# Council of Governors – Public Session

Meeting to be held at 13.00 on Thursday 11 January 2018 in the Horseshoe Room, Diss Business Hub, Diss Business Park, Hopper Way, Diss IP22 4GT

Governors Please Note:  
Governor Private Session from 10:00 – 12:00

## AGENDA

<table>
<thead>
<tr>
<th>Time</th>
<th>Item No</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>12:30</td>
<td>18.01</td>
<td>Chair’s welcome, notification of any urgent business and apologies for absence:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>i. Changes to the Council of Governors’ membership/election results 2017 Attachment A</td>
</tr>
<tr>
<td></td>
<td></td>
<td>ii. Declarations of interest (All) Verbal</td>
</tr>
<tr>
<td>12:35</td>
<td>18.02</td>
<td>To approve the minutes of the previous public meetings held on 12 October and 1 November 2017 Attachment B &amp; Bi</td>
</tr>
<tr>
<td>12:40</td>
<td>18.03</td>
<td>To address any matters arising from the minutes of the meeting in public 12 October 2017 Attachment C</td>
</tr>
<tr>
<td>12:50</td>
<td>18.04</td>
<td>Representing Interests Register (Suffolk public, Norfolk public, Service User, Partner, Staff governors) Attachment D</td>
</tr>
<tr>
<td>13:15</td>
<td>18.05</td>
<td>Partner Governor Feedback Verbal</td>
</tr>
<tr>
<td>13:35</td>
<td>18.06</td>
<td>Chief Executive’s report (Julie Cave) Attachment E</td>
</tr>
<tr>
<td>13:45</td>
<td>18.07</td>
<td>Update on Overview Assurance Group (Catherine Wells) Attachment F</td>
</tr>
<tr>
<td>13:55</td>
<td>18.08</td>
<td>Governor updates on STPs (Martin Wright / Nigel Boldero) Attachment G</td>
</tr>
<tr>
<td>14:05</td>
<td>18.09</td>
<td>Report from Regional Governors’ Conference, Newark - 2 October, 2017 (Anne Humphreys, Howard Tidman, Zeyar Win, Nigel Boldero) Attachment H</td>
</tr>
<tr>
<td>18.10</td>
<td></td>
<td>Items for approval</td>
</tr>
<tr>
<td>14:15</td>
<td>i.</td>
<td>BoD/CoG joint working agreement (Robert Nesbitt) Attachment I</td>
</tr>
</tbody>
</table>
14:25  ii. Governor Publicity Material *(Catherine Wells)*  Verbal

14:35  iii. Nominations Committee Terms of Reference *(Robert Nesbitt)*  Attachment J

14:40  BREAK

18.11  Items for assurance

15:00  i. Council of Governors’ self-evaluation *(Robert Nesbitt)*  Attachment K

15:10  ii. Community Service User Survey Report *(Marcus Hayward)*  Attachment L

15:30  18.12  Standing Item: Feedback from the sub-groups and committees

    i. Service User and Carer Trust Partnership feedback from 5 December 2017 *(Gary Page)*  Attachment M

    ii. Trust Member and Governor Development sub Chair’s reports for 7 November 2017 *(Nigel Boldero)*  Attachment N

    iii. Performance & Planning subgroup Chairs’ report for 16 November 2017 *(Catherine Wells)*  Attachment O

    iv. Nominations Committee Chair’s Report for 14 November 2017 *(Marion Saunders)*  Attachment P

    v. IPC Committee Chair’s Report for 18 December 2017 *(Catherine Wells)*  Attachment Q

15:50  18.13  Highlight report to members: to agree the agenda items to be highlighted for members and the public *(Nigel Boldero)*  Verbal

15:55  18.14  Any other urgent business, previously notified to the Chair

Date, time and location of next meeting
The next meeting of the Council of Governors will be held in Public on 12 April 2018 in Conference Room 2, Ip-City, Ipswich.

16:00  CLOSE
### Council of Governors at 11.01.18 29 seats

<table>
<thead>
<tr>
<th>Service User (4)</th>
<th>Public – Suffolk (6)</th>
<th>Norwich</th>
<th>Suffolk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Norfolk</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Ginnie Benedettini</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Richard Gorrod</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Suffolk</td>
<td>Paul Gaffney</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Malcolm Blowers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Carer (2)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Anne Humphrys (Suffolk)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Vacant (Norfolk)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Staff (4)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Dr Nanayakkara De Silva</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Dr Zeyar Win</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Howard Tidman</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Marcus Hayward</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Appointed = 3

### Council of Governors at 01.02.18 29 seats

<table>
<thead>
<tr>
<th>Service User (4)</th>
<th>Public – Norfolk (7)</th>
<th>Norwich</th>
<th>Suffolk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Norfolk</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Ginnie Benedettini</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Richard Gorrod</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Suffolk</td>
<td>Georgia Butler+</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Malcolm Blowers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Carer (2)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Anne Humphrys (Suffolk)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Christine Hawkes(Norfolk)+</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Staff (4)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Jill Curtis+</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Dr Zeyar Win</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Howard Tidman+</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Marcus Hayward</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Appointed = 3

---

+ elected or re-elected in 2017/18 governor elections
Minutes of the Council of Governors – Public Session
Held on 12 October 2017 at 12.30pm in the Rose Room, Endeavour House, Russell Road, Ipswich IP1 2BX

Present:
Gary Page, Trust Chair
Julie Cave, Chief Executive Officer
Ginnie Benedettini, Service User Governor, Norfolk
Kathleen Ben Rabha, Public Governor, Suffolk
Nigel Boldero, Public Governor, Norfolk
Sian Coker, Partner Governor, University of East Anglia
Paddy Fielder, Public Governor, Suffolk
Stephen Fletcher, Public Governor, Norfolk (until 15.19)
Ronald French, Public Governor, Norfolk
Paul Gaffney, Service User Governor, Suffolk
Hilary Hanbury, Public Governor, Norfolk
Marcus Hayward, Staff Governor
Anne Humphrys, Carer Governor, Suffolk (from 13.35)
Jane Millar, Public Governor, Suffolk
Guenever Pachent, Public Governor, Suffolk
Sheila Preston, Public Governor, Norfolk
Mary Rose Roe, Carer Governor, Norfolk
Richard Rout, Partner Governor, Suffolk County Council
Howard Tidman, Staff Governor
Catherine Wells, (Lead) Public Governor, Norfolk
Zeyar Win, Staff Governor
Martin Wright, Public Governor, Suffolk

In Attendance:
Robert Nesbitt, Company Secretary
Kate Hope, Assistant Company Secretary (minutes)
Lesley Drew

There was 1 Non-Executive Director, 1 member of the public and 1 staff member in the public gallery.

Certain items were taken out of order, but for clarity the minutes reflect the agenda

The meeting commenced at: 12.30pm

17.49 Chair’s Welcome, notification of any urgent business and apologies for absence

The Chair (Gary Page) welcomed the Council of Governors (CoG) and reported that no notifications of urgent business had been received.
Apologies were noted from Julie Cave, Sian Coker, Richard Garrod and Andrew Good.

i. Declarations of Interest

None.

17.50 To approve the minutes of the previous public meeting held on:-

6 July 2017

The minutes of the meeting held on 6 July 2017 were approved subject to the following amendments:-

Action 17.18a: It was clarified that the lanyard issue would be considered as part of the uniform policy.

Action 17.19b: This action in relation to mobile and smartphones will be reallocated to Gary Page.

Item 17.36: The third bullet point should be amended to specify ‘medical’ undergraduate teaching.

Action 17.50

a. A response is to be circulated to the CoG on how assured the NEDs are that there is an organised approach around mobile working and smartphones (Gary Page)

31 August 2017

The minutes of the meeting held on 31 August 2017 were approved.

17.51 To address and matters arising from the minutes of the meetings in public on 6 July 2017

Action 17.34a: The position on MHA/MCA eLearning is to be clarified to staff.

Robert Nesbitt confirmed that in order to boost training levels eLearning has been rolled out on MCA and MHA. This training is complimented by further training by the MHA team which is more scenario based, the provision of a support line and the guidance of the Mental Health Act Office and Trust Lawyer.

Action 17.34b: More information to be circulated on the alternative arrangements following the closure of on call pharmacy together with the pharmacy out of hours flowchart.

This information has been provided and will be circulated following the meeting on 13 October 2017.
Action 17.34d: E-rostering report to OD&W is to be shared with the governors once reviewed by the Committee.

The report will be presented to the OD&W Committee on 14 November 2017 and circulated to the CoG thereafter.

Action 17.38ii: An update is to be circulated to the CoG on target dates for the Trust Actions contained in the Bed Review. This information has been provided by Julie Cave and will be circulated to the CoG following the meeting.

All other matters were noted as being completed.

Action 17.51

Information provided on 17.34b and 17.38ii will be circulated to the CoG following the meeting. 17.34d will be actioned following the meeting of OD&W on 14 November 2017 (Kate Hope)

17.52 Representing Interests Register

The responses were reviewed and the following points were noted:-

C65: Employment Support - The information provided regarding employment support in Norfolk was pleasing but it was noted there was no reference to employment advisers in Suffolk. It was confirmed that these are in place.

SU65: Social Recovery – The answer provided does not refer to Suffolk (Voluntary and Statutory Partnerships (VASPs)). In addition, the response provides a list of organisations and groups the Trust works with but does not explain who the groups are and what their function is. No reference points are provided and it should be presented in language that everyone understands. It was agreed that the CoG require more than a basic response to issues raised and this will be fed back to the Executive Directors.

Staff70: Poor Staff Engagement – Governors expressed concern that the manner in which the issues are responded to reflects how staff are viewed by the Board of Directors. It was not felt that an adequate response had been provided for this question. Whilst it is noted that the Trust was an outlier in 2015 and improvements have been made which now place the Trust on a similar scale with other Trusts, NSFT still has a long way to go. The answer provided shows an optimism bias. It was agreed that Staff Survey Results would be added to the CoG planner so that when the results are released. Julie Cave will present the results to the CoG and provide information on what steps are to be taken to make any improvements required.

Staff71: High Community Caseloads – Staff governors highlighted this as one of the most important issues faced by the Trust. The response given does not reflect this. It was queried as to whether the caseload waiting tool had been implemented. Gary Page confirmed that it was in the process of being implemented in Norfolk and that there is a slight delay in the rollout for Suffolk. However, the tool would be used to
validate what staff are reporting and assists with the Trust’s discussions for funding with commissioners.

In relation to unallocated caseloads, it was confirmed that Gary Page had already circulated further information and figures on unallocated cases for both counties.

Staff73: Electronic records system administration reducing time to care – As the reality is that with Lorenzo, it takes longer to use, the Board are making arrangements to deploy more administrative staff throughout teams to free up clinical staff to spend time with patients. It was agreed that this issue would be an item for the CoG agenda in January 2018.

No issues had been raised by Norfolk or Suffolk public governors. It was agreed that awareness of the Representing Issues Register should be raised amongst the Youth Council to encourage members to raise issues, should they have any.

A late issue had been submitted by a staff governor and this had not been included in the Register. It was agreed that a response would be obtained and circulated following the meeting.

All items were approved by the Council as closed.

### Action 17.52

- a. Responses to governor issues should provide more than just a basic response and should be presented in a language accessible to all. This information to be fed back to the Executive Directors (*Robert Nesbitt*)
- b. An item on Lorenzo is to be added to the CoG agenda following the administration review which will be completed at the end of 2017 (*Kate Hope*)
- c. Contact should be made with the Youth Council to ensure they are aware of Representing Issues Register, should they wish to raise issue via this route (*Kate Hope*)
- d. Late staff governor issue response to be circulated to the CoG (*Kate Hope*)

### 17.53 Chief Executive’s Report

Gary Page presented Julie Cave’s report to the CoG in her absence and highlighted the following points:-

1. The Care Quality Commission (CQC) Report is due to be published tomorrow (13 October 2017). Whilst the CQC press releases are being issued today, the contents are subject to an embargo until midnight. The media will be reporting on the findings the following day. The governors will be provided with a link to the full report via email. A constructive meeting took place with NHS Improvement on 11 October 2017 to agree plans for the future following the release of the CQC report.
2. Delayed discharge and transfers of care (DToCs) continue to be a challenge, particularly in Norfolk. Currently the Trust has 20 service users in services that are clinically well enough to be discharged but have no accommodation. As this is a social care issue, Gary Page and Debbie White met with the CEO and Head of Adult Social Care of Norfolk County Council to discuss the use of the Better Care Fund. This funding was additional money allocated to the Council to help with delayed transfers of care yet the submission made by Norfolk County Council did not include mental health. This has now been challenged by NSFT to ensure that position has now changed. The use of this funding would go a long way to solving the position in Norfolk. It is not healthy for service users to be in hospital if they are well enough to be discharged. The Trust currently has 23 service users in services in Mundesley Hospital. This is almost exactly the number of people on our DToCs list. No further patients will be admitted to Mundesley at the current time and NSFT has reserved some space in a private unit in Ellingham. The Care Commissioning Groups in Norfolk have agreed to continue to fund the costs of these placements for this year. However this does not solve the underlying problem.

The issue of STPs was raised. Michael Scott played an important role in the planning process and assurance was requested that STPs would be a continued priority for NSFT. Gary Page confirmed that Julie Cave would be taking on this responsibility. She had already been involved in the STP planning and her replacement for the Director of Finance role, Daryl Chapman was previously the finance lead for the STP in Norfolk. He will now assume the role Julie Cave previously played in the STP planning process. In relation to Suffolk, Gary Page is not assured that the seniority of the people involved in the discussions is good enough. This will be a priority for Julie Cave.

Following the changes in the Board Gary Page confirmed that he would review the buddy arrangements for governors.

The CoG noted the report.

**Action 17.53**

Buddy arrangements for governors are to be reviewed (Gary Page)

**17.54 Governor Updates on STPs**

Martin Wright emphasised the following for Suffolk:-

a. There are concerns that NSFT have a strong enough voice on the negotiations for this STP.

b. There is a unique situation with this STP in that there is a powerful axis between Ipswich and Colchester Hospital which is the dominant force in that area. The STP administration appears centred in Colchester which takes much of the emphasis away from Suffolk.
c. It has been challenging to have a proper line of communicate with the STP. A meeting has been arranged for 13 November 2017 for NEDs and governors which Gary Page will be attending.

Governors who attended the regional workshop on 2 October 2017 confirmed that STPs were discussed at length and that it was clear that the Trust Chair role is vital. The governor role in engaging with public will be extremely important and another key focus is to establish the roles of NEDs in the STP process.

Nigel Boldero provided an update for Norfolk:-

1. Nigel Boldero and Marion Saunders attended an STP NED/Governor event in Norfolk on 7 September 2017. Mental health has a specific focus in Norfolk and Waveney and is also cross referenced in work streams. Several important projects are now moving forward under the mental health work streams.

2. The focus has shifted from planning to working as partner agencies as part of the STPs.

3. The key challenges are resources, whether there is the political will for transformative change and the complexities of the organisations involved in the STP process. The reality is that the STP remains a partnership but it does not remove accountabilities and legal responsibilities that Trusts still have. In addition there has been an acknowledgement that more work is needed on promoting public engagement.

Gary Page confirmed that he would share updates on the planning for STPs in both counties with the CoG where relevant and would continue to push the need for governor engagement at meetings.

The CoG noted the updates.

17.55 **Items for Approval**

i. **Appointment of Interim CEO**

Following Michael Scott’s retirement, Julie Cave has been asked to take the role of CEO. This will be an interim appointment until a permanent appointment is made.

Gary Page assured the CoG that any recruitment process undertaken for a permanent replacement will have the full involvement of stakeholders including the CoG and services users.

Jane Millar confirmed that she formally supported Julie Cave's appointment to CEO. She has done an exceptional job as Director of Finance and thanked her for stepping up to the role of CEO. This was seconded by Stephen Fletcher.

The CoG took a vote on the appointment of Julie Cave to Interim CEO and the results were:-
13 in favour
4 against
2 abstained

The CoG approved the appointment of Julie Cave as Interim CEO.

ii. Code of Conduct, role profile, core document updates

Robert Nesbitt thanked all those governors who attended the Code of Conduct meeting on 30 August 2017 and the CoG reviewed the suggested changes to the following documents:-

- Code of Conduct for Governors: approved.
- Role Description for Staff Governor: approved.
- Role Description for Public/Service User/Care Governor: approved.

The Role Description for Partner Governors was approved and it was agreed that it would be useful to have a slot on each CoG agenda for partner governor feedback. This will be added to the CoG Agenda Planner.

The Role Description for the Lead Governor was reviewed and it was agreed that point 1 (meeting with regulators) in the Role Summary should be amended to include feedback to the CoG. The proposed amended wording of point 1 will be drafted and circulated to the CoG for approval.

There were no changes to Media Principles for Governors and Guidelines for Governors.

It was noted that the Code of Conduct Terms of Reference footer should be amended to 2017.

Action 17.55ii

The proposed amendments to point 1 of the Role Description for the Lead Governor will be drafted and circulated to the CoG for approval (Anne Humphrys)

iii. Constitution: Staff Governor Constituency Proposals

The proposed changes to the staff governor constituency, agreed by the CoG on 6 October 2017 were reviewed at length. The proposals agreed were to change the staff governor constituency to ensure there were 2 staff governors from Suffolk and 2 from Norfolk.

This change does impact on the existing governors whose term is coming to an end as they would then have to wait to be able to stand again in the 2018/19 elections.
A number of governors stated that since the original decision was made, their thinking has changed. Recent attendance at the regional governor workshop in Newark saw some best practice being shared on this issue.

After a debate the CoG took a vote on the proposal. 9 governors voted for the proposal with 9 voting against. The Chair had the casting vote and voted for the staff governor constituency to remain the same.

It was agreed that an overall review of the pattern of governorship should be carried out and this would be part of the consideration for the Code of Conduct subgroup next year.

**Action 17.55iii**

Formal review of staff governor constituencies to take place as part of the Code of Conduct subgroup in 2018 (Robert Nesbitt)

The meeting took a break from 14.30 - 14.47

iv. Meeting Dates for 2018

The meeting dates submitted were approved.

**17.56 Items for Assurance**

i. Update on service user/carer partnership developments by locality

The report was taken as read and Lesley Drew circulated a more detailed report on service user and carer participation activities to the CoG.

The governors requested that in future they would prefer a summary report.

Progress on the West Norfolk Locality Hub was requested. Lesley Drew stated that it is challenging to move a forum to a locality hub but that the hub was moving in the right direction. However, it was noted there are not currently enough spokes to feed into that hub however the progress observed so far was encouraging.

It was agreed that as each locality hub develops more membership, more projects would naturally emerge. Is the Trust liaising with local Councils to avoid parallel mapping? Richard Rout said that he would investigate how best to liaise with locality officers at District Council level in Suffolk to ensure that the Trust was aware of exactly what services and groups involved in mental health were available to connect with.

It was noted that there was no mention of young people or parents and carers of young people in the report and assurance was required that parents and carers of young children were being listened to. In addition the new Youth Participation Lead has not yet attended any of the Service User and Carer Trust Partnership (SU&CTP) meetings. The CoG was informed that there...
were extenuating circumstances for the lead’s non-attendance at these meetings, she was unable to attend the last as she was accompanying some young people to the International Youth Conference in Dublin. She is planning to attend future SU&CTP meetings and has been extremely active in her role to date. It was agreed that Youth Participation would be put on the agenda for the Service User and Carer Trust Partnership meeting due to take place on 5 December 2017.

It was noted that there is no specific place to share information and connect people and groups. However the new NSFT website, due for release in March/April 2018 should go some way to bridging that gap and allow people to access information on forums and meetings of interest.

In relation to carer groups it was raised that it was important for the Trust to have regular links with carers to take their feedback and bring them into the hubs if possible. It was agreed that it would be checked as to whether carer leads are attending regular meetings with Norfolk County Council.

Figures for service users and carers who use the wellbeing service were requested. Marcus Hayward confirmed that this information does need to be mapped and he is due to have a meeting with the Wellbeing Service Manager and he will raise this with him and report back to the CoG.

**Action 17.56i**

a. Youth Participation to be added to the Agenda for the Service User and Carer Trust Partnership meeting due to take place on 5 December 2017 *(Kate Hope)*

b. Information mapping/figures for service users and carers who use the Wellbeing Service is to be shared with the CoG *(Marcus Hayward)*

**ii. Confirmation of details of the next election**

Robert Nesbitt confirmed that that there were 8 seats up for election, not 7.

The CoG noted the report.

**iii. Governor membership of governor CoG subgroups**

It was noted that Marcus Hayward is a member of the Trust Member and Governor Development subgroup.

**Action 17.56iii**

Council of Governor Subgroups to be amended to include Marcus Hayward as a member of Trust Member and Governor Development subgroup *(Kate Hope)*
iv. Developing member involvement

The report was taken as read. Nigel Boldero confirmed that he was asking the governors to sign up in principal to play a more active part in recruiting and engaging with members.

A budget has been allocated for governors to have a display and material for available for events and it is proposed that a small working party of governors is established to represent everyone's views on the content and design of this material. It was agreed that governors would let Nigel Boldero or Catherine Wells know of their interest within a week of the meeting.

v. Update on Allied Health Professionals Conference 27 September 2017

Catherine Wells provided an update on the Allied Health Professionals (AHP) Conference she attended which took place on 27 September 2017, the first since 1993.

The conference was well attended with a variety of professionals and was used to identify an AHP strategy for the NSFT workforce which links in with the National strategy. This work should be completed by 1 January 2018.

Catherine Wells gave a talk on her work as an Occupational Therapist and her role as governor at NSFT.

The event was inspirational and the feedback following the event was positive.

17.57 Standing Item: Feedback from the subgroups and committees

i. Service User and Carer Trust Partnership feedback from 8 August 2017

Gary Page took the report as read and confirmed that the infrastructure for the Involvement Strategy was in place but now focus will move to outcomes.

Council noted the report.

ii. Trust Member and Governor Development subgroup Chair's report for 8 August 2017.

This report was taken as read.

Nigel Boldero said that some changes were planned for the 2018 Governor Training Plan. Induction training will be comprised of 2 half days and will continue with more in depth briefing sessions prior to the CoG each quarter.

Skill development and review session are planned to build on knowledge of holding to account and representing interests. A review of current governor practices and approaches is planned and will be timed to take place in autumn to coincide with the governor evaluation. Guenever Pachent paid a tribute to some of the existing
governors who are exceedingly active and role models in the work they do on holding to account and representing interests.

Governors were encouraged to complete the governor self-evaluation which has already been circulated as this was a key resource to establish what governor training was required throughout the following year. Any assistance required with completing this can be sought from Robert Nesbitt.

It was queried whether the Executive Directors and NEDs would be part of the evaluation process. Robert Nesbitt confirmed that the evaluation had only been sent to governors so far but there were evaluations ready to be submitted to the Executive Team and NEDs and it is also planned to put together a member survey. It was suggested that when surveying the members the Trust asks their views on how they would better engage with NSFT. Gary Page confirmed that a better way forward in terms of the NEDs would be to add the governor evaluation to the agenda for the next NED conference call for discussion. Gary Page will then provide qualitative feedback to the CoG. Robert Nesbitt will provide Gary Page with a copy of the questions for the evaluation in the meantime.

**Action 17.57ii**

Governor evaluation to be added to the agenda for the next NED conference call for discussion *(Kate Hope)*


The report for the meeting on 20 July 2017 was taken as read and the attached Terms of Reference were approved.

The report for 21 September 2017 was noted.

**17.58 Highlight Report to Members: to agree the agenda items to be highlighted for members and the public**

It was agreed that the following issues from this meeting are to be highlighted:

1. All items on the Representing Issues Register to be listed with the actions agreed today.
2. CEO report, highlighting the bed management issue and actions arising
3. STPs
4. CEO appointment
5. Update on the staff constituency for governors
6. Improving services together
7. Member involvement

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

There were no items of urgent business.
Gary Page announced that this would be the last CoG meeting for Mary Rose Roe who is relocating to Bristol. He thanked her for her enormous hard work and dedication on behalf of carers and wished her well for the future.

There will be a further informal meeting of the CoG on 25 October 2017 at 2pm at Diss Business Hub. Feedback from the Regional Governor’s Conference in Newark will be considered at this event.

**Date, time and location of next meeting**

The next meeting of the Council of Governors will be held in Public on 11 January 2018 in Norwich, venue to be confirmed.

**The meeting closed at: 15.41**

Chair: ……………………………….

Date: ……………………………….
Unconfirmed Minutes of the Council of Governors – Public Session
Held on 01 November 2017 at 12.30pm in the Ashton Studio, Jerwood Dance House, Ipswich IP4 1DW

Present:
Gary Page, Trust Chair
Catherine Wells, (Lead) Public Governor, Norfolk
Nigel Boldero, Public Governor, Norfolk
Stephen Fletcher, Public Governor, Norfolk
Paul Gaffney, Service User Governor, Suffolk
Hilary Hanbury, Public Governor, Norfolk
Anne Humphrys, Carer Governor, Suffolk
Jane Millar, Public Governor, Suffolk
Guenever Pachent, Public Governor, Suffolk
Martin Wright, Public Governor, Suffolk
Richard Garrod, Service User Governor, Norfolk
Andrew Good, Public Governor, Suffolk

In Attendance:
Robert Nesbitt, Company Secretary (Minutes)

There were no members of the public present.

The meeting commenced at: 12.15 pm

17.63 Chair’s welcome and apologies for absence

Gary Page welcomed the Council of Governors (CoG) and explained that there was only one item of business which was to consider extending the KPMG external audit contract for two years.

Apologies were noted from:
Kathleen Ben Rhaba, Heather Rugg, Howard Tidman, Ginnie Benedettini, Ron French, Sheila Preston, Paddy Fielder.

i. Declarations of Interest

None.

17.64 External Auditors’ Contract Extension

Gary Page introduced the paper and said that when the contract with KPMG for external audit services was approved by the Council of Governors in 2014 it had been on the basis of a 3 + 2 years period. There was an oversight in that the 3 years ran until 30th September 2017 and this date had passed but, on the basis that there
were no issues with the services provided by KPMG, the board of directors recommended to the Council of Governors that the contract run for the full five years.

Guenever Pachent noted that none of the governors who had been involved in the original procurement process in 2014 were present and said that it would have been preferable if there had been a process whereby they had been consulted. This was agreed. Robert Nesbitt said that a calendar note had been made to ensure that there was sufficient lead-in time for the next procurement exercise in 2019.

The governors unanimously approved the two year extension of the contract with KPMG for external audit services.

Date, time and location of next meeting

The next meeting of the Council of Governors will be held in Public on 11 January 2018 in the Horseshoe Room, Diss Business Hub, Diss Business Park, Hopper Way. IP22 4GT.

The meeting closed at: 12:25

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

Date: ........................................
## Action 17.50 – Minutes of the meeting of 6 July 2017

A response is to be circulated to the CoG on how assured the NEDs are that there is an organised approach around mobile working and smartphones *(Gary Page)*

**Completed.** Response circulated 14 December 2017 by Lucy Want.

## Action 17.51 – Matters Arising

Information provided on 17.34c and 17.38ii will be circulated to the CoG following the meeting. 17.34d will be actioned following the meeting of OD&W on 14 November 2017 *(Kate Hope)*

| 17.34c – to follow. | 17.38ii – see below. |
| 17.34d is currently in the process of being reviewed by the executive team. The report was not presented to November OD&W. It has now been picked up by Mark Gammage who will take it to the Executive team and will present a summary of the report and any agreed actions to January OD&W. |

## Action 17.52 – Representing Interests Register

| a. Responses to governor issues should provide more than just a basic response and should be presented in a language accessible to all. This information to be fed back to the Executive Directors *(Robert Nesbitt)* |
| Completed. |

| b. An item on Lorenzo is to be added to the CoG agenda following the administration review which will be completed at the end of 2017 *(Kate Hope)* |
| Completed. |

| c. Contact should be made with the Youth Council to ensure they are aware of Representing Issues Register, should they wish to raise issue via this route *(Kate Hope)* |
| Completed. |

| d. Late staff governor issue response to be circulated to the CoG |
| Completed. |

---

**BoG Public – 12Oct2017**

**Matters Arising**

**Version 0.3**

**Author:** Kate Hope

**Department:** Corporate

**Page 1 of 4**

**Date produced:** 23Oct 2017

**Retention period:** 20 years
Action 17.38ii: Matters Arising – update on target dates for the Trust actions contained in the bed review

1.0 BED REVIEW

The Mental Health Workstream for the Norfolk and Waveney STP has agreed to include some of the recommendations arising from the bed review within its work plan. These are:

(i) Clinical variation
   The project will address the clinical variation for both primary and secondary care with objectives as follows:
   - To understand and address variation in primary care referral patterns
   - To understand and address variation in secondary care practice
   - To identify and address blockages that impact on integrated working between primary and secondary care
   - To further understand internally within NSFT the variances by service model, admission rates and delivery within community teams.
   - To make recommendations on standardisation where appropriate.
The project is on-going with the CCGs and reports on a monthly basis to the STP Mental Health Workstream.

(ii) Crisis Hub

The project’s overarching aim is to design and implement a new service model (Crisis Hub), initially in Norwich, to support people experiencing heightened emotional distress – those on an escalation path to crisis. The model will be flexible and responsive, offering immediate access for those that need it. Its approach will primarily be non-medical and will focus on de-escalating the individual’s immediate need, offering appropriate interventions, ensuring the individual has a short-term support plan and engage the individual with appropriate community resources. The model will be supported by clinical staff to ensure risk is appropriately managed and where necessary people can be escalated to more appropriate services. The objectives are:

- Design a crisis hub, or mental health urgent response hub, incorporating best practice examples and appropriate local engagement
- Ensure the hub is adequately resourced, open at the times when most needed and sustainable for the future
- Integrate the hub with existing resources to improve the continuity of care for service users and maximise the affordability of the hub model

The business case has been approved by the Norfolk and Waveney CCGs and they are undertaking a procurement exercise for the service. The hub will be accommodated at Churchman House (the old registry office) in Norwich. The timescale to establishment of the crisis hub is estimated at October 2018.

(iii) Alternatives to admission: step down beds

Seven step down beds have been provided by Evolve in Aylsham Road. This project was agreed in July 2017 and was fully operational by October 2017.

(iv) Community personality disorder service

The project is underway and is included in our clinical strategy work. The pathway is being designed to include the following components:

- High quality assessment of needs, including physical health and risks to self and others
- A clear psychological formulation
- High quality supervision – which requires time and skill – to ensure the formulation and crisis plans remain relevant and based on best practice
- A range of proportionate interventions – active listening; psychotherapy; crisis response
- Provision of containing environments form ‘crisis café’ to admission
- Avoid multiple hand-offs/transitions, encourage continuity of care
- Medication reviews to limit the usage of drugs

The project is led by a Trust clinical psychologist and the design and business case is expected to be complete by the end of April 2018.

(v) Demand and capacity
A number of business cases are in development to provide additional capacity to support the increased demand in our services. These are under discussion with the CCGs for funding and include, crisis team support, community team and link worker support and psychiatric liaison capacity. The outcome to these discussions will be known by March 2018.

**Action 17.52d – Representing Interests Register**

We are aware of a higher than desirable number of patient transfers because of the pressure on beds. This is particularly the case in Norfolk and particularly between Mundesley and Norwich and to and from Yarmouth beds. For some patients who have moved mid-treatment plan or who have dementia this can be counter-therapeutic. Are NEDs sighted on this issue? What mechanism does the board use track the impact of patient transfers (and out of Trust placements more generally) on quality of care?

This was identified as an issue during the CQC inspection. “*The Trust must minimise disruption to patients during their episode of care and ensure that discharge arrangements are fully effective.*”

All board members are aware that unnecessary moves should be avoided wherever possible. It has therefore been proposed that as soon as practicable:

1. The Board Performance report will monitor:
   a. Length of stay by ward against national benchmarks
   b. All internal transfers (ward to ward) by time
   c. All – re-admissions by ward by national benchmarks
   d. All Mixed sex breaches by ward

2. The Board Quality Committee will receive a report analysing trends/themes from datix incidents of service user inter-ward transfers and details of remedial action to be taken.

3. The Medical Director will review the practice on any ward that has a re-admission rate above national benchmarks over a 3 month period and present the finding to the Board.

A protocol is being drafted to address this issue for approval by the Executive Team on 10 January 2018.

Marion Saunders/Debbie White
COUNCIL OF GOVERNORS
REPRESENTING ISSUES
REGISTER
Agreed Process

1. Prior to the Council of Governors meeting, the Lead Governor emails each governor and asks them to act together within their constituencies to prepare a maximum of five issues to be sent to the Trust at least five weeks in advance of the next Council of Governors meeting.

2. In the papers for the Council of Governors the Trust will have provided a response to the issues raised.

3. Governors will have the opportunity at the meeting to speak to any of the Trust responses. The item will either be closed, put on the agenda of a future Council of Governors Sub-Group or Board Sub-Committee, or additional information will be sought as a matter arising.

4. Past Issues are available on request from the Company Secretary.
CARER GOVERNORS

Carer Governors

None

SERVICE USER GOVERNORS

Service User Governors

SU67: Home educated children and young people

There is an increasing number of children and young people who are in “education otherwise” in Norfolk and Suffolk, and an increasing number of children and young people who are taken out of school when they are struggling with mental health problems. What is NSFT doing, or planning, to ensure that routes into services and provisions for those from this group with mental health problems are visible and accessible given that referral is often made via the school or at least with support from educational professionals? Does it have a link with the County Council education departments so that home educating families who wish to refer to services are supported through the process?

NORFOLK

Norfolk and Waveney have links with the Local Authority at a number of levels.

The locality managers attends the children’s strategic partnership where access to services is discussed and strategic plans are made to address issues, accessibility has been one such area that is being addressed by the introduction of navigators into the system commissioned as part of the Local Transformation Plan and supplied by Ormiston.

The Local authority commission the Compass Outreach Project, this team is designed to be a specific help to the LA and they direct referrals to it, mostly to prevent the need for a young person to be looked after or go to residential school or to support families where the issues are complex and involve health and social care responses.

We attend and speak at the Norfolk wide head teachers conference every year.

We accept self referrals for secondary mental health, in Norfolk Ormiston provide primary care services for this group, we liaise weekly.

We encourage schools not to “sign off sick” young people but to make reasonable adjustments to the curriculum to meet the needs of the young person.
We meet our statutory requirements under the SEND legislation. (Special educational needs and disability (SEND) and high needs [https://www.gov.uk/education/special-educational-needs-and-disability-send-and-high-needs](https://www.gov.uk/education/special-educational-needs-and-disability-send-and-high-needs)) In Suffolk NSFT are represented on the SEND improvement board.

Each area holds meetings with professionals in that area where they can bring cases to discuss.

Each area has a duty worker every day for consultation.

We have a number of schools that purchase services directly from us.

Many schools have undertaken mental health first aid and are supported by the Education Psychology Service.

The Local Authority must review all children that are home educated and refer as appropriate.

Debbie White – 5 December 2017

**SUFFOLK**

Suffolk Family Focus (SFF) Psychology Service: The Local Authority (LA) Early Help services (including Educational Welfare) in each area of Suffolk have access to a full-time NSFT clinical psychologist whose role is to offer consultation, training and support around the mental health and emotional wellbeing of children and young people (CYP) on their caseload. The LA policy states that the threshold for intervening where there are concerns about the wellbeing of a child or young person in elective home education (EHE) should be the same as for any other child or family.

An SFF Psychologist regularly attends the LA County Resource Panel for children in care, where there are direct links with the Virtual School Head to discuss any looked after children that are in EHE or whose school placement is at risk of breaking down.

Primary Mental Health Worker (PMHW) Service: Every school in East and West Suffolk has access to an NSFT Primary Mental Health Worker, whose role is to offer consultation, advice and brief interventions around children’s mental health and emotional wellbeing. Where parents have concerns about a school, these practitioners are in a good position to work towards resolution and to support children’s continued attendance.

Thurston Academy in Bury St Edmunds has commissioned a full-time clinical psychologist from NSFT to offer consultation, training and support for school staff in relation to pupils. Again, instances where the school placement is at risk will be a particular focus for interventions.

Training is available free-of-charge for schools and for parents and carers around supporting the emotional wellbeing of children and young people (Suffolk Needs Met and Mental Health First Aid; see:
A similar training offer is also available to professionals across the range of teams and organisations that may come into contact with children in EHE.

From April 2018, the Suffolk Emotional Wellbeing Hub for children and young people will offer parents and carers direct access to highly-trained practitioners who will offer advice and guidance around mental health and emotional wellbeing as well as links to the right services for additional support.

There are a number of locally-developed online resources that offer information and advice for parents and carers, including The Source for young people in Suffolk (http://www.thesource.me.uk/) and the Emotional Wellbeing Gateway (http://infolink.suffolk.gov.uk/kb5/suffolk/infolink/infolink.page?infolinkchannel=2-1-1).

An action that we will be taking forward to strengthen this position is to:

- For SFF to develop links between the LA’s Elective Home Education Team and the practitioners mentioned above (SFF Psychologists, PMHWs, EWB Hub)

Pete Devlin – 19 December 2017

SU68: Homeless people

There is a rising number of people sleeping on the streets in cities and towns such as Ipswich and Norwich and coastal areas such as Sheringham and Cromer. What is NSFT doing to address the mental health needs of this population given their “no fixed abode”? Is NSFT working with other organisations such as housing schemes, the Council and Foodbanks in order to make contact with rough sleepers who may benefit from assessment and treatment but are as a result of their circumstances extremely hard to reach?

NORFOLK

We have a Band 6 practitioner in the City Reach GP practice who specifically cater for the Homeless Community. We also have direct contact and liaison with Caroline Kingham who is the Homeless lead for NCC, and links with The ARC Salvation Army Centre. We are in regular contact with the foodbanks and assist service users in accessing food parcels. We would like to pitch next year a business case to provide ‘Street Triage’ service in central Norwich.

Debbie White – 5 December 2017

SUFFOLK

We have a longstanding jointly funded (Ipswich Borough & Suffolk CC) Mental Health Homelessness Social Worker situated in Ipswich Integrated Delivery Team, Adult Pathway. This role involves working as the conduit between mental health services
and housing providing specialist advice to both organisations and expediting ‘priority need’ housing assessments.

In partnership with Ipswich Borough Council and Suffolk Coastal District Council (who successfully secured grant funding from the Department for Communities and Local Government to help those new to the street, or at imminent risk of rough sleeping to get the rapid support they need to recover and move on from a rough sleeping crisis). NSFT is providing a Mental Health Link Worker who will be aligned with Suffolk Access and Assessment with responsibility for completing targeted assessments for hard to engage homeless people. The position is due to go out to advert imminently – see attached scope at Appendix 1 for further details.

Pete Devlin – 19 December 2017

SU69: Long term counselling

Many people with mental health problems require or seek counselling or psychological therapy of a duration far longer than that offered on the NHS. What established links does NSFT have with local voluntary organisations that offer counselling that is not time limited, but currently receive no funding from the CCGs? Is it involved in discussions to try to secure money for these agencies that rely upon a large number of highly experienced volunteer counsellors to give the time and therapeutic support that many service users, past, present and future desperately depend upon? How does NSFT recognize the role of these organisations in the mental health of the community it serves?

As a secondary mental health service, NSFT does commission specialist psychotherapy from other agencies, which the Trust’s External Placement Panel (with support from CCGs) scrutinise and monitor. Counselling is commissioned from the Wellbeing service with very specific referral criteria and treatment and outcome expectations. There is joint working with 3rd sector organisation with Mind. The Criminal Justice Liaison Service has links with Julian Support, and NRP with the Matthew Project.

Beyond this, NSFT are not involved in provision or commissioning of counselling. The Trust does not have any formal links with any voluntary organisations outside the jointly commissioned services.

We are exploring whether we can make links with voluntary agencies with regards to suicide prevention. An ‘asset map’ is being created by the multi-agency suicide prevention group, the idea being to explore all means of supporting people at times of mental distress.

There is no current plan to formalise links with voluntary counsellors, but the Trust would be open to considering this as part of a wider understanding of what informal help is available.

The issue of ‘validating’ voluntary counsellors is a problem. There is no formal nationally recognised register that I am aware of outside the NHS. The risk is that ‘counselling’ can cover a very wide range of interventions, so we would need to have an idea of what we approve / recommend. It would be worth further discussions.

Bohdan Solomka – 8 January 2018
SU70: Women who have experienced domestic/sexual violence

What specialist resources and links with other agencies does NSFT have, and what plans does it have to enhance its provision for this group of women who present with mental health problems having experienced violence of this nature?

What training do mental health workers have with respect to looking after women who have been traumatised in this way?

Domestic abuse awareness is delivered as part of the induction safeguarding training. This will be enhanced due to inclusion of bespoke higher level training as part of the safeguarding adult training as of 1st January 2018.

The Trust supports the local Domestic Champion initiative in Norfolk with a number of champions across the organisation. There is not a similar initiative in Suffolk.

The safeguarding team provides information to both Norfolk and Suffolk MARAC processes, as well as providing expert consultation advice through the teams duty function.

This includes formulating safety plans plus referring and supporting service users to access the advocacy services in both counties (IDVA).

The Head of patient safety has been invited to attend the Domestic Abuse Board in Norfolk, and MARAC steering groups in both counties. In Suffolk health providers are represented at the Domestic Abuse Board equivalent by the CCG.

Dawn Collins – 7 December 2017

Submitted by Ginnie Benedettini on behalf of Service User Governors for Norfolk

STAFF GOVERNORS

Staff Governors

Staff74: Issues previously raised by staff governors and the CQC report

On the Representing Issues register between October 2016 and October 2017, Staff Governors raised the issue of inadequate resources on 5 separate occasions, concerns about electronic systems on 4 occasions and high caseloads / excessive workload on 3 occasions. Each time the responses implied that the situation was being monitored, actions being taken to address or that the situation was already improving. Yet, these are all issues that have not only been identified in the CQC report, they are considered so serious that showing improvements by March 2018 is now a must do requirement.
Please can we be advised how the Board is going to address what appears to be the devaluing of governor issues and take more serious account in the future of what staff tell us is the actual state of affairs on the front line?

I acknowledge that issues raised by staff governors around resources, Lorenzo and high caseloads feature in the CQC report. I would not accept that the Board has de-valued governor issues however I accept that we need to be more realistic about the impact of some of these issues.

Staffing challenges will remain but work is underway to have a consistent approach to caseload sizes across the trust to evaluate resourcing requirements; work is underway to evaluate the Lorenzo system which requires in the short term further improvements from the system provider and in the longer term a consideration of whether Lorenzo is the right system for the trust. Governors will be kept informed on these developments.

Gary Page – 13th December 2017

Staff75: Excessive workloads and CQC action plan

Staff governors are aware there have been urgent locality-spanning service line meetings in the last months of 2017 and involving managers and clinical and quality leads in the development of action plans to address CQC must dos. It is likely that many resultant remedial actions will impact on the day to day work of front line staff and be seen as more things to do on top of their already excessive workloads.

Please can we be advised:

1. How clinical staff working on the front line have opportunity to meaningfully engage with and influence CQC remedial work?

   A number of workshop sessions have been set up to allow front line staff to be involved with the CQC plans:-
   
   Workshops on our safety culture for ward staff are planned on a monthly basis December to March.
   Community workshops to address the CQC.
   Medical engagement sessions are due to start at the end of January.
   Quality summit for clinical staff on 11 January 2018.
   Monthly matron meetings

2. How staff will be supported to undertake essential CQC remedial work without it negatively impacting on existing clinical duties or morale

   How staff will be supported:-
- Staff have been seconded to the CQC remedial work, so that this does not impact negatively on their ‘day job’.
- Some additional resource has been agreed, for example 40 admin staff to free up clinical time.
- Additional project staff who will support the process and plans.

Julie Cave – 4 January 2018

Staff76: Referrals to Suffolk IDTs

Staff working in Suffolk’s Integrated Delivery Teams (IDTs) have raised a concern about the number of referrals transferred from the Suffolk Wellbeing Service directly to the IDTs for what appears to be reasons of risk like self-harm or suicidal ideation. These referrals are bypassing the Access & Assessment service and therefore are waiting for a service with incomplete assessments / risk assessments and require additional work by the receiving IDT. This situation would appear to exacerbate rather than mitigate risk.

Please can we be advised if the Suffolk Wellbeing Service works to the same criteria as the Norfolk wellbeing service?

If it is the same in both counties, please can we be advised how learning from similar problems that occurred at the commencement of the Norfolk wellbeing service is being applied in Suffolk?

If the criteria is different, please can we be advised how additional demand on the IDTs is being managed?

NORFOLK

Suffolk Wellbeing is a separate contract to Norfolk and as such has different criteria. Norfolk is commissioned to manage all of clusters 1 – 4 other than those requiring immediate admission to inpatient wards. Suffolk is commissioned to deliver to all of cluster 1 -3 and also offer interventions to people in clusters 4 and 7 whom are appropriate for IAPT interventions. Other service users in clusters 4 and 7 with higher levels of risk and acuity including requiring psychiatric interventions are expected to be managed by secondary care. There is no Psychiatry commissioned within the wellbeing service and so any clusters 4,5 or 7 that require psychiatric input will also need to be seen by secondary care.

A step up step down clinical process is in place and was agreed between both Wellbeing senior team and IDT management. (See attachment) If these individuals were to go via Access and Assessment we would effectively be subjecting them to duplicate assessments inappropriately and in so doing will delay them accessing suitable treatment. They will have been assessed by Wellbeing and this includes a risk assessment.
In terms of lessons being learnt I'm afraid I need some more detail on what the issues are that are perceived to have occurred at the lunch of the Norfolk service? If the concern is relating to lessons learnt following on from the recent Intensive Support Team visit to Norfolk then we are able to reassure governors that indeed a paper has been submitted to the Suffolk CCG outlining issues that will impact on Suffolk services if contract changes are not agreed. This is awaiting approval from the CCG but is expected to be agreed.

Debbie White – 5 December 2017

SUFFOLK

Collaborative work has taken place between the IDTs and Wellbeing to establish an agreed pathways to support the interface between the services – negating the need for referrals for intervention to go back through AAT which would serve to protract time access to treatment and result in multiple layers of assessment. The pathway also acknowledges and predicts the inevitability of service users stepping up or down between primary and secondary care without additional assessments if known to either of the services. This work has posed challenges brought about by the use of different clinical systems but the pathway provides a work-round to this.

Further actions that are in progress is a review of the wellbeing under 18 assessment template to try and ensure it captures and replicates more of the secondary care template to make the transition smoother, Wellbeing Service has also obtained ‘word’ documents of the core and risk and will be looking into wellbeing using these documents again to help IDT colleagues input if a patient is stepped up to handover patient information.

A recent survey monkey questionnaire has been issued to the relevant teams seeking feedback. This information is currently undergoing analysis and will form the basis of an overview report.

Interface meetings are now set up in east and west of the county to discuss cases that need a cross service agreement on next outcomes to avoid cases getting stuck in the system and to improve service user experience.

Pete Devlin – 19 December 2017

Submitted by Marcus Hayward on behalf of the Staff Governors

SUFFOLK PUBLIC GOVERNORS

Suffolk Public Governors

PSUF67: Carer Leads
1. There is a lack of a job role and job specification leading to inconsistent practice across the Trust and inconsistent preparation of care plans. Following the chair's helpful intervention we note that a job description is being addressed but with a lower salary band in Suffolk apparently due to the application of section 75 in Norfolk. If One Trust is to mean anything this salary anomaly should be urgently addressed and we seek assurance on this matter.

There is an issue not with a lack of Carer Lead job descriptions but with there being some inconsistency in respect of the content Carer Lead roles in different parts of the organisation resulting in different job descriptions and different bandings. The Head of HR has recently written to Locality Managers to identify who our Carer Leads are, their bands and to ask for their job descriptions. She is also leading a review in partnership with our Staffside Officer. The job descriptions are being compared to see what the key similarities and differences are. The plan is to then develop and evaluate a generic ‘Carers Lead’ job description that can be used consistently across the Trust. In some areas, broader responsibilities have been added to the role. We will therefore consider whether there needs to be a ‘Senior Carers Lead’ or similar if the roles are not unique to particular areas.

Dawn Collins – 15 December 2017

2. There is very little supervisory support or understanding of the Carer Lead's role by iDT managers. This lack of local leadership means inconsistent application of policy, poor and inconsistent support and variable reporting of performance information. We seek assurance that this situation will be remedied in order that the Carer Leads can feel supported and that CQC can be assured that the triangle of care and preparation of care plans are consistently implemented.

This issue has been taken up by Dawn Collins to discuss with her relevant colleagues to gain a resolution. Dawn Collins will provide a report on her findings to the CoG, via email as soon as this issue has been resolved.

PSUF68: Mental Health Services for Hoarders

Hoarding is now considered a stand alone mental disorder and can be a symptom of other mental disorders-says the recent "Self Neglect and Hoarding-Suffolk Multi Agency Policy and Practice Guideline", where mental health services are described as having "a crucial role".(para 5.8)

The well-respected Lofty Heights CIC organisation in Suffolk provides clearance and support services and works in partnership and, in their experience, individuals/families with a significant hoarding problem do very often have underlying and sometimes longstanding significant mental ill health. Indeed research indicates that 92% of hoarders who come to the attention of services have a mental health diagnosis.

To give an indication of scale, Lofty Heights have received 112 requests this year to help hoarders.

However, Lofty Heights have said it is extremely difficult for this client group to access secondary mental health services
Are the NEDs assured that NSFT will take up a place on the Suffolk multi agency panel?

Is the Board assured that there are effective arrangements in place to ensure multi-agency work and support for mentally ill hoarders, including access to specific mental health assessments and appropriate follow up mental health care treatment and support?

I can confirm that we were involved in the development of the policy and offered contributions by way of comments to the draft policy.

Our lead person for the multi-agency high risk panels is Margaret Little in her role as Deputy Operational Director although we have indicated that this may be delegated to Paul Clarke or Simon Leach as Locality Managers. The delegation is intended to match operational management attendance to the cases on the agenda, so we have a manager with direct responsibility and authority to make decisions on the cases coming through the panel.

Saranna Burgess, Head of Patient Safety and Safeguarding for NSFT has also been fully sighted on this initiative.

The first multi-agency high risk panel is scheduled for 4th January. We will have representation present.

Pete Devlin – 19th December 2017

PSUF69: Wellbeing Service Suffolk (WBSS)

We hear from the management of WBSS that service users will move directly to one-to-one therapies (Step 3), if they demonstrate the need. We hear stories that, on the contrary, all service users must first go through group therapies (Step 2). Please would you provide the statistics for this dispute e.g. numbers who go direct to Step 3, numbers who do Step 2 only, and numbers who do Step 2 and then Step 3. If statistics are not available, please, will NEDS say how they are assured that service users go straight to Step 3 when they demonstrate the need? In addition, we have been told by WBSS that there is a six month waiting list for 1:1 therapy.

The Wellbeing Service is following a stepped care model which is based on NICE guidelines. Those whose presenting problem is an anxiety disorder or low mood would start their treatment at step 2 – this includes courses, guided self-help via telephone or face to face, online guided CBT, employment support. They would be stepped up to appropriate step 3 treatment if the step 2 intervention has not been successful in achieving recovery as measured by PHQ-9 and GAD-7. These treatments include one to one CBT, IPT, EMDR, Counselling for Depression and Couples Counselling, and Mindfulness, Compassion focus and Confidence courses.

The need demonstrated for direct step 3 treatment is based on NICE guidelines, and would include presentations such as PTSD and Social Anxiety to which there is insufficient evidence base to suggest step 2 treatment. People may also be stepped up directly to step 3 treatment if they have already had step 2 interventions in their previous episodes in the service or if they would benefit from attending Mindfulness
course or Confidence course. The service is also able to provide direct access to step 3 couples’ counselling for depression if clinically appropriate.

There is a high demand for one to one step 3 treatment and currently the service does have a waiting list for this. Of the people currently waiting for step 3 one to one intervention 60% have been stepped up directly from the assessment and 40% have been stepped up following an intervention at step 2 level.

Clinical decision making is monitored and supervised, and all step ups are discussed in case management supervision to ensure the service follows NICE guidelines.

The data requested is not available in the way that it has been requested. Certainly though the full clinical pathway can be presented to governors at any point to provide clarity around how clinical decision making drives the decision as to who receives step 3 1:1 interventions.

Debbie White – 5 December 2017

PSUF70: Dragonfly Unit, Excellent practice and One Trust

The Dragonfly unit is a great success and an inspirational unit to visit. CQC recognised Dragonfly as outstanding. Although this unit is, of course, specifically for young people there must be many good ways of working and ideas that could be applied to adult units within the Trust. Is the One Trust theme being supported and progressed through examples such as this and wherever there is an opportunity to follow and adopt excellent practice? Does the Trust have a "Knowledge Management Process or a Register of Best Practice?"

There is no formal knowledge management process or register of best practice currently but this is something we can look at. Dragonfly have prepared a presentation to assist other areas in learning the lessons of how they achieved best practice and secure services are also sharing their experiences of the secure transformation programme which took them from inadequate to good.

Debbie White – 9 January 2018

Submitted by Martin Wright, Guenever Pachent, Andrew Good and Jane Millar on behalf of the Suffolk Public Governors

NORFOLK PUBLIC GOVERNORS

Norfolk Public Governors

PNOR47: Governor and NED representatives
The profile of the governors who are not partnership, service users or staff governors is mainly people of a similar age and status. Is NSFT attracting people who work during the day to become governors when all governor meetings take place during the day? How do NSFT enable this cohort of the public to be governor?

Similarly, are NSFT’s Non-Executive Directors representative of the general public? If not what is NSFT intending to do to make the interface between public and director level more representative?

We have worked hard to try and diversify the governor group and our NEDs. I appreciate that governor meetings occurring during the day does limit the attractiveness of these roles for working people. If governors wish to consider meetings taking place at different times I am open to the debate although mindful of the difficulties this may present for attendance by other staff.

Governors appoint NEDs and we have, as I mentioned, tried hard to diversify the group with limited success. However NEDs are active in the wider community which means we do hear from a wide range of people across both counties. Again any improvements the governors can suggest to help us in the future would be welcome.

Gary Page – 13th December 2017

*PNOR48: Wellbeing Service and referrals*

What assurance can NEDS give the governors and members of the Trust that the well being service is effective. Specifically, how can the referral system be improved to ensure that people who are in severe distress because of referrals being cancelled at short notice or just not followed up, are seen within an appropriate time scale?

I have discussed the governor’s issue with Andy Mack, Service Manager.

There is a National dataset for all Wellbeing Services that is available to all including the public and which essentially form the contract standards that Wellbeing must achieve. These provide the detail on how soon people are seen, how many people are seen and how well they respond to the treatment provided and in so doing provide assurance.

We are required to see 75% of patients for their first treatment contact within 6 weeks. In October 2017 we saw 83.2% of patients within 6 weeks and in November 2017 the number was 74.5%. We are required to see 95% of patients within 18 weeks and in October 2017 we saw 99.9%, and in November 2017 we saw 100% with an average wait of 31 days.

Regarding how the referral system could be improved. Again the timescales to which we work are set out by the contract and National waiting time standards and to provide anything above that requirement would require additional resources.

In terms of people having appointments cancelled at short notice this would only be because of staff sickness in general. All of our staff have individual performance
dashboards that look at their DNA and cancellation rates so that we are aware if any clinician is cancelling appointments inappropriately. All caseloads are also reviewed through clinical supervision to ensure that people are followed up. The service is a primary care service however and expectations can often be beyond what is commissioned.

People in the service can contact us online, by telephone, in writing anytime and as such wellbeing is one of the most accessible services.

Gary Page – 19th December 2017

**PNOR49: Complaints procedure**

Former patients are concerned that the current complaints procedures when in hospital are not appropriate for people who may be experiencing extreme trauma. There is a lack of accessible information to enable patients to understand the settling in process. Apart from their badges which can be difficult to read, there is nothing to tell patients who are staff/support workers. Would NEDS consider proposing to the board the use of coloured arm bands to denote staff (a suggestion from a former in patient) or to carry out a survey of inpatients pre-release to pick up any ideas / issues and deal with them?

Complaints/concerns regarding immediate treatment, when someone is very unwell, should be dealt with then and there on the ward. There is subsequently the opportunity to use the formal procedure if that did not achieve the desired outcome. Every ward should also have information regarding the advocacy service.

All wards should have patient booklets and it is planned that these will also be available on the internet when this is upgraded next year.
All staff of the Trust should be wearing a badge which gives their name job title and each ward has a picture board of all the staff working on the ward with their designation.

The Family and Friends survey operates in real time and should be offered to patients. This provides the opportunity to raise any issues which have occurred on the wards. There is currently a push to increase the number of the completed F&F feedback forms to provide a better picture of service user views.

Marion Saunders – 1 December 2017

**PNOR50: Communication with carers and families**

What steps are NEDs taking to ensure that NSFT increase the communication to carers and families of service users to ensure that there is sufficient knowledge about the support that they can access in their own community?

For Norfolk based carer enquiries, NSFT’s Patient Advice and Liaison Service (PALS) keeps a stock of the very informative ‘Norfolk Carers Handbook’ that is updated every year. This is sent to carers in response to queries to PALS related to carer support.
For Suffolk based carer enquiries, PALS keeps a stock of the Suffolk Family Carers leaflet ‘Living Fuller Lives’ that contains signposting information for further carer support in Suffolk.
Both the Norfolk Carers Handbook and Suffolk Family Carer’s, Living Fuller Lives leaflet are available on line and clinical services and teams also have the option to order stocks to include with information provided to carers.

Most services in Norfolk and Suffolk now have established Carer Lead posts. These are mental health practitioners whose roles is dedicated to the support of carers in their respective services lines and includes providing information about community support. Working with the carer leads, the Participation Team has just commenced compiling a spreadsheet of carer organisations throughout Norfolk and Suffolk. When completed this will be shared with service lines to further inform the support and information provided to carers.

We will also be considering in January and February, the outcome of:
1) the NSFT Carers Survey 2017 that is seeking feedback about carers experience of NSFT services (and was open from late November to 31st December)
2) the Triangle of Care stage 2 Community services self-assessments that captures team views on their delivery of the Triangle of Care standards.

Together these will inform actions in 2018 to further improve the support for and communication with carers.

Gary Page – 15th December 2017

Submitted by Sheila Preston and Hilary Hanbury on behalf of the Norfolk Public Governors
Introduction

In partnership, Ipswich Borough Council and Suffolk Coastal District Council have been successful in securing grant funding from the Department for Communities and Local Government to help those new to the street, or at imminent risk of rough sleeping to get the rapid support they need to recover and move on from a rough sleeping crisis.

As part of the bid application, local authorities had to demonstrate how they will:

- reduce the flow of new rough sleepers to the street, through more targeted prevention activity,
- ensure that people have a safe place to stay while services work with them to resolve the homelessness crisis.
- help new rough sleepers off the street and into independence, through more rapid crisis interventions and support to access and sustain move-on accommodation.

The project will deliver four key elements, to link together and achieve the aims of the grant funding, in conjunction with and complimenting existing pathways to settled accommodation in the two localities.

The funding awarded is to be used over the period from 01.04.2017 to 31.3.2018. One element of the funding is to be used to provide a dedicated Mental Health Link worker across the 2 districts.

Purpose of the service

Ensuring speedy and effective mental health intervention is critical for the 39% of people sleeping rough in the area. This will be provided by the Norfolk and Suffolk NHS Foundation Trust Access and Assessment Team. This new “wrap-around” intensive support will focus on mental health assessments and treatment for clients rough sleeping or at imminent risk of rough sleeping due to threat of eviction, acting as a liaison and gateway into mental health services and developing effective joint working practices with other services involved with the client group.

Following assessment, where a mental health need is identified, clients will be supported to receive treatment and access appropriate services, with a focus on stabilising clients to prevent eviction or enable taking up an offer of accommodation. Where no specific mental health need is identified, clients are referred to relevant partner services such as drug and alcohol recovery, learning disability or GP led interventions.

The service this will deliver an improved and effective gateway into the full range of mental health services for these clients. With mental health effectively addressed, clients can better...
plan for independence and will be able to sustain existing accommodation.

The MHLW will be working with and receive referrals from the Rough Sleeper Street Outreach, the STEP bed provider and the 2 housing options and housing needs teams, delivering services in the community and across the two borough boundaries. Referrals may also be made by supported housing providers and existing social landlords where accommodation is at risk.

**Delivery of the service**

The service and funding will be for 37 hours per week provided over the 24 months of the project. The service will be required to include early or late in the day to engage with rough sleepers and cover the relevant geographical areas.

The partner organisation will be expected to work closely with any relevant organisations in order to secure the best level of support for the clients and to include active membership of the project working group to link with the other elements of the project.

**Performance Outcomes and monitoring**

- A reduction in Rough Sleeping in both areas; to reduce the numbers found in the annual rough sleeper count by 50% over the 24 month term from the November 2016 rough sleeper estimate.

- Monitoring as required by DCLG, IBC and SCDC

- Stabilise individual’s lives to improve their accommodation pathways, their health and reduce offending behaviour.

- Reduce evictions from Supported Housing.

- Secure accommodation for service users that are currently homeless.

- Referrals received and assessments completed with follow up case work.

**Level of Funding**

The maximum level of funding available for this project over the 2 year period is £75,000 which will be paid in the form of a grant quarterly. The funding covers the Ipswich, and Suffolk Coastal areas.
Executive Summary:

The purpose of this report is to provide the Board with the Chief Executive Officer’s update on significant developments and key issues over the past quarter.

1.0 Norfolk and Waveney STP Chair visit:

1.1 Patricia Hewitt, the chair of the Norfolk and Waveney STP, and Antek Lejk, the lead Executive for the STP, visited the Trust on 3rd November to discuss mental health and the issues facing the Trust and to consider how the STP can support the Trust over the next few months.

1.2 Ms Hewitt and Mr Lejk met with a number of members of staff, including the Recovery College team, Wellbeing teams and visited the wards on the Hellesdon Hospital site.

1.3 Following the visit Ms Hewitt said she was very impressed by ‘the dedication, enthusiasm and compassion’ of everyone she met.

2.0 Care Quality Commission:

2.1 The summary report of actions was submitted to the CQC on 14th November. The report was presented at the Oversight and Assurance meeting on 15th November where stakeholders from a number of organisations were represented. This includes the CQC, NHS Improvement, NHS England, Suffolk CCGs, Norfolk and Waveney CCGs, the County Council, Health Overview and Scrutiny Committee, Healthwatch, representatives of Service Users and Carers, Staffside, the GMC and Trust Governors. These meetings have been scheduled on a monthly basis with the next meeting on 9th January 2018.

2.2 Monthly calls have been established with the Head of Inspection to discuss progress against the plan and to discuss any issues or concerns.
3.0 **New appointments:**

3.1 You will be aware that interim appointments have been made namely Daryl Chapman, Director of Finance and Dawn Collins, Director of Nursing.

3.2 In addition to these roles we have appointed Dearden HR to provide external advice to the Board of Directors on workforce issues. Mark Gammage of Dearden HR will be with us over the next few months.

3.3 Also Josie Spencer has started with us on 2nd January 2018. Josie is on secondment from Coventry and Warwickshire Partnership Trust as Chief Operating Officer and Deputy Chief Executive.

4.0 **Communications:**

4.1 The second live broadcast from the CEO to staff took place on 16th November. This takes the form of a brief introduction and then is open to questions from staff. We plan to do this on a monthly basis. A further live broadcast took place on the 20th December 2017 with Dawn Collins and Bohdan Solomka. Both broadcasts have been received very positively by our staff.

4.2 The Senior Management Engagement Forum took place on 14th November with discussions on the key themes within our CQC improvement plan: leadership, staff engagement and culture. As part of our engagement with the local media the EDP were invited to participate. Positive media coverage was received.

4.3 We also held a very successful Christmas Fayre for charitable fund raising, similar to the summer fete. This event was a fantastic success raising nearly £3.8k and we were delighted to see some of our governors attend the event. Our next fund raiser will be in the summer so please note in your diary 14th July 2018.

4.4 The EDP will run a ‘Facebook Live’ interview with the Chief Executive on 22nd January 2018 at 1pm.

4.5 The Medical Director, Director of Operations (Norfolk & Waveney) and I attended the Norfolk Health Overview & Scrutiny Committee to brief the Committee members on the CQC plan. The local CCGs were also represented. The overall meeting went well and feedback is that our team was professional, knowledgeable and addressed the questions in a transparent and open manner. The Suffolk HOSC is in January.

4.6 The GMC Chief Executive, Charlie Massey, visited the Trust on 4th January. NSFT is the first Mental Health Trust that he has visited. He offered support and commented how pleased he was to be welcomed by the Trust which was unusual in the circumstances of special measures.

5.0 **East London NHS Foundation Trust (ELFT)**

5.1 ELFT has been appointed as our ‘buddy trust’ as part of the special measures
package of support. Jonathan Warren (Director of Nursing) and Richard Evans (Medical Director) have spent some time with us, meeting the teams and assessing the ward environments.

5.2 We have agreed that ELFT will work with us on the following areas:

- Nursing structures and practice
- Governance arrangements
- Service user and carer involvement
- Clinical leadership
- Quality Improvement
- Estates strategy and processes, including clinical ownership

6.0 CEO visits:

6.1 In the past months the following visits have taken place to:

- The Coastal IDT team at Walker Close in Ipswich where they explained about the service they provide, what they are proud of, some of the frustrations and where we can make things easier for staff.
- The Crisis Team at Hellesdon Hospital in Norwich where I listened to their plans for their services and discussed how we can improve the environment in which they work.
- The team at Wedgewood House, Bury St Edmund, to tour the wards and talk to staff about their concerns.
- The ‘Finding our Way’ spirituality event in Great Yarmouth which I was invited to open.

7.0 Environment Scan August/September 2017

Environmental Scan November 2017

<table>
<thead>
<tr>
<th>External</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>National</strong></td>
<td><strong>Local System</strong></td>
</tr>
<tr>
<td>NHSE putting pressure on government re funding ahead of Budget (22 Nov)</td>
<td>Norfolk and Suffolk STPs told to increase GP WTEs by 174 by 2020</td>
</tr>
<tr>
<td>Plan for MH Trusts to face regulatory action over out of area placements</td>
<td>Carnall Farrar appointed by Suffolk STP to develop an Accountable Care System bid.</td>
</tr>
<tr>
<td>Carter Review suggests mental and community health services could save £181m through combining corporate services.</td>
<td></td>
</tr>
</tbody>
</table>
### Internal

<table>
<thead>
<tr>
<th>Trust-wide</th>
<th>Locality/Service-specific</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Action plans underway across the Trust to meet CQC requirements.</td>
<td>- Senior operational managers seconded to lead CQC action plan service lines across the Trust</td>
</tr>
<tr>
<td></td>
<td>- CGL (Care Grow Live) have been awarded the Norfolk Alcohol and Drug Behaviour Change Service contract, which will replace NRP from April.</td>
</tr>
</tbody>
</table>

Julie Cave  
Chief Executive
Executive Summary:

This paper notifies the Council of Governors of the progress of the Overview and Assurance Group to date.

Overview and Assurance Group

Membership: The OAG, chaired by the Delivery and Improvement Director of NHSI is attended by Executives from NSFT, with representation from a wide range of stakeholders, including CCGs, Healthwatch, HOSC, County Councils, NHSE, HEE, CQC, GMC, Trust staff, Carers, Service users, the Buddy Trust, Improvement Director and Lead Governor. Representation is from both counties and the monthly meetings alternate between Ipswich and Norwich.

There have been two meetings to date:

Meeting 1: November 2017

Review and agree terms of reference
Oversight group purpose and function
Presentation of the inspection findings from the CQC
Role of the Improvement Director and risks to delivery
Review of the Trust’s Quality Improvement Plan and supporting governance.

Key Objectives of the oversight group:-

- Agree the Trust’s quality improvement plan and monitor progress
- Work together to gain the required assurance of sustained quality improvement
- Work together to support and challenge the Trust towards safer patient care
- Reduce the burden of multiple contacts, multiple plans and requests for the Trust
- Understand the Trust’s risks and support riskmitigation and take action as required
- Coordinate and organise additional support to ensure delivery of safe services
- Work collectively in line with NHS Constitution values
Summary:

Following the CCQ presentation on the findings of the inspection which placed the Trust in special measures the Trust presented the Quality Programme Board governance structure and the systems surrounding delivery, progress, evidence and accountability. Leadership roles were identified throughout the core services with fortnightly monitoring of progress. The QPB meets weekly. The Improvement Plan includes the four systemic long term issues (leadership, medical engagement, staff engagement, culture ) and reports on the S29A issues reported by the CQC inspection with their action plans.

Meeting 2: December 2017

Agreement of the Terms of Reference
Progress report from the Improvement Director
Review of a recent inpatient death
Update on progress of the Quality Improvement plan
Deep Dive 1 – well led, board development, divisional / locality leadership.

Summary:

The meeting agreed the Terms of Reference and received an update on the Quality Improvement Plan. This identified the processes which underpin the Plan in terms of assurance and considered measures for success and risks to delivery.

The Improvement Director (Philippa Slinger) reported on progression and the need for sustained change as well as short term solutions. There is a much activity being undertaken however service users and carers were outwith the loop. This has subsequently been considered.

There was discussion on four areas of concern; Lorenzo, Risk assessments, Waiting times and Communications. There was no December Board meeting planned therefore there is a potential delay in information being received by the OAG.

The first Deep Dive addressed ‘well led, board development and divisional and locality leadership’. It identified key issues, what is trying to be achieved and the strategy to underpin the changes. The current Board membership was explained with the recruitment process. There was an emphasis on a different approach to achieving assurance and how success will be measured.

The second Deep Dive, ‘Workforce safety and safe staffing’, was deferred to the next meeting.

Lead Governor Overview:

It was agreed at the Planning and Performance meeting in November that the Improvement Plan Coordination subgroup would undertake a teleconference monthly to monitor the performance of the Trust in relation to meeting the requirements of the CQC, and that this group (IPC3) would report to the Council of Governors. The initial meeting identified that the group was seriously hampered by the lack of information and that there was no input from Trust personnel. This has been rectified and Robert Nesbitt will chair the meetings as the PMO is within his portfolio. There will be a January Board meeting therefore the updated Improvement Plan should be available for scrutiny. Further involvement and engagement of the Governors in assuring improvement needs to be clarified and addressed.

Recommendations

Governors are asked to note the report.

---

Background Papers / Information – OAG ToR

<table>
<thead>
<tr>
<th>CoG Public – 11 January 2018</th>
<th>Version 1.0</th>
<th>Author: Catherine Wells</th>
</tr>
</thead>
<tbody>
<tr>
<td>Governor Update on OAG</td>
<td></td>
<td>Department: Corporate</td>
</tr>
<tr>
<td>Page 2 of 2</td>
<td>Date produced: 2 January 2018</td>
<td>Retention period: 20 years</td>
</tr>
</tbody>
</table>
1. Purpose

The Oversight Group’s principal aim will be to support and challenge continued quality improvement in the Trust and provide the system with a collective oversight and assurance of the progress, thus ensuring sustained progression towards safer patient care.

The Group’s timespan will mirror the duration that the Trust remains in special measures which commenced 13 October 2017. The inaugural meeting will occur during November 2017.

The Group is accountable for gaining assurance directly from the Trust Board for the delivery of the quality improvement plan. The oversight mechanism does not replace the statutory accountabilities of the Trust or partner organisations. The key purpose of oversight is to add value to the organisation and provide stakeholders with the oversight forum of the improvements as set out in the quality improvement plan. The group should also be made aware of current and emerging risks to the delivery of the quality improvement plan.

The meeting will be aligned to the principals of the NHS Constitution in all aspects.

The membership is expected to share the outcomes and progress with their own organisations as required.

The roles of each organisation are outlined:

| NHS Improvement |  
|-----------------|--------------------------------------------------|
| Chair the group. |
| Work with all parties to ensure effective oversight of quality improvement plan. |
| Oversee the assessment of the Trust specifically within patient safety and delivery of improvement and change. |
| Initiate board and governance arrangements and improvements. |
| Engage and communicate with relevant stakeholders. |
| Work with partners to drive quality improvement. |

| Improvement Director |  
|----------------------|--------------------------------------------------------------------------------|
| Support and challenge the Trust Board to drive improvement and actively work in the well led space challenging governance and leadership assumptions and behaviours. |
| Draw on resources from the buddy Trust to support quality improvement. |

| Trust Executives and a Non-Executive Director |  
|-----------------------------------------------|--------------------------------------------------------------------------------|
| Respond effectively to the support and challenge. |
| Implement the required changes to service. |
| Evidence the change in using an outcomes format at each meeting via the quality improvement plan. |
| Work with partners to drive quality improvement. |
| Develop accompanying metrics to the quality improvement plan to monitor outcomes. |
| Ensure the patient voice contributes to improvements. |
| Healthwatch - Norfolk and Suffolk | • Share views of service users, carers and local population with the aim of driving improvements in care.  
• Ensure that the patients and wider family voice is firmly embedded within the service improvements.  
• Work with and support all parties to ensure effective oversight of improvements in care.  
• Work with partners to drive quality improvement. |
| Norfolk and Suffolk CCGs | • Ensure that commissioned services Trust meet the quality requirements of the contract.  
• Manage risks and mitigations within the contractual arrangements and ensure pace in quality improvement.  
• Provide progress reports to the quality surveillance group.  
• Lead commissioner engagement in respect to Trust issues and outcomes on behalf of the local population.  
• Work with partners to drive quality improvement.  
• Engage and communicate with relevant stakeholders. |
| Service user representatives | • To ensure that the work and priorities have service users interests and perspective at the centre. |
| Borough Councils | • Provide intelligence and information on quality and safety concerns and inform the process of continuous improvement.  
• Link with internal processes such as OSC  
• Engage and communicate with relevant stakeholders. |
| NHS England – East and including Specialist Commissioning | • Lead commissioner engagement in respect to NHS England and manage risks and issues within commissioning.  
• Engage as a direct commissioner of services (primary care and specialist commissioning) and to inform the oversight group on relevant issues.  
• Work with partners to drive quality improvement.  
• Engage and communicate with relevant stakeholders. |
| Health Education England – East of England | • Commissioner of education for all trainee professional groups.  
• Support all HEE funded learners to maximise their experience whilst at the Trust.  
• Support the Trust with workforce planning activities. |
| Care Quality Commission | • To ensure that timely progress is being made and gain interim assurance. |
| Trust staff side | • To ensure that workforce views are fully considered. |
| General Medical Council | • To contribute to the quality improvement work focussing on modernising medical practice to improve patient outcomes. |
In addition it will be the responsibility of each member representative to ensure that information and reporting on progress and outcomes is disseminated to appropriate individuals within their own organisations and back into the oversight group. All parties will ensure relevant wider stakeholder engagement is in place and sustained throughout the life of the group.

2. Key Objectives
The key objectives of the oversight group will be to:

- Agree the Trust’s quality improvement plan and monitor progress.
- Work together to gain the required assurance of sustained quality improvement.
- Work together to support and challenge the Trust towards safer patient care.
- Reduce the burden of multiple contacts, multiple plans and requests for the Trust.
- Understand the Trust’s risks and support risk mitigation and take action as required.
- Coordinate and organise additional support to ensure delivery of safe services.
- Work collectively in line with the NHS Constitution values.

Members of the Trust shall be in attendance at each meeting.

3. Chairmanship
The Oversight Group will be chaired by NHS Improvement’s Delivery and Improvement Director. The vice chair position will be another regional NHSI representative at director level.

4. Governance and Reporting Arrangements
Statutory governance arrangements remain within each organisation. Each organisation will be required to report back to their respective boards and governing bodies on progress. Each organisation is responsible for the delivery of improvements in care. The group does not replace any of the respective statutory board’s authority.

5. Frequency
The first meeting will occur during November 2017 and then monthly until such time as special measures status has been lifted.

6. Administration
Administration will be managed by the Trust in partnership with NHSI the intention that:

- Notes, actions and key messages from each meeting shall be circulated to members one week after the meeting has taken place via email.
- Meeting papers shall be circulated to members at least three working days prior to each scheduled meeting via email.
Executive Summary:

This paper notifies the Council of Governors of the progress of the Suffolk and North East Essex STP at the meeting on Monday 13 November 2017.

The general tone of the meeting was very positive. There were around 40 people present with very little representation from the local authorities. A good number of governors from the 3 acute hospital trusts and for NSFT myself, Andrew Good, Gary Page and Pete Devlin.

This STP is considered advanced with the objective of moving towards an ACS (Accountable Care System) by April 2018. The message that came over strongly at this meeting was that the STP areas are very much the footprint on which health services will be developed. The STPs are considered to be "organisations without walls", an interesting but hard to envisage concept. The planning stage of the STP has passed and the "P" now represents Partnership.

Nick Hulme the CEO of Ipswich and Colchester Hospitals gave a very forward looking speech including vision for much improved, efficient health services. This STP has already achieved new capital funding for physical health projects in Clacton and Newmarket. They have also appointed a CCL for mental health - I am not clear what the scope of this role is. Rationalisation of CCGs within the next 12 months was also mentioned.

Some serious concerns remain specific to this STP:-

1. The STP is dominated by the influence of Ipswich and Colchester hospitals and
the relative importance consequently of mental health provision and issues.

2. The geographical issues are considerable - Trusts, CCGs and STPs; all with different footprints.

3. The local authorities seem disinterested in this STP.

4. No mention of how Governors will interact with STPs in the long term?

3.0 Recommendations

Governors are asked to note the report.

Martin Wright
Suffolk Public Governor
25 November 2017

Background Papers / Information

None
1. Background

1.1 Around 50 people attended this event. The only other Norfolk and Suffolk Trust represented was the Queen Elizabeth Hospital. This is a summary of the day together with some points we feel that NSFT should consider.

2. Policy update

2.1 We had an overview of the current and likely future position on political context, finance and performance, STP’s and Accountable Care Systems, workforce and regulation.

2.2 Key points:
- lack of Government appetite for further NHS or Social Care reform
- severe financial pressure and challenges to national performance targets
- the emerging importance of STP’s (moving from Plans to Partnerships) and ACS’s and the potential important role of governors in helping to engage with the public on these
- lack of effective workforce planning
- 53% Trusts ’require improvement’
- emphasis on ‘taking control locally’, but sometimes contradictory messages from the centre on this and a lack of clear understanding and strategy about what STP’s are and will become.

3. CQC

3.1 We had a presentation about the new approach to inspection.
Key points:
- CQC moving towards using different methods and timing of inspections to include focusing on working with Trusts on innovations, quality of care and how well resources are being used (in conjunction with NHSI)- latter to roll out to Mental Health Services from 2019.
- Inspections will focus on services requiring improvement, be smaller and more focused and more will be unannounced
- Trusts will be asked to rate themselves
- Reports will be shorter, produced more quickly and with a fuller explanation of how conclusions reached
• CQC interested in attending CoG and other Governor meetings, likely to be spread over a year
• There will be an Annual Review with Trusts to determine where to focus inspection activity.

4. Staff governors

4.1 Howard Tidman and Zeyar Win attended the morning staff governors only session. Challenges and opportunities for staff governors were identified by discussion groups. Whole group discussion covered what is working well, what is not working well, what can be improved and how NHS Providers can help staff governors. It was noted that other Trusts have a larger number of staff governors, even though the total number of staff were less than NSFT.

4.2 The presentation of a case study at one London Trust showed a plan for wider use of secured, separate social media for the Council of Governors, supported by the Trust, so that Governors could engage more effectively with their wider constituencies.

5. Holding to account

5.1 We had a presentation on the approach being taken in Lincolnshire Partnership NHS FT.

5.2 Key points:
- The governors held a review of how well they were holding NED’s to account and concluded there was a need for change; they tended to focus on the Executive Team Performance Report and found themselves doing the NED job rather than holding NED’s to account.
- They have developed a new approach after a Joint Board-CoG Development Day to explore roles and responsibilities together, focusing on how to best enable each to fulfil their key duties. They considered structural and behavioural changes and developed a new approach based on this which was trialled for 6 months, with proper evaluation.

5.3 Their system now features:
- **Balance of governors**- 8 public (elected from specific localities), 13 Service users/Carers, 7 staff, 7 appointed/stakeholder
- **Evalu8**- they use this tool to carry out self evaluation- this includes effective in mapping improved performance of NED’s etc.
- **Specially written Performance Report for CoG** (shorter and more summarised than the one that goes to BoD) which focuses on assurance, presented by NED’s and questions to NED’s on how they are getting assurance.
- 'Representation Committee' chaired by Lead Governor and held in public, with Chair, senior independent NED, plus Trust Secretary and Governor Support Officer attending; This enables scrutiny, focus on Governor priorities and links to members and their constituencies. It can call in Executive Team and reports to CoG.
- **Joint BoD- CoG meetings in private** structured to tackle critical strategic work and which enables early and real influence from Governors on key strategies.
- **Nominations and Remuneration committee- outcomes to CoG in public domain**

5.4 What this means-
- NEDs effectively held to account, expect challenge from governors and need to evidence their assurance, earlier engagement with governors to enable influence and contribution-and trusting relationships built.
- Governors not a rubber stamp, have high level engagement, focus on holding NED’s to account, clarity of role and improved governance and Trust performance.
5.5 Points for NSFT to consider:
1. Balance of governors of different types and more specific geographical basis for public governors.
2. The nature of information and reports put to CoG and committees- specially written with a focus on what governors need to look at and how, with back up, more detailed information available via BoD papers etc..
3. Joint BoD - CoG development day to explore roles and responsibilities.
4. Regular joint BoD - CoG meetings to have early discussion of critical strategic issues and build trust.
5. Explore the potential of the Self-evaluation tool ‘Evalu8’

6. Engaging members and the public

6.1 We had a presentation from Northamptonshire Healthcare NHS FT. This covered the work of one governor and the associated governor Committee in reviewing their approach to membership and ways of improving engagement. There were several similarities to the approach now being taken in NSFT.

6.2 Key points included;
- seeking to ensure that membership is owned by the whole Trust and not marginalised as a governor only responsibility
- expanding the use of appropriate social media as a means of contacting and hearing form members, especially younger people
- recognising different levels of membership involvement and being clear on this
- ‘rebranding’ membership and the offer
- holding regular ‘campaigns' to engender interest and feedback on specific topics of relevance to the Trust
- tailoring events and engagement activities to the demographic and other characteristics of the population
- encouraging more effective involvement by the various stakeholders in mental health
- identifying various ‘Recruitment Champions’ to seek out members especially in underrepresented groups
- key targets including increasing overall membership, seeing member involvement as a key part of the Trust’s overall approach to Participation and public involvement’, getting all constituencies involved though appropriate approaches and communication methods.

6.3 Points for NSFT to consider:
1. Ensuring that member involvement is seen as a central, Trust-wide responsibility, not a marginally important function handled by governors.

2. Tailoring communication and engagement methods to different constituencies and population groups, including social media and other online methods.

3. The responsibility of all governors, supported by the Communications team and others in the Trust to play an active part in recruiting and engaging members for their constituency groups and more widely.

4. Identifying ‘Membership Champions' to aid recruitment.

5. At the right time, consider rebranding Trust membership, perhaps to ‘Trust partnership’, once the practical offer has been improved through more effective engagement etc.

Nigel Boldero – Chair, Norfolk Public Governor - 4 October 2017
Joint working agreement for governors, non-executive directors and the wider Trust

30 November 2017 (BoD approved)
11 January 2018 (for CoG approval)
1. Purpose and status

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

Although the governors’ duty to ‘hold to account’ is set out in law, it is not defined anywhere. NHS Improvement (previously known as Monitor) acknowledges that there is no ‘right way’ to hold non-executive directors to account and it recommends that a jointly agreed process be developed.

The document sets out the structures, flows of information, relationships and behaviours that underpin good governance for governors and non-executive directors working together.
Once agreed by governors and directors it is intended to complement and put into practice the legal and governance framework.

2. Legal and governance framework

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

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

S.151 (4)

"The general duties of the council of governors are—

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

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

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

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

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

NHS Providers offer this definition of accountability:

“To be accountable is:

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

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

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

The formal exercise of governors’ duties is carried out at the Council of Governors’ (CoG) general meetings as set out in the Constitution. The Council of Governors meets across the two counties six times a year. Four of these meetings deal with Council of Governor formal business. Two of these meetings have a smaller business component and focus on member engagement. Governors need to commit to attend these meetings which usually include a development session. Each meeting normally lasts a full day (c. 10:00 to 16:00). In order to ensure that the meetings are accessible to members and the public, venues usually have microphones and are accessible by public transport. Whilst these meetings are sufficient to make appointments and receive reports, this is not frequent enough to fulfil an effective scrutiny role nor to capture the interests of the wider public.

The CoG therefore delegates some functions to subgroups which are empowered by their approved terms of reference to act on behalf of the full CoG. The CoG has approved meeting standards which also apply to its subgroups.

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

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

II. Performance monitoring functions

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

The purpose of this scrutiny is not to duplicate the work of the BoD in challenging information, but to gain assurance on the performance of the board in doing so. The focus of questions from governors should therefore be “What have NEDs done to examine this issue and to ensure that the board addresses it?”, and not “How can this performance be improved by governors?”

In order for governors to be able to fulfil their role the Trust must supply subgroup members with information that is up-to-date, accurate, relevant and timely (i.e. received in sufficient time for governors to read and consider). At least two non-
executive directors will normally attend each Planning and Performance Subgroup meeting with NED attendance varying over the course of the year. Their purpose is to answer questions put by the subgroup, either at the meeting or in writing within a given timescale. As this subgroup primarily looks into the organisation it provides a valuable opportunity for governors to hold NEDs to account.

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

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

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

The Improvement Plan Coordination subgroup (IPC) was set up by governors when the Trust entered special measures in 2015. The IPC continued after the Trust left special measures in 2016 and the role of the subgroup will be reviewed to consider the response to the Trust re-entering special measures in 2017.

III. Planning functions

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

Engaging with members and the wider public is led by with the work of the Trust Member and Governor Development Subgroup (see 3.IV below).

The Council of Governors express a view on the Board of Directors’ forward plans. Governors should be involved throughout the planning cycle and should not be presented with plans as a ‘fait accompli’. The Planning and Performance Subgroup informs and tracks the development of the plan and has been delegated authority to lead on the forward plan to ensure that it receives appropriate attention. The subgroup also leads on the CoG role in relation to the Quality Account.

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

IV. Trust Member and Governor Development Subgroup

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

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

The current Trust membership totals around 16,000 (including staff) of whom around 3,500 public, service user and carers have email addresses. The Trust’s Governor and Membership Development (TMGD) sub group leads on reviewing the Trust’s Membership Strategy, including what is expected of members and what they are offered, how they are communicated with and engaged. Current communication methods include the Trust’s Insight Magazine, email newsletters, member events and forums.

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

The Chair of the Trust is the lead as far as Trust membership and governor development is concerned. Regular contact between the Chair of the TMGD sub Group, Trust Chair and Lead Governor on membership and governor development matters and occasional attendance by the former two at TMGD sub Group meetings will ensure ownership of membership and governor development matters by the Board and their coordination with other Trust strategies.

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

V. Governor attendance at BoD meetings in public

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

For governors, these meetings provide an important opportunity to assess the performance of the BoD, to consider how the NEDs fulfil their functions within it, and to gain understanding of the BoD’s decisions for onward sharing with service users, carers, staff and stakeholders as appropriate when out and about. The role of the governor at a BoD is therefore as an observer. Whilst the Chair may invite questions and comments from governors, the function of these is to assist governors in their role rather than for governors to act as an additional member of the BoD.

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

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

VI. Governor attendance at other BoD committee meetings

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

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

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

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

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

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

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

Separate guidance for governors on visiting services is available.

VIII. Director attendance at CoG meetings

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

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

There are several ways to request information.

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

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

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

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

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

X Governor feedback on services

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

4. Working relationships and behaviours

i. Support for governors to carry out their role

The TMGD sub group produces an Annual Training Plan for governors largely based on an annual self-evaluation of governors, alongside governor evaluations by Service Users and Carer members and Trust directors. This includes annual induction sessions for all governors. NSFT has a legal duty to ensure that governors are equipped with the skills and knowledge that they need to discharge their duties. The training and development needs of governors are overseen by the Trust Member and Governor Development Subgroup.
The Trust organises annual induction sessions for all new governors and arranges development sessions for all governors throughout the year on specific topics. So far as possible these are held on CoG days. Additional sessions between CoG days can also be arranged at the request of the Trust Member and Governor Development Subgroup.

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

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

The Chair of the Council of Governors, who is also Chair of the Board of Directors is available for one to one conversations, and holds regular meetings with relevant governors to discuss matters of interest or concern in Norfolk and Suffolk, respectively.

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

ii. Objective setting and appraisals

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

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

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

iii. Promoting good relationships

Effective relationships between governors and directors are promoted by all parties:
• Acknowledging that governors and directors have the same goals but different responsibilities.

• Accepting that constructive tension is required in any accountability structure and that an effective relationship is neither cosy nor adversarial.

• Fulfilling but not exceeding their remits.

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

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

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

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

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

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

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

v. The role of the lead governor

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

1. Authority

1.1 The Council of Governors of the Trust (‘the CoG’) has established a committee of the CoG to be known as the Nominations Committee (‘the Committee’) which shall have the following terms of reference.

1.2 The committee is authorised by the CoG to act within its terms of reference. All members of staff are requested to cooperate with any request made by the committee.

1.3 The committee is authorised by the CoG, subject to funding approval by the Board of Directors, to request professional advice and request the attendance of individuals and authorities from outside the Trust with relevant expertise if it considers this necessary for the exercise of its functions.

1.4 The committee is authorised to request such internal information as is necessary to the fulfilment of its functions.

1.5 If, appropriate, the Nominations committee will liaise with the Transformation Programme Board over any relevant aspects of the Quality Improvement Plan that relate to the Committee’s work.

2. Membership

2.1 The Senior Independent Director (SID) of the Foundation Trust will chair the Committee. The Lead Governor will chair the meeting should the SID be unable to attend or the remuneration or appointment of the SID is to be discussed.

2.2 Arrangements for selecting members of the committee:

2.2.1 The core voting members of the committee will consist of:

- The SID
- The Lead Governor
- 2 public governors (Norfolk)
- 2 public governors (Suffolk)
- A Service User governor
- A Carer governor

- A partner governor. If no partner governor is available an additional public governor from the other county to the lead governor (i.e. if lead governor is from Norfolk the additional governor would be from Suffolk public constituency and vice versa) will be elected.
• A Staff governor
• The Chair of the Council of Governors / Board of Directors

2.2.2 With the exception of the lead governor who is always a voting member, the remaining voting governor members of the Committee will be elected by the CoG from amongst the Governor members. The election will be administered by the Trust Secretariat.

2.2.3 The election process will take place every two years with the process starting in September 2016.

2.2.4 Governors will be asked to nominate themselves and where there is a contested seat they will be asked to provide a short written account of the qualities they bring to the role. Governors for that constituency will then vote for their nomination committee representative(s). Where there is a tie a decision will be made by drawing lots.

2.2.5 Where a seat becomes vacant between two year election cycles, an election process may take place to fill the vacancy for the remainder of the two year period. The decision as whether and when to run an election mid-cycle will be made by the nominations committee.

2.3 No Director or Chair shall be involved in deciding his / her own reappointment or remuneration and they must declare an interest and leave the meeting at that point.

2.4 If the SID is standing for appointment as the Chair of the Foundation Trust, another Non-Executive Director should chair the Committee.

2.5 The CoG shall keep the membership of the Committee under regular review and having regard to any potential conflict of interest of any member may remove an existing member and or appoint an additional independent Non-Executive Director to be a member of the Committee at any time.

3. Nomination Role

The committee will:

3.1 Periodically review the balance of skills, knowledge, experience and diversity of the non-executive directors, and having regard to the views of the board of directors (BoD) and relevant guidance on board composition, making recommendations to the CoG as appropriate.

3.2 Review the results of the board evaluation that relate to composition of the BoD and take these into account in planning recruitment.

3.3 Review annually the time commitment required from NEDs.

3.4 Consider succession planning for NEDs, taking into account the future needs and challenges of the organisation and the make-up of the BoD as a whole.

3.5 Recommend to the CoG proposed arrangements for NED and Chair succession planning.

3.6 Keep the leadership needs of the Trust under review at NED level to ensure the continued ability of the Trust to operate effectively within the health and social care economy.

3.7 Recommend to the CoG a robust and transparent process for Chair and NED recruitment, and lead on the implementation of this process.
3.8 Review the person specification for each recruitment exercise updating it to take account of the skills and experience required and the balance of skills on the BoD and being clear about the time commitment required to fulfill the role.

3.9 Identify and nominates suitable candidates to fill vacancies for appointment by the CoG.

3.10 Ensure that a proposed NED’s other significant commitments are disclosed to the CoG before appointment and that any changes post-appointment are reported to the CoG as they arise.

3.11 Ensure that a proposed NED’s current or known future business interests are disclosed to the CoG prior to appointment, and that the CoG are kept aware of any changes to these interests.

3.12 Advise the CoG on recommendations in relation to re-appointment of non-executive directors on the basis that there will normally be market-testing for a position after two three year terms, unless there are over-riding reasons for re-appointment for a third.

3.13 Advise the CoG in relation to any matters relating to a removal from office of the Chair or a non-executive director, and take the lead on managing any such processes prior to a recommendation being made to the CoG.

3.14 Consider NED membership and Chairing of appropriate BoD committees, particularly the Audit and Risk Committee, and advise the Chair of these views so as to inform his / her decisions.

3.15 Lead on the governor role in the board of directors’ external and internal evaluation processes, including subsequent additional aspects such as the development plan.

3.16 The nominations committee will oversee arrangements for the election of the lead governor when required.

4. Remuneration Role

The committee will:

4.1 Review the remuneration and terms of service policy (including review and approval of the non-executive director expenses payment policy) for non-executive directors, taking into account the views of the Chair (except in relation to the Chair’s remuneration and terms of service), the Chief Executive, and any relevant external advisors.

4.2 Make recommendations to the CoG on any changes to the remuneration and terms of service of non-executive directors for decision.

4.3 Agree a process for the performance appraisal of non-executive directors and the Chair, and receive and evaluate reports on these appraisals.

4.4 Adhere to relevant legislation and regulations and have regard to best practice in setting remuneration levels for the Chair and non-executive directors,. The remuneration package is to be sufficient to attract, retain and motivate individuals with the skills and experience required to lead the Trust without paying more than necessary to achieve this end, and at a level which is affordable for the Trust. It will reflect the time commitment and responsibilities of the roles, take into account appropriate benchmarking and market-testing, and be sensitive to pay and employment conditions elsewhere in the trust.
5. **Quorum**

5.1 A quorum shall be one non-executive director and three Governors, but no member shall be able to form part of the quorum for or be present at the meeting at a time when its business concerns the search for or identification or nomination of candidates to fill the vacancy which will arise on that member ceasing to hold office.

5.2 No member shall form part of the quorum where their remuneration is under discussion as they will not be present for that part of the meeting.

6. **Attendance**

6.1 The following persons shall attend meetings of the Committee:

   1. the Company Secretary or Deputy to advise on governance matters, take minutes of the meeting and provide appropriate administrative support to the Committee;
   2. internal or external advisers as appropriate;

But no person shall be present at the meeting at a time when the Committee is discussing any office or position held by that person or for which that person might be a candidate or applicant if it is or were to become vacant.

6.2 Governors who are not voting members of the committee may attend as observers.

7. **Frequency of Meetings**

Meetings shall be held as required and not less than once a year. The Chair of the Committee or any two members of the Committee may call a meeting at any time.

8. **Authority**

The Committee is authorised by the CoG to obtain, via the Company Secretary, outside legal or other independent professional advice and to secure the attendance of external advisors with relevant experience and expertise if it considers this necessary.

9. **Reporting**

9.1 Minutes of the meeting will not normally be circulated, but a report on each committee meeting will be prepared for the next CoG meeting.

9.2 The Committee will report to the CoG annually on its work, specifically on changes in Board membership and the process it has used in relation to appointments. The Chair of the Committee shall draw the CoG’s attention to issues that the Committee feel require disclosure to the full CoG, or executive action. The work of the committee for the years will be described in the Trust’s annual report.
9.3 The Chair will report to the Remuneration and Terms of Service Committee significant decisions made by the Nominations Committee, and vice versa.

9.4 These Terms of Reference of the Committee, including its role and the authority delegated to it by the CoG, shall be made available on reasonable request.

10. Review

The committee will review its performance against these Terms of Reference annually and report on this to the CoG.

The Terms of Reference shall be reviewed annually by the Committee and the CoG.

Version Control
CoG last approved: 8th January 2015
CoG approved: 7th July 2016
CoG 2.2.5 change approved: 2nd March 2017
1.0 Introduction

1.1 Each year all governors are asked to complete an online self-evaluation of how well they think the Council of Governors (CoG) is working, including reflections on their individual training needs.

1.2 This report summarises the findings of the survey. 21 governors completed the survey (names shown in appendix). Not all governors answered all questions and so the percentages and numbers in brackets in the report reflect this.

1.3 The CoG subgroup, the Trust Member and Governor Development Group, reviewed the outcomes at their meeting on 07.11.17 (see report elsewhere on today’s meeting agenda). They confirmed that the training plans for 2018 are aligned with the needs identified in the survey. There are useful insights into the two skills sessions which will feed into the 2018 planning.

1.4 The full survey report runs to 36 pages and so is not reproduced here but is available from the Company Secretary on request.

2.0 Knowledge

2.1 This section asks governors to feed back on their knowledge of the role of the council of governors, the role of the board of directors, their knowledge of the Trust’s services and mental health more generally as well as the methods governors have used to increase their knowledge.

2.2 *Role of CoG*. 95% (20/21) said that they had sufficient knowledge about the role of the Council of Governors to carry out their role as a Governor.

2.3 *Role of the board of directors*. 75% (15/21) said that they felt confident about their understanding of the role of the board of directors. Some governors wanted to
understand the interface with governors better or felt that the directors seemed somewhat remote. In 2018 there will be more joint director / governor opportunities to improve mutual understanding. Governors are also welcome to attend board of director meetings to understand the work of the board and also to watch the non-executive directors carry out their roles.

2.4 Trust structures and processes. 81% (17/21) thought that their knowledge of the organisation was sufficient to enable them to carry out their role with the other 4 being unsure. Only 61% (13/21) felt that they had sufficient knowledge of the Trust’s services and activities. The Trust is large and complex and many issues within the Trust are fast-moving. The pre-CoG informal sessions have been used to provide briefings to governors to assist with this. This will continue in 2018.

2.5 More general understanding of mental health. 81% (17/21) thought that they had sufficient general understanding of mental health issues. The remainder thought they had some understanding but wanted to increase this.

2.6 Ways of gaining knowledge. 90% of respondents had visited services and read Trust publications to help keep up to date with our services. 86% attend non-Trust meetings in the role of governor and 80% read about mental health in non-Trust publications.

3.0 Skills

3.1 Representing interests of members and the wider public. 75% (15/21) of governors feel confident in their skills in this area but 25% felt that it was an area that they would like to develop further particularly to get a wider view. We will be holding a half day skills session on ‘representing interests’ in the autumn of 2018 when the newly elected governors have had a chance to get used to their role. The evaluation of the 2017 session on this topic was mostly ‘helpful’ and ‘very helpful’ but the turnout was poor (only 9 respondents had attended it).

3.2 Holding the NEDs to account. 63% (12/21) of respondents were confident in their skills in this area. No governors felt completely unconfident but 37% wanted to develop these skills further. A concern noted in the comments is that governors do not always think that they get full answers to questions raised. The feedback on the skills session on holding to account was more mixed with only 3 (out of 12) rating it as very helpful. This feedback will be taken into account in the design of the 2018 session.

4.0 Work of the CoG subgroups

4.1 Evaluation of the subgroups is more challenging because of course most governors only attend one or two but from those respondents who were able to comment the following feedback was given.

4.2 Planning and Performance subgroup. The subgroup was thought to be working effectively but development areas included holding NEDs to account and steering away from operational issues.
4.3 *Improvement Plan Coordination subgroup.* The majority of respondents thought it was working well or quite well. One governor thought it ineffective.

4.4 *Trust Member and Governor Development subgroup.* Respondents thought that more could be done in relation to member engagement and recruitment and in taking forward governor development.

4.5 Nominations Committee. Respondents thought that the committee was effective but 17% (3/14) would like to see more feedback the CoG.

5.0 **Lead governor**

5.1 89% (16/18) respondents said that the lead governor was effective in listening to governors and (78%) 14/18 said that she was effective in representing the interests of governors as a whole.

6.0 **Relationships and support**

6.1 *Relationship to link NED (where applicable).* There was quite a mixed range of views on the effectiveness of this relationship. In terms of acting as a valuable resource, 9/20 agreed or strongly agreed, and 11 were unsure or disagreed. Looking at the wider question of the effectiveness of NED / governor relationships 37% (7/19) thought them effective 37% thought they were ‘ok’ and 26% (5/19) thought they were ineffective. The increase in joint director / governor working in 2018 may go some way to addressing these concerns.

6.2 *Information for governors.* Feedback identified a need for better pre-election information and the information pack for the most recent elections was updated. Feedback from these most recent face to face sessions was positive. Induction and training sessions were mostly rated as good or excellent and Trust Secretariat support on general queries was rated positively.

7.0 **Summary**

7.1 Compared to last year, governor respondents rated the overall effectiveness of the CoG as somewhat lower. From the comments given this appears to reflect the fact that the Trust moved back into Special Measures in 2017.
Appendix 1

Respondents:

<table>
<thead>
<tr>
<th>Dr Nanayakkara De Silva</th>
<th>Richard Garrod</th>
<th>Guenever Pachent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Martin Wright</td>
<td>Hilary Hanbury</td>
<td>Sheila Preston</td>
</tr>
<tr>
<td>Rob French</td>
<td>Ginnie Benedettini</td>
<td>Catherine Wells</td>
</tr>
<tr>
<td>Jane Millar</td>
<td>Paul Gaffney</td>
<td>Malcolm Blowers</td>
</tr>
<tr>
<td>Zeyar Win</td>
<td>Heather Rugg</td>
<td>Paddy Fielder</td>
</tr>
<tr>
<td>Nigel Boldero</td>
<td>Howard Tidman</td>
<td>Stephen Fletcher</td>
</tr>
<tr>
<td>Sian Coker</td>
<td>Andrew Good</td>
<td>Anne Humphrys</td>
</tr>
</tbody>
</table>

Note: As Cllr Rout had only just joined the CoG when the survey was sent out he was not included in the invitation this year.
Executive Summary:

- The Community Mental Health Service Users Survey is an annual survey of all Mental Health Trusts in England commissioned by the Care Quality Commission.

- The results of the 2016 survey were poor and put NSFT in the bottom 20% of Trusts nationally.

- In the 2017 survey results NSFT has shown significant improvement compared to 2016 in most of the 32 rateable questions, with 27 showing an improvement of more than 10%. 3 questions show no change and only 2 questions show deterioration in the score (of -1% and -4% respectively). However, all Mental Health Trusts also showed similar remarkable improvement compared to 2016.

- Overall, the rate of improvement achieved by NSFT was 96% points greater than the national average. This equates to a rate of improvement 3% greater than the average for all MH Trusts.

- The Locality breakdown of results show exceptional performance by East Suffolk who have moved from the worst performing locality in 2016 to first place this year and greatly exceeded the rate of improvement nationally. Central Norfolk has also seen a rate of improvement that was above the national average, albeit marginally.

- While the improvements in the 2017 results compared to the poor performance in 2016 are noted and great to see, there remains more to do if NSFT is to continue to improve more rapidly than other MH Trusts. This will be necessary to achieve average or better than average performance in subsequent survey periods.

- Remedial actions are summarised in this report, and wherever possible align closely to improvement actions that are already underway in response to the CQC report.

1.0 Background

1.1 The Community Mental Health Service Users Survey is an annual survey of all Mental Health Trusts in England commissioned by the Care Quality Commission.
1.2 NSFT is with the majority of Trusts who have contracted Quality Health Ltd to undertake the survey on our behalf.

1.3 In scope services include: most secondary community services for adults aged 18 and over (e.g. CMHTs/IDTs), Crises Resolution and Home Treatment teams (CRHT), Flexible Assertive Community Treatment and Assertive Outreach (FACT/AO), Dementia and Memory Treatment (Community DCLL/DIST) and other specialist and complex needs community services like Community Eating Disorders (CED) and other Intensive Support teams (IST).

1.3 Services not in scope include: Psychological Therapy and Wellbeing, Learning Disabilities (including Neurodevelopmental), Acute Hospital Liaison, Forensic, Court Liaison and Diversion, Drug and Alcohol and Gender Dysphoria.

1.4 We have to follow strict guidance when drawing the random sample from the caseloads of included services and teams. At least two contacts are required to have taken place during a pre-determined period (1st September to 30th November in the preceding year), at least one of which must have been a face to face treatment contact.

1.5 After exclusions rules are applied, the Trust is required to draw a random sample of 850, with the option to provide an additional sample. In 2017 we provided an additional sample of 350, which is our usual practice and will be doing likewise in 2018. The sample is drawn in January of each year.

1.6 Surveys are sent out by Quality Health in February, and two reminders are issued prior to the survey period closing in June.

2.0 2016 Survey Results

2.1 Overall NSFT results in 2016 put us in the bottom 20% of MH Trusts.

2.2 In addition to specific areas that required attention, including medication information and crises care, Quality Health advised:

“The general impression is that services need to promote a recovery-oriented service to support people to build lives for themselves outside of mental health services, with an emphasis on hope, control and opportunity.”

2.3 Key actions taken in response to the 2016 survey outcome include:

- Locality based workshops to review each Locality’s results and inform local remedial action plans
- Pharmacy department reviewed and updated medication information leaflets and accessibility
- Introduced community teams to the Team Recovery Implementation Plan (TRIP)
- Cross referencing community survey results with the recovery principles in Our Recovery Strategy 2017 to 2022, launch from June 2017.

3.0 2017 Survey: Overall NSFT Results

3.1 Quality Health was provided with a base sample of 1,200 NSFT service users in January 2017, of which 1,155 were found to be usable (i.e. received survey questionnaires). 344 returns were received, from a usable total sample of 1155. This represents a 30% return rate which is about 4% above the national average.
3.2 NSFT has shown significant improvement compared to 2016 in most of the 32 rateable questions, with 27 showing an improvement of more than 10%. 3 questions show no change and only 2 questions show deterioration in the score (of -1% and -4% respectively).

3.3 However, overall, all Mental Health Trusts also showed similar remarkable improvement compared to 2016. It is therefore important to compare NSFT’s rate of improvement with the national picture.

3.4 Overall, the rate of improvement achieved by NSFT was 96% points greater than the national average. This averages 3% more improvement per question than achieved nationally.

3.5 Although NSFT still remains below the average for MH Trust performance, the greater rate of improvement has led to our relative position compared to all other MH Trusts climbing out of the bottom 20%.

4.0 2017 Survey: Results by Locality Breakdown

4.1 Responses by CCG area were as follows:

<table>
<thead>
<tr>
<th>CCG</th>
<th>Returns</th>
<th>CCG</th>
<th>Returns</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suffolk East</td>
<td>88</td>
<td>South Norfolk</td>
<td>35</td>
</tr>
<tr>
<td>GYW</td>
<td>61</td>
<td>North Norfolk</td>
<td>29</td>
</tr>
<tr>
<td>Norwich</td>
<td>54</td>
<td>West Norfolk</td>
<td>27</td>
</tr>
<tr>
<td>Suffolk West</td>
<td>49</td>
<td>North East Essex</td>
<td>1</td>
</tr>
</tbody>
</table>

Due to Survey rules, it is not possible to retrieve rateable question response information by CCG / Locality area when responses are less than 30. While North Norfolk CCG results will be included in the Central Norfolk Locality results, it is not possible to see the West Norfolk Locality results in either the Locality or CCG breakdown. However, West Locality returns along with all others are included in the overall Trust scores.

4.2 Sections 1 to 10 in Appendix 1 shows the breakdown of results by Locality (excluding West Norfolk), and trend performance compared to 2016 as well as with the average of all other MH Trusts.

4.3 Section 11 in Appendix 1 shows a combined RAG rated Trend Map of Locality performance for all the 32 rateable questions.

4.4 This shows that all localities have improved compared to their performance in 2016, but only Central Norfolk and East Suffolk also show greater improvement than achieved nationally.

4.5 While the overall performance in Central Norfolk is only a marginal improvement compared to 2016, the rate of improvement achieved by East Suffolk is exceptional, taking it from the worst performing Locality in 2016 to the best performing Locality in 2017.

4.6. It is as a result of East Suffolk’s remarkable performance that has enabled the Trust’s overall position to have improved compared to the national picture.

5.0 2017 Survey: Priority Areas and Remedial Actions

5.1 The following provides a summary of key areas for remedial actions and are listed under the categories used in the survey.
5.2 **OVERALL**

In comparison with other mental health trusts, most scores are in the intermediate 60% range. However there are still some scores in the bottom 20% of Trusts. We will be focusing on these areas to increase overall scores while continuing to improve all across all areas.

**What:** Focus on the ‘bottom’ scores, but also ensure the improving trend between 2016 and 2017 continues in 2018 and at a greater rate than other Mental Health Trusts to initially move the Trust out of the bottom 20% and continue progress over subsequent years to above average.

**How:** 1) Take results breakdown to localities and community teams (17/18 Q4); 2) Undertake an Always Event pilot project within Central Norfolk to explore the community care pathway involvement in care with service users and carers, with the outputs shared with all localities to inform subsequent actions (17/18 Q4 onwards).

5.3 **CARE AND TREATMENT**

**What:** Not seen often enough to meet needs (Q3).

**How:** CQC Improvement Plan actions NSFT.08, NSFT.10, NSFT.19; Formulation implementation.

5.4 **ORGANISING CARE**

**What:** Knowing how to contact and care poorly organised care (Q9,10)

**How:** Encourage all community practitioners to use business cards; Formulation implementation (also Q4); Always Event project (also Q4).

5.5 **CRISIS CARE**

**What:** How to make out of hours contact and the right response (Q21, 23)

**How:** CQC Improvement Plan action NSFT.17; STP plans for Crises Hub developments.

5.6 **TREATMENTS AND THERAPIES**

**What:** Ensure involvement in deciding treatments and understanding about them (Q31,32)

**How:** Share results with all teams, with focus on prescribing staff and all doctors; Formulation implementation; Always Event.

5.7 **SUPPORT AND WELLBEING**

**What:** Ensure support with physical health needs, finding work, and what is important to the service user (Q33,35,39).

**How:** CQC Improvement Plan actions NSFT.14; NSFT.10; Formulation implementation; Always Event to inform further actions; introducing Dialog+ PROM; develop more robust and active partnerships with employment support agencies and in developing Individual Placement Support (IPS) in the NSFT region.

6.0 **Conclusion and Recommendations**

6.1 Staff in community services across the Trust deserve to be congratulated for achieving such notable improvements in these results compared to 2016.

6.2 Additionally, the Central Norfolk and East Suffolk Localities deserve additional recognition for achieving a rate of improvements that is greater than the national trend.
6.3 The improvement achieved by East Suffolk in particular is remarkable, and the Adult Community Quality Improvement Forum should explore this further to identify the key developments that have contributed to this.

6.4 While the improvements in the 2017 results compared to the poor performance in 2016 are noted and great to see, there remains more to do if NSFT is to continue to improve more rapidly than other MH Trusts. This will be necessary to achieve average or better than average performance in subsequent survey periods.

6.5 The summary of actions in section 5, align as far as possible with improvement work already underway to minimise the risk of duplication and action plan fatigue within community teams.

6.6 The annual community service user survey is a very valuable and welcome method for receiving feedback about the experience of using our community services.

Marcus Hayward
Head of Recovery, Participation & Partnership.
Appendix 1
Mental Health Community Service Users Survey 2017: Results Breakdown by Locality

Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.0</td>
<td>Introduction (1.0 to 1.9)</td>
<td>2</td>
</tr>
<tr>
<td>Section 1</td>
<td>Your Care and Treatment (Questions 1 to 3)</td>
<td>3</td>
</tr>
<tr>
<td>Section 2</td>
<td>Your Health and Social Care Workers (4 to 6)</td>
<td>7</td>
</tr>
<tr>
<td>Section 3</td>
<td>Organising Your Care (Questions 7 to 10)</td>
<td>9</td>
</tr>
<tr>
<td>Section 4</td>
<td>Planning Your Care (Questions 11 to 13)</td>
<td>12</td>
</tr>
<tr>
<td>Section 5</td>
<td>Reviewing Your Care (Questions 14 to 16)</td>
<td>14</td>
</tr>
<tr>
<td>Section 6</td>
<td>Changes in Who You See (Questions 17 to 20)</td>
<td>16</td>
</tr>
<tr>
<td>Section 7</td>
<td>Crisis Care (Questions 21 to 23)</td>
<td>19</td>
</tr>
<tr>
<td>Section 8</td>
<td>Treatments (Questions 24 to 32)</td>
<td>21</td>
</tr>
<tr>
<td>Section 9</td>
<td>Support and Wellbeing (Questions 33 to 39)</td>
<td>26</td>
</tr>
<tr>
<td>Section 10</td>
<td>Overall (Questions 40 &amp; 41)</td>
<td>31</td>
</tr>
<tr>
<td>Section 11</td>
<td>Summary of Results by Locality</td>
<td>33</td>
</tr>
</tbody>
</table>
Introduction

1.1 This report provides a breakdown of the results of the national Mental Health Service User Survey 2017 (MHSUS 2017) by Locality area.

1.2 A random base sample of 850 and an extended sample of 350 was sent to Quality Health, the survey provider. 344 returns were received from a usable total sample of 1155. This represents a 30% return rate which is above the national average.

1.3 Responses by CCG area were as follows:

<table>
<thead>
<tr>
<th>CCG</th>
<th>Returns</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suffolk East</td>
<td>88</td>
</tr>
<tr>
<td>South Norfolk</td>
<td>35</td>
</tr>
<tr>
<td>GYW</td>
<td>61</td>
</tr>
<tr>
<td>North Norfolk</td>
<td>29</td>
</tr>
<tr>
<td>Norwich</td>
<td>54</td>
</tr>
<tr>
<td>West Norfolk</td>
<td>27</td>
</tr>
<tr>
<td>Suffolk West</td>
<td>49</td>
</tr>
<tr>
<td>North East Essex</td>
<td>1</td>
</tr>
</tbody>
</table>

It is not possible to retrieve rateable question response information by CCG / Locality area for responses of less than 30. For this reason, only the combined Central Norfolk Locality responses will be considered in the bar chart breakdown for the rateable questions in sections 1 to 10. West Norfolk cannot be included as the returns for the locality are the same as for the CCG.

1.4 This report includes trend comparison with results in 2016 to show improvement or deterioration in performance.

1.5 In Sections 1 to 10, a RAG Rating for trend comparison with results in 2016 has been used for all questions that indicate satisfaction levels, as follows:

- Improvement of 5% or more = Green
- Percentage change of +/- less than 5% = Amber
- Percentage change of -5% or more = Red

The first column shows the percentage point change compared to NSFT results in 2016. The second column shows the trend over or under the change for all mental health trusts.

1.6 The responses to questions 1, 2, 8, 17, 22, 24, 26, 28, 30 and 31 do not indicate satisfaction with the service provided and are therefore not included in the overall RAG rating.

1.7 Section 11 shows a map of the RAG scores comparing 2017 with:

A) Our results in 2016 (Trend Map A), and
B) The average improvement trend of MH Trusts nationally (Trend Map B).

1.8 As a comparator with the Trend Map, Section 11 (on page 34) also shows a bar graph and table with relative positions and overall performance by Locality.

1.9 East Suffolk Locality has shown remarkable improvement, moving from last potion in 2016 to be our best performing Locality in 2017 and has outstripped by an average of 14% the national improvement trend!
Section 1: YOUR CARE AND TREATMENT

Question 1 – When was the last time you saw someone from the NHS mental health services?

- In the last month
- 7-12 months ago
- 1-3 months ago
- More than 12 months ago
- 4-6 months ago
- Don’t know / Can’t remember

National

NSFT

West Norfolk

North Norfolk

/-
Question 1 continued…

Norwich

South Norfolk

Great Yarmouth & Waveney

Ipswich & East Suffolk

West Suffolk
Question 2 – Overall, how long have you been in contact with NHS mental health services?

<table>
<thead>
<tr>
<th>Duration</th>
<th>National</th>
<th>NSFT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 1 year</td>
<td>2%</td>
<td>3%</td>
</tr>
<tr>
<td>1 to 5 years</td>
<td>29%</td>
<td>29%</td>
</tr>
<tr>
<td>6 to 10 years</td>
<td>12%</td>
<td>11%</td>
</tr>
<tr>
<td>More than 10 years ago</td>
<td>38%</td>
<td>38%</td>
</tr>
<tr>
<td>I am no longer in contact</td>
<td>19%</td>
<td>18%</td>
</tr>
<tr>
<td>Don’t know / Can’t remember</td>
<td>4%</td>
<td>4%</td>
</tr>
</tbody>
</table>

West Norfolk

<table>
<thead>
<tr>
<th>Duration</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 1 year</td>
<td>4%</td>
</tr>
<tr>
<td>1 to 5 years</td>
<td>4%</td>
</tr>
<tr>
<td>6 to 10 years</td>
<td>17%</td>
</tr>
<tr>
<td>More than 10 years</td>
<td>38%</td>
</tr>
<tr>
<td>I am no longer in contact</td>
<td>25%</td>
</tr>
</tbody>
</table>

North Norfolk

<table>
<thead>
<tr>
<th>Duration</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 1 year</td>
<td>10%</td>
</tr>
<tr>
<td>1 to 5 years</td>
<td>23%</td>
</tr>
<tr>
<td>6 to 10 years</td>
<td>35%</td>
</tr>
<tr>
<td>More than 10 years</td>
<td>38%</td>
</tr>
<tr>
<td>I am no longer in contact</td>
<td>0%</td>
</tr>
</tbody>
</table>

/-
Question 2 continued…

<table>
<thead>
<tr>
<th>Less than 1 year</th>
<th>More than 10 years ago</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>1 to 5 years</td>
<td>I am no longer in contact</td>
</tr>
<tr>
<td>6 to 10 years</td>
<td>Don’t know / Can’t remember</td>
</tr>
</tbody>
</table>

Norwich

South Norfolk

Great Yarmouth and Waveney

Ipswich & East Suffolk

West Suffolk

<MHCSUS 2017 – breakdown of results>  Version <1.1>  Author: <Marcus Hayward>
Department: <Recovery & Participation>
Page 6 of 34  Date produced: <30/11/17>  Retention period: 30 years
Question 3 – In the last 12 months, do you feel you have seen NHS mental health services often enough for your needs?

National: 62% (2016: 47%)   NSFT Score: 55% ↑   NSFT 2016: 38%

<table>
<thead>
<tr>
<th>Response</th>
<th>Numerator</th>
<th>Denominator</th>
<th>Score</th>
<th>Trend NSFT</th>
<th>Trend w/All</th>
</tr>
</thead>
<tbody>
<tr>
<td>Norfolk West</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>Norfolk Central</td>
<td>53</td>
<td>97</td>
<td>55%</td>
<td>+12</td>
<td>-3</td>
</tr>
<tr>
<td>GY&amp;W</td>
<td>27</td>
<td>56</td>
<td>48%</td>
<td>+9</td>
<td>-6</td>
</tr>
<tr>
<td>Suffolk East</td>
<td>47</td>
<td>80</td>
<td>59%</td>
<td>+30</td>
<td>+15</td>
</tr>
<tr>
<td>Suffolk West</td>
<td>23</td>
<td>45</td>
<td>51%</td>
<td>+9</td>
<td>-6</td>
</tr>
</tbody>
</table>

Section 2: YOUR HEALTH AND SOCIAL CARE WORKERS

Question 4 – Did the person or people you saw listen carefully to you?
National: 81% (2016: 70%)  NSFT Score: 78% ↑  NSFT 2016: 66%

<table>
<thead>
<tr>
<th>Response</th>
<th>Numerator</th>
<th>Denominator</th>
<th>Score</th>
<th>Trend NSFT</th>
<th>Trend w/All</th>
</tr>
</thead>
<tbody>
<tr>
<td>Norfolk West</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>Norfolk Central</td>
<td>73</td>
<td>97</td>
<td>75%</td>
<td>+7</td>
<td>-3</td>
</tr>
<tr>
<td>GY&amp;W</td>
<td>44</td>
<td>55</td>
<td>80%</td>
<td>+13</td>
<td>+2</td>
</tr>
<tr>
<td>Suffolk East</td>
<td>65</td>
<td>81</td>
<td>80%</td>
<td>+14</td>
<td>+3</td>
</tr>
<tr>
<td>Suffolk West</td>
<td>35</td>
<td>49</td>
<td>71%</td>
<td>+2</td>
<td>-9</td>
</tr>
</tbody>
</table>

Question 5 – Where you given enough time to discuss your needs and treatment?

National: 75% (2016: 63%)  NSFT Score: 72% ↑  NSFT 2016: 59%

<table>
<thead>
<tr>
<th>Response</th>
<th>Numerator</th>
<th>Denominator</th>
<th>Score</th>
<th>Trend NSFT</th>
<th>Trend w/All</th>
</tr>
</thead>
<tbody>
<tr>
<td>Norfolk West</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>Norfolk Central</td>
<td>70</td>
<td>98</td>
<td>71%</td>
<td>+14</td>
<td>+2</td>
</tr>
<tr>
<td>GY&amp;W</td>
<td>38</td>
<td>55</td>
<td>69%</td>
<td>+7</td>
<td>-5</td>
</tr>
<tr>
<td>Suffolk East</td>
<td>62</td>
<td>82</td>
<td>76%</td>
<td>+20</td>
<td>+8</td>
</tr>
<tr>
<td>Suffolk West</td>
<td>33</td>
<td>48</td>
<td>69%</td>
<td>+8</td>
<td>-4</td>
</tr>
</tbody>
</table>
Question 6 – Did the person or people you saw understand how your mental health needs affect other areas of your life?

**National: 72% (2016: 56%)**

NSFT Score: 70% ↑

NSFT 2016: 53%

<table>
<thead>
<tr>
<th>Response</th>
<th>Numerator</th>
<th>Denominator</th>
<th>Score</th>
<th>Trend NSFT</th>
<th>Trend w/All</th>
</tr>
</thead>
<tbody>
<tr>
<td>Norfolk West</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>Norfolk Central</td>
<td>65</td>
<td>94</td>
<td>69%</td>
<td>+12</td>
<td>-4</td>
</tr>
<tr>
<td>06M (GY&amp;W)</td>
<td>37</td>
<td>55</td>
<td>67%</td>
<td>+11</td>
<td>-5</td>
</tr>
<tr>
<td>06L (Suffolk East)</td>
<td>57</td>
<td>77</td>
<td>74%</td>
<td>+33</td>
<td>+17</td>
</tr>
<tr>
<td>07K (Suffolk West)</td>
<td>31</td>
<td>45</td>
<td>69%</td>
<td>+13</td>
<td>-3</td>
</tr>
</tbody>
</table>

**Section 3: ORGANISING YOUR CARE**

Question 7 – Have you been told who is in charge of organising your care and services?
National: 75% (2016: 77%)
NSFT Score: 76% ↑
NSFT 2016: 69%

<table>
<thead>
<tr>
<th>Response</th>
<th>Numerator</th>
<th>Denominator</th>
<th>Score</th>
<th>Trend NSFT</th>
<th>Trend w/All</th>
</tr>
</thead>
<tbody>
<tr>
<td>Norfolk West</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>Norfolk Central</td>
<td>54</td>
<td>79</td>
<td>68%</td>
<td>-9</td>
<td>-7</td>
</tr>
<tr>
<td>GY&amp;W</td>
<td>34</td>
<td>47</td>
<td>72%</td>
<td>+9</td>
<td>+11</td>
</tr>
<tr>
<td>Suffolk East</td>
<td>59</td>
<td>70</td>
<td>84%</td>
<td>+24</td>
<td>+26</td>
</tr>
<tr>
<td>Suffolk West</td>
<td>32</td>
<td>40</td>
<td>80%</td>
<td>+1</td>
<td>+3</td>
</tr>
</tbody>
</table>

**Question 8 – Is the person in charge of organising your care and services:**

<table>
<thead>
<tr>
<th>Response</th>
<th>National</th>
<th>All NSFT</th>
<th>Norfolk West</th>
<th>Norfolk Central</th>
<th>GY&amp;W</th>
<th>Suffolk East</th>
<th>Suffolk West</th>
</tr>
</thead>
<tbody>
<tr>
<td>A CPN (Community Psychiatric Nurse)</td>
<td>20%</td>
<td>22%</td>
<td>26%</td>
<td>25%</td>
<td>15%</td>
<td>30%</td>
<td>8%</td>
</tr>
<tr>
<td>A psychotherapist / counsellor</td>
<td>5%</td>
<td>3%</td>
<td>0%</td>
<td>5%</td>
<td>7%</td>
<td>1%</td>
<td>2%</td>
</tr>
<tr>
<td>A social worker</td>
<td>7%</td>
<td>9%</td>
<td>0%</td>
<td>4%</td>
<td>5%</td>
<td>13%</td>
<td>20%</td>
</tr>
<tr>
<td>A psychiatrist</td>
<td>17%</td>
<td>13%</td>
<td>4%</td>
<td>6%</td>
<td>20%</td>
<td>18%</td>
<td>12%</td>
</tr>
<tr>
<td>A mental health support worker</td>
<td>10%</td>
<td>15%</td>
<td>30%</td>
<td>10%</td>
<td>16%</td>
<td>9%</td>
<td>24%</td>
</tr>
<tr>
<td>A GP</td>
<td>10%</td>
<td>10%</td>
<td>19%</td>
<td>10%</td>
<td>11%</td>
<td>6%</td>
<td>10%</td>
</tr>
<tr>
<td>Another type of health or social care worker</td>
<td>4%</td>
<td>5%</td>
<td>4%</td>
<td>5%</td>
<td>5%</td>
<td>7%</td>
<td>2%</td>
</tr>
<tr>
<td>Don't know</td>
<td>4%</td>
<td>4%</td>
<td>7%</td>
<td>4%</td>
<td>5%</td>
<td>4%</td>
<td>2%</td>
</tr>
</tbody>
</table>
Question 9 – Do you know how to contact this person if you have a concern about your care?

![Bar chart showing breakdown of results for different regions.

National: 97% (2016: 97%)
NSFT Score: 96% ↓
NSFT 2016: 97%

<table>
<thead>
<tr>
<th>Region</th>
<th>Numerator</th>
<th>Denominator</th>
<th>Score</th>
<th>Trend NSFT</th>
<th>Trend w/All</th>
</tr>
</thead>
<tbody>
<tr>
<td>Norfolk West</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>Norfolk Central</td>
<td>37</td>
<td>38</td>
<td>97%</td>
<td>-1</td>
<td>-1</td>
</tr>
<tr>
<td>GY&amp;W</td>
<td>30</td>
<td>32</td>
<td>94%</td>
<td>-6</td>
<td>-6</td>
</tr>
<tr>
<td>Suffolk East</td>
<td>51</td>
<td>51</td>
<td>100%</td>
<td>+3</td>
<td>+3</td>
</tr>
<tr>
<td>Suffolk West</td>
<td>22</td>
<td>26</td>
<td>85%</td>
<td>-9</td>
<td>-9</td>
</tr>
</tbody>
</table>

Question 10 – How well does this person organise the care and services you need?

![Bar chart showing breakdown of results for different regions.

Breakdown

Score
Section 4: PLANNING YOUR CARE

Question 11 – Have you agreed with someone from NHS mental health services what care you will receive?

<table>
<thead>
<tr>
<th>Response</th>
<th>Numerator</th>
<th>Denominator</th>
<th>Score</th>
<th>Trend NSFT</th>
<th>Trend w/All</th>
</tr>
</thead>
<tbody>
<tr>
<td>Norfolk West</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>Norfolk Central</td>
<td>34</td>
<td>44</td>
<td>77%</td>
<td>-3</td>
<td>+6</td>
</tr>
<tr>
<td>GY&amp;W</td>
<td>23</td>
<td>31</td>
<td>74%</td>
<td>-17</td>
<td>-8</td>
</tr>
<tr>
<td>Suffolk East</td>
<td>43</td>
<td>54</td>
<td>80%</td>
<td>-3</td>
<td>+6</td>
</tr>
<tr>
<td>Suffolk West</td>
<td>22</td>
<td>29</td>
<td>76%</td>
<td>-10</td>
<td>-1</td>
</tr>
</tbody>
</table>

National: 83% (2016: 92%)  NSFT Score: 78%  NSFT 2016: 82%

National: 59% (2016: 44%)  NSFT Score: 59%  NSFT 2016: 37%
Question 12 – Were you involved as much as you wanted to be in agreeing what care you will receive?

National: 74% (2016: 56%)  
NSFT Score: 71%  
NSFT 2016: 50%

<table>
<thead>
<tr>
<th>Response</th>
<th>Numerator</th>
<th>Denominator</th>
<th>Score</th>
<th>Trend NSFT</th>
<th>Trend w/All</th>
</tr>
</thead>
<tbody>
<tr>
<td>Norfolk West</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>Norfolk Central</td>
<td>47</td>
<td>67</td>
<td>70%</td>
<td>+18</td>
<td>-</td>
</tr>
<tr>
<td>GY&amp;W</td>
<td>25</td>
<td>36</td>
<td>69%</td>
<td>+15</td>
<td>-3</td>
</tr>
<tr>
<td>Suffolk East</td>
<td>52</td>
<td>68</td>
<td>76%</td>
<td>+40</td>
<td>+22</td>
</tr>
<tr>
<td>Suffolk West</td>
<td>26</td>
<td>41</td>
<td>63%</td>
<td>+6</td>
<td>-12</td>
</tr>
</tbody>
</table>

Question 13 – Does this agreement on what care you will receive take your personal circumstances into account?
Section 5: REVIEWING YOUR CARE

Question 14 – In the last 12 months have you had a formal meeting with someone from NHS mental health services to discuss how your care is working?

<table>
<thead>
<tr>
<th>Response</th>
<th>Numerator</th>
<th>Denominator</th>
<th>Score</th>
<th>Trend NSFT</th>
<th>Trend w/All</th>
</tr>
</thead>
<tbody>
<tr>
<td>Norfolk West</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>Norfolk Central</td>
<td>53</td>
<td>67</td>
<td>79%</td>
<td>+19</td>
<td>+1</td>
</tr>
<tr>
<td>GY&amp;W</td>
<td>25</td>
<td>34</td>
<td>74%</td>
<td>+17</td>
<td>-1</td>
</tr>
<tr>
<td>Suffolk East</td>
<td>52</td>
<td>66</td>
<td>79%</td>
<td>+45</td>
<td>+27</td>
</tr>
<tr>
<td>Suffolk West</td>
<td>25</td>
<td>37</td>
<td>68%</td>
<td>-</td>
<td>-18</td>
</tr>
</tbody>
</table>

National: 77% (2016: 59%)  NSFT Score: 76%  NSFT 2016: 55%

<table>
<thead>
<tr>
<th>Response</th>
<th>Numerator</th>
<th>Denominator</th>
<th>Score</th>
<th>Trend NSFT</th>
<th>Trend w/All</th>
</tr>
</thead>
<tbody>
<tr>
<td>Norfolk West</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>Norfolk Central</td>
<td>31</td>
<td>48</td>
<td>68%</td>
<td>+2</td>
<td>+2</td>
</tr>
<tr>
<td>GY&amp;W</td>
<td>46</td>
<td>67</td>
<td>61%</td>
<td>-8</td>
<td>-8</td>
</tr>
<tr>
<td>Suffolk East</td>
<td>39</td>
<td>55</td>
<td>76%</td>
<td>+5</td>
<td>+5</td>
</tr>
<tr>
<td>Suffolk West</td>
<td>36</td>
<td>51</td>
<td>66%</td>
<td>-5</td>
<td>-5</td>
</tr>
</tbody>
</table>

National: 72% (2016: 72%)  NSFT Score: 69%  NSFT 2016: 69%
Question 15 – Were you involved as much as you wanted to be in discussing how your care is working?

National: 77% (2016: 62%)  NSFT Score: 73% ↑  NSFT 2016: 57%

<table>
<thead>
<tr>
<th>Response</th>
<th>Numerator</th>
<th>Denominator</th>
<th>Score</th>
<th>Trend NSFT</th>
<th>Trend w/All</th>
</tr>
</thead>
<tbody>
<tr>
<td>Norfolk West</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>Norfolk Central</td>
<td>31</td>
<td>44</td>
<td>70%</td>
<td>–</td>
<td>-15</td>
</tr>
<tr>
<td>GY&amp;W</td>
<td>19</td>
<td>28</td>
<td>73%</td>
<td>+21</td>
<td>+6</td>
</tr>
<tr>
<td>Suffolk East</td>
<td>38</td>
<td>50</td>
<td>76%</td>
<td>+35</td>
<td>+20</td>
</tr>
<tr>
<td>Suffolk West</td>
<td>16</td>
<td>24</td>
<td>67%</td>
<td>+6</td>
<td>-9</td>
</tr>
</tbody>
</table>

Question 16 – Did you feel that decisions were made together by you and the person you saw during this discussion?
Section 6: CHANGES IN WHO YOU SEE

Question 17 – In the last 12 months, have the people you see for your care or services changed?

<table>
<thead>
<tr>
<th>Response</th>
<th>National</th>
<th>All NSFT</th>
<th>Norfolk West</th>
<th>Norfolk Central</th>
<th>GY&amp;W</th>
<th>Suffolk East</th>
<th>Suffolk West</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>41%</td>
<td>45%</td>
<td>36%</td>
<td>55%</td>
<td>40%</td>
<td>40%</td>
<td>40%</td>
</tr>
<tr>
<td>Yes, but this was because I requested the change</td>
<td>2%</td>
<td>2%</td>
<td>5%</td>
<td>0%</td>
<td>7%</td>
<td>0%</td>
<td>2%</td>
</tr>
<tr>
<td>Yes, but this was because I moved home</td>
<td>2%</td>
<td>1%</td>
<td>5%</td>
<td>1%</td>
<td>2%</td>
<td>1%</td>
<td>0%</td>
</tr>
<tr>
<td>No</td>
<td>52%</td>
<td>47%</td>
<td>50%</td>
<td>38%</td>
<td>44%</td>
<td>57%</td>
<td>49%</td>
</tr>
<tr>
<td>My care has started but not changed</td>
<td>4%</td>
<td>5%</td>
<td>5%</td>
<td>5%</td>
<td>7%</td>
<td>1%</td>
<td>9%</td>
</tr>
<tr>
<td>Don’t know / not sure</td>
<td>8%</td>
<td>8%</td>
<td>8%</td>
<td>8%</td>
<td>12%</td>
<td>7%</td>
<td>4%</td>
</tr>
</tbody>
</table>
Question 18 – Were the reasons for this change explained to you at the time?

National: 62% (2016: 48%)  NSFT Score: 59%  NSFT 2016: 32%

<table>
<thead>
<tr>
<th>Response</th>
<th>Numerator</th>
<th>Denominator</th>
<th>Score</th>
<th>Trend NSFT</th>
<th>Trend w/All</th>
</tr>
</thead>
<tbody>
<tr>
<td>Norfolk West</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>Norfolk Central</td>
<td>28</td>
<td>50</td>
<td>56%</td>
<td>+13</td>
<td>-1</td>
</tr>
<tr>
<td>GY&amp;W</td>
<td>11</td>
<td>18</td>
<td>61%</td>
<td>+30</td>
<td>+16</td>
</tr>
<tr>
<td>Suffolk East</td>
<td>19</td>
<td>27</td>
<td>70%</td>
<td>+43</td>
<td>+29</td>
</tr>
<tr>
<td>Suffolk West</td>
<td>9</td>
<td>18</td>
<td>50%</td>
<td>+17</td>
<td>+3</td>
</tr>
</tbody>
</table>

Question 19 – What impact has this had on the care you receive?

Responses shown are for “it got better”
National: 69% (2016: 23%)  
NSFT Score: 63% ↑  
NSFT 2016: 16%

<table>
<thead>
<tr>
<th>Response</th>
<th>Numerator</th>
<th>Denominator</th>
<th>Score</th>
<th>Trend NSFT</th>
<th>Trend w/All</th>
</tr>
</thead>
<tbody>
<tr>
<td>Norfolk West</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>Norfolk Central</td>
<td>28</td>
<td>49</td>
<td>57%</td>
<td>+39</td>
<td>-7</td>
</tr>
<tr>
<td>GY&amp;W</td>
<td>13</td>
<td>19</td>
<td>68%</td>
<td>+49</td>
<td>+3</td>
</tr>
<tr>
<td>Suffolk East</td>
<td>18</td>
<td>28</td>
<td>64%</td>
<td>+50</td>
<td>+7</td>
</tr>
<tr>
<td>Suffolk West</td>
<td>7</td>
<td>15</td>
<td>47%</td>
<td>+42</td>
<td>-4</td>
</tr>
</tbody>
</table>

Question 20 – Did you know who was in charge of organising your care while this change was taking place?

National: 54% (2016: 55%)  
NSFT Score: 58% ↑  
NSFT 2016: 43%

<table>
<thead>
<tr>
<th>Response</th>
<th>Numerator</th>
<th>Denominator</th>
<th>Score</th>
<th>Trend NSFT</th>
<th>Trend w/All</th>
</tr>
</thead>
<tbody>
<tr>
<td>Norfolk West</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>Norfolk Central</td>
<td>21</td>
<td>42</td>
<td>36%</td>
<td>+14</td>
<td>+15</td>
</tr>
<tr>
<td>GY&amp;W</td>
<td>11</td>
<td>17</td>
<td>47%</td>
<td>+18</td>
<td>+19</td>
</tr>
<tr>
<td>Suffolk East</td>
<td>24</td>
<td>28</td>
<td>46%</td>
<td>+40</td>
<td>+41</td>
</tr>
<tr>
<td>Suffolk West</td>
<td>4</td>
<td>15</td>
<td>39%</td>
<td>+12</td>
<td>+13</td>
</tr>
</tbody>
</table>
Section 7: CRISIS CARE

Question 21 – Do you know who to contact out of office hours if you have a crisis?

National: 71% (2016: 70%)  
NSFT Score: 68% –  
NSFT 2016: 68%

<table>
<thead>
<tr>
<th>Response</th>
<th>Numerator</th>
<th>Denominator</th>
<th>Score</th>
<th>Trend NSFT</th>
<th>Trend w/All</th>
</tr>
</thead>
<tbody>
<tr>
<td>Norfolk West</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>Norfolk Central</td>
<td>53</td>
<td>89</td>
<td>60%</td>
<td>-5</td>
<td>-6</td>
</tr>
<tr>
<td>GY&amp;W</td>
<td>34</td>
<td>54</td>
<td>63%</td>
<td>-10</td>
<td>-11</td>
</tr>
<tr>
<td>Suffolk East</td>
<td>59</td>
<td>70</td>
<td>84%</td>
<td>+14</td>
<td>+13</td>
</tr>
<tr>
<td>Suffolk West</td>
<td>29</td>
<td>45</td>
<td>64%</td>
<td>-3</td>
<td>-4</td>
</tr>
</tbody>
</table>

Question 22 – In the last 12 months, have you tried to contact this person or team because your condition was getting worse?
<table>
<thead>
<tr>
<th>Response</th>
<th>National</th>
<th>All NSFT</th>
<th>Norfolk West</th>
<th>Norfolk Central</th>
<th>GY&amp;W</th>
<th>Suffolk East</th>
<th>Suffolk West</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>38%</td>
<td>43%</td>
<td>31%</td>
<td>47%</td>
<td>50%</td>
<td>32%</td>
<td>71%</td>
</tr>
<tr>
<td>No</td>
<td>62%</td>
<td>57%</td>
<td>69%</td>
<td>53%</td>
<td>50%</td>
<td>68%</td>
<td>29%</td>
</tr>
<tr>
<td>Can’t remember</td>
<td>2%</td>
<td>2%</td>
<td>0%</td>
<td>4%</td>
<td>3%</td>
<td>0%</td>
<td>3%</td>
</tr>
</tbody>
</table>

**Question 23 – When you tried to contact them, did you get the help you needed?**

Responses shown are for ‘yes’

![Bar chart showing responses by region]

**National: 57% (2016: 45%)**  
**NSFT Score: 46% ↑**  
**NSFT 2016: 33%**

<table>
<thead>
<tr>
<th>Response</th>
<th>Numerator</th>
<th>Denominator</th>
<th>Score</th>
<th>Tend NSFT</th>
<th>Tend w/All</th>
</tr>
</thead>
<tbody>
<tr>
<td>Norfolk West</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>Norfolk Central</td>
<td>14</td>
<td>24</td>
<td>20%</td>
<td>+38</td>
<td>+26</td>
</tr>
<tr>
<td>GY&amp;W</td>
<td>7</td>
<td>17</td>
<td>32%</td>
<td>+9</td>
<td>-3</td>
</tr>
<tr>
<td>Suffolk East</td>
<td>7</td>
<td>17</td>
<td>33%</td>
<td>+8</td>
<td>-4</td>
</tr>
<tr>
<td>Suffolk West</td>
<td>7</td>
<td>18</td>
<td>53%</td>
<td>-14</td>
<td>-28</td>
</tr>
</tbody>
</table>
Section 8: TREATMENTS

Question 24 – In the last 12 months, have you been receiving any medicines for your mental health needs?

<table>
<thead>
<tr>
<th>Response</th>
<th>National</th>
<th>All NSFT</th>
<th>Norfolk West</th>
<th>Norfolk Central</th>
<th>GY&amp;W</th>
<th>Suffolk East</th>
<th>Suffolk West</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>83%</td>
<td>84%</td>
<td>88%</td>
<td>79%</td>
<td>79%</td>
<td>94%</td>
<td>85%</td>
</tr>
<tr>
<td>No</td>
<td>17%</td>
<td>16%</td>
<td>12%</td>
<td>21%</td>
<td>21%</td>
<td>6%</td>
<td>15%</td>
</tr>
</tbody>
</table>

Question 25 – Were you involved as much as you wanted to be in decisions about which medicines you receive?
Question 26 – In the last 12 months, have you been prescribed any new medicines for your mental health needs?

<table>
<thead>
<tr>
<th>Response</th>
<th>Numerator</th>
<th>Denominator</th>
<th>Score</th>
<th>Trend NSFT</th>
<th>Trend w/All</th>
</tr>
</thead>
<tbody>
<tr>
<td>Norfolk West</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>Norfolk Central</td>
<td>49</td>
<td>71</td>
<td>69%</td>
<td>+28</td>
<td>+10</td>
</tr>
<tr>
<td>GY&amp;W</td>
<td>31</td>
<td>41</td>
<td>76%</td>
<td>+20</td>
<td>+2</td>
</tr>
<tr>
<td>Suffolk East</td>
<td>47</td>
<td>69</td>
<td>68%</td>
<td>+28</td>
<td>+10</td>
</tr>
<tr>
<td>Suffolk West</td>
<td>21</td>
<td>39</td>
<td>54%</td>
<td>+4</td>
<td>-14</td>
</tr>
</tbody>
</table>

National: 71% (2016: 53%)  
NSFT Score: 67% ↑  
NSFT 2016: 47%

Question 27 – The last time you had a new medicine prescribed for your mental health needs, were you given information about it in a way that you were able to understand?
National: 70% (2016: 54%)  NSFT Score: 70% ↑  NSFT 2016: 42%

<table>
<thead>
<tr>
<th>Response</th>
<th>Numerator</th>
<th>Denominator</th>
<th>Score</th>
<th>Trend NSFT</th>
<th>Trend w/All</th>
</tr>
</thead>
<tbody>
<tr>
<td>Norfolk West</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>Norfolk Central</td>
<td>39</td>
<td>50</td>
<td>78%</td>
<td>+26</td>
<td>+10</td>
</tr>
<tr>
<td>GY&amp;W</td>
<td>18</td>
<td>27</td>
<td>67%</td>
<td>+23</td>
<td>+7</td>
</tr>
<tr>
<td>Suffolk East</td>
<td>26</td>
<td>38</td>
<td>68%</td>
<td>+29</td>
<td>+13</td>
</tr>
<tr>
<td>Suffolk West</td>
<td>13</td>
<td>23</td>
<td>57%</td>
<td>+9</td>
<td>-7</td>
</tr>
</tbody>
</table>

Question 28 – Have you been receiving any medicines for your mental health needs for 12 months or longer?

<table>
<thead>
<tr>
<th>Response</th>
<th>National</th>
<th>All NSFT</th>
<th>Norfolk West</th>
<th>Norfolk Central</th>
<th>GY&amp;W</th>
<th>Suffolk East</th>
<th>Suffolk West</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>87%</td>
<td>84%</td>
<td>65%</td>
<td>82%</td>
<td>86%</td>
<td>88%</td>
<td>79%</td>
</tr>
<tr>
<td>No</td>
<td>13%</td>
<td>16%</td>
<td>35%</td>
<td>18%</td>
<td>12%</td>
<td>13%</td>
<td>21%</td>
</tr>
<tr>
<td>Not sure</td>
<td>2%</td>
<td>1%</td>
<td>5%</td>
<td>1%</td>
<td>2%</td>
<td>0%</td>
<td>0%</td>
</tr>
</tbody>
</table>
Question 29 – In the last 12 months, has an NHS mental health worker checked with you about how you are getting on with your medicines?

National: 77% (2016: 78%)
NSFT Score: 75% ↑
NSFT 2016: 70%

<table>
<thead>
<tr>
<th>Response</th>
<th>Numerator</th>
<th>Denominator</th>
<th>Score</th>
<th>Trend NSFT</th>
<th>Trend w/All</th>
</tr>
</thead>
<tbody>
<tr>
<td>Norfolk West</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>Norfolk Central</td>
<td>41</td>
<td>59</td>
<td>69%</td>
<td>+16</td>
<td>+17</td>
</tr>
<tr>
<td>GY&amp;W</td>
<td>28</td>
<td>37</td>
<td>76%</td>
<td>+3</td>
<td>+4</td>
</tr>
<tr>
<td>Suffolk East</td>
<td>54</td>
<td>59</td>
<td>92%</td>
<td>+12</td>
<td>+13</td>
</tr>
<tr>
<td>Suffolk West</td>
<td>21</td>
<td>32</td>
<td>66%</td>
<td>-5</td>
<td>-4</td>
</tr>
</tbody>
</table>

Question 30 – In the last 12 months, have you received any treatments or therapies for your mental health needs that do not involve medicines?
Response | National | All NSFT | West Norfolk | Norfolk Central | GY&W | Suffolk East | Suffolk West
--- | --- | --- | --- | --- | --- | --- | ---
Yes | 47% | 42% | 39% | 39% | 37% | 43% | 53%
No, but I would have liked this | 26% | 33% | 33% | 37% | 35% | 33% | 33%
No, but I did not mind | 27% | 25% | 28% | 24% | 28% | 24% | 15%
This was not appropriate for me | 17% | 14% | 25% | 12% | 9% | 14% | 13%
Don't know / Can't remember | 6% | 6% | 0% | 6% | 14% | 1% | 2%

Question 31 – Were these treatments or therapies explained to you in a way you could understand?

![Bar chart showing response percentages]

**National: 74% (2016: 68%)**  
**NSFT Score: 69%**  
**NSFT 2016: 69%**

<table>
<thead>
<tr>
<th>Response</th>
<th>Numerator</th>
<th>Denominator</th>
<th>Score</th>
<th>Trend NSFT</th>
<th>Trend w/All</th>
</tr>
</thead>
<tbody>
<tr>
<td>Norfolk West</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>Norfolk Central</td>
<td>26</td>
<td>38</td>
<td>68%</td>
<td>-4</td>
<td>-10</td>
</tr>
<tr>
<td>GY&amp;W</td>
<td>18</td>
<td>26</td>
<td>69%</td>
<td>-5</td>
<td>-11</td>
</tr>
<tr>
<td>Suffolk East</td>
<td>26</td>
<td>32</td>
<td>81%</td>
<td>+6</td>
<td>-</td>
</tr>
<tr>
<td>Suffolk West</td>
<td>15</td>
<td>23</td>
<td>65%</td>
<td>+2</td>
<td>-4</td>
</tr>
</tbody>
</table>
Question 32 – Were you involved as much as you wanted to be in deciding what treatments or therapies to use?

![Bar chart showing involvement scores across different regions]

**National: 67% (2016: 56%)**  
**NSFT Score: 62% ↑**  
**NSFT 2016: 53%**

<table>
<thead>
<tr>
<th>Response</th>
<th>Numerator</th>
<th>Denominator</th>
<th>Score</th>
<th>Trend NSFT</th>
<th>Trend w/All</th>
</tr>
</thead>
<tbody>
<tr>
<td>Norfolk West</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>Norfolk Central</td>
<td>19</td>
<td>34</td>
<td>56%</td>
<td>-6</td>
<td>-17</td>
</tr>
<tr>
<td>GY&amp;W</td>
<td>13</td>
<td>22</td>
<td>59%</td>
<td>+3</td>
<td>-8</td>
</tr>
<tr>
<td>Suffolk East</td>
<td>21</td>
<td>29</td>
<td>72%</td>
<td>+34</td>
<td>+23</td>
</tr>
<tr>
<td>Suffolk West</td>
<td>15</td>
<td>24</td>
<td>63%</td>
<td>+15</td>
<td>+4</td>
</tr>
</tbody>
</table>

Section 9: SUPPORT AND WELLBEING

Question 33 – In the last 12 months, did NHS mental health services give you any help or advice with finding support for physical health needs?
National: 51% (2016: 37%)  
NSFT Score: 45% ↑  
NSFT 2016: 31%

<table>
<thead>
<tr>
<th>Response</th>
<th>Numerator</th>
<th>Denominator</th>
<th>Score</th>
<th>Trend NSFT</th>
<th>Trend w/All</th>
</tr>
</thead>
<tbody>
<tr>
<td>Norfolk West</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>Norfolk Central</td>
<td>24</td>
<td>50</td>
<td>41%</td>
<td>+7</td>
<td>-7</td>
</tr>
<tr>
<td>GY&amp;W</td>
<td>12</td>
<td>33</td>
<td>39%</td>
<td>-3</td>
<td>-17</td>
</tr>
<tr>
<td>Suffolk East</td>
<td>18</td>
<td>41</td>
<td>21%</td>
<td>+23</td>
<td>+9</td>
</tr>
<tr>
<td>Suffolk West</td>
<td>10</td>
<td>22</td>
<td>31%</td>
<td>+14</td>
<td>-</td>
</tr>
</tbody>
</table>

Question 34 – In the last 12 months, did NHS mental health services give you any help or advice with finding support for financial advice or benefits?

National: 44% (2016: 33%)  
NSFT Score: 42% ↑  
NSFT 2016: 28%

<table>
<thead>
<tr>
<th>Response</th>
<th>Numerator</th>
<th>Denominator</th>
<th>Score</th>
<th>Trend NSFT</th>
<th>Trend w/All</th>
</tr>
</thead>
<tbody>
<tr>
<td>Norfolk West</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>Norfolk Central</td>
<td>21</td>
<td>59</td>
<td>35%</td>
<td>+1</td>
<td>-10</td>
</tr>
<tr>
<td>GY&amp;W</td>
<td>12</td>
<td>38</td>
<td>27%</td>
<td>+5</td>
<td>-6</td>
</tr>
<tr>
<td>Suffolk East</td>
<td>23</td>
<td>43</td>
<td>29%</td>
<td>+24</td>
<td>+13</td>
</tr>
<tr>
<td>Suffolk West</td>
<td>12</td>
<td>29</td>
<td>15%</td>
<td>+26</td>
<td>+15</td>
</tr>
</tbody>
</table>
Question 35 – In the last 12 months, did NHS mental health services give you any help or advice with finding support for finding or keeping work?

National: 42% (2016: 29%)  
NSFT Score: 34% ↑  
NSFT 2016: 16%

<table>
<thead>
<tr>
<th>Response</th>
<th>Numerator</th>
<th>Denominator</th>
<th>Score</th>
<th>Trend NSFT</th>
<th>Trend w/All</th>
</tr>
</thead>
<tbody>
<tr>
<td>Norfolk West</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>Norfolk Central</td>
<td>10</td>
<td>21</td>
<td>48%</td>
<td>+40</td>
<td>+27</td>
</tr>
<tr>
<td>GY&amp;W</td>
<td>6</td>
<td>20</td>
<td>30%</td>
<td>+6</td>
<td>-7</td>
</tr>
<tr>
<td>Suffolk East</td>
<td>7</td>
<td>23</td>
<td>30%</td>
<td>+12</td>
<td>-1</td>
</tr>
<tr>
<td>Suffolk West</td>
<td>7</td>
<td>17</td>
<td>41%</td>
<td>+24</td>
<td>+11</td>
</tr>
</tbody>
</table>

Question 36 – Has someone from NHS mental health services supported you in taking part in an activity locally?
### National: 44% (2016: 30%)

NSFT Score: 41% ↑

<table>
<thead>
<tr>
<th>Response</th>
<th>Numerator</th>
<th>Denominator</th>
<th>Score</th>
<th>Trend NSFT</th>
<th>Trend w/All</th>
</tr>
</thead>
<tbody>
<tr>
<td>Norfolk West</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>Norfolk Central</td>
<td>14</td>
<td>50</td>
<td>28%</td>
<td>+6</td>
<td>-8</td>
</tr>
<tr>
<td>GY&amp;W</td>
<td>14</td>
<td>30</td>
<td>47%</td>
<td>+11</td>
<td>-3</td>
</tr>
<tr>
<td>Suffolk East</td>
<td>21</td>
<td>40</td>
<td>53%</td>
<td>+36</td>
<td>+22</td>
</tr>
<tr>
<td>Suffolk West</td>
<td>15</td>
<td>30</td>
<td>50%</td>
<td>+34</td>
<td>+20</td>
</tr>
</tbody>
</table>

### Question 37 – Have NHS mental health services involved a member of your family or someone else close to you as much as you would like?

#### National: 68% (2016: 56%)

NSFT Score: 66% ↑

<table>
<thead>
<tr>
<th>Response</th>
<th>Numerator</th>
<th>Denominator</th>
<th>Score</th>
<th>Trend NSFT</th>
<th>Trend w/All</th>
</tr>
</thead>
<tbody>
<tr>
<td>West Norfolk</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>Norfolk Central</td>
<td>46</td>
<td>64</td>
<td>72%</td>
<td>+17</td>
<td>+5</td>
</tr>
<tr>
<td>GY&amp;W</td>
<td>23</td>
<td>43</td>
<td>53%</td>
<td>+2</td>
<td>-10</td>
</tr>
<tr>
<td>Suffolk East</td>
<td>37</td>
<td>55</td>
<td>67%</td>
<td>+29</td>
<td>+17</td>
</tr>
<tr>
<td>Suffolk West</td>
<td>20</td>
<td>34</td>
<td>59%</td>
<td>+16</td>
<td>+4</td>
</tr>
</tbody>
</table>
Question 38 – Have you been given information by NHS mental health services about getting support from people who have experience of the same mental health needs as you?

National: 38% (2016: 25%)  
NSFT Score: 34% ↑  
NSFT 2016: 20%

<table>
<thead>
<tr>
<th>Response</th>
<th>Numerator</th>
<th>Denominator</th>
<th>Score</th>
<th>Trend NSFT</th>
<th>Trend w/All</th>
</tr>
</thead>
<tbody>
<tr>
<td>Norfolk West</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>Norfolk Central</td>
<td>19</td>
<td>61</td>
<td>31%</td>
<td>+5</td>
<td>-8</td>
</tr>
<tr>
<td>GY&amp;W</td>
<td>15</td>
<td>39</td>
<td>38%</td>
<td>+14</td>
<td>+1</td>
</tr>
<tr>
<td>Suffolk East</td>
<td>17</td>
<td>52</td>
<td>33%</td>
<td>+24</td>
<td>+11</td>
</tr>
<tr>
<td>Suffolk West</td>
<td>14</td>
<td>31</td>
<td>45%</td>
<td>+34</td>
<td>+21</td>
</tr>
</tbody>
</table>

Question 39 – Do the people you see through NHS mental health services help you with what is important to you?
### National: 64% (2016: 47%)  
NSFT Score: 60% ↑  
NSFT 2016: 38%

<table>
<thead>
<tr>
<th>Response</th>
<th>Numerator</th>
<th>Denominator</th>
<th>Score</th>
<th>Trend NSFT</th>
<th>Trend w/All</th>
</tr>
</thead>
<tbody>
<tr>
<td>Norfolk West</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>Norfolk Central</td>
<td>55</td>
<td>95</td>
<td>38%</td>
<td>+20</td>
<td>+3</td>
</tr>
<tr>
<td>GY&amp;W</td>
<td>31</td>
<td>58</td>
<td>42%</td>
<td>+11</td>
<td>-6</td>
</tr>
<tr>
<td>Suffolk East</td>
<td>51</td>
<td>78</td>
<td>33%</td>
<td>+32</td>
<td>+15</td>
</tr>
<tr>
<td>Suffolk West</td>
<td>29</td>
<td>48</td>
<td>39%</td>
<td>+21</td>
<td>+4</td>
</tr>
</tbody>
</table>

### Section 10: OVERALL

**Question 40 – Overall please indicate whether you had a very good or poor experience.**

<table>
<thead>
<tr>
<th>Response</th>
<th>Numerator</th>
<th>Denominator</th>
<th>Score</th>
<th>Trend NSFT</th>
<th>Trend w/All</th>
</tr>
</thead>
<tbody>
<tr>
<td>Norfolk West</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>Norfolk Central</td>
<td>62</td>
<td>97</td>
<td>64%</td>
<td>+30</td>
<td>-6</td>
</tr>
<tr>
<td>GY&amp;W</td>
<td>34</td>
<td>64</td>
<td>63%</td>
<td>+30</td>
<td>-6</td>
</tr>
<tr>
<td>Suffolk East</td>
<td>53</td>
<td>78</td>
<td>68%</td>
<td>+52</td>
<td>+16</td>
</tr>
<tr>
<td>Suffolk West</td>
<td>26</td>
<td>44</td>
<td>59%</td>
<td>+29</td>
<td>-7</td>
</tr>
</tbody>
</table>
Question 41 – Overall in the last 12 months, did you feel that you were treated with respect and dignity by NHS mental health services?

National: 83% (2016: 74%) NSFT Score: 78% ↑ NSFT 2016: 69%

<table>
<thead>
<tr>
<th>Response</th>
<th>Numerator</th>
<th>Denominator</th>
<th>Score</th>
<th>Trend NSFT</th>
<th>Trend w/All</th>
</tr>
</thead>
<tbody>
<tr>
<td>Norfolk West</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>Norfolk Central</td>
<td>77</td>
<td>100</td>
<td>77%</td>
<td>+6</td>
<td>-3</td>
</tr>
<tr>
<td>GY&amp;W</td>
<td>44</td>
<td>58</td>
<td>76%</td>
<td>-2</td>
<td>-11</td>
</tr>
<tr>
<td>Suffolk East</td>
<td>66</td>
<td>78</td>
<td>85%</td>
<td>+23</td>
<td>+14</td>
</tr>
<tr>
<td>Suffolk West</td>
<td>34</td>
<td>47</td>
<td>72%</td>
<td>+8</td>
<td>-1</td>
</tr>
</tbody>
</table>
## Section 11: SUMMARY OF RESULTS BY LOCALITY

### Trend Map A (comparing NSFT results in 2016)

<table>
<thead>
<tr>
<th>Q No.</th>
<th>Norf. West</th>
<th>Norf. Cent.</th>
<th>GYW</th>
<th>Suffolk East</th>
<th>Suffolk West</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>n/a</td>
<td>12</td>
<td>9</td>
<td>30</td>
<td>9</td>
</tr>
<tr>
<td>4</td>
<td>n/a</td>
<td>7</td>
<td>13</td>
<td>14</td>
<td>2</td>
</tr>
<tr>
<td>5</td>
<td>n/a</td>
<td>14</td>
<td>7</td>
<td>20</td>
<td>8</td>
</tr>
<tr>
<td>6</td>
<td>n/a</td>
<td>12</td>
<td>11</td>
<td>33</td>
<td>13</td>
</tr>
<tr>
<td>7</td>
<td>n/a</td>
<td>-9</td>
<td>9</td>
<td>24</td>
<td>1</td>
</tr>
<tr>
<td>9</td>
<td>n/a</td>
<td>-1</td>
<td>-6</td>
<td>3</td>
<td>-9</td>
</tr>
<tr>
<td>10</td>
<td>n/a</td>
<td>-3</td>
<td>-17</td>
<td>-3</td>
<td>-10</td>
</tr>
<tr>
<td>11</td>
<td>n/a</td>
<td>16</td>
<td>7</td>
<td>42</td>
<td>28</td>
</tr>
<tr>
<td>12</td>
<td>n/a</td>
<td>18</td>
<td>15</td>
<td>40</td>
<td>6</td>
</tr>
<tr>
<td>13</td>
<td>n/a</td>
<td>19</td>
<td>17</td>
<td>45</td>
<td>0</td>
</tr>
<tr>
<td>14</td>
<td>n/a</td>
<td>2</td>
<td>-8</td>
<td>5</td>
<td>-5</td>
</tr>
<tr>
<td>15</td>
<td>n/a</td>
<td>0</td>
<td>21</td>
<td>35</td>
<td>6</td>
</tr>
<tr>
<td>16</td>
<td>n/a</td>
<td>10</td>
<td>10</td>
<td>21</td>
<td>9</td>
</tr>
<tr>
<td>18</td>
<td>n/a</td>
<td>13</td>
<td>30</td>
<td>43</td>
<td>17</td>
</tr>
<tr>
<td>19</td>
<td>n/a</td>
<td>39</td>
<td>49</td>
<td>50</td>
<td>42</td>
</tr>
<tr>
<td>20</td>
<td>n/a</td>
<td>14</td>
<td>18</td>
<td>40</td>
<td>12</td>
</tr>
<tr>
<td>21</td>
<td>n/a</td>
<td>-5</td>
<td>-10</td>
<td>14</td>
<td>-3</td>
</tr>
<tr>
<td>23</td>
<td>n/a</td>
<td>38</td>
<td>9</td>
<td>8</td>
<td>-14</td>
</tr>
<tr>
<td>25</td>
<td>n/a</td>
<td>28</td>
<td>20</td>
<td>28</td>
<td>4</td>
</tr>
<tr>
<td>27</td>
<td>n/a</td>
<td>26</td>
<td>23</td>
<td>29</td>
<td>9</td>
</tr>
<tr>
<td>29</td>
<td>n/a</td>
<td>16</td>
<td>3</td>
<td>12</td>
<td>-5</td>
</tr>
<tr>
<td>31</td>
<td>n/a</td>
<td>-4</td>
<td>-5</td>
<td>6</td>
<td>2</td>
</tr>
<tr>
<td>32</td>
<td>n/a</td>
<td>-6</td>
<td>3</td>
<td>34</td>
<td>15</td>
</tr>
<tr>
<td>33</td>
<td>n/a</td>
<td>7</td>
<td>-3</td>
<td>23</td>
<td>14</td>
</tr>
<tr>
<td>34</td>
<td>n/a</td>
<td>1</td>
<td>5</td>
<td>24</td>
<td>26</td>
</tr>
<tr>
<td>35</td>
<td>n/a</td>
<td>40</td>
<td>6</td>
<td>12</td>
<td>24</td>
</tr>
<tr>
<td>36</td>
<td>n/a</td>
<td>6</td>
<td>11</td>
<td>36</td>
<td>34</td>
</tr>
<tr>
<td>37</td>
<td>n/a</td>
<td>17</td>
<td>2</td>
<td>29</td>
<td>16</td>
</tr>
<tr>
<td>38</td>
<td>n/a</td>
<td>5</td>
<td>14</td>
<td>24</td>
<td>34</td>
</tr>
<tr>
<td>39</td>
<td>n/a</td>
<td>20</td>
<td>11</td>
<td>32</td>
<td>21</td>
</tr>
<tr>
<td>40</td>
<td>n/a</td>
<td>30</td>
<td>30</td>
<td>52</td>
<td>29</td>
</tr>
<tr>
<td>41</td>
<td>n/a</td>
<td>6</td>
<td>-2</td>
<td>23</td>
<td>8</td>
</tr>
<tr>
<td>Total</td>
<td>n/a</td>
<td>388</td>
<td>302</td>
<td>828</td>
<td>343</td>
</tr>
</tbody>
</table>

### Trend Map B (comparing NSFT change with All)

<table>
<thead>
<tr>
<th>Q No.</th>
<th>Norf. West</th>
<th>Norf. Cent.</th>
<th>GYW</th>
<th>Suffolk East</th>
<th>Suffolk West</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>n/a</td>
<td>-3</td>
<td>-6</td>
<td>15</td>
<td>-6</td>
</tr>
<tr>
<td>4</td>
<td>n/a</td>
<td>-3</td>
<td>2</td>
<td>3</td>
<td>-9</td>
</tr>
<tr>
<td>5</td>
<td>n/a</td>
<td>-2</td>
<td>-5</td>
<td>8</td>
<td>-4</td>
</tr>
<tr>
<td>6</td>
<td>n/a</td>
<td>-4</td>
<td>-5</td>
<td>17</td>
<td>-3</td>
</tr>
<tr>
<td>7</td>
<td>n/a</td>
<td>-7</td>
<td>11</td>
<td>26</td>
<td>3</td>
</tr>
<tr>
<td>9</td>
<td>n/a</td>
<td>-1</td>
<td>-6</td>
<td>3</td>
<td>-9</td>
</tr>
<tr>
<td>10</td>
<td>n/a</td>
<td>6</td>
<td>-8</td>
<td>6</td>
<td>-1</td>
</tr>
<tr>
<td>11</td>
<td>n/a</td>
<td>1</td>
<td>-8</td>
<td>27</td>
<td>13</td>
</tr>
<tr>
<td>12</td>
<td>n/a</td>
<td>0</td>
<td>-3</td>
<td>22</td>
<td>-12</td>
</tr>
<tr>
<td>13</td>
<td>n/a</td>
<td>-1</td>
<td>-1</td>
<td>27</td>
<td>-18</td>
</tr>
<tr>
<td>14</td>
<td>n/a</td>
<td>2</td>
<td>-8</td>
<td>5</td>
<td>-5</td>
</tr>
<tr>
<td>15</td>
<td>n/a</td>
<td>-15</td>
<td>6</td>
<td>20</td>
<td>-9</td>
</tr>
<tr>
<td>16</td>
<td>n/a</td>
<td>-3</td>
<td>-3</td>
<td>8</td>
<td>-4</td>
</tr>
<tr>
<td>18</td>
<td>n/a</td>
<td>-1</td>
<td>16</td>
<td>29</td>
<td>3</td>
</tr>
<tr>
<td>19</td>
<td>n/a</td>
<td>-7</td>
<td>3</td>
<td>7</td>
<td>-4</td>
</tr>
<tr>
<td>20</td>
<td>n/a</td>
<td>15</td>
<td>19</td>
<td>41</td>
<td>13</td>
</tr>
<tr>
<td>21</td>
<td>n/a</td>
<td>-6</td>
<td>-11</td>
<td>13</td>
<td>-4</td>
</tr>
<tr>
<td>23</td>
<td>n/a</td>
<td>26</td>
<td>-3</td>
<td>-4</td>
<td>-26</td>
</tr>
<tr>
<td>25</td>
<td>n/a</td>
<td>10</td>
<td>2</td>
<td>10</td>
<td>-14</td>
</tr>
<tr>
<td>27</td>
<td>n/a</td>
<td>10</td>
<td>7</td>
<td>13</td>
<td>-7</td>
</tr>
<tr>
<td>29</td>
<td>n/a</td>
<td>17</td>
<td>4</td>
<td>13</td>
<td>-4</td>
</tr>
<tr>
<td>31</td>
<td>n/a</td>
<td>-10</td>
<td>-11</td>
<td>0</td>
<td>-4</td>
</tr>
<tr>
<td>32</td>
<td>n/a</td>
<td>-17</td>
<td>-8</td>
<td>23</td>
<td>4</td>
</tr>
<tr>
<td>33</td>
<td>n/a</td>
<td>-7</td>
<td>-17</td>
<td>9</td>
<td>0</td>
</tr>
<tr>
<td>34</td>
<td>n/a</td>
<td>-10</td>
<td>-6</td>
<td>13</td>
<td>15</td>
</tr>
<tr>
<td>35</td>
<td>n/a</td>
<td>27</td>
<td>-7</td>
<td>-1</td>
<td>11</td>
</tr>
<tr>
<td>36</td>
<td>n/a</td>
<td>-8</td>
<td>-3</td>
<td>22</td>
<td>20</td>
</tr>
<tr>
<td>37</td>
<td>n/a</td>
<td>5</td>
<td>-10</td>
<td>17</td>
<td>4</td>
</tr>
<tr>
<td>38</td>
<td>n/a</td>
<td>-8</td>
<td>1</td>
<td>11</td>
<td>21</td>
</tr>
<tr>
<td>39</td>
<td>n/a</td>
<td>3</td>
<td>-6</td>
<td>15</td>
<td>4</td>
</tr>
<tr>
<td>40</td>
<td>n/a</td>
<td>-6</td>
<td>-6</td>
<td>16</td>
<td>-7</td>
</tr>
<tr>
<td>41</td>
<td>n/a</td>
<td>-3</td>
<td>-11</td>
<td>14</td>
<td>-1</td>
</tr>
<tr>
<td>Total</td>
<td>n/a</td>
<td>6</td>
<td>-81</td>
<td>448</td>
<td>-40</td>
</tr>
</tbody>
</table>

**Trend Map A** shows marked improvement compared to our results in 2016 with an average increase of 15% points per survey question. However, there has also been marked improvement in scores nationally.

**Trend Map B** shows comparison with the national results for all MH Trusts. Suffolk East shows a remarkable average of 14% greater improvement per question compared to other mental health Trusts. Central Norfolk kept pace with the national improvement trend, while GY&W shows an average of 2.5% per question behind the national trend and West Suffolk 1.25% behind.
### Overall Performance by Locality in 2016 and 2017:

<table>
<thead>
<tr>
<th>Locality</th>
<th>2016</th>
<th>Position</th>
<th>2017</th>
<th>Position</th>
</tr>
</thead>
<tbody>
<tr>
<td>West Norfolk</td>
<td>45%</td>
<td>4th</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>Central Norfolk</td>
<td>53%</td>
<td>2nd</td>
<td>60%</td>
<td>3rd</td>
</tr>
<tr>
<td>GY&amp;W</td>
<td>54%</td>
<td>1st</td>
<td>60%</td>
<td>2nd</td>
</tr>
<tr>
<td>Suffolk East</td>
<td>44%</td>
<td>5th</td>
<td>66%</td>
<td>1st</td>
</tr>
<tr>
<td>Suffolk West</td>
<td>52%</td>
<td>3rd</td>
<td>58%</td>
<td>4th</td>
</tr>
</tbody>
</table>

---

Marcus Hayward  
Head of Recovery, Participation and Partnership
Report To: Council of Governors
Meeting Date: 11 January 2018
Title of Report: Service User & Carer Trust Partnership Chairs report – 5 December 2017
Action Sought: For Assurance
Estimated time: 10 minutes
Author: Gary Page – Non-Executive Director

Executive Summary:

The report provides an update to the CoG on issues reviewed by the Trust’s Service User & Carer Trust Partnership on 5 December 2017.

Assurance review

<table>
<thead>
<tr>
<th>Issue reviewed by committee</th>
<th>Commentary (including actions where required)</th>
<th>Level of assurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improving Services Together Project</td>
<td>We discussed concerns expressed by some Governors that issues raised by Service Users and carers were not being heard because the Locality Hub model was not working. It was agreed that whilst formal meetings had a place they could not be the channel through which the SU voice was expected to be heard. It was agreed that a delegation would visit East London’s equivalent to the Partnership and Marcus would bring a proposal back to the March meeting recommending some changes to how we can better hear what service users are telling us.</td>
<td>RED</td>
</tr>
<tr>
<td>Recovery Strategy</td>
<td>PMO support for rolling out the next stage has been put on hold because of the focus on the CQC Report but assurance was provided that this is not impacting on the day to day operations of the Recovery College.</td>
<td>GREEN</td>
</tr>
<tr>
<td>Youth Participation</td>
<td>We received an update from the Youth Participation Lead. There is an initiative to focus the YCS on 18-25 year olds with under 18s being signposted to Mancroft Advice Project in Norfolk or CCG led youth structures in Suffolk. This</td>
<td>GREEN</td>
</tr>
</tbody>
</table>
appeared to been contrary to the youth strategy and was to be taken up outside the meeting and reported back. Overall good assurance on the progress being made although efforts need to be made especially in Suffolk to increase the number of people involved. We will now have a Youth Partner Governor again which is welcome.

Recommendations

The CoG is asked to note the highlighted issues within the Partnership.

Gary Page
Chair of Service User and Carer Trust Partnership
6 Governors attended the meeting

The main topics discussed are set out below.

1.0 Task and finish groups

a. Website and social media - It had not been possible to convene a meeting to discuss this. The Communications Team will attempt to set up another meeting once current workload to do with CQC follow up subsides. In the meantime, all governors are asked to review their personal profile information on the website.

b. Governor display materials - three governors are working on revised leaflets and poster type materials to be used at events and engagement opportunities. There is money available for this from the vacant Membership Officer post and the communications Team will assist in putting the new material together with a view to having it available in the New Year.

2.0 Community engagement

We had a useful discussion with Oliver Cruickshank from South Norfolk CCG about the potential for governors to attend meetings of CCG Community Engagement Panels and concluded that we should pursue this as part of a more systematic approach to Governor engagement with the public. Further groundwork will be undertaken with a view to identifying opportunities for governor attendance in 2018, as new Governors take up their positions.

3.0 Member survey

We discussed the results of a simple survey of members to which 190 people had responded (about 6% of the member database). We were surprised that staff were not included in the database and recommend that they be asked if they wish to be included and if so to supply a private email address.

Key results from the survey:
• Around a third of respondents were not sure or did not agree that they were **adequately informed** as a member of the Trust.

• **Attendance at Trust events** where they could express their views- just under a half agreed that they had attended events where they could express their views.

• **Involvement**- around a third said they would like to get more involved.

• **Governor contact**- around 40% thought that governors stayed in touch with them, but nearly a third disagreed. The group agreed that a diversity of communication methods needed to be developed, including a further look at the relative costs and benefits of 'Insight' and shorter, more frequent newsletter style publications.

• **Knowing how to contact governors**- over half were not sure or did not know how to contact Governors. The Group discussed things like personalising email contact addresses and personal business cards as opposed to corporate ones.

• **Governor performance**- around a quarter agreed that Governors were fulfilling their duties, the same proportion disagreeing. Around a half were unsure. This underlines the importance of Governor visibility and accountability in demonstrating their effectiveness.

4.0 **Member half day events**

We reviewed the **Talking Therapies' event**. Evaluations from those attending (completed by about half of the attendees) were generally positive and members of the Sub group agreed that the event was very useful; there was a good variety of presentations and balance between these and questions.

**The dates and venues for 2018 were agreed as**

- March 22\textsuperscript{nd} - Norwich (King’s Centre)- topic ‘Social Prescribing’
- November 1\textsuperscript{st} - Ipswich (venue and topic to be considered)

We also agreed that localities should be encouraged to organise outward facing events such as the recent one on Men’s Mental Health in king’s Lynn, to complement the Norwich and Ipswich locations of these major events.

5.0 **Governor Self Evaluation and Governor Training Programme**

We did not go into the Governor self-evaluation in detail, but agreed that there was nothing in it to alter the previously discussed and agreed Training Programme for 2018, the dates and venues for which had been circulated to Governors.

We noted the recent CoG decision to convert the three former ‘strategy’ training sessions into joint CoG-BoD meetings to discuss and develop strategy in key areas, but decided to hold off firming up the topics for these until the New Year, once CQC related work and personnel changes had had time to bed in.

6.0 **Recommendation:**

The CoG is asked to note the report.

**Nigel Boldero, Chair - Norfolk Public Governor**

19 November 2017

### Background Papers / Information

None
Executive Summary:

The Planning and Performance Sub Group met on 16 November 2017 and draws your attention to the following issues below.

1.0 Overview and Assurance Group Presentation

Gary Page advised that two meetings had been undertaken with NHSI to date, a Performance Review meeting with NSFT, and the initial Overview and Assurance Group (OAG) meeting. NSFT is supported in its progress by the appointment of an Improvement Director, (Philippa Slinger) and a Buddy Trust (East London). It was recognised that there would be differences in the Trust’s approach to the CQC requirements and a plan was in place to address the four systemic issues (Leadership, Medical Engagement, Staff Engagement, and Culture.) The plan had been extensively debated by the NEDs and the Executive team and one NED would attend the weekly Quality Programme Board to evaluate progress and slippages. Other differences reflected greater NED involvement, engagement and capacity of the Buddy Trust, alignment of service lines and a different tone within the Executive team regarding manageable targets and performance.

The changes to the Executive team were outlined and the plans for recruitment.

2.0 Overview and Assurance Group inaugural meeting

Catherine Wells, as Lead Governor attends the OAG meetings which include representation from NSFT, CCGs, Healthwatch, HOSC, County Councils, NHSE, HEE, CQC, the GMC, Carers, Service Users, The Buddy Trust, the Improvement Director and NHSI. Both counties were represented and the monthly meetings alternate between Norfolk and Suffolk.

The purpose of the meetings is to seek assurance thus it will support and challenge continued quality improvement in the Trust and provide the system with a collective oversight and assurance of this progress.

The initial meeting included a presentation from CQC regarding the process and outcome from the visit and a response from the NSFT Executive on the Improvement Plan.
3.0 P and P governor representatives for the Quality Account.

It was agreed that the P and P Co Chairs, Catherine Wells and Martin Wright would undertake the Quality Account report.

4.0 NED observations on their locality / service – Gary Page

Gary reported that staffing in West Norfolk remains challenging particularly for consultants with an overreliance of locums. The Psychiatric Liaison services are poor and support for mental health issues outside normal working hours is very limited. However the relocation of the inpatient beds to Chatterton House is positive and the relationship with the CCQ is improving. The Service User and Carer hub is making good progress.

5.0 IPC subgroup – Guenever Pachent

The subgroup questioned the Director of Nursing, Quality and Patient Safety recruitment process and also the equity of engagement between Norfolk and Suffolk staff.

It was agreed that IPC3 would replace IPC2 in the light of the Trust reverting to special measures and that the format of the meetings would be through monthly teleconferencing. IPC3 would report to the Council of Governors as opposed to the Planning and Performance subcommittee.

6.0 Recommendation

The Council of Governors is asked to note this report.

Catherine Wells
Co-Chair P&P
Public Governor, Norfolk
30 December 2017
1.0 Update on NHSI guidance on developmental well-led reviews

It was reported that NHSI had removed the requirement for the Council of Governors to be involved in the selection of a provider to deliver well-led reviews. The new guidance applies to all NHS Trusts since NHSI now regulates both Foundation Trusts and NHS Trusts. The latter do not have Governing bodies hence the removal of the reference.

However it was agreed that the outcome of a review would be reported to the Council of Governors via the Nominations Committee as had occurred previously.

2.0 Update on interim appraisals

The outcome of interim appraisals of the non-executive directors and the Chair were received by the committee and discussed.

Following the CQC inspection in the summer, the NEDs had discussed the possibility of re-aligning themselves by service line instead of the current locality arrangements. Following the publication of the report this was agreed as a sensible way forward as there are different challenges within different service lines across the Trust and this is now in effect.

Elections for the vacancies on the Nominations Committee will be considered at the April Council of Governors meeting.

3.0 Recommendations

The CoG is asked to note the contents of this report.

Marion Saunders
SID / Chair of Nominations Committee
11 December 2017

Background Papers / Information
None.
Executive Summary:

The IPC3 Sub-Group met on 18 December 2017 and the Chair draws your attention to the following issues below.

1.0 Improvement Plan Co-ordination subgroup (IPC3)

The inaugural meeting of IPC3 took place in December by teleconference. This was attended by four members of the IPC2 group and, whilst secretarial support was provided to circulate the agenda and supporting papers, there was no Trust representative on the committee.

Purpose of the Group:

It was agreed at the Planning and Performance meeting (November 2017) that the current subgroup, IPC2, should revert to its former arrangements which were instigated when the Trust was in special measures for the first time. The monthly IPC3 meetings will precede, by three days, the Board of Directors meetings so that the IPC governors may comment on, seek assurance and contribute, via the Chair, to the progress of the Improvement Plan.

Key activities of IPC3:

- To coordinate IPC member observations of Board subcommittees, (OD &W, QGC, Finance, Audit and Risk)
- To review the Quality Programme Board report to receive progress on the CQC Improvement Plan
- To receive feedback from the Lead Governor on the Overview and Assurance Group meetings
• To report the activity of the group to the Chair of NSFT and to the Council of Governors

The December meeting addressed the following items:-

• The terms of reference required updating – in progress
• Membership: expressions of interest will be sought from existing governors wishing to join the group as there will be two vacancies. The membership will be limited to 8 members, therefore each Board sub-committee will have two named members to share the committee observation role which provides assurance on the work of the NEDs in chairing and contributing to the business of the committee.
• Quality Programme Board review and Improvement plan update: There were no updated papers received as there was no Board meeting for December. There was positive comment on the action plan with its clearly defined responsibilities but, as there was no representation from the Trust the group were unable to gain assurance or undertake their role of holding to account.
• Oversight and Assurance Group update: The lead governor had attended the first two monthly meetings which were chaired by NHSI and included representatives from NSFT and a wide range stakeholders across Norfolk and Suffolk. The first meeting included a presentation from CQC on their visit and findings with a response from NSFT on their action plan. The second meeting agreed the terms of reference, and considered a progress report and changes to personnel. The first Deep Dive item was ‘Well led, board development, divisional/locality leadership’ which reviewed changes to date, what is different in this approach and how success will be measured.
• Sub-committee observations: One report from the Finance subcommittee was received and discussed to ensure sufficient assurance.

Following the meeting there was discussion between the lead governor and the Company Secretary regarding the concerns which were raised that information was not getting through to the committee in an informed and timely manner. It was agreed that, as the PMO forms part of the Company Secretary’s portfolio, he would be able to facilitate the meeting and provide information on the quality programme board report.

The next meeting of IPC3 will take place by teleconference on 22.01.18 which precedes the January Board of Directors meeting.

2.0 Recommendation

The Council of Governors is asked to note this report.

Catherine Wells
Lead Governor – Chair IPC
2 January 2018
Terms of Reference
Improvement Plan Coordination (IPC) - Governor Sub-Group

1. Purpose and context

The IPC was set up as a governor response to the Trust entering special measures in February 2014. The Trust exited special measures in October 2016 following a reassessment by the CQC (Care Quality Commission) as ‘requires improvement’.

The Council of Governors agreed at its meeting on 05.01.17 that a streamlined version of the IPC would continue in order to support the Trust as it sought to improve its CQC rating. It was agreed, at that stage, that the IPC would link to the Council of Governors’ Planning and Performance (P&P) Subgroup in order to strengthen its work in holding non-executive directors to account for the performance of the board of directors.

With the return of NSFT to special measures in October 2017, it was agreed to revert to the original workings of the IPC. Monthly IPC meetings will precede, by three days, the Board of Directors meetings, so that IPC governors may comment upon, seek assurance and contribute, via the Chair, to the progress of the action plan.

2.0 Key activities

2.1 To coordinate IPC member observation of committees.

2.1.1 The purpose of committee observation is to provide assurance on the work of the non-executive directors in chairing and contributing to committees. Governors who carry out this role do not participate in the meeting and do not focus on the content of the meetings but on the robustness of the processes.

2.1.2 Governor observers use the template shown in (to be revised 12/17) appendix A in order to feed back to the IPC.

2.2 To track progress on the CQC Improvement Plan

2.2.1 The Improvement Plan is the main mechanism through which the Trust plans to achieve sufficient improvement to exit special measures. The Quality Programme Board coordinates specific projects and reports to the board each month. The focus of the IPC is to consider those aspects where there are concerns about progress and to follow up these under the governor role of holding the non-executives to account for the performance of the board. IPC members will normally attend BoD meetings in order to observe how progress is tracked.

2.3 To consider progress and issues as demonstrated in other reports.

2.3.1 From time to time other reports and evaluations become available (for
example, PLACE visit reports) which provide a useful source of triangulation for the work of the IPC. The focus of the IPC is to analyse this information and to report this to the Council of Governors.

2.3.2 The lead governor will attend the Overview and Assurance stakeholders monthly meeting and will provide feedback from those meetings to the IPC.

3.0 Reporting and relationship with the Council of Governors and the NSFT Chair

3.1 The group will meet by teleconference on the Monday of the Board of Directors meeting.

3.2 The IPC chair will summarise the agreed issues arising from the IPC and will send these observations to the Chair of NSFT.

3.3 The IPC will report back to the full Council of Governors by means of written report.

4.0 Membership

4.1 Membership of the IPC (including the allocation of IPC governor members as committee observers) will be refreshed each year following the annual governor elections. When considering the membership each year experience, succession planning, knowledge and skills and availability are to be taken into account and therefore refreshing the whole Committee membership should be avoided.

4.2 The optimal number of members is eight, ideally with a spread of constituencies and including service user / carer representation.

4.3 As part of the annual refresh of membership, all governors will be asked to express an interest in joining the IPC. This invitation will include attaching the Terms of Reference and clarifying what is expected of the governor. It should also identify the current members of the IPC, including those who will continue. Governors who join commit to engage fully with the tasks set out in 2.0 above and to attend IPC meetings. Members must have a clear understanding of the role of non-executive directors.

4.4 Where more than one governor from the same constituency wishes to join the IPC then they will be asked to resolve this by discussion and if this does not resolve the matter then there will be a secret ballot amongst that constituency's governor members and if there is a tie the position will be allocated by drawing of straws.

4.5 Allocation of IPC members as committee observers will normally be by discussion of best fit of experience and availability with the final decision resting with the IPC Chair. Governor observers must be able to focus on their role of observing the governance processes rather than the committee meeting content.

5. Confidentiality

5.1 The confidentiality rules set out in the code of conduct apply to the information shared through the IPC and especial care must be taken by governors to
5.2 All IPC members must have signed the special confidentiality agreement on private board papers.

5.3 Reports from IPC governors are to be shared with the IPC subgroup, Trust Secretariat, the Lead Governor and the Chair of the Committee meeting. The IPC governors will send the report to the Chair of the Committee.

6. Frequency and quoracy

6.1 The IPC will normally meet ten times a year prior to the Board of Directors meeting. Under special circumstances, and at the discretion of the IPC chair, the IPC may decide to hold additional meetings including by conference call.

6.2 The IPC will be quorate if three governor members are present.

7. Support

7.1 Owing to workload, the Company Secretary will no longer attend the IPC meetings with effect from December 2017. NSFT will ensure that there is other administrative support. The lead governor will compile reports arising from the IPC.

Robert Nesbitt
Company Secretary
13.01.17

Amended 19.01.1
Amended 19.12.17, by IPC discussion