Quality Improvement Plan, 27/03/15

Norfolk and Suffolk NHS
NHS Foundation Trust

Completed and evidenced
Complete
In progress
Overdue

Ref	Domain	Trust Outcomes	CQC Imperatives/ Foresight Plan	Key Actions	Completion Quarter	Measurable outcomes	Board/Exec lead
SA1	Safe	Our care environments are welcoming, therapeutic and safe	CQC 3. Our Trust will ensure that action is taken so that our environment does not increase our risks to patients' safety.	1. Ward Managers will meet quarterly with estates staff to discuss performance and priorities. 2. Ward Managers will communicate ligature and Health and Safety audits with staff and ensure staff are aware of expected response times, escalation procedures and mitigating actions they can take. 3. The facilities team will monitor response compliance with SLA. 4. The wards at the Julian Hospital will be reviewed to ensure they are as dementia friendly as possible. 5. Blickling Ward (dementia assessment) will move to Beach ward at Hammerton Court 6. Review the accomodation on the remaining ward to utilise the additional space. 7. The environment at Walker Close will be reviewed to ensure that challenging patients are managed appropriately. 8. Our Trust will undertake a review of the estate at the Norvic Clinic and improve the environment as necessary. See Estates Log	Jun-15 for all actions 1-7. Mar-16 for action 8.	1. Ward staff will understand the expected response times and be able to describe how they report maintenance issues and take mitigating actions until the required work is complete. 2. There is a 50% reduction in incidents reported that relate to the ward environment, and none that are associated with significant harm. 3. Ligature and H&S assessments will be understood and available to all staff. 4. QIVs will demonstrate that the necessary actions have been completed. 5. Where indicated, environment changes will be made at Walker Close	Director of Strategy and Resources
SA2	Safe	Our care environments are welcoming, therapeutic and safe	CQC 4. Our Trust will ensure that action is taken to remove identified ligature risks and to mitigate where there are poor lines of sight. Risk register 928, 1136	1. Our Trust has a plan to undertake annual ligature audits and to produce an action plan to remove ligatures. Where ligatures cannot be eliminated immediately, this is known to our ward staff and actions taken to mitigate the risk. 2. Ligature action plans in place. All staff aware of the ligature action plan and the need to take mitigating action 3. Each ward area will undertake a risk assessment to identify lines of sight issues. 4. Where poor lines of sight are identified, action plan or plans for mitigation will be put in place, including the use of parabolic mirrors or CCTV. 5. Our Trust will undertake a review of the estate at the Norvic Clinic and improve the environment as necessary. See Estates Log	Jun-15 for all actions 1-4. Mar-16 for action 5.	1. Incidents related to ligatures are minimised. 2. Staff understand the policy with regard to the use of CCTV. 3. Staff will be aware of the ligature risk assessment and the mitigating actions required.	Director of Strategy and Resources

Ref	Domain	Trust Outcomes	CQC Imperatives/ Foresight Plan	Key Actions	Completion Quarter	Measurable outcomes	Board/Exec lead
SA3	Safe	Our care environments are welcoming, therapeutic and safe	CQC 6. The Trust will ensure that all mixed sex accommodation meets guidance and promotes safety and dignity.	1. Compliance with mixed sex accommodation guidelines will be undertaken as part of QIV. Sep 15. 2. A plan will be developed and delivered to ensure that female service users on Poppy and Avocet have access to female only community spaces. Sep 15. 3. Alternatives to the access arrangements to seclusion on Southgate ward will be explored, and current mitigation strengthened. Jun 15. 4. Bedroom on Sandringham Ward will be formally decommissioned. Mar 15. 5. The seclusion facilities at the Norvic Clinic will be reconfigured to ensure they meet guidance on maintaining privacy and dignity. Dec 15. See Estates Log	Sep-15 for all actions 1-4. Mar-16 for action 5	1. All in-patient areas comply with DH guidance on mixed sex accommodation. 2. Service users moved to seclusion on Southgate will have their privacy and dignity maintained. 3. Service users will report that they feel safe and treated with respect.	Director of Nursing
SA4	Safe	Our care environments are welcoming, therapeutic and safe	CQC 7. The Trust will ensure that seclusion facilities are safe and appropriate and that seclusion and restraint are managed within the safeguards of national guidance and the MHA Code of Practice. Risk 1169	1. All seclusion/segregation facilities will be reviewed against revised Code of Practice requirements, and required changes will be implemented. Jun 15 (Mar-16 for Norvic). 2. Review policy to ensure that all guidance is included as required. Jun 15. 3. Seclusion that lasts in excess of 48 hours will be classified as long term segregation and reported to the DoN and Medical Director. Mar 15. 4. Undertake monthly review of seclusion data and governance team to work with localities to ensure all staff are aware of the requirements and definitions. Jun 15. 5. Training package developed and delivered following the changes to the Code of Practice in relation to restraint and seclusion. Jun 15. 6. Use existing data to identify areas using high levels of seclusion and restraint to provide targeted support for improvements . Jun 15. 7. Our Trust will implement the recommendations in "Positive and Proactive Care" and develop a restrictive practice reduction plan. Sep 15. Action will be taken to address 'restrictive and punitive practice' a)-Implement formulation driven care b)-Review of induction and PMA training c)-Individualised care planning d)-service user engagement e)- implement 'safewards' See Estates Log See Positive and Proactive Care Plan	Sep-15 (Mar-16 for Norvic)	1. Seclusion and segregation facilities meet national requirements and are used in compliance with the Code of Practice. 2. Reduction in use of restrictive interventions to below national average in national benchmarks.	Director of Nursing

Ref	Domain	Trust Outcomes	CQC Imperatives/ Foresight Plan	Key Actions	Completion Quarter	Measurable outcomes	Board/Exec lead
SA5	Safe	Our care environments are welcoming, therapeutic and safe	CQC 37. The Trust must address the identified environmental health and safety concerns in the health-based places of safety.	1. Estates review to be undertaken assessing: a) entrances b) non-frosted glass c) furniture d) anti-barricade doors	Jun-15	1. All HBPOS will be provided in accordance with H&S guidance and MHA Code of Practice.	Director of Strategy and Resources
SA6	Safe	Our care environments are welcoming, therapeutic and safe	CQC 5. The Trust will ensure there are enough personal alarms for staff and visitors and carry out and document regular checks of emergency equipment.	1. Personal alarms will be ordered and a stock retained to ensure alarms are always available. 2. Checks of emergency equipment will be made, and matrons will audit this monthly. 3. Annual checks will be made by the risk management team and any actions required identified, to be followed up by locality managers.	Dec-14	1. Personal alarms are always available, and this will be checked in QIVs. 2. Emergency equipment is checked and updated at required intervals, so is always available for use.	Operations Directors
SA7	Safe	Our care environments are welcoming, therapeutic and safe	CQC 9. The Trust will ensure that there are robust policies and procedures that keep staff and patients safe in the community.	1. Policies to be reviewed and any changes made to reflect the needs of specific groups. This will be communicated to teams, and Clinical Team Leaders will record that all staff are aware of the policy. Apr 15. 2. Community teams will embed the following (Sep 15): a) patients/ appointments are reallocated when staff are sick in line with DNA policy b) robust duty system in place to ensure timely response to queries, referrals c) all service users have a crisis plan and know how to access help out of hours d) carers are listened to and their views are recorded e) DNAs are followed up in accordance with policy f) CTLs have a checklist, to be discussed and developed at acute service forum.	Sep-15	1. Lone worker policy will be robust and relevant to all teams across our Trust. 2. When a member of staff is unable to undertake their commitments, these are reallocated to other team members. 3. Duty system is in place in all relevant teams. 4. All service users will have an individual co-produced crisis plan containing the details of OOH access which is shared with the people they identify to share it with. 5. Service user records will include carer views and carers will report increased levels of involvement.	Operations Directors

Ref	Domain	Trust Outcomes	CQC Imperatives/ Foresight Plan	Key Actions	Completion Quarter	Measurable outcomes	Board/Exec lead
SA8	Safe	Our care environments are welcoming, therapeutic and safe	CQC 10. The Trust will ensure that people receive the right care at the right time by placing them in suitable placements that meet their needs and giving them access to 24 hour crisis teams. Risk 1062	1. Thurne ward assesment model to be developed. 2. Work with CCGs to develop a model for the provision of DIST and CAMHS out of hours crisis response. 3. All staff to be aware that where appropriate, other services can be utilised eg social care services and specialist advice available for younger people or older adults within the adult teams.	Jun-15	1. 12 bedded ward opened to perform an assessment and discharge function. 2. Commissioning decisions will be made by April 2015 as part of the current commissioning negotiations. 3. There will be a clear pathway in place for 24 hour access to services. This may be commissioned from NSFT or by access and support from other teams/services. 4. Staff are able to say what the arrangements are for services out of hours and service users report that they are able to access the pathway of care.	Operations Directors
SA9	Safe	Everyone knows how learning is supported, and takes personal responsibility to use opportunities for learning to improve quality	CQC 1. The Trust will have an effective system to share learning from incidents in order to make changes to patients care and reduce the potential for harm to patients. Risk register 1145	1. Our Trust will strengthen current systems to provide feedback and learning from incidents and complaints. Jun 15. 2. Implement pilot project to embed learning in Suffolk, evaluate and develop similar approach in Norfolk. Sep 15. 3. Additional training to be developed to train more staff to provide debriefs. Sep 15. 4. Each locality to identify a debrief lead. Jun 15. 5. List of people trained to offer debrief to be developed. Jun 15. 6. Locality quality governance arrangements will be strengthened by re-focussing of the matron role, investment in deputy matron posts, and increasing and embedding clinical skills tutors in clinical services. These posts will have formal reporting lines to the quality and governance team, and will lead practice improvement in line with Trust and local priorities. Sep 15. 7. Locality governance groups have a focus on quality improvement and embedding success. Jun 15. 8. Quality improvement is a standing item on key Trust agendas, commencing with Senior Management Forum. Jun 15.	Sep-15	1. Reduction in the number of recommendations that are repeated across Serious Incidents and complaints, checking with frontline staff that they are able to describe their learning from incidents in their own and other areas. 2. All relevant staff will report that debriefing has taken place following a serious incident and identify what they have learnt. 3. Locality governance groups demonstrate a programme of quality improvement initiatives and completed actions that have measurable outcomes. 4. Quality improvement is shared and celebrated in Trust forums, including Senior Management Forum.	Director of Nursing

Ref	Domain	Trust Outcomes	CQC Imperatives/ Foresight Plan	Key Actions	Completion Quarter	Measurable outcomes	Board/Exec lead
SA10	Safe	All of the fundamental standards of care are met and staff take pride in going the extra mile	CQC 2. The Trust will ensure that medicines prescribed to patients who use the service are stored, administered, recorded and disposed of safely.	1. Review the current management of medicines policy. Apr 15. 2. Local managers to ensure staff are aware of the medicines policy C112 and that they adhere to the policy. Apr 15. 3. A simple monitoring checklist for the storage of medication will be developed. Apr 15. CTLs/Ward Managers will ensure that daily temperatures are recorded. April 15. 4. Ward pharmacists will check that temperatures are recorded and action taken where required. Mar 15. 5. Weekly matrons' audit will check that medication is prescribed and administered in accordance with policy. Breaches will be raised to the CTL and immediate action taken. Mar 15. 6. Process to be developed to identify and record prescribing errors. Jun 15. 7. Medication errors policy is currently being updated. Jun 15. 8. Competency checks for registered nurses in medicines administration will be implemented, linked to regular line management supervision. Jun 15. 9. Competency checks for medicines administration in community teams will be developed. Sep 15.	Sep-15	1. Medication will be stored correctly and disposed of in accordance with policy. 2. Medication will be prescribed correctly and errors addressed. 3. Medication will be administered and recorded in accordance with policy and NMC Code of Conduct. 4. Medication errors will be managed in accordance with the performance managment process. 5. RNs will be assessed as competent in medication administration.	Director of Nursing
SA11	Safe	All of the fundamental standards of care are met and staff take pride in going the extra mile	N/A	1. Our Trust will continue to implement programmes of improvements that promotes safety including: a) Safe Wards b) Sign up to Safety c) Safer Care Pathway on Blickling and Sandringham d) Community caseload monitoring tool e) early warning system trigger tool, initially for inpatient units 2. Staff are recognised for their effort and dedication through managerial support and Trust awards. Dec 15.	Dec-15	1.Evidence-based approaches to improving safety are embedded in practice. 2. Teams that are struggling are identified early and given appropriate resources and support to improve. 3. There is a system of staff recognition in place.	Director of Nursing

Ref	Domain	Trust Outcomes	CQC Imperatives/ Foresight Plan	Key Actions	Completion Quarter	Measurable outcomes	Board/Exec lead
SA12	Safe	We have the right numbers of staff with the right skills across our Trust	CQC 8. The Trust will ensure there are sufficient staff at all times to provide care to meet patients' needs. Multiple risk register entries relevant to the specific team	1. Our Trust has implemented the safe staffing guidance and is actively recruiting to all posts. Where vacancies exist, NHSP and agency staff are used. 2. Implementation of Healthroster to monitor staffing in real time and move resources to reflect need. Dec 15. 3. Additional funding has been identified to provide community posts in Norfolk, and caseload monitoring will be rolled out across our Trust. Sep 15. 4. Work with the third and independent sectors to provide additional cost effective support services to maintain people in their own homes. Sep 15. 5. Locality structure and AAT will be reviewed to provide local ownership of assessment and caseload management (Norfolk) Jun 15. See Recruitment Plan	Sep-15	1. Vacancy levels in clinical services are reducing in line with planned trajectory. 2. All patient care needs are met. 3. Wards are staffed with Trust employees according to the safer staffing guidelines and staff moved to ensure optimum availability. 4. Unallocated cases are eliminated, and caseloads are at manageable levels and monitored regularly. 5. Community service users are supported to remain in their own homes.	Director of Strategy and Resources
SA13	Safe	We have the right numbers of staff with the right skills across our Trust	CQC 30. The Trust will ensure that all staff working with vulnerable adults and children have a DBS check completed.	1. All staff commencing work with our Trust currently have a DBS check. Our Trust will undertake regular DBS checks for all staff in post following publication of the Lampard report. 2. Locality managers will ensure that all staff receive their checks in accordance with agreed Trust process.	Sep-15	1. All staff must have a current DBS check before commencing in post. 2. A process for rechecking DBS will be in place to ensure that checks are undertaken at regular intervals.	Director of Strategy and Resources
CA1	Caring	1.1 People who use our services say that we help them to achieve their potential 1.2 Carers say that they are supported and valued in their roles	N/A	1. Approve Service User and Carer Strategy at Trust Board March 2015. 2. Devise implementation plan and programme, and method for measuring outcomes. Apr 15. 3. Launch strategy. May 15.	Jun-15	1. The commitments made in the Service User and Carer Strategy are delivered successfully. 2. Service Users report satisfaction with our Trust in the annual community survey 3. Friends and family test scores demonstrate improvement.	Director of Nursing

Ref	Domain	Trust Outcomes	CQC Imperatives/ Foresight Plan	Key Actions	Completion Quarter	Measurable outcomes	Board/Exec lead
EF1	Effective	Systems that support recovery, including health records, e-rostering, training and appraisal assist staff to deliver care safely and effectively	CQC 17. The trust will ensure all staff including bank and agency staff have completed statutory, mandatory and where relevant specialist training Risk 1115, 1056 CQC 17A. The Trust will review its provision of duty and crisis services for young people to ensure that staff undertaking assessments have the appropriate skills to ensure this is carried out to an appropriate standard	1. Training templates are simplified and competence is assessed. Jun 15. 2. Staff will book to attend training and be supported to attend by managers. May 15. 3. Training compliance will be discussed at monthly supervision to identify where training compliance is not met. May 15. 4. The introduction of Practice Educators will result in more local and team based training. Jun 15. 5. Our Trust only uses temporary staff procured via the East of England procurement hub. This system ensures that only agencies who have staff trained in mandatory requirements are procured and utilised. The EoE hub also maintains responsibility for ongoing checks Our Trust will explore with NHSP, the potential for introducing additional checks. Jun 15. 6. Specialist training will be identified by all staff at appraisal. Sep 15. 7. Where specific teams have training needs, these will be discussed with the training department and a training package commissioned or other forms of development identified. Sep 15.	Sep-15	1. All staff will know which training they are required to undertake. 2. Compliance with mandatory training will reach agreed compliance target by September 2015. 3. Our Trust will be confident that all temporary staff have completed the required statutory / mandatory training. 4. Staff will be supported to undertake training relevant to their current needs and development for future roles.	Director of Nursing
EF2	Effective	Systems that support recovery, including health records, e-rostering, training and appraisal assist staff to deliver care safely and effectively	CQC 18. The Trust will ensure all staff receive regular supervision and annual appraisals Risk 1170	1. Supervision policy to be reviewed, to ensure it meets the needs of all staff groups, Jun 15. 2. Locality managers will monitor that all staff including regular NHSP/agency staff receive clinical supervision in accordance with policy, Sep 15. 3. Locality managers will monitor that all staff receive an annual appraisal in accordance with policy, May 15.	Sep-15	1. Staff will report that they receive regular supervision and annual appraisal that supports their development.	Operations Directors
EF3	Effective	Systems that support recovery, including health records, e-rostering, training and appraisal assist staff to deliver care safely and effectively	CQC 25. The Trust will review its procedures for maintaining records, storage and accessibility including out of hours provision.	1. Implement the Lorenzo patient records system with appropriate access to historical records including out of hours, April 2015.	Jun-15	1. Lorenzo will be available to all Trust staff from April 2015	Director of Strategy and Resources

Ref	Domain	Trust Outcomes	CQC Imperatives/ Foresight Plan	Key Actions	Completion Quarter	Measurable outcomes	Board/Exec lead
EF4	Effective	Systems that support recovery, including health records, e-rostering, training and appraisal assist staff to deliver care safely and effectively	CQC 13. The Trust will ensure that all risk assessments and care plans are updated consistently in line with multidisciplinary reviews.	1. Prioritise completion of risk assessment training, particularly for staff in crisis and access and assessment teams, May 15. 2. Risk assessments and care plans must be updated regularly according to policy, and this will be discussed in supervision, Jun 15. 3. Revise risk assessment documentation for Lorenzo, Mar 15. 4. Make specialist DICES training available from March 2015	Jun-15	1. Audit will demonstrate that: a) Service users are engaged in the process b) Risk assessments are completed involving the service user and using our Trust tool c) Care plans are co-produced with the service user and accurately reflects their views d) Risk assessments and care plans are reviewed in the timeframes set out in policy or as needs change. 2. Service user feedback will identify that updates are completed with their involvement.	Operations Directors
EF5	Effective	Stakeholders have confidence in our ability to translate our values into consistent benefits for local people	CQC 12. The Trust will ensure that a 'standard operating procedure' is introduced to manage effectively the interface between the various community services provided.	1. As part of Lorenzo implementation, a Standard Operating Procedure is in place. 2. The Standard Operating Procedures will be embedded across clinical services as part of the Lorenzo implementation. This will include the production of an organogram demonstrating the relationships between teams for easy reference	Jun-15	1. Organogram in place 2. Staff are able to describe the relationship between teams and the process for transferring or transitioning service users between teams is consistent and timely 3. Service users report that they have a positive experience of contacting services.	Operations Directors
EF6	Effective	Our Trust has an operating model that ensures accountability for quality is owned locally, and that encourages celebration of innovation in service design and effectiveness	CQC 24. The Trust will ensure that there are systems in place to monitor quality and performance of the teams	1. Our Trust has a structure of meetings that reviews the quality and performance of teams. This includes performance review group, locality governance groups, business meetings and the quality governance committee. This structure will be enhanced by the development of quality metrics. Jun 15. 2. The QUESTT early warning system trigger tool will be implemented to provide information on teams that require additional support. Mar 15.	Jun-15	1. A comprehensive dashboard of quality metrics will be available to all localities to inform their discussions. 2. The QUESTT tool will be implemented across inpatient teams initially and will identify need for additional support to prevent teams going into crisis.	Director of Nursing

Ref	Domain	Trust Outcomes	CQC Imperatives/ Foresight Plan	Key Actions	Completion Quarter	Measurable outcomes	Board/Exec lead
EF7	Effective	Our financial recovery path is clear, does not compromise safety, and leads to a sustainable future	N/A	1. The Trust expects to recover to a break even position by the end of 2016/17. 2015/16 will see continuing deficit and a COSRR of 1 as steps are taken in both supporting the Quality Improvement Plan and in delivering improved CIP performance over the next three years. PwC our external advisors have already undertaken a CIP feasibility study on a range of schemes and advised on PMO set up. Further work will be commissioned in early 2015/16 to boost CIP delivery. 2.Key actions: • Implement revised PMO arrangements for delivery of the Quality Improvement Plan, including CIP programme with the support of PwC to set up – March/April 2015 • Conclusion of current contract funding negotiations with CCGs – March/April 2015 • Undertake review of MH Trust corporate benchmarking with a view to identifying additional corporate savings for delivery in second half of year – April – June 2015 • PwC to undertake an immediate cost reduction review focusing on temporary pay and non-pay with implementation by Quarter 2 – April/May 2015 • PwC to undertake clinical workforce benchmarking review with a view to recommending areas for CIP development for implementation in Q3 and Q4 with full year effect in 2016/17 – July 2015 • Further development of the remaining feasibility study recommendations to be worked into the plans for delivery in 2016/17 – September 2015 • Contract funding negotiations for 2015/16 and parity of esteem for mental health services –January to March 2016	Sep15 - Mar 16	Measurable Outcomes: • Financial Plan • COSRR • CIP identified • CIP delivered	Director of Finance
EF8	Effective	Practitioners are able to describe their responsibilities for delivering quality, the frameworks that support this, and how accountability mechanisms work	N/A	1. Clinical strategy is developed that sets out clear expectations of clinical staff, and that develops networks of good practice. 2. Profession-specific strategies are produced that support delivery of the clinical strategy. 3. Locality governance groups and Clinical Cabinet support reflection on and promotion of quality clinical delivery.	Dec-15	1. Our Trust has a clinical strategy that practitioners use to support their practice, and that is used as a framework for clinical quality governance processes.	Medical Director

Ref	Domain	Trust Outcomes	CQC Imperatives/ Foresight Plan	Key Actions	Completion Quarter	Measurable outcomes	Board/Exec lead
EF9	Effective	Practice is evidence-based, compliant with legislation, and consistent with NICE guidelines	CQC 20. The Trust will ensure that proper procedures are followed for detention under the Mental Health Act and that the required records relating to patients' detention are in order	1. Our Trust will strengthen its system for ensuring that detention records are in order, monitored by the central MHA team. The suite of measures will be agreed at the Mental Health Law Forum meeting on 23.03.15 2. MHA adminstrators will undertake monthly checks to ensure that all paperwork is in place and filed correctly from April 2015. 3. Bi-monthly monitoring report to law forum and shared with managers for action. Standing item on agenda from May 2015.	Jun-15	1. All detention documentation will be correct/lawful and available for scrutiny.	Trust Secretary
EF10	Effective	Practice is evidence-based, compliant with legislation, and consistent with NICE guidelines	CQC 21. The Trust will ensure that arrangements for patients taking section 17 leave are clear for their safety and that of others.	1. Responsible clinicians will ensure that leave details are recorded in full on the documentation, and audits will be in place to monitor this. The timetable for this will be agreed at the Mental Health Law Forum on 23.03.15	Mar-15	1. Section 17 documentation is completed in full 2. Service users/carers and staff are aware of their leave requirements.	Trust Secretary
EF11	Effective	Practice is evidence-based, compliant with legislation, and consistent with NICE guidelines	CQC 22. The Trust will ensure that patients who are detained under the Mental Health Act have information on how to contact the CQC.	1. The information leaflet given to detained patients will be changed to include the contact details for CQC. Jan 15. 2. Posters advising how to contact the CQC will be available on all wards. Mar 15.	Mar-15	1. Leaflets will contain the contact details for CQC. 2. Posters will be available on all wards. 3. Service users say that they have the contact details of the CQC.	Director of Nursing
EF12	Effective	Practice is evidence-based, compliant with legislation, and consistent with NICE guidelines	CQC 16. The Trust will carry out assessments of capacity and record these in the care records Risk 1162	1. All relevant staff will undertake MCA/DOLS training to ensure they understand the importance of establishing capacity. 2. Capacity will be recorded in the patient notes, and audits undertaken regularly.	Jun-15	1. All relevant staff will complete training 2. All patients will have a record of their capacity with regard to specific decision making	Operations Directors
EF13	Effective	Practice is evidence-based, compliant with legislation, and consistent with NICE guidelines	CQC 39. The Trust will ensure that the good example of health-based place of safety monitoring information seen at one unit is used throughout this service	1. 1. Operations adopt good practice and monitor this through information systems.	May-15	1. Good practice noted will be implemented across our Trust	Operations Director

Ref	Domain	Trust Outcomes	CQC Imperatives/ Foresight Plan	Key Actions	Completion Quarter	Measurable outcomes	Board/Exec lead
EF14	Effective	Practice is evidence-based, compliant with legislation, and consistent with NICE guidelines	CQC 14. Outcome measurement tools will be used to assess appropriateness and effectiveness of care and treatment provided	1. The outcome tool development plan will be implemented: a)Board Development sessions on outcome tools b) Trust workshops regarding outcome tools including staff, stakeholders, service users and carers c) Selection of appropriate tools d) Development of system of recording, learning from, reporting and refining outcome measures.	Dec-15	1. Outcome tools will be routinely used in clinical practice to inform individual service user progress and to monitor the performance of teams	Medical Director
EF15	Effective	Practice is evidence-based, compliant with legislation, and consistent with NICE guidelines	CQC 15. The Trust will ensure that all physical healthcare monitoring forms are completed and acted upon where relevant	1. All staff will ensure that patients receive a physical health check on admission. Where the patient is too unwell or refuses, this should be documented in the health record and further attempts offerred. Jun 15. 2. The relevant physical health monitoring record will be completed in full. Jun 15. 3. Where physical health problems are identified, these will be addressed and the relevant actions taken. Jun 15. 4. All relevant staff will undertake physiological workbook training. Sep 15.	Sep-15	1. All patients will have a physical health assessment and where an issue is identified, the necessary action will be taken and reflected in the care plan.	Director of Nursing
EF16	Effective	Practice is evidence-based, compliant with legislation, and consistent with NICE guidelines	CQC 35. The Trust will ensure that physical healthcare needs are monitored and managed	1. Implementation of the physical health strategy. Dec 14. 2. Physical health checks will be undertaken for all inpatients, and community patients will be supported to seek regular health checks. Jun 15. 3. Reinforce the importance of physical health at each intake of junior doctors. Sep 15. 4. Trial of Rethink document "My Physical Health" in West Suffolk. Sep 15.	Sep-15	1. Physical health checks are correctly recorded 2. Physical checks are completed and necessary actions taken. 3. Physical health issues are included in care plans.	Director of Nursing
WL1	Well -led	1.1 There is a clear, collaborative, cyclical process for developing a 3 – 5 year strategy which is regularly refreshed.	FP1. Away day to agree annual strategic planning cycle and compelling narrative.	1. The BoD held a workshop to plan the process in Jan 2015. 2. Our Trust has trialled a collaborative engagement process for refreshing its strategic priorities in March 2015 with four public workshops. 3. The Board of Directors approves the strategic priorities which inform the annual plan for approval in April 2015. 4. The annual plan cascades through the executive team and staff objectives for 2015/16 in Q1.	Jun-15	1. Our Trust strategy has been expressed as SMART objectives and, when asked, stakeholders recognise them as appropriate. 2. The directors' objectives for 2015/16 are comprehensive in addressing all of the strategic priorities. 3. The appraisal system cascades the objectives so that all staff members understand how their work supports the work of our Trust.	Director of Strategy and Resources

Ref	Domain	Trust Outcomes	CQC Imperatives/ Foresight Plan	Key Actions	Completion Quarter	Measurable outcomes	Board/Exec lead
WL2	Well -led	1.2 There is a compelling organisational vision that staff have bought into and that has service quality at its heart. 1.3 The values and behaviours that support this vision are part of our Trust's culture. 1.4 There is a clear statement of NSFT's purpose that staff can articulate and that external stakeholders can recognise and to which our Trust's plans (e.g. LTFM, workforce, quality) are aligned.	CQC 23. The Trust will review the delivery of their vision and values to ensure they are understood and owned by all staff. Risk 1163	1. April Strategy consultants engaged to augment Trust's capability and capacity in this work. 2. Chair, NED and exec team interviews and Board workshop took place with April in February 2015. 3. Senior and Middle Management Forum workshop took place with April March 2015 to ensure buy-in. 4. Roll-out of work with front line staff dovetails with Lorenzo deployment in April 2015 with May 2015 start date. 5. Executive team visits used to trail events and encourage involvement at front line from March 2015. 6. New vision and values come to the board for approval, Sep 15.	For April Work - Sept 2015 For National Staff Survey - March 2016	1. Staff uptake of workshop places and evaluation from event shows evidence of re-engagement / building of trust in organisation. 2. Vision and values statements from staff are referenced in all engagement work and form a recognisable narrative in Trust communications. 3. The direction of indicators from the staff F&FT changes to positive and forms a positive trend by the end of Dec 2015. 4. The national staff survey ratings show statistically significant improvements when published in Spring 2016. 5. Most staff, when asked, know what our Trust's vision and values are and approve of them. 6. Board members are able to say how they are assured that our Trust's supporting strategies are aligned with the vision and values.	Director of Strategy and Resources
WL3	Well -led	1.1 There is a clear, collaborative, cyclical process for developing a 3 – 5 year strategy which is regularly refreshed.	FP2. Resource the strategy function realistically.	1. Design and consult on resources for strategy function within corporate restructure. 2. Implement corporate structure and communicate ownership of functions.	Apr-15	1. There is a sustainably resourced structure for developing strategy that horizon scans, and leads on an iterative process for refreshing strategic priorities.	Director of Strategy and Resources

Ref	Domain	Trust Outcomes	CQC Imperatives/ Foresight Plan	Key Actions	Completion Quarter	Measurable outcomes	Board/Exec lead
WL4	Well -led	2.1 The arrangements for the organisation to be held to account for the delivery of the strategy are clear and can be seen functioning in the day to day working of our Trust. 2.2 The organisation operates effectively with transparency and candour. 2.3 The systems for control and assurance are clear and reliable.	FP2. Clarify and provide a rationale for the operational model • How is accountability held? • What are the parameters of freedom and accountability? • Processes for locality interface • Clinical leader accountability • Management of medical staff and alignment with work around AHP and nurse leader roles • Right balance of resources – corporate versus locality – in tandem with corp, reorganisation FP3. development of locality staff to support this model (via SMF) FP6. Refresh locality performance review	1. Finalise and implement the Operational Model, ensuring that everyone in our Trust understands their role within it. The BoD approved the principles of the OM in December 2014 with input from the Senior Management Forum. 2. Ensure that managers implement the appraisal and supervision requirements of their roles so that staff are clear about their responsibilities and are supported to deliver them. Sep 2015 3. Check, and if required, realign internal control systems so as to provide assurance that performance management systems are functioning. Sep 2015. 4. Review the working of the Performance Review Group and ensure that it is appropriately resourced and challenging on delivery. May 2015. 5. Agree and implement a new management climate, led by the executive team, that requires delivery of agreed objectives. Jun 2015	Sep-15	1. Managers have signed off objectives as appropriate and realistically resourced, with a clear undertaking that they will be delivered. 2. Staff, when asked, are able to validate evidence of a 'we promised / we delivered' approach to delivery of the strategy. 3. Board members are able to describe how they are assured that staff are held to account for delivery of their objectives. 4. Fair consequences for non-delivery of agreed objectives are clear and can be evidenced.	Chief Executive Officer
WL5	Well -led	2.1 The arrangements for the organisation to be held to account for the delivery of the strategy are clear and can be seen functioning in the day to day working of our Trust.	FP4. Refresh existing NED-ED role descriptions – ensure that this understanding is broadly shared. FP7. Refresh board reporting format to include narrative, analysis, improvement actions and trajectory to ‘green’.	1. Following discussions with the board of governors' nominations committee, the NED role description has been updated in line with the FTN governance compendium of best practice. It was approved at the board of governors in Jan 2015. 2. Executive director JDs, and NED appointment letters updated taking into account FPPT requirements. May 2015. 3. Senior managers briefed on the refocused role profiles for EDS and NEDs, and the FPPT at April 2015 SMF. 4. The board reporting format has been amended to emphasise the importance of narrative, analysis and improvement to green and managers responsible for drafting key board assurance reports are receiving coaching on board requirements and feedback on their work from the Trust Secretary. April 2015.	Jun-15	1. Directors are able to articulate the functioning of a unitary board in an FT, and board meetings / minutes evidence this functioning through constructive challenge with an evident focus on delivery and intolerance of missed deadlines. 2. Senior Managers understand the role of NEDs and EDs and their contribution to board governance through well-written board reports. 3. Board members say that reports provide an accurate assessment of quality and risk when triangulated with other sources of information.	Chief Executive Officer

Ref	Domain	Trust Outcomes	CQC Imperatives/ Foresight Plan	Key Actions	Completion Quarter	Measurable outcomes	Board/Exec lead
WL6	Well -led	2.2 The organisation operates effectively with transparency and candour.		1. Board members routinely ask staff about their knowledge of arrangements for escalating issues, and their experiences as part of their routine visits to teams. Jun 15. 2. There are regular briefings as part of the 'learning lessons' work which thank staff who raise issues and suggest ways of improving quality. Sep 15. 3. Feedback is routinely sought from complainants about their experience of the process and ways of improving the process acted upon. Jun 15. 4. Governor views are sought through the bi-monthly Planning and Performance subgroup. Dec 14. 5. The quality governance committee scrutinises reporting on actions under the duty of candour and reports on this to the BoD. Jun 15.	Sep-15	1. Staff can describe our Trust's systems for escalating issues and concerns. 2. Staff say that the identification of issues and concerns is welcomed by managers and the board. 3. Service users and carers say that their complaints and comments are welcomed and responded to fairly. 4. Governors say that they have confidence in the evidence they see of a culture of transparency and candour.	Director of Nursing
WL7	Well -led	2.4 Board decisions (in developing and implementing the strategic plan) are risk / benefit based.	FP8. Check that risks to quality are aligned to the refreshed BAF	1. The BAF and Risk Register have been line-by-line reconciled in March 2015 and the results reported to IA and Jane Sayer. 2. BAF to be further improved when 2015/16 strategic priorities approved. May 2015	Jun-15	1. Board members say that the BAF is a helpful tool in assessing and managing risk to Trust objectives. 2. Board reports are clear as to their risk / benefit impacts on Trust objectives and board decisions take account of these analyses.	Trust Secretary
WL8	Well -led	2.1 The arrangements for the organisation to be held to account for the delivery of the strategy are clear and can be seen functioning in the day to day working of our Trust.	FP9. Reshape ToR of Investment Committee to give robust oversight of delivery of strategy FP10. Explore committee rationalisation FP11. Refresh the board and committee cycle and the reporting arrangements between committees and the board to ensure that business is only done once in the right ????	1. The committee structure has been reviewed so as to separate NED role from executive tasks with the Investment Committee being subsumed with a changed function into the Finance Committee and with the Communications Committee being dissolved. Complete. 2. Committee reporting to the board has been reviewed with an exception reporting approach being adopted. Complete. 3. The committee structure is kept under review by the board as part of an annual board development plan. April 2015.	Apr-15	1. There is a timetable for board development that is externally facilitated and has a balance of behaviours, knowledge and skills foci.	Trust Secretary

Ref	Domain	Trust Outcomes	CQC Imperatives/ Foresight Plan	Key Actions	Completion Quarter	Measurable outcomes	Board/Exec lead
WL9	Well -led	2.1 The arrangements for the organisation to be held to account for the delivery of the strategy are clear and can be seen functioning in the day to day working of our Trust. 2.3 The systems for control and assurance are clear and reliable.	FP12. Consider rationalisation of committees below service governance	1. All board committees clarify their assurance requirements so that the executive team can consider the 'fit' of the executive groups that report into the committee governance structure. June 2015. 2. Drawing on SMF views the executive team consider and propose changes to the executive groups so as to streamline decision making and lines of accountability. June 2015.	Sep-15	1. Board committee chairs report that they are receive accurate, timely and relevant information to enable them to discharge their functions.	Trust Chair
WL10	Well -led	3.1 The board's behaviour and actions clearly prioritise quality.		1. From March 2015 for the rest of the year there is a programme of executive visits to teams which is based on the work with April Strategy. This complements the existing NED visit programme. Complete. 2. There is board development time set aside for directors to reflect on their role in shaping culture and to agree how behaviours and actions will reinforce this. The board development plan to be agreed by April 2015	Jun-15	1. Directors have a visible profile in the organisation, using an appreciative enquiry approach to hear about quality from staff, service users, carers and other stakeholders (such as governors). 2. There is evidence from board discussions that the board approach to strategy is driven by its values. 3. The board's agendas and minutes provide evidence of a transparent approach to sharing insight into quality (including equality and diversity) with robust challenge on concerns. 4. There is evidence that directors seek out and welcome innovation.	Trust Chair
WL11	Well -led	3.2 The board models an open approach to learning.	FP13. Develop a 'lessons learnt' document relating to TSS and recent strategy implementation from the perspective of the Board - What would we do differently? FP14. Share Board 'lessons learnt' with governors, service users and carers, SMF and staff, external stakeholders.	1. The TSS lessons learnt report has been shared at the December BoD, Jan BoG and Feb SU / C partnership. Mar 15. 2. A 'learning Trust' ongoing system is developed and rolled out comprehensively, with checking systems including Performance Review Group. Cross reference to 'SAFE SA9' organisational learning actions. Sep 15.	Sep-15	1. All directors can articulate a consistent account as to how the board promotes learning from incidents and national recommendations. 2. Board members routinely test our Trust's approach to learning when visiting services. 3. Board members can describe how they are assured that the whistle-blowing arrangements are effective.	Director of Nursing

Ref	Domain	Trust Outcomes	CQC Imperatives/ Foresight Plan	Key Actions	Completion Quarter	Measurable outcomes	Board/Exec lead
WL12	Well -led	3.3. The board's interpersonal relationships model constructive challenge in pursuit of quality		1. The board has external facilitation (taking place in March / April 2015) on board behaviours. 2. Each board member has a personal development plan that identifies how they will strengthen the board's interpersonal functioning. June 2015	Jun-15	1. The board invests time in developing effective inter-personal relationships. 2. All directors receive feedback on their individual contribution to board functioning and take responsibility for acting on this. 3. The Foresight Partnership reassessment in <Date> provides assurance that board behaviours are appropriate.	Trust Chair
WL13	Well -led	1.3 The values and behaviours that support this vision are part of the Trust's culture.	FP14. Engage with staff, service users and carers to build quality governance arrangements at locality level that ensure appropriate accountability at that level – make meaning of IMROC principles. FP16. Ensure that user/carer perspectives are at the heart of the process.	1. BoD to approve the Service User and Carer Strategy on 26.03.15. 2. The strategy is a two year plan with an end date of 2017. 3. The strategy, once approved will be project managed with dates and deliverables by June 2015.	Jun-15	1. Robust plan in place to deliver the 'what you will see' outcomes set out in the SU/C strategy.	Director of Nursing
WL14	Well -led	3.4 The board is outward looking and engages stakeholders proactively.	FP15. Review and refresh existing stakeholder engagement plan: • Existing 'health of relationships' evaluation may be helpful • Active monitoring of relationships • Include the role of Governors • Systematic approach including stakeholder register • Make use of NED networks and experience as appropriate	1. A review of the current state of play for stakeholder relationships will form part of a board development session by May 2015. 2. The board session is used as the basis for a refreshed stakeholder engagement plan which is is supported by a stakeholder register and is reviewed by the board each quarter from May 2015.	Jun-15	1. There is a stakeholder register in place with quarterly board reviews of the 'health of relationships'.	Director of Strategy and Resources

Ref	Domain	Trust Outcomes	CQC Imperatives/ Foresight Plan	Key Actions	Completion Quarter	Measurable outcomes	Board/Exec lead
WL15	Well -led	2.1 The arrangements for the organisation to be held to account for the delivery of the strategy are clear and can be seen functioning in the day to day working of our Trust.	FP5. Refresh Service Governance terms of reference and ensure that Lead Clinicians within localities are represented	1. The Service Governance Committee has amended its ToR and membership so as to include locality lead clinicians. There is a new chair for the re-named Quality Governance Committee.	Apr-15	1. The quality governance committee is independently assessed as fulfilling its purpose by Foresight Partnership on their re-assessment in Q3 2015/16.	Director of Nursing
RE1	Responsive	Age appropriate inpatient care is available in the right place and at the right time for all who need it.	CQC 10. The trust will ensure that people receive the right care at the right time by placing them in suitable placements that meet their needs and giving them access to 24 our crisis teams. Risk 1062	1. Additional acute admission beds to open in Norwich on a phased basis from 16 March 2015 subject to securing safe staffing levels. 2. Review OOA capacity placements to enable patients to return to our Trust's care as soon as possible consistent with the individual's therapeutic needs. 3. Bed management team to continue to provide detailed daily updates on all service users placed out of area.	Apr-15	1. The trajectory of OOA placements has fallen to 7 and will continue to fall so as to remain at zero other than at periods of exceptional demand where patient safety requires an OOA placement for a short period.	Operations Director (N&W)
RE2	Responsive	Age appropriate inpatient care is available in the right place and at the right time for all who need it.	CQC 10A The trust will review its procedures for admitting young people to services out of area placement arrangements	1. Following a review of young people's needs, a joint procedure is in place with Suffolk commissioners for use of out of area placements. 2. The procedure is monitored with an agreed escalation process. 3. An additional 5 young people's beds will be available from Jan 16 at Carlton Court near Lowestoft.	Mar-16	1. Local YP beds are used efficiently so that capacity OOA placements are used as a last resort. 2. Specialist YP inpatient care OOA placements are reviewed at appropriate intervals and there is an agreed escalation process with commissioners for OOA placements so as to prevent drift.	Operations Director
RE3	Responsive	Age appropriate inpatient care is available in the right place and at the right time for all who need it. Community services work with services users and carers to provide safe, effective support which promote recovery.	CQC 38. The trust will review the provision of in-patient beds to ensure that the needs of the local population are met.	1. Provision of inpatient beds as part of the full care pathway is reviewed in both counties and for secure services and in conjunction with commissioners. 2. The findings of the review report via the Quality Governance Committee to the BoD along with any process agreed with commissioners to address gaps. 3. The post-consultation implementation plan in GY&W progresses to plan with regular updates to CCG and NSFT Executive.	Mar-16	1. The board is assured that there is an agreed process with commissioners to identify inpatient requirements as part of the care pathway and that our Trust is playing a full part in meeting those requirements.	Operations Directors

Ref	Domain	Trust Outcomes	CQC Imperatives/ Foresight Plan	Key Actions	Completion Quarter	Measurable outcomes	Board/Exec lead
RE4	Responsive	Age appropriate inpatient care is available in the right place and at the right time for all who need it. Community services work with services users and carers to provide safe, effective support which promote recovery.	CQC 40. The trust will review the provision of their single bedded health based place of safety units in the light of the potential demand for this service.	1. As part of CQC 38, urgent access including S.136 suite provision will be reviewed following the piloting of closer joint working with Norfolk and Suffolk Constabularies in control rooms and in Ipswich police cars. The pilots have led to significant reductions in the use of place of safety units and the review will consider how to resources extensions of this work.	Sep-15	1. The board is assured that there is an agreed process with commissioners to identify inpatient requirements as part of the care pathway and that our Trust is playing a full part in meeting those requirements.	Operations Directors
RE5	Responsive	Age appropriate inpatient care is available in the right place and at the right time for all who need it.	CQC 28. The Trust will ensure that there is a clear admission criteria for the service	1. Each inpatient area to have a clear statement of its admission criteria. 2. The admission criteria are approved by Senior Operational Teams for both counties to ensure that transitions are facilitated and that they do not create unintential gaps, and will report to the Trustwide Acute Services Forum.	Jun-15	1. Admission critieria are available for each ward online. 2. SOT meeting minutes show that the interfaces between wards have been checked and signed off as safe.	Operations Directors
RE6	Responsive	Community services work with services users, carers and partner agencies to provide safe, effective support which promote recovery.	CQC 11. The trust will review the unallocated cases in community services and ensure that there is an allocated care coordinator Risk 1033	1. Following a review of Access and Assessment services deploy staff into community teams to increase team care coordinator capacity from June 2015. 2. From May 2015 Implement the Flexible assertive community treatment (FACT) model to localities that have not yet implemented (Central and West Norfolk) to provide more intensive support that is responsive to risk. 3. Implement the Waves model for service users with a personality disorder by Mar 16. 3.1 Identify funding as part of budget setting 3.2 Identify lead person and third sector partner 3.3 Work together to develop implementation plan, learning lessons from Suffolk pilot. 4. The crisis support telephone line in Norfolk now available through collaboration with MIND. 5. Develop crisis support telephone line business case for Suffolk . 6. Following identification of funding currently recruiting an additional 12 band 6 nurses and 5 band 4 nurses in the community. 7. Dedicated resource to review unallocated cases by Jun 15.	Mar-16	1. All care coordinators have caseloads which enable them to practice safely and effectively. 2. Waiting times for care coordinator allocation are minimised and are risk assessed appropriately. 3. Telephone crisis support is available out of hours across both counties.	Operations Directors

Ref	Domain	Trust Outcomes	CQC Imperatives/ Foresight Plan	Key Actions	Completion Quarter	Measurable outcomes	Board/Exec lead
RE7	Responsive	Community services work with services users, carers and partner agencies to provide safe, effective support which promote recovery. Age appropriate inpatient care is available in the right place and at the right time for all who need it.	CQC 33. The Trust should ensure they review the out of hours arrangements with the commissioners for young adults age 14-18.	1. Agree with commissioners: objectives, stakeholder enagement, method and timescales for review of YP out of hours services 14 - 18.	Mar-16	1. There is an agreed plan to improve out of hours arrangements for young people based on the review of current gaps and including the views of young people and their carers.	Operations Directors
RE8	Responsive	Services are accessible to everyone in the community who needs them.	CQC 19. The Trust will ensure that they provide people with the right information about services and that this is in the right format for the individual.	1. Re-publicise the availability of INTRAN translation and interpreter services (including LanguageLine) in all teams and on the intranet, with a leaflet to this effect translated into the most commonly requested languages in Norfolk and Suffolk (as recorded by INTRAN). May 2015 2. Provide 'easy read' documentation to ensure that people with learning disabilities have access to information about their entitlements to NSFT services. May 2015	Jun-15	1. Information about services including who they are for and how to access them is available online and can be made available in any format on request. 2. All teams have leaflets for service users and carers that tell them that they can request interpreters and translated information to meet their needs. 3. Service users report that they have the right support and information about services.	Trust Secretary
RE9	Responsive	Services are responsive to people's individual needs and preferences including, but not limited to, those covered by the Equalities Act (2012)	CQC 26. The Trust will review their engagement processes for young people, staff and others for the planning and delivery of specialist community mental health services for children and young people across the trust	1. Build on the work of the two Youth Councils (Norfolk and Suffolk) by inviting them to work on a co-production approach to planning and delivery of community MH services in collaboration with commissioners and staff. 2. Consult with the Board of Govenors on using the second of the public engagement events on CYP mental health on 12 Nov 2015 to present on this approach.	Dec-15	1. There is a report summarising the outcomes of the review of engagement processes in CYP MH planning and delivery	Operations Directors

Ref	Domain	Trust Outcomes	CQC Imperatives/ Foresight Plan	Key Actions	Completion Quarter	Measurable outcomes	Board/Exec lead
RE10	Responsive	Services are responsive to people's individual needs and preferences including, but not limited to, those covered by the Equalities Act (2012)	CQC 27. The Trust will review their engagement processes for staff and others for the planning and delivery of Trustwide services/specialised eating disorder services	1. A framework is agreed with commissioners for ED disorders in both counties that sets out the engagement processes for stakeholders in planning and delivery of Trust-wide and specialist services. 2. This framework is cross-checked with the CQC 38 care pathway review so as to ensure consistency.	Dec-15	1. The commissioning arrangements, and NSFT's role within these, are clearly stated in a published report.	Operations Directors
RE11	Responsive	Services are responsive to people's individual needs and preferences including, but not limited to, those covered by the Equalities Act (2012)	CQC 36. The Trust will look at contingency arrangements in the autism diagnostic service for Suffolk to manage the build up of the waiting list to this service	1. The waiting list review shows no-one waiting for more than 15 weeks. 2. A contingency plan is in place.	Jun-15	1. Arrangements for supporting people with autistic spectrum disorders and their carers meet contractual requirements and include contingency plans to manage waiting lists on a risk-responsive basis.	Operations Director (Suffolk)
RE12	Responsive	Services are responsive to people's individual needs and preferences including, but not limited to, those covered by the Equalities Act (2012)		1. Suffolk HealthWatch have been commissioned to engage with BME communities who under-access MH services in order to inform service planning and design. Complete. 2. Monthly joint project meetings with report due in Jun 2015. 3. Summer conference to publicise findings - linking with the National NHS BME reverse commissioning work. June 2015. 4. Services have equality action plans in place informed by above by Sept 2015	Sep-15	1. Service accessibility and experience improvement plans are in place	Trust Secretary
RE13	Responsive	Services are responsive to people's individual needs and preferences including, but not limited to, those covered by the Equalities Act (2012)		1. Support formation of BME user reference group as part NHS BME reverse commissioning work and to assist with co-production of service design. Individuals identified and group to be formed by May 2015	May-15	1. BME service users have a voice in service user engagement and can influence the design of services.	Trust Secretary

Ref	Domain	Trust Outcomes	CQC Imperatives/ Foresight Plan	Key Actions	Completion Quarter	Measurable outcomes	Board/Exec lead
RE14	Responsive	Community services work with services users, carers and partner agencies to provide safe, effective support which promote recovery.		1. Collaborate in multi-agency suicide prevention interventions (such as the work at Norwich multi-storey car park) to reduce suicides.	Apr-16	1. Known risk sites for suicide are identified and steps taken to reduce opportunities.	Operations Director (N&W)