th>
<th>Inpatients</th>
<th>Locations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health Services</td>
<td>✓</td>
<td>all</td>
</tr>
<tr>
<td>Learning Disabilities’ Services</td>
<td>✓</td>
<td>all</td>
</tr>
<tr>
<td>Children and Young People’s Services</td>
<td>✓</td>
<td>all</td>
</tr>
</tbody>
</table>

Who does the procedure apply to? (Staff roles and responsibilities)
- Service/deputy service managers
- Ward/unit managers
- Nurses in charge of inpatient wards/units

When should the procedure be applied? (Context)
- In situations where staffing level is insufficient within an inpatient ward/unit

How to carry out this procedure (step step-by-step information)

<table>
<thead>
<tr>
<th>Rating</th>
<th>Trigger/Impact</th>
<th>Action</th>
<th>Authorisation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Green</td>
<td>Staffing levels: ‘We have’ matches ‘We planned’.</td>
<td>All care and routine tasks will be carried out.</td>
<td>Nurse in charge</td>
</tr>
<tr>
<td></td>
<td>Patient acuity &amp; dependency: is within usual expected range for the area.</td>
<td>Allocation of duties, tasks, breaks etc. by nurse in charge (NIC).</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Situation: “business as usual”.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Amber</td>
<td>Staffing levels: A shortfall has occurred between ‘We have’ and ‘We planned’ e.g. due to staff absence.</td>
<td>Some non-essential activities may be postponed or cancelled until situation is resolved as determined by the nurse in charge.</td>
<td>Nurse in charge</td>
</tr>
<tr>
<td></td>
<td>And/or</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Patient acuity &amp; dependency: is increased from that usually expected e.g. requiring increased clinical observation levels or other staff-intensive interventions.</td>
<td>NIC seeks redeployment of staff from other areas.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Situation: A short term (1 - 2 shifts) increase in activity that can be resolved by short term provision of additional resources.</td>
<td>Or, where this is unsuccessful, requests additional bank cover as required.</td>
<td></td>
</tr>
<tr>
<td>Red</td>
<td>Staffing levels: A shortfall has occurred between ‘We have’ and ‘We planned’ that cannot be met in the short term by redeployment of</td>
<td>All non-essential tasks are suspended – specifics agreed by service manager and unit manager/nurse in charge.</td>
<td>Advise unit manager and service manager (out of hours - manager on call) of situation and seek authorisation for actions to</td>
</tr>
</tbody>
</table>

Trust Public Board – Safer Staffing Six Monthly Review
Version 1.0
Author: Dawn Collins Deputy Director of Nursing and Professional Practice
Department: Trust Management

Page 7 of 12 Date produced: 9th November 2016 Retention period: 30 years
Additional guidance to ensure safe staffing and manage the use of agency staff:

- Assessing patient acuity and dependency to see how far the existing nursing skill mix could be flexed to meet patients’ needs cost-effectively.

- Considering not filling shifts when there is a short-term staff shortage and only if it is safe to do so.

- Depending on the level of patient risk, engaging on a temporary and fixed basis another member of the MDT who is professionally qualified; staff such as allied health professionals, technical support staff such as activity co-ordinators or nurse therapists or clinical psychologists to supplement the nursing workforce.

- Flexibly deploying existing nursing staff from neighbouring areas to undertake work beyond their usual area (provided they are competent to do so).

- Assessing nursing staff availability on all frameworks that have been approved such as NHSP.

**Where** do I go for further advice or information?

- Your service/deputy service manager, matron
- Locality manager

**Training**
Staff may receive training in relation to this procedure where it is identified in their appraisal as part of the specific development needs for their role and responsibilities.

Please refer to the Trust’s Mandatory & Risk Management Training Needs Analysis for further details on training requirements, target audiences and update frequencies.

**Monitoring / review of this procedure**
In the event of planned changes in the process(es) described within this document or an incident involving the described process(es) within the review cycle, this SOP will be reviewed and revised as necessary to maintain its accuracy and effectiveness.

**Equality Impact Assessment**
Please refer to overarching policy.

**Data Protection Act and Freedom of Information Act**
Please refer to overarching policy.
## Appendix 2

<table>
<thead>
<tr>
<th>Location</th>
<th>Early</th>
<th>Late</th>
<th>Night</th>
<th>Changes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gt Yarmouth &amp; Waveney</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>GY&amp;W Acute</td>
<td>Registered</td>
<td>2 (3)</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>20 beds (previous in brackets)</td>
<td>Un-registered</td>
<td>4 (2)</td>
<td>4 (3)</td>
<td>3 (2)</td>
</tr>
<tr>
<td>Foxglove</td>
<td>Registered</td>
<td>2</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>11 beds</td>
<td>Un-registered</td>
<td>3</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>Fernwood</td>
<td>Registered</td>
<td>2</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>11 beds</td>
<td>Un-registered</td>
<td>3</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>Dragon fly Unit</td>
<td>Registered</td>
<td>2</td>
<td>2</td>
<td>2(1)</td>
</tr>
<tr>
<td>(5 Airey Close) Still currently under review</td>
<td>Un-registered</td>
<td>2</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Sweetbriar</td>
<td>Registered</td>
<td>2</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Temp closed</td>
<td>Un-registered</td>
<td>3</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td><strong>6 &amp; 7 Airey Close not on e-Rostering</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>West Norfolk</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Churchill Ward</td>
<td>Registered</td>
<td>3</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>20 beds</td>
<td>Un-registered</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td><strong>Central Norfolk</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rose</td>
<td>Registered</td>
<td>2</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>13 beds</td>
<td>Un-registered</td>
<td>3</td>
<td>3 (1 tw)</td>
<td>3</td>
</tr>
<tr>
<td>Reed</td>
<td>Registered</td>
<td>2</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>13 beds</td>
<td>Un-registered</td>
<td>3</td>
<td>3 (1 tw)</td>
<td>3</td>
</tr>
<tr>
<td>Beach</td>
<td>Registered</td>
<td>3</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>13 beds</td>
<td>Un-registered</td>
<td>3</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>Sandringham</td>
<td>Registered</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>15 beds</td>
<td>Un-registered</td>
<td>3</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Glaven</td>
<td>Registered</td>
<td>3</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>20 beds</td>
<td>Un-registered</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Waveney</td>
<td>Registered</td>
<td>3</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Location</td>
<td>Beds</td>
<td>Registered</td>
<td>Early</td>
<td>Late</td>
</tr>
<tr>
<td>------------------</td>
<td>--------</td>
<td>------------</td>
<td>-------</td>
<td>------</td>
</tr>
<tr>
<td>Rollesby</td>
<td>20</td>
<td>Un-registered</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Thurne</td>
<td>10</td>
<td>Un-registered</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>12 beds</td>
<td></td>
<td>Un-registered</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Secure Services</td>
<td></td>
<td>Registered</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Acle</td>
<td>8</td>
<td>Un-registered</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Catton</td>
<td>10</td>
<td>Un-registered</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Drayton</td>
<td>16</td>
<td>Un-registered</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Thorpe</td>
<td>8</td>
<td>Un-registered</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Yare</td>
<td>15</td>
<td>Un-registered</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Whittingham</td>
<td>12</td>
<td>Un-registered</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Foxhall House - 30904</td>
<td>8 beds (previous in brackets)</td>
<td>Un-registered</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Suffolk East</td>
<td></td>
<td>Registered</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Poppy</td>
<td>21</td>
<td>Un-registered</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Avocet</td>
<td>21</td>
<td>Un-registered</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Lark (PICU)</td>
<td>10</td>
<td>Un-registered</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Willow</td>
<td>21</td>
<td>Un-registered</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Location</td>
<td>Registered</td>
<td>Un-registered</td>
<td></td>
<td></td>
</tr>
<tr>
<td>----------------</td>
<td>------------</td>
<td>---------------</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Walker Close</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>None</td>
</tr>
<tr>
<td>11 beds</td>
<td>Un-registered</td>
<td>4</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>Suffolk West</td>
<td>None</td>
<td>None</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Northgate</td>
<td>Registered</td>
<td>3</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>21 beds</td>
<td>Un-registered</td>
<td>2</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Southgate</td>
<td>Registered</td>
<td>3</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>20 beds</td>
<td>Un-registered</td>
<td>3</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Abbeygate</td>
<td>Registered</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>17 beds</td>
<td>Un-registered</td>
<td>4</td>
<td>4</td>
<td>3(2)</td>
</tr>
</tbody>
</table>

Figures in brackets are from the previous review in May 2016
This report highlights the key issues arising out of the Quality Governance ("QG") Committee on 25th October 2016. A learning event on Reducing Restrictive Interventions was held prior to the QG Committee Meeting.

**Assurance review**

<table>
<thead>
<tr>
<th>Issue reviewed by committee</th>
<th>Commentary (including actions where required)</th>
<th>Level of assurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Serious Incident (SI's) Annual Update (April 2015 to March 2016)</td>
<td>We received the Annual Update which showed a reduction in SI's from 228 to 216 but an increase in Unexpected Deaths. There is a noticeable increase in deaths from natural causes but the number of suicides, based on Coroners Verdicts received to date, does not show an increase. We asked the Nursing Director to bring the data and analysis to the November Board given the importance of the subject matter.</td>
<td>AMBER</td>
</tr>
<tr>
<td>Lorenzo Update</td>
<td>Whilst the benefits of a single electronic patient record are becoming more evident, there is widespread agreement amongst the clinical staff that productivity of clinical staff is lower. Having worked with the system for a considerable period of time it was felt that clinicians are inputting information which could be more efficiently done by administrative staff thereby freeing up clinical time. The Board were encouraged to look at the processes in Lorenzo and to increase admin support</td>
<td>AMBER</td>
</tr>
<tr>
<td>Ligature Reduction Programme Annual Update</td>
<td>We received the Annual Update and sought additional assurance that the Trust now had a robust process in place to assess and mitigate ligature risk. We were advised that all</td>
<td>AMBER</td>
</tr>
</tbody>
</table>
assessments will be completed by end November and services expressed greater confidence in the new system but wanted clarification on the escalation process in the event that identified works had not been carried out within an agreed timeframe.

Staffing Concerns

The Report from the Great Yarmouth and Waveney Governance Meeting highlighted concerns around staffing levels and specifically the number of Band 5 vacancies. This issue is well known to the Board but the Trust was urged to ensure it was doing everything to make sure that was making the maximum use of Allied Health Professionals.

**RED**

**Forward look**

<table>
<thead>
<tr>
<th>Issue considered by committee</th>
<th>Commentary</th>
<th>Level of assurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Section 17 Leave</td>
<td>Following persistent weaknesses identified in the recording of Section 17 Leave a workshop is taking place on 3rd November to produce clear guidelines about roles and responsibilities best on best practice in the Trust. This will report back to Novembers QGC</td>
<td></td>
</tr>
</tbody>
</table>

**Recommendations**

Please note the Report.

Gary Page  
Chair Quality Governance Committee  
30th October 2016
Executive Summary:

The purpose of the report is to inform the Board of the Trust’s financial performance as at 31\textsuperscript{st} October 2016.

- The retained deficit for the month was £0.3m which is line with annual plan. The year to date favourable variance is £0.15m.
- The forecast is a deficit of £4.8m by March 2017 in line with our agreed control total.
- The financial performance of the Trust is assessed by NHS Improvement through the Financial Sustainability Risk Rating. Both our Plan and our performance against the Plan are rated at a ‘2’. It is anticipated that this rating will continue throughout the year.
- Out of Trust (OOT) placements have increased from September, and this continues to be a risk.
- The forecast spend on agency staffing is within the NHS improvement agency cap for the year.
- The 2016/17 CIP target is forecast to deliver the plan of £10m.
- Cash held by the Trust at 31 October was £9.14m which exceeds plan.
- The full finance report was discussed at the Finance Committee on 15\textsuperscript{th} November.

1.0 FINANCIAL ANALYSIS

Our financial position is as follows:
The full year annual plan deficit reflects the reduction from the original £6.1m to £4.8m. This is due to the national allocation of £1.27m from the national Sustainability and Transformation Fund (STF).

2.0 FINANCIAL COMMENTARY

OUT OF TRUST (OOT) PLACEMENTS
There was an increase in the numbers of OOT placements in the month, with total bed days increasing from 547 in September to 609 in October. The sum of £3.3m is included in the forecast position for the year.

SECONDARY COMMISSIONED SPECIALIST PLACEMENTS
There was 1 admission and 1 discharge during October. Expenditure to date is £1.9m with a current forecast position of £3.3m for secondary commissioned placements. A team of clinicians has been set up to review current placements and future care plans to inform discussions with Commissioners.

TEMPORARY STAFFING
NHS Improvement (NHSI) has set the Trust an agency spending cap of £10.783m, which has been phased in the annual plan to produce a reduction each month.

The YTD spend on agency for 2016/17 is £6.5m compared to the 2015/16 YTD spend of £10.4m.
The following table provides a summary on overall agency spend.

<table>
<thead>
<tr>
<th>ACTUAL SPEND £'000s</th>
<th>OCTOBER</th>
<th>ACTUAL SPEND £'000s</th>
<th>YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Agency</td>
<td>Bank</td>
<td>Total</td>
</tr>
<tr>
<td>Medical</td>
<td>314</td>
<td>314</td>
<td></td>
</tr>
<tr>
<td>Qualified nursing</td>
<td>341</td>
<td>81</td>
<td>422</td>
</tr>
<tr>
<td>Unqualified nursing</td>
<td>90</td>
<td>614</td>
<td>704</td>
</tr>
<tr>
<td>Clinical a&amp;c</td>
<td>39</td>
<td>13</td>
<td>52</td>
</tr>
<tr>
<td>Scientific &amp; Therapeutic</td>
<td>36</td>
<td>36</td>
<td></td>
</tr>
<tr>
<td>Corporate</td>
<td>122</td>
<td>122</td>
<td></td>
</tr>
<tr>
<td>NHS Improvement Control Total</td>
<td>942</td>
<td>708</td>
<td>1,650</td>
</tr>
</tbody>
</table>

The key booking reason for agency for qualified nursing (90%) and medical staff is unfilled vacancies.

CIP
The agreed CIP target for 2016/17 submitted in the Annual Plan was £10.0m and this is forecast to be achieved in full.

Of this £10.0m target £7m is recurrent and £3m is non recurrent.

CASH FLOW
As at the end of month 7, the Trust held cash and cash equivalents of £9.14m. This is ahead of the Annual Plan figure of £5.97m by £3.17m.

BALANCE SHEET
The variances on the balance sheet are explained by the positive variance on cash, with other differences being due to operational working capital movements.
The capital spend incurred year to date in 2016/17 is £1.86m against a plan of £3.31m.

The forecast year-end spend has been reviewed and is expected to be £5.81m.

3.0 QUALITY IMPLICATIONS

Adherence to our financial plan and compliance with Standing Financial Instructions enables the Trust to improve its service quality within the financial resources available.

4.0 RISKS

Based upon current performance and in order to achieve the Trust financial target deficit of £4.8m, the following areas need to be closely monitored and controlled

(i) Out of Trust Placements and Secondary Commissioned Placements
(ii) Agency and locum spend

5.0 RECOMMENDATION

The Board is asked to review and note the report.
Executive Summary:

The purpose of this report is to provide information on our performance against a range of key performance indicators and assurance on the indicators which are not meeting the required standard for the period to 30th September 2016.

The following information is provided:

Section A: Summary Dashboards

Section B: Commentary

Appendices with historic trends and activity.

The Board is asked to note the performance as at the end of September.
## NHS IMPROVEMENT (MONITOR)

<table>
<thead>
<tr>
<th>ACTUAL</th>
<th>TARGET</th>
<th>CHANGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>96.5%</td>
<td>95%</td>
<td>1.1%</td>
</tr>
<tr>
<td>95.9%</td>
<td>95%</td>
<td>0.2%</td>
</tr>
<tr>
<td>3.5%</td>
<td>7.5%</td>
<td>-0.1%</td>
</tr>
<tr>
<td>98.2%</td>
<td>95%</td>
<td>0.2%</td>
</tr>
<tr>
<td>128.6%</td>
<td>95%</td>
<td>4.6%</td>
</tr>
<tr>
<td>99.7%</td>
<td>97%</td>
<td>-0.03%</td>
</tr>
<tr>
<td>78.0%</td>
<td>50%</td>
<td>4.1%</td>
</tr>
<tr>
<td>6</td>
<td>6</td>
<td>0.0%</td>
</tr>
<tr>
<td>93.3%</td>
<td>75%</td>
<td>0.4%</td>
</tr>
<tr>
<td>99.9%</td>
<td>95%</td>
<td>0.1%</td>
</tr>
<tr>
<td>60.0%</td>
<td>50%</td>
<td>-25.7%</td>
</tr>
</tbody>
</table>

- CPA patients receiving follow up within 7 days of discharge: 96.5% (ACTUAL), 95% (TARGET), 1.1% (CHANGE)
- CPA patients having formal review within 12 months: 95.9% (ACTUAL), 95% (TARGET), 0.2% (CHANGE)
- Minimising delayed transfers of care: 3.5% (ACTUAL), 7.5% (TARGET), -0.1% (CHANGE)
- Admissions to inpatient services had access to CRHT teams: 98.2% (ACTUAL), 95% (TARGET), 0.2% (CHANGE)
- Meeting commitment to serve new psychosis cases by early intervention teams: 128.6% (ACTUAL), 95% (TARGET), 4.6% (CHANGE)
- Data completeness: identifiers: 99.7% (ACTUAL), 97% (TARGET), -0.03% (CHANGE)
- Data completeness: outcomes: 78.0% (ACTUAL), 50% (TARGET), 4.1% (CHANGE)
- Self-certification against compliance r.e. access to healthcare for people with LD: 6% (ACTUAL), 6% (TARGET), 0.0% (CHANGE)
- People referred to the IAPT programme will be treated within 6 weeks of referral: 93.3% (ACTUAL), 75% (TARGET), 0.4% (CHANGE)
- People referred to the IAPT programme will be treated within 18 weeks of referral: 99.9% (ACTUAL), 95% (TARGET), 0.1% (CHANGE)
- Referrals with suspected FEP start NICE recommended care within 2 weeks: 60.0% (ACTUAL), 50% (TARGET), -25.7% (CHANGE)

## ORGANISATIONAL DELIVERY

<table>
<thead>
<tr>
<th>ACTUAL</th>
<th>TARGET</th>
<th>CHANGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>95.3%</td>
<td>95%</td>
<td>0.0%</td>
</tr>
<tr>
<td>7.68%</td>
<td>7.50%</td>
<td>0.18%</td>
</tr>
<tr>
<td>41.4%</td>
<td>50.0%</td>
<td>-3.4%</td>
</tr>
<tr>
<td>85.8%</td>
<td>90%</td>
<td>-6.3%</td>
</tr>
<tr>
<td>84.9%</td>
<td>90%</td>
<td>-7.4%</td>
</tr>
<tr>
<td>29.1</td>
<td>28</td>
<td>2.8</td>
</tr>
</tbody>
</table>

- % of qualifying patients with a MHCT cluster: 95.3% (ACTUAL), 95% (TARGET), 0.0% (CHANGE)
- IAPT patients who have depression and/or anxiety disorders who receive psychological therapy: 7.68% (ACTUAL), 7.50% (TARGET), 0.18% (CHANGE)
- IAPT patients who complete treatment and move to recovery: 41.4% (ACTUAL), 50.0% (TARGET), -3.4% (CHANGE)
- Medium Secure Bed Occupancy Rate (including leave): 85.8% (ACTUAL), 90% (TARGET), -6.3% (CHANGE)
- Low Secure Bed Occupancy Rate (including leave): 84.9% (ACTUAL), 90% (TARGET), -7.4% (CHANGE)
- Average Length of Stay - Adult Acute Service: 29.1 (ACTUAL), 28 (TARGET), 2.8 (CHANGE)

## QUALITY, SAFETY & EXPERIENCE

<table>
<thead>
<tr>
<th>ACTUAL</th>
<th>TARGET</th>
<th>CHANGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>137</td>
<td>0</td>
<td>28.5%</td>
</tr>
<tr>
<td>87.0%</td>
<td>80.0%</td>
<td>-2.4%</td>
</tr>
<tr>
<td>89.9%</td>
<td>95%</td>
<td>-2.4%</td>
</tr>
<tr>
<td>100.0%</td>
<td>100%</td>
<td>0.0%</td>
</tr>
<tr>
<td>90.3%</td>
<td>1.0%</td>
<td></td>
</tr>
<tr>
<td>95.7%</td>
<td>95%</td>
<td>2.5%</td>
</tr>
<tr>
<td>93.5%</td>
<td>95%</td>
<td>3.0%</td>
</tr>
<tr>
<td>85.6%</td>
<td>95%</td>
<td>22.9%</td>
</tr>
<tr>
<td>104.1%</td>
<td>95%</td>
<td>3.9%</td>
</tr>
<tr>
<td>99.8%</td>
<td>95%</td>
<td>0.7%</td>
</tr>
</tbody>
</table>

- Waiting Times - Number of incomplete pathways waiting > 18 weeks: 137 (ACTUAL), 0 (TARGET), 28.5% (CHANGE)
- Waiting Times - % of CAMHS patients seen within standard: 87.0% (ACTUAL), 80.0% (TARGET), -2.4% (CHANGE)
- Patient Safety Thermometer: 89.9% (ACTUAL), 95% (TARGET), -2.4% (CHANGE)
- Long-term (> 12 months) inpatients have received an annual health check: 100.0% (ACTUAL), 100% (TARGET), 0.0% (CHANGE)
- In area bed days - Adult Acute (Development KPI): 90.3% (ACTUAL), 1.0% (TARGET),
- Bed occupancy adult acute (including leave): 95.7% (ACTUAL), 95% (TARGET), 2.5% (CHANGE)
- Bed occupancy PICU (including leave): 93.5% (ACTUAL), 95% (TARGET), 3.0% (CHANGE)
- Bed occupancy adult continuing support (Including Leave): 85.6% (ACTUAL), 95% (TARGET), 22.9% (CHANGE)
- Bed occupancy older adult acute (Including Leave): 104.1% (ACTUAL), 95% (TARGET), 3.9% (CHANGE)
- Bed occupancy older adult continuing care (Including leave): 99.8% (ACTUAL), 95% (TARGET), 0.7% (CHANGE)

Notes:
1. The number of new psychosis cases accepted by existing 14-35 year old early intervention services
2. Only reporting on referrals to existing 14-35 year old early intervention services

Board of Directors – Public–24th Nov 2016
Business Performance Report
Version 1.0
Authors: Karen Rix
Page 2 of 24
Date produced: 8th November 2016
Retention period: 30 years
### Section A (ii): Summary Workforce Performance Dashboard September 2016

#### Engaged Workforce KPI

<table>
<thead>
<tr>
<th>Performance</th>
<th>Benchmark</th>
<th>Current Performance</th>
<th>April</th>
<th>May</th>
<th>June</th>
<th>July</th>
<th>August</th>
<th>September</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annualised Sickness absence %</td>
<td>4.65%</td>
<td>4.71%</td>
<td>4.69%</td>
<td>4.79%</td>
<td>4.76%</td>
<td>4.84%</td>
<td>4.71%</td>
<td></td>
</tr>
<tr>
<td>Monthly Sickness absence %</td>
<td>4.65%</td>
<td>4.29%</td>
<td>4.58%</td>
<td>4.87%</td>
<td>4.99%</td>
<td>5.50%</td>
<td>4.29%</td>
<td></td>
</tr>
<tr>
<td>% of anxiety/stress/depression</td>
<td>22.5%</td>
<td>27.6%</td>
<td>26.1%</td>
<td>26.1%</td>
<td>26.8%</td>
<td>27.1%</td>
<td>27.4%</td>
<td>27.6%</td>
</tr>
<tr>
<td>Staff recommending as place to work</td>
<td>56%</td>
<td>79.0%</td>
<td>48.0%</td>
<td>79.0%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Survey Response Rate</td>
<td>46%</td>
<td>49.2%</td>
<td>45.6%</td>
<td>49.2%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Skilled Workforce KPI

<table>
<thead>
<tr>
<th>Performance</th>
<th>Benchmark</th>
<th>Current Performance</th>
<th>April</th>
<th>May</th>
<th>June</th>
<th>July</th>
<th>August</th>
<th>September</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vacancy Rate - All Staff</td>
<td>13.7%</td>
<td>11.7%</td>
<td>11.2%</td>
<td>11.5%</td>
<td>11.6%</td>
<td>11.6%</td>
<td>11.7%</td>
<td></td>
</tr>
<tr>
<td>All Turnover</td>
<td>13.0%</td>
<td>12.3%</td>
<td>16.4%</td>
<td>16.4%</td>
<td>12.4%</td>
<td>12.1%</td>
<td>12.3%</td>
<td></td>
</tr>
<tr>
<td>Voluntary Turnover</td>
<td>10.0%</td>
<td>9.7%</td>
<td>10.1%</td>
<td>9.9%</td>
<td>9.4%</td>
<td>9.4%</td>
<td>9.7%</td>
<td></td>
</tr>
<tr>
<td>Fringe turnover</td>
<td>25.0%</td>
<td>20.8%</td>
<td>26.7%</td>
<td>27.2%</td>
<td>29.7%</td>
<td>33.8%</td>
<td>22.4%</td>
<td>20.8%</td>
</tr>
<tr>
<td>Time to Hire (Days)</td>
<td>75.0</td>
<td>80.8</td>
<td>75</td>
<td>83</td>
<td>70</td>
<td>68</td>
<td>61</td>
<td>81</td>
</tr>
<tr>
<td>% of registered nursing staff</td>
<td>58.0%</td>
<td>59.8%</td>
<td>60.5%</td>
<td>60.1%</td>
<td>60.0%</td>
<td>59.7%</td>
<td>59.8%</td>
<td></td>
</tr>
<tr>
<td>Appraisal % - Non Medical</td>
<td>89.0%</td>
<td>68.9%</td>
<td>60.1%</td>
<td>64.8%</td>
<td>66.9%</td>
<td>69.7%</td>
<td>68.9%</td>
<td></td>
</tr>
<tr>
<td>Appraisal % - Medical</td>
<td>89.0%</td>
<td>89.0%</td>
<td>89.0%</td>
<td>89.0%</td>
<td>89.0%</td>
<td>89.0%</td>
<td>89.0%</td>
<td></td>
</tr>
<tr>
<td>Mandatory Training %</td>
<td>80.0%</td>
<td>87.0%</td>
<td>78.1%</td>
<td>82.6%</td>
<td>85.3%</td>
<td>85.8%</td>
<td>86.6%</td>
<td>87.0%</td>
</tr>
</tbody>
</table>

#### Responsive Workforce KPI

<table>
<thead>
<tr>
<th>Performance</th>
<th>Benchmark</th>
<th>Current Performance</th>
<th>April</th>
<th>May</th>
<th>June</th>
<th>July</th>
<th>August</th>
<th>September</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Agency spend £k</td>
<td>898.5k</td>
<td>992</td>
<td>775</td>
<td>853</td>
<td>903</td>
<td>1,060</td>
<td>1,014</td>
<td>992</td>
</tr>
<tr>
<td>Temp Nursing Demand (‘000’s hrs)</td>
<td>N/A</td>
<td>58</td>
<td>59</td>
<td>62</td>
<td>59</td>
<td>64</td>
<td>61</td>
<td>63</td>
</tr>
<tr>
<td>Temp Nursing fill rate #</td>
<td>90.0%</td>
<td>90.3%</td>
<td>87.9%</td>
<td>90.2%</td>
<td>84.3%</td>
<td>88.9%</td>
<td>88.9%</td>
<td>90.3%</td>
</tr>
<tr>
<td>Net Nurse Contracted Hrs Worked (%)</td>
<td>0.0%</td>
<td>3.3%</td>
<td>3.9%</td>
<td>3.3%</td>
<td>0.9%</td>
<td>1.6%</td>
<td>3.3%</td>
<td></td>
</tr>
<tr>
<td>% of Approved Job Plans</td>
<td>89.0%</td>
<td>92.0%</td>
<td>64.0%</td>
<td>64.0%</td>
<td>64.0%</td>
<td>64.0%</td>
<td>88%</td>
<td>92%</td>
</tr>
</tbody>
</table>

Notes: * Represents 12 month rolling trend/performance
* This is a management performance indicator, not a contract based KPI
Section B (i): Indicators not achieved in the period

Table 1 summarises the indicators which were not achieved in the period. A commentary is provided on these indicators.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Target</th>
<th>Actual</th>
</tr>
</thead>
<tbody>
<tr>
<td>Referrals to and within the Trust with suspected first episode psychosis that start a NICE-recommended care package within 2 weeks of referral</td>
<td>50%</td>
<td>60.0%</td>
</tr>
<tr>
<td>IAPT patients who complete treatment and 'move to recovery'</td>
<td>50%</td>
<td>41.4%</td>
</tr>
<tr>
<td>Waiting Times - Number of incomplete pathways waiting &gt; 18 weeks</td>
<td>0</td>
<td>137</td>
</tr>
<tr>
<td>Patient Safety Thermometer</td>
<td>95%</td>
<td>89.9%</td>
</tr>
<tr>
<td>Annualised Sickness absence %</td>
<td>4.65%</td>
<td>4.71%</td>
</tr>
<tr>
<td>% of anxiety/stress/depression</td>
<td>22.5%</td>
<td>27.6%</td>
</tr>
<tr>
<td>Time to Hire (Days)</td>
<td>75.0</td>
<td>80.8</td>
</tr>
<tr>
<td>% of registered nursing staff</td>
<td>58.0%</td>
<td>59.8%</td>
</tr>
<tr>
<td>Appraisal % - Non Medical</td>
<td>89.0%</td>
<td>68.9%</td>
</tr>
<tr>
<td>Total Agency spend £k</td>
<td>898.5</td>
<td>992</td>
</tr>
<tr>
<td>Net Nurse Contracted Hrs Worked (%)</td>
<td>0.0%</td>
<td>3.3%</td>
</tr>
</tbody>
</table>
Section B (ii): Commentary: Indicators not achieved in the period

Although the focus of this commentary is targeted on indicators where the Trust is not achieving stated targets, good performance is again noted against the NHS Improvement targets where in total the Trust continues to exceed the targets in 10 of the 11 indicators.

1. Referrals to and within the Trust with suspected first episode psychosis that start a NICE-recommended care package within 2 weeks of referral

This standard is ‘two-pronged’: both conditions must be met for the standard to be deemed to have been achieved. The standard is targeted at people aged 14-65:

1. A maximum wait of two weeks from referral to start of treatment (Referral to Treatment Time (RTT)); this is measured in 3 ways. This is when the person:
   a. has had an initial assessment, and;
   b. has been accepted on to the caseload of an EIP service (inclusive of At Risk Mental State), and;
   c. has been allocated to and engaged with an EIP care coordinator and;

2. Treatment delivered in accordance with NICE guidelines and quality standards for psychosis and schizophrenia – either in children and young people CG155 (2013) and QS102 or in adults CG178 (2014) and QS80. A baseline self-assessment has been completed which provides information on performance. This will be used to inform the national development of performance for 2017/18 and beyond.

As previously reported NSFT did not receive increased funding from Commissioners to deliver the new national standards to all ages. The Trust and Commissioners have worked together to develop a business case using the national workforce model and this is under consideration by Commissioners. NHSE Clinical Networks Leads for Midlands and East have confirmed that no organisation is meeting the standard at this time.

The Trust is commissioned to deliver a maximum wait of 2 weeks for people aged 14-35. Performance by localities that did not achieve the target when applied to the commissioned service is as follows:

<table>
<thead>
<tr>
<th>Location</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Great Yarmouth &amp; Waveney</td>
<td>40%</td>
</tr>
<tr>
<td>Suffolk East</td>
<td>0%</td>
</tr>
</tbody>
</table>

Commentary is as follows:

- Great Yarmouth & Waveney: There were 3 breaches in total and each exception has been reviewed in detail for lessons learnt. The locality has received 59 new referrals between April and September
- Suffolk East: This only equated to 1 breach in total in the month. The locality has received 22 new referrals between April and September

Actions:
• The service has been reviewed and some process changes are being made during November to streamline the care coordinator allocation process

• Breach reports are reviewed and followed up with clinical teams.

2. Improving Access to Psychological Therapies – patients who complete and ‘move to recovery’

Performance by services that did not achieve the target of 50%:

<table>
<thead>
<tr>
<th>Service</th>
<th>July</th>
<th>Aug</th>
<th>Sep</th>
</tr>
</thead>
<tbody>
<tr>
<td>Norfolk Wellbeing Service (actual)</td>
<td>40%</td>
<td>41%</td>
<td>39%</td>
</tr>
<tr>
<td>Norfolk Wellbeing Service (trajectory)</td>
<td>42%</td>
<td>44%</td>
<td></td>
</tr>
<tr>
<td>Variance to trajectory</td>
<td>-1%</td>
<td>-5%</td>
<td></td>
</tr>
</tbody>
</table>

Commentary is as follows for each service:

• Norfolk Wellbeing Service: A remedial action plan is now in place and in September the service was 5% behind trajectory. The agreed trajectory to meet the 50% target by December 2016 is currently being revised as the impact on recovery performance will not be seen by the end of December

Actions:

• The 6 month enhanced non IAPT care pathway pilot has commenced looking at recovery for complex cases and a midpoint review is booked for January 2017

• Increased consistency in the application of the clinical model to ensure that the interventions offered to service users are in line with the NICE guidelines for stepped care. Implementation of individual clinician KPI dashboards due in November 2016

• Reduction in the number of people dropping out of stress control groups and an expansion of service offer for depression. The new ‘depression’ pathway and ‘Wellbeing tracker’ have been implemented

3. Waiting times – number of incomplete pathways waiting over 18 weeks

Performance by localities that did not achieve the target is as follows:

<table>
<thead>
<tr>
<th>Locality</th>
<th>May</th>
<th>June</th>
<th>July</th>
<th>Aug</th>
<th>Sep</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central Norfolk</td>
<td>121</td>
<td>95</td>
<td>46</td>
<td>47</td>
<td>87</td>
</tr>
<tr>
<td>Gt Yarmouth &amp; Waveney</td>
<td>7</td>
<td>6</td>
<td>5</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>Suffolk East</td>
<td>26</td>
<td>26</td>
<td>23</td>
<td>11</td>
<td>8</td>
</tr>
<tr>
<td>Suffolk West</td>
<td>72</td>
<td>105</td>
<td>28</td>
<td>22</td>
<td>18</td>
</tr>
<tr>
<td>Suffolk Countywide</td>
<td>33</td>
<td>21</td>
<td>25</td>
<td>10</td>
<td>16</td>
</tr>
</tbody>
</table>

The number breaching the 18 week standard in Central Norfolk has increased by 85% between August and September. Approximately 60% of the Central Norfolk breaches reported in September were attributable to the South/North/City Assessment Focussed Intervention teams
which are currently being restructured. The number breaching the 18 week standard across the Suffolk and Great Yarmouth and Waveney localities between August and September remained static.

Actions:
- In Central Norfolk legacy Assessment Focussed Intervention team Waiting lists will be cleared in Oct following completion of caseload ‘transition’ phase of the Adult Community restructure
- Breach reports are sent to team managers to address and to follow up with clinical teams
- Further analysis on waits and importantly the 87 waits attributed to Central Norfolk will be completed to better understand the underlying issues and establish if the actions taken are sufficient

4. Patient Safety Thermometer

Performance by localities that did not achieve the target is as follows:

<table>
<thead>
<tr>
<th></th>
<th>July</th>
<th>Aug</th>
<th>Sep</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central Norfolk</td>
<td>89%</td>
<td>94%</td>
<td>89%</td>
</tr>
<tr>
<td>Great Yarmouth &amp; Waveney</td>
<td>95%</td>
<td>86%</td>
<td>91%</td>
</tr>
<tr>
<td>Suffolk East</td>
<td>100%</td>
<td>86%</td>
<td>86%</td>
</tr>
<tr>
<td>West Norfolk</td>
<td>100%</td>
<td>100%</td>
<td>50%</td>
</tr>
</tbody>
</table>

Commentary is as follows for each locality:
- Central Norfolk: 6 incidents in total; 3 patient falls, 1 new pressure ulcer category 2-4, 2 new VTE’s
- Great Yarmouth & Waveney: 2 incidents in total; 1 fall, 1 with a healing pressure ulcer
- Suffolk East: 4 incidents in total; 3 new cases of DVT and 1 old DVT case
- West Norfolk: 1 incident in total; 1 fall, % heavily skewed by low denominator

Actions:
- Staff are repeating their slips, trips and falls training
- The teams will continue to focus on physical health care
- Physical health care is reviewed at the Quality Governance meeting
5. Other issues – including update on National Performance Indicators and the Five Year Forward View

a. Improving Access to Psychological Therapies – patients who have depression and/or anxiety disorders who receive psychological therapy

This indicator reports on the proportion of people entering treatment against the level of need in the general population, commonly referred to as the ‘access target’.

Performance by localities that did not achieve the target is as follows:

<table>
<thead>
<tr>
<th>Location</th>
<th>Sep</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suffolk East</td>
<td>6.97%</td>
</tr>
</tbody>
</table>

Actions:
- The service is 0.5% behind trajectory which equates to 220 people and is currently working on an action plan to address this which will be available December 1st 2016

b. Waiting Time - % of CAMHS patients seen within commissioning standards

Performance by localities that did not achieve the target is as follows:

<table>
<thead>
<tr>
<th>Location</th>
<th>Sep</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central Norfolk</td>
<td>67%</td>
</tr>
</tbody>
</table>

- The locality is reviewing the waiting lists and treating those who have waited the longest. This was a predicted drop in performance whilst the back log was cleared

Actions:
- Additional non recurrent funding has been secured from NHS England to reduce the backlog of children and young people on waiting lists. This will enable NSFT to continue to clear the waiting list, acknowledging that performance for the remainder of 2016 will be impacted until the back log is cleared
- As part of the Contract Performance Notice (CPN) joint investigation which has just reported its findings with the Commissioners it has been agreed that NSFT will propose a new waiting times standard that will be reflect the increase in demand for CAMHS services and can therefore be sustainably delivered

c. Minimising delayed transfers of care

Performance by localities that did not achieve the target is as follows:

<table>
<thead>
<tr>
<th>Location</th>
<th>May</th>
<th>June</th>
<th>July</th>
<th>Aug</th>
<th>Sep</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suffolk East</td>
<td>8.5%</td>
<td>8.9%</td>
<td>11.1%</td>
<td>9.9%</td>
<td>10.3%</td>
</tr>
</tbody>
</table>
The Suffolk East locality is the only locality in the Trust that has Learning Disability wards. Walker Close has often run with 50% of beds being taken up by delayed transfers due to the delay by Suffolk County Council in finding appropriate accommodation and providers in a timely fashion. Commissioners have asked for delayed transfer of care out of area placements to be returned to Walker Close so the position may worsen in the short/medium term.

There were 11 Suffolk East service users with a delayed transfer of care (DTOC) status:

- 7 awaiting residential home placements or availability (social care attributable). In 1 instance the delayed transfer of care commenced in 2015 where the service user has dementia, physical health problems and a learning disability. Social care maintained they could not find a provider who will accept them
- 2 patient/family choice (NHS attributable)
- 1 awaiting further NHS care waiting for void work to be completed at Chilton Houses
- 1 homeless service user who was very vulnerable and has schizophrenia. The local council would not accept them as their assessment pointed towards supported housing which was initially refused by the service user

Actions:
- The DTOC issues have all been escalated to the appropriate senior managers
- Continuing to work with social care to support discharge facilitation to suitable accommodation

**d. Follow up with 7 days of discharge**

Performance by localities that did not achieve the target is as follows:

<table>
<thead>
<tr>
<th></th>
<th>Aug (Jul-Aug)</th>
<th>Sep (Jul-Sep)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suffolk West</td>
<td>90.4%</td>
<td>94.1%</td>
</tr>
</tbody>
</table>

- The KPI reports on quarterly performance. There were 7 breaches in total for the quarter: none of these occurred within September 2016 where performance had improved to 100% for the month

Actions:
- Home Treatment Team to lead an evaluation with the acute service on recent breaches to identify improvements on handover process between the two teams

**e. Average length of stay – adult acute service**

Performance by localities that did not achieve the target is as follows:

<table>
<thead>
<tr>
<th></th>
<th>June</th>
<th>July</th>
<th>Aug</th>
<th>Sep</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central Norfolk</td>
<td>41</td>
<td>29</td>
<td>45</td>
<td>29</td>
</tr>
<tr>
<td>Locality</td>
<td>Patients &gt; 28 days</td>
<td>Patients &gt; 100 days</td>
<td>Patients &gt; 300 days</td>
<td>Patients &gt; 300 days</td>
</tr>
<tr>
<td>--------------</td>
<td>--------------------</td>
<td>---------------------</td>
<td>---------------------</td>
<td>---------------------</td>
</tr>
<tr>
<td>Suffolk West</td>
<td>49</td>
<td>72</td>
<td>27</td>
<td>36</td>
</tr>
<tr>
<td>West Norfolk</td>
<td>43</td>
<td>18</td>
<td>23</td>
<td>44</td>
</tr>
</tbody>
</table>

Commentary is as follows for each locality:

- **Central Norfolk:** There were 15 patients whose length of stay was greater than 28 days. There was 1 service user whose length of stay exceeded 100 days. In this instance a service user had spent 134 days on 5 Airey Close before being transferred to an Adult Acute ward and being discharged 12 days later.

- **Suffolk West:** There were 11 patients whose length of stay was greater than 28 days. There were 3 service users whose length of stay exceeded 100 days.

- **West Norfolk:** There were 9 patients whose length of stay was greater than 28 days. There was 1 service user whose length of stay exceeded 300 days. In this instance it related to a service user who had remained untreated for many years in the community and had a very protracted recovery. Additionally there was a delay in placing the service user in Norfolk County Council (NCC) residential care due to a changeover in NCC workers.

**Actions:**

- Weekly discharge meetings discuss service users with longer length of stays
- Ward manager attendance at discharge meetings to enable timely discharge

**f. Bed occupancy**

**Adult Acute**

Bed occupancy continues to remain a concern with demand for beds continuing to be high which is impacting on the volume of out of area bed use in Norfolk and Waveney. There are daily bed management meetings and the admissions process continues to be monitored.

**PICU**

In Norfolk bed occupancy reached 109% whilst in Suffolk a number of unoccupied bed days continued to be attributable to a service user being on Long Term segregation (LTS). Adding the days lost to LTS would show the occupancy to be 85.8% within the expected occupancy levels.

**Older Adult Acute/Continuing Care**

Bed occupancy remains a concern with demand for beds continuing to be high which is impacting on the volume of out of area bed use in Norfolk and Waveney.

**Adult Continuing Support**

In Suffolk 1 bedroom became unavailable as a result of a cleaning process which affected the bed occupancy.
g. Mental Health Five Year Forward View Dashboard

NHS England has developed a quarterly dashboard which has identified metrics for monitoring key performance and outcomes data that will allow NHS England to hold national and local bodies to account for implementing the Five Year Forward View. It includes a suite of metrics based on proposals in the implementation plan:

- Perinatal mental health
- Children and young people’s mental health
- Adult mental health: common mental health problems
- Adult mental health: community, acute and crisis care
- Secure pathway
- Health and justice
- Suicide prevention

NSFT will review this to assess the impact on future reporting

h. Ethnicity Coding

As part of the NHS Standard Contract NSFT are expected to achieve 90% completion of Mental Health Services Data Set (MHSDS) ethnicity coding for all Service Users. Where the number of breaches in the month exceeds the tolerance permitted by the threshold, £10 in respect of each excess breach above that threshold can be charged. In Suffolk we were under the 90% threshold and the commissioners enforced the mandatory fine, however following discussions with the Trust these monies have now been reinvested within the Trust.

Section B (iii): Workforce

This section presents analysis against a series of workforce indicators aligned to our Workforce and Organisational Development Strategy where performance is below target. The indicators have been broken into 3 key areas of focus:

- Engaged Workforce
- Skilled Workforce
- Responsive Workforce.

Improved performance in these areas will support the delivery of our Trust goals, in particular, improving quality and achieving financial sustainability and ‘working as one Trust’.

Although the focus of this report is to explore areas where the Trust is not achieving its targets, overall good performance is noted against vacancy rate, turnover, medical appraisal and mandatory training. However, whilst overall good performance is noted, there are variances across localities. These variances are monitored by the Workforce and Organisational Development Committee and through the Performance, Accountability and Review Meetings. Workforce Locality Plans highlight the action being put in place locally to address issues.
The results of the Quarter 2 Staff Friends and Family Test (a short survey conducted amongst new starters) are very encouraging. Almost 50% of new starters responded (63 out of 128 new starters), with 79% of respondents saying that they would recommended the Trust as place to work.

A breakdown of the results by locality can be seen in table 1:

Table 1

<table>
<thead>
<tr>
<th>Locality</th>
<th>How likely are you to recommend this organisation to friends and family if they needed care or treatment?</th>
<th>How likely are you to recommend this organisation to friends and family as a place to work?</th>
<th>I am able to contribute to improvements at work</th>
<th>I feel motivated at work</th>
<th>I would recommend my own department as a good place to work</th>
<th>I would recommend my own department as a good place to receive treatment/care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central Norfolk</td>
<td>88%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Corporate Services</td>
<td>100%</td>
<td>50%</td>
<td>100%</td>
<td>83%</td>
<td>100%</td>
<td>17%</td>
</tr>
<tr>
<td>Great Yarmouth and Waveney</td>
<td>67%</td>
<td>89%</td>
<td>89%</td>
<td>75%</td>
<td>89%</td>
<td>89%</td>
</tr>
<tr>
<td>Norfolk Wellbeing Service</td>
<td>83%</td>
<td>83%</td>
<td>67%</td>
<td>83%</td>
<td>67%</td>
<td>67%</td>
</tr>
<tr>
<td>Norfolk West</td>
<td>67%</td>
<td>50%</td>
<td>67%</td>
<td>83%</td>
<td>67%</td>
<td>33%</td>
</tr>
<tr>
<td>Secure Services</td>
<td>60%</td>
<td>80%</td>
<td>80%</td>
<td>80%</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td>Substance Misuse *</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Suffolk Access &amp; Assessment *</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Suffolk East</td>
<td>83%</td>
<td>83%</td>
<td>92%</td>
<td>83%</td>
<td>91%</td>
<td>91%</td>
</tr>
<tr>
<td>Suffolk West *</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Support Services *</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Total</td>
<td>78%</td>
<td>79%</td>
<td>84%</td>
<td>87%</td>
<td>85%</td>
<td>74%</td>
</tr>
</tbody>
</table>

*localities marked with an asterisk received less than 5 responses and therefore are unreportable.

The low score of staff recommending their own department as a good place to receive treatment or care within Corporate Services (17%) could be due to confusion on how best to answer this question; the low score for the same question for West Norfolk (33%) is of particular concern and requires further exploration and management response. The low level of recommendation is thought to be linked with the staffing challenges experienced within adult acute and community services within this locality.

Engaged Workforce KPI

1. **Annualised Sickness absence %**

The Trust’s annualised sickness absence rate reduced from 4.84% to 4.71% within the month. This has been the first reduction reported since the start of 2016/17 following a positive trend of.
reduction throughout the previous year. A reduction of 0.13% is equivalent to 1,650 full-time equivalent days – or 4.5 full-time equivalent members of staff attending work for a whole year.

Graph 1 shows the range of sickness absence rates for all mental health Trusts in England obtained from iView for June 2016 (latest available data). Whereas the Trust was the second best performing mental health Trust in the region at the same time last year, the Trust is currently above the reported average of 4.54% at 4.88% (highlighted in green on the graph 1) – those highlighted in pink are other east of England mental health Trusts. It is, however, performing better than its buddy Trust which has a rate of 5.01%.

Graph 1

Table 2 shows the highlighted values from the graph above for June 2016.

Table 2

<table>
<thead>
<tr>
<th>Trust</th>
<th>Jun-16</th>
</tr>
</thead>
<tbody>
<tr>
<td>North Essex MH</td>
<td>3.69%</td>
</tr>
<tr>
<td>Cambridgeshire &amp; P’boro MH</td>
<td>4.39%</td>
</tr>
<tr>
<td>South Essex Partners</td>
<td>4.46%</td>
</tr>
<tr>
<td>Norfolk &amp; Suffolk</td>
<td>4.88%</td>
</tr>
<tr>
<td>Nottinghamshire Health (buddy Trust)</td>
<td>5.01%</td>
</tr>
</tbody>
</table>

Time lost due to absences occurring in the month reduced from 5.50% to 4.29%, however, Central Norfolk, Great Yarmouth and Waveney, Suffolk East, West Norfolk and Substance Misuse services all had monthly absence values above 4.65% (Central Norfolk, Suffolk East and West Norfolk were rated ‘amber’). In the main, this is due to a reduction in long-term absence. During August, long-term absence was reported at 4.18%, whereas in September this reduced to 3.40%. This reduction in long term absence, coupled with a reduction in short term absence within the month, has impacted the annualised sickness rate.

Long term absence episodes represent 10.8% of absence episodes for clinical staff and 7.10% for non-clinical. The slightly higher proportion of long term absence episodes as a proportion of sickness absence within clinical staff groups is what we would expect as there are less opportunities for role adjustments for staff in clinical roles who may not be fully fit (eg for prevention and management of aggression interventions). We employ three times as many clinical versus non clinical staff. In September 2016, there were 3.5 times as many long term absence episodes amongst clinical staff (21 episodes) compared to non clinical (6).
The improvement in the absence rate has, in part, been affected by a review of sickness absence cases by senior HR Managers which identified five ‘open’ absence cases that should have been closed and a small number of cases where advice has been provided to accelerate employee support and case management. In the vast majority of cases, however, the review identified that timely and appropriate interventions were taking place. Of the 67 cases reviewed, five had end dates (ill health dismissals and ill health retirements) and twenty two had planned return dates. The impact of this is therefore expected to be seen in improving performance for October to December 2016.

2. % of anxiety/stress/depression/other psychiatric illnesses

Sickness attributed to stress/anxiety/depression/other psychiatric illnesses increased by 0.02% in the month, accounting for 27.6% of all sickness absence, and is above our Target of 22.5%. Overall, it is the sixth consecutive month that this indicator has increased. Outliers from the Trust average are:

- Support Services 46.5%
- Suffolk Access and Assessment – 36.8%
- Suffolk East – 34%
- Suffolk West – 31.5%
- Central Norfolk – 30.8%
- West Norfolk – 30%

Whilst stress/anxiety/depression/other psychiatric illnesses accounts for 46.5% of absence within Support Services, the volume of all absence is low at 1,702 days lost in the year (2.72% of contracted time available). Stress/anxiety/depression/other psychiatric illnesses accounts for 790 of these days, made up of 20 episodes of absence, 5 of which were work related.

Graph 2 shows the total calendar days lost to stress/anxiety/depression/other psychiatric illnesses, including those reported as being ‘work-related’ which is small (72 of the 538 episodes (13%)).
Our Wellbeing Strategy 2016-21 includes a significant focus on supporting our staff to be as mentally (as well as physically) well as they can be and to improve personal resilience. A project group has been set-up to review how members of staff who need to access mental health services are able to access these in a safe and confidential manner as well as a group exploring how we might better support staff who have been involved in a traumatic incident. A review of our sickness absence policy is currently underway. This is being repositioned to have a focus on maintaining health at work as much as managing ill health when this arises. It is not possible to separate stress/anxiety/depression and report on the individual elements due to this being a national reporting grouping. Investigation of if an internal process can be adopted will be explored.

**Skilled Workforce KPI**

3. **Time to Hire**

Time to hire increased by 20 days from August 2016 to September 2016, increasing from 61 days to 81 days (11.5 weeks). This is largely due to a significant increase in activity. To illustrate this, 118 unconditional contracts were produced in September 2016 compared with 45 in August 2016.

Table 3 gives a breakdown, by locality, of the average time to hire and the corresponding number of unconditional contracts produced in the month:

<table>
<thead>
<tr>
<th>Locality</th>
<th>Average of Time to hire (days)</th>
<th>Number of unconditional contracts in period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central Norfolk</td>
<td>76</td>
<td>36</td>
</tr>
<tr>
<td>Corporate Services</td>
<td>49</td>
<td>12</td>
</tr>
<tr>
<td>East Suffolk</td>
<td>91</td>
<td>23</td>
</tr>
<tr>
<td>Great Yarmouth &amp; Waveney</td>
<td>62</td>
<td>8</td>
</tr>
<tr>
<td>Norfolk Wellbeing</td>
<td>46</td>
<td>1</td>
</tr>
<tr>
<td>Secure Services</td>
<td>135</td>
<td>15</td>
</tr>
<tr>
<td>Substance Misuse Services</td>
<td>65</td>
<td>3</td>
</tr>
<tr>
<td>Suffolk Access &amp; Assessment</td>
<td>65</td>
<td>1</td>
</tr>
<tr>
<td>West Norfolk</td>
<td>66</td>
<td>5</td>
</tr>
<tr>
<td>West Suffolk</td>
<td>70</td>
<td>14</td>
</tr>
</tbody>
</table>

East Suffolk have the highest average time to hire but this is coupled with the highest level of recruitment activity.

Breaking the performance of these localities into greater detail, it is clear to see that the time elapsed between an advertisement closing and the interview being set-up is the longest component. This component is controllable and is being raised with managers to seek to improve performance across all localities.

<table>
<thead>
<tr>
<th>Locality</th>
<th>Average advert published length (days)</th>
<th>Average time to Interview (days)</th>
<th>Average of time for employment checks (days)</th>
</tr>
</thead>
<tbody>
<tr>
<td>East Suffolk</td>
<td>15</td>
<td>26</td>
<td>25</td>
</tr>
<tr>
<td>Secure Services</td>
<td>16</td>
<td>45</td>
<td>32</td>
</tr>
</tbody>
</table>
Under the Trust's recruitment timeframe, interviews should be held within 7 days of adverts closing and interview dates should be identified at the beginning of the recruitment process and included in adverts. This is not happening consistently. A firmer line will now be taken, including the rejection of adverts that do not include a timely interview date.

To further support improving our time to hire, the Transformation Programme Board (TPB) has approved the purchase of an applicant management system (TRAC). This system includes excellent appointing manager and recruitment officer dashboards to better track performance and highlight and prioritise action that needs to be taken against the required timeframes at each stage of the recruitment process. Trusts that have implemented this system report it having a significant impact with time to hire reducing to 8 weeks (our target).

4. Appraisal % - Non Medical

The Trust's appraisal rate is currently 68.9%, falling slightly from 69.1% in the previous month.

HR Business Partners are working with line managers to ensure that appraisals are completed and logged using the new format. Particular focus is required in services with an appraisal completion rate of less than 60%, these are:

<table>
<thead>
<tr>
<th>Locality</th>
<th>Appraisal rate%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Corporate</td>
<td>54.5%</td>
</tr>
<tr>
<td>Norfolk and Waveney Wellbeing</td>
<td>52.1%</td>
</tr>
<tr>
<td>Secure Services</td>
<td>51.2%</td>
</tr>
<tr>
<td>Substance misuse services</td>
<td>52.1%</td>
</tr>
</tbody>
</table>

Across corporate services, appraisal take-up is low in estates, facilities and ICT.

Having launched a new appraisal scheme in April 2016, one that is now closely links with our values and behaviours, a 6 month review of this paper work is now due.

A recent audit on the appraisal documents highlighted specific issues concerning (1) being able to locate the paper appraisal where the appraisal had been logged as being completed and (2) the quality of the written documents.

Responsive Workforce KPI

5. Total Agency spend £k

The NHSI control target for September 2016 was £900k; the Trust's agency spend was £992k in the same period, £92k above the target. The Trust's year to date variance is £174k above the target position.

Medical agency spend accounts for 35% of all agency spend at £350k in the month; agency medical spend within West Norfolk alone accounts for £146k of the total monthly spend. The medical agency usage in West Norfolk is due to vacancies. An offer has been made on one of the medical posts following a recent recruitment exercise and another of the vacancies is being replaced with an advanced nurse practitioner post.
From the beginning of November 2016, the bank band 5 nurse rate has been increased to encourage a migration of registered nurses from agency to the bank to help reduce agency spend and to increase quality. This is being piloted for six months. During this time, focus is also being paid to increasing the registration of existing Trust staff on the bank.

6. Temp Nursing Demand ('000's hrs)

The Trust’s demand in September 2016 decreased to 57,645 hours from 63,460 hours in August 2016. The demand for registered staff decreased slightly to 16,854 hours compared to 16,988 in August 2016. Overall, however, performance in quarter 2 (July to September 2016) has been largely similar to quarter 1 (April to June 2016) with 186,477 hours demanded in Q1 and 182,646 hours in Q2.

The control of demand for temporary staffing is an operational issue and requires engagement at all levels of the organisation to address.

Temporary nursing demand trends seen locally largely reflects national trends. Nationally most Trusts are seeing an increase in temporary demand with specialising being a feature within mental health, reflected within our own organisation. A review of specialising practises has been running since September 2016 at Hammerton Court. Early results show positive reductions in specialising requirements and temporary staffing demand.

In September 2016 the percentage of temporary hours filled by workers increased from 88.9% to 90.3%.

Within this, bank fill increased from 61.5% in August 2016 to 61.7% in September 2016, agency fill increased from 27.5% to 28.6% and the number of unfilled shifts decreased to 9.7% from 11.1%.

7. Net Nurse Contracted Hrs Worked (%)

In the last completed roster period (commencing 15th August - 11th September 2016) a total of 142,203 contracted hours were available within the 34 teams using the e-rostering system but 2,281 of these available contracted hours were not rostered. This equates to approximately 15.48 wte staff. Performance, however, varies across services and across teams. Table 6 shows this breakdown. The minus figure in East Suffolk shows that more hours were worked than contracted.

<table>
<thead>
<tr>
<th>Locality</th>
<th>August</th>
<th>WTE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central</td>
<td>614.78</td>
<td>4.10</td>
</tr>
<tr>
<td>East Suffolk</td>
<td>-169.18</td>
<td>-1.13</td>
</tr>
<tr>
<td>GYW</td>
<td>873.95</td>
<td>6.10</td>
</tr>
<tr>
<td>Secure</td>
<td>690.06</td>
<td>4.60</td>
</tr>
<tr>
<td>West Norfolk</td>
<td>21.17</td>
<td>0.14</td>
</tr>
<tr>
<td>West Suffolk</td>
<td>250.39</td>
<td>1.67</td>
</tr>
<tr>
<td>Grand Total</td>
<td>2,281.17</td>
<td>15.48</td>
</tr>
</tbody>
</table>

Not allocating all hours can be due to issues such as the pattern of individual working arrangements and how these fit with shift patterns. The system will look to allocate and ensure that all staff work their contracted hours within the year. Given that there was 57,645 hours of temporary nursing demand in September 2016, focus is on reviewing individual flexible working arrangements where these do not meet service needs and supporting managers to better manage such as annual leave as poor management of this also impacts rostering efficiency.
Appendix 1: KPI - Reported achievement in September 2016

### NATIONAL TARGETS

<table>
<thead>
<tr>
<th>Achieved</th>
<th>Indicator Title</th>
<th>Indicator Ref</th>
<th>Regulator</th>
<th>Period</th>
<th>Target</th>
<th>Actual</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>CPA patients receiving follow up within 7 days of discharge</td>
<td>MO1</td>
<td>NHS Improvement</td>
<td>Sep-16</td>
<td>95%</td>
<td>96.5%</td>
<td>▲</td>
</tr>
</tbody>
</table>

**Indicator Description**

The number of people under adult mental illness specialties on CPA who were followed up (either by face-to-face contact or by phone discussion) within seven days of discharge from psychiatric inpatient care. Quarter to date figure at month end

*Red <92%  Amber >=92% and <95%  Green >=95%*

<table>
<thead>
<tr>
<th>Achieved</th>
<th>Indicator Title</th>
<th>Indicator Ref</th>
<th>Regulator</th>
<th>Period</th>
<th>Target</th>
<th>Actual</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>CPA patients having formal review within 12 months</td>
<td>MO2</td>
<td>NHS Improvement</td>
<td>Sep-16</td>
<td>95%</td>
<td>95.9%</td>
<td>▲</td>
</tr>
</tbody>
</table>

**Indicator Description**

The number of adults who have had at least one formal review in the last 12 months.

*Red <92%  Amber >=92% and <95%  Green >=95%*

<table>
<thead>
<tr>
<th>Achieved</th>
<th>Indicator Title</th>
<th>Indicator Ref</th>
<th>Regulator</th>
<th>Period</th>
<th>Target</th>
<th>Actual</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Minimising delayed transfers of care</td>
<td>MO3</td>
<td>NHS Improvement</td>
<td>Sep-16</td>
<td>7.5%</td>
<td>3.5%</td>
<td>▲</td>
</tr>
</tbody>
</table>

**Indicator Description**

The number of non-acute patients (aged 18 and over on admission) per day under consultant and non-consultant-led care whose transfer of care was delayed. Quarter to date figure at month end

*Red >=8%  Amber >7.5% and <8%  Green <=7.5%*

<table>
<thead>
<tr>
<th>Achieved</th>
<th>Indicator Title</th>
<th>Indicator Ref</th>
<th>Regulator</th>
<th>Period</th>
<th>Target</th>
<th>Actual</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Admissions to inpatient services had access to CRHT teams</td>
<td>MO4</td>
<td>NHS Improvement</td>
<td>Sep-16</td>
<td>95%</td>
<td>98.2%</td>
<td>▲</td>
</tr>
</tbody>
</table>

**Indicator Description**

The number of admissions to the foundation trust’s mental health psychiatric inpatient care for service users of working age (16-65) which has been gate-kept by a crisis resolution team prior to admission. Quarter to date figure at month end

*Red <92%  Amber >=92% and <95%  Green >=95%*

<table>
<thead>
<tr>
<th>Achieved</th>
<th>Indicator Title</th>
<th>Indicator Ref</th>
<th>Regulator</th>
<th>Period</th>
<th>Target</th>
<th>Actual</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Meeting commitment to serve new psychosis cases by early intervention teams</td>
<td>MO5</td>
<td>NHS Improvement</td>
<td>Sep-16</td>
<td>95%</td>
<td>128.6%</td>
<td>▲</td>
</tr>
</tbody>
</table>

**Indicator Description**

The number of new psychosis cases accepted by existing 14-35 year old early intervention services. Acceptance is defined as having had a second face-to-face contact with the early intervention services.

*Red <92%  Amber >=92% and <95%  Green >=95%*

<table>
<thead>
<tr>
<th>Achieved</th>
<th>Indicator Title</th>
<th>Indicator Ref</th>
<th>Regulator</th>
<th>Period</th>
<th>Target</th>
<th>Actual</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Data Completeness: Identifiers</td>
<td>MO6</td>
<td>NHS Improvement</td>
<td>Sep-16</td>
<td>97%</td>
<td>99.7%</td>
<td>▼</td>
</tr>
</tbody>
</table>

**Indicator Description**

The number of valid entries for each of the following data items; NHS number, date of birth, postcode (normal residence), current gender, registered General Medical Practice organisation code, commissioner organisation code

*Red <94%  Amber >=94% and <97%  Green >=97%*
### Achieved Indicator Title

| Data Completeness : Outcomes | MO7 | NHS Improvement | Sep-16 | 50% | 78.0% |

**Indicator Description**

The number of adults in the denominator whose accommodation and employment status is known at the time of their most recent assessment, formal review or other multidisciplinary care planning meeting and had at least one HoNOS assessment in the past 12 months

- **Red <47% Amber >=47% and <50% Green >=50%**

### Achieved Indicator Title

| Self-certification against compliance regarding access to healthcare for people with LD | MO8 | NHS Improvement | Sep-16 | 6 | 6 |

**Indicator Description**

Self-certification against compliance regarding access to healthcare for people with LD

- **Red <6 Green = 6**

### Achieved Indicator Title

| People with common mental health conditions referred to the IAPT programme will be treated within 6 weeks of referral | MO9 | NHS Improvement | Sep-16 | 75% | 93.3% |

**Indicator Description**

People with common mental health conditions referred to the IAPT programme will be treated within 6 weeks of referral

- **Red <72% Amber >=72% and <75% Green >=75%**

### Achieved Indicator Title

| People with common mental health conditions referred to the IAPT programme will be treated within 18 weeks of referral | M10 | NHS Improvement | Sep-16 | 95% | 99.9% |

**Indicator Description**

People with common mental health conditions referred to the IAPT programme will be treated within 18 weeks of referral

- **Red <92% Amber >=92% and <95% Green >=95%**

### Achieved Indicator Title

| Referrals to and within the Trust with suspected first episode psychosis that start a NICE-recommended package care package within 2 weeks of referral | M11 | NHS Improvement | Sep-16 | 50% | 60.0% |

**Indicator Description**

The standard is ‘two-pronged’ both conditions must be met for the standard to be deemed to have been achieved.

- **Red <47% Amber >=47% and <50% Green >=50%**
<table>
<thead>
<tr>
<th>Indicator Description</th>
<th>Achieved</th>
<th>Ind. Title</th>
<th>Indicator Ref</th>
<th>Regulator</th>
<th>Period</th>
<th>Target</th>
<th>Actual</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>% of qualifying patients with a MHCT cluster</strong></td>
<td></td>
<td>OD07 Local</td>
<td>Sep-16</td>
<td></td>
<td></td>
<td>95%</td>
<td>95.3%</td>
<td></td>
</tr>
<tr>
<td><strong>IAPT patients who have depression and/or anxiety disorders who receive psychological therapy</strong></td>
<td></td>
<td>OD12 National</td>
<td>Sep-16</td>
<td></td>
<td></td>
<td>7.50%</td>
<td>7.68%</td>
<td>▲</td>
</tr>
<tr>
<td><strong>IAPT patients who complete treatment and ‘move to recovery’</strong></td>
<td></td>
<td>OD13 National</td>
<td>Sep-16</td>
<td></td>
<td></td>
<td>50.0%</td>
<td>41.4%</td>
<td>▼</td>
</tr>
<tr>
<td><strong>Medium Secure Bed Occupancy Rate (including leave)</strong></td>
<td></td>
<td>OD14 Local</td>
<td>Sep-16</td>
<td></td>
<td></td>
<td>90.0%</td>
<td>85.8%</td>
<td>-6.3%</td>
</tr>
<tr>
<td><strong>Low Secure Bed Occupancy Rate (including leave)</strong></td>
<td></td>
<td>OD15 Local</td>
<td>Sep-16</td>
<td></td>
<td></td>
<td>90.0%</td>
<td>84.9%</td>
<td>-7.4%</td>
</tr>
<tr>
<td><strong>Average Length of Stay - Adult Acute Service</strong></td>
<td></td>
<td>OD16 Local</td>
<td>Sep-16</td>
<td></td>
<td></td>
<td>28</td>
<td>29.1</td>
<td>2.8</td>
</tr>
</tbody>
</table>

**ORGANISATIONAL DELIVERY**

**Board of Directors – Public – 24th Nov 2016**
**Business Performance Report**
**Version 1.0**
**Authors: Karen Rix**
**Page 21 of 24**
**Date produced: 8th November 2016**
**Retention period: 30 years**
## QUALITY, SAFETY & EXPERIENCE

### Achieved Indicator Title

<table>
<thead>
<tr>
<th>Achieved</th>
<th>Indicator Title</th>
<th>Indicator Ref</th>
<th>Regulator</th>
<th>Period</th>
<th>Target</th>
<th>Actual</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Waiting Times - Number of incomplete pathways waiting &gt; 18 weeks</td>
<td>QU04</td>
<td>Local</td>
<td>Sep-16</td>
<td>0</td>
<td>137</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Indicator Description**
Number of service users aged 18 and over currently waiting for treatment over 18 weeks in secondary care

- Red >3
- Amber 0 and <=3
- Green <=0

### Achieved Indicator Title

<table>
<thead>
<tr>
<th>Achieved</th>
<th>Indicator Title</th>
<th>Indicator Ref</th>
<th>Regulator</th>
<th>Period</th>
<th>Target</th>
<th>Actual</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Waiting Times - % of CAMHS patients seen within standard</td>
<td>QU05</td>
<td>Local</td>
<td>Sep-16</td>
<td>80.0%</td>
<td>87.0%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Indicator Description**
Referrals to service users aged under 18 treated within local standards in secondary care. Norfolk and Waveney = 8 week standard. Suffolk = 15 week standard

- Red >=100%
- Amber >=95% and <100%
- Green <95%

### Achieved Indicator Title

<table>
<thead>
<tr>
<th>Achieved</th>
<th>Indicator Title</th>
<th>Indicator Ref</th>
<th>Regulator</th>
<th>Period</th>
<th>Target</th>
<th>Actual</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Safety Thermometer</td>
<td>QU14</td>
<td>National</td>
<td>Sep-16</td>
<td>95.0%</td>
<td>100.0%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Indicator Description**
The NHS Safety Thermometer is a local improvement tool for measuring, monitoring and analysing patient harms and 'harm free' care

- Red <92%
- Amber >=92% and <95%
- Green >=95%

### Achieved Indicator Title

<table>
<thead>
<tr>
<th>Achieved</th>
<th>Indicator Title</th>
<th>Indicator Ref</th>
<th>Regulator</th>
<th>Period</th>
<th>Target</th>
<th>Actual</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of long-term (over 12 months) inpatients that have received an annual health check</td>
<td>QU17</td>
<td>Local</td>
<td>Sep-16</td>
<td>100.0%</td>
<td>100.0%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Indicator Description**
The proportion of long-term (over 12 months) inpatients that have received an annual physical health check

- Red <97%
- Amber >=97% and <100%
- Green =100%

### Achieved Indicator Title

<table>
<thead>
<tr>
<th>Achieved</th>
<th>Indicator Title</th>
<th>Indicator Ref</th>
<th>Regulator</th>
<th>Period</th>
<th>Target</th>
<th>Actual</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>In area bed days - Adult Acute (Development KPI)</td>
<td>QU24</td>
<td>Sep-16</td>
<td>90.3%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Indicator Description**
The proportion of bed days where this service user is registered to the CCG aligned to the inpatient locality delivering the care e.g. Ipswich & East Suffolk CCG service user receiving inpatient care in the Woodlands unit in the Suffolk East locality would be classed as 'In Area'

### Achieved Indicator Title

<table>
<thead>
<tr>
<th>Achieved</th>
<th>Indicator Title</th>
<th>Indicator Ref</th>
<th>Regulator</th>
<th>Period</th>
<th>Target</th>
<th>Actual</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bed occupancy adult acute (Including leave)</td>
<td>QU25</td>
<td>Local</td>
<td>Sep-16</td>
<td>95.0%</td>
<td>95.7%</td>
<td>2.5%</td>
<td></td>
</tr>
</tbody>
</table>

**Indicator Description**
The proportion of beds used (as at midnight) of the total number of beds available, including those on home leave, in adult mental health wards

- Red >100%
- Amber >=95% and <100%
- Green <95%
<table>
<thead>
<tr>
<th>Achieved</th>
<th>Indicator Title</th>
<th>Indicator Ref</th>
<th>Regulator</th>
<th>Period</th>
<th>Target</th>
<th>Actual</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>✔️</td>
<td>Bed occupancy PICU (Including leave)</td>
<td>QU26</td>
<td>Local</td>
<td>Sep-16</td>
<td>95.0%</td>
<td>93.5%</td>
<td>3.0%</td>
</tr>
</tbody>
</table>

**Indicator Description**
The proportion of beds used (as at midnight) of the total number of beds available, including those on home leave, in Psychiatric Intensive Care Unit (PICU) wards.

- Red =>100%  
- Amber =>95% and <100%  
- Green <95%

<table>
<thead>
<tr>
<th>Achieved</th>
<th>Indicator Title</th>
<th>Indicator Ref</th>
<th>Regulator</th>
<th>Period</th>
<th>Target</th>
<th>Actual</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>✔️</td>
<td>Bed occupancy adult continuing support (including Leave)</td>
<td>QU27</td>
<td>Local</td>
<td>Sep-16</td>
<td>95.0%</td>
<td>85.6%</td>
<td>22.9%</td>
</tr>
</tbody>
</table>

**Indicator Description**
The proportion of beds used (as at midnight) of the total number of beds available, including those on home leave, in adult continuing support wards.

- Red =>100%  
- Amber =>95% and <100%  
- Green <95%

<table>
<thead>
<tr>
<th>Achieved</th>
<th>Indicator Title</th>
<th>Indicator Ref</th>
<th>Regulator</th>
<th>Period</th>
<th>Target</th>
<th>Actual</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>✔️</td>
<td>Bed occupancy older adult acute (including Leave)</td>
<td>QU28</td>
<td>Local</td>
<td>Sep-16</td>
<td>95.0%</td>
<td>104.1%</td>
<td>3.9%</td>
</tr>
</tbody>
</table>

**Indicator Description**
The proportion of beds used (as at midnight) of the total number of beds available, including those on home leave, in Older People's Mental Health wards.

- Red =>100%  
- Amber =>95% and <100%  
- Green <95%

<table>
<thead>
<tr>
<th>Achieved</th>
<th>Indicator Title</th>
<th>Indicator Ref</th>
<th>Regulator</th>
<th>Period</th>
<th>Target</th>
<th>Actual</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>✔️</td>
<td>Bed occupancy older adult continuing care (including leave)</td>
<td>QU29</td>
<td>Local</td>
<td>Sep-16</td>
<td>95.0%</td>
<td>99.8%</td>
<td>0.7%</td>
</tr>
</tbody>
</table>

**Indicator Description**
The proportion of beds used (as at midnight) of the total number of beds available, including those on home leave, in adult continuing care wards.

- Red =>100%  
- Amber =>95% and <100%  
- Green <95%
Appendix 2: Activity Dashboard 2016/17

This reports the current activity levels across the Trust.

ACTIVITY DASHBOARD 2016-2017
Activity relates to secondary care - excluding NRP/secure services

Trustwide Access & Assessment Service Line - New Referrals

Trustwide Access & Assessment Service Line - Discharged after two or less contacts

Trustwide - Active Service Users

Trustwide - Attended Contacts
Executive Summary:

The report provides a further assessment of the financial position, including issues which impact on our financial plans, as at the end of October 2016.

Assurance review

<table>
<thead>
<tr>
<th>Issue reviewed by committee</th>
<th>Commentary (including actions where required)</th>
<th>Level of assurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Business Performance Report</td>
<td>The FC noted the definition and clarification of the extended Early Intervention in Psychosis target. The full national target has not been commissioned and this will be a discussion point with Commissioners for 2017/18. The FC noted the length of time that medically fit people remain within the Trust and asked for an update from those organisations that are responsible for the on-going care. The national dashboard for mental health was discussed. When this is available this will be included as an appendix within the report. The FC noted the workforce length of time to hire and asked for the outliers to be reviewed. Other workforce issues will be referred to the O&amp;DCommittee. The need to review trends in performance was agreed and will be assessed on a quarterly basis.</td>
<td>Green</td>
</tr>
<tr>
<td>Financial Plan 2016/17</td>
<td>The FC noted the financial position for October, being a positive variance of £154k against the plan. The forecast for the year continues to achieve the £4.8m control total.</td>
<td>Green</td>
</tr>
</tbody>
</table>
The Committee noted the position with ‘Out of Trust’ placements expenditure and asked for a detailed discussion at the next FC. The agency spend against the control total was noted and a report requested on the actions to keep within the control total. There was discussion about the underspend on the capital programme. It was noted that the programme had fully committed plans although some of the schemes were yet to spend their allocated funds.

**Estates Issues**
The FC discussed the master plan for estates. A strategy will be provided to the February Committee. This will include the outcome of the bed review and establish the plans for our estate in the future.
The FC discussed the governance process for the approval of business cases and agreed that this should be reviewed. **Amber**

**QIP Schemes**
The FC noted the closed schemes and the good progress to date. **Green**

**Recommendations**
The Board is asked to note the highlighted issues within the Committee and the risks to achieving our year end financial position.

Tim Newcomb
Chair of Finance Committee
15th November 2016
Executive Summary:

The joint agreement between the Council of Governors (CoG) and the Board of Directors (BoD) sets out the lines of communication and ways of working for the two bodies. The agreement is refreshed each year with both the CoG and BoD agreeing an updated version at their respective meetings.

1.0 Main changes to the joint agreement

1.1 The changes are shown underlined in the attached agreement For the most part these changes consist of minor updates or removal of duplication.

1.2 Now that the Trust has exited special measures it is proposed that the governors’ Improvement Plan Coordination subgroup (IPC) meets bimonthly before the Planning and Performance Subgroup meeting instead of by conference call ahead of each BoD meeting.

2.0 Financial implications (including workforce effects)

2.1 There are no financial implications.

3.0 Quality implications

3.1 There are no quality implications

4.0 Equality implications / summary of consultation

4.1 There are no equality implications. Directors and governors are consulted as part of the annual review process via the BoD and CoG.
5.0 Risks / mitigation in relation to the Trust objectives

5.1 The joint agreement supports good governance and the Trust’s strategic objectives of improving quality and working together as one Trust.

6.0 Recommendations

6.1 Directors are asked to review the joint agreement and approve any changes.

Background Papers / Information

BoD / CoG jointing agreement attached.
Joint working agreement for governors, non-executive directors and the wider Trust

November 2016 (BoD review)
January 2017 (CoG review)
Norfolk and Suffolk NHS Foundation Trust
Joint working agreement for governors, non-executive directors
and the wider Trust

1. Purpose and status

The FT code of governance recommends that the roles and responsibilities of the Council of Governors should be set out in a written document and should establish an engagement policy with the Board of Directors. The purpose of this document is therefore to fulfil these functions by clarifying expectations for governors, non-executive directors, and for the wider Trust in order to promote effective and efficient accountability to the people we serve.

Although the governors’ duty to ‘hold to account’ is set out in law, it is not defined anywhere. NHS Improvement (previously known as Monitor) acknowledges that there is no ‘right way’ to hold non-executive directors to account and it recommends that a jointly agreed process be developed.
The document sets out the structures, flows of information, relationships and behaviours that underpin good governance for governors and non-executive directors working together. Once agreed by governors and directors it is intended to complement and put into practice the legal and governance framework.

2. Legal and governance framework

Foundation Trust governance is based on accountability of Boards of Directors to the local population through the Council of Governors. This is reflected in the powers of governors for the appointment and removal of NEDs and the Chair, the appointment of the external auditors, the approval of the appointment of the CEO and the approval of the forward plan.

The Health and Social Care Act (2012) strengthened the role of governors by placing a two-fold duty upon them;

S.151 (4)

“The general duties of the council of governors are—

(a) to hold the non-executive directors individually and collectively to account for the performance of the board of directors, and

(b) to represent the interests of the members of the corporation as a whole and the interests of the public.”

For its part the FT, under S.151 (5);

“...must take steps to secure that the governors are equipped with the skills and knowledge they require in their capacity as such.”

In addition to the legal powers and duties, Monitor’s Code of Governance and the publication, “Your statutory duties: a reference guide for NHS foundation trust governors (Aug 2013)” provide further guidance on joint working arrangements.

NHS Providers offer this definition of accountability:

“To be accountable is:

- To be responsible for the delivery of a specific task or outcome,
- To be liable to explain and justify to another party,
- To be subject to judgement and possible sanction or reward.
- To hold to account is to receive the explanation or justification, to test it through questioning, to form a judgement and to feed back.”

For their part, governors must understand the role of non-executive directors, the importance of their independence and the distinction between non-executive and executive directors in order to carry out their role. Non-executive directors maintain their independence partly in order to be able to test the evidence provided by executives and where appropriate to provide assurance that the governance systems are working effectively. Where assurance is lacking then they check what the significance is of this and where the testing identifies weaknesses then they require changes to address these.
3. Structures, functions and the flow of information

I. The relationship between the Council of Governors and its subgroups

The formal exercise of governors’ duties is carried out at the Council of Governors’ (CoG) general meetings as set out in the Constitution. The CoG meets four times a year, twice in Ipswich and twice in Norwich for all day meetings. In addition the CoG holds two half-day member engagement meetings each year and holds short business meetings on the same day if required. In order to ensure that the meetings are accessible to members, venues usually have microphones and are accessible by public transport. Whilst these meetings are sufficient to make appointments and receive reports, this is not frequent enough to fulfil an effective scrutiny role nor to capture the interests of the wider public.

The CoG therefore delegates some functions to subgroups which are empowered by their approved terms of reference to act on behalf of the full CoG. The CoG has approved meeting standards which also apply to its subgroups. Governor work in subgroups is formal business and the same principles apply in that all members must follow the topics on the agenda and not impede the work of the subgroup by introducing their own interests unless they are directly relevant to the subgroup agenda for that meeting. No member may dominate discussions and it is the responsibility of all members to ensure that quieter members have the opportunity to contribute fully. Members must respect the decisions of the Chair of the meeting and recognise that the Chair’s decision with respect to the running of the meeting is final.

Final decisions in relation to the CoG’s legal powers and duties can only be made at a general meeting.

Although the subgroups are an important way in which detailed work can take place, governors remain collectively responsible for the delegated functions. For example, every governor must individually engage with members and the wider public. This role cannot be left to the Membership Subgroup. Similarly, every governor must take individual responsibility for monitoring the performance of the board – this role cannot be left solely to the Planning and Performance Subgroup.

II. Performance monitoring functions

Consideration of performance information takes place at the Planning and Performance Subgroup and is in the context of assessing the performance of the board of directors (BoD).

The purpose of this scrutiny is not to duplicate the work of the BoD in challenging information, but to gain assurance on the performance of the board in doing so. The focus of questions from governors should therefore be “What have NEDs done to examine this issue and to ensure that the board addresses it?”, and not “How can this performance be improved by governors?”
In order for governors to be able to fulfil their role the Trust must supply subgroup members with information that is up-to-date, accurate, relevant and timely (i.e. received in sufficient time for governors to read and consider). At least two non-executive directors will normally attend each Planning and Performance Subgroup meeting with NED attendance varying over the course of the year. Their purpose is to answer questions put by the subgroup, either at the meeting or in writing within a given timescale. As this subgroup primarily looks into the organisation it provides a valuable opportunity for governors to hold NEDs to account.

This does not mean that governors need to see all reports or to question every line of information that they receive. To do so would risk getting lost in the detail of Key Performance Indicator definitions and measurement problems instead of taking a wider view of board performance.

Governors will normally therefore question a small selection of measures or reports which reflect issues of concern. These concerns could include incongruence between the data and other sources of information or a theme emerging from complaints made by patients or the wider public.

For the period when the Trust is in special measures an additional group has been formed. This is the Improvement Plan Coordination (IPC) Subgroup. This group focuses more specifically on the Trust’s Quality Improvement Plans, learning from other organisations and the working of the board committees. The lead governor, or another member of the IPC attends the monthly Stakeholder Assurance Meeting that is convened with Monitor, CQC and other stakeholders as part of the special measures support package.

For the period when the Trust was in special measures, an additional subgroup operated (the Improvement Plan Coordination (IPC) subgroup). It is proposed that this will continue in modified form following the Trust’s exit from special measures. The IPC will meet prior to each P&P subgroup meeting and review post-inspection action plan progress and feedback from committee observations.

III. Planning functions

In order for governors to contribute effectively to forward planning they need to have an understanding of members’ and the public’s views, and have a clear mechanism through which to feed these views into the process.

Engaging with members and the wider public overlaps with the work of the Trust Member and Governor Development Membership Subgroup (see 3.4).

The Council of Governors express a view on the Board of Directors’ forward plans. Governors should be involved throughout the planning cycle and should not be presented with plans as a ‘fait accompli’. The Planning and Performance Subgroup informs and tracks the development of the plan.
The CoG can influence the direction of the organisation through the selection of the Chair and NEDs, but responsibility for setting the Trust’s strategy sits solely with BoD. The CoG does not set the strategy of the Trust.

In setting the strategy and the forward plan that flows from it, the BoD should be able to demonstrate how they have taken account of governor views, particularly in so far as they flow from S.151 (4)b whereby governors represent “the interests of the members of the corporation as a whole and the interests of the public.” This does not mean that the CoG and BoD will necessarily agree. The BoD have to take into account their formal obligations (such as to operate the Trust as a going concern) and a divergence of views may simply reflect the different responsibilities of governors and directors. It is for this reason that the CoG cannot veto the forward plan.

IV. Trust Member and Governor Development

Elected governors are accountable to their members and should report to them on work undertaken. To some extent this function is fulfilled by the publication of the minutes of CoG meetings on the public website, but this is a narrow format and few members are likely to read these documents. The governors’ document Governor engagement with members and the public: our approach, sets out how governors approach engagement with members and the public.

The main method of communicating with members is through the Trust’s Insight Magazine. Governors can communicate directly with their constituents by submitting material for articles in Insight. The communications team can assist by drafting text based on these materials.

The membership database also includes c. 3500 member email addresses although with only about 1 in 10 emails being read this is less effective as a means of communication.

The Trust employs a full-time membership and engagement officer to support this function and pays for stands at community events across both counties. This provides an opportunity for governors to listen to the views of local people, talk about the work of the Trust, and explain the governor role.

Coordination of membership recruitment, and member and public engagement takes place through the Trust Member and Governor Development Membership and Communications Subgroup. This group also oversees preparation of election materials.

As this group primarily looks out from the organisation to the communities served, NED attendance is less relevant and not expected.

Members can contact their governors through a general email address governors@nsft.nhs.uk which is monitored by the Trust Secretariat. Member
queries will be forwarded to the relevant governor, usually the Lead Governor, with advice and support on options for responding. A summary of the issue raised by the member will then be shared with the CoG maintaining the confidentiality of the matter.

V. Governor attendance at BoD meetings in public

There are ten BoD meetings in public a year. These are held in public in Ipswich and Norwich.

For governors, these meetings provide an important opportunity to assess the performance of the BoD, and to consider how the NEDs fulfil their functions within it. The role of the governor at a BoD is therefore as an observer. Whilst the Chair may invite questions and comments from governors, the function of these is to assist governors in their role rather than for governors to act as an additional member of the BoD.

In order to fulfil their general duty to hold the NEDs to account for the performance of the BoD, governors should therefore aim to attend several BoD meetings a year. To facilitate governors in doing this, the BoD needs to ensure that governors and the public can hear what the directors are saying. This may require the use of microphones, or excellent acoustics.

The BoD conducts a small amount of confidential (in that it relates to individual staff or service users) or commercially sensitive business in private. There is a requirement for FTs to share the agenda and minutes from these meetings with governors, but NSFT goes further and shares all private board papers with those governors who have signed a special confidentiality form. This form deals with the handling and disposal of the private papers as well as the protection of the information they contain. Governors can return papers to the Trust Secretariat for secure disposal.

VI. Governor attendance at other BoD committee meetings

Governors are also welcome to attend BoD committee meetings, in the role of observer, by prior arrangement with the Chair of the committee. BoD committee meetings are chaired by NEDs. Following the learning from the experience of monitoring the Trust exiting special measures (through the IPC subgroup), governors intend to develop a process in which identified governors observe the committee meetings (see 3.ii above).

It is important to be clear as to the rationale for attending BoD committee meetings since the governors’ role can usually be assured by the committee reports that come to the BoD. The advantage of governors observing committee meetings is that it can contribute to governor insights into the performance of the non-executive directors they appoint. For this to be effective, governors observing committees must have a
sound understanding of the role of non-executive directors and what effective committee governance consists of.

Most committee agendas are very full and it would impede the work of the committee if time was spent explaining the background to papers or answering governor questions. There may be value, however, in governors attending as ad hoc observers to understand the role of the committee and the work of the NED in more detail. A briefing before or after the meeting with the NED may also be useful.

Guidance on observing committee meetings is available from the Company Secretary.

VII. Governor attendance at Trust operational / management meetings and visiting services

There are a small number of operational meetings that NEDs attend (but do not chair). For the most part governors would not attend operational meetings since this is not part of their role (and, if the limited time available to governors was spent in this way, it would be time lost to fulfilling their core duties).

When visiting services it is important for governors to bear in mind that they are not in the role of inspector, regulator or auditor. The purpose of a governor visit to a service is to understand what the service is for and how it works. In talking to service users (say on a visit to a ward) governors may gather insights that help in their role of representing the interests of members and the wider public. In order to avoid slipping into an inspector role, governors should not normally visit the same team more than once. The value of service visits for governors is that it enables them to gain a broad understanding of how care pathways and the whole work of the Trust operates and so visits should reflect this.

Separate guidance for governors on visiting services is available.

VIII. Director attendance at CoG meetings

There are six CoG meetings a year, held in Ipswich and Norwich.

For directors, the CoG provides a good opportunity to meet governors and to listen to their priorities and concerns; this is particularly important for NEDs who are directly accountable to governors. The expectation therefore is that NEDs will try to attend CoG meetings where practicable and that EDs will make reasonable efforts to attend when the agenda is relevant to their responsibilities.

IX. Governor requests for information
Governors cannot fulfil their role unless they can ask questions and request information and the Trust must try to provide up-to-date, accurate replies to fulfil its accountability to local people.

There are several ways to request information.

The first is informally through a discussion with a board member or the Company Secretary about why the information is needed. This is helpful because it may be that the information sought would not meet the need, but that there is another way of addressing the same question. A meeting or telephone discussion with a manager may be more useful than a table of figures.

Where appropriate, governors can also request information through the ‘issues register’ section in each Council of Governors meeting. The issues register also provides a way for governors to flag issues as part of their ‘representing interests’ role and has a ‘holding to account’ function in consideration of the responses received.

Any governor can ask that an item be put on the CoG agenda, giving two weeks’ notice. This right is set out in the Constitution and would generally be used when the other methods have proved ineffective.

If the information is already collected it will be shared as soon as practical.

If the information is not already collected then a discussion will take place about the benefits and costs of retrieving it. Normally this will resolve the matter to everyone’s satisfaction but if agreement cannot be reached the Chair will be asked to adjudicate.

Governor feedback on services

Governors frequently hear feedback about services not working quite as they should, or indeed about them working exceptionally well. Governors should normally report such feedback to the Directors of Operations (Norfolk & Waveney or Suffolk) so that they can take appropriate action.

4. Working relationships and behaviours

i. Support for governors to carry out their role

NSFT has a legal duty to ensure that governors are equipped with the skills and knowledge that they need to discharge their duties. The training and development needs of governors are overseen by the Education–Trust Member and Governor Development Subgroup.

The Trust organises annual induction sessions for all new governors and arranges development sessions throughout the year on specific topics. So far as possible these are held on CoG days. Additional sessions between CoG days can also be
arranged at the request of the Trust Member and Governor Development Education Subgroup.

The Trust is also a member of the NHS Providers which provides training events.

Ways to support governors are continually being refined and improved. Currently, elected governors are paired with a director who can act as an initial contact for queries and exchange of ideas. Partner governors can also request to be paired. This informal relationship can be used in whatever way is most useful to the governor.

Governors also elect a Lead Governor from among their number, normally for a three year period. The Lead Governor is available for conversation and advice.

The Chair of the Council of Governors, who is also Chair of the Board of Directors, is available for one to one conversations.

Any governor is also welcome to contact the Trust’s Company Secretary for informal information or advice about any aspect of the work of the Trust, the Constitution, the role of governors or wider corporate governance queries.

ii. Objective setting and appraisals

The role of the CoG is first to define the process for objective setting and evaluating the performance of the Chair and, in consultation with the Chair, the NEDs and second, to be assured that it has been followed.

The Nominations Committee oversees this on behalf of the CoG and reports the outcomes of the appraisals to the full CoG for approval. In line with Monitor’s NHSI’s Code of Governance, the Senior Independent Director carries out the Chair’s appraisal and the Chair carries out the NEDs’ appraisals. The process followed is overseen by the Nominations Committee in both cases.

As part of the appraisal process, governors are invited to provide confidential feedback on the performance of the Chair and NEDs. This is the formal point at which governors reflect on the performance of the Chair and NEDs as they have seen them operate during the year, for example at the meetings of the CoG, the BoD and its committees or the P&P Subgroup, and provide their feedback on their performance.

iii. Promoting good relationships

Effective relationships between governors and directors are promoted by all parties:

- Acknowledging that governors and directors have the same goals but different responsibilities.
• Accepting that constructive tension is required in any accountability structure and that an effective relationship is neither cosy nor adversarial.

• Fulfilling but not exceeding their remits.

• Working to common solutions rather than insisting on a single answer.

iv. **Resolving disagreements between the Board of Directors and the Council of Governors**

The Chair, in liaison with the Lead Governor and the Senior Independent Director, will facilitate discussions between the two Boards to resolve any disagreements.

An informal approach to resolving disagreements will usually be sufficient and the requirements will depend on the matter under consideration. It may consist of ensuring that further information is made available (for example, where there is a disagreement over the basis for a decision) or taking legal advice where there is a question over interpretation of responsibilities.

Where an informal approach does not resolve the matter to the satisfaction of the governors and a motion is passed by two thirds of the Council of Governors to call a Resolution Meeting then this will be arranged as soon as practical, but no later than 20 working days after the motion.

A Resolution Meeting is a joint meeting (of the CoG and BoD) held in private. The agenda and papers will be issued in line with the Trust Constitution and quoracy requirements for both Boards apply. The Chair may choose to invite a facilitator to the meeting.

All participants will make every effort to resolve the matter, but if the issues cannot be resolved to the satisfaction of both boards (by a simple majority vote of those present from each board separately) then the final decision rests with the Board of Directors. The Council of Governors may then decide to escalate the matter to the Panel for Advising Governors (established by the Health and Social Care Act (2012)) or through the lead governor to Monitor in relation to a potential breach of the terms of its licence.

v. **The role of the lead governor**

The lead governor is the main contact point for Monitor-NHSI (although any governor may contact Monitor-NHSI if they feel this is appropriate). The lead is elected by governors through a secret ballot. The role is set out in full in the role profile (available separately).

Robert Nesbitt
Company Secretary
Executive Summary:

The BAF has been updated to take into account changes in the risk register since July 2016. The executive team reviewed the BAF on 09.11.16

The risks to the Trust’s objectives are:

| 1. Improving quality and achieving financial sustainability | Low staff morale.  
Poor Lorenzo performance.  
Reduction in service safety.  
Not maintaining quality improvements post special measures.  
Risk to quality of service due to financial pressures.  
Not controlling expenditure / maximising income and achieving the financial recovery plan (FRP).  
Clinical strategies not being deliverable within budget. |
|---|---|
| 2. Working as One Trust | Differing STP (Sustainability and Transformation Plan) arrangements.  
Commissioning variations in service provision. |
| 3. Focussing on prevention, early intervention (EI) and promoting Recovery. | Under-resourcing of EI and other prevention and Recovery initiatives. |
1.1 The BAF is considered by the board four times per year.

1.2 The executive team reviewed the BAF at their meeting on 09.11.16.

1.3 Feedback from Lorna Squires (NHSI) on the BAF was that it would benefit from linking in with the strategic horizon scan of the CEO report so as to be more outward-looking. Whilst the STP is included in this BAF iteration, the timing of the report means that this outward perspective is limited on this occasion but will feature next time (Jan 2017).

2.0 Financial implications (including workforce effects)

2.1 The financial implications are set out in the Finance Report each month. Whilst our financial pressures remain significant the FRP is on target and good progress has been made. It may be possible to reduce this risk score shortly.

2.2 Workforce pressures are also significant and potentially impact on service quality and staff morale.

2.3 The workforce measures are included in the Business Performance Report.

3.0 Quality implications

3.1 The risk of not exiting special measures has been removed and replaced by a risk of not maintaining quality progress or of slipping back. The outstanding actions from the CQC inspection are of course those that were most difficult to address (since they were not fully closed in the 18 months of special measures) and so particular care will be needed to ensure that this risk does not escalate. This is mitigated by the executive focus on the action plan.

3.2 The quality implications are set out in a wide range of reports to the board this month.

2.0 Equality implications

4.1 There are no specific equality implications identified in the BAF.

3.0 Risks / mitigation in relation to the Trust objectives

5.1 The focus of the report is solely on this topic. The Quality Report (section 4.3) also includes an update on the changes in the risk register.

4.0 Recommendations

6.1 Directors are asked to review the BAF and consider:

Are the risks as set out in the BAF a true reflection of the position of the Trust?

Are the risks complete and appropriately rated?
Is the assurance adequate or are the actions to address the gaps in assurance appropriate and timely?

6.2 If additional actions are identified to manage the risks then directors are asked to specify these including timescales and lead executive.

Robert Nesbitt  
Company Secretary

Background Papers / Information
Board Assurance Framework
1a. Improving quality (patient experience, safety and effectiveness) (C = Consequence, L = Likelihood)

<table>
<thead>
<tr>
<th>Ref.</th>
<th>Risk Description</th>
<th>Current Risk Rating (C x L)</th>
<th>Target Risk Rating (C x L)</th>
<th>Key Assurances / Gaps</th>
<th>Action Plan Progress</th>
<th>Owner / Last Updated</th>
<th>Ctte</th>
</tr>
</thead>
<tbody>
<tr>
<td>1a.1</td>
<td>Risk: Poor Lorenzo performance affecting quality. Cause: System / network performance problems beyond Trust’s direct control; product design issues require new releases which are beyond Trust’s direct control; staff getting used to new product takes more time. Effect: Patient care and commissioner confidence will be adversely affected; staff morale affected.</td>
<td>5 x 4 = 20</td>
<td><strong>5 x 1 = 5</strong></td>
<td>Negative assurance BoD received undertakings from supplier at BoD meeting in May 2016. Release of V2.8 took place on 13.07.16 and has brought improvements such as resolving the cursor jumping problem. The freezing and crashing problem has not been solved. Many (but not all) staff continue to experience significant impacts on workflow and productivity which in turn affects quality. Gaps in control: the main gap in control is that the solution to the problem is dependent on outside providers over whom we have no direct control although we continue to attempt influence as strongly as possible.</td>
<td>Onsite CSC team continues diagnostic work. BT being pressed to expedite hardware solution. Ongoing in-house actions to address training and local issues where we can. Strong track record of ‘you said -we did’ and staff feedback continues to be gathered and actioned where possible. Michael Scott wrote to CSC to query progress and response received setting out actions being taken.</td>
<td>Leigh Howlett Director of Strat. &amp; Res. Nov 2016</td>
<td>Finance</td>
</tr>
<tr>
<td>1a.2</td>
<td>Risk: Poor staff morale. Causes: A. Organisational culture. B. Too many staff vacancies are not filled. Effect: Quality may fall below acceptable levels; patient and staff safety could be compromised; increased cost pressures.</td>
<td>4 x 4 = 16</td>
<td>4 x 1 = 4</td>
<td>A. Strong improvement in the Staff FFT results has continued into October 2016 results. This indicates that the efforts over the last 12 – 18 months are now bearing fruit and staff morale is starting to lift. B. Benchmarking data shows that NSFT has lowest clinical vacancies of MH trusts in region although this in itself is unlikely to be of comfort to staff facing gaps on shift rotas it does provide assurance that recruitment and retention initiatives are effective in a very difficult skills market.</td>
<td>A comprehensive suite of HR related strategies have been developed and approved by the board. Specific action plan agreed 01.11.16 in place to mitigate national shortfall in qualified nursing staff. Board monitoring of progress will largely be via ODFW complemented by the Workforce Dashboard which is reviewed each month by the executive team.</td>
<td>Leigh Howlett Director of Strat. &amp; Res. Nov 2016</td>
<td>ODFW</td>
</tr>
<tr>
<td>Ref.</td>
<td>Risk Description</td>
<td>Current Risk Rating (C x L)</td>
<td>Target Risk Rating (C x L)</td>
<td>Key Assurances / Gaps</td>
<td>Action Plan Progress</td>
<td>Owner / Last Updated</td>
<td>Ctte</td>
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<tr>
<td></td>
<td></td>
<td>5 x 3 = 15 AMBER</td>
<td>5 x 1 = 5 GREEN</td>
<td>Gap in control: Hot spots in some areas (E.g. West Norfolk) remain, resulting in higher risks to quality in those wards although mitigating action has been taken to protect safety by capping bed numbers in W. Norfolk.</td>
<td>Locality leads development session with executive team took place Nov 2016.</td>
<td>Jane Sayer DoN Nov 2016</td>
<td>Quality Governance</td>
</tr>
<tr>
<td>1a.3</td>
<td>Risk: Services become less safe. Cause: Service pressures; weak controls and assurance systems. Effect: Could cause increase in unexpected deaths and serious incidents.</td>
<td></td>
<td></td>
<td>Assurance: Patient safety report Controls: Operating model introduced and locality leads have received training and development investment on their roles and responsibilities. Performance Assurance Review Meetings established from September 2016. Gap in assurance: Performance information is improving but is not yet at the stage where it provides firm forward looking / trajectory based assurance on safety.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1a.4</td>
<td>NEW Risk: Having exited special measures, improvements stagnate or fall back. Cause: Loss of focus Effect: Reduction in quality of services.</td>
<td>4 x 2 = 8 AMBER</td>
<td>5 x 1 = 5 GREEN By 31.03.17</td>
<td>Assurance: PMO report shows reducing number of reds and ambers. Controls: The PMO arrangements that were in place in the lead up to the reinspection remain in place. There is an updated CQC action plan that takes into account October 2016 report findings. Ongoing peer inspection and director visits provide evidence of progress and highlight any new concerns for action.</td>
<td>PMO continues to support and report on QIP progress.</td>
<td>Alison Armstrong / Debbie White Directors of Operations Nov 2016</td>
<td>Quality Governance</td>
</tr>
</tbody>
</table>

BoD 24Nov2016 BAF

Version 1.0

Author: Robert Nesbitt

Department: Corporate

Page 2 of 8

Date produced: 15Nov2016

Retention period: 20 years
<table>
<thead>
<tr>
<th>Ref.</th>
<th>Risk Description</th>
<th>Current Risk Rating (C x L)</th>
<th>Target Risk Rating (C x L)</th>
<th>Key Assurances / Gaps</th>
<th>Action Plan Progress</th>
<th>Owner / Last Updated</th>
<th>Ctte</th>
</tr>
</thead>
<tbody>
<tr>
<td>1a.5</td>
<td>Risk: Financial balance is prioritised over patient care. Cause: Under-funding. Effect: Quality may fall below acceptable levels; patient and staff safety could be compromised.</td>
<td>5 x 2 = 10 AMBER Reduced from 5 x 3</td>
<td>5 x 1 = 5 GREEN Dependent on all CIP plans being finalised</td>
<td>Quality dashboard measures impact on quality of service. CIPS are quality impact assured to test impact on quality and mitigate where required. Revised arrangements for QIAs for CIP plans strengthen protection of quality.</td>
<td>Clinical oversight group planned to review risks identified in 2017/18 planning process</td>
<td>Jane Sayer Director of Nursing Nov 2016</td>
<td>Quality Governance</td>
</tr>
</tbody>
</table>

**1b. Improving financial sustainability** (C = Consequence, L = Likelihood)

<table>
<thead>
<tr>
<th>Ref.</th>
<th>Risk Description</th>
<th>Current Risk Rating (C x L)</th>
<th>Target Risk Rating (C x L)</th>
<th>Key Assurances / Gaps</th>
<th>Action Plan Progress</th>
<th>Owner / Last Updated</th>
<th>Ctte</th>
</tr>
</thead>
<tbody>
<tr>
<td>1b.1</td>
<td>Risk: Financial deficit is not addressed. Cause: Expenditure is not controlled and / or income is not maximised. Effect: The Trust’s medium term stability and short to medium term liquidity is undermined.</td>
<td>4 x 4 = 16 RED No change</td>
<td>4 x 1 = 4 GREEN 31 March 2018</td>
<td>Assurance - 2015/16 came in £0.5m ahead of plan and 2016/17 financial performance is on plan. Controls: Treasury management, CIP plan programme management.</td>
<td>Liquidity under close monitoring and active management via 13 week cash profiling.</td>
<td>Julie Cave DoF Nov 2016</td>
<td>Finance</td>
</tr>
<tr>
<td>1b.2</td>
<td>Risk: Financial Recovery Plan is not implemented quickly and effectively. Cause: Easy and high return savings plans were implemented in previous years meaning that remaining plans are hard to identify, difficult to implement, and may realise low savings. Effect: The Trust will not be financially addressed.</td>
<td>5 x 4 = 20 RED</td>
<td>5 x 2 = 10 AMBER 30.04.16</td>
<td>Assurance: Good progress made against plans. Progress made on reducing agency costs with cash benefits and quality improvements. Gap in control: Out of area placement numbers volatile and needs-led.</td>
<td>Continued close management of OOA placements by medical director to balance patient benefits and affordability.</td>
<td>Julie Cave DoF Nov 2016</td>
<td>Finance</td>
</tr>
<tr>
<td></td>
<td>Sustainable.</td>
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</tr>
<tr>
<td>1b.3</td>
<td>Risk: The FRP will be weakened. Cause: Clinical strategies are not affordable. Effect: The Trust will not be financially sustainable if unaffordable clinical strategies are implemented</td>
<td>5 x 4 = 20 RED</td>
<td>Assurance: The brief for the strategies is that they must be affordable. Negative assurance: Implementation of work had been delayed and is 'red' on the PMO list. Gaps in assurance: The implementation methods / costs have not yet been approved so this may impact on timescale. The strategies are not yet at a level of detail that can be costed.</td>
<td>Executive team review of issues and remedial action 16.11.16</td>
<td>Bohdan Solomka Med Dir Nov 2016</td>
<td>Quality</td>
<td></td>
</tr>
</tbody>
</table>
## 2. Working as One Trust

<table>
<thead>
<tr>
<th>Ref.</th>
<th>Risk Description</th>
<th>Current Risk Rating (C x L)</th>
<th>Target Risk Rating (C x L)</th>
<th>Key Assurances</th>
<th>Action Plan Progress</th>
<th>Owner / Last Updated</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.1</td>
<td>Risk: The ability to run an effective “One Trust” may be weakened. Cause: Different commissioner requirements take localities in different directions. STP arrangements in the region may pull Suffolk and Norfolk in different directions. Effect: The Trust will be less well-led.</td>
<td>4 x 2 = 8 AMBER</td>
<td>4 x 2 = 6 AMBER 2020</td>
<td>Controls: Single values and behaviours, clinical strategies, workforce indicators, financial reports and activity reports assist in management of one Trust. Board development session has scoped what One Trust means in practice. Gaps in controls: STP collaborative approach means some elements not within Trust direct control.</td>
<td>Incremental plan agreed to move to One Trust by 2020. A further board development session on implications of STPs took place on 11.11.16. and reviewed approach.</td>
<td>Michael Scott CEO Nov 2016</td>
</tr>
<tr>
<td>2.2</td>
<td>Risk: Inconsistent funding from different commissioners impacts on equitable service provision Cause: Variable funding. (E.g. reduction in CCG funding for WSH psychiatric liaison. Peri-natal contract). Effect: Inability to provide same basic quality service across both counties which impacts on patient care and service interfaces.</td>
<td>4 x 4 = 16 RED</td>
<td>4 x 2 = 8 AMBER Dependent on contract neg ns</td>
<td>Gap in assurance: whilst staff will try their best to mitigate risks, there is no timescale for equitable basic provision will be provided. Gap in control: Only able to provide service where there is funding. Whilst trying to influence this we have no direct control over commissioning decisions.</td>
<td>Negotiations continue.</td>
<td>Alison Armstrong Dir Ops Suffolk Nov 2016</td>
</tr>
</tbody>
</table>
3. Focussing on prevention, early intervention and promoting Recovery

<table>
<thead>
<tr>
<th>Ref.</th>
<th>Risk Description</th>
<th>Current Risk Rating (C x L)</th>
<th>Target Risk Rating (C x L)</th>
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<th>Action Plan Progress</th>
<th>Owner / Last Updated</th>
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</tr>
</thead>
<tbody>
<tr>
<td>3.1</td>
<td>Risk: Lack of resources for prevention, EI and Recovery to support strategic goal. Cause: Resources for EI have not reached NSFT. Funding arrangements make prevention and Recovery initiatives more difficult to resource. Effect: Realisation of strategic goal impaired so patients receive suboptimal models of care.</td>
<td>4 x 4 = 16 RED</td>
<td>4 x 2 = 8 GREEN 2018</td>
<td>Negative assurance: Contract system does not incentivise preventative work. Wider NHS cost pressures limit opportunities to innovate. Gap in control: dependent on CCG funding with CCGs facing financial pressures.</td>
<td>Continue to press for EI funding to deliver model. Clinical Strategies implementation has emphasis on prevention and Recovery using existing resources. Use next contract round to further engage commissioners in this agenda.</td>
<td>Michael Scott CEO Nov 2016</td>
<td>QGC</td>
</tr>
</tbody>
</table>

Risk Register reconciliation (including all ‘high’ (16 – 25) risks on Datix at 15.11.16) mapped on to BAF.

<table>
<thead>
<tr>
<th>Risk Description</th>
<th>Datix Mapping (current level)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1a.1 Risk: Poor Lorenzo performance; Causes: System / network performance problems beyond Trust’s direct control. Product design issues require new releases which are beyond Trust’s direct control. Staff getting used to new product takes more time. Effects: Patient care and commissioner confidence will be adversely affected. Staff morale affected.</td>
<td>D.1267 Lorenzo system performance issues SPOA (high - 20). LH  D.1332 Lorenzo Risks (cross-Trust) (high – 20). LH</td>
</tr>
<tr>
<td>1a.2 Risk: Over-reliance on temporary staff; Cause: Too many staff vacancies are not filled; Effects: Quality may fall below acceptable levels; patient and staff safety could be compromised; increased cost pressures.</td>
<td>D.1129 Carlton Court CC wards staffing shortages (significant - 12). DW.  D.1040 Delivery of Norfolk West acute services (high - 20). DW.  D.1183 SRHT team resource Norfolk West (high - 16) DW.  D.1212 Assessment and focussed intervention in Central locality ability to manage volume of assessments (high - 16). DW.  D.1116 Clinical vacancies. (significant - 12)</td>
</tr>
<tr>
<td>1a.3 Risk: Services become less safe; Cause: Service pressures / weak practice Effect: Might cause increase in unexpected deaths and serious incidents.</td>
<td>D.1256 E. Suffolk team capacity (high – 20). AA  D.1059 Shortage of qualified nurses in secure in-patient wards (high – 16) DW.  D.1264 If services become less safe it could lead to increase in unexpected deaths (high - 15). JS  D.1116 Clinical vacancies (significant – 12). LH  D.914 Statutory / mandatory training below target (significant 9. Reduced from high – 16 July)</td>
</tr>
<tr>
<td>Risk Description</td>
<td>Datix Mapping (current level)</td>
</tr>
<tr>
<td>------------------</td>
<td>------------------------------</td>
</tr>
<tr>
<td>Cause: Loss of focus</td>
<td></td>
</tr>
<tr>
<td>Effect: Reduction in quality of services.</td>
<td></td>
</tr>
<tr>
<td>1a.5 Risk: Financial balance is prioritised over patient care;</td>
<td>D. 1265 If financial balance is prioritised over quality it could impact on patient safety. (Significant - 10). JS</td>
</tr>
<tr>
<td>Cause: Under-funding</td>
<td></td>
</tr>
<tr>
<td>Effect: Quality may fall below acceptable levels; patient and staff safety could be compromised.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Risk Description</th>
<th>Datix Mapping (current level)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1b.1 Risk: Financial deficit is not addressed;</td>
<td>D.1253 Insufficient cash to maintain our services (high - 16). JC</td>
</tr>
<tr>
<td>Cause: Expenditure is not controlled and income not maximised</td>
<td></td>
</tr>
<tr>
<td>Effect: The Trust’s medium term stability and short to medium term liquidity is undermined.</td>
<td></td>
</tr>
<tr>
<td>1b.2 Risk: Financial Recovery Plan is not implemented quickly and effectively;</td>
<td>D.1240 Impact on FRP of income being insufficient to cover service costs (high - 16). JC. D.1233 Potential non-achievement of CIP Suffolk-wide (high - 16). AA. D.1205 CIP shortfall impact on Trust finances (high – 12, down from 15 in July 2016). JC.</td>
</tr>
<tr>
<td>Cause: Easy and high return savings plans were implemented in previous years meaning that remaining plans are hard to identify, difficult to implement, and may realise low savings.</td>
<td></td>
</tr>
<tr>
<td>Effect: The Trust will not be financially sustainable.</td>
<td></td>
</tr>
<tr>
<td>1b.3 Risk: The FRP will be weakened;</td>
<td>D.1237 Clinical strategies affordability (moderate - 6) BS.</td>
</tr>
<tr>
<td>Cause: Clinical strategies are not affordable;</td>
<td></td>
</tr>
<tr>
<td>Effect: The Trust will not be financially sustainable.</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Risk Description</th>
<th>Datix Mapping (current level)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.1 Risk: The ability to run an effective Trust may be weakened.</td>
<td>D. 1308 4 x 2 = 8 (significant). MS</td>
</tr>
<tr>
<td>Cause: Different commissioner requirements take localities in different directions. STP arrangements in the region may pull Suffolk and Norfolk in different directions.</td>
<td></td>
</tr>
</tbody>
</table>
**Effect: The Trust will be less well-led**

<table>
<thead>
<tr>
<th>Risk Description</th>
<th>Datix Mapping (current level)</th>
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</thead>
<tbody>
<tr>
<td>Risk: Inconsistent funding from different commissioners impacts on equitable service provision. Cause: Variable funding. (E.g. reduction in CCG funding for WSH psychiatric liaison. Perinatal contract). Effect: Inability to provide same basic quality service across both counties which impacts on patient care and service interfaces.</td>
<td>D.1290 WSH Psych Liaison (High – 16) (AA)</td>
</tr>
</tbody>
</table>

**Risk Description**

<table>
<thead>
<tr>
<th>Risk Description</th>
<th>Datix Mapping (current level)</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.1 Risk: Lack of resources for prevention, EI and Recovery to support strategic goal. Cause: Resources for EI have not reached NSFT. Funding arrangements make prevention and Recovery initiatives more difficult to resource. Effect: Realisation of strategic goal impaired so patients receive suboptimal models of care.</td>
<td>D.1307 Lack of resources for this strategic goal (16 – High) MS.</td>
</tr>
</tbody>
</table>

Datix ‘high’ risks not mapped above so included for completeness:

- D. 1250 IAPTUS reporting inaccuracy Suffolk Wellbeing (high – 16). Update 20.09.16. As part of the new Suffolk Wellbeing Service we are appointing to a specific Business Support Manager who will be overseeing reporting and will review the business processes to reduce and remove this risk.

- D.1100 Disaster recovery. (high – 16). Update 31.09.16. Work underway to reset N3 lines. Key clinical system, HR and finance not stored locally so staff will be able to operate these systems. Robust plan expected to be approved by year end.
If approved, IPC will report to P&P from Feb 2017

att - bod cog ctte and subgroup structure 24nov2016.docx
Guide to committee and group governance structure diagram (March 2016 – Updated July 2016)

<table>
<thead>
<tr>
<th>Name of group</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Council of Governors</td>
<td>Constituencies (elected governors): Public Suffolk (5), Public Norfolk (6), Staff (4), Service User Suffolk (2), Service User Norfolk (2), Carer Suffolk (1), Carer Norfolk (1). Partner governors include Suffolk and Norfolk County Councils. 4 full sessions per year plus two member event days that may also have short business meetings.</td>
</tr>
<tr>
<td>Council of Governor Subgroups and Committees:</td>
<td></td>
</tr>
<tr>
<td>Nominations Committee</td>
<td>NED / Chair appointment, remuneration and appraisal oversight.</td>
</tr>
<tr>
<td>Planning and Performance Subgroup</td>
<td>Bi-monthly holding NEDs to account subgroup of governors planning meeting.</td>
</tr>
<tr>
<td>Membership and Communications Subgroup</td>
<td>Bi-monthly member engagement subgroup of governors planning meeting.</td>
</tr>
<tr>
<td>Education subgroup</td>
<td>Quarterly subgroup of governors meeting to assess governors’ training needs and plan training and development.</td>
</tr>
<tr>
<td>Improvement Plan Subgroup</td>
<td>Monthly conference call meeting for subgroup of governors to review progress on special measures improvements. Proposal to move to bi-monthly reporting to P&amp;P subgroup from 2017.</td>
</tr>
<tr>
<td>Board of Directors</td>
<td>Meets in public 10 times a year (not August or December).</td>
</tr>
<tr>
<td>Remuneration Committee</td>
<td>Quarterly NED committee with CEO makes executive director appointments, sets remuneration for exec and senior management, keeps oversight of appraisals.</td>
</tr>
<tr>
<td>Finance and Performance Committee</td>
<td>Monthly committee with delegated authority for investment appraisal and financial monitoring and assurance.</td>
</tr>
<tr>
<td>Quality Governance Committee</td>
<td>Monthly committee oversees all aspects of quality aligned to safe, effective, responsive, caring, well-led.</td>
</tr>
<tr>
<td>Organisational Development and Workforce Committee</td>
<td>Quarterly committee oversees leadership and culture, resourcing / flexible workforce, workforce development</td>
</tr>
<tr>
<td>Audit and Risk Committee</td>
<td>Quarterly NED meeting oversees governance, risk management, financial and quality accounts, internal and external audit and system controls.</td>
</tr>
<tr>
<td>Hospital Managers Committee</td>
<td>Quarterly meeting of MHA hospital managers, oversees practice, quality, recruitment of HMS and training and development. Produces annual report on its work to the BoD.</td>
</tr>
<tr>
<td>Charitable Funds Committee</td>
<td>Quarterly meeting including representatives of other agencies whose charitable funds NSFT hosts. Oversees stewardship of the funds and allocation in line with delegated authority.</td>
</tr>
</tbody>
</table>
# Reporting operational groups

<table>
<thead>
<tr>
<th>Name of group</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Performance Review Group</td>
<td>Monthly meetings chaired by the Director of Finance / Deputy CEO with locality managers to review KPI performance issues and identify plans to address where appropriate.</td>
</tr>
<tr>
<td>Lorenzo Programme Board / ICT strategy Programme board</td>
<td>Oversees Lorenzo deployment and development alongside wider ICT strategy implementation. Monthly.</td>
</tr>
<tr>
<td>Trust Partnership Meeting / Local Negotiation Council</td>
<td>Staff / management consultative meetings. Monthly.</td>
</tr>
<tr>
<td>Information Gov Sub-Group</td>
<td>Oversees and coordinates all aspects of information governance including data protection and IG toolkit requirements. Meets quarterly.</td>
</tr>
<tr>
<td>SU &amp; Carer Trust Partnership</td>
<td>Monthly coordinating umbrella group for service user and carer involvement local forums.</td>
</tr>
<tr>
<td>Clinical Cabinet</td>
<td>Monthly meeting providing clinical review and oversight of Trust policy and initiatives as requested by the Executive Team and Board of Directors.</td>
</tr>
<tr>
<td>Transformation Programme Board</td>
<td>Monthly executive and PMO meeting with oversight of quality improvement plans (QIPs) and Financial Recovery Plan (FRP).</td>
</tr>
<tr>
<td>Medical Staff Ctte</td>
<td>Reviews and oversees working conditions including training for doctors. Meets three times per year.</td>
</tr>
<tr>
<td>Locality / Service Governance Groups</td>
<td>Locally based quality groups that oversee and address quality issues aligned to safe, effective, responsive, well-led and caring.</td>
</tr>
<tr>
<td>Equality and Diversity Group</td>
<td>Bi-monthly group with oversight of Equality Delivery Scheme (EDS). Include both service and workforce aspects.</td>
</tr>
<tr>
<td>Drugs and Therapeutics Committee</td>
<td>Clinically led group that reviews implementation of NICE guidance, alerts, best practice. Bi-monthly.</td>
</tr>
<tr>
<td>Clinical Effectiveness &amp; Policy Group</td>
<td>Reviews and approves clinical policies including related documents such as leaflets. Monthly.</td>
</tr>
<tr>
<td>Health and Safety Group</td>
<td>Quarterly meeting overseeing H&amp;S concerns including incidents, themes, relevant CAS alerts.</td>
</tr>
<tr>
<td>Research Governance Group</td>
<td>Carries out governance reviews each month to quality check proposals and approve / feedback for improvements. Meets monthly.</td>
</tr>
<tr>
<td>Infection Control and Prevention Group</td>
<td>Meets three times a year. Reviews and approves related policies and monitors compliance / safety issues.</td>
</tr>
<tr>
<td>Mental Health Law Forum</td>
<td>Bi-monthly inter-agency forum that reviews and approves policy and monitors compliance with MHA administration requirements as well as MHA activity.</td>
</tr>
<tr>
<td>Physical Health Strategy Group</td>
<td>Bi-monthly meetings progresses physical health strategy. Oversees compliance through audits including flu vaccination programme. Approves relevant policies.</td>
</tr>
<tr>
<td>Mortality Review Group</td>
<td>Twice yearly review of all deaths to identify themes and any causes for concern.</td>
</tr>
<tr>
<td>Preventing Death by Suicide Group</td>
<td>Newly formed group meets bi-monthly to oversee development and delivery of the Trust’s internal suicide prevention strategy. (ToR not yet formally approved)</td>
</tr>
</tbody>
</table>
Executive Summary:

The main business of a brief October Charitable Funds committee was to be assured that funding commitments made previously were being satisfactorily progressed to expenditure.

Assurance review

<table>
<thead>
<tr>
<th>Issue reviewed by committee</th>
<th>Commentary (including actions where required)</th>
<th>Level of assurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Progress on Beccles Hospital Development and funds utilisation</td>
<td>The Committee was pleased to learn that the early instalments of funding for the Beccles Hospital development previously agreed by the Trust Board in April had been made and building work was underway. Final funds would only be released when all required checks had been made and an outstanding VAT ambiguity resolved.</td>
<td>AMBER</td>
</tr>
<tr>
<td>NSFT Quarterly Return on Fund Balances (April – September 2016)</td>
<td>The Committee looked in some detail at some of the remaining (circa £200k only) funds remaining with NSFT, after all the transfers of funds previously agreed had been completed, to see whether there were ways of relaxing any of the very long standing fund holding constraints preventing expenditure. Executives will investigate a number of</td>
<td>AMBER</td>
</tr>
</tbody>
</table>
Review the Draft Annual Report and Accounts

The Charitable Fund draft annual review and accounts were agreed by the Committee for progressing to audit and Trust Board finally in January.

GREEN

Forward look

Review the current Terms of Reference

Discussion of the future Committee Terms of Reference was postponed until such a date, perhaps January or April 2017, when the Committee's purposes and funds will have been so significantly reduced that fundamental consideration of the Committee's whole future will be timely.

AMBER

Recommendations

For Board assurance.

Author: Brian Parrott, Non-Executive Director
Title: Chair’s Report on Charitable Funds Committee held on 25th October 2016
Date: 25th October 2016
Executive Summary:

We continue to focus on the Implementation of the Service User and Carer Trust Strategy and the transition from the SUCTP to the Central Hub

Assurance review

<table>
<thead>
<tr>
<th>Issue reviewed by committee</th>
<th>Commentary (including actions where required)</th>
<th>Level of assurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Implementation of the Service User and Carer Involvement Strategy</td>
<td>We were updated on the Involvement Strategy. Pilot projects are underway in Great Yarmouth and Waveney (“GYW”) and East Suffolk. It is clear that the GYW pilot is working well but that in East Suffolk the attempt to create a separate Locality Hub has not worked. Representatives of Service User Forums questioned the need for a separate Locality Hub where existing forums were already functioning well. It was agreed that there was not a “one size fits all” and we should not seek to impose an additional layer in the structure if existing Forums could adapt to fulfil the function. Progress is being made against most elements of the strategy and the pilot projects will report before the end of the year with a view to the new structure being put in place in February 2017. However there is no project Plan in place for 2017 and we asked for this to be developed as a matter of urgency.</td>
<td>AMBER</td>
</tr>
<tr>
<td>Expenses and Payment Policy for Service Users and Carers</td>
<td>The Committee were updated on the process which is underway to review the Payment Policy. A period of consultation is underway to review when it is appropriate for Service Users to receive</td>
<td>GREEN</td>
</tr>
</tbody>
</table>
a payment (over and above the reimbursement of expenses) for services provided to the Trust. It has already been agreed that payments for Recovery College Peer Tutors will cease at the end of the Autumn Term and alternative options for remuneration are being looked at. The revised policy is expected to be published in January 2017.

Forward look

<table>
<thead>
<tr>
<th>Issue considered by committee</th>
<th>Commentary</th>
<th>Level of assurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Creation of the Central Hub</td>
<td>It has been agreed that the Central Hub will replace the SUCTP but we will not stand this group down until the new structure is in place and agreed. This will not happen until February 2017 at the earliest</td>
<td></td>
</tr>
</tbody>
</table>

Recommendations

The Board of Directors is asked to note the Report

Gary Page
Chair Service User and Carer Trust Partnership
16th November 2016