Great Yarmouth & Waveney Joint Health Scrutiny Committee
20 January 2017
Item no 6

Norfolk and Suffolk NHS Foundation Trust – update on mental health services in Great Yarmouth and Waveney

Suggested approach from Maureen Orr, Democratic Support and Scrutiny Team Manager

An update on the outcomes and impacts for mental health services in Great Yarmouth and Waveney arising from the latest Care Quality Commission inspection of Norfolk and Suffolk NHS Foundation Trust (NSFT)

1. Background

1.1 Great Yarmouth and Waveney Joint Health Scrutiny Committee (GY&W JHSC) has monitored the implementation of changes to adult and dementia mental health services in Great Yarmouth and Waveney since the consultation on changes to service in 2014. The Joint Committee received updates adult and dementia on 22 January 2016, when capacity and timeliness of referrals for the new 'Wellbeing Service' were a concern, and again on 15 July 2016, when discussions also covered progress in establishing a children's mental health service at Carlton Court.

1.2 Members have visited mental health services on two occasions in the past year; the adult acute mental health ward at Northgate Hospital, Great Yarmouth on 4 March and the new children's facility at Carlton Court, Carlton Colville on 29 September 2016.

1.3 The Joint Committee also received the results of the 2015 National NHS Staff Survey for NSFT as an Information Bulletin on 15 April 2016.

1.4 Throughout the period from February 2015 NSFT was rated 'inadequate' by the Care Quality Commission (CQC) and was in special measures with NHS Improvement (formerly Monitor). The Joint Committee asked for an update on the outcomes and impacts for the Great Yarmouth and Waveney area following the latest inspection by the CQC. The inspection took place on 12 – 22 July and the report was published on 14 October 2016. The CQC rated NSFT as 'requires improvement' overall and NHS Improvement took the Trust out of special measures. The Trust is still rated 'inadequate' for safety.

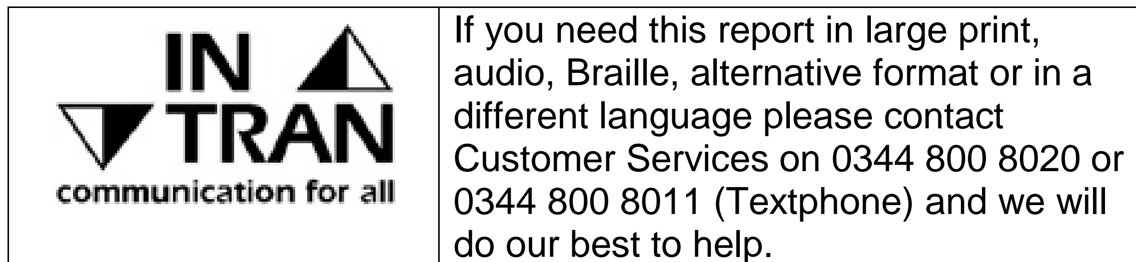
2. Purpose of today's meeting

2.1 NSFT has been asked to report to today's meeting regarding their action plan in response to the CQC's inspection report, specifically as it affects the Great Yarmouth and Waveney locality. NSFT's report is attached at

Appendix A and a representative from the Trust will attend to answer questions.

3. Suggested approach

3.1 After representative from NSFT has presented their report, Members may wish to discuss the progress of mental health services in Great Yarmouth and Waveney in response to the CQC's findings, with particular emphasis on safety of services.



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The following item is to be published for the Health Scrutiny Committee Meeting Date: Friday 20th January 2017

Norfolk and Suffolk NHS Foundation Trust update from CQC Inspection

The committee has requested a formal update following the CQC inspection to Norfolk and Suffolk NHS Foundation Trust in July 2016.

The trust was inspected by the CQC over a two week period in July 2016. This inspection followed an earlier inspection in 2014 which resulted in the Trust being rated as inadequate and placed in special measures.

Following the initial report, a project management team was put in place to oversee a quality improvement plan for the Trust. This process managed trust-wide improvement schemes whilst improvements related to business as usual were monitored via a quality dashboard.
As required by the CQC inspection model, the Trust received support from an improvement director and a 'buddy trust' in this case, Nottinghamshire Mental Health Foundation Trust.

The table below shows the initial ratings from the CQC and the subsequent ratings achieved in 2016. The 2016 ratings include ratings achieved by the substance misuse service provided in Norfolk which was not inspected in 2014 and includes a separate inspection of the Suffolk Rehabilitation and Recovery Service which was inspected as part of the acute ward service line in 2014.

	2014	2016
Trust wide rating	Inadequate	Requires improvement
Safe	Inadequate	Inadequate
Effective	Requires improvement	Requires improvement
Caring	Good	Good
Responsive	Requires improvement	Requires improvement
Well led	Inadequate	Requires improvement

The trust overall rating in 2016 is now 'requires improvement' and the trust has been removed from special measures. An updated action plan is now in place which is reported monthly to trust board and supported by team level plans to ensure that all staff are engaged in the improvements required.
With particular regard to the safe domain, many of the issues relate to the estate and a comprehensive work plan is in place.
Staffing issues are being addressed through a number of innovative schemes as well as ensuring safe staffing numbers.

For further information, please contact: Sue Barrett, Head of Governance, 01603 421538.

Trustwide- Quality Improvement Plan									
	Purpose:	To monitor local quality improvement and risk management actions to improve CQC standards compliance.			**Service line/ locality**	Trustwide			
	Completed by:				**Date last updated:**		**Version No.:**	2.1	
Trust QIP ref	Core service	Description	Outcomes (SMART)	Actions	Exec Lead/locality lead	Evidence	Completion / target date	Notes	RAG
SA1		The trust must ensure that action is taken to remove identified ligature anchor points and to mitigate risks where there are poor lines of sight	The trust will have a schedule of works to remove ligatures. Staff will know where the ligatures are on the ward and the actions required to mitigate the risks	Dedicated resource to carry out ligature assessments of all areas. Matron/CTL to participate in the annual ligature assessment process (November) Assessment booklets for each area to be published Simple infrastructure actions to be completed by the estates team Detailed spreadsheet of ligatures to be agreed at executive team and a RAG rated plan for removal or mitigation put in place. All staff to make matron aware of any new ligatures for reporting to patient safety meeting Matron/deputy to communicate plans for ligature removal to staff and ensure staff are aware of the mitigating actions required. Business change team to work with ward managers to implement ligature management process Ligature risks to be added to locality risk register	Julie Cave	Ligature audit and plan in place Minutes of patient safety meeting Staff will describe ligatures as part of peer review process	December 2016 Ongoing		
SA2		The Trust must ensure that action is taken so that the environment does not increase the risks to patient safety	See below		Julie Cave				

SA2.9	Crisis and HBPOS	The trust must address the environmental concerns in the HBPOS: 1.HTT Woodlands does not have dedicated interview rooms 2.Entrance to Woodlands/Northgate and Wedgwood HBPOS is open to view by the public 3.HBPOS at Hellesdon and Northgate only admit one patient 4.Hellesdon CRHT has no disabled facilities 5. Northgate HBPOS has single sex breach issue		1,2,4,5 to be costed and added to estates plan. Estates plan to be risk rated and actions prioritised 3. External bid for capital funding has been succesful and Norfolk HBPOS will be upgraded as per the bid. Detailed plan to be in place new suite to be opened	Julie Cave		December 2016 December 2017		
SA1.1	Adult acute	The trust must ensure there are clear lines of sight in the gardens	Lines of sight will be maintained in gardens	Planned maintenance schedule in place CTL to review any outside spaces and check for lines of sight. Any areas that could be hidden to be reported to estates to cut down bushes, move plants etc. Action to be reported to patient safety meeting	Julie cave	Minutes of patient safety meeting	Ongoing		
SA3	OP wards	The Trust must ensure that all mixed sex accomodation meets DOH and MHA code of practice guidance and promotes safety and dignity	All wards will comply with guidance	Fernwood: Plan to move to laurel Ward or make single sex to be agreed Abbeygate/Willows ward: Options to install sensors to prevent patients accessing opposite gender areas to be discussed. Management plan to access assisted bathroom to be in place in the interim Trustwide single sex assessment to be undertaken as part of annual environmental review	Julie Cave/Ruth Pillar Julie Cave/Vanessa Cotter Jane Sayer/Risk team		February 2017 December 2016 December 2016		
		The Trust must ensure that seclusion facilities are safe and appropriate and that seclusion and restraint are managed within the safeguards of national guidance and MHA code of practice	All seclusion facilities will meet the required standards	Staff will ensure that the seclusion room meets the required standards as per checklist. Deficiencies will be added to the estates plan Plan in place to develop seclusion facility on Southgate ward Plan to remove seclusion facility on Abbeygate ward	CTL Julie Cave	estates plan in place	December 2016 December 2016		

SA4	Adult acute		Seclusion heatmap will demonstrate that seclusion is recorded in accordance with the CoP	All staff sign to say that they are aware of the content of the seclusion policy and understand the definition of seclusion matron to undertake awareness training for staff who are unsure of the definition All staff to record seclusion as per policy Any gaps in seclusion reporting to be raised in management supervision	CTL All staff Manager/CTL	Staff signature sheet Supervision records	December 2016 and ongoing		
			Template care plans will also contain personalised information and records will demonstrate service user involvement	All staff will ensure that seclusion care plans are personalised and the patient is involved where possible Development of seclusion tab on Lorenzo Seclusion heatmap to be produced weekly (IN PLACE)	All staff Leigh Howlett Audit team	Seclusion heatmap	Spring 2017		
SA5	All	The Trust must ensure that all staff including bank and agency staff have completed statutory, mandatory and where relevant specialist training, particularly in restrictive interventions	Records demonstrate 90% compliance with stat/man training and relevant specialist training	Substantive staff All staff must ensure that they book onto stat/man training Managers/team leaders to check compliance as part of supervision. Managers/team leaders to support staff to attend training Managers team leaders to ensure specialist training needs are identified and met. temporary staff Review of induction for NHSP staff/booklet to be developed Agency staff to meet basic competency standards, E roster system to include skill requirement Communication to all staff	Debbie White/Alison Armstrong All staff Manager/CTL Trudii Isherwood Jane Parris Dawn Collins Sue Barrett	Training compliance data	Ongoing December 2016		
SA6	Crisis and HBPOS All wards	The Trust must ensure there are enough personal alarms for staff and that patients have a means to summon assistance when required	All staff to have personal alarms whilst on duty Patient call system to be reviewed by exec team	CTL to ensure that there are sufficient alarms for staff and vistors System to be in place to report and or replace non functioning alarms. Provision of alarms, baseline audit to be completed Need for alarms to be added to estates plan	CTL Sue Barrett Julie Cave	ward records	Ongoing November 2016		

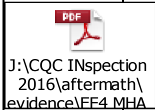
SA7	All	The trust must ensure there are sufficient staff at all times, including medical staff, to provide care to meet patients needs	Sufficient staff will be available to meet patients care needs	Workforce strategy in place: Employment guarantee to all newly qualified staff Collaborative recruitment across the trust using social media campaign TRAC recruitment system to reduce time to hire Skill mix alternative work with localities HEE to undertake workforce planning courses Review of pathways in community teams participation in initiatives to develop assistant practitioners,	Leigh Howlett Debbie White/Alison Armstrong/		February 2017 and ongoing		
SA7.9	Crisis and HBPOS	The Trust must review the out of hours staffing provision of crisis services	Data will show that teams are staffed to establishment	Workforce strategy in place:- Employment guarantee to all newly qualified staff Collaborative recruitment across the trust using social media campaign TRAC recruitment system to reduce time to hire Skill mix alternative work with localities HEE to undertake workforce planning courses development of nurse consultants, advanced practitioners and assistant nurse practitioners Review the community model through the CPA review group review of the emergency assessment function in Suffolk	leigh Howlett Debbie White Alison Armstrong/ Margaret Little		01/02/2017 and ongoing Feb 2017 March 2017		
SA7.9.1	Adult acute	The trust must review staffing levels for CRHT at Fermoy	data will show that teams are staffed to establishment	CRHT establishment has been revised to ensure that there is a higher level of senior staff available for complex clinical situations Workforce strategy to include: bespoke development planning and placement opportunities for recruited nurses needing to develop new skills greater development and use of assistant practitioners; development of advanced nurse practitioners and non-medical prescribers to demonstrate opportunity for greater responsibility, career advancement and offer motivation.	Debbie White		Feb-17		

SA7.9.2	Adult community	The trust must review the medical input to the HTT in Suffolk West		Medical staffing input has been reviewed and will increase with effect from early 2017. There is also an NMP post being piloted to provide additional support which will be evaluated in December. Options of how to cover the increased medical time are being explored	Alison Armstrong		March 2017 December 2016 December 2016		
SA7.9.3	Crisis and HBPOS	The trust must ensure there are adequate staff to receive and support patients at the HBPOS Fermoy unit	Review provision of service in West Norfolk	Workforce strategy in place as above development of nurse consultants, advanced practitioners and assistant nurse practitioners Review the community model through the CPA review group	Leigh Howlett Jane Sayer Debbie White		Feb-17		
SA8	ALL	The Trust must ensure that all risk assessments and care plans are in place, updated consistently in line with multidisciplinary reviews and incidents and reflect the full and meaningful involvement of patients	Data reported monthly demonstrates 95% compliance with core assessments, risk assessments and care plans Audit demonstrates 95% compliance with quality indicators.-	CPA task and finish group to continue to monitor and improve compliance All staff to ensure that full CPA documentation is completed and updated regularly. Monthly data to be reviewed and discussed at PARM Gaps in compliance to be discussed in management supervision Additional training to be provided where necessary Quarterly audit reported to QGC and PARM Audit results to be discussed in the team and at management supervision Improvement plans to be put in place where the 95% threshold isn't achieved.	Debbie White/ Alison Armstrong Manager/CTL	CPA data Audit report	January 2017 then Ongoing		
SA8.2	Adult community	The trust must ensure that all CPA reviews take place and are fully recorded		As above					

SA9	All	The Trust must ensure that medicines prescribed to patients who use the service are stored, administered, recorded and disposed of safely. The trust must consistently maintain medication at correct temperatures in all areas and ensure action is taken if outside correct range PRN medication must be documented fully in the continuation notes, including name of medication, dose and the reason for giving it and its efficacy	Data shows the ambient temperature and fridge temperature has been recorded daily. Evidence shows that where temperatures are outside normal limits, action is taken. Where a patient has been prescribed PRN medication, this is regularly reviewed and the outcome documented in the clinical record Audit demonstrates 100% compliance with signatures for the administration of medication CD medication is recorded according to policy	Staff member to be allocated to record temperatures each day Staff to be aware what action they should take should the temperature be outside normal Matron to undertake weekly check. baseline audit of aircon provision to inform estates plan Manager/team leader to review as part of management supervision. review as a standing item at patient reviews Matrons to carry out audit Breaches to be reported to Manager/team leader Manager/team leader to address performance with the Staff member, involving HR where relevant Matrons to carry out audit Breaches to be reported to Manager/team leader Manager/team leader to address performance with Staff member, involving HR where relevant	CTL All staff Matron Sue Barrett Manager/CTL Matron manager/CTL Matron Manager/CTL		November 2016 then ongoing Nov 2016		
SA10	Trust	The Trust must ensure it is compliant with controlled drug legislation when ordering controlled drug medication from another Trust	The trust will be compliant.	Pharmacy lead will work with provider to ensure the legislation is adhered to	Bohdan Solomka/ Esther Johnston				
SA11	Op wards Adult acute	The trust must ensure that the prescribing,administration and monitoring of vital signs of patients are completed as detailed in the NICE guidance on violence and aggression. C111 Rapid tranquillisation policy	EWS form to be completed for every episode of rapid tranquillisation Evidence in the health record that appropriate action has been taken depending on the EWS score	All staff to be trained in modules 1and 3 of the physical health observations workbook training Staff to complete a EWS form for all rapid tranquillisations (form on paper not yet Lorenzo) Staff to act on the EWS score according to guidance and document in the health record Audit to be completed	Manager/CTL All staff All staff Sue Barrett	Training records Audit report	January 2017 January 2017 January 2017 February 2017		
SA14	Adult acute	The trust should review the use of shared bedrooms Churchill, Glaven, Waveney	All rooms will uphold privacy and dignity	Churchill ward, partition walls to be costed and added to estates plan Glaven and Waveney wards to be factored into the bed review	Julie Cave Debbie White	Estates plan in place	Nov 2016 Jan 2017		

SA18	OP wards LD wards	The trust must ensure that appropriate arangements are in place for ensuring that administration of covert medication is carried out with the correct documentation in place	Covert administration will be carried out in line with the appropriate legal framework (MCA policy) Covert medication will be documented in accordance with policy C59	MCA Task and Finish group to undertake and review the Trust MCA and DoLs processes incorporating EF8 and SA18 to ensure: All staff to be familiar with MCA policy and practice All staff have attended MCA training All staff understand the process and necessity for the implementation of DoLs including the limitations of DoLs and use of restrictive practices All staff understand the need to implement best practice guidelines whilst awaiting a DoLs authorisation All staff understand the need to re-assess when considering covert medication and the relationship between the MHA and MCA in such circumstances MCA training to be reviewed to address practice based learning and scenarios highlighting the areas above. MCA policy to be reviewed to issue guidance	Saranna Burgess Manager/team leaders Dawn Collins Law forum		December 2016 January 2017 then ongoing		
SA19.3	OP wards	The trust must ensure that safety checks are undertaken routinely for equipment	All portable equipment is checked regularly and a sticker is provided showing the dates	Planned preventative maintenance (PPM)schedule to be reviewed and updated Matrons to check equipment as part of weekly environmental audit	Julie Cave Matrons	PPM schedule in place Audit	December 2016 Ongoing		
SA22	Community CAMHS	The Trust review the practice of requiring service users to "opt in" to services	All people referred will be offerred an appointment and all DNA's will be followed up.	Protocol rewritten and disseminated for implementation.	Debbie White/Alison Armstrong		December 2016		
EF1	Trust	The Trust must take an immediate review into clinical information handling and information systems so that risks can be identified in order to protect patient safety	All clinical information can be found as needed	Work with the CSC developers in Chennai continues to solve the freeezing and crashing issue. Trust equipment now shipped to the team for indepth investigation, outcome expected by the end of November 16. Pilot of laptps in seclusion areas now complete and in place, building works for additional data and electric points requested. Lorenzo user group reviewing the use of documentation and tabulation to ensure information can be found quickly. The basic patient search tool is available to any member of staff and identifies which system in the Trust holds any patient data. Care plan and CPA compliance being taken forward by the CPA task and finish group under the Director of Nursing. Additional training plus video on 'how to' now available.	Leigh Howlett/Dave Huggins		31/11/2016 and Ongoing, Lorenzo is a dynamic product we will adapt over its lifetime		

EF1.1	ALL	The Trust should ensure the electronic records system can be navigated and used by staff in such a way it enhances care provision	All staff report feeling confident that they are able to record and retrieve information from the system.	Managers/team leaders to establish the curent ability of staff to use Lorenzo Managers/team leaders to ensure staff take up any additional training required When all regular training has been taken up, clinical leads in IT team to be contacted to organise any additional or bespoke training that is required CPA training to be developed to include Lorenzo actions Trustwide survey monkey	Manager/CTL Helen Blee		February 2017		
EF2	All	The trust must ensure that all staff receive regular supervision and annual appraisals, and that this is recorded.	All staff report receiving supervision in line with policy Data will show 89% compliance with annual appraisals	Supervision policy to be reviewed and relaunched All staff to receive supervision in line with revised policy Supervision to be recorded as per policy All staff to receive an annual appraisal All appraisals to be recorded on the electronic system as per policy	Dawn Collins manager/CTL manager/CTL		March 2017 then ongoing		
EF3	All	The trust must carry out assessments of capacity for patients whose ability to make decisions about their care and treatment is in doubt and record these in the care records There should be clear documented evidence of the staff reach capacity decisions	Audit demonstrates capacity assessments are undertaken in accordance with policy and recorded in the health record.	MCA Task and Finish group to undertake and review the Trust MCA and DoLs processes incorporating EF8 and SA18 to ensure: All staff to be familiar with MCA policy and practice All staff have attended MCA training All staff understand the process and necessity for the implementation of DoLs including the limitations of DoLs and use of restrictive practices All staff understand the need to implement best practice guidelines whilst awaiting a DoLs authorisation All staff understand the need to re-assess when considering covert medication and the relationship between the MHA and MCA in such circumstances MCA training to be reviewed to address practice based learning and scenarios highlighting the areas above. All staff have attended MCA training All staff to be familiar with MCA policy managers to contact Helen Dewson for further training for staff MCA training to be reviewed to include more opportunities to practice carrying out assessments.	Saranna Burgess manager/CTL Dawn Collins		November 2016 February 2017 then ongoing December 2016		
EF4.1	Adult acute	The cancellation of sec 17 leave must be recorded and reported	Data shows that no patients had their leave cancelled because of lack of staff	As from 1st November, reporting will be via Datix, guidance to be issued. (COMPLETE) All staff to record any sec 17 leave that is cancelled and the reason why Monthly data to be dicussed at PARM	Sue Barrett All staff/CTL Manager/CTL		November 2017 then ongoing		

Ref	Service	Requirement	Outcome	Action	Lead	Evidence	Date		
EF5	Adult community CAMHS community OP community	The trust should review the different working arrangements within each team, in order to ensure the consistency of care provided to patients. The trust should adopt a standardised caseload allocation tool	Working practices are aligned across the Trust Standardised tool is used across the trust	Contractual discussions with CCG's leading to one contract for Norfolk and one for Suffolk Standard operating procedures for single point of contact in both counties to be developed where possible. To be discussed at ASF revised service specifications in place Standardised tool to be adopted ensuring that the tool meets the needs of all service lines where possible. Standardised allocation process in Suffolk as part of operating framework. Pilots to be implemented in Suffolk	Debbie White/ Alison Armstrong Veno Sunghuttee		01/03/2017 December 2017 March 2017		
EF8	OP wards	The trust must have adequate governance systems in place to assess risk and to protect the rights of patients awaiting DOL's authorisations and ensure staff have adequate information regarding their legal roles and responsibilities.	System in place	MHA administrators to ensure that staff are given information on the progress of applications. New process in place	Helen Dewson		Nov-17		
RE1	OP community	The trust must 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	Patients will be able to access treatment close to home 24 Hour crisis services will be available to older people and CAMHS patients where commissioned	Contractual discussions with CCG's Trustwide bed review Action plan to be put in place following the bed review	Debbie White/ Alison Armstrong		Jan-17		
RE2.9	Crisis and HBPOS	The trust must ensure that an overarching operating procedure, clearly defines KPI's The Trust must review their compliance with KPI's for response times to assessment in crisis services The trust should review the process to enable locality managers to be able to monitor their services against KPI's and have this information easily accessible.	Operating policies to include KPI's. Compliance data to be produced monthly and shared at team level KPI's to be reviewed at monthly PARM meetings	Operating policies to be reviewed and KPI's added where necessary. Crisis team data to be produced monthly and discussed at PARM. There is an Operating Framework for the emergency assessment team which includes the 4 hour ansd 72 hour response times. the KPIs which we report on will be added to the Document by 10th November. KPIs are discussed as part of the business meetings and reported on by the service daily.	CTL's Debbie White/Alison Armstrong		November 2016 and ongoing		