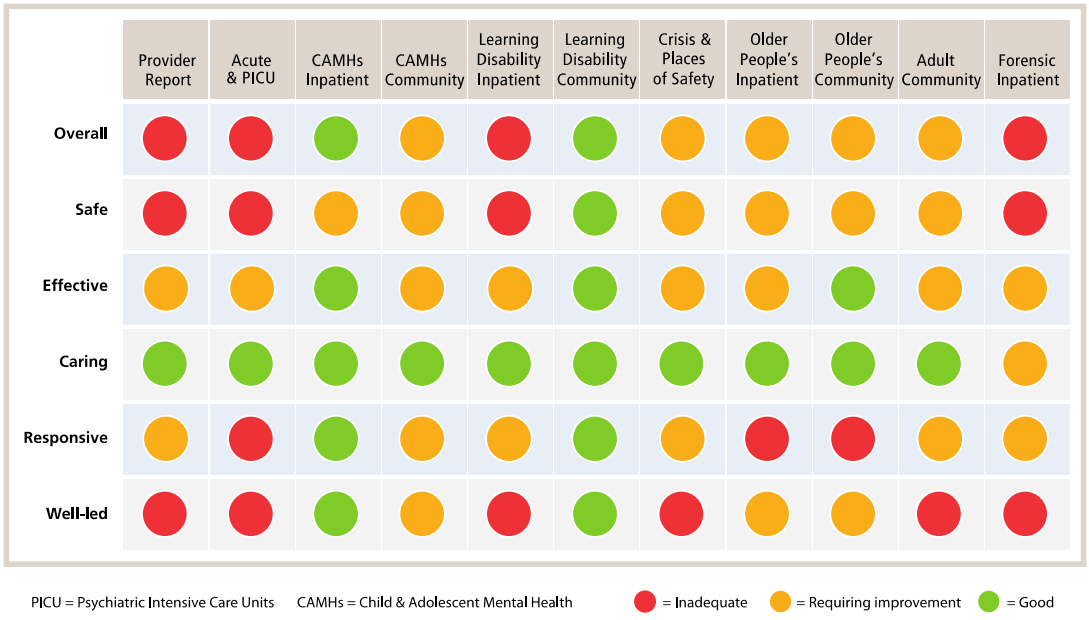
**EVIDENCE SET 1**

**Norfolk and Suffolk NHS Foundation Trust**
**Report to the Suffolk Health Scrutiny Committee**
**7 July 2015**

1) **What were the findings of the latest Care Quality Commission (CQC) inspection of Norfolk and Suffolk NHS Foundation Trust (NSFT) which took place in October/November 2014?**

1.1 During the week commencing 20th October 2014, a total of 93 inspectors from the CQC visited all of the registered locations within the Norfolk and Suffolk NHS Foundation Trust. The inspection lasted for 4 days and was followed by unannounced inspections during the evening of the 6th November to in-patient areas.
This inspection was the first inspection to take place in a mental health trust in line with the new CQC inspection regime and therefore the Trust was the first mental health trust to receive a rating. The ratings were as follows;

**Figure 1: CQC ratings**




The reports and ratings were discussed at a Quality Summit on the 2nd February 2015 which included the Trust leaders, commissioners and other stakeholders, including both Norfolk and Suffolk County Councils as well as Healthwatch.

1.2 The overall rating of inadequate was the trigger for the CQC to recommend to Monitor that the Trust be placed in special measures.

2) **What actions have been taken by the Trust to address concerns highlighted by the CQC since the inspection took place?**

2.1 Whilst the Trust was pleased that the care provided was rated as good for caring, the Trust was extremely disappointed in the overall outcome. However

the Trust had already put in place steps to begin urgent remedial action identified during the inspection, some occurring whilst the inspection carried on. The final day of the inspection provided initial verbal feedback to the Trust and a letter was received subsequently outlining a number of urgent issues. These issues included learning from incidents, seclusion practice, leadership, workload and ligatures. An immediate programme of actions was initiated and progress reported to the CQC.

2.2 The CQC draft reports were received in late December 2014 and each report contained recommendations for improvements which were transposed by the Trust into a Quality Improvement Plan (QIP). The Trust has committed to the QIP as the single plan for improvement and the actions required from a previous review of the Board function has been included as part of the 'well led' domain. The most up to date QIP is attached at **Appendix 1.**

The QIP was shared with localities and additional and supplementary plans have been developed locally in order to support delivery and quality.
Both the trust wide QIP and local plans are regularly shared with all key stakeholders, and a formal Monitor led progress review, which is also an assurance process is undertaken on a bi-monthly basis, and which all key stakeholders attend. **Sample Agenda and attendance list Appendix 2.**

2.3 Following confirmation from Monitor that the Trust would be placed in special measures, a recommendation was made by them, that a project management approach supported by a skilled project management team be put in place to manage the delivery of the QIP. This has been actioned and a Project Management Office (PMO) is now in situ supporting the delivery of the QIP and associated local delivery plans. The PMO forms part of the ongoing support to the Trust which also includes a Monitor appointed improvement director, Alan Yates, and a buddy trust, Nottinghamshire NHS FT.

2.4 These recommendations have been received positively by the Trust, and the interventions thus far have helped us to focus on some of our more complex quality issues.

## 3) What further action is planned and what are the timescales for completion?

3.1 The Trust has achieved a number of objectives and implemented improvements. Some key examples are:

- Service user and carer strategy agreed by the Board of Directors and ready for launch
- Actions to remove all ligatures or to mitigate the risk have taken place, and are being regularly audited
- Implementation of the safe wards initiative operationalised, including recruitment of additional matron and practice educators, who will work across both in-patient and community areas
- Reduced the number of people seen in health based place of safety by working with Suffolk and Norfolk constabularies, supported by the Police Triage model
- Implemented a single electronic patient record, Lorenzo, across the Trust, which has replaced a variety of both electronic and paper based systems

- A detailed review of quality management including governance, which is now overseen and held to account by the Quality Committee, chaired by the Trust Chairman, Gary Page. Locality governance meetings share a common terms of reference at **Appendix 3** and report monthly to the Quality Committee
- Engagement events held with stakeholders to identify strategic priorities
- A timetable of mock CQC inspections has been prepared, with participants from CCGs, both County Councils, Healthwatch, Voluntary Associations Suffolk, including Service User and Carer organisations as well as staff from across NSFT. Support to participate and generally to improve connectivity with NSFT, has been immense.

3.2 Whilst a number of short term actions have been completed, implementation and delivery of the whole quality plan and the necessary changes to practice and ethos will take longer.

3.3 The Trust has stated that it aims to be out of special measures by spring 2016 and the QIP demonstrates the intention for all actions to be completed by April 2016. To ensure this is achieved and can be demonstrated, clear objectives and outcomes have been set, which are reviewed by the Trust Board, and agreed with Monitor, which are measurable and achievable with clear outcomes.

4) **What are the key challenges faced?**

The key challenges faced by the Trust are as follows:

4.1 **The financial situation:**

At a time of budgetary constraint across the public sector, increasing demand for services and increasingly complex clinical presentations, implementing the changes required is a challenge that has to be delivered within the current financial envelope. This situation is exacerbated by the need to meet new clinical guidance and access targets and increasing standards for the Trust estate which are costly to implement. Whilst our CCG commissioners have been hugely supportive, the investment anticipated as part of Parity of Esteem was much less than anticipated due to competing pressures elsewhere in the Health system.

The Trust however has a robust plan to deliver both quality and financially sustainable services which, as stated earlier, is overseen by Monitor.

4.2 **Staffing capacity:**

The Trust has implemented the safer staffing initiative to ensure that the wards are appropriately staffed for the safety of patients. This however has not been easy to implement, and has been exacerbated by a shortage of staff which is regularly reported widely as national problem.

Similarly whilst we do not experience the rapid turnover that some of the more metropolitan cities do, we have a large ageing workforce and local delivery plans pay attention to succession planning.

NHS Professionals (NHSP) and agency staff are currently being used to provide cover for vacancies and absences; again this has been well documented as carrying a high premium cost.

Whilst a robust recruitment programme is underway, we are also working with local universities, county councils and acute and community trusts, who are experiencing similar problems, to support and deliver more innovative and sustainable solutions across the whole system.

4.3 **System Change and Pace**

Whilst we welcome and enjoy the benefits of working across a multitude of systems in both Norfolk and Suffolk, this also brings capacity, competing and occasionally conflicting challenges.

This has been particularly evident at both a strategic and operational level regarding the development and modernisation of our services to service users (adults and children) who have a complex learning disability.

There has been a variety of strategies and approaches which health and social care commissioners have found difficult to conclude in order to provide more positive outcomes for both adults and children.

This is similar regarding Looked After Children (LAC), where a system change within Suffolk County Council Children's Services resulting in the decommissioning of the Integrated Access Team (IAT) has had an unintended consequence of referring agencies requesting detailed assessment from our Children and Young People's Secondary Care Mental Health services, as the previous integrated pathway has been fractured.

Internally within NSFT, in addition to ensuring capacity for staff to undertake clinical roles, capacity to undertake the improvements required as part of the QIP is limited, and interim specialist support is being sourced, again at a premium to NSFT.

5) **In light of concerns highlighted by Norfolk Health Overview and Scrutiny Committee (HOSC) in respect of the availability of acute mental health beds in Norfolk, what is the picture for acute beds in Suffolk?**

5.1 There has been no change to the number of acute admission beds for both adults and later life adults over the past two years in Suffolk. Included within scope is provision of both acute and community provision to Thetford for all age groups.

**Table 1: Suffolk inpatient beds**

| | East Suffolk | West Suffolk | Total |
|---|---|---|---|
| PICU (Psychiatric Intensive Care Unit) | 10 | 0 | 10 |
| Adult acute | 42 | 37 | 79 |
| Dementia | 11 | 7 | 18 |
| Complex later life (CLL) | 10 | 10 | 20 |

***PICU beds are used across East and West localities and are based in Woodlands Unit**

5.2 Our use of acute Out of Area (OOA) beds has been minimal, and would normally only be considered for current employees or other detailed clinical risks reasons e.g. arson, victim of extreme domestic violence where it would be considered too high risk for the person to remain in the locality.

5.3 We remain however concerned by the lack of robust case management of Children and Young People's Tier 4 beds across the country, which is perceived by some as lack of adequate commissioned beds. Whilst NHS England (NHSE), the commissioner, is working hard with current providers, the impact for Suffolk is that we sometimes have to admit Suffolk children and young people to adult beds in East and West Suffolk, whilst a clinically (and age) appropriate bed is sourced. Unfortunately this can take up to two weeks, and 1:1 nursing cover has to be provided throughout the young person's stay in order to ensure safeguarding.

5.4 Over the last year we have introduced discharge co-ordinator roles to our acute admission units in East and West Suffolk. They have focused on patient flow, and ensured closer working with social care and housing providers, as well as ensuring whole system working with both patient and carers.

5.5 Over the last 2 years we have also worked collaboratively with Suffolk County Council (SCC) and CCG partners developing "Alternatives to Admission" beds in our community supported housing projects, thus preventing repeated admissions to hospital, with service users reporting a very positive experience and feeling much more in control of their own destinies.

5.6 Our Psychiatric Liaison Services have expanded in both acute hospitals, and although not 24/7, do work outside core hours. The services work with staff and patients in Accident and Emergency (A&E), Medical Assessment Units (MAU), Intensive Care Unit (ICU), wards and specialist clinics.

Outside these hours, our Access and Assessment Team (AAT) and Home Treatment Teams (HTT) offer additional support to rapid assessment and access to treatment.

5.7 Similarly we offer support to both nursing and residential homes across Suffolk, where often complex management issues of a service user, require specialist clinical interventions. Our primary aim is always to support a person in their home environment in order to increase positive outcomes for the individual.

5.8 Along with our other partners across the health and social care system, we are in the process of further developing two pilot integrated neighbourhood schemes in Sudbury and IP3/4 East Ipswich area. Initially the focus for us will be older adults, but we hope to include other vulnerable groups including children and learning disability, as the pilots progress.

5.9 We also continue with our Section 75 pooled budget arrangement with SCC which allows us to provide integrated adult community mental health services, and are currently working towards developing this further to include services for people with a learning disability and also for children and young people.

6) **Since implementation of different service models for Norfolk and Waveney and for Suffolk under the Trust's Service Strategy 2012-16, is there any learning from this which could help inform future service design?**

6.1 A paper was presented to the December 2014 Trust Board by the Director of Strategy Leigh Howlett, which summarised "Lessons Learnt" regarding implementation of the Trust Service Strategy for the whole organisation. The key areas considered were:

- Leadership
- Planning & Data
- Workforce
- Communication & Engagement
- Finance, Estates and ICT Support

The following were the agreed key actions;

- The establishment of a Programme Management Office (PMO) to oversee all organisational change to include dedicated corporate support functions led by a single Executive Director
- The Trust should supplement its own staff with external expertise where it is clear that a particular skill set or knowledge is not available with the Trust. Ideally as part of this, the external support should provide some transfer of these skills to existing staff
- Training for all staff on Project Lite and LEAN should be rolled out from the New Year. These are project and change management tools which will help staff to understand their roles in how to deliver change effectively and efficiently
- HR processes to be re-evaluated to ensure a consistent approach.
- All change plans should be clear on their intended outcomes, drivers and principles, focussing on how benefits will be realised and not on benefit mapping
- The PMO should provide / support the rationale and evidence to support the need for change
- The timescale for change should be challenging but realistic to allow for the organisational design piece to be robust, this in turn will facilitate an easier, quicker transition phase
- Communication of, and engagement in, any change should begin before decisions or choices are made.

6.2 With regard to Suffolk specifically, the new Director of Operations, supported by her senior operational leadership team, is currently developing a discussion paper on the care pathway learning, which will support any further development work required across the care pathways.

This approach has been welcomed by stakeholders, with offers of support, particularly by Healthwatch, who are keen to understand the impact on Whole System Change across Suffolk.