## Agenda

<table>
<thead>
<tr>
<th>Timing</th>
<th>Item No</th>
<th>Item</th>
<th>Presenter</th>
<th>Paper/Verbal</th>
</tr>
</thead>
<tbody>
<tr>
<td>11:30</td>
<td>20.43</td>
<td>Staff Improvement Story</td>
<td>Presentation</td>
<td></td>
</tr>
<tr>
<td>11:30</td>
<td>20.44</td>
<td>Chair’s welcome, apologies for absence and notification of any urgent business:</td>
<td>Marie Gabriel</td>
<td></td>
</tr>
<tr>
<td>11:35</td>
<td>20.45</td>
<td>Declarations of Interest</td>
<td>Marie Gabriel</td>
<td>Paper A</td>
</tr>
<tr>
<td>11:40</td>
<td>20.46</td>
<td>Voice of the Service User</td>
<td>Diane Hull</td>
<td>Verbal</td>
</tr>
<tr>
<td>12:10</td>
<td>20.48</td>
<td>To approve the minutes of the previous public meeting, held on 19th March 2020</td>
<td>Marie Gabriel</td>
<td>Paper B</td>
</tr>
<tr>
<td>12:15</td>
<td>20.49</td>
<td>To address any Matters Arising from the minutes of the previous meeting and Action Log</td>
<td>Marie Gabriel</td>
<td>Paper C</td>
</tr>
<tr>
<td>12:20</td>
<td>20.50</td>
<td>Chair’s report</td>
<td>Marie Gabriel</td>
<td>Paper D</td>
</tr>
<tr>
<td>12:30</td>
<td>20.51</td>
<td>Chief Executive’s report</td>
<td>Jonathan Warren</td>
<td>Paper E</td>
</tr>
<tr>
<td>12:40</td>
<td>20.52</td>
<td>Patient Safety and Quality Report</td>
<td>Diane Hull</td>
<td>Paper F</td>
</tr>
<tr>
<td>12:50</td>
<td>20.53</td>
<td>CQC Reports</td>
<td>Diane Hull</td>
<td>Paper G</td>
</tr>
<tr>
<td>13:00</td>
<td>20.54</td>
<td>Mortality and Learning from Deaths Report</td>
<td>Dan Dalton</td>
<td>Paper H</td>
</tr>
<tr>
<td>13:10</td>
<td>20.55</td>
<td>Guardian of Safe Working Reports</td>
<td>Dan Dalton</td>
<td>Paper I</td>
</tr>
<tr>
<td>13:20</td>
<td>20.56</td>
<td>People and Performance Report</td>
<td>Mark Gammage</td>
<td>Paper J</td>
</tr>
<tr>
<td>13:30</td>
<td>20.57</td>
<td>Culture Report</td>
<td>Mark Gammage</td>
<td>Paper K</td>
</tr>
<tr>
<td>13:40</td>
<td>20.58</td>
<td>Strategic Activity Update</td>
<td>Mason Fitzgerald</td>
<td>Paper L</td>
</tr>
<tr>
<td>14:00</td>
<td>20.59</td>
<td>Integrated Performance Report</td>
<td>Stuart Richardson</td>
<td>Paper M</td>
</tr>
<tr>
<td>14:10</td>
<td>20.60</td>
<td>Freedom to Speak Up Report</td>
<td>Jonathan Warren</td>
<td>Paper N</td>
</tr>
</tbody>
</table>

## Breaks

**Break for Lunch**

**Break**
<table>
<thead>
<tr>
<th>Time</th>
<th>Item Code</th>
<th>Item Details</th>
<th>Author</th>
<th>Paper</th>
</tr>
</thead>
<tbody>
<tr>
<td>15.20</td>
<td>20.61</td>
<td>Mental Health Law Annual Report</td>
<td>Dan Dalton</td>
<td>Paper O</td>
</tr>
<tr>
<td>15.30</td>
<td>20.62</td>
<td>Scheme of Reservation &amp; Delegation and Standing Financial Instructions</td>
<td>Daryl Chapman</td>
<td>Paper P</td>
</tr>
<tr>
<td>15.40</td>
<td>20.63</td>
<td>Licence Self Certification and review of FT Code</td>
<td>Mason Fitzgerald</td>
<td>Paper Q</td>
</tr>
<tr>
<td>15.45</td>
<td>20.64</td>
<td><strong>Items for Information:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Quality Assurance Committee Chair’s Report</td>
<td>Tim Newcomb</td>
<td>Paper R</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Audit &amp; Risk Committee Chair’s Report</td>
<td>Adrian Matthews</td>
<td>Paper S</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Finance, Business and Investment Committee Chair’s Report</td>
<td>Adrian Matthews</td>
<td>Paper T to follow</td>
</tr>
<tr>
<td></td>
<td></td>
<td>People Participation Committee Chair’s Report</td>
<td>Pip Coker</td>
<td>Paper U</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Mental Health Act Committee</td>
<td>Marie Gabriel</td>
<td>Paper V</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Appointments and Remuneration Committee Chair’s Report</td>
<td>Tricia Fuller</td>
<td>Paper W</td>
</tr>
<tr>
<td>15.50</td>
<td>20.65</td>
<td>Questions from the public in relation to the Board papers presented at today’s meeting</td>
<td>Marie Gabriel</td>
<td></td>
</tr>
<tr>
<td>16.00</td>
<td>20.66</td>
<td>Any other business previously notified to the Chair</td>
<td>Marie Gabriel</td>
<td></td>
</tr>
<tr>
<td>20.67</td>
<td></td>
<td><strong>Date, time and location of next meeting</strong></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>The next meeting of the Board of Directors in public will be held on Thursday 16th July 2020</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Motion to exclude public and press from the confidential part of the meeting to be held on 16th July 2020</td>
<td></td>
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</tr>
</tbody>
</table>

**CLOSE**
Our values... Our behaviours... Our future
Working together for better mental health...

Positively...
- Be proactive...
  - Look for solutions, think creatively and focus on what we can do
- Take pride...
  - Always do our best
- Take responsibility...
  - Run ahead, be realistic and do what we say we will
- Support people to...
  - Set and achieve goals...
  - And be the best they can
- Recognise people...
  - Their efforts and achievements, and say thank you

Respectfully...
- Value everyone...
  - Acknowledge people's unique experiences, skills and contribution
- Step into other people's shoes...
  - Notice what's actually happening
- Take time to care...
  - Be welcoming, friendly and support others
- Be professional...
  - Respect people's time and be aware of our impact
- Be effective...
  - Focus on the purpose and keep it as simple as possible

Together...
- Involve people...
  - Make connections and learn from each other
- Share...
  - Knowledge, information and learning
- Keep people updated...
  - With timely, open and honest communication
- Have two-way conversations...
  - Listen and respond
  - Speak up...
  - Seek, welcome and give feedback
Norfolk and Suffolk NHS Foundation Trust is committed to openness and transparency in its work and decision making. As part of that commitment, we maintain and publish this Register which draws together Declaration of Interests made by members of the Board of Directors.

In addition, at the commencement of each Board meeting, members of the Board are required to declare any interests on items on the agenda.

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
<th>Interests</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mr Tim</td>
<td>Non Executive Director</td>
<td>NIL</td>
</tr>
<tr>
<td>Mr Adrian</td>
<td>Non Executive Director</td>
<td>Owner - XE Associates Consulting Specialist Advisor - CQC National Job Evaluation Trainer - NHS Employers Trustee/NED - Diversa Multi Academy Trust Director - Diversa Trading Ltd. Trustee/NED - Evolution Academy Trust Audit Committee Member - Norfolk Police &amp; Crime Commission &amp; Norfolk Constabulary</td>
</tr>
<tr>
<td>Mr Ken</td>
<td>Non Executive Director</td>
<td>NIL</td>
</tr>
<tr>
<td>Ms Pip</td>
<td>Non Executive Director</td>
<td>Continued relationship with Julian Support Trustees and Management Team. I will not take part in any matters relating to their business relationship with the Trust. 2008 to present. Former CEO of Julian Support</td>
</tr>
<tr>
<td>Ms Katy</td>
<td>Non Executive Director</td>
<td>NHS - Isle of Wight Trust, Belfast NHS Trust, London Leadership Academy Trustee of Oxfam GB (ongoing until June 2020)</td>
</tr>
<tr>
<td>Ms Tricia</td>
<td>Non Executive Director</td>
<td>Co-Opted Governor West Earlham Junior School</td>
</tr>
<tr>
<td>Mr Jonathan</td>
<td>CEO</td>
<td>Faculty Member - Institute Healthcare Innovation Chairman - Ardingly Rowing Club Employed by East London NHS Foundation Trust and seconded to Norfolk and Suffolk NHS Foundation Trust.</td>
</tr>
<tr>
<td>Mr Mason</td>
<td>Deputy CEO and Director of Strategic Partnerships</td>
<td>Employed by East London NHS Foundation Trust and seconded to Norfolk and Suffolk NHS Foundation Trust.</td>
</tr>
<tr>
<td>Mr Daryl</td>
<td>Interim Finance Director</td>
<td>Volunteer Treasurer for Spooner Row Primary School Pre-School</td>
</tr>
</tbody>
</table>
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<table>
<thead>
<tr>
<th>Ms/Mr.</th>
<th>Name</th>
<th>Title</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Diane Hull</td>
<td>Chief Nurse</td>
<td>NIL</td>
</tr>
<tr>
<td></td>
<td>Stuart Richardson</td>
<td>Chief Operating Office</td>
<td>NIL</td>
</tr>
<tr>
<td>Dr</td>
<td>Daniel Dalton</td>
<td>Chief Medical Officer/ Hellesdon</td>
<td>National Specialist Adviser (Specialised commissioning) Mental Health, remunerated, NHSE</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Honorary member of the Secretary of State for Transport’s Clinical Advisory Panel on mental disorders and driving, DfT</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Spouse is a clinical psychologist employed by Cambridgeshire Community Services NHS Trust who also undertakes private clinical practice in Norfolk</td>
</tr>
<tr>
<td>Dr</td>
<td>Jan Falkowski</td>
<td>Medical Director/ Workforce</td>
<td>Private and Medical Legal Work - Self Employed</td>
</tr>
<tr>
<td></td>
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<td></td>
<td>Trustee Royal College of Psychiatrists</td>
</tr>
</tbody>
</table>
Some items were taken out of order, but for clarity are recorded as per the agenda.

<table>
<thead>
<tr>
<th>Item No</th>
<th>Agenda title</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>20.21</td>
<td>Staff improvement story</td>
<td></td>
</tr>
<tr>
<td></td>
<td>i. This item was not taken.</td>
<td></td>
</tr>
<tr>
<td>20.22</td>
<td>Chair's welcome, notification of any urgent business and apologies for absence</td>
<td></td>
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<tr>
<td></td>
<td>i. TN welcomed those present, and confirmed that the meeting was not being</td>
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<td></td>
<td>held in public due to Covid-19 preventative measures and given timescales and</td>
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<td></td>
<td>venue, it was not possible to establish virtual attendance. However, the</td>
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<td></td>
<td>minutes would still be made public and questions from the</td>
<td></td>
</tr>
</tbody>
</table>
Tab 7 20.48 To approve the minutes of the previous public meeting, held on 19th March 2020

<table>
<thead>
<tr>
<th>Item No</th>
<th>Agenda title</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>20.23</td>
<td>Declarations of Interest</td>
<td>i. There were no additional declarations of interest.</td>
</tr>
<tr>
<td></td>
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<td>20.24</td>
</tr>
<tr>
<td></td>
<td></td>
<td>i. DD presented the paper, adding that new information was coming through from the Government all the time. Public Health England were projecting that if no action was taken, there would be approx 250k deaths over the next 18 months, with approx. 1% mortality. The most vulnerable groups within the Trust will be the older service users and those with metabolic and other health conditions. It is thought that approx. a third to a half of people with Covid-19 are asymptomatic.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>ii. A major incident team has been set up in the Board Room at Hellesdon Hospital. DD is the Strategic Commander, with JF as deputy and DH as deputy to JF. Dawn Edwards, Deputy Chief Nurse, is also part of the major incident team with four deputies on a rota.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>iii. Decisions and instructions for the NHS are coming from the Government via the Dept. of Health and Social Care through the regional offices to the trusts. The Trust was working with the wider system and other partners. Acute hospitals may look to discharge patients to free up space.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>iv. The Care Group Service Directors or Lead Nurses were attending daily Trust briefings, giving situation reports which were then passed up to the regional offices. Each Care Group had a business continuity plan and were looking at their patients to see who needed a face-to-face appointment, who could have a virtual appointment, and who could have less intensive support. This was being kept under close review, with thresholds to provide more support when required. The ICT department were helping with real-time information on wards, and isolations for staff and patients, though there was more to do on this and modelling.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>v. There were currently 157 staff self-isolating, with staff working from home where they can and laptops being made available to facilitate this.</td>
</tr>
</tbody>
</table>
|         |              | vi. DD assured the Board that the Trust’s planning was ahead of other trusts, with a lot of work having been done over the last ten months on business continuity and emergency processes led by Amie McGrory, who was thanked for her work. MGe added that they were trying to ensure that staff were not financially disadvantaged, such as lease cars or special leave for self-isolation or family. JF advised that retired staff were coming back, and training and development was being flexed to allow for this. There were international demands on PPE for staff because so much was manufactured in China. There was a consensus amongst NHS CEOs that this should be prioritised for the acute sector. The Trust had ordered some...
<table>
<thead>
<tr>
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<tbody>
<tr>
<td>PPE in January 2020, but this had not been delivered as yet.</td>
<td></td>
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</tr>
<tr>
<td>vii.</td>
<td>Testing was also a national issue for current and past infections. It was hoped that health and social care staff would be tested as a priority.</td>
<td></td>
</tr>
<tr>
<td>viii.</td>
<td>As mentioned, there may be difficult decisions to be made, with significant consequences. A Clinical and Ethical Group had been established, with PPLs, CCGs and service representatives to consider these issues. Where possible, advance directives will be put in place, and additional training would be given to staff for end-of-life care. PC advised that there had been problems previously with Lorenzo not highlighting advance directives, which DD agreed to look at: ACTION.</td>
<td></td>
</tr>
<tr>
<td>ix.</td>
<td>MG advised that the Governors were obviously also anxious about supporting and protecting staff, service users and carers. Some voluntary organisations had developed mental wellbeing guides, which may be useful. IC added that these were being looked at for links from the Trust’s website and hard-copies where necessary. While local voluntary groups were also helping, it was important that they were not inadvertently spreading the virus.</td>
<td></td>
</tr>
<tr>
<td>x.</td>
<td>Following the announcement that schools would be closing, an appeal had been made to child minders to help outside school hours. DD added that Care Groups were looking at how they work and communicate, so people can do more from home were possible.</td>
<td></td>
</tr>
<tr>
<td>xi.</td>
<td>Because this was an international issue, staff, service users, carers and the wider public had been accepting of the need to make changes in the current circumstances and were pulling together.</td>
<td></td>
</tr>
<tr>
<td>xii.</td>
<td>TN thanked everyone for the work they were doing, adding that this will be something they look back on with pride on how they coped.</td>
<td></td>
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</table>

20.25 To approve the minutes of the last meeting – held on 23 January 2020

i. The Board approved the minutes of the last meeting with no changes.

20.26 To address any matters arising from the minutes of the previous meeting and the action log

i. Min 19.89: DH confirmed that they were currently looking at the patient safety strategy and would give an update at the next Board: ACTION. It was hoped that the strategy would be ready for the July 2020 Board.

ii. Min 19.137v: DH advised that there was still work underway on physical health checks.

iii. Min 19.137vi: DH agreed to update the Board at their next meeting on the work on the Quality KPIs: ACTION.

iv. Min 19.147v: MG confirmed that a multi-disciplinary review was underway on banding and recognition, which would be presented to the
<table>
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<tr>
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</thead>
<tbody>
<tr>
<td>v.</td>
<td>Min 20.03vi: JW confirmed that he had met with Steve and Robyn W following the last Board meeting.</td>
<td>MGe</td>
</tr>
<tr>
<td>vi.</td>
<td>Min 20.06v: A NED visit flow-chart had been produced, but there was work to do on feeding back to staff and to NEDs. TN and JC agreed to look at how this could be done, and recirculate the process: ACTION.</td>
<td>TN, JC</td>
</tr>
<tr>
<td>vii.</td>
<td>DH confirmed that following issues raised by a NED visit, she had spoken to MF and other staff about dental provision in the secure wards, which would be raised with the commissioners and primary care colleagues.</td>
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<tr>
<td>viii.</td>
<td>Min 20.08a ix: CLOSED – reported in the patient safety and CQC reports.</td>
<td></td>
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<tr>
<td>ix.</td>
<td>Min 20.08a viii: CLOSED – MG advised that staffing numbers and measures were now reported consistency across the Board papers.</td>
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<tr>
<td>x.</td>
<td>Min 20.13i: CLOSED – counselling for problem gambling was included within addiction services</td>
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<tr>
<td>xi.</td>
<td>Min 20.13v: CLOSED – MF advised that the new name for the Hellesdon site development was “Next Generation for Mental Health Services”</td>
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</tr>
<tr>
<td>xii.</td>
<td>Min 20.15ii: JW agreed to talk to Liz Keay regarding a review of the Freedom to Speak Up role: ACTION.</td>
<td>JW</td>
</tr>
</tbody>
</table>

**20.27 Chair’s report**

i. MG presented the Chair’s report, adding that a briefing was being drafted for the Governors on the Trust’s Covid-19 response and how they can discharge their duties during this period.

**20.28 Chief Executive’s report**

i. JW presented his report, correcting Section 5.2 to state that no Prevention of Future Deaths notices had been received. The two notices referred to had been received in the last reporting period.

**20.29 Patient safety and quality report**

i. DH advised that there had been nine serious incidents in the reporting period, which would be investigated. There had been 13 Quality and Safety reviews, showing the continued improvements on the Hellesdon Hospital wards, and the recovery and rehab wards in Ipswich, although there was still more to do. These reviews were to help staff make the necessary improvements and check implementation and triangulated well with the NED visits.

ii. The QI in-person training had unfortunately had to be cancelled, but alternatives were being looked at. There were approx. 60 projects running across the Trust.
### Item No | Agenda title                                                                                                                                                                                                                                                                   | Action
---|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---
iii.  | Clinical audit was now devolved to the Care Groups with central support.                                                                                                                                                                                                           |   
iv.   | There had been two focussed CQC inspections: Wedgewood Unit adult wards and 80 St Stephen’s youth services, with the draft reports expected for review.                                                                                                                                  |   
v.    | A one-page physical health strategy was approved at the recent QAC meeting. The Board discussed smoke-free policies, and balancing with service users’ stress and anxiety. DH confirmed that no-one should be smoking on site and that alternatives, such as vaping, and cessation support were available to both staff and service users. DD added that this contributed to the 12-15year mortality gap for mental health service users, and would be discussed by the clinical team. |   

#### 20.30 Care Quality Commission action plan

i. SR took the Board through the actions that had taken place following the CQC report in January 2020, with workstreams set up to look at specific themes. Performance against the required actions were reported internally via the Quality Committee, QAC and Board, and externally via the Oversight and Assurance Group.  

ii. DH advised that there were detailed plans and reports behind this update, and that all staff were taking these actions seriously. This was part of the cultural changes work to embed a safety ethos within the Trust, starting from basic principles of care and management. DD advised that there was history to work through for some of these areas, such as medicines management.  

iii. MG noted that psychology provision had been highlighted during recent NED visits. To provide an update at a future Board meeting: **ACTION.**  

#### 20.31 Access and waiting times

i. SR presented the report and advised that CFYP had been a specific area of focus in the reporting period. The eating disorder service in Suffolk had also be looked at in detail, with work to redesign the service with commissioners and reference to best practice. There had obviously also been a lot of work within the Care Groups in relation to Covid-19, and how to ensure a safe and effective service appropriate to local need.  

ii. The introduction of service user trackers was welcomed.  

iii. Additional managerial support had been put in place for the Central Norfolk CFYP service. This would help speed-up the necessary improvements such as reductions in waiting times and numbers, and culture change.  

iv. The devolution of clinical risk management to the Care Groups had had variable results, with additional support being put in place for those Care Groups that needed it, to make sure that all care was safe and effective, including those people on the waiting lists.
<table>
<thead>
<tr>
<th>Item No</th>
<th>Agenda title</th>
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</thead>
<tbody>
<tr>
<td>Break: 13:56-14:09</td>
<td></td>
</tr>
<tr>
<td>20.32</td>
<td>People and workforce report</td>
</tr>
<tr>
<td>i.</td>
<td>MGe advised that CW, JP and JCh had joined the meeting to discuss the staff survey results and culture work. The second Phase of the leadership review was starting. A recruitment campaign was also underway in West Suffolk for nurses. Since February 2019, over 40 nurses had been recruited, over 50 support workers and 15 doctors, which was welcomed by the Board.</td>
</tr>
<tr>
<td>ii.</td>
<td>The Trust was working on retaining their nursing staff, with the conference and preceptorship programme being well received. Detailed information had been taken to the recent Quality Committee and could be sent to a director on request.</td>
</tr>
<tr>
<td>iii.</td>
<td>In light of Covid-19, final year medical and nursing students may be fast-tracked to be able to work, with emergency registration being looked at. Virtual interviews were planned for 27th March 2020 for 27 student nurses.</td>
</tr>
<tr>
<td>iv.</td>
<td>There continued to be a focus on supervision and appraisals, as well as job planning for consultants. This will be even more important with the additional stresses of Covid-19 on staff. JF added that the Royal College of Psychiatrists was relaxing the annual CPD requirements.</td>
</tr>
<tr>
<td>v.</td>
<td>Additional HR capacity had been put in place for a year to help manage sickness-absence and return-to-work, working with service directors. It was hoped that these would be cost neutral, by reducing the need for temporary staff. DC clarified that the figures in the report referred to days lost to sickness-absence, not number of staff.</td>
</tr>
<tr>
<td>vi.</td>
<td>JP advised that the deep dive had identified that some leavers chose not to have an exit interview, and some were not recorded very well by the interviewing manager. There was still work to be done in this area.</td>
</tr>
<tr>
<td>vii.</td>
<td>The staff survey results were published on 18 February 2020, with 48% of staff taking part against a national average for mental health trusts of 54%. Unfortunately, the scores had not changed from the previous year. The survey was sent out while the new Care Group structure was being implemented, Phase 1 of the leadership review, and the CQC inspection. The work from the survey was being split into seven workstreams.</td>
</tr>
<tr>
<td>viii.</td>
<td>The Culture Group had been set up a year ago, with volunteers from clinical and corporate areas, and services users. The group was using the NHS England &amp; Improvement tool as the basis for their work.</td>
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<tr>
<td>ix.</td>
<td>CW advised that she has been working for the NHS for over 20 years, and was very enthusiastic about the culture change. The group had developed a dashboard to monitor their work. The interviews with Board members and leadership surveys had given useful data and comments to build on. Some of the areas identified to focus on were not new and were similar</td>
</tr>
</tbody>
</table>
### Agenda title

Tab 7 20.48 To approve the minutes of the previous public meeting, held on 19th March 2020

<table>
<thead>
<tr>
<th>Item No</th>
<th>Agenda title</th>
<th>Action</th>
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<tbody>
<tr>
<td>across the whole organisation, and an important validation for the group and showed that the Board and staff were not as disconnected as feared. This could be shared with the Board if they wished to see it. It was important to realise that this would be a slow, and potentially difficult, journey. Staff have expressed their appreciation of the group's work and felt that they are being listened to.</td>
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<tr>
<td>x. JCh gave his background, and his view that mental health services had a problem taking risks as society becomes more litigious, relationship with regulators, the press and others. To counter this, more layers of bureaucracy and KPIs were put in place, which impacted on the provision of care and the autonomy of staff in their therapeutic relationship with service users, and may not actually reduce overall risk. It was not possible to eliminate risk entirely, particularly suicides. Staff could feel like they had failed when someone takes their life, which unfortunately was unavoidable.</td>
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<tr>
<td>xi. The main purpose of the Trust was to help people with serious mental ill-health and actions that reduce clinical time should be questioned. The results of the survey show staff's dissatisfaction and demoralisation. MGe added that this was the aim of the “People before Process” work, to free-up time for clinical work. CW went on to advise that the group was looking at key items to communicate, “you said …, we did …” notices and how to help all staff live and work by the values of the Trust.</td>
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<tr>
<td>xii. TN thanked CW, JP and JCh for joining the meeting and their work on these important topics.</td>
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<td>20.33 Strategic activity update</td>
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<tr>
<td>i. MF presented the report, highlighting that the pension tax relief had been well received. The clinical and financial case for the New Care Models Collaborative, with the governance arrangements and risks, should come to the Board in June/July 2020 for final approval, after review by FBIC.</td>
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<tr>
<td>ii. Suffolk Mental Health Alliance had reviewed some of their implementation timelines before Covid-19. A telephone conference was planned with the CCGs to see what can and cannot be deferred.</td>
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<tr>
<td>20.34 Annual plan</td>
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<tr>
<td>i. MF took the Board through a presentation on the annual planning for 2020-21. Unfortunately, the last two annual plan consultation events had been cancelled due to Covid-19. These events had been very well receive and it was hoped that similar engagement sessions could be arranged when possible. There had been some very useful feedback from the events that had been held, as well as from Care Groups, which had been led to some draft annual plan priorities.</td>
<td></td>
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<tr>
<td>ii. National and regional timetables and deadlines were under review because of Covid-19, as well as additional funding being made available to the NHS. Contractual targets and sanctions were being flexed or</td>
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NSFT Board of Directors – meeting in public
Draft minutes – 19 Mar 2020

Page 7 of 11
Tab 7 20.48 To approve the minutes of the previous public meeting, held on 19th March 2020

<table>
<thead>
<tr>
<th>Item No</th>
<th>Agenda title</th>
<th>Action</th>
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<td></td>
<td>suspended. Publication of long-term plans, their implementation and other transformation work were also being deferred. It was likely that the annual plan and annual report timetables would also be reviewed.</td>
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<tr>
<td>i.</td>
<td>MF took the Board through the planned next steps for the annual planning process: Council-Board discussions to finalise Trust and Care Group priorities, with performance and risk frameworks and “you said …, we did …” communications. Approval of the new CCG contracts will need Board approval, but this could be done by email or another conference call. DC advised that there was an e-meeting with the national NHS England &amp; Improvement CFO the next day and would pass on the key information: ACTION.</td>
<td>DC</td>
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<tr>
<td>ii.</td>
<td>MG thanked JC and her team for the annual plan events and advised that they were working with the ICT department for additional support to the Governors.</td>
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<tr>
<td>iii.</td>
<td>Digital strategy</td>
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<tr>
<td>i.</td>
<td>DH advised that the strategy had been put together following consultation and was driven by the needs of service users and staff and aligned to the Trust strategy. The workstreams are not being led by ICT staff, with PPLs, Mike Seaman, Amy Eagle and MF leading groups. The Board welcomed the involvement of the PPLs, with PC suggesting that the Recovery College could help with implementation and training, as their courses had had to be cancelled. Some of the implementation having been brought forward because of Covid-19, such as using MS Teams.</td>
<td></td>
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<tr>
<td>ii.</td>
<td>The Trust had put in a digital aspirant bid for £4m over three financial years, including the current year. The initial £500k had covered hardware costs, with the remaining two years for transformational work. This will include a decision on the EPR for the Trust: Lorenzo or another system.</td>
<td></td>
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<tr>
<td>iii.</td>
<td>The strategy should provide staff with productivity and efficiency tools, to free-up time for clinical activities. It was therefore hard to track the benefits, as the money was spent in ICT for front-line benefits.</td>
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<tr>
<td>iv.</td>
<td>JW thanked DH and the ICT department for their help and support in the Trust’s response to Covid-19, and TN asked DH to pass on the Board’s thanks to the team.</td>
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<tr>
<td>20.35</td>
<td>Integrated performance report</td>
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<tr>
<td>i.</td>
<td>SR presented the report which had been considered at the recent FBIC, highlighting that a business case had been submitted to the CCG for additional funding to help with waiting times. There had been a problem with the data for ADHD in Suffolk and CFYP in Norfolk which had been corrected; this contributed to the increase in longer waiting times being reported. TN asked for a brief report to summarise the work and impact, which SR agreed to do: ACTION. Overall, the Trust was steadily improving against the metrics in a sustainable way, which was welcomed.</td>
<td>SR</td>
</tr>
</tbody>
</table>
### 20.48 To approve the minutes of the previous public meeting, held on 19th March 2020

**Item No** | **Agenda title** | **Action**
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ii. | DC advised that the Trust will meet its control total, but the next year would be a challenge, especially for the wider local system. The Trust may have to contribute £650k to the system recovery fund in Norfolk & Waveney. |  
iii. | Out of area placements continued to be a challenge to achieve zero and then 85% bed occupancy: these were overseen by the FBIC. The commissioners were helping through additional beds and alternatives to admission or out of area placements. The current Covid-19 crisis was likely to reduce delayed transfers of care, as hospitals try to free-up beds. |  
iv. | JC advised that the BAF was being reviewed for the next financial year’s risks. JC agreed to look whether Covid-19 should be added to each risk, how its own, or both: **ACTION.** PC added that public and patient engagement will need to considered as it will not be possible to hold events and meetings as previously done. | **JC**

### 20.37 Freedom to Speak Up Guardian (FTSUG) report

i. | JW advised that as agreed in the private session, a review of the FTSUG would be brought to a future Board. A regional meeting had been cancelled due to Covid-19, but it was hoped that work following the staff survey results could continue as this was so important to staff wellbeing. |  
ii. | LK advised that people were coming to her to simply talk through their issues and options, and not necessarily expecting any action taken. The cases had mostly been to do with the emotional impact of interactions between colleagues, with a case study given to highlight this. LK thanked HR for their support to her and the staff she referred to go them. |  
iii. | The report had been written before the recent Covid-19 developments and restrictions, but it was interesting to note the staff’s response and whether this positivity will continue once the crisis is over. It was confirmed that the FTUSG would continue during this period; in other trusts people have returned to the front line. |  
iv. | LK and KA had recently attended a national meeting, which had been interesting to talk to, and hear from, colleagues in other trusts: these will be followed up with visits when possible. The best practice from other trusts would be added to the review paper to come to the Board, which JW agreed to help with by contacting the relevant CEOs: **ACTION.** KA stated that not all trusts had a full-time dedicated post, with some having champions and advocates across their organisations, but a strong FTSUG presence was key to high-performing trusts. Work was also underway with NHS E&I to develop a longer-term FTSUG strategy, which will be brought to the Board when available. | **LK**

### 20.38 Modern Slavery annual statement

i. | The Board **approved** the annual statement, with the addition of the safeguarding and employments processes. |  

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<thead>
<tr>
<th>Item No</th>
<th>Agenda title</th>
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<tbody>
<tr>
<td>20.39</td>
<td>Items for information</td>
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</tr>
<tr>
<td>i.</td>
<td>The following items were noted.</td>
<td></td>
</tr>
<tr>
<td>a.</td>
<td>Internal Audit plan</td>
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<tr>
<td>ii.</td>
<td>This would be discussed at a future Board development session.</td>
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<td>b.</td>
<td>Quality Assurance Committee – Chair’s report</td>
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<td>c.</td>
<td>Audit &amp; Risk Committee – Chair’s report</td>
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<td>d.</td>
<td>Finance, Business and Investment Committee – Chair’s report</td>
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<td>e.</td>
<td>People Participation Committee – Chair’s report</td>
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<td>f.</td>
<td>Mental Health Act Committee – Chair’s report</td>
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<td>g.</td>
<td>Appointments and Remuneration Committee – Chair’s report</td>
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<tr>
<td>20.40</td>
<td>Questions from the public in relation to the Board papers presented at today’s meeting</td>
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<tr>
<td>i.</td>
<td>MG and JC advised on questions received from the Governors, and a briefing would be sent to them after the meeting: ACTION</td>
<td>JC</td>
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<tr>
<td>ii.</td>
<td>Jill Curtis (JCu), Staff Governor, asked about the Triangle of Care, inclusion of carers in the People Participation Strategy and carers being considered as equal partners in care. JCu also expressed her thanks for the work and leadership on the Covid-19 response. PC stated that these items had been discussed at the PPC but had not been included in the Chair’s report. DH added that Dawn Collins was working with Carer Leads to look at a Carers Strategy, which would be brought to the Board, and that Carers would be included within the People Participation Strategy. JC added that she had been working with JCu on engaging the FT carer members.</td>
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<td>iii.</td>
<td>Sara Muzira (SM), Public Suffolk Governor, asked about the response to the staff survey (Item 20.32), communications, improvements to patient safety, Covid-19 (Item 20.24), and annual plan (Item 20.34). JW stated that he shared the Governors’ concerns about the staff survey results and hoped the work underway would produce improvements in future years. TN agreed that more positive stories needed to come from the Trust, to counter other stories. IC advised that the communications team were working with Care Groups, PPLs and Carer Leads to facilitate this. MF advised that there were several national and local voluntary groups and charities providing information on how to stay well, which the Trust could signpost to: ACTION. Resilience Groups had also been set up by the Local Authorities in response to Covid-19, and the Trust was part of these groups. DH advised that the data showed that quality and safety was improving, but would look to report this more clearly in future: ACTION.</td>
<td>IC, DH</td>
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<td>iv.</td>
<td>Katy Axford (KAx), Public Suffolk Governor, asked about the incident</td>
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<td>mentioned in the reported emails, and the impact of Covid-19 on service users’ health and wellbeing (Items 20.24 and 20.40iii). JW stated that the report into the incident was publicly available through the Safeguarding Board, with a number of actions agreed and put in place within the Trust and across the wider system. MG added that Carers’ health and wellbeing was also important during this difficult time.</td>
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<tr>
<td>20.41</td>
<td>Any other business, previously notified to the Chair</td>
<td></td>
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<tr>
<td>a.</td>
<td>NED role</td>
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<tr>
<td>i.</td>
<td>PC stated that the Board’s behaviour and leading by example was critical at this difficult time. It was agreed that it was not appropriate for the NED visits to continue, but other ways of supporting the executives and staff had been discussed in the private morning session. MG suggested that regular NED e-meetings be set up, which was agreed: ACTION.</td>
<td>MG</td>
</tr>
<tr>
<td>20.42</td>
<td>Date, time and location of next meeting</td>
<td></td>
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<tr>
<td>i.</td>
<td>The next meeting of the Board of Directors in public will be on Thursday 21 May 2020 in The King’s Centre, King Street, Norwich, NR1 1PH</td>
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</table>

There being no other business, TN and MG thanked those present for their contribution and hoped everyone stayed safe and well: the meeting was closed at 16:03.

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

Date: ......................................................
<table>
<thead>
<tr>
<th>Agenda item no</th>
<th>Date</th>
<th>Item</th>
<th>Action</th>
<th>Action by</th>
<th>Due Date</th>
<th>Status / Comments</th>
</tr>
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<tbody>
<tr>
<td>19.89</td>
<td>18/07/2019</td>
<td>Strategic Activity Update</td>
<td>To update the Board on the patient safety strategy once discussed by the Quality Assurance Committee (QAC)</td>
<td>Diane Hull</td>
<td>July 2020</td>
<td>Developing Quality Strategy which will incorporate the Patient Safety Strategy and will be discussed by QAC. Strategy is expected to be available for the July 2020 meeting.</td>
</tr>
<tr>
<td>19.134vi</td>
<td>21/11/2019</td>
<td>Patient safety and quality report</td>
<td>Paper to the Board to include recruitment, development and career opportunities being developed, skill mix and staffing within teams and medics, AHPs and STP requirements</td>
<td>Mark Gammage</td>
<td>May 2020</td>
<td>Work is being undertaken by a group consisting medical education, nurse and AHP/ psychology education and non-clinical education to review how education is managed going forward and how this supports career development</td>
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<tr>
<td>19.137v</td>
<td>21/11/2019</td>
<td>Integrated Performance Report</td>
<td>Timing of physical health checks against other Trusts to be looked at in benchmarking information</td>
<td>Diane Hull</td>
<td>March 2020</td>
<td>Looking at other Trusts for benchmarking information. Close here and for Quality Committee to review</td>
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<tr>
<td>19.137vi</td>
<td></td>
<td>QAC to review Quality KPIs in February and include in proposal to Board in March 2020</td>
<td>QAC to review Quality KPIs in February and include in proposal to Board in March 2020</td>
<td>Diane Hull</td>
<td>July 2020</td>
<td>Working to map all KPIs to Trust Strategy. Developing new KPIs against Annual Plan 20/21 to be reported in Quality Dashboard with oversight from QC and QAC. As contract planning</td>
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<td>Item</td>
<td>Date</td>
<td>Description</td>
<td>Owner</td>
<td>Action Date</td>
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<td>19.147v</td>
<td>21/11/2019</td>
<td>Questions from the public: To include more detail in the Workforce report on banding and recognition</td>
<td>Mark Gammage</td>
<td>May 2020</td>
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<tr>
<td>20.06v</td>
<td>23/01/2020</td>
<td>Chair’s Report: Discuss with Tim Newcomb and Diane Hull how actions following NED visits could be reported back to staff</td>
<td>Tim Newcomb, Jean Clark</td>
<td>March 2020</td>
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<tr>
<td>20.08viii</td>
<td>23/01/2020</td>
<td>CQC Report: updates at each board meeting on progress with CQC actions, particularly with the ‘red’ areas</td>
<td>Diane Hull</td>
<td>March 2020</td>
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<tr>
<td>20.10iii</td>
<td>23/01/2020</td>
<td>Safer Staffing: To confirm how night bank and agency staffing is reported as some will be NSFT staff working bank shifts</td>
<td>Diane Hull</td>
<td>July 2020</td>
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<tr>
<td>20.15ii</td>
<td>23/01/2020</td>
<td>FTSU Report: Ensure that staff are aware of the FTSU role and how to contact Liz Keay</td>
<td>Jonathan Warren</td>
<td>May 2020</td>
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<tr>
<td>20.24viii</td>
<td>19/03/2020</td>
<td>Emergency Planning – Covid-19: Dan Dalton to look at possible issues with Lorenzo not highlighting advance directives</td>
<td>Dan Dalton</td>
<td>May 2020</td>
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Impacted by Covid, having system discussions with commissioners re MH KPIs.

As action 19.134vi, paper to board in May to include additional information.

Reports from NED and exec visits are discussed at Executive Committee to identify actions, report back to NEDs and shared with comms to ensure feedback to staff/Care Groups. Flowchart shared with BoD.

Discussed in Patient Safety & Quality report and CQC action plan at each board.

This will be included in the Safer Staffing Report to the July 2020 Board meeting.

LK continues to publicise FTSUG role via intranet, induction, safeguarding training, E&D training. JW/LK reviewing FTGUG role: working with NHSIE on strategy and comms plan.

Dedicated Lorenzo form for Advance Directives for admissions to acute services, but no alert from this and no specific form for.
<table>
<thead>
<tr>
<th>Item</th>
<th>Date</th>
<th>Action Plan</th>
<th>Description</th>
<th>Owner</th>
<th>Due Date</th>
<th>Notes</th>
</tr>
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<tbody>
<tr>
<td>20.49</td>
<td>21/05/2020</td>
<td>DNACPR. N&amp;W moving to new form for shared decision making at end of life ReSPECT. Roll-out paused during covid but DD in active discussions with resuscitation lead and other providers to rapidly adopt this approach and ensure automation.</td>
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<td>20.30iii</td>
<td>19/03/2020</td>
<td>CQC Action Plan</td>
<td>To provide an update on psychology provision for a future Board meeting</td>
<td>Dan Dalton</td>
<td>May 2020</td>
<td>Developing psychology strategy based on review by Lead Psychologists highlighting variation in Trust provision, alongside work on formulation-based care planning and expanding psychological therapies offer. Plan for head of therapies post to lead psychological services whilst harmonising psychology support within care groups as integrated clinical leaders in MDTs. Paper to July board.</td>
</tr>
<tr>
<td>20.34iii</td>
<td>19/03/2020</td>
<td>Annual Plan</td>
<td>Key information from a meeting with the national NHS England / Improvement CFO to be circulated</td>
<td>Daryl Chapman</td>
<td>March 2020</td>
<td>Close. Information from NHSEI calls shared 31/03/20</td>
</tr>
<tr>
<td>20.36i</td>
<td>19/03/2020</td>
<td>Integrated Performance Report</td>
<td>Brief report on waiting lists specifically the corrections to ADHD in Suffolk and CFYP in Norfolk data</td>
<td>Stuart Richardson</td>
<td>May 2020</td>
<td>Update to Board in May</td>
</tr>
</tbody>
</table>
### Integrated Performance Report

Look at whether Covid-19 should be added to each BAF risk, on its own or both

Jean Clark  
May 2020  
the impact of covid-19 has been added to each risk and a separate risk added as well  
21/05/20

### FTSUG report

Future reports to include best practice from other Trusts

Jonathan Warren  
May 2020  
reviewing best practice  
31/03/20

### Questions from the public

Briefing to be sent to the Governors following the meeting

Jean Clark  
March 2020  
Regular briefings sent to governors  
31/03/20

### Questions from the public

Trust to signpost to national and local voluntary groups and charities regarding how to stay well

Isabel Cockayne  
March 2020  
Enhanced wellbeing offer to staff and public, promoted by Trust comms, on website  
31/03/20

### Questions from the public

Diane Hull to look to show more clearly the improvement in quality and safety in the next board report.

Diane Hull  
May 2020  
May Board report  
31/03/20

### NED role

Regular NED e-meetings to be set up

Marie Gabriel  
March 2020  
Close. These are in progress  
31/03/20
Executive Summary:

The report informs the Board of the
- key points arising from the Council of Governors discussions to ensure their views are taken into account in Board decision making
- Chair and NED most significant activities that will particularly inform the strategic direction of the Trust

The report specifically outlines the Council of Governors focus on ensuring the delivery of safe and accessible services during the Covid-19 pandemic. In presenting the report there will also be verbal feedback from a Council of Governors meeting and a Joint Board and Council of Governors meeting that have not yet taken place at the time of writing this report. This joint meeting will consider what is being described as the ‘second’ or ‘recovery’ phase of Covid-19.

The report will impact on service users and carers by ensuring that we maintain our focus on delivering safe and improving services.

1.0 Background/Introduction

1.1 I would like to begin by thanking each and every staff member for their dedication, flexibility and kindness over the last few months. Thank you to our frontline staff who have continued to deliver compassionate care, even though I know that you may have felt anxious yourself and thanks to the staff who work in the background to ensure that we can continue to deliver services. I know that many of us will have lost loved ones and so also offer my sincere condolences.

1.2 The remainder of this report informs the Board of the Council of Governors key conclusions so that the Council views inform Board decisions. It also provides information on the Chair’s main activities and strategic outcomes of those activities.
2.0 Council of Governors

2.1 I will be providing verbal feedback from the first virtual Council of Governors and the joint Board and Council of Governors meeting that are taking place over the next two weeks. Although Governors have not been able to come together as they would usually, they have been very engaged with the Trust. There has been a regular dialogue with briefings and the opportunities for Governors to seek assurance by submitting questions for a response. Governors have sought assurance on a range of issues relating to the safety of services and to staff wellbeing and have also passed their thanks on to staff. The May Council of Governors virtual meeting will discuss these areas in more detail. In addition, in lieu of postponed joint training, the Governors have been sent links to on line resources to raise awareness and knowledge of the conditions experienced by the people accessing our services.

2.2 We have continued our Council work as much as possible. This includes the Nominations and Conduct Committee meeting to progress the appointment of a Non-Executive Director with interviews planned for the end of May and plans for the Communications and Engagement and Significant Business Committees to meet soon. I have also had the opportunity to meet virtually or on the phone with our newly appointed Governors and we are in regular conversation with the Lead and Deputy Lead Governor to review what else we can do to improve Governor engagement. This has led to the development of shorter but more regular virtual Governor meetings.

2.3 Finally, I take this opportunity to welcome Lucinda Bray, who has been begun her role as Membership Officer; Lucinda will work with Governors on our Membership Strategy and ongoing Membership engagement. I am also pleased to announce that Jean Clark has been confirmed in post as our permanent Trust Secretary.

3.0 Chair Activities

3.1 A key focus of my work since the last meeting has been to ensure effective governance is in place to enable us to respond effectively to Covid-19, to deliver services and to continue our improvement journey. Although national guidance has not required us to do so, we took the decision to continue to have full agendas at Board meetings and continue to operate our Board Committees, particularly our Quality Assurance Committee. We have ensured careful recording of decisions taken relating to Covid-19 and used the expertise of two of our NEDs to test our emergency response. Through our People Participation Committee, we have heard how our People Participation Leads are continue to liaise with and provide support to service users and carers. We have also worked with our regulators, NHS England/Improvement to appoint an Improvement Director, James Innes, who will bring additional expertise. I welcome James to his first Board meeting.

3.2 I have been actively involved in local, Sustainability and Transformation Partnership, (STP) and national discussions about what is often called the ‘Recovery Phase’ of Covid-19. This phase recognises that we will still need to plan for the delivery of safe services for those affected by Covid-19 and those who are not. It recognises that as a health and care system we must resume services that may have been postponed and that there is likely to be a surge in need as people begin to feel safe to access services. In addition, this phase will seek to identify the advances made as we responded to Covid-19 and will ensure work our service users and carers to agree those we would wish to continue and build upon. To help us with our recovery plan we are also working with our STPs and Governors, with ‘Recovery’ being the focus of our joint Board and Council meeting. I will provide a verbal report on the outcome of those discussions.

3.3 Finally, whilst we know that Covid-19 can affect anyone, it has become apparent that some communities are more affected than others, including older people, people with long term conditions, men and people from black and minority ethnic communities. In addition, to working with the Board to be
assured on the risks assessment and support that take place for both our staff and service users, I have been involved in national conversations and webinars to identify the actions that we can take place to address those communities more affected. These national conversations have highlighted the need to act in partnerships to radically tackle health inequalities and we will continue to review how to successfully deliver this element of our NSFT ambition.

4.0 Action Being Requested

4.1 The Board is asked to RECEIVE and NOTE the report.

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<th>Quality implications</th>
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<td>The report emphasises the need to focus on continued quality improvement during the current pandemic, enabling us to maintain momentum</td>
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<th>Equality implications / summary of consultation</th>
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<td>The report emphasises the need to address health inequalities as part of our ambition, in response to the differential impact of Covid-19</td>
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<th>Risks / mitigation in relation to the Trust objectives</th>
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<td>Understanding and participating in discussions about ‘Recovery’ will better enable the Board to identify and thereby mitigate associated risks.</td>
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<th>Recommendations</th>
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<th>Background papers / information</th>
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<td>For verbal report 14th May 2020 virtual Council of Governor and 19th May 2020 virtual Joint Board and Council meeting discussions.</td>
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Executive Summary:

This report sets out a broad overview of the last two months which has largely been focused on our response to COVID-19. There are a number of points to highlight in how we have worked with partners and other important issues. The Board is asked to receive and note this report.

1.0 Purpose

1.1 To update the Trust Board on significant developments and/or key issues that have happened in the past two months.

2.0 COVID-19

2.1 Our lives have been changed forever during this pandemic. Dawn Collins, our deputy chief nurse and Tactical Commander, and Dan Dalton, our Strategic Commander have been at the forefront of our response to COVID-19. The Incident Management Team – made up of leaders across the organisation - has been sitting since February, meeting daily and contributing to the huge effort focused on patients and supporting staff to do their jobs. The work everyone has put in has been amazing. It has been a team effort for NSFT, and also a tremendous piece of work with all of our partners and communities in Norfolk and Suffolk. Thank you to each and every one of you.

2.2 Sadly, two patients with underlying health conditions passed away at a ward in Suffolk during April. They had tested positive for COVID-19. Our thoughts and condolences remain with those patients’ families and loved ones at this difficult time.
2.3 Under a Level 4 major incident, such as this, NHS England has the authority to repurpose all services and resources. The NHS was instructed to move forward at pace.

2.4 Our response included the following:

- Established an all-age, open access, crisis helpline, launched on 15 April. This has been supported by NHS partners, local authorities, voluntary and community sector, and 111 services.

- Continued to provide mental health services for existing patients using telephone and video conferencing, such as Attend Anywhere for video consultations. Face-to-face appointments are still offered for some, when necessary. This included ensuring that children and young people have access to mental health services, such as setting up an advice and support line for 4-25 year olds living in Norfolk and Waveney on 6 April, commissioning Kooth, an online counselling service 1 May. Kooth is already offered in Suffolk. We are also improving information about referral routes for our partners.

- Prepared for a surge in demand during the next phases of the pandemic, including adding to the wellbeing services. We launched a series of special wellbeing webinars for people in our communities who might be anxious or stressed. Their aim is to reassure people that they are not alone while social distancing, in isolation or unable to go to work. These focus on subjects such as sleep, mindfulness, working from home, isolation and dealing with relationships. If you live in Norfolk, you can sign up for a webinar by visiting www.wellbeingnands.co.uk/norfolk/get-support/courses/. For Suffolk, please go to www.wellbeingnands.co.uk/suffolk/get-support/courses/

- Our preparation saw us actively recruit as well as encouraging staff who have retired recently to return to work to support our services. Staff numbers have also been bolstered by students joining us from local universities.

- We set up a dedicated helpline for staff to talk to people should they feel anxious or stressed. This helpline has now been rolled out to other NHS colleagues across the system.

- Supported completion of annual health checks for people with a learning disabilities and Care (Education) and Treatment Reviews.

- Continued to take into account inequalities in access to mental health services, and in particular the needs of BAME communities. For example, our core materials are available in suitable languages and made sure that service-users always have access to confidential face to face interpreting within 30 minutes of booking. Videos have been for communities with low literacy levels.

- We have worked with and supported BAME staff, including developing bespoke psychological and wellbeing support for BME staff, as well as ongoing research into the impact on BME staff. Guidance has been shared for all managers on supporting BAME staff during Covid-19. We also coproduced our response with BME staff and disabled staff in line with EDI Strategy commitment.

2.5 We have also set aside five wards to nurse patients with Covid-19 symptoms. This included two wards prepared for people suffering from Covid-19 symptoms (Blicking and Eaton). This has been an incredible team effort, from putting in beds, fitting showers and other things for service users, to staffing it and funding it.
2.6 Like all other wards in the NHS, changes were made to the visiting rules. To make sure that service users still had contact with their loved ones, our People Participation Leads were at the forefront of making sure that tablets were provided on the wards to allow virtual visits. In some circumstances we have allowed family visits.

2.7 We have had excellent supplies of Personal Protection Equipment (PPE), and offered different ways to explain the guidance on its use. We also gave people the chance to ask more questions about its use in a series of online events.

2.8 Much of our abilities to carry on has been because our IT department had already planned to use new technologies to improve services. We were able to roll out technology, such as Microsoft Teams, which has meant people have been able to continue to work to support patients and staff.

2.9 We have worked with voluntary agencies to improve offers of help and support for local people. For example, Healthwatch Suffolk and Norfolk have put together support packages, as have SENsational Families in Norfolk and Suffolk Parent Carer Network for those children and families who need more support.

3.0 Other important issues

3.1 On 6 April, we launched an advice and support line for people Norfolk and Waveney CFYP. A letter was incorrectly sent to 326 families for which we apologised. As soon as this mistake was noticed, clinicians began making contact with those young people. Diane Hull appeared on Radio Norfolk on 6 May to apologise to the families concerned and stress that people should contact us.

3.2 Children, Families and Young People’s (CFYP) Advice and Signposting Team - Norfolk and Waveney – is for young people aged 4-25 years, who have already been referred to the Children, Families and Young People’s (CFYP) core teams. This is a new service to enhance the offer to patients.

3.3 The experienced team can offer advice and signposting about all common mental health difficulties (e.g. anxiety, low mood, trauma), where there are no significant risks known. Typically, recipients will receive one telephone call or video call session lasting up to an hour. For those who require additional support, clinicians will be able to direct people to the right service (e.g. online / telephone counselling with ‘Kooth’). If the clinician feels the young person is experiencing more significant mental health difficulties, or if the clinician feels the young person is in need of regular support, they will be directed to the appropriate CFYP service (e.g. one of the Under 14s or Youth services in their area).

4.0 Partnership working

4.1 Before COVID-19 really took hold, the Norfolk & Waveney Health & Care Partnership MH Programme Board sat to discuss the key transformation projects. We have made some progress already and we will work on improving services across the whole system.

4.2 While physical visits are challenging, partners have been meeting regularly to ensure we can support each other through the pandemic, particularly about creating capacity and supporting patients to go home.

4.3 Thanks to the technologies available to us, I have been able to join staff across the patch. This included meetings as part of the Reverse Mentoring Programme with my BAME partner and the BAME network. We have continued with our Quality Performance Meetings with various care groups to add insight into colleagues’ work.
4.4 I was also lucky enough to be in contact with several of our Members of Parliament, being able to brief them on the work of our staff in their constituencies.

5.0 Campaigns

5.1 From 11 to 15 May we ran a ‘Shine a Light’ campaign to celebrate mental health nurses. Every day over this week – which has been set aside nationally to celebrate the work of nurses everywhere - we featured staff from across the Trust. This is a real highlight, as it expresses from their angles how important mental health nursing is.

6.0 Recommendation

6.1 The Board is asked to RECEIVE and NOTE the report.
Executive Summary:

Serious incidents demonstrate a downward trend over six months. Through this period the overall number of reported incidents has fallen. Particular attention is drawn to incidents associated with smoking and staffing. The Patient Safety Incident Framework pilot has been placed on hold by NHSE/I, yet the Trust has taken the opportunity to implement two changes to process which improve the decision making governance and quality of reviews.

The Trust has seen an exceptional spike in the use of restraint over this reporting period, this is likely due to several factors and does not constitute a trend. However, the Reducing Restrictive Interventions Committee will monitor this with the Lead Nurse group accountable for monitoring local practice and quality.

There has been a reduction in complaints and an increase in compliments during this period yet contact with PALS has decreased. Themes and learning from complaints are being shared with Quality Improvement project leads and workstream leads as appropriate.

The Trust is taking account of the guidance from NHSE/I regarding priorities for the recovery phase post Covid-19. This includes a focus on the predicted increase in presentation of service users in response to the consequences of this period of lock down, namely recession and hardship, as well as the impact of anxiety for health and loved ones. Another priority will be responding to a predicted surge in safeguarding concerns and activity.

The report links to the risks 3.1, 3.2, 3.3, 3.4 on the BAF.
1.0 Report Contents

2.0 Reducing Restrictive Interventions

2.1 Restraint

2.2 Innovation

3.0 Serious Incidents and Patient Safety Updates

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3.2 Prevention of future deaths (PFD - Regulation 28)

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5.4 Experienced Based Co-Design Project – Introducing Zero Suicide Ambition to Inpatient Units

5.5 Family Liaison Officer

6.0 Safeguarding

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2.0 Reducing Restrictive Interventions

2.1 Restraint

Incidents of restrictive interventions are experiencing special cause variation evident in the SPC charts in Appendix 1. This is likely to be due to a significant range of factors having a cumulative impact on the overall figures including changes to ward structures (personnel) and purpose, temporary blanket restrictions on wards due to COVID-19 (leave, visiting of family and carers) and increased complexity of needs. Restrictions are reviewed by the Ethics Committee.
The service lines experiencing the rise are Acute/PICU and Specialist Services. Services are actively reviewing people’s experience trying new ideas and actions, including the use of tablets to maintain contact with family and friends. The areas which have experienced higher than the average number of incidents of restraint in the past two months are Catton Ward, Kingfisher Mother and Baby Unit, Samphire Ward, Lark Ward, Rollesby Ward, Dragonfly Unit, Yarmouth. For some of these wards the complexity of an individual’s needs is requiring repeat restrictive interventions to maintain their and others’ safety.

Areas such as Whittingham have also had a few more incidents than usual whilst other wards just a little more than their average; this leads to a large cumulative increase. Positively, Walker Close has been reducing numbers of incidents; this is due to the service user approaching recovery of her acute illness and the sustained compassionate care of the staff. Older persons’ units also saw a slight reduction in incidents.

In terms of actions, teams are using personal behaviour support plans (PBS) and other interventions but all areas are currently hampered by COVID-19 restrictions such as the loss of use of leave and contact with family or friends for service users.

2.2 Innovation

The national Reducing Restrictive Interventions Collaborative has now concluded. Three Trust wards were involved with all experiencing reductions in use over the 18-month period of 25%. The learning and methodology underpinning this success has been shared across all inpatient areas and is being taken forward by our Lead Nurses.

3.0 Serious Incidents and Patient Safety Updates

3.1 Serious incidents within the Trust

There have been 14 serious incidents reported during the two-month reporting period; all but two occurred during this period. Nine of these were unexpected deaths and are to be fully investigated; it is not apparent at this stage whether care and/or service delivery issues contributed to these patients’ deaths. The other incidents all require further investigation; two unexpected/potentially avoidable injuries requiring treatment, two patient accidents and one incident demonstrating existing risk that is likely to result in significant future harm.

There have been two inpatient deaths related to COVID-19 within the Trust’s older persons’ services and 11 deaths in the community confirmed as related to COVID-19, again within the older persons’ teams. The inpatient deaths were reviewed under the Structured Judgement Review process by the patient safety and physical health team, there were no concerns regarding the care and treatment the service users received. All the community deaths occurred either in Care Homes or the Acute General Hospitals, all were older persons. These deaths will be subject to a thematic review to ascertain if there is any learning for the Trust.

There has been one local Patient Safety Alert issued in this period for immediate action related to undertaking and recording patient observations.
Serious incidents and unexpected deaths demonstrate a downward trend which would indicate a sustained reduction in both areas; this is visible within both SPC charts in Appendix 1.

3.2 Prevention of future deaths (PFD - Regulation 28)

The Trust has received one PFD notification from the Norfolk Coroner in this reporting period. The gentleman who died was a service user with both learning disabilities and physical health issues, he died in a care setting. The Coroner raised concern that the Trust had not evaluated the effectiveness of the reasonable adjustments in place to engage with the service user, ostensibly that more could be improved on at both a team and wider organisational level. The Trust is formulating a response which is due for submission in June 2020.

3.3 Incident reporting

Incident reporting has been impacted by COVID-19, with an overall reduction in reporting. The largest reduction has been in staffing issues such as low staffing numbers. Other areas where we have seen reductions are incidents associated with leave and, significantly, with smoking-related incidents, for example, smoking in inappropriate areas as demonstrated in the chart below.

Smoking cessation forms one of the Trust’s priority workstreams; work to improve the approach to this is being led by the Chief Nurse.

- Self-harm incidents:
  
  There were four incidents reported of self-harm using a fixed ligature point (low or no harm). These were all within acute wards for adults of working age at Hellesdon Hospital, noting two incidents relate to the same individual and have resulted in removal of the identified ligature point in this specific area. A Patient Safety Alert has been distributed across the Trust requiring each area to carry out specific safety checks.
There were 60 incidents reported, related to 28 individuals this is within normal variance, all incidents were reported as low or no harm. Eight required brief attendances in A&E departments, with no sustained harm.

- Falls:
  There were 36 incidents reported involving 27 individuals; this is within normal variance. Low or no harm was reported in all but one incident which resulted in moderate harm; the patient sustained a fracture having fallen whilst jumping from bed (accident, not attempt at self harm).

- Pressure Ulcers:
  Three Grade 2 pressure ulcers were reported; two relate to same frail individual. This patient has specialist pressure-relieving equipment in place, careful monitoring of diet and fluid intake; although intake remains poor, continuous medical reviews take place. For the second individual the area is now fully healed.

No Grade 3 or 4 ulcers were reported.

3.4 Patient Safety Incident Reporting Framework update
The pilot launch of the new Patient Safety Incident Framework (PSIF) has been placed on hold by NHSE/I in light of COVID-19. However, the Trust has implemented a new screening tool and review panel with a view to improving the responsiveness and quality of reviews. This includes enhanced clinical involvement of the Care Groups in decision-making around review type, promoting ownership and accountability.

The panel use the quality standards outlined by the RCPsychs serious incident accreditation scheme and the PSIF ‘draft’ Quality Standards to provide governance and consistency.

4.0 Quality and Clinical Effectiveness

4.1 Complaints

In response to a request from Board members this report includes more detail on the themes and actions in response to complaints. There has been an overall reduction in complaints in this period and a rise in compliments. However, contacts with PALS has fallen (Appendix 1).

The five main themes identified in complaints from 1st March to 30th April are analysed below:

1. Thirteen complaints for which the primary concern is identified as 'Disagreement about care provided'.

Of these, five refer to support and contact being impacted upon by restrictions resulting from the team’s response to the pandemic. These ranged from upset caused by staff wearing PPE, commenting that this heightened distress to a person experiencing poor mental health. Other complainants raised issues about cancellations and delays in contact as appointments were changed from face to face to telephone.
Action:
Learning from the Patient Safety and Information Exchange Project is being captured and shared with the QI Team with clinicians describing changes in contact methods, frequency of contacts and assessment of risks to determine these and also the clinical decisions during the pandemic which led to discharges from services during the pandemic. This intelligence will be shared with the recovery planning post Covid-19.

2. Thirteen complaints were made in this period which were categorised as ‘Staff member rude/dismissive’

Three complaints refer to staff seeming “patronising”, “dismissive” and “belittling”. These complaints follow therapeutically challenging sessions within Wellbeing services.

Six complaints refer to community services; these express dissatisfaction with staff response to their situation, whether in the language and tone used or the poor response to communication and requests for contact.

Action:
Workforce and culture are a strategic priority within the Quality Improvement Plan and there are focussed workstreams such as a culture improvement programme, an employee experience team within the HR restructure and People before Process, each being underpinned by QI methodology, Expect Respect has also been launched. Feedback from the complaints informs all these initiatives plus the People Participation Leads across the Trust are developing methods of service user feedback to provide rich sources of commentary and information.

3. Five complaints categorised as ‘Waiting time for treatment to be provided’

Two relate to Wellbeing services, one from a parent describing x3 cancellations of appointments for her son who, it is believed, is at high risk of self-harm and for whom it is currently undecided which team can provide support. The other is a service user awaiting contact having disclosed sexual abuse from a family member. These make some references to services’ responses during the pandemic.

Action:
Although these cite reference to COVID-19, adaptations to services, access to and engagement with services, are strategic priorities for the Trust. Assurance has been sought from all Care Groups in response to how they ensure safeguarding concerns are addressed. Safeguarding response forms part of the Trust recovery plan post COVID-19 lockdown measures with increased capacity already agreed by the Trust senior leadership team.

4. Five complaints fall under the category of ‘Medication prescribed/withdrawn incorrectly’

Three relate to inpatient care one regarding night medication being given in the early hours, concerns around over-sedation and being forced to take depot medication.
Another refers to Wellbeing and concerns that changes in prescription are not communicated with the GP. The fifth relates to a request for a medication review which is perceived as overdue.

Action:
Medication management is a strategic priority and is also a QI project in the Medicines Collaborative.

5. Five complaints are themed as ‘Discharged with insufficient care package’
These relate to several service lines across the Trust.

Action:
Access to Services and Care Planning and Risk Assessment, which incorporates discharge planning, are strategic workstreams.

4.2 Quality and Safety Reviews (QSR)
Since the social distancing requirements came into place the Trust suspended the planned physical quality and safety review schedule to ensure the safety of both service users and staff.

Virtual quality and safety documentation checks to support Acute and Secure Services were undertaken, a revised virtual schedule is in place to review other areas. There were similar themes found:

Combined assessments were detailed in both areas and gave an accurate picture of the service user’s journey. Care plans, overall, were individualised with a marked improvement noted within the North Norfolk and City inpatient areas. In Secure Services the staff utilise My Shared Pathway with service users which is generally well received and up to date; however, this is a lengthy document and could prove cumbersome for some service users. The documentation related to capacity assessments in respect of admission (in the acute service line) and treatment (across both service lines) was not always present in the patient record or easy to locate; this is an issue which is reflected in the CQC MHA visits also. Continuation notes are, in the main, detailed and descriptive of the service user’s activities; however, this is not consistent, and quality is variable.

Actions in response to these reviews:

- Capacity assessments will be added to the Lorenzo checklist, the MHA team are aware, this will be on the agenda for the Mental Health Committee in June 2020.
- Coaching is to be provided to the Matron to support consistent, meaningful and good quality documentation including care plans, continuation notes and the core assessment.
- Improvement to the quality of enhanced observations will form part of the upcoming policy review and a co-produced workstream.

The QSRs will continue to support teams with their focus on quality and safety, especially during these times of rapid change as a result of COVID-19. Scheduled reviews with teams expecting CQC MHA monitoring visits to support readiness (Waveney Ward, Northgate Ward...
and Poppy Ward) are in place. Walker Close will also be reviewed to provide them with an objective perspective on quality and safety following their rapid improvement work.

The Quality and Patient Safety Team will review quality and safety indicators each month and collaboratively organise objective deep dives with care groups where extra assurance is required.

4.3 Quality Improvement (QI) projects

There are 58 QI projects active currently, plus two new projects in planning stages (Carers receiving bad news and Care Planning). COVID-19 has had a temporary impact on the majority due to significant changes in working patterns and accessibility. Projects that relied on face to face interactions have been reviewing their improvement actions making suitable adjustments to the current conditions. The coaching of improvement teams has successfully transferred online enabling ongoing support.

The national Sexual Safety (inpatient) Collaborative, involving two Trust wards, has been suspended until September.

The Medicines Management, Reducing Restrictive Interventions, and 48-hour Discharge collaboratives continue, returning to pace following the period of adjustment linked with COVID-19.

4.4 National Audits

In general, we have been informed by audit institutions that the national audit programme is going ahead as planned during the COVID-19 pandemic. However, due to unprecedented pressures on trusts/health boards, deadlines have been extended as audit is considered to be ‘non-essential work’. The NSFT Clinical Audit Support Team will ensure the Trust is kept up to date with any changes and requirements so that our Trust can fully participate.

Progress Update;

- **Falls and Fragility Fractures Audit Programme (FFFAP):** The Trust re-registered for the National Audit of Inpatient Falls which now includes an expanded dataset containing criteria on preventative measures.

- **NCEPOD - Physical Health in Mental Health Hospitals:** Patient data requested by the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) has been produced by Informatics. However, the audit has been indefinitely delayed due to this period of pandemic.

- **National Audit of Care at the End of Life (NACEL):** The Trust has registered for the National Audit of Care at the End of Life (NACEL) audit for 2020. Data collection is provisionally set to start in June 2020.

- **National Clinical Audit of Psychosis (NCAP) - EIP spotlight audit:** The Trust participated in the National Clinical Audit of Psychosis (NCAP) for 2019/20 with a 100% submission rate. Results to be published later in the year.
Prescribing Observatory for Mental Health (POMH-UK) Quality Improvement Audits;

- **Topic 9d: Antipsychotic prescribing for people with a learning disability under the care of mental health services:** Data collection completed on 27th March 2020; 170 audit tools were submitted by NSFT. Increased participation in national audits is a strategic aim of the Clinical Audit Support Team and this shows an increase from the previous POMHUK (Topic 17b March 20) audit which was 73.

- **Topic 20a: Improving the quality of prescribing valproate in mental health services:** Eligible patients will be currently prescribed valproate under the care of adult mental health services (including forensic services) irrespective of age. Patients under the care of other services, such as CAMHS, Learning Disability and Older Person’s Services, should not be included. The start of data collection for this audit has been delayed from May 2020 to September 2020.

- **Topic 17b: The use of depot/long acting injectable antipsychotic medication for relapse prevention:** Report published March 2020 and uploaded to the intranet.

### 5.0 Suicide Prevention Updates

#### 5.1 48-hour discharge project

As part of the Trust’s “Zero Suicide Ambition for Inpatient Units”, a QI project is proposed to ensure that a meaningful 48-hour contact takes place with the patient following discharge from an inpatient unit. National evidence indicates that people are at increased risk of suicide on day three following discharge from an inpatient unit.

A QI training day was held on 5th May 2020 with representatives from the selected inpatient units, Community and Crisis Teams. Teams made a collective decision that the 48-hour contact would remain the wards’ responsibility and they would focus upon how they can make this contact more meaningful. Due to changes in management and impact of COVID-19 this project has not made the progress hoped; however, both Suffolk Care Groups have successfully re-engaged with the QI project. Awaiting feedback from Central and South Norfolk Care Groups.

#### 5.2 National suicide prevention funding - wave 1

QI project, Stepping Back Safely, has been successfully delivered and the project is now closed. We are hoping that the learning from this will be rolled out across the Trust post COVID-19. Certainly, other trusts (not just mental health) are keen to explore using this.

#### 5.3 National suicide prevention funding - wave 2

Both Norfolk and Waveney STP and Suffolk and North Essex STP have received funding for wave 2. It has been agreed that NSFT will commence a piece of work focusing on safety planning in inpatient areas. The aim of the project is that every service user who is discharged from one of the inpatient units in the project area will leave with an individualised safety plan. The funding is being used to ensure each ward will receive a 3-hour Safety Planning Course from the Recovery College and a Peer Support Worker is employed for 1 - 2 hours a week on each ward to help staff formulate safety plans with service users, carers and families.
Both Norfolk and Suffolk Public Health are aware that this has had to be suspended due to COVID-19. Once training restrictions have been lifted, we have had feedback that this training will need repeating. In the meantime, the Senior Peer Support Worker is meeting via Microsoft Teams with current Peer Support Workers to train them fully in safety planning so once the training has been delivered to the wards the Peer Support Workers will be able to assist this as planned.

5.4 Experienced Based Co-Design Project – Introducing Zero Suicide Ambition to Inpatient Units

As part of the Trust’s “Zero Suicide Ambition to Inpatient Units” an Experienced Based Co-Design Project (EBCD) is to take place on Samphire Unit, West Norfolk, learning from staff, service users and carers about how we make the inpatient environment more therapeutic which will increase the inpatient ability to engage in inpatient treatment and lessen the risk that they will take their life. The EBCD project will have people with experience of feeling suicidal engaging with current inpatients and carers to formulate ideas of change. A core group has been established; however, this will be revisited once COVID-19 restrictions have been lifted.

5.5 Family Liaison Officer (FLO)

There are approximately 60 mental health trusts in England, 14 of these have a Family Liaison Officer. The role design is varied and feedback from families equally varied. So far, we have received only positive feedback for our FLO who was invited to speak at a planned Making Families Count conference in the summer; however, this was cancelled due to COVID-19.

Since the role began, six months ago, in the Trust our FLO has offered support to 33 families; 16 have taken up that offer so far. Support is offered to suit the needs of the family and continues through the review period up to inquest. The FLO has spent approximately 125 hours in face to face consultation with families and provides telephone and email contact outside of this.

The FLO is able to signpost families to bereavement support, help with accessing information around practical issues and, in some cases, is able to refer a family member to receive urgent psychological support. The role acts as a conduit between the review investigator and family to ensure that the family are involved and understand the processes, timescales, strengths and challenges of a clinical review.

Areas of learning for the Trust from family feedback are; the need to improve involvement of families in core assessment and care planning, listening to families when their loved one is in crisis, explaining risk assessment and decision-making to families, involving families in discharge planning.

Due to the limitations on capacity and time, it does mean that not all families are able to access the FLO if a significant time period has passed since the death of their loved one.
“Supporting staff to deliver bad news and co-ordinate aftercare” QI project

In response to learning from SI 1511, a six-month project has commenced with the FLO, People’s Participation Lead, Chaplin’s and Carers’ Leads to deliver a course to assist clinicians to deliver bad news. This is being led by the QI Lead.

5.6 Pilot Study – Reducing Self Harm and Suicide amongst Children and Young People (CYP) in Norfolk and Suffolk

Funding has been received to implement a new rapid response pathway for CYP aged 16-24 who present at either Norfolk & Norwich or Ipswich hospitals’ A&E departments with self-harm.

The aims of this pilot will be to:

- Provide rapid access to therapeutic interventions for CYP aged 16-24 who present in A&E with self-harm (with flexibility for younger ages as appropriate).
- Provide expert training and development to existing liaison services to further enhance the provision of psychosocial assessment at the point of crisis. This will focus on reinforcing messages of compassionate care and good therapeutic assessment.
- Reduce repeat attendances at A&E of CYP with self-harm.
- Provide a holistic approach to this cohort of young people to try and address all factors which may influence the need to self-harm.
- Identify CYP who are at increased risk of suicide and proactively manage their health and social care to reduce this risk.

A senior manager from CAMHS is leading this for Norfolk and the Mancroft Advice Project (MAP) has been funded to complete this. The Deputy Lead Nurse is leading for Suffolk CAMHS and is exploring how this can be achieved from the Suffolk service.

5.7 NHSE/I COVID-19 updates and priorities going into recovery

NHSE/I complimented NSFT about how they have embraced the use of technology, in particular Attend Anywhere, to address support in the community while under lockdown.

The National Suicide Prevention Alliance is holding regular support sessions to see what is seen nationally about suicide and COVID-19. Main themes so far:

- Mental health trusts and third sector organisations are relying far more on SKYPE/ Microsoft Teams in the absence of face to face contacts. Concern that not everyone has access to IT equipment – are they being missed?
- Reports of self-harm presentations at A&E are down. Does this mean that there will be hidden implications to people not seeking help (increase in infections, liver disease)? How do we record the hidden costs of COVID-19?
- How are teams preparing to manage when restrictions are lifted? What are we doing to ensure services are prepared for the expected surge?
- Third sector organisations have had an increase in demand. Also, they have had to adjust to be adaptable to those who are self-referring - for example CALM (a predominately male charity) has experienced an increase in females contacting them reporting domestic violence.
• Mental health trusts across the country are noticing a drop-in referral for suicide but an increase in psychosis.

**Local priorities:**

• 24 hr crisis support - ensure that suicide bereavement services are linked with established 24/7 crisis support;
  - FLO to work with the new 24/7 telephone advice line and all crisis services to advise of Family Liaison role, highlighting that people who are bereaved by suicide are at increased risk of suicide.
  - To consider making this a joint presentation with the third sector services commissioned to provide bereavement support across the whole of Norfolk and Suffolk (Norfolk and Waveney MIND and Amparo).
• IAPT services – ensure that suicide bereavement services are linked with established 24/7 IAPT services;
  - Action as above.
• Need to adapt suicide prevention training;
  - We are currently reviewing Risk Assessment / Suicide Prevention training; this includes working with the Recovery College.
  - How to deliver quality training digitally.
  - Training currently needs to identify who is the most vulnerable in the community and greater awareness of what third sectors are still able to provide.

### 6.0 Safeguarding

#### 6.1 Referrals

In NSFT there is an observed reduction in safeguarding referrals likely linked to the rapid changes in all community services for families and children linked to COVID-19 and noted nationally. This is more marked in referrals related to children for NSFT. There have been some local issues with the referral process/portal provided by the local authorities; these are known to both county providers. A predicted rise in the number of concerns will form part of the Trust recovery plan.

#### 6.2 Duty/consultation activity and communication

The Trust Safeguarding Team continue to provide a 5-days a week duty function which has proved extremely busy during this period. The team have reinstated supervision via Microsoft Teams. The team are working with the local safeguarding partnerships to ensure national and local communications are shared with the Trust in a consistent way. This includes awareness raising and signposting within the weekly COVID-19 update provided by the Trust to all staff. The team is beginning discussions with training colleagues to reinstate training in different, safe, formats including virtual, e-learning and briefings. The Trust is supporting increased capacity within the team in anticipation of increased demand.

#### 6.3 Local reviews

There have been no published reviews in this period covering safeguarding child or adult reviews or Domestic Homicide Reviews.
Appendix 1

Patient Safety SPC Charts

- Incident reporting - c chart
- Serious incidents - c chart
- Unexpected deaths reported as an SI - c chart
- Medication incidents during administration - c chart
- Inpatient services - self harm leading to attendance at acute hospital - c chart
- Number of absconsions from a ward - c chart
- Number of failures to return from leave - c chart
- Safeguarding adult referrals - c chart
- Safeguarding children referrals - c chart
Total Trust Restraints per 1000 Occupied Bed Days

Total Trust Prone Restraints per 1000 Occupied Bed Days

Total Trust Rapid Tranquillisations per 1000 Occupied Bed Days

Total Trust Seclusions per 1000 Occupied Bed Days
Service user experience SPC charts

Complaints - c chart

Trust Compliments - c chart

Positive responses via Friends and family test - p chart

PALS contacts - c chart
Report To: Trust Board of Directors
Meeting Date: 21 May 2020
Title of Report: CQC Inspection reports of; Child, Family and Young Persons Services at 80 St Stephens Road, Norfolk and Acute Wards for Adults of Working Age at Wedgwood Unit, Suffolk.
Action Sought: For Information and Assurance
Estimated time: 15 Minutes
Author: Diane Hull – Chief Nurse
Director: Diane Hull – Chief Nurse

Executive Summary:

This report provides an outline of the findings of the CQC responsive inspection of Specialist Community Mental Health Services for Children and Young People (CFYP) at 80 St Stephens Road, Norwich, Norfolk and the Acute Wards for Adults of Working Age at Wedgwood House, Bury St Edmunds, Suffolk. The inspections took place over two days, 24 and 25 February 2020.

This paper provides an outline of the context for each of these services at the point of inspection and the work that was in progress, due to known issues prior to the CQC inspection, through two Rapid Improvement Boards. In response to the inspection findings, this work has been enhanced, the pace of improvements has been increased and the controls in place are being routinely evaluated for efficacy.

For the Children and Young People service line, the Rapid Improvement Board will be supported in the future through the oversight of the recently appointed Improvement Director.

The Board of Directors are asked to note the content of the CQC Inspection reports and formally accept them.

The report links to the risks 3.1, 3.2, 3.3, 3.4 on the BAF.
1.0 Report Contents:

80 St Stephens Road, CFYP- Norfolk CFYP Care Group
   1.1 Background
   1.2 Inspection Report Findings
   1.3 Improvement Programme

Wedgwood House – Acute Wards for Adults of Working Age – West Suffolk Care Group
   1.4 Background
   1.5 Inspection Report Findings
   1.6 Improvement Programme

Conclusion

2.0 80 St Stephens Road, Specialist Community Services for Children and Young People. Norfolk

2.1 Background

80 St Stephens Road in Norwich is a large base for a number of services which includes youth services. Plans are in place for the Early Intervention service (not included within this inspection) to move out from this base.

The Trust had, prior to this inspection, identified that additional support was required to deliver and maintain required improvements and had established a multi-agency Rapid Improvement Board which commenced in early February 2020.

The CQC carried out an inspection of 80 St Stephens Road as a result of information passed directly to them anonymously, and as a result of their routine monitoring arrangements. The inspection focused on the cohort of patients who were waiting to be allocated a Lead Professional.

2.2 Inspection Report Findings

The CQC were not assured that service users who were on waiting lists for assessment or treatment were being adequately managed, in terms of monitoring and support provided. Where a change in the service users’ individual risks were identified, risk assessments were not always being updated. Some appointments and therapy groups were found to have been cancelled as a consequence of lack of staff availability. This meant that there was a risk that patients whose needs changed might not be identified or receive support in a timely manner.

The CQC understood that the trust was working to rationalise the waiting lists in place and establish a principal list for each team, but at the time of the inspection staff were still referring to numerous waiting lists. This was considered potentially confusing and ineffective and did not ensure there was appropriate oversight for the teams.

The report notes that the building at 80 St Stephens Road was not well maintained, and the décor needed updating. Internet access at the time of the inspection was not reliable which meant that patient records were not always accessible.
Whilst the trust was refining its governance arrangements, these were not yet working effectively for this service. The data on waiting lists needed improvement to ensure staff in the teams had the information they required to meet the needs of the patients. They commented that the trust also needed to be assured that patients were being assessed and treated in a timely and safe manner. In addition, the governance meetings taking place in the service had been revised and needed to be embedded. Staff particularly in the North Team needed the support and guidance from leaders to use the new systems and processes.

However, the inspection noted that in response to the concerns raised within the inspection report, the trust leadership team provided assurance of action which had begun just prior to the inspection. For example:

- on 13 February 2020, an executive-led Rapid Improvement Board had been established. This aimed to accelerate improvements and had increased senior leadership oversight
- the care group leadership team were visible spending four to five days per week at St Stephens Road
- the CQC were told of plans in place to undertake a large-scale clinical review of the waiting list in early March 2020
- a review of the duty system and supervision processes were also planned
- new terms of reference for leadership meetings had been agreed including a specific section on learning from incidents, complaints and inquests
- a programme of site meetings was planned along with maintenance walkarounds. This had already seen the implementation of hygiene audits and projects identified to improve the environment
- recruitment into posts had begun and the CQC recognised that key roles had been appointed to with plans in place for further recruitment
- the trust had also increased senior management oversight to the service
- there was an improvement on staffing resources which was of particular concern in the North team in December 2019
- work had begun just prior to this inspection to draw all the waiting lists together and provide a clear view and understanding of action required. This was being developed as a Service User Tracker List (SUTL) to monitor all patients. This system had been successfully implemented in other teams in the trust. It involved a weekly meeting to discuss actions required for patients on the list.

The report includes a series of actions the Trust must implement;

- Ensure adequate staff resources are available to reduce the patient waiting lists for triage, assessment and treatment in the children and young person service and for attention deficit hyperactivity disorder patients. This includes, ensuring patients managed on team-held waiting lists are supported safely. Regulation 12: Safe care and treatment 12 (1)

- The trust must review their systems to ensure that patients have risk assessments which are updated as needed and care plans in the children and young person service. Regulation 12: Safe care and treatment 12 (2)(a), (b)

- The trust must review governance systems to ensure compliance with actions from past CQC inspections in the children and young person service. Regulation 17:
- Good governance 17(1), (2) (a), (b) and (f)
2.3 Improvement Programme

The inspection provided an opportunity to take stock and review the existing plan along with the organisation of the Rapid Improvement Board. Initial progress had been positive but there was a concern that momentum had been difficult to maintain. The Lead Nurse and Clinical Director have been working clinically with the team to revise the governance arrangements and help bring clarity to the waiting times along with the list of people triaged and waiting to be allocated a Lead Professional.

The recruitment programme has successfully addressed the vacancies across both the North and South teams with just one shared Community Support Worker post outstanding.

The Lead Nurse and Clinical Director have provided senior specialist clinical input undertaking assessments of young people waiting for a service and supporting the team with the redesign work ensuring young people are seen in a timely fashion. These senior clinicians are working with practitioners on risk assessments and care planning systems.

A revised governance framework is being developed which is informed by learning from elsewhere in the Trust.

There will be some movement from the team base which will release space and improve the clinical environment. A review of the IT outage was completed which clarified the operational arrangements and business continuity plans.

The improvement plan for Norfolk CFYP is closely aligned to the wider system Transformation work and has drawn partner organisations together. The work to date has led to an understanding of the system pressures and the actions required to address the challenges upon and within the service. The Trust now has the opportunity to better support improvement in Norfolk and Suffolk CFYP services working closely with CCG and local authority colleagues. With robust clinical leadership established in both counties and as a result of successful recruitment, the foundations are in place to pursue improvement through rigorous application of Quality Improvement methodology supported by the Improvement Director.

3.0 Wedgwood Unit – Adult Acute Inpatient Wards – West Suffolk

3.1 Background

Northgate and Southgate Wards are located at Wedgwood Unit and provide adult acute inpatient services within the West Suffolk Care Group. Although noted that these wards had previously demonstrated significant improvements, it had not been maintained, and the Trust recognised additional support was required. In November 2019 additional senior nursing leadership was
provided and a number of changes were made within management and senior leadership roles. A multi-agency Rapid Improvement Board led by the Chief Nurse was established and an improvement plan was put in place which was shared with partner organisations.

The CQC carried out their inspection as a result of anonymous information and through their routine monitoring arrangements. They note that the Trust had kept the CQC appraised of emerging concerns through the regular Engagement Meetings which had included the measures taken to support the wards.

### 3.2 Inspection Report Findings

The inspection identified a number of occasions where the staffing levels on the wards were below the safer staffing levels set by the trust. Vacancies for registered nurses were 51% and 26% for support workers although recruitment was taking place with some staff due to come into post. Staff and patients described the impact of this where leave and activities were sometimes cancelled and both patients and that staff did not always feel safe on the wards.

The CQC noted that care records had not been fully updated to reflect all the patients’ risks following concerning incidents. There were not always records of a risk assessment being undertaken prior to a patient leaving the ward.

Learning from incidents was not always shared and embedded systematically across the wards. However, staff knew what safety incidents to report and had reported incidents appropriately.

Some mandatory training still needed to take place. Whilst overall compliance across the two wards was 80% some courses had lower completion rates.

Staff were not all receiving regular supervision with their manager, although the trust was working to make improvements and learn from other parts of the organisation where this was going better.

Prior to the inspection there had been gaps and changes to leadership at the hospital. Some staff told the CQC that while senior staff had visited the wards, they did not feel they were being listened to. The report recognises that the trust had recently appointed a Lead Nurse, a temporary Modern Matron, a permanent Ward Manager for Northgate ward and a temporary Ward Manager for Southgate ward. Staff were noted to be positive about the recent appointments. Ward managers told the CQC they felt they had support from senior leaders and that they had acknowledged staff’s concerns and spent significant time at the wards since January 2020.

The report notes that some governance systems needed to be strengthened. For example, it was difficult to get accurate data on staffing levels during the inspection which was essential information needed to manage and monitor the service. The inspection acknowledges that the trust had recognised prior to the inspection that improvements were needed at the Wedgwood Unit establishing a rapid improvement board and improvement plan.

Prior to publication of the report and an opportunity for the Trust to respond to the initial findings, the CQC issued a Section 31 notice of decision to pause admissions. This was lifted four days later due to the swift response by the trust which clarified initial concerns and provided details and evidence of the actions taken to ensure the safety of patients and staff.

### 3.3 The inspection report details a series of actions the Trust must take. These includes;

- The Trust must ensure there are sufficient nursing staff to keep people safe from avoidable harm. Regulation 18: Staffing 18 (1)
• The trust must ensure that staff have undertaken mandatory training, supervision and appraisal in line with trust policy. Regulation 18: Staffing 18 (1) and (2)

• The trust must review their systems to ensure that patients have risk assessments which are robust and updated as needed. This must include the risk assessment processes prior to patients being allowed leave from the ward. Regulation 12: Safe care and treatment 12 (2)(a), (b)

• The trust must ensure that there is robust learning from patient safety incidents and that learning is shared and implemented by staff. Regulation 17: Good governance 17(1), (2) (a) and (b)

• The trust must review governance systems to ensure compliance with actions from past CQC inspections in the acute services. Regulation 17: Good governance 17(1), (2) (a), (b) and (f)

• The trust must ensure they support all managers to use the trust’s governance systems and performance management systems in the acute service. Regulation 17 (1), (2) (a), (b), (c) and (f)

3.4 Improvement Programme

The CQC inspection coincided with the development of an improvement plan which was being overseen by the Rapid Improvement Board. The CQC findings were consistent with the Trust’s assessment and priorities, and early progress was noted during the inspection.

This intensive work has continued at pace and has delivered improvements across the full range of priorities and concerns highlighted by CQC through the inspection;

• nursing staff vacancies have reduced to 8 Registered Nurses and 2 Clinical Support Workers across both Northgate and Southgate wards. In terms of temporary staff, the Wedgwood team have worked with NHS Professionals to secure 12 regular agency staff. The accommodation and support offer to new recruits has been clarified

• weekly Listening Events continue which are valued by the staff. Welcome Events are an established part of the orientation for new staff along with a revised induction programme

• ward staff have implemented the Safety Bundle comprising the Brosot Violence Checklist and Safety Cross. A new Acute Services Meeting is in place, the care group Governance meeting is developing, and a quality dashboard is in place. A revised assurance toolkit will be confirmed by leadership team

• the People Participation Lead role is being advertised and Wedgwood Unit has benefitted from the commitment of Experts By Experience and their work with service users on gaining their experience. This is helping to further inform the improvement plan and the effectiveness of the changes being made. Covid-19 side-lined the planned work with Suffolk User Forum but the commitment remains to pursue further joint work when the restrictions are lifted.
• the ward environment has benefitted from £20k of new furniture and Southgate Ward has been decorated. The Wedgwood Unit senior nursing staff routinely meet with the estates team and GFM, the facilities provider, to monitor maintenance issues.

• the unit activity programme has been jointly reviewed and 1-1s are routinely monitored. A care plan training programme is planned and audit and quality monitoring support is in place.

• Supervision and reflective practice sessions are in place.

• Covid-19 has impacted upon the early work on the smoking policy but the principles and lead responsibilities have been established.

4.0 Conclusion

Both reports highlight concerns and it is disappointing to note that improvements had not been maintained or progressed at the required pace despite initial positive progress. However, in both services, the Trust had recognised that additional support was required with Rapid Improvement Boards in place. Further action had been taken which had sought to include external partners as important stakeholders which can make a material impact upon the improvement work.

Work had started and at the time of the inspection, the impact was noted along with early signs of improvement. This has continued at a pace in Wedgwood Unit which continues to build upon the progress. Similarly, the CFYP work provides the foundation upon which services for young people across Suffolk and Norfolk can pursue at pace a programme of improvement supported by the Improvement Director.

The Board of Directors are asked to note the content of both inspection reports within the context of the governance and improvement work that continues to support the experience of young people and adults of working age under the care and treatment of Norfolk and Suffolk NHS Foundation Trust.
Norfolk and Suffolk NHS Foundation Trust

Acute wards for adults of working age and psychiatric intensive care units

Quality Report

Hellesdon Hospital
Drayton High road
Norwich
Norfolk
NR6 5BE
Tel: 01603 3421412
Website: www.nsft.nhs.uk

Date of inspection visit: 24 - 25 February 2020
Date of publication: This is auto-populated when the report is published

Locations inspected

<table>
<thead>
<tr>
<th>Location ID</th>
<th>Name of CQC registered location</th>
<th>Name of service (e.g. ward/unit/team)</th>
<th>Postcode of service (ward/unit/team)</th>
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</thead>
<tbody>
<tr>
<td>RMYNR</td>
<td>Wedgwood House</td>
<td>Northgate Ward</td>
<td>IP33 2QZ</td>
</tr>
<tr>
<td>RMYNR</td>
<td>Wedgwood House</td>
<td>Southgate Ward</td>
<td>IP33 2QZ</td>
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</tbody>
</table>

This report describes our judgement of the quality of care provided within this core service by Norfolk and Suffolk NHS Foundation Trust. Where relevant we provide detail of each location or area of service visited.

Our judgement is based on a combination of what we found when we inspected, information from our ‘Intelligent Monitoring’ system, and information given to us from people who use services, the public and other organisations.

Where applicable, we have reported on each core service provided by Norfolk and Suffolk NHS Foundation Trust and these are brought together to inform our overall judgement of Norfolk and Suffolk NHS Foundation Trust.

1Acute wards for adults of working age and psychiatric intensive care units Quality Report This is auto-populated when the report is published
### Summary of findings

#### Ratings

We are introducing ratings as an important element of our new approach to inspection and regulation. Our ratings will always be based on a combination of what we find at inspection, what people tell us, our Intelligent Monitoring data and local information from the provider and other organisations. We will award them on a four-point scale: outstanding; good; requires improvement; or inadequate.

<table>
<thead>
<tr>
<th>Overall rating for the service</th>
<th>Requires improvement</th>
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</thead>
<tbody>
<tr>
<td>Are services safe?</td>
<td>Requires improvement</td>
</tr>
<tr>
<td>Are services effective?</td>
<td>Requires improvement</td>
</tr>
<tr>
<td>Are services caring?</td>
<td>Good</td>
</tr>
<tr>
<td>Are services responsive?</td>
<td>Requires improvement</td>
</tr>
<tr>
<td>Are services well-led?</td>
<td>Requires improvement</td>
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</tbody>
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**Mental Health Act responsibilities and Mental Capacity Act / Deprivation of Liberty Safeguards**

We include our assessment of the provider’s compliance with the Mental Health Act and Mental Capacity Act in our overall inspection of the core service.

We do not give a rating for Mental Health Act or Mental Capacity Act; however we do use our findings to determine the overall rating for the service.

Further information about findings in relation to the Mental Health Act and Mental Capacity Act can be found later in this report.
# Summary of findings

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- Our inspection team 7
- Why we carried out this inspection 7
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- What people who use the provider’s services say 8
- Areas for improvement 8

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- Action we have told the provider to take 16

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**Tab 12.1** Paper Gi. Acute Wards for Adults of working age and psychiatric intensive care units Quality Report This is auto-populated when the report is published
Overall summary

This was a focused inspection looking at specific areas of concern. The inspection was of two acute wards, Southgate and Northgate, located at the Wedgwood Unit, West Suffolk Hospital, Bury St Edmunds. The ratings shown in the report are from the previous inspection of acute wards across the trust which took place in October 2019.

We found the following areas the trust needed to improve at Southgate and Northgate wards:

- There were a number of occasions where the staffing levels on the wards were below the safer staffing levels set by the trust. Vacancies for registered nurses were 51% and 26% for support workers although recruitment was taking place with some staff due to come into post. Staff and patients described the impact of this. Leave and activities were sometimes cancelled and both patients and staff did not always feel safe on the wards.
- Care records had not been fully updated to reflect all the patients’ risks following concerning incidents. There were not always records of a risk assessment being undertaken prior to a patient leaving the ward.
- Learning from incidents was not always shared and embedded systematically across the wards. However, staff knew what safety incidents to report and had reported incidents appropriately.

- Some mandatory training still needed to take place. Whilst overall compliance across the two wards was 80% some courses had lower completion rates such as a fire safety, intermediate life support and adult safeguarding level 3.
- Staff were not all receiving regular supervision with their manager, although the trust was working to make improvements and learn from other parts of the organisation where this was going better.
- Prior to our inspection there had been gaps and changes to leadership at the hospital. Some staff told us that while senior staff had visited the wards, they did not feel they were being listened to. However, the trust had recently appointed a lead nurse, a temporary modern matron, a permanent ward manager for Northgate ward and a temporary manager for Southgate ward. Staff were positive about the recent appointments. Ward managers told us they felt they had support from senior leaders and that senior leaders had acknowledged staff’s concerns and spent significant time at the wards since January 2020.
- Some governance systems needed to be strengthened. For example, it was difficult to get accurate data on staffing levels during the inspection which was essential information needed to manage and monitor the service. However, the trust had recognised prior to the inspection that improvements were needed at the Wedgwood Unit establishing a rapid improvement board and improvement plan.
Summary of findings

The five questions we ask about the service and what we found

Are services safe?
The rating provided was the rating given following the inspection which took place in October 2019. This has not been revised.

- There were a number of occasions where the staffing levels on the wards were below the safer staffing levels set by the trust. Vacancies for registered nurses were 51% and 26% for support workers although recruitment was taking place with some staff due to come into post. Staff and patients described the impact of this. Leave and activities were sometimes cancelled and both patients and staff did not always feel safe on the wards.
- Care records had not been fully updated to reflect all the patients’ risks following concerning incidents. There were not always records of a risk assessment being undertaken prior to a patient leaving the ward.
- Learning from incidents was not always shared and embedded systematically across the wards. However, staff knew what safety incidents to report and had reported incidents appropriately.
- Some mandatory training still needed to take place. Whilst overall compliance across the two wards was 80% some courses had lower completion rates such a fire safety, intermediate life support and adult safeguarding level 3.

Are services effective?
The rating provided was the rating given following the inspection which took place in October 2019. This has not been revised.

- Staff were not all receiving regular supervision with their manager, although the trust was working to make improvements and learn from other parts of the organisation where this was going better.

Are services caring?
We did not inspect this domain

The rating provided was the rating given following the inspection which took place in October 2019. This has not been revised.

Are services responsive to people’s needs?
We did not inspect this domain

The rating provided was the rating given following the inspection which took place in October 2019. This has not been revised.

 Requires improvement

Good

Requires improvement

Good
**Are services well-led?**
The rating provided was the rating given following the inspection which took place in October 2019. This has not been revised.

- Prior to our inspection there had been gaps and changes to leadership at the hospital. Some staff told us that while senior staff had visited the wards, they did not feel they were being listened to. However, the trust had recently appointed a lead nurse, a temporary modern matron, a permanent ward manager for Northgate ward and a temporary manager for Southgate ward. Staff were positive about the recent appointments. Ward managers told us they felt they had support from senior leaders and that senior leaders had acknowledged staff’s concerns and spent significant time at the wards since January 2020.
- Some governance systems needed to be strengthened. For example, it was difficult to get accurate data on staffing levels during the inspection which was essential information needed to manage and monitor the service. However, the trust had recognised prior to the inspection that improvements were needed at the Wedgewood Unit establishing a rapid improvement board and improvement plan.
Summary of findings

Information about the service

Norfolk and Suffolk NHS Foundation Trust was formed when Norfolk and Waveney Mental Health NHS Foundation Trust and Suffolk Mental Health Partnership NHS Trust merged on 1 January 2012. Norfolk and Waveney Mental Health NHS Foundation Trust had gained foundation trust status in 2008.

Norfolk and Suffolk NHS Foundation Trust provides services for adults and children with mental health needs across Norfolk and Suffolk. Services to people with a learning disability are provided in Suffolk. They also provide secure mental health services across the East of England and work with the criminal justice system. Several specialist services are also delivered including a community-based eating disorder service.

The Care Quality Commission placed Norfolk and Suffolk NHS Foundation Trust in special measures in 2017. There were further inspections in 2018 and 2019. Following the October 2019 inspection, there was an improvement in rating from inadequate to requires improvement overall. The core service acute wards for adults of working age and psychiatric intensive care units (PICU) was rated as requires improvement for safe, effective, responsive and well led and requires improvement overall. Despite the improved overall rating, the trust remained in special measures as it was too soon to judge if the early improvements made could be sustained.

The trust has been inspected six times in the previous 12 months including this inspection.

The trust provides 12 acute wards and psychiatric intensive care units (PICU) for adults of working age at five locations across Norfolk and Suffolk.

This was a focussed inspection and we looked solely at the two acute wards, Southgate and Northgate, located at the Wedgewood Unit, West Suffolk Hospital, Bury St Edmunds.

Our inspection team

The team that inspected the service comprised of one inspection manager and two CQC inspectors.

Why we carried out this inspection

We carried out this inspection of Southgate and Northgate Wards, located at the West Suffolk Hospital, Bury St Edmunds, in response to a range of concerning information as a result of whistleblowing information and other intelligence. This was a focussed, unannounced inspection specifically to look at patient case management, staffing and team management/leadership and actions following serious incidents.

All requirement notices issued in the last inspection remain in place. The Section 29a warning notice amended in 2018 also remains in place.

We do not revise ratings following an inspection of this type. Ratings seen in this report were issued following the comprehensive inspection in October 2019 and remain in place.

How we carried out this inspection

We have reported on the following domains:

• Is it safe?
• Is it effective?
• Is it well-led?

We did not follow up all the requirement notices issued at the last inspection. They will be looked at in detail during the next comprehensive inspection. This was an unannounced inspection. We focused on issues raised following whistleblowing concerns and other intelligence.
**Summary of findings**

Therefore, our report does not include all the headings and information usually found in a comprehensive inspection report. We did not explore all key lines of enquiry within each domain, the inspection team focussed on specific areas of concern.

Before the inspection visit, we reviewed information that we held about the location. During the inspection visit, the inspection team:

- spoke with two ward managers and three senior managers
- spoke with nine other staff members; including nurses and occupational therapists
- spoke with six patients
- looked at six care and treatment records of patients
- looked at incident information and staff records
- looked at a range of policies, procedures and other documents relating to the running of the service.

**What people who use the provider's services say**

We spoke with six patients during this inspection. Patients told us that there was not always enough staff to meet their needs, and that leave from the ward and activities were sometimes cancelled or delayed as a result. This was particularly evident during evenings and at weekends. Three patients told us that at times the ward did not feel safe due to staffing levels. All patients, including informal patients, told us that they were unable to access the outside space after 22.00.

Three patients told us that they did not get to speak with their doctor when they had requested this.

Patients stated that while most staff were caring and did their best to meet their needs there was a lack of consistent staff meaning that some staff did not know them well.

Most patients stated that the two ward managers were good and accessible. However, three patients stated that they had complained about the service and had not received a response to their complaints.

**Areas for improvement**

**Action the provider MUST take to improve**

- The trust must ensure there are sufficient nursing staff to keep people safe from avoidable harm. Regulation 18: Staffing 18 (1)
- The trust must ensure that staff have undertaken mandatory training, supervision and appraisal in line with trust policy. Regulation 18: Staffing 18 (1) and (2)
- The trust must review their systems to ensure that patients have risk assessments which are robust and updated as needed. This must include the risk assessment processes prior to patients being allowed leave from the ward. Regulation 12: Safe care and treatment 12 (2)(a), (b)
- The trust must ensure that there is robust learning from patient safety incidents and that learning is shared and implemented by staff. Regulation 17: Good governance 17(1), (2) (a) and (b)
- The trust must review governance systems to ensure compliance with actions from past CQC inspections in the acute services. Regulation 17: Good governance 17(1), (2) (a), (b) and (f)
- The trust must ensure they support all managers to use the trust’s governance systems and performance management systems in the acute service. Regulation 17 (1), (2) (a), (b), (c) and (f)
### Norfolk and Suffork NHS Foundation Trust

**Acute wards for adults of working age and psychiatric intensive care units**

**Detailed findings**

<table>
<thead>
<tr>
<th>Name of service (e.g. ward/unit/team)</th>
<th>Name of CQC registered location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Northgate Ward</td>
<td>Wedgewood House</td>
</tr>
<tr>
<td>Southgate Ward</td>
<td>Wedgewood House</td>
</tr>
</tbody>
</table>

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9Acute wards for adults of working age and psychiatric intensive care units Quality Report This is auto-populated when the report is published
Are services safe?
By safe, we mean that people are protected from abuse* and avoidable harm

* People are protected from physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse

Our findings

Safe staffing

The service did not have enough nursing staff, who knew the patients well. Patients stated there was a lack of consistent staff meaning that some staff did not know them well.

The managers informed us that Northgate and Southgate wards had vacancies. At the time of inspection, the overall vacancy rate for registered nursing staff was 51% and for health care workers was 26%. Sickness absence was above the trust target at 5.8%.

The trust were not filling all the shifts and meeting their safer staffing levels. The trust told us that they would attempt to cover staffing gaps by use of bank and agency staff. Managers stated that where possible they used long term bank and agency staff to cover. However, in the week prior to our inspection 12 different agency staff had been deployed across the wards alongside many bank staff.

We also reviewed the incident reports for the wards for the six months prior to our inspection. These showed that staff had reported concerns about inadequate staffing levels on 171 separate occasions. Thirty of these related to Northgate Ward and 141 to Southgate ward. Thirty of these reports had been made in February 2020. On 22 February 2020, there were reported to be unsafe staffing levels across Northgate ward, Southgate ward and no staff were available from the neighbouring warden Abbeygate to support the acute wards.

On five occasions staff reported that there were insufficient staff to form a prevention and management of aggression team should physical intervention be required. Staff told us that there were occasions when a nurse from another ward had to visit Southgate Ward or Northgate Ward to give service users their routine medication. The trust confirmed this was due to the lone nurse on the ward at the time not having completed their medicines competency training.

Staff from Southgate ward had responsibility for the management of the place of safety based at the hospital. The incident reports reviewed, documented that the section 136 suite was closed on five occasions in February 2020 in order to mitigate staff shortages at the wards.

The trust told us that there was a comprehensive and varied programme of activities delivered at the wards including during evenings and weekends. However, the management team and patients told us that there were occasions when occupational therapy staff had to make up staff numbers. This had led to occupational therapy activities being cancelled on occasion. Staff told us that they did not have capacity to support service users when they needed to be escorted outside the building. This information was supported by patients who told us that there was not always enough staff to meet their needs, and that time off the ward and activities were sometimes cancelled or delayed as a result. This was particularly evident during evenings and at weekends. Three patients told us that at times the ward did not feel safe due to staffing levels.

We observed and saw in records that senior staff were frequently deployed within staffing numbers, but this was not effective in alleviating the staff’s concerns or providing support for day to day decision making.

The trust told us that overall mandatory training rates were at 82%. However, staff had not received all required basic training to keep patients safe from avoidable harm. For example, immediate life support training was at 67%; health, safety and welfare at 63%; safeguarding adults’ level three at 68%; fire safety at 42%. Staff told us that they did not have sufficient time to complete all required training.

Assessing and managing risk to patients and staff

We reviewed care records for six patients in detail. We found that for four patients, risk assessments had not been fully updated to reflect all the patients’ risks following concerning incidents. Staff also completed a situation, background, assessment, recommendation (SBAR) tool, which was a structured method for communicating critical information that required immediate attention and action. However, we found that some information was incomplete
Are services safe?

By safe, we mean that people are protected from abuse* and avoidable harm

and not all information was recorded in a clear manner. We found examples where patients had indicated that they were at increased risk however these had not resulted in changes to risk management plans.

The wards have a process in place for assessing a patient’s risk prior to them commencing leave which required registered staff to undertake a risk assessment. However, we found that there were not always records of the assessment being undertaken prior to leave. Staff told us that an administration staff member inadvertently signed a service user off the ward without the service user having been seen by a clinician.

The wards had implemented the Safewards initiative which included the use of daily safety huddles. These were informal meetings where staff met to discuss ward or unit safety. These meetings included a discussion of staffing, incidents, environmental risks and individual patient risk. Staff we spoke with told us these meetings had a positive impact on safety. However, at the time of the inspection the safety huddles were not being held daily on Southgate ward. We raised this with the trust who immediately ensured that huddles were implemented on both wards twice daily.

Track record on safety

There had been three serious incidents relating to patients who were receiving inpatient care. One of these incidents had taken place whilst the patient was on leave and another while the patient was receiving treatment at another hospital. Two of the incidents had occurred in January 2020. Both were subject to a full root cause analysis investigation that had not yet been completed at the time of the inspection. We reviewed the early learning reports for these incidents and found that there were areas of risk management that could be improved.

Reporting incidents and learning from when things go wrong

Staff including agency staff had access to an incident reporting system. Staff knew what incidents to report and how to report them. We saw evidence of incidents being reported. There had been 880 reports made by staff since September 2019.

The managers confirmed that they would look at themes for learning however there had been a delay in completing incident reviews and investigations due to staff capacity. The trust confirmed that the psychologist had offered staff a debrief following these incidents. However, some staff told us that while ward managers had been supportive following the serious incidents there had not been an opportunity for a full debrief.

There was a lack of structure for feeding back lessons learned at meetings or via other methods of communication. Local team meetings did not have a clear meeting agenda and we saw that few meetings were documented as actually taking place. Of those meetings that did take place, there were several where lessons learned were not discussed at team level, despite there being discussions at clinical governance meetings. However, we did see some safety bulletins that had been shared with staff.

Following a serious incident in 2019, the trust had implemented a process to manage access to plastic bags on the acute wards. There had been a significant incident involving a patient accessing a plastic bag on Northgate ward just prior to our inspection.
Are services effective?

By effective, we mean that people’s care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

Our findings

Staff we spoke with during the inspection told us they had not been receiving regular managerial and clinical supervision in line with the trusts policy due to staffing capacity and management gaps. Ward managers confirmed that they were attempting to ensure supervision occurred, but this had been challenging. The percentage of staff that had received regular supervision prior to our inspection was 50% on Northgate ward and 46% on Southgate ward.

The trust told us that 83% of staff on Northgate and 90% of staff on Southgate had received an appraisal. On Northgate Ward the ward manager told us that three staff due their appraisal in January 2020 had not had these as scheduled.
Are services caring?
By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

Our findings
We did not inspect this domain.
Our findings

We did not inspect this domain.
Are services well-led?

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

Our findings

Good governance of risk, issues and performance

Some governance systems needed to be strengthened. For example, it was difficult to get accurate data on staffing levels during the inspection which was essential information needed to manage and monitor the service.

The trust told us about a number of quality improvement initiatives that staff had been involved in. These included programmes focusing on the multi-disciplinary meeting and care planning, reducing restrictive interventions, medication management and discharge planning.

Staff told us they did not have regular opportunities to meet, discuss and learn from the performance of their service. There were few records that team meetings had taken place. Where meetings had taken place, there was a lack of agenda structure and several where lessons learned from safety incidents had not been discussed at team level, despite there being discussions about these incidents at clinical governance meetings. In addition, staff and managers confirmed that safety huddles had not been occurring daily on Southgate ward.

Managers did not have effective systems in place to ensure staff were undertaking clinical risk assessment processes appropriately. This included assessments of risks prior to allowing patients to leave the ward. We found staff had not updated risk assessments following significant incidents, or fully completed leave risk assessments for the patients we reviewed. Managers had not identified or addressed these gaps with staff members.

In response to the concerns raised within this report, the trust leadership team provided assurance of action that had begun to take shape just prior to the inspection and immediately following the inspection. This included the development of an improvement plan and rapid improvement board to oversee this work. The trust redeployed 13 whole time equivalent staff from other services, to ensure safer delivery while recruitment efforts continued. Staffing levels were increased on Southgate ward and the temporary staff booking process was strengthened. Senior managers were ensuring a presence on the wards and holding twice daily escalation meetings. Safety huddles were increased to twice per day.

Leadership, morale and staff engagement

Prior to our inspection there had been significant gaps and changes to leadership at the hospital. Since the establishment of the care group in September 2019 the lead nurse had left and there were gaps within the modern matron and ward manager roles. At the time of the inspection a lead nurse and temporary modern matron had been appointed. A permanent ward manager had come in to post for Northgate ward and a temporary manager had been recruited for Southgate ward following a long gap in these posts.

Ward managers told us they felt they had support from senior leaders and had autonomy to make daily decisions in their role. The manager on Northgate ward had recently held an away day for substantive staff to begin to address their concerns and improve morale. Managers told us that senior leaders had acknowledged staff’s concerns and spent significant time at the wards since January 2020. However, local managers acknowledged that there had been significant staffing difficulties and that this had negatively impacted on the service and staff morale. Managers also acknowledged that their capacity to manage the ward was limited due to the significant time they spent working on shift to fill gaps.

Staff told us that some local leaders were approachable however they did not know or feel engaged with the senior leadership team. Staff told us that while senior staff had visited the wards, they did not feel they were being listened to. Morale was poor, and staff felt that managers did not recognise that they were stressed and burnt out or understood their concerns, particularly around staffing levels and feeling safe on the wards. Staff were, however, more positive about the recent appointment of the ward managers and the matron.
Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

<table>
<thead>
<tr>
<th>Regulated activity</th>
<th>Regulation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assessment or medical treatment for persons detained under the Mental Health Act 1983</td>
<td>Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment</td>
</tr>
<tr>
<td>Treatment of disease, disorder or injury</td>
<td>• The trust must review their systems to ensure that</td>
</tr>
<tr>
<td></td>
<td>patients have risk assessments which are robust and updated as needed.</td>
</tr>
<tr>
<td></td>
<td>This must include the risk assessment processes prior to patients being</td>
</tr>
<tr>
<td></td>
<td>allowed leave from the ward.</td>
</tr>
<tr>
<td>Assessment or medical treatment for persons detained under the Mental Health Act 1983</td>
<td>Regulation 17 HSCA (RA) Regulations 2014 Good governance</td>
</tr>
<tr>
<td>Treatment of disease, disorder or injury</td>
<td>• The trust must ensure that there is robust learning from patient safety</td>
</tr>
<tr>
<td></td>
<td>incidents and that learning is shared and implemented by staff.</td>
</tr>
<tr>
<td></td>
<td>• The trust must review governance systems to ensure compliance with</td>
</tr>
<tr>
<td></td>
<td>actions from past CQC inspections in the acute services.</td>
</tr>
<tr>
<td>Assessment or medical treatment for persons detained under the Mental Health Act 1983</td>
<td>Regulation 18 HSCA (RA) Regulations 2014 Staffing</td>
</tr>
<tr>
<td>Treatment of disease, disorder or injury</td>
<td>• The trust must ensure there are sufficient nursing staff to keep people</td>
</tr>
<tr>
<td></td>
<td>safe from avoidable harm.</td>
</tr>
<tr>
<td></td>
<td>• The trust must ensure that staff have undertaken mandatory training,</td>
</tr>
<tr>
<td></td>
<td>supervision and appraisal in line with trust policy.</td>
</tr>
</tbody>
</table>
This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

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</tr>
<tr>
<td>Treatment of disease, disorder or injury</td>
<td>Norfolk and Suffolk NHS Foundation Trust is in special measures and all enforcement action taken following the previous inspections in 2018 remain in place as they had not been addressed. A Section 29a Warning notice was amended in 2018 and is not yet compliant. There were no new areas for improvement noted at this inspection.</td>
</tr>
</tbody>
</table>

Due to the significant concerns regarding safe staffing we issued a Section 31 notice of decision to pause admissions. This was lifted four days later due to the swift response by the trust.

The concerns raised in this report were escalated to NHS Improvement/England for their consideration and action.
Norfolk and Suffolk NHS Foundation Trust
Specialist community mental health services for children and young people

Quality Report

Hellesdon Hospital
Drayton High road
Norwich
Norfolk
NR6 5BE
Tel: 01603 421412
Website: www.nsft.nhs.uk

Date of inspection visit: 24 - 25 February 2020
Date of publication: This is auto-populated when the report is published

Locations inspected

<table>
<thead>
<tr>
<th>Location ID</th>
<th>Name of CQC registered location</th>
<th>Name of service (e.g. ward/unit/team)</th>
<th>Postcode of service (ward/unit/team)</th>
</tr>
</thead>
<tbody>
<tr>
<td>RMY01</td>
<td>Hellesdon Hospital</td>
<td>80 St Stephens Road</td>
<td>NR1 3RE</td>
</tr>
</tbody>
</table>

This report describes our judgement of the quality of care provided within this core service by Norfolk and Suffolk NHS Foundation Trust. Where relevant we provide detail of each location or area of service visited.

Our judgement is based on a combination of what we found when we inspected, information from our ‘Intelligent Monitoring’ system, and information given to us from people who use services, the public and other organisations.

Where applicable, we have reported on each core service provided by Norfolk and Suffolk NHS Foundation Trust and these are brought together to inform our overall judgement of Norfolk and Suffolk NHS Foundation Trust.
Ratings

We are introducing ratings as an important element of our new approach to inspection and regulation. Our ratings will always be based on a combination of what we find at inspection, what people tell us, our Intelligent Monitoring data and local information from the provider and other organisations. We will award them on a four-point scale: outstanding; good; requires improvement; or inadequate.

<table>
<thead>
<tr>
<th>Overall rating for the service</th>
<th>Inadequate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are services safe?</td>
<td>Requires improvement</td>
</tr>
<tr>
<td>Are services effective?</td>
<td>Requires improvement</td>
</tr>
<tr>
<td>Are services caring?</td>
<td>Requires improvement</td>
</tr>
<tr>
<td>Are services responsive?</td>
<td>Inadequate</td>
</tr>
<tr>
<td>Are services well-led?</td>
<td>Inadequate</td>
</tr>
</tbody>
</table>

**Mental Health Act responsibilities and Mental Capacity Act / Deprivation of Liberty Safeguards**

We include our assessment of the provider’s compliance with the Mental Health Act and Mental Capacity Act in our overall inspection of the core service.

We do not give a rating for Mental Health Act or Mental Capacity Act; however we do use our findings to determine the overall rating for the service.

Further information about findings in relation to the Mental Health Act and Mental Capacity Act can be found later in this report.
Summary of findings

Contents

Summary of this inspection

Overall summary
The five questions we ask about the service and what we found
Information about the service
Our inspection team
Why we carried out this inspection
How we carried out this inspection
Areas for improvement

Detailed findings from this inspection

Findings by our five questions
Action we have told the provider to take
### Summary of findings

#### Overall summary

This was a focused inspection looking at specific areas of concern. The inspection was of the CAMHS youth service located at St Stephens Road, Norwich. The ratings shown in the report are from the previous inspection of specialist community mental health services for children and young people across the trust which took place in October 2019.

At this inspection we found the following areas where the trust needed to improve:

- We were not assured that patients who were on waiting lists for assessment or treatment were being adequately managed by the teams responsible for their care. Patients on those waiting lists were not always being adequately monitored or supported. Where a change in the patients’ individual risk was identified, their risk assessments were not always being updated. We also found some appointments and therapy groups being cancelled as there were not enough staff available. This meant that there was a risk that patients whose needs changed might not be identified or receive support in a timely manner.

- Whilst the trust was working to rationalise the waiting lists in place and establish a principal list for each team, at the time of the inspection staff were still referring to numerous waiting lists. This was confusing, ineffective and did not ensure there was appropriate oversight for the teams.

- The building at 80 St Stephens Road was not well maintained and the décor was shabby. Internet access at the time of the inspection was not reliable which meant that patient records were not always accessible.

- Whilst the trust was refining its governance arrangements they were not yet working effectively for this service. The data on waiting lists needed improvement to ensure staff in the teams had the information they needed to meet the needs of the patients. The trust also needed to be assured that patients were being assessed and treated in a timely and safe manner. In addition, the meetings taking place in the service had been revised and needed to be embedded so they were working well. Staff particularly in the North team needed the support and guidance from leaders to use the new systems and processes.

However:

- In response to the concerns raised within this report, the trust leadership team provided assurance of action which had begun just prior to the inspection. For instance, on 13 February 2020, an executive-led rapid improvement board had been established. This aimed to accelerate improvements and had increased senior leadership oversight. The care group leadership team were spending four to five days per week at St Stephens Road. We were told of plans in place to undertake a large scale clinical review of the waiting list in early March 2020. A review of the duty system and supervision processes were also planned. New terms of reference for leadership meetings had been agreed including a specific section on learning from incidents, complaints and inquests. A programme of site meetings was planned along with maintenance walkarounds. This had already seen the implementation of hygiene audits and projects identified to improve the environment at 80 St Stephens Road.

- Recruitment into posts had begun and we saw key roles had been appointed to with plans in place for further recruitment. The trust had also increased senior management oversight to the service. This was an improvement on staffing which was of particular concern in the North team in December 2019.

- Work had begun just prior to this inspection to pull all the waiting lists together and provide a clear view and understanding of action required. This was being developed as one service user tracker list (SUTL) to monitor all patients. This system had been successfully implemented in other teams at the trust. It involved a weekly meeting to discuss actions required for patients on the list.
Are services safe?
The rating provided was the rating given following the inspection which took place in October 2019. This has not been revised.

We found the following areas the trust needed to improve:

- Staffing had not always been sufficient to meet patient need. In December 2019 there were large gaps in staffing in the North team. There was one Band 7 vacancy, four Band 6 vacancies and one Band 4 vacancy. This meant there were only two Band 6 staff in post in the North team. This was insufficient to address the needs of patients. Evidence of impact was reflected in patients’ records. We saw that patients were not always being seen by clinicians in a timely way and that therapy groups were cancelled on more than one occasion. There was an increase in patients being added to the team-held waiting lists at this time due to staff leaving and a heavy demand from referrals. Staff admitted they had significant concerns that they could not manage caseloads safely and that patients were not always being seen according to their need or risk. At the time of our inspection we saw that staffing had improved due to an ongoing recruitment campaign. There were fewer vacancies and these were currently being advertised for recruitment.

- We reviewed 10 care records and found that four did not reflect all of the current risks. Crisis plans, if in place, were minimal in content, often just listing phone numbers of who to contact and lacked plans specific to the individual.

- We were not assured that processes for managing waiting lists, particularly team-held waiting lists, kept people safe. Where a patients’ risk was discussed in team meetings and there was an identified change to risk, we saw that risk assessments were not always updated. There was no clear process to ensure patients on team-held waiting lists were appropriately monitored and supported. We saw large gaps in records, with one patient not having had direct contact since July 2019. Patient waiting list concerns had been mentioned at the last four inspections and it was disappointing that this had not been fully addressed within this team.

- Discussions about patients at case meetings did not always translate into action and did not transfer into patient records. It was unclear how actions were implemented and who was responsible to follow them up. Staff confirmed this was a risk.

- The building at 80 St Stephens Road was not well maintained. The décor was shabby and internet access was not reliable. The unreliable access to the internet meant that patient records...
were not always accessible. We saw this during inspection when there was a lack of access for several hours. Consequently, some patient sessions were cancelled by one of the teams in the building.

- The business resilience plan for the trust lacked sufficient detail at a local level. The plan talked about such events as loss of access to clinical records, however, there were no locally driven protocols to manage such events. This is despite it being a known issue as loss of connectivity had happened on previous occasions.
- There was a lack of structure for discussing lessons learned at meetings. Local team meetings did not have a clear meeting agenda. We saw that few meetings were documented as actually taking place although we were told some were happening. Of those meetings that did take place, there were several where lessons learned were not discussed at team level, despite there being discussions at clinical governance meetings.

However:

- The trust was aware of most of the concerns identified above and had recently provided additional leadership support. There was a review being undertaken by the lead nurse from the care group and a project lead was pulling all the waiting lists onto one tracker so everyone could see the patient journey. The trust provided evidence of a reduction in waiting times with the longest time reduced from over 52 weeks to 19 weeks.
- We saw evidence of incidents being reported. The manager confirmed that they would look at themes for learning. One theme the manager identified was of letters being sent to the wrong address due to records not being updated. A small system change was implemented and reported cases reduced significantly from 16 in November 2019 to one in January 2020.
- We saw that there had been some success in recruiting to vacant posts since December 2020 and two of the applicants had just started with more to follow.

### Summary of findings

<table>
<thead>
<tr>
<th>Are services effective?</th>
<th>Requires improvement</th>
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<tbody>
<tr>
<td>We did not inspect this domain.</td>
<td></td>
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<table>
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<th>Are services caring?</th>
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<table>
<thead>
<tr>
<th><strong>Are services responsive to people's needs?</strong></th>
<th>Inadequate</th>
</tr>
</thead>
<tbody>
<tr>
<td>The rating provided was the rating given following the inspection which took place in October 2019. This has not been revised.</td>
<td>Inadequate</td>
</tr>
<tr>
<td>We found the following areas the trust needed to improve:</td>
<td></td>
</tr>
<tr>
<td>• The team lacked effective systems to monitor and manage referrals, triage, assessment and treatment. None of the staff we spoke with understood the process or even knew if there was a process. This meant it was impossible to be assured that systems were safe and patients were seen in a timely and effective way.</td>
<td></td>
</tr>
<tr>
<td>• We were concerned that all staff spoken with had a different understanding of how they managed ‘team-held’ waiting lists. No-one was able to clearly articulate what was supposed to happen.</td>
<td></td>
</tr>
<tr>
<td>• The team struggled to keep up with referrals which came from a variety of sources. One senior clinician told us they did not know what the referral criteria were and that there was a perception that the team just took anyone that other teams did not take. Staff were concerned that there was an expectation to address the waiting list for assessment without the resource in place to then offer any treatment identified in this process.</td>
<td></td>
</tr>
<tr>
<td>• The lead nurse provided data that showed there were a total of 228 patients waiting for assessment, 149 of which were outside of the trust target for assessment. These figures were disappointing, but the trust provided evidence of plans in place, recently developed, to address this concern.</td>
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</tbody>
</table>

However:

| • Work had just begun at the time of inspection to combine the various waiting lists and provide a clear view and understanding of action required. This was being developed as one service user tracker list to monitor all patients. This system had been successfully implemented at other teams in the trust. It involved a weekly meeting to discuss actions required for patients on the list. | |
| • Post inspection we were told by the senior executive leadership team that extra clinics had now been scheduled at weekends to reduce the assessment waiting time. | |

<table>
<thead>
<tr>
<th><strong>Are services well-led?</strong></th>
<th>Inadequate</th>
</tr>
</thead>
<tbody>
<tr>
<td>The rating provided was the rating given following the inspection which took place in October 2019. This has not been revised.</td>
<td>Inadequate</td>
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7Specialist community mental health services for children and young people Quality Report This is auto-populated when the report is published
We found the following areas the trust needed to improve:

- There was a disconnect between the clinical team staff and managers. We spoke to a team that was fractured, concerned about the management of risk and lacking in leadership. We saw staff moving in different directions, making decisions about their work that did not follow process as there was a lack of understanding of what those processes were. Some staff felt they were not listened to when they tried to raise concerns.

- The meetings taking place in the service had been revised and needed to be embedded so they were working well. During the inspection we heard of a significant number of meetings, some with a lack of structure, clear agenda and process. It was significant that every member of staff spoken with did not understand the meeting structures or have a clear awareness of processes they needed to follow to address issues.

- We were not assured that waiting lists were accurate and this was also verified by the team managers. However, we saw work was being undertaken to begin to correct this.

- Further work was needed to ensure that the teams were applying and managing the risk registers to identify and manage potential risks safely.

However:

- Some staff reported that they felt that the recently appointed lead nurse was prioritising concerns appropriately and could see plans developing to address issues at pace.

- In response to the concerns raised within this report, the trust leadership team took decisive action and have already provided assurance of action which had begun just prior to the inspection. For instance, on 13 February 2020, an executive-led rapid improvement board had been established. This aimed to accelerate improvements and have senior leadership oversight. The care group leadership team were spending four to five days per week at St Stephens Road. We were told of plans in place to undertake a large-scale clinical review of the waiting list in early March 2020. A review of the duty system and supervision processes were also planned. New terms of reference for team meetings had been agreed, including a specific section on learning from incidents, complaints and inquests. A programme of site meetings was planned as well as maintenance walkarounds. This had already seen the implementation of hygiene audits and projects identified to improve the environment at 80 St Stephens Road.
**Summary of findings**

### Information about the service

Norfolk and Suffolk NHS Foundation Trust was formed when Norfolk and Waveney Mental Health NHS Foundation Trust and Suffolk Mental Health Partnership NHS Trust merged on 1 January 2012. Norfolk and Waveney Mental Health NHS Foundation Trust had gained foundation trust status in 2008.

Norfolk and Suffolk NHS Foundation Trust provides services for adults and children with mental health needs across Norfolk and Suffolk. Services to people with a learning disability are provided in Suffolk. They also provide secure mental health services across the East of England and work with the criminal justice system. Several specialist services are also delivered including a community-based eating disorder service.

The Care Quality Commission placed Norfolk and Suffolk NHS Foundation Trust in special measures in 2017. There was a further inspection in 2018 and 2019. Following the 2019 inspection, there was an improvement in rating from inadequate to requires improvement overall. However, the core service for specialist community mental health services for children and young people remained with an inadequate rating. Despite the improved overall rating, the trust remained in special measures as it was too soon to judge if the early improvements made could be sustained.

The trust provides specialist community mental health services for children and young people for patients aged 0 to 25 throughout Norfolk and Suffolk under one registered location: Hellesdon Hospital and was rated as inadequate at the last inspection in October 2019.

The trust has been inspected six times in the last 12 months including this inspection.

There are 18 specialist community mental health services for children and young people team across the trust. During this inspection we looked solely at the Central Norwich youth team at 80 St Stephens Road, Norwich. This team sits within the specialist community mental health services for children and young people and supports patients aged 14 to 25. There were three youth teams at this location, North, South and Central. We predominantly looked at the North youth team which was where concerns had been raised leading to this inspection.

### Our inspection team

The team that inspected the service comprised of one inspection manager and one CQC inspector.

### Why we carried out this inspection

We carried out this inspection of 80 St Stephens Road, Norwich Youth team, as a result of whistleblowing information and other intelligence. This was a focussed, responsive, unannounced inspection specifically to look at patient case management, staffing and team management/leadership.

All requirement notices issued in the last inspection remain in place. The Section 29a warning notice amended in 2018 also remains in place.

We do not revise ratings following an inspection of this type. Ratings seen in this report were issued following the comprehensive inspection in October 2019 and remain in place.

### How we carried out this inspection

We have reported on the following domains:

- Is it safe?

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9Specialist community mental health services for children and young people Quality Report This is auto-populated when the report is published
**Summary of findings**

- Is it responsive?
- Is it well-led?

We did not follow up all the requirement notices issued at the last inspection. They will be looked at in detail during the next comprehensive inspection. This was an unannounced inspection. We focussed on issues raised following a whistleblowing concern and other intelligence.

Therefore, our report does not include all the headings and information usually found in a comprehensive inspection report. Not all key lines of enquiry were explored within each domain, the inspection team focussed on specific areas of concern.

**Areas for improvement**

**Action the provider MUST take to improve**

- The trust must ensure adequate staff resources are available to reduce the patient waiting lists for triage, assessment and treatment in the children and young person service and for attention deficit hyperactivity disorder patients. This incudes ensuring patients managed on team-held waiting lists are supported safely. Regulation 12: Safe care and treatment 12 (1)
- The trust must review their systems to ensure that patients have risk assessments which are updated as needed and care plans in the children and young person service. Regulation 12: Safe care and treatment 12 (2)(a), (b)
- The trust must review governance systems to ensure compliance with actions from past CQC inspections in the children and young person service. Regulation 17: Good governance 17(1), (2) (a), (b) and (f)
- The trust must ensure they support all managers to use the trust’s governance systems and performance management systems in the children and young person service. Regulation 17 (1), (2) (a), (b), (c) and (f)
- The trust must ensure access to electronic records is available at all times. Regulation 17: Good governance 17 (1)
Norfolk and Suffolk NHS Foundation Trust

Specialist community mental health services for children and young people

**Detailed findings**

<table>
<thead>
<tr>
<th>Name of service (e.g. ward/unit/team)</th>
<th>Name of CQC registered location</th>
</tr>
</thead>
<tbody>
<tr>
<td>80 St Stephens Road, Norwich</td>
<td>RMY01</td>
</tr>
</tbody>
</table>
Are services safe?

By safe, we mean that people are protected from abuse* and avoidable harm

* People are protected from physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse

Our findings

Safe staffing

Staffing had not always been sufficient to meet patient need. In December 2019 there were large gaps in staffing in the North team. There was one Band 7 vacancy, four Band 6 vacancies and one Band 4 vacancy. This meant there were only two Band 6 staff in post in the North team. This was insufficient to address the needs of patients. Evidence of impact was reflected in patients’ records. We saw that patients were not always seen by clinicians in a timely way and that therapy groups were cancelled on more than one occasion. There was an increase in patients being added to the team-held waiting lists at this time due to staff leaving and a heavy demand from referrals. This meant they no longer had a care co-ordinator until a replacement could be identified. Staff admitted they had significant concerns. They could not manage caseloads safely and patients were not always being seen according to their need or risk.

However, staffing had improved at the time of inspection and appointments had been made to the majority of posts with some people now in post.

Managers told us that vacancies were advertised with some success and we saw during this inspection, two posts had been filled and those staff had recently started – one on the day of inspection and one the previous week. Other posts had been filled and the new appointees were awaiting a start date. The remaining vacancies continued to be advertised for recruitment. The impact on patient care was noticeable and although other teams within St Stephens Road had better staffing, there had not been sufficient action to support the North team. One staff member recruited could not start until September 2020 and the manager could not advise of a plan on how this vacancy would be managed until then.

Assessing and managing risk to patients and staff

We reviewed 10 care records and found that four did not reflect all of the patients’ current risks. For instance, it was discussed in a team meeting that a patient’s parent was at risk. This was not documented in the patient’s records. Crisis plans, if in place, were minimal in content, often just listing phone numbers of who to contact and lacked plans specific to the individual.

We were not assured that patients on team-held waiting lists received adequate monitoring for changes to risk. We saw that risk assessments were not always updated when there was an identified change to risk.

Discussions about patients and actions from case meetings did not transfer into patient records. It was unclear how actions were implemented and who was responsible to follow up. Staff confirmed this was a risk.

There was no clear process to ensure patients on team-held waiting lists were appropriately monitored and supported. We saw gaps in records; one patient had not been contacted since July 2019. Another patient had several attendances at the acute hospital emergency department whilst waiting for allocation, the GP had followed up with concerns and in the summer of 2019 the liaison staff at the Accident and Emergency department submitted an incident report due to the lack of availability for support from the youth team. A further patient had been referred to the team in March 2019. The patient was added to the waiting list for a care co-ordinator in July 2019 but only made it to the priority meeting in January 2020. We were not assured that processes for managing waiting lists, particularly team-held waiting lists, kept people safe.

The trust was aware of some of the concerns identified above and they had been discussed at a recent engagement meeting between CQC and the trust. The trust had recently provided additional leadership support. There was also a review being undertaken by the lead nurse from the care group, and a project lead was pulling all the waiting lists onto one tracker so everyone could see the patient journey. Patient waiting list concerns had been mentioned at the last four inspections and whilst it is encouraging that action was now taking shape, it was disappointing that this had not previously been addressed in this team.

Staff access to essential information

The building at 80 St Stephens Road was not well maintained. Internet access was not reliable. This meant...
that patient records were not always accessible. During inspection some patient sessions were cancelled by one of the teams in the building when there was a lack of access for several hours.

The business resilience plan for the trust lacked sufficient detail. The plan talked about events as loss of access to clinical records, however, there were no locally driven protocols to manage such events. This is despite loss of connectivity being a known issue that had happened on previous occasions.

**Safe and clean environment**

The décor was shabby and in need of improvement. The trust shared with us a plan to address this which included the redecoration of clinical areas, staff areas and group rooms.

**Track record on safety**

We reviewed the early learning report from a recent serious incident. We saw that at the time of the incident, the patient had recently been seen by clinicians. However, in the months prior to this we saw missed opportunities to engage with the patient, cancelled appointments and cancelled group sessions due to staff sickness. We saw evidence of a decline in the patients mental health that was not immediately acted upon. The patient was on the team-held list and did not have one single clinician overseeing their care. This is currently subject to a full root cause analysis investigation that has not yet been completed.

**Reporting incidents and learning from when things go wrong**

We saw evidence of incidents being reported. The manager confirmed that they would look at themes for learning. One theme the manager identified was several instances of letters being sent to the wrong address due to records not being updated. A small system change was implemented and reported cases reduced significantly from 16 in November 2019 to one in January 2020.

There was a lack of structure for feeding back lessons learned at meetings or via other methods of communication. Local team meetings did not have a clear meeting agenda and we saw that few meetings were documented as actually taking place. Of those meetings that did take place, there were several where lessons learned were not discussed at team level, despite there being discussions at clinical governance meetings. However, we did see some safety bulletins that had been shared with staff.
Are services effective?
By effective, we mean that people’s care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

Our findings
We did not inspect this domain.
Our findings

We did not inspect this domain.

Are services caring?

By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

Requires improvement
Our findings

Access and discharge

The team lacked effective systems to monitor and manage referrals, triage, assessment and treatment. None of the staff we spoke with understood the process or even knew if there was a process. This meant it was impossible to be assured that systems were safe, and patients were seen in a timely and effective way.

We were concerned that all staff spoken with had a different understanding of how they managed team-held waiting lists. No one was able to clearly articulate what was supposed to happen.

The team struggled to keep up with referrals which came from a variety of sources. One senior clinician told us the team did not know what the referral criteria were, and there was a perception by some team members that the team accepted patients that other teams did not take. We did not see evidence to support or refute this, however it was significant that this was the perception of the team. The staff member was concerned that the team was expected to address the waiting list for assessment without the resource in place to then offer support identified in this process. The trust told us that there is an expectation that the agreed process is applied consistently and that young people waiting for a service are safe. The Trust is working with partners to explore new care models and secure additional funding to meet the needs of children and young people.

The clinical lead showed us evidence of 54 patients on the North ‘team-held’ waiting list. The longest time a patient had been waiting was over 12 months. Plans were in development to address this as a priority action. Post inspection the leadership team provided assurance that the wait had reduced to 19 weeks.

The lead nurse provided data that showed there were a total of 228 patients waiting for assessment, 149 of which were outside of the target for assessment. These figures were disappointing, however, the trust shared with us a recently developed plan in place to address this. Post inspection, the trust told us extra clinics had been scheduled at weekends to reduce this wait.

We saw that there were several patient waiting lists, which added to staff confusion. Work had just begun at the time of inspection to pull all the lists together and provide a clear view and understanding of action required. This was being developed as one service user tracker list to monitor all patients. This system had been successfully implemented at other teams in the trust. It involved a weekly meeting to discuss actions required for patients on the list.
**Are services well-led?**

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

**Our findings**

**Leadership, morale and staff engagement**

Staff confirmed they still did not fully understand the care group leadership structure but did feel there had been more support recently. They were hopeful that improved processes would follow. Senior managers had reviewed the management structure in 2019. There were now ‘care groups’ across the trust with four key leaders for each group. However, leadership for this care group consisted of five key leaders. The extra lead identified, reflected the particular work required and size of the service. One post remained unfilled.

The team was fractured and concerned about the management of risk, lack of leadership, clear structures and processes. We saw staff moving in different directions, making decisions that did not follow process as there was a lack of understanding of what those processes were. Some staff told us that there was an air of learned helplessness and acceptance that the team was not functioning as it should.

Several staff expressed concern that the lack of structure hindered their ability to carry out safe and effective care and that they did not feel listened to when raising concerns. There was a disconnect between the team and managers.

However, some staff reported that they felt that the lead nurse was prioritising concerns appropriately and could see plans developing to address issues at pace.

**Good governance**

We were not assured of the governance structures within the team at St Stephens Road. We saw a high number of meetings, with a lack of structure and process. It was significant that every member of staff spoken with did not understand the structures or have a clear awareness of processes they needed to follow. We were told of different structures from different staff.

Governance systems were not effective in supporting staff to prioritise their work. An effective system would allow staff to manage their work more efficiently.

In response to the concerns raised within this report, the trust leadership team provided assurance of action which had begun just prior to the inspection. For instance, on 13 February 2020, an executive-led rapid improvement board had been established. This aimed to accelerate improvements and have senior leadership oversight. The care group leadership team were spending 4 to 5 days per week at St Stephens Road. We were told of plans to undertake a large-scale clinical review of the waiting list early in March 2020. A review of the duty system and supervision processes were also planned. New terms of reference for leadership meetings had been agreed including a specific section on learning from incidents, complaints and inquests. A programme of site meetings was planned along with maintenance walkarounds. This had led to the implementation of hygiene audits and projects to improve the environment at 80 St Stephens Road.

**Management of risk, issues and performance**

We were not assured of processes to manage events such as loss of power and how the service would minimise risk to patients. However, we saw some work had commenced to look at this. Managers gave us a draft business impact analysis spreadsheet showing identified risks of not being able to deliver services. The business continuity plan or resilience plan provided oversight on what needed to happen in certain events such as loss of power. The team were unaware of there being any local protocols or plans on how this would be implemented within the local team. During inspection when there was a loss of access to the clinical records, one clinician told us that they planned to cancel appointments as it was unsafe. There was no thought to contact other services to access the information or consider an alternative plan.

We were told there was no local team risk register and that the care team were developing new risk registers attributable to the services they were now accountable for.

We were not assured that waiting lists were accurate and this was also verified by the team managers. However, we saw work was being undertaken to correct this.

We were not assured that patients could be kept safe as it was difficult to identify emerging risks using the current processes.
**Action we have told the provider to take**

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

<table>
<thead>
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This section is primarily information for the provider

Enforcement actions

**Action we have told the provider to take**

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<td></td>
<td>Norfolk and Suffolk NHS Foundation Trust is in special measures and all enforcement action taken following the previous inspections in 2019 remain in place as they had not been addressed. A Section 29a Warning Notice was amended in 2018 and is not yet compliant. There were no new areas for improvement noted at this inspection.</td>
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<tr>
<td></td>
<td>The concerns raised in this report were escalated to NHS Improvement/England for their consideration.</td>
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</table>
Report to: Board of Directors
Meeting date: 21st May 2020
Title of report: Mortality and Learning from Deaths
Action sought: For assurance and debate
Estimated time: 5 minutes
Author: Dr Daniel Dalton, Chief Medical Officer
Director: Dr Daniel Dalton, Chief Medical Officer

Executive Summary:

Every person who dies is more than a number, and each death leaves behind a grieving family and friends. Although this paper reports on trends in the number of people who die, and presents assurance about these, there is never a time that we should lose sight of the human beings affected by every death.

This paper:

- Describes how the Trust learns from all incidents leading to death of a service user, to help eliminate preventable mortality and its causes
- Presents adjusted data to support longer term understanding of trends in these incidents
- Describes the impact of COVID 19 on the number of people known to the Trust who have died

Publishing the data, discussing trends and learning and monitoring changes to practice is part of the Trust's ongoing duty for compliance with National Guidance on Learning from Deaths.

The Board is asked to note the report and comment on the proposal to defer external review of mortality until the COVID incident has moved into a stable phase.

The report links to the risk 3.2 on the BAF.
1.0 Mortality Governance

1.1 The Serious Incident and Mortality Review Group (SIMRG) has continued to meet on a monthly basis throughout the review period. The SIMRG is chaired by the Chief Medical Officer and Chief Nurse. Attendance from the senior clinical leadership of all care groups is essential and has been maintained throughout; a People Participation Lead is also present. Despite the challenges and uncertainties of the COVID incident, the SIMRG has been sitting virtually during lockdown.

1.2 The SIMRG reports to the Board of Directors through a written report to the Quality Committee, which reports in turn to the Quality Assurance Committee, a subcommittee of the Board.

1.3 Each month, the SIMRG undertakes a deep dive into a serious incident; considers any trustwide recommendations emerging from all Serious Incident Reports; considers any learning from Structured Judgement Reviews undertaken following deaths that are not considered Serious Incidents; ensures that there is awareness and engagement amongst all care groups of important strategic priorities, such as the Zero Suicide Ambition for Norfolk and Suffolk, and reviews any trends in mortality.

1.4 The SIMRG has additionally undertaken in depth reviews of the service provided by the Trust’s Family Liaison Officer and the Trust’s contribution to the LeDER process.

2.0 Review of Learning from Deaths Policy

2.1 The Trust Learning from Deaths Policy was reviewed by the membership of the SIMRG in anticipation of the implementation of the national Patient Safety Investigation Framework (PSIF). This included consultation with other mental health providers, to maintain best practice. The ambition remains to develop a structured approach to review of all incidents of harm that supports identification and fuller investigation of moderate harm incidents with similar themes to those that have led to a patient’s death. The ambition remains to develop an approach to learning which is anchored in the development of overarching Quality Improvement Plans emerging from these themes, rather than focussing on incremental improvements relating to local failures of best practice.

2.2 Following the national mandate to delay implementation of the PSIF during the COVID incident the changes to the policy have been limited to recognising the updated governance structures and moving the emphasis of learning towards the thematic identification of casual factors contributing to people’s deaths. In order to maintain focus on the wider ambition, the Policy has been set for review within 12 months, in anticipation that the COVID response will have moved by then into a more stable state.

3.0 Thematic Analysis of Incidents

3.1 As part of continuously adapting our systems to improve learning, NSFT has undertaken a review of its whole approach to learning from deaths. NSFT has worked with other NHS trusts to review best practice and drive improvement and is proposing to introduce a more systematic approach to timely identification of those cases where a person’s death requires investigation, and a focus on developing a thematic quality improvement planning cycle that should support the changes to our care and treatment needed to reduce the risk of anyone dying from preventable causes. This builds on the work of previous years, drawing out the themes from investigations and case reviews.
and focussing on identification of incidents where similar themes might underlie opportunities for improvement in practice.

3.2 In 2019, the 3 commonest themes identified in recommendations from Serious Incident reviews were:

- **Risk Assessment and Management**: Improving this dimension of practice was identified as an area for improvement in 38% of serious incidents in 2019
- **Ownership and Accountability/Collaborative Working and Decision Making**: these dimensions of practice were identified as areas of improvement in 32% of serious incidents in 2019
- **Information Sharing**: improving this dimension of practice was identified as an area for improvement in 24% of serious incidents in 2019.

3.3 Each theme will be incorporated into a screening tool that will be applied to support decision making when considering the need for a desktop review or full investigation following an incident. SIMRG will work with care groups to develop local plans to improve practice in these areas.

4.0 Trends in Mortality

4.1 In October, November and December of 2019, NSFT changed its approach to reporting of the total number of people known to our services who died. Prior to this period, the data had only included people whose death was identified by reporting on the internal incident reporting system, Datix. During these months, the Trust’s patient safety team manually searched for, and added to these data, cases of people who had been known to the trust, but whose death had not come to the trust’s attention in this way. These are likely cases of people who were seen at some point by the Trust’s services at some time in the 6 months prior to, but not actively under the care of NSFT’s services, at the time of their death. This led to a significant increase in the number of people reported to have died during these months, but a more accurate reflection of the total number of people who had died during the period.

4.2 These additional data are not available to NSFT in real time but must be entered retrospectively. The intention remains to present these data in the long term however it has not been possible to access these data during the COVID incident. Therefore, in order to allow a meaningful long-term comparison of trends in the number of people who have died, without giving a false impression that death rates have fallen excessively in the early part of 2020, these additional data have been removed from the analysis. The chart below reflects a consistent methodology for reporting across the timespan.
4.3 As can be seen from the above data, there is month to month variation either side of a mean of around 50 of NSFT’s patients who are reported to have died in any month, with no sustained trends either side of this. The rolling 6-month average of the monthly data is presented as the pale grey line, which shows no sustained trend over time.

4.4 Removing the April 2020 data point, there is no significant trend in the data over time. Including the April 2020 data point suggests that over the 2 years of review, there has been a slight overall tendency towards an increase in the number of people reported to have died whilst under the care of the trust, however this trend does not exceed the 95% confidence interval and may have arisen by chance or due to the impact of this single month. Over the course of the review period, the total number of people under the care of the trust has increased by 13%, which is also likely to have contributed to the number of those people who have sadly died.

5.0 Impact of COVID 19

5.1 During the COVID 19 incident that has been a significant increase in the number of people who die in almost all settings. Most data suggest that this is a higher excess than the number of people who are known to have died from COVID directly. This may be because people have died as a result of COVID which was not confirmed, or because people have not had access to the same health and social care during the COVID incident as in normal times. Analysis of the Office for National Statistics data suggests that, in the East of England, the proportion of excess deaths during the COVID incident has been around 58%. This means that the number of people who have died during the COVID incident in the East of England, from all causes, is 1.58 times higher than would have been expected during a typical similar period.

5.2 Norfolk and Suffolk Foundation Trust has sadly seen the death from COVID19 of 2 patients under our care in our inpatient services. Both of these people died in our older people’s ward at Carlton Court, with their care provided in continuous consultation with their families and medical experts at the James Paget Hospital. Spiritual care was available to both patients. One patient’s relatives were supported to visit, whilst the other patient’s relatives were continuously updated remotely. The Patient Safety Team has supported an early learning review of both cases and identified areas of good practice and opportunities for learning.

5.3 The number of deaths reported in April 2020 is higher than in preceding months. Although it is possible that this is a chance finding, the rate of increase is similar to the number of excess deaths that have been seen elsewhere as a result of COVID (a 62% excess compared to the mean).
Most of those who die and who are known to NSFT’s services are people in later life. In April 2020, 83% were over the age of 60.

5.4 Of the 127 people whose deaths have been reported prior to April in 2020, the cause of death is known for 62%. The commonest known causes of death prior to April 2020 were cardiovascular disease (23% of known causes), respiratory failure (17%) and dementia (15%). In April 2020 the commonest known cause of death was COVID19 (42% of known causes of death). SIMRG will continue to review these data. We will seek to present a more detailed analysis as the number of people whose cause of death remains unknown reduces. It will be important to ensure that the trust remains vigilant in seeking trends in mortality data that might be masked by the impact of COVID.

5.5 Given the complexity of analysis of these data and need to be confident that the changes to the denominator due to the above considerations are not masking an underlying cause for concern, it is proposed to commission an external expert review of the whole mortality data to identify any cause for concern or opportunity for improvement. This is intended to follow resolution of the acute phases of the COVID incident.

Recommendations

The board is invited to:

- Note the contents of this report, and that there are no indications of underlying trends in the mortality data that give rise to added concern.
- Note that the some of data presented have been adjusted from previous reports to remove data that are not presently available in order to allow longitudinal analysis and that the intention is to bring these data back once the COVID incident is over.
- Note that COVID appears to have an impact on the number of people who die that goes beyond the number of people who are known to have died from the Coronavirus directly.
Executive Summary:

The new Junior Doctors’ Contract has been implemented and exception reporting systems are in place to monitor any resulting problems.

As part of my role as GOSW I attend the Junior Doctor Forum and Junior Doctor’s Inductions to encourage them to exception report and clarify any questions or concerns they may have around exception reporting.

The Junior Doctor Handbook has now been updated with accurate information regarding exception reporting and there is now a policy for exception reporting that is in the process of being ratified and published.

Ways of supporting supervisors with exception reporting are being explored, including the possibility of developing an exception reporting handbook and advice around the use of the Allocate system for supervisors.

As GOSW I meet with the Director of Medical Education to discuss any potential issues pertinent to the wellbeing of junior doctors and working collaborative to improve the experience of trainees in NSFT.

1.0 Progress So Far

1.1 We currently have 43 junior doctors in NSFT and all doctors are on the new contract.

1.2 The impact COVID has had on both the rota and exception reports will be more apparent in the next report.
1.3 We continue to use the Allocate exception reporting system. The system is user friendly and there is increased awareness of the system. Junior doctors and supervisors can contact medical HR for advice around the use of the Allocate system.

1.4 The Junior Doctor Forum (JDF) is now well established with meetings being held in Thetford prior to COVID coming into place. The plan is to move to holding the JDF remotely using Teams to ensure the meetings continue and juniors’ doctors have a space to discuss issues and concerns.

1.5 The GOSW has shared her contact details with all junior doctors and is encouraging them to get in touch if there are any issues they wish to discuss.

1.6 GOSW is also attending induction for doctors in training and was part of the Seniors educators away day in February 2020.

1.7 GOSW is part of the East of England regional network.

1.8 A policy for exception deporting has been written and is currently in draft form, undergoing the process of ratification and approval.

### 2.0 Exception reporting

2.1 The Trust is using the Allocate system for online exception reporting and resolution of rota and hours of work issues. This system is live and is central to the implementation of the new contract.

2.2 We continue to encourage Junior doctors to exception report and the GOSW has been exploring with the Director of Medical Education ways of expanding the system to include more areas to report on those relevant to educational opportunities to further support the wellbeing of junior doctors.

2.3 We continue to look at ways of resolving any outstanding reports. COVID appears to have had an impact on how quickly trainees are meeting with their supervisors to discuss exceptions. This is being monitored and will be explored further in the next report. None of the exceptions reported in this quarter have related to immediate safety concerns.

2.4 Since the exception reporting system was introduced there have been a total of 131 exceptions.
The graphs below show the activity each quarter for year 2019/2020.
2.5 In the last quarter there have been 12 exception reports, 10 have been for additional hours worked, 1 has been for missed natural breaks and in one report no breach was identified. Considering our current number of trainees this equates to approximately 3.5 reports per junior doctor in the last quarter.

2.6 Most reports continue to be from Suffolk however we are starting to see reports from a wider number of different placements.

2.7 There are currently 3 outstanding exceptions submitted. GOSW is in discussion with HR around these reports and has emailed the supervisors and trainees involved to review progress.

2.8 We have not had any step-down occurrences in the rota in the last quarter.

2.9 All the junior doctor rotas are currently compliant with the junior doctor contract.

2.10 No work schedule reviews because of exception reporting have been required or taken place in the last quarter.

3.0 Remedial actions and fines

3.1 Exceptions reported have been resolved either by overtime payment of by provision of time in lieu. It has not been necessary or appropriate for the Guardian to levy any fines on the Trust for persistent breaches of contract.
4.0 Junior Doctor Engagement

4.1 The Junior Doctors’ Forum is established. The Director of Medical Education and local supervisors are encouraging attendance and promoting the forum.

4.2 As GOSW I continue to write to all junior doctors to introduce myself and encourage junior doctors to raise concerns and make contact. Further efforts will be made to contact supervisors to clarify any questions or concerns they may have around exception reports as well as looking at the development of a handbook around exception reporting and the use of the Allocate system for supervisors.

4.3 We are working on ensuring good quality exposure in Psychiatry for trainees including experience in acute as well as community Psychiatry. I am in regular contact with the DME and senior educators are currently working hard to enhance the junior doctors educational programme, improve engagement and review current placements. Trainees appear more engaged and have been generally positive about the changes. The education department have also worked hard to adapt to the changes brought about by COVID.

4.4 Junior doctor’s mess facilities in different areas are currently undergoing a process of refurbishment across the Trust. Facilities used by junior doctors will require further improvement, including on-call rooms, however the improvements to the mess are having a positive impact on the morale of junior doctors.

4.5 The impact of COVID on trainees has been variable depending on the type of placement and the level of support in each placement. Junior doctors are being encouraged to raise their concerns and exception report.

Dr Sara Ramirez Overend  
Guardian of Safe Working  

Background Papers / Information

None
Executive Summary:

This report provides an update on progress against the Trust’s People Plan and in regard to workforce performance exceptions.

PEOPLE PLAN

Equality Diversity and Inclusion
A major focus over the last month has been on how we best support our black, Asian and minority ethnic (BAME) staff given our concerns on the disproportionate impact of Covid-19 on BAME populations. It is important to us that our BAME colleagues feel listened to, understood and supported and that we work together on how we best respond. We have therefore been working closely with our BAME Network colleagues. Key actions are set out under section 2.1 and include updating our risk assessment approach to include ethnicity as a co-factor and introducing a BAME support role.

Culture Change
A Culture Strategy is being reported to the Board as a separate agenda item.

We use regular Pulse Surveys to test the ‘temperature’ on how our staff are feeling. Performance is quite variable from month to month. Positive trends include staff recommending the Trust as a place to receive treatment, an increase in staff reporting that they are able to make suggestions to improve their team/department and an overall improving trend on the quality of appraisals. In March, having adequate resources was an area of concern for staff which is understandable in the context of what was happening at that time and remains a key priority for the Trust.

Leadership Review Phase 2
Phase 2 of the leadership review has involved the redesign of the structure and roles reporting into the Care Group leads. Following the close of the consultation period in February 2020, the majority of roles have been appointed to, with active recruitment into the small number of remaining vacancies in West Suffolk and North Norfolk and Norwich. Seven voluntary redundancies were supported which prevented the need for compulsory redundancies and we continue to work with
six individuals in seeking suitable alternative roles for them within the Trust. They are all undertaking alternative meaningful work in the meantime.

**Leadership Development**

Proposals for our leadership development offerings for 2020 to 2022 have been shared with the Executive Team for approval. The proposals have been developed to take into account the themes arising from the culture diagnostics and to embed the culture principles shared with the Board at its last meeting. They include introducing a managers’ induction, a Leading Confidently programme, Leadership Summits and an individual and team coaching programme for our Care Group leads.

**People Before Process**

This programme of work has continued to focus on the review and redesign of our disciplinary policy. We have successfully recruited to the role of Investigating Officer, commencing in post on the 1st June 2020, and we are embedding a new approach to wellbeing support for individuals involved in employee relation cases. The next area of focus is to review our grievance and bullying and harassment policies.

**Recruitment and Retention**

At the end of March 2020, the Trust’s overall vacancy rate was 8% of our funded establishment, equivalent to 347 whole time equivalent (wte) vacant posts, of which 66 wte vacancies comprised medical staff (21.4% vacancies) and 186 wte registered nursing vacancies (14.2% vacancy rate). 23 of the medical vacancies were covered by locums, reducing the vacancy rate to 17%. Whilst we still need to recruit more, and we have concerns in particular areas where vacancies are particularly high, looking at the picture over the last year, we can see some progress. We have recruited an additional 4% in overall staff employed over the last year (April 2019 to April 2020), which includes a 5% increase in clinical staff – an additional 129 wte clinical staff. In summary, 94% of our increase in staff has been in clinical areas. We have 50 wte more nurses and 13.5 wte more doctors than we employed a year ago.

We have had a really positive response to our efforts to attract returners and to increase our bank capacity in response to Covid-19. This includes an additional 250 available bank staff.

Despite all the positive achievements in regard to recruitment, we are concerned by an increase in voluntary turnover. This has increased over the year from what historically has been a fairly stable rate of about 10% to 11.18%. We are undertaking an urgent review to better understand the issues and to put remedial plans in place.

**Core Workforce Metrics (Exceptions)**

**Sickness Absence**

Our monthly sickness absence rate rose to 6.13% to the end of March 2020 with Covid-19 related absences having an impact. As at 5 May 2020, we have been running at overall staff availability of 83%. This is an improved position from 63% in the earlier stages of the pandemic. Despite the impact on staff availability, shift fill actually improved in March 2020, supported, where needed, by staff being redeployed to ensure the safe staffing of our most critical services.

Whilst the sample is small at this stage to be able to draw any definite conclusions, early indicators, based on the March 2020 data, show a higher proportion of BAME staff having reported off sick with Covid-19 related symptoms than non-BAME staff compared to the ethnicity of our workforce profile. We will continue to monitor the trend as more data becomes available.

In light of the psychological impact of Covid-19, we have introduced a staff helpline, run by psychologists, that is available seven days a week, as well as wider staff wellbeing support and resources.
As there had been concern about the increasing sickness absence trend since November 2019, which was a reverse of a previous improving trend, additional Human Resources capacity has been introduced for the next year to work with managers within the Care Groups to ensure proactive sickness management alongside a focus on absence prevention supported by the Human Resources Business Partners.

Appraisals and Management Supervision
Whilst a reduction in performance was perhaps to be expected in March 2020 in light of the impact of Covid-19, given the trend of deteriorating performance, the undertaking and reporting of appraisals and management supervision continues to be an area of concern. To the end of March, the reported non-medical appraisal rate was 64.5%, medical appraisals were 79% and supervision was just 53.2%. Importantly, staff continue to report higher rates through the Pulse Survey (April 2020); 82% reported having had an appraisal within the last year and 87% reported having had management supervision within the last month. This therefore indicates an ongoing data quality issue which operational managers must address. Given the particularly challenging working arrangements our staff are working within in light of Covid-19, regular supportive supervision is more important than ever and now that initial response plans are in place, this is an area of particular priority.

Mandatory Training
Compliance has been reducing since January 2020 and is now at 85.7%. Classroom based training has been suspended due to infection control risks which is impacting compliance rates. To help maintain knowledge, where possible, classroom training is being replaced with virtual and on-line training.

OTHER WORKFORCE ISSUES

Covid-19
Our shared response to Covid-19 is a feature of all our professional and personal lives at present. We have put in place a range of measures to support our staff and to focus our staffing resource where it is most needed. At the beginning of May 2020, our Chief Executive wrote to all staff to thank them for the amazing work they are doing, in very difficult circumstances, and to set out our commitments to them.

Annual Leave
We have changed our annual leave year arrangements to run from April, in line with the majority of the wider NHS, and have changed our recording system from those not using the Healthroster system to the Electronic Staff Record (ESR) with effect from April 2020. This means we can decommission the previous system (Staff Pathways) and can have greater confidence in the accurate calculation of leave entitlements.

ESR Manager Self Service
ESR Manager Self Service has also been implemented, removing the need for manual payroll forms. This reduces paperwork, improves the efficiency of payroll processes and will reduce payroll errors.

The information in the paper relates to BAF risks 1.1, 1.2
1.0 INTRODUCTION
This report provides information and an update on key people issues, particularly focused on our People Plan priorities, as well as workforce performance exceptions.

Figures presented are those that relate to performance as at end of March 2020. A copy of the Trust’s Workforce Performance Dashboard can be seen in Appendix 1. The main source of the data is the Electronic Staff Record. The information was taken during April 2020 (between 1st and 12th) to allow for data processing.

2.0 PEOPLE PLAN
2.1 Equality, Diversity and Inclusion

We continue to progress the delivery of the Trust’s Equality, Diversity and Inclusion (EDI) Strategy. The first meeting of the reformed Equality and Diversity Group was held in March 2020 with good attendance from network leads. A new framework to support the work of network leads and improve systems for monitoring EDI issues was introduced at the meeting.

There has been considerable media interest in the disproportionate impact of Covid-19 on black, Asian and minority ethnic (BAME) people. The reasons are not clear at this stage but socio-economic issues are likely to be a factor as well as certain underlying health conditions being more common in some BAME populations, which increase risks with Covid-19. Urgent research is being undertaken by the NHS to better understand the issues.

Understandably, particularly given the history of health inequalities, there are anxieties amongst our BAME staff. We are working closely with our BAME network leads to ensure we are appropriately supporting our BAME colleagues. This urgent need is very much in line with our Expect Respect campaign.

Actions include:

• Having an honest and open dialogue about the issues through our BAME Network.
• We have highlighted the issue in a staff letter from the Chief Executive and have also covered this in the Coronavirus communications.
• We are encouraging people to disclose underlying health conditions so that their managers can work with them to plan their work accordingly to keep them safe.
• Occupational Health have been updating our risk assessment tool and have also been working with a partner to look at an artificial intelligence solution that will support with the risk assessment process. Guidance has also been issued to managers. BME network colleagues have been involved in discussion with Occupational Health which has provided some reassurance on the well informed and considered approach being taken. As well as incorporating ethnicity as a co-factor as part of the risk assessment process, gender (as men seem to have worse outcomes than women), disability and BMI are also being incorporated. The new tool should be available before the end of May. Healthcare Academics are supporting its development so it is as evidence based as possible. It will be updated as new guidance becomes available.
• A survey is being undertaken to better understand the anxieties of our BME staff to inform how we best support them. This is being conducted in collaboration with the BME network and Research department.
• We are considering prioritising BME healthcare staff for testing.
• We are monitoring levels of Covid-19 related sickness and staff testing to see whether there is any disproportionate impact for BME staff (see section 2.7.1.2 below).
• The Employee Experience team is linking with HR Business Partners to provide some sessions in the Care Groups with local managers about the issues and how they can best support BME staff. This is being supported by guidance/briefing notes for managers.
• A role is being introduced to support BME staff during the pandemic.
• Discussions are being held with the BME network chairs about supporting some protected time for network activities.

2.2 Culture Change
Following the feedback to the Board at the last meeting on the outcome of the culture diagnostics, proposals on a culture change strategy are being presented to the Board as a separate agenda item.

Outside of the Staff Survey period, we run monthly Pulse Surveys. These are sent to a randomly selected 800 staff per month and provide a ‘snapshot’ picture of how are staff are feeling and provide an indicator of whether some of the actions we are putting in place to improve staff experience and our culture are having the desired impact.

The results for April 2020 can be found at Appendix 2. As can be seen, performance is quite variable from month to month. Positive trends include staff recommending the Trust as a place to receive treatment, an increase in staff reporting that they are able to make suggestions to improve their team/department and an overall improving trend on the quality of appraisals. In March, having adequate resources was an area of concern for staff which is understandable in the context of what was happening at that time.

2.3 Leadership Phase 2 Review
Phase 2 of the leadership review has focused on redesigning the leadership level below the Care Group leads.

Formal consultation for Phase 2 concluded on the 20th February 2020 and formal selection processes have now been completed across all Care Groups resulting in the majority of roles being successfully filled. The few remaining vacant posts (in West Suffolk and North Norfolk and Norwich) are being advertised.

The seven voluntary redundancies agreed prior to the selection processes that have been previously notified to the Board have all been finalised and, with the exception of one person, these staff have now left the Trust.

Eight staff were unsuccessful in securing a post as an outcome of the selection processes. A resignation has subsequently been received and one employee has chosen to take retirement. The six remaining staff are being supported to find suitable alternative roles via redeployment. So far, three have been able to secure fixed term contracts whilst we continue to support them in securing suitable substantive roles. The remaining three staff are currently using their skills to support our teams during the pandemic. These staff wish to continue to work in the Trust and we are committed to working with them to secure suitable alternative employment so as to avoid compulsory redundancies.

2.4 Leadership Development
Proposals for leadership development for 2020 to 2022 have been shared with the Executive Team for approval. The proposals have been developed to take into account the themes
arising from the culture diagnostics and to embed the culture principles shared with the Board at its last meeting. Proposals include:

- A managers’ induction to set expectations for leadership roles within the Trust for those joining the organisation and to include the fundamentals of ‘how we do things around here’;
- A programme for Bands 4 to 7, including modules on leading self and others;
- Leadership Summits for everyone in a management role;
- Team and individual coaching for Care Group leads to embed the new leadership model, plus a coaching offer for other leaders as needed.

These offerings will operate alongside role specific development programmes, for example, for Band 5 and 6 clinicians.

The immediate offer will be provided in the knowledge that social distancing remains and

2.5 **People Before Process**

The People Before Process programme of work has continued to progress with a current focus on reviewing and redesigning our approach to the management of conduct concerns. Members of the Freedom to Speak Up Group have also been engaged in supporting the review of the Freedom to Speak Up Policy. Where we can, we are taking the immediate learning and actions from this group and reviewing and adjusting practices in relation to employee relations (ER) case management. An example being a more structured and defined approach to ensure that a dedicated wellbeing support role is assigned to individuals involved in ER cases.

We have successfully appointed to the new role of Investigating Officer. Our Investigating Officer will commence in post on 1st June 2020. This role will focus on improving the quality of our internal disciplinary investigations, reducing the time it takes to investigate allegations, and on sharing learning to support and feed into the wider cultural improvement workstreams. As it is just one post, there will not be capacity for this individual to lead on all disciplinary investigations, but it will provide a good opportunity to test out the value of such a role with a view to expanding the capacity if impactful.

The next focus for the group will be to follow this collaborative working approach with our regional and local union colleagues to review and evaluate our approach to grievances and bullying and harassment.

2.6 **Recruitment and Retention**

At the end of March 2020, the Trust's overall vacancy rate was 8% of our funded establishment, equivalent to 347 whole time equivalent (wte) vacant posts, of which, 66 wte vacancies were for medical staff (21.4% vacancies) and 186 wte were for registered nurses (14.2% vacancy rate). 23 of the medical vacancies were covered by locums, reducing the vacancy rate to 17%.

Whilst we still need to recruit more, and we have concerns in particular areas where vacancies are higher, looking at the picture over the last year, we can see some progress. We have recruited an additional 4% in overall staff employed in the last year (April 2019 to April 2020), which includes a 5% increase in clinical staff – an additional 129 wte clinical staff. In summary, 94% of our increase in staff has been in clinical areas and we are employing 50 wte additional nurses and 13.5 wte additional doctors than a year ago.
With the support of a recruitment head-hunting agency, we have now offered medical Specialist and Associate Specialist (SAS) roles to nine overseas doctors who will join us in various locations across the Trust as soon as flight restrictions are lifted. These doctors will be given the opportunity to undertake the Certificate of Eligibility for Specialist Registration (CESR) which will allow them to apply for Consultant posts in the coming years so will provide us with a good supply pipeline for these difficult to full roles. We have also had some recent success with Consultant appointments which have been from a mixture of internal and external doctors.

The Trust has continued to hire nurses each month, recently recruiting 41 third year final placement student nurses who started on 20 April 2020. The students have been appointed as Band 4 nurses whilst completing their studies on six month paid clinical placements, prior to being registered, and as such these staff are not included in the growth figures in registered nurses noted above. The arrangement of employing these is in line with nationally guided changes to education and training for third year nursing students as part of the response to Covid-19. Once the nurses have received confirmation of their registration, they will move into their substantive Band 5 positions that have already been offered to them.

In addition to the final placement nurses, we have also recruited, on fixed term contracts, 75 second and third year student nurses and student Allied Health Professionals who are not at the final placement stage of their training. These will have all started by 11th May. These students can be released to us to be employed as Clinical Support Workers (CSW) on fixed term contracts, working up to 30 hours per week to allow them a day a week for the continuation of their academic studies. This is a great opportunity for us to give the students a really positive experience and to make them feel part of the NSFT ‘family’ so that they choose to stay with us when they qualify.

In addition to the above, we have had eighteen staff returning to work after having written to people who had left in the last two years as part of our response to Covid-19. Through this approach and also as a result of a social media campaign to attract people to work for us, we have had 270 people apply to join our bank since March, 250 of which have completed the recruitment process and are available for work. We have only received a very small number of people through the NHS ‘Bring Back Staff’ campaign but that campaign started later than our own.

All staff turnover (calculated on a rolling 12-month basis) to the end of March 2020 was recorded at 12.90%. Voluntary turnover has increased over the year and is now 11.18%, 2.68% points above the 8.5% target rate; this equates to 439 voluntary leavers in the 12 months to end March 2020. This is an unusual trend as our overall voluntary turnover rate has historically been fairly stable at around the 10% mark. We are undertaking an urgent review to better understand the issues and to put remedial plans in place.

2.7 Core Workforce Metrics (Exceptions)

2.7.1 Sickness Absence

The Trust’s annualised absence rate in January 2020 was recorded at 5.25%, an increase of 0.06% points compared to February 2020 and 0.62% points above the 4.63% target. This is the highest annualised absence rate for the 2019/20 financial year. The monthly absence rate for March 2020 was 6.13% with the absence rate being impacted by the advent of Covid-19 shown by the increased rates of absence for colds/coughs/flu, respiratory and infectious diseases as per the chart below and a notable corresponding increase in mental health related absence (these absences had all been recorded on Healthroster/ESR as Covid-19
related). (More detailed information on the impact of Covid-19 on staff availability is in section 2.7.2 below).

In light of the psychological impact, we have introduced a staff helpline, staffed by psychological practitioners, to support staff during the pandemic. This is in addition to webinars and a variety of other resources covering physical, mental and financial wellbeing, as well as carers support and in relation to domestic abuse. We have also started to think about the longer term impact of the current pandemic on staff and the psychological support that is likely to be needed.

Prior to the onset of the pandemic, we were already concerned about the deteriorating sickness trend. As a result, the Executive Team agreed some additional Human Resources capacity over the next year to support managers in reviewing and managing cases to help reverse the trend, particularly given that, in November 2019, we were reporting a five-month improving trend and had been on trajectory, at that time, to meet the sickness absence target. Two of the three Human Resources Advisor roles have now been appointed to. These will be based in the Care Groups and will enable a strong focus on sickness management with the main aim of supporting our employees back into the workplace and to support a reduction in our sickness rates. The Human Resources Business Partners will continue to work with Care Group leadership teams to also focus on preventative actions to improve workplace wellbeing.

### 2.7.1.1 Impact of Covid-19 on staff availability

As at 5 May 2020, we have been running at 83% overall staff availability (factoring all types of absence). 140 staff absent were absent on this date due to Covid-related reasons, the vast majority being on special leave as they are unable to work, for example, due to shielding, self or household isolation or for other reasons. The position has improved quite significantly since the early part of April when there was a low of 63%. Despite the significant impact of the pandemic, safe staffing levels were maintained with shift fill rates for registered and unregistered nurses for day and night shifts actually improving, with staff redeployed to support with staffing in critical areas where needed.
As at the end of March 2020, Norfolk Children, Families and Young People (CFYP) reported the highest number of absences related to Coronavirus. 225 fte days lost from 26 absence occurrences. This Care Group has 488 wte staff in post (end March 2020). Suffolk East Care Group lost 65.8 fte days across 10 occurrences from a staff in post of 397 wte and continues to be one of the worst affected Care Groups from the perspective of staffing impact.

The estimated cost of sickness absence due to Covid-19 during March was just under £61,000 (note that this figure does not include the cost of covering absence with bank or agency staff when required.)

### 2.7.1.2 Covid Related Absences – Impact of BAME staff

We have been saddened by the emerging picture through national data of the disproportionate impact of Covid-19 on BAME people. We are therefore monitoring the impact on our staff. Whilst the sample of data at this stage is fairly small so we are unable to draw any firm conclusions, it does indicate a higher proportion of BME staff reporting absence with Covid-19 related symptoms than is proportionate to our workforce profile (approximately 13% of all Covid-19 related sickness absence in March 2020 related to BME staff compared to BME staff making up about 7% of our total workforce).

We do not have a clear picture centrally of which staff have been tested and what the outcomes were as staff refer themselves for testing and results only require sharing with managers. In the trial of testing asymptomatic staff that was undertaken by the Trust at the end of April, however, almost 500 staff were tested and 6 were Covid-19 positive; three of these were BAME.

We will continue to monitor any trends.

### 2.7.2 Time to Hire

Time to hire (i.e. authorisation to advertise to staff in post) in March 2020 has improved by 4 days to 73 days for non-medical roles compared to February 2020; 11 days above the 62 day target. Covid-19 has impacted start dates with non-clinical staff in particular having start dates postponed and this has adversely affected the time to hire metric. There were no substantive medical staff appointments during March 2020, so no reportable time to hire data.
2.7.3 Appraisals and Management Supervision

The reported non-medical appraisal rate has deteriorated significantly to 64.5% to the end of March 2020, 12.2% points lower than the 77.7% rate reported at end January 2020 and 25.5% points below the 90% target rate.

Medical appraisals were reported at 79% at the end of March 2020, a 4.1% decrease on February’s rate and 11% points below the 90% target. As with non-medical appraisals, this is the lowest rate in the year to date.

Management supervision rates in March 2020 were reported at 53.2%, an 11.3% point decrease in compliance from January 2020, 35.8% points below the 89% target; the lowest supervision rate in the year to date.

As reported to the Board previously, there continues to be an issue with data quality with managers not consistently recording activity. In the Pulse Survey undertaken in April 2020, 87% of staff responding said they had had management supervision over the last month and 82% said they had had an appraisal in the last year.

Whilst Covid-19 no doubt had an impact on appraisals due in March 2020 and on supervision as managers prioritised putting plans in place to respond to the pandemic, supporting our staff is more important now than ever so a refreshed focus in this area is required. Postponed appraisals need to re-booked and completed in the near future and regular supervision needs to be in place and recorded. Fortnightly appraisal and supervision reporting to managers has resumed (this was temporarily suspended in late March / April) and Human Resources Business Partners are working closely with line managers to try and ensure processes are in place and that data quality is improved.

Oversight for medical appraisals will be transferring to the Human Resources function shortly with the creation of an Appraisals, Revalidation and Job Planning role, which is currently being recruited to. This role will work closely with the Chief Medical Officer/ Director of Medical Workforce and Clinical Directors to improve performance and to ensure more meaningful, service focused job planning arrangements and links with individual performance outcomes and a new approach to job planning is due to be launched shortly. Job planning completion will be incorporated into the workforce dashboard for April 2020 data onwards. An electronic medical appraisal system has been purchased and will be rolled out once the Appraisal, Revalidation and Job Planning Lead is in post.

It should be noted that both the General Medical Council and the Nursing and Midwifery Council have suspended revalidation as an interim measure.

2.7.4 Training Compliance

Mandatory training compliance is now reported at 85.7%, a deterioration of 0.5% points compared to February 2020 and 4.3% points below the 90% target.

Until January 2020, compliance was consistently on, or just below, the 90% target, however, there has been a noticeable deterioration since the start of 2020. More recently, as a result of Covid-19, classroom-based courses have been cancelled due to the risk of infection. This position is to be reviewed at the end of May 2020 and will be reviewed against the latest government guidance. These include prevention and management of aggression, fire training and level 3 safeguarding (both adults and children). This action is consistent with how other Trusts have responded.
Some training, previously provided through practical training has been made available via e-learning, for example, personal safety theory videos are available and will help maintain compliance. Videos are in the process of being created for physical restraint. A review is also underway of all classroom-based training to identify what can move to a digital platform.

Clinical staff can complete on-line fire training which will maintain their compliance.

Compliance with infection control training to the end of March 2020 was 79.3% for clinical staff and 96.1% for non-clinical staff. A major focus of our Coronavirus communications has related to infection prevention, specific to Covid-19, to ensure a good level of understanding across a whole workforce, including the use of Personal Protective Equipment as relevant to the activities being undertaken. Guidance and training has been provided as needed.

2.7.5. Key performance indicators

The current Key Performance Indicators (KPIs) for staffing have been reviewed in line with regional and national trends. The changes for the 2020/21 reporting year will be reflected in the workforce dashboards for April 2020 onwards and therefore reported in the next Board report. Additions include reporting timeframes for disciplinary cases given our focus on improving this and also the completion of job plans. Targets are being updated to take account of sector relevant benchmarks.

3.0 OTHER WORKFORCE UPDATES / ISSUES

3.1 Covid-19

The impact of Covid-19 is unprecedented. In addition to what has been set out earlier in this report, below is a brief summary of some of the workforce issues and actions that have been taken in response to the pandemic:

- Where staff have been able to work from home, they have been supported to do so. ICT colleagues have reported that over 2300 staff have been working from home.

- We have identified over 50 day nurseries who are willing to support our staff staying in work by looking after their children and have also identified other childcare options across the counties, in addition to the school provision for the children of key workers. We have offered to pay for extraordinary childcare costs to keep our healthcare staff being able to work.

- To supplement the national accommodation offer, we have identified over 50 accommodation options local to where our staff work.

- We have put in place arrangements with local taxi firms to take our staff (including bank staff) to and from work where their normal transport arrangements are not available (paid for by the Trust).

- A skills audit has been undertaken of staff not working in clinical roles to identify those with clinical qualifications and experience who can provide healthcare support as needed, as well as identifying other skills amongst those working in non-clinical services that may be helpful in our response to the pandemic. To date, we have not had to formally call on this pool of staff for redeployment to any significant degree, but we have seen a great detail of flexibility and support, for example, with Finance staff supporting with the distribution of personal protective equipment across sites.
• We have issued a letter to all staff from the Chief Executive to thank them for their amazing hard work and to set out our commitments to support them and keep them safe. The commitments can be seen at Appendix 3.

• We have signed up to Mutual Aid agreements that support the movement of staff across NHS organisations to enable NHS staffing to be focused in priority areas as we work together to respond to the pandemic.

3.2 **Annual Leave**

All non-medical staff have now entered the transitional period to manage an agreed change to an April to March annual leave year pattern from the previous birthday to birthday pattern. Staff have been written to outlining the changes, which include ending the use of the Staff Pathways system to book and record annual leave for all staff not using HealthRoster, with this now being recorded via the Electronic Staff Record (ESR). The use of ESR will allow improved central monitoring of annual leave and year end accounting and removes the requirement for managers to calculate annual leave entitlement for their staff, resulting in reduced errors. It will allow staff to book annual leave through any device at any time of the day.

The majority of employees have experienced a smooth transition to using ESR to manage their leave, with just a small number of outstanding queries to be resolved. Our Annual Leave and E-rostering policies include provisions to ensure that proportionate amounts of annual leave are taken throughout the year in order to prevent build up with high numbers wishing to take leave in March each year. Medical representatives of the Local Negotiating Committee are not currently supportive of a change to an April to March leave year. This is for no clear reason other than they wish to stay with their current arrangement. Discussions are ongoing.

3.3 **Manager Self Service**

ESR Manager Self Service (MSS) has been implemented following a period of testing to action staff changes, including hires, changes to assignments and terminations. As well as reducing the requirement for individuals to sign forms, using MSS to action changes is quicker and simpler than the completion of the ‘P’ forms. It had originally been planned to eliminate the use of ‘P’ forms by the end of March 2020. This has been delayed due to Covid-19 pressures so managers are currently able to use either method to carry out a change for an employee.

3.4 **Agency and Bank Collaborative**

In the report to the March 2020 Board, it was reported that work was being undertaken by Norfolk and Waveney Sustainability and Transformation Partnership to work more collaboratively in regard to reducing non-medical agency rates and bank arrangements. This project has been put on hold for a couple of months in light of the pandemic.

4.0 **Financial implications (including workforce effects)**

Focus in the areas set out above will positively impact financial performance (directly and indirectly).

Any aspects of the Trust’s People Plan that are likely to require investment have been discussed and agreed with the Executive Team.

5.0 **Quality Implications**
Focus on the areas set out in this report support the delivery of the Trust’s Strategy, in particular, the priority of engaging and inspiring our staff. This will lead to improved experience for our staff and service users.

6.0 Equality Implications
Equality, diversity and inclusion is a key element of our People Plan.

We are currently particularly concerned about the disproportionate impact of Covid-19 on BAME people and are monitoring this and working with BME Network colleagues to protect and support our BME staff.

7.0 Risks / mitigation in relation to the Trust objectives
Risks and mitigation in relation to strategic workforce issues are presented throughout this paper.

8.0 Recommendations
The Board is recommended to note the contents of this report, including actions and progress being made.
## Appendix 1 – Workforce Performance Dashboard

### Workforce Dashboard 2019/20

**March 2020**

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### Engaged Workforce KPI

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Reporting Period</th>
<th>Target</th>
<th>Current Performance</th>
<th>Change</th>
<th>Performance Tracker</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annualised Sickness absence %</td>
<td>WP01</td>
<td>Reporting 12 months</td>
<td>4.83%</td>
<td>2.25%</td>
<td>0.06%</td>
<td></td>
</tr>
<tr>
<td>In Month Total Sickness Absence Rate %</td>
<td>WP02</td>
<td>Monthly</td>
<td>4.63%</td>
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<td>0.20%</td>
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<td>of which Short Term Sickness Absence Rate %</td>
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<td>Monthly</td>
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<td>0.16%</td>
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<tr>
<td>of which Long Term Sickness Absence Rate %</td>
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<td>0.20%</td>
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</tr>
<tr>
<td>% of time lost to stress/anxiety/depression</td>
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<td>Monthly</td>
<td>1.16%</td>
<td>1.62%</td>
<td>-0.01%</td>
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### Skilled Workforce KPI

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<th>Indicator</th>
<th>Reporting Period</th>
<th>Target</th>
<th>Current Performance</th>
<th>Change</th>
<th>Performance Tracker</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>In Month Overall Vacancy Rate %</td>
<td>WP04</td>
<td>Monthly</td>
<td>7.3%</td>
<td>8.04%</td>
<td>-0.73%</td>
<td></td>
</tr>
<tr>
<td>of which Internal Vacancy Rate %</td>
<td>WP04a</td>
<td>Monthly</td>
<td>5.0%</td>
<td>5.15%</td>
<td>0.30%</td>
<td></td>
</tr>
<tr>
<td>of which Medical Staff Vacancy Rate %</td>
<td>WP04b</td>
<td>Monthly</td>
<td>12.4%</td>
<td>11.4%</td>
<td>5.36%</td>
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</tr>
<tr>
<td>of which Registered Nursing Vacancy Rate %</td>
<td>WP04c</td>
<td>Monthly</td>
<td>11.6%</td>
<td>14.22%</td>
<td>-0.53%</td>
<td></td>
</tr>
<tr>
<td>of which Supportive Clinical Staff Vacancy Rate %</td>
<td>WP04d</td>
<td>Monthly</td>
<td>5.0%</td>
<td>3.03%</td>
<td>-0.19%</td>
<td></td>
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<tr>
<td>of which HLTH &amp; Social Care Vacancy Rate %</td>
<td>WP04e</td>
<td>Monthly</td>
<td>5.0%</td>
<td>1.53%</td>
<td>-2.44%</td>
<td></td>
</tr>
<tr>
<td>All Staff Turnover %</td>
<td>WP05</td>
<td>Reporting 12 months</td>
<td>11.5%</td>
<td>12.94%</td>
<td>0.03%</td>
<td></td>
</tr>
<tr>
<td>Voluntary turnover %</td>
<td>WP06</td>
<td>Reporting 12 months</td>
<td>8.5%</td>
<td>11.18%</td>
<td>0.04%</td>
<td></td>
</tr>
<tr>
<td>Time to Hire (non-medical)*</td>
<td>WP07a</td>
<td>Monthly</td>
<td>62.0</td>
<td>73.33</td>
<td>-11.39</td>
<td></td>
</tr>
<tr>
<td>Time to Hire (medical)*</td>
<td>WP07b</td>
<td>Monthly</td>
<td>75.0</td>
<td>12</td>
<td>65.00</td>
<td></td>
</tr>
<tr>
<td>Management Supervision %</td>
<td>WP08</td>
<td>Monthly</td>
<td>89.0%</td>
<td>53.26%</td>
<td>-3.90%</td>
<td></td>
</tr>
<tr>
<td>% Total Appraisal Rates</td>
<td>WP09</td>
<td>Monthly</td>
<td>90.0%</td>
<td>85.06%</td>
<td>-3.65%</td>
<td></td>
</tr>
<tr>
<td>% Non-Medical Staff Appraisal Rate</td>
<td>WP09a</td>
<td>Monthly</td>
<td>90.0%</td>
<td>84.53%</td>
<td>-5.26%</td>
<td></td>
</tr>
<tr>
<td>% Medical Staff Appraisal Rate</td>
<td>WP09b</td>
<td>Monthly</td>
<td>90.0%</td>
<td>78.95%</td>
<td>-1.05%</td>
<td></td>
</tr>
<tr>
<td>% Mandatory Training Completed</td>
<td>WP10</td>
<td>Monthly</td>
<td>90.0%</td>
<td>85.73%</td>
<td>-0.23%</td>
<td></td>
</tr>
</tbody>
</table>

### Safe Workforce KPI

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Reporting Period</th>
<th>Target</th>
<th>Current Performance</th>
<th>Change</th>
<th>Performance Tracker</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Day Time Average shift fill rate - registered nurses</td>
<td>WP11a</td>
<td>Monthly</td>
<td>90.0%</td>
<td>94.12%</td>
<td>7.04%</td>
<td></td>
</tr>
<tr>
<td>Day Time Average shift fill rate - non-medical staff</td>
<td>WP11b</td>
<td>Monthly</td>
<td>90.0%</td>
<td>117.90%</td>
<td>2.28%</td>
<td></td>
</tr>
<tr>
<td>Night Time Average shift fill rate - registered nurses</td>
<td>WP11c</td>
<td>Monthly</td>
<td>90.0%</td>
<td>127.00%</td>
<td>107.30%</td>
<td></td>
</tr>
<tr>
<td>Night Time Average shift fill rate - non-medical staff</td>
<td>WP11d</td>
<td>Monthly</td>
<td>90.0%</td>
<td>149.52%</td>
<td>28.69%</td>
<td></td>
</tr>
</tbody>
</table>

### Staff in post

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Reporting Period</th>
<th>Target</th>
<th>Current Performance</th>
<th>Change</th>
<th>Performance Tracker</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Substantive Staff at the end of month</td>
<td>WP12</td>
<td>Monthly</td>
<td>N/A</td>
<td>3927.77</td>
<td>-9.01</td>
<td></td>
</tr>
</tbody>
</table>

### Bank and Agency Usage

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Reporting Period</th>
<th>Target</th>
<th>Current Performance</th>
<th>Change</th>
<th>Performance Tracker</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Day Time Bank/Agency registered nurses</td>
<td>WP13a</td>
<td>Monthly</td>
<td>N/A</td>
<td>37.18%</td>
<td>-1.14%</td>
<td></td>
</tr>
<tr>
<td>Day Time Bank/Agency non-medical staff</td>
<td>WP13b</td>
<td>Monthly</td>
<td>N/A</td>
<td>48.06%</td>
<td>-0.87%</td>
<td></td>
</tr>
<tr>
<td>Night Time Bank/Agency registered nurses</td>
<td>WP13c</td>
<td>Monthly</td>
<td>N/A</td>
<td>49.25%</td>
<td>-5.22%</td>
<td></td>
</tr>
<tr>
<td>Night Time Bank/Agency non-medical staff</td>
<td>WP13d</td>
<td>Monthly</td>
<td>N/A</td>
<td>71.96%</td>
<td>2.15%</td>
<td></td>
</tr>
</tbody>
</table>

*Please note, from 1st April 2019 the definition for calculating time to hire has changed. See meta-data info for details.
Appendix 2

Pulse Survey Score Card - Overall Summary

Trend Analysis

- I would recommend my organisation as a place to work
- I would recommend my organisation as a place to receive treatment
- I am able to make suggestions to improve the work of my team / department
- I am able to do my job to a standard I am pleased with

- There are enough staff within my organisation for me to do my job properly
- I have had an appraisal in the last 12 months
- In my appraisal I was able to have good dialogue with my manager about my needs at work and felt listened to and cared about
- In the last 12 months I have had regular management supervision meetings

- In the last 12 months I have had regular clinical supervision meetings (clinical staff only)
- Communication between senior management and staff is effective
- My immediate manager asks for my opinion before making decisions that affect my work
- I have a regular opportunity to talk to my director or other directors or the CEO

In the last 12 months I have experienced harassment, bullying or abuse at work

Notes:
- Survey sent to random selection of 800 staff monthly
- Survey not completed between October and December due to clashing with national NHS staff survey.
- Scale scores are out of 5, 5 representing most positive scoring.
1. We will provide safe working environments

Your safety is a priority to us. We encourage you to speak openly with your manager about any underlying health issues and to share a copy of your shielding letter if you have received one from your GP. Managers will work with you, taking account of the latest national and Occupational Health guidance and advice. Together you will plan your work accordingly, including, where necessary, to support you with self-isolating.

We will support those who are able to work from home to do so, including ensuring the provision of necessary ICT equipment.

For those providing direct care to patients, we continue to review the latest national guidance on personal protective equipment (PPE). This advice has changed over time. Please ensure you read the daily Coronavirus bulletins and check the Coronavirus page on the intranet for the latest guidance. We continue to have a good supply of PPE. If you have any concerns about access to PPE, or what is appropriate PPE for the work you are doing, please let us know urgently and we will address it.

2. Your manager will be supported to support you

Your Care Group/Corporate and Support Service leaders are involved in a call every morning with the Incident Management Team, which has been led by Tactical Commander and Deputy Chief Nurse Dawn Collins. All services provide an update at these meetings on key issues (clinical and staffing) and have an opportunity to escalate any issues that may be of concern locally so that appropriate support can be put into place urgently. These also provide an opportunity to share some of great work and innovations that you are leading locally so that others may learn and benefit from this.

3. We will work with others to ensure that there is adequate testing

We will continue to work with colleagues in the system to ensure access to adequate testing for our staff (including bank, agency and subcontracted staff) and their households, as well as our patients. This helps us manage risks to keep you and others safe and it also helps ensure as many people are able to work as possible where they might otherwise require to be in self or household isolation.

4. If you need to take sick leave or other types of leave related to COVID-19, this will not impact your pay, job role or future progression

Where you are unfit to work due to COVID-19 symptoms or need to take other forms of leave related to the pandemic, for example, because you are required to self-isolate, you will be paid normally, as if you had been at work.

5. Your wellbeing is important to us

Supporting better mental health is our purpose. We will all have days where we find things particularly hard. It’s okay to not be okay. If you’d find it helpful to talk to someone independent and entirely confidentially about how you’re feeling, please contact our dedicated employee support helpline on 0300 123 1335 which is staffed by psychological practitioners. This is available between 2pm and 5pm, every day. There is also an NHS service available from 7am to 11pm on 0300 131 7000, plus a 24/7 text service (text ‘frontline’ to 85258).

A variety of support is available to you on physical, emotional and financial wellbeing. We also appreciate that current times can be particularly difficult for those of you who have caring responsibilities or who find themselves in difficult home situations. Support around domestic violence and for carers is also available. Please see the ‘Staff Wellbeing’ section on our Coronavirus support page on the intranet for further information. Please don’t suffer in silence.

Last week, one of the Coronavirus updates referred to vitamin D supplements. We do not know the exact relevance of vitamin D to Covid-19. Vitamin D is important for bones and muscles and it is known to provide support with general health and immunity. It is something the British Association of Physicians of Indian Origin has written to NHS organisations suggesting they recommend and we want to highlight this to you. Good sources of vitamin D are sunlight and in food, such as oily fish, egg yolks and fortified foods like some cereals. Nhs guidance is to consider taking supplements if you are not spending as much time outdoors. Some 15 minutes exposure to light twice a day is enough for all skin tones. To support our staff, if you would like to use Vitamin D supplements, please feel free to reclaim the cost through expenses on e-Pay (please note this is taxable as a benefit in kind).

6. We will support you to speak out

It is really important that our staff feel safe to speak up if they have any concerns. You can speak to your manager, Care Group leaders, HR Business Partners, the Incident Management Team, Freedom to Speak Up Guardian (Liz Keay) or members of the Executive team. If you have a concern, please let us know so we can address it. You have our assurance that you will not be criticised or suffer any detriment for doing the right thing.
Report to: Board of Directors
Meeting date: 21st May 2020
Title of report: Culture Change - Creating the Organisation that we want to be
Action sought: For comments, approval and assurance
Estimated time: 20 minutes
Author: Ade Adetukasi, Interim Head of Employee Experience
Director: Mark Gammage, HR Advisor to the Board

Executive Summary

This is a draft strategy for comments and approval. The paper sets out the vision and the pathway for moving forward to create a culture of “Connection and Compassion” with everyone – staff, service users, patients and carers - moving forward, caring and working together. The findings and framework set out in the paper were jointly developed in collaboration with a range of stakeholders.

The purpose of the culture change programme is to change the way we think, work and behave from an environment characterised by bullying, disempowerment, lack of respect, unreasonableness and lack of direction to one which is compassionate, connected and focused, with teamworking and learning at the heart of it.

The Trust’s vision is to be in the top quartile of Trusts for safety and quality by 2023 and we aspire to be in the top quartile of Trusts for staff engagement by the same date. We know that our staff and service users have described our culture as being disempowering, fractious and stifling and this is what we aim to change. To do this, we have identified where we need to make changes to our culture, what we want to be, and how we will achieve this.

To embark on the journey to create the organisation we want to be, our immediate priority is to:

- Start taking a structured approach to develop our leaders, especially front line and middle level managers
- Start embedding core behaviours that will bring our values alive for our workforce

To ensure that these measures are not just cosmetic changes that temporarily cover bad practice and old behaviour, we have identified the following enabling strategies to ensure sustained and effective delivery of the culture change measures.

- Learning from our response to COVID-19
- Visible top management engagement
- New organisational narrative

Based on the findings from the diagnostic phase of the culture change programme, our new culture will be built around the following six key principles with disempowerment and lack of respect featuring as immediate concerns.

1. Caring for each other
2. Empowerment
3. Expect respect
4. Involve each other
5. Develop and grow
6. Working together
We have made provisions for monitoring demonstrable progress towards realising these principles. Success of the programme will be measured on how staff and service users feel about working and being treated here and a range of metrics will be used to support and monitor progress, and these will be reported to the Trust Board. A list of key milestones is provided in Appendix 1.

The information in the paper relates to BAF risks 1.1, 1.2

<table>
<thead>
<tr>
<th>Contents</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.0</td>
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<tr>
<td>2.0</td>
</tr>
<tr>
<td>3.0</td>
</tr>
<tr>
<td>4.0</td>
</tr>
<tr>
<td>5.0</td>
</tr>
<tr>
<td>6.0</td>
</tr>
<tr>
<td>7.0</td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

1.0 Introduction

1.1 Our programme of Culture Change is led by the Chair and CEO. It is supported by the Trust Board with Culture Steering Group leading the detailed work and with active support from our staff-side colleagues. The programme is already underway through various workstreams and our approach is to co-create a “new culture” with staff, service users and leaders across the Trust. The Trust Board supports this endeavour and continue to engage in the different elements of the programme to ensure we see the culture changes necessary to allow the Trust to succeed.

The Culture Steering Group comprises 20 staff, service users, and carer volunteers from across the organisation. It is chaired by a Non-executive Director and supported by an Executive Director. The membership of the group is currently being reviewed to ensure it has the right composition for the next phase of the programme. The work of the Group feeds directly to the Trust Board and Executive. The Group provides a steer to our approach on changing the culture of the organisation and direct feedback from the front-line.

The Trust uses the definition of culture at NSFT as ‘the way we do things around here’. It is how we think, feel and behave and how we treat others. It is how it feels to work here and also how it feels to be treated by our staff and service users; it has an internal focus from within the organisation by our staff and also external with how we are viewed by others, most notable service users, carers and prospective employees.

To be the organisation we aspire to be, and to succeed as an organisation providing safe and high quality care, we need a culture where our people want to come to work and service users want to be treated. Our goal is therefore for staff to see culture change happen through being treated well and better people management, better personal experience and seeing more collaborative, positive, compassionate and personal leadership.
According to Kings Fund, healthy cultures in NHS organisations are crucial to ensure high quality patient care and an inclusive work environment. The Culture Change programme is based on NHSE/I Culture and Leadership Framework consisting of three stages – Discover; Design and Deliver – and was introduced to the Board in an earlier paper on the Culture Change programme in September 2019. The discovery phase of the programme, which is the diagnostic stage, has now been completed and this paper will focus on the design and the delivery plan for the programme.

1.2 Key Context

As context for the proposed culture change programme, there are two underlining issues which cut across the findings and the themes set out in this paper and which were at the core of the culture diagnostic work recently undertaken. These are fundamental to the changes we need to make to our culture.

Disempowerment

Disempowerment in the Trust is in the form of individuals and groups feeling they have no control to operate within a clear framework. This includes individuals not feeling empowered to do their job and not feeling able to do their best for the people we care for. The severity and impact on staff of incidents of abuse from colleagues or service-users is frequently misjudged. Historically, staff report a poor leadership culture of "command and control" style which has inhibited staff being able to do their best for service users.

Lack of respect

Lack of respect in the Trust has manifest in the form of individuals not feeling valued or respected at work. There is a lack of shared values and this impact on behaviours in the way we engage with one another. There is a pattern of discrimination, complaints of harassment and bullying, and the culture does not encourage such behaviour to be challenged constructively and with empathy. This has been typified by a lack of kindness and consideration.

To tackle these fundamental issues, at the core of our future leadership and culture programmes are connection and compassion.

2.0 Where the Trust is and our way forward

2.1 We have recognised the destructive elements of our culture for some time, especially after the Trust was placed in special measures by the CQC in 2017. The culture has felt to staff and service users as being too top down with decisions taken remotely and staff disempowered to make the changes they see necessary. The Trust committed to an extensive series of feedback events with staff, service users and carers during 2018/2019 and, to further understand the current culture within the Trust, engaged NHSE/I in 2019 to use their Culture and Leadership diagnostic tools. This focused on the following six strands in gathering feedback, data and insight about the Trust.

- Leadership workforce analysis
- Outcomes dashboard
- Patient experience
- Board interviews
- Culture focus group
- Leadership behaviour survey
As part of the diagnostic process, the Culture Steering group used the five NHSE/I cultural metrics below as measures for benchmarking the Trust against other similar NHS organisations based on recommended indicators. The metrics are based on nationally collected data drawn heavily from the annual NHS staff survey.

1. Visions and values
2. Goals and performance
3. Learning and innovation
4. Support and compassion
5. Teamwork

The table below is the overall position of the Trust as compared to 24 NHS Trusts in the benchmark (the higher the score, the worse the reported performance).

**Table 1**

<table>
<thead>
<tr>
<th>Overall Trust position</th>
<th>Position</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trust position compared to other trusts in the same trust category</td>
<td>24</td>
</tr>
<tr>
<td>Lowest position in trust category</td>
<td>24</td>
</tr>
</tbody>
</table>

The table below shows how the Trust performs out of the 24 Trust on cultural measures.

**Table 2**

<table>
<thead>
<tr>
<th>Culture dimension position</th>
<th>Position</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vision and values</td>
<td>5</td>
</tr>
<tr>
<td>Goals and Performance</td>
<td>22</td>
</tr>
<tr>
<td>Learning and Innovation</td>
<td>24</td>
</tr>
<tr>
<td>Support and Compassion</td>
<td>24</td>
</tr>
<tr>
<td>Teamwork</td>
<td>22</td>
</tr>
</tbody>
</table>

2.2 The diagnostics activities, which included various synthesis workshops, were used as a deep dive into what is going on in the Trust and patterns of behaviour. We have now extracted the key themes from the feedback and data gathered as listed below. This has taken considerable time and reflection which has helped us in understanding where change needs to happen, where the Trust current is, and where we want to be. A detailed breakdown of this analysis is available.

2.3 Key themes from diagnostics phase and planned interventions.

**Table 3**

<table>
<thead>
<tr>
<th>Themes</th>
<th>Planned Interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relationship between staff and the Trust</td>
<td>Embedding Signature Behaviour for Trust’s Values – Campaign (see section 3 below)</td>
</tr>
<tr>
<td></td>
<td>Executive to continue programme of “walkarounds”</td>
</tr>
</tbody>
</table>
Reverse mentoring to continue and extended to other levels of leadership

Systems and Controls

Workshops with services, Care Groups, and other stakeholder to do deep dive on fragmented systems and poor controls impacting on culture.

Partnership and Transparency

Embedding Signature Behaviour for Trust’s Value – Campaign

Belonging and Leadership

New Leadership Development Programme (see section 3 below)

Organisational Narrative

Co-production of new organisational narrative

3.0 Overarching Framework and Interventions

3.1 To act on what we have heard we need to shift the culture people want to be a part of from one characterised as ‘process and status’ to a culture of ‘connection and compassion’ (see image below). We have embarked on co-creating the ‘new’ culture with leaders and other stakeholders across the Trust, using the culture steering group as one of the main driving forces, to help more by way of conversations, road shows, workshops, and designing solutions.

For us to make timely and effective changes in our culture, our approach is to prioritise delivering the following two interventions specifically aimed at tackling key issues having significant impact on our culture. These two interventions are inter-connected, and their impact could potentially reach the heart of the Trust. The other interventions listed in table 3 are ongoing and form part of the culture change programme. The timescales for developing the workplans are stated in Appendix 1.

Prioritised Interventions

1. New Leadership Development Programme
2. Embedding signature behaviours for Trust’s values
Table 4

<table>
<thead>
<tr>
<th>Interventions</th>
<th>Lead/s</th>
<th>Goals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Leadership Development programme</td>
<td>Interim Head of Employee Experience</td>
<td>- To ensure managers have knowledge and confidence to undertake day-to-day line management in line with NSFT’s values &amp; behaviours framework</td>
</tr>
<tr>
<td></td>
<td>Leadership Development Lead</td>
<td>- To ensure a consistent approach to line management across the Trust</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- To ensure managers understand and support culture change</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- To ensure managers understand and support employee experience</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- To develop clinical leadership capability in the Trust</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- To ensure that the Trust is more intentional in building leadership capability</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- To provide managers with the tools and skills to engage and lead their team through change</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- To define what good line/team management looks like</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- To influence how our staff are treated and managed on a daily basis</td>
</tr>
</tbody>
</table>

Recent research has proven that Culture and Leadership are intertwined. It is generally believed that leadership influences culture and culture influences leadership (Edgar Schein). The Leadership Development Programme will therefore serve as a key delivery vehicle for the Culture Change Programme.

The programme set out a framework for building the Trust’s leadership capability. It is based on a continuous learning approach to enable the Trust to become more successful at developing its leadership capability.

In line with the findings of the diagnostics phase, the programme has a people management focus in response to the disempowerment, lack of respect, staff wellbeing and staff engagement challenges in the Trust. The programme is aimed at developing core competencies that managers need to possess to manage people and teams effectively. The first phase of the programme will focus on band 4 – 6 managers and will be compulsory.

The full content of the programme is currently being developed as part of the design stage of the Culture Change Programme. The initial core leadership competencies identified as key to tackling the themes and issues explained above are listed below.

1. Supervising others
2. Conflict Resolution
3. Managing Performance
4. Self-Awareness
5. Building Effective Teams
6. Understanding Managers’ Toolkits

In recognition of the differing needs of managers in nursing or medical roles, part of the programme will be specifically designed for developing clinical leadership to support clinicians and address psychological safety within clinical areas and clinical governance.
Embedding Signature Behaviours for Trust’s values - Campaign

One of the hardest parts of the diagnostics phase has been hearing stories where we have failed to live to our values. There are numerous examples of these and they cut right across the five themes of the findings from the diagnostics process.

As individual behavioural change lies at the core of culture change, this intervention will focus on driving the critical shift in behaviour by reinforcing core signature behaviours required to bring the Trust’s values alive. Below are the Trust values and examples of corresponding signature behaviour.

<table>
<thead>
<tr>
<th>Trust Value</th>
<th>Signature Behaviour</th>
</tr>
</thead>
<tbody>
<tr>
<td>Positively</td>
<td>Focus on what we can do</td>
</tr>
<tr>
<td>Respectfully</td>
<td>Value everyone</td>
</tr>
<tr>
<td>Together</td>
<td>Open &amp; honest communication</td>
</tr>
</tbody>
</table>

As values refer to what people find important in their life or work, signature behaviours express what people value in the course of everyday interaction (Cieciuch and Schwartz, 2017).

The purpose of the campaign is to galvanise and engage all staff and also services users, patients and cares in making behavioural changes to ensure alignment with the Trust’s values.

The focus of the campaign is to identify the top three behaviors out of the 15 listed under the Trust values and behaviours framework based on the Trust’s current priorities. These will then be profiled as Signature Behaviour for a 12 months period to ensure anchoring, after which it will be increased to 6. The effectiveness and impact of the campaign as way for embedding the Trust’s values and behaviours will be reviewed after the first 12 months.

- Reinforcing the signature behaviours will help create an environment for change
- To influence behaviours in the right direction
- To use the campaign to create a work environment where the Trust values come alive
- To ensure working practices and employee experience reflects the Trust values
- To tackle engrained behaviours pattern that has contributed to the current blame culture and staff dis-empowerment
- To help staff and managers internalise Trust’s values and behaviour
- The new culture will be mostly expressed in behavioural terms, so the campaign will help deliver culture change
- Change or a new culture can’t be imposed on staff, only change in behavioural pattern can bring about culture change, hence the use of this campaign
- Using the campaign to challenge unacceptable practices
- To encourage little step changes
The campaign will help create an environment for change by influencing staff behaviour. It will involve supporting individuals and teams through interactive group sessions and other activities that will help reset the gravitational pull of old or familiar behaviour that has contributed to the dis-functional culture identified during the diagnostic.

The current Trust’s values – “Positively; Respectfully; Together” – was successfully launched in 2016 following extensive consultation with staff, service users, and carers. It has achieved good visibility and awareness across the Trust since then. However, the planned second phase to embed the values and required behaviour was put on hold following major senior management changes.

This campaign is therefore a timely next step building on the visibility and awareness already achieved, and with a renewed focus on reinforcing signature behaviours. A full list of the behaviours under the Trust values are listed in the Value and Behaviour Framework attached as a supporting document.

- The real value of the Trust values is in new behaviour, so the campaign will help bring the values alive.

4.0 Enabling Strategies

Launching the Culture Change programme is not enough to bring about the changes required to address the gaps identified in our culture. Various elements of the existing environment in the Trust could undermine the above interventions and other planned changes. Therefore, to ensure effective and sustained culture change, we have identified key enabling strategies to support the delivery of the culture change programme.

4.1 Learning from our response to COVID-19

The ongoing Coronavirus pandemic and the Trust programme of response to COVID-19 has had a profound impact on staff and the organisation as a whole. To cope with the challenges of the pandemic, the Trust has had to be adaptive and introduced temporary measures which completely changed our normal way of working. This includes having over 50% of our workforce working from home and skills redeployment at a pace and scale unimaginable before the pandemic. Some of the temporary changes introduced are helping to accelerate much needed changes in our working practices.

Although the Trust lacks the ambidextrous capability to maintain the transformative way of working and also return to normal service provision, particularly as the demands on some areas or teams in the Trust are not sustainable, there is a lot of learning from both the successes and the challenges. The following learning from COVID-19 will therefore form part of the enabling strategies for delivering the culture change programme.
- **Focused and intentional engagement with staff:** Communication has been critical to the Trust’s response to the pandemic. The communication strategy followed, especially the introduction of a daily COVID-19 update and the creation of a dedicated intranet page, has enabled a flow of information that has ensured awareness, direction and assurance throughout the pandemic. Anecdotal feedback from staff indicates that the daily updates on operational and services situation facing the Trust helped create awareness and good engagement with the activities of the Incident Management Team. According to a frontline staff commenting on the Daily COVID Update, “we have not seen this level of communication and transparency in a long time”. There has also been specific positive feedback about the regular communication from senior management as the daily update is usually signed off by a senior manager or director. In relation to handling of sensitive issues like PPE, the feedback indicate that the messaging has been clear and sensitive.

To build on this, we are working with the communications team to create a communication plan to support the delivery of the culture change in programme. We will also be launching a Culture Change intranet web page which among other functions will allow for real time feedback.

- **Responsive leadership:** Some have described the Trust as being more responsive to staff wellbeing and other staff issues during this crisis period. Apart from the additional central wellbeing provision like the Staff Helpline, there are reports of managers that have been reaching out – more than usual - to respond to staff needs. This includes managers making daily or weekly calls to individuals or teams working from home, and also managers having more regular one-to-one or team briefing sessions. The overall picture is of better employee engagement. It has also been reported that the shared vulnerability experienced by staff at all levels prompted expressions of generosity and forgiveness.

To maximise the learning opportunities from these, case studies from this period will be used in designing the content of the new leadership development programme.

- **Cross-functional working:** In adjusting to the pandemic lockdown restriction and high level of COVID-related absences, Care Groups and corporate services team had to work jointly across functions. Under the direction of the Incident Management Team, temporary operational and service changes were put in place to maintain essential services. These included the redeployment of staff and setting up of cohort wards to meet the demands of COVID-19.

By transcending functional boundaries and historical silos, the Trust was able to maintain a flexible and effective response to daily operational and resource management challenges to provide quality care for service users under such difficult circumstances. This will hopefully help accelerate much need changes in the Trust. Some staff have expressed anxiety about the Trust going back to the old way of working after the pandemic and some are struggling to cope with the temporary changes. Both the Signature Behaviour campaign and the Leadership Development programme will reflect learning from cross-functional working during the pandemic.

Overall, there has been pockets of excellence in our response to the pandemic, showing that as an organisation, we can be responsive and creative. There has also been concerns about staff and team resilience. Learning from these will serve as enabling strategies for delivering the culture change programme.
4.2 Visible top management engagement

Successful culture change relies heavily on senior management playing the key role of promoting, supporting and role modelling the right behaviour and values. Most importantly, senior management use their behaviour to set the tone for what is acceptable. This helps to inspire and engage staff at all level on required changes in culture. According to CultureIQ annual Top Company Culture programme award, confidence in senior leadership is the greatest differentiator when comparing culture change programme. Also, the need for Increased visibility from senior management was one of the specific feedbacks from the culture focus group.

Therefore, in addition to having the Trust Board support the Culture Change programme, the following will be arranged to ensure visible leadership for the culture change programme.

- The Chair and the CEO will lead the staff communication to launch the “campaign”
- The membership of the Culture Steering Group is currently been reviewed to include senior management staff from both corporate services and Care Groups and a wider representation from BME staff and service users/ carers.
- As a minimum, all road show events will be attended by a member of the senior management team or a member of Care Group leadership.
- The Culture Steering Group will meet with the leadership of all Care Groups and will provide joint staff briefing to support the culture change programme
- Care Groups and Corporate Services leadership team will be partly responsible for the delivery of the culture change programme in their service area.
- As part of the communication plan for the culture change programme, there will be regular vlog and written communication where leaders cross the Trust will share what behaviours the company values in its culture.
- Our communications will constantly and consistently reinforce these messages (see 4.3. below)

Whilst engaging all staff is key and changing hearts and mind at all levels is imperative, we will need to ensure that the Trust Board, Executive team, Care Group leadership teams, senior corporate staff and Governors fully understand and are committed to the culture change programme. The Culture Steering Group members will support this work in acting as ambassadors as do our staff-side colleagues working in the People Before Process group.

4.3 New organisational narrative

With 50 sites and over 4,000 staff, the culture change programme seeks to effect behavioural change on a large scale. A clear and consistent organisational narrative is therefore critical and will serve as a strong context for encouraging staff in different arms of the Trust and in different sites to follow the same everyday behaviour. Creating an organisational narrative as an enabler for the culture change programme will help refresh the alignment between the Trust strategy and its values. This will also help staff to have a stronger connection with the purpose and priorities of the Trust.

The purpose of the organisational narrative is to draw together a range of element to create a compelling story about the Trust – its history, purpose, vision, strategy, values and the context for

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1 The proposed approach is to run the culture change programme with the internal intensity of a campaign (actions, deadlines, deliverables) but without launching a new initiative to the organisation which it is felt would be counterproductive. The organisation needs to know and be constantly reminded that we are changing the culture but we will not badge it as a single initiative.
change – to inspire and give direction to staff and other stakeholders. It will describe the Trust's aspirational journey to achieving its strategic goals and to a new culture in an actionable format to drive engagement.

This will specifically address the findings about staff having concerns about the reputation of the trust and those that are unsure about the direction of travel of the Trust. This includes the frequently expressed concern about the "Norfolk-Suffolk divide" which requires a clear and strong statement on the integration journey.

A clear organisational narrative will help connect the Trust purpose to desired behaviours and therefore a cultural catalyst for change. It will strengthen connection and loyalty from staff and service users. It will help to create a coherent message about the Trust's relationship with staff, service users and carers. It will also encourage staff to see the organisation in a new light, and as a relationship to be explored and developed.

The process of co-creating a new organisational narrative for the Trust will be led by the Director of Communication and will involve staff from across the Trust. The scoping phase for this task has already commenced.

### 5.0 Measures

We will use a mix of quantitative and qualitative metrics to measure success and report on progress. The Culture Steering Group has a dashboard comprising these elements and which will be used to monitor and report progress to the Executive Team and Trust Board.

<table>
<thead>
<tr>
<th>Tasks Completion</th>
<th>Quantitative Metrics</th>
<th>Qualitative Metrics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Explanation</td>
<td>Explanation</td>
<td>Explanation</td>
</tr>
<tr>
<td>These are tasks and actions with an end date so we can monitor completion rate</td>
<td>Pulse Survey and Staff Survey</td>
<td>Thematic analysis of free text comments from staff surveys</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Workforce performance metrics - Vacancies, Turnover, Sickness Absence and other dashboard indicators</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Potential drawbacks</strong></td>
<td><strong>Potential drawbacks</strong></td>
<td><strong>Potential drawbacks</strong></td>
</tr>
<tr>
<td>Completion may not guarantee success</td>
<td>Other factors can affect the metrics e.g. national shortages of nurses.</td>
<td>Can be more subjective and less evidence based</td>
</tr>
<tr>
<td>However, we will know when we have completed an action and can review what further action needs to be taken</td>
<td>However, these objective metrics will give some indication as to whether the culture is changing</td>
<td>However, constant monitoring can provide general themes and what may be driving some of the quantitative metrics</td>
</tr>
</tbody>
</table>
### 6.0 Risks

Cultural inclinations are entrenched and tackling ingrained practices and behaviour is difficult. The interventions proposed have some risk of failure and as mitigation, the programme has been designed to include activities that will also serve as mitigations to the potential risks.

<table>
<thead>
<tr>
<th>Risk</th>
<th>Mitigating/Enabling Strategies</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Lack of buy-in from staff and managers</td>
<td>- Learning from the diagnostic phase and from previous change programmes has been captured, reflected in the design of the intervention, and will be referenced in all activities.</td>
</tr>
<tr>
<td>2. Lack of support from middle management</td>
<td>- Both the promotion of the culture change programme and planning of the roadshow will include dedicated sessions to engage middle-level managers.</td>
</tr>
<tr>
<td>3. Inadequate resources</td>
<td>- The programme has full Board and Executive team support as a priority agenda for the Trust. - Majority of the required activities will be internally resourced, and a robust procurement process will be followed for external support.</td>
</tr>
<tr>
<td>4. Conflicting organisational priorities</td>
<td>- The programme has full Board and Executive team support as a priority agenda for the Trust.</td>
</tr>
<tr>
<td>5. Poor or under-communication</td>
<td>- A dedicated Communication Plan has been developed for the programme. - The programme is supported by the Communication Team with direct input from the Director of Communication</td>
</tr>
<tr>
<td>6. Lack of leadership visibility</td>
<td>- This is covered under the enabling strategies for the programme with an activity plan in place to ensure leadership visibility</td>
</tr>
<tr>
<td>7. Seen as just another initiative</td>
<td>- The cultural change is embedded in everything we do and the next stage of will not be launched as a single campaign but as part of changing the fabric of the organisation - The involvement of staff and service users is critical</td>
</tr>
</tbody>
</table>
Appendices

Appendix 1: Key Milestones

<table>
<thead>
<tr>
<th>What are we going to need to do?</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Phase 1</strong></td>
<td></td>
</tr>
<tr>
<td>Confirm roles and membership of newly invigorated culture steering group</td>
<td>By June 2020</td>
</tr>
<tr>
<td>Establish a core values and behaviours framework to inform the design of the people management aspects of the Leadership Development programme based on case studies and learning from Covid - covering cross functional working, responsive leadership behaviours and engagement with staff.</td>
<td>By July 2020</td>
</tr>
<tr>
<td>Establish a leadership behaviour framework.</td>
<td>By July 2020</td>
</tr>
<tr>
<td>Design an approach to leadership development which can then guide the delivering the programme and answers the question: which leaders need development in what behaviours by when?</td>
<td>By July 2020</td>
</tr>
<tr>
<td>Develop a new narrative for the organisation and a strategy for how to roll it out.</td>
<td>By July 2020</td>
</tr>
<tr>
<td>Clarify the Signature Behaviours campaign – roadshows, engaging the care groups, engaging corporate services, describe the role of Freedom To Speak up and what the ask is of Change ambassadors in the Change team.</td>
<td>By July 2020</td>
</tr>
<tr>
<td>Design and implement a system to monitor the outcomes and review the implementation of the elements of the strategy including measuring realisation of the 6 key principles (i.e. demonstrable actions designed to address the key principles)</td>
<td>By July 2020</td>
</tr>
<tr>
<td>Design a strategy that will engage the care group leads and corporate services in what it means to be an NSFT leader and how they will be supported</td>
<td>By July 2020</td>
</tr>
<tr>
<td>Design strategy for embedding signature behaviours embed into all aspects of staff, service users and carers experience</td>
<td>By July 2020</td>
</tr>
<tr>
<td><strong>Phase 2</strong></td>
<td></td>
</tr>
<tr>
<td>Roll out the leadership development</td>
<td>By September 2020</td>
</tr>
<tr>
<td>Roll out the campaign</td>
<td>September 2020 - September 2021</td>
</tr>
<tr>
<td>Establish further programmes of work that will embed the other core areas of the culture change</td>
<td>By February 2021</td>
</tr>
<tr>
<td>Establish an oversight framework of the other key areas identified by the change team as being important to a culture of engagement: appraisals, appraisal training, career development, capacity, new staff roles, QI culture.</td>
<td>By December 2020</td>
</tr>
<tr>
<td>Review Leadership programme and make any changes to improve effectiveness</td>
<td>April 2021</td>
</tr>
<tr>
<td>Agree next promotion of signature behaviours and reiterate work on ensuring these are embedded (taking any learning from the initial promotion)</td>
<td>May 2021</td>
</tr>
</tbody>
</table>
Our values…Our behaviours…Our Future…

Framework of Behaviours

Our values and behaviours help us to check and measure our own ways of working. They also help us to guide others around what their services users and carers, their colleagues and our Trust expects of them.

We will…

Positively...

Be proactive…
Look for solutions, think creatively and focus on what we can do
Take pride…
Always do our best
Take responsibility…
Plan ahead, be realistic and do what we say we will
Support people to set and achieve goals…
And be the best they can
Recognise people…
Their efforts and achievements, and say thank you

We will not…

Focus on the problem…
Rather than the solution, make excuses or say “It’s not my job”
Be negative…
Take part in unkind gossip, moan or criticise
Avoid responsibility…
Make false promises, blame others or ‘pass the buck’
Abandon people…
Without a point of contact or advice
Devalue other’s efforts and achievements…
Take people’s contributions for granted or avoid giving praise

Respectfully…

Value everyone…
Acknowledge people’s unique experiences, skills and contribution
Step into other people’s shoes…
Notice what’s actually happening
Take time to care…
Be welcoming, friendly and support others
Be professional…
Respect people’s time and be aware of our impact
Be effective…
Focus on the purpose and keep it as simple as possible

We will not…

Undermine others…
Belittle, criticise, ‘nit pick’, ignore or dismiss other people’s expertise and input
Be insensitive…
Make assumptions, be judgmental or impose our views and feelings on to others
Be uncaring…
Unsupportive, unapproachable, distant or rude to others
Be unprofessional…
Be distracted, clock watch or lack awareness of our impact on others
Be obstructive…
Put up barriers, make things more complicated than they need to be

Together…

Involve people…
Make connections and learn from each other
Share…
Knowledge, information and learning
Keep people updated…
With timely, open and honest communication
Have two-way conversations…
Listen and respond
Speak up…
Seek, welcome and give feedback

We will not…

Ignore people…
Ignore wider views or show favouritism
Be defensive…
Keep knowledge, information or learning to ourselves
Leave people not knowing…
With vague, missing, incorrect or out-of-date information and communication
Tell instead of listen…
Impose and ‘do to’ people, ask for input but not follow through or explain decisions
Ignore problems…
Accept poor practice or dismiss feedback
Executive Summary:

The aim of this report is to provide the Trust Board with an update on key areas of the Trust’s strategic decision-making, planning and management. It is structured to provide information on:

- The national context.
- Our partnership working in local integrated care systems.
- Progress in developing the new Trust strategy.

The report contains a number of national news items that will be of interest to the Trust, as well as updates from our local systems. The report also provides an update on the implementation of the Trust strategy.

The report links to the risk 2.2 on the BAF.

Recommendation:

The Board is asked to discuss and discuss the contents of this report.
Strategic Activity Update

1.0 National Context: Emerging Themes, Policies and Initiatives

HM Government’s recovery strategy

On Sunday 10 May PM Boris Johnson last night unveiled a ‘conditional plan’ to reopen society with a new slogan to ‘Stay Alert’. This included:

• Unlimited exercise, some sports and meeting one other person outdoors to be allowed from Wednesday. 2m social distancing applies to members outside your household.
• Return to the workplace if you cannot work from home but avoid public transport (from Wednesday).
• A new Covid Alert System with five levels governing how quickly lockdown restrictions could be eased.
• Schools in England could re-open for some primary pupils from 1 June.
• June 1 could also involve re-opening shops but only if ‘supported by science’.
• Some businesses, hospitality and other public places reopening ‘if the numbers support it’ but not earlier than 1 July.

The Government’s recovery strategy was published on 11 May. This document describes the progress the UK has made to date in tackling the coronavirus (COVID-19) outbreak, and sets out the plans for moving to the next phase of its response to the virus.

The strategy sets out a cautious roadmap to easing existing measures in a safe and measured way, subject to successfully controlling the virus and being able to monitor and react to its spread. The roadmap will be kept constantly under review as the epidemic, and the world’s understanding of it, develops.

NHS “Open for Business”

NHS chief executive Sir Simon Stevens warned that delays in getting treatment due to coronavirus fears pose a long term risk to people’s health. The plea comes alongside new findings that four in ten people are too concerned about being a burden on the NHS to seek help from their GP.
Seeking medical help is one of the four reasons that people can safely leave home, in line with government guidance. And Sir Simon stressed that the NHS is still there for patients without coronavirus who need urgent and emergency services for stroke, heart attack, and other killer conditions.

England’s top cancer doctor has urged people not to hesitate to get checked as new research revealed that nearly half of the public have concerns about seeking help during the coronavirus pandemic. One in 10 people would not contact their GP even if they had a lump or a new mole which did not go away after a week, the survey found. Another third of people would worry about seeking help, according to polling carried out by Portland.

Getting coronavirus or giving it to their family were among the top reasons that people would not come forward when they have cancer symptoms along with fears that they could be a burden to the health service. Professor Peter Johnson, the NHS clinical director for cancer, stressed that NHS staff had worked hard to make sure people can get cancer checks and treatment safely so there is no need to delay.

NHS England is also encouraging people to attend all regular vaccination appointments to prevent outbreaks of serious diseases and reduce pressure on the health service.

The NHS is continuing to help people to manage illness linked to coronavirus but is still urging parents to bring children forward for lifesaving jabs to stop killer diseases like measles and mumps.

Applications to work in the NHS have jumped as the nation has backed nurses, doctors and countless other health workers battling coronavirus. Millions have shown their support for NHS staff and other key workers by taking to the streets for the weekly ‘clap for carers’. That support has also translated into a rise in people wanting to work in the health service with 407,000 applications submitted last month. That was an increase of 13,500 on the same month last year.

Care Quality Commission inspection regime

Hearing from people about their care has never been more important and the CQC are reviewing every whistleblowing concern they are receiving including those from people who use services and their families. They will continue to inspect and take action where mental health, learning disability and autism services are not protecting people’s human rights and providing poor care. A number of services remain in special measures and they are closely monitoring these and will be re-inspecting them as soon as possible.

The Emergency Support Framework (ESF) is part of the regulatory approach during the coronavirus (COVID-19) pandemic.
It provides a structured framework for the regular conversations that inspectors are having with providers and covers the following four areas:

- Safe care and treatment
- Staffing arrangements
- Protection from abuse
- Assurance processes, monitoring, and risk management

The information that is gathered through this route is a further source of intelligence that is used to monitor risk, identify where providers may need extra support to respond to emerging issues, and ensure they are delivering safe care which protects people’s human rights.

It aids understanding of the impact of coronavirus on staff and people using services, and where we may need to follow up directly with an inspection, or escalate concerns to regional, and national system partners where they are best placed to address.

These conversations also provide a forum for providers to talk through any tough decisions they need to take and for inspectors to offer targeted local advice where appropriate. The framework will be rolled out across all sectors but is initially being used with adult social care providers.

**Four new Integrated Care Systems approved**

The NHS and its partners will be able to ‘lock in’ improvements to their work by putting whole-system planning at the heart of coronavirus recovery plans, the NHS’s Chief Operating Officer said today.

The comments came as NHS England and NHS Improvement confirmed four new ‘integrated care systems’, together serving more than six million residents.

As part of the effort to respond to the COVID-19 health emergency, NHS and local government staff have been fast-tracking new technology, new partnerships and new ways of working, to make services easier and more convenient for residents.

*Integrated care systems* (ICSs) and, in other areas, sustainability and transformation partnerships have been central to the coordination and delivery of this response, bringing together hospitals, care homes, GPs and others to plan for immediate and future needs. This has included important initiatives between NHS and local government, such as mutual aid agreements.
A further four ICSs were confirmed, joining 14 previously announced plus two devolved health systems in Greater Manchester and Surrey. Taken together, around half of England’s population is now served by such a system.

This includes the whole of Yorkshire (with the confirmation of an ICS covering Humber, Coast and Vale) and all of London south of the river Thames (with South West London joining its neighbour in South East London). The two other partnerships confirmed are one covering Sussex, and another in Hertfordshire and West Essex.

2.0 New Care Models Collaborative

2.1 In mid-March the Collaborative agreed with NHS England that, due to the Covid-19 epidemic the timescales for the transfer of commissioning responsibilities would be amended. The contract is now due to transfer in April 2021 rather than October 2020.

2.2 There has been a reduction in focus on New Care Models during the first few weeks of the epidemic, but the financial due diligence work has continued. NHSE/I remain committed to the programme and is committed to seeing the full Provider Collaborative model implemented as soon as system pressures permit. In recent days the clinical design groups for each of the Collaborative’s service areas have reconvened remotely and begun to discuss the potential impact that the epidemic will have on the models that have been developed.

2.3 The Collaborative has continued to work closely and has agreed a collective approach to the crisis. Each member will support the others should their specialist services be unable to manage the volume of Covid-positive service users in their care.

3.0 Suffolk Mental Health Alliance

3.1 Throughout the Covid crisis there has been a high level of collaboration across providers, commissioners and third sector representatives. The urgency to change the way services are delivered to enable them to sustain through the pandemic has enabled planned improvements to move at pace. The requirement to implement a 24 hour, seven day a week mental health helpline as part of the Covid response meant that the planned Crisis First Response Line was brought forward, and implemented across Suffolk and Norfolk in a collaboration between NSFT and commissioners. Mental health staff have been made more available to primary care, and people with a lower level of acuity are being supported by third sector partners. Plans are now in place to
proceed with additional primary care pilots, and the wider transformation programme is now resuming.

4.0 Norfolk & Waveney STP

4.1 A series of mental health projects have been established in response to Covid-19. As well as the 24/7 helpline referenced above, these involve the adaptation of services to ensure they are sustainable through the pandemic, enhanced community support models and improved access to support and advice for children, families and young people. As in Suffolk, we have worked collaboratively as a system, sharing resources where possible to enable necessary changes to progress swiftly.

5.0 Trust strategy

5.1 The Trust’s process for developing the annual plan for 2020/21 has been disrupted by COVID-19. The implementation of the NHS Long Term Plan has been suspended, the Trust’s annual plan engagement event was cut short, and contract discussions with commissioners stopped.

5.2 Despite that disruption the senior leadership teams and Trust Board have continued to discuss the priorities for the year, which have been amended in light of COVID-19.

5.3 There are seven annual plan priorities as follows:

1. To save lives and prevent suffering and ensure the health and wellbeing of staff and people in the communities we serve during the COVID-19 outbreak and implementing effective plans for recovery and development.

2. Continuing to develop the culture of the organisation through implementing our People Participation Strategy, and our culture and leadership, staff engagement, wellbeing and inclusion programmes.

3. Further development of clinical leadership across the organisation, and developing clinical services in line with COVID priorities, the Long Term Plan and local commissioner priorities.

4. Providing effective care closer to home, through further reductions in out of area placements and focus on delayed transfer of care.

5. Improvements in access, physical environments and medication management.

6. Financial sustainability – working within national guidance during COVID, and then delivery of a Trust plan for the remainder of 2020/21, as well as working with partners to achieve system priorities.
7. Developing our role in our local systems, ensuring that system working adds value and leads to improved quality of life for the people we serve, and improving our approach to wider partnership working, in particular with the voluntary sector and local community groups.

5.4 The feedback received from the annual plan engagement exercise will be discussed with the Council of Governors in order to inform the Council’s priorities for the year.

5.5 The Trust’s quality, performance and risk management systems are being adapted to take account of the above priorities and the current focus on COVID-19.

5.6 The priorities will be updated throughout the year as the Trust develops and implements its COVID-19 recovery plan.

6.0 Partnership working

6.1 In line with the annual plan priorities, there is increased focus on partnership working across the Trust, and COVID-19 has also acted as a catalyst to work more closely with our partners, stakeholders and local communities.

6.2 The central coordination of this work is led by the Deputy CEO/Director of Strategic Partnerships, who is now supported by Naomi Farrow.

6.3 In April 2020 the following contacts were made:

- Norfolk Community Foundation
- Healthwatch Norfolk
- Voluntary Norfolk
- Norfolk CCG Colleagues
- Evolve
- Wells Community Hospital,
- Sing Your Heart Out
- The Nurture Project
- Athena Education & Support
- Community Action Norfolk
- Suffolk Community Foundation

6.4 A common theme from discussions is the need to share information about the Trust and the services it provides, establishing clear lines of communication, as well as the opportunity to obtain
a wider range of feedback about Trust services. An initial meeting has been held with the Communications Department to consider how we can support this work.

6.5 Further meetings are planned for May and Governors and Care Groups have also been asked to identify local groups.

6.6 Updates on this work will be included in this report as a standing item going forward, and it is also planned to have a board development session on partnership working.
Executive Summary:

The purpose of this report is to provide information on Trust wide performance against a range of key performance indicators for the period to 31st March 2020 and the financial performance as at 30th April 2020.

The information contained within this report is to identify areas for improvement, and to ensure NSFT delivers effective and efficient care for its service users.

Operational Performance

Care Planning – The percentage of Service users allocated to either a CPA or Non CPA level was 93.3% and 1.7% under the 95% target.

Under CPA Completeness 86.0% of service users had four or more components present; under nCPA Completeness 77.5% of service users had four or more components present. Discussions to replace this metric with a qualitative measure have been delayed due to the COVID situation.

Waiting Times – Challenges with achievement of waiting times to assessment targets remain. Emergency waits are down from 84.2% in March’s report to 81.2%. Whilst routine waits at 75.3% are similar to the 75.0% in March’s report.

Overall 95.6% of people were seen for their first treatments within 18 weeks in March 2020. However, 438 people waited longer than 18 weeks for treatment as at the end of March 2020.

The Trust has three Contract Performance Notices outstanding for failure to meet waiting time standards; assurances remain from Commissioners that financial sanctions will not be taken.

Care Groups continue to work on Remedial Action Plans to address waiting time performance, and these will be tracked through the ongoing Quality and Performance Meetings. A review of the policy for downgrading referrals appropriately is also underway.

Delayed Transfers of Care (DToC) - Delayed Transfers of Care (DToC) have deteriorated slightly and are 0.6% higher than target for March 2020. DToC’s in Norfolk and Waveney, largely driven by delays within older people services, account for 85.3% of DToC days reported in March 2020.
Inappropriate Out of Area Placement (OAP) bed days - Inappropriate OAP bed days for adult mental health services reported at 869, which was 596 bed days over target. OAPs in Norfolk and Waveney account for 99% of the bed days reported in January 2020.

Local commissioner specific metrics

- The Norfolk and Waveney Wellbeing service was 2.9% under the cumulative IAPT access target for the 19/20 financial year. Performance for Qtr. 4 was 4.5%, which was 0.15% (151 people) under target of 4.75%. The decrease in number entering treatment in March (1.33% vs 1.65% in February) is partially attributable to the impact of the COVID situation.
- In Suffolk 75.0% of people under 19 with an eating disorder received NICE-approved treatment within 1 week for urgent cases, which was 9% below the locally agreed 84.0% target. In Norfolk and Waveney 90.0% of people under 19 with an eating disorder received NICE-approved treatment within 4 weeks for routine cases, which was 5% below the national 95% target.
- In Suffolk the Psychiatric Liaison emergency referrals seen within 1 hour reported at 82%, 13% under the 95% target. In Central Norfolk Psychiatric Liaison emergency referrals seen within 1 hour reported at 86.8%, 3.2% under the 90% target.
- In Suffolk the % of inpatients admitted with a mental illness who received a physical health check was reported at 70.5% against a target of 95%.
- In Suffolk the % of LD Service users who have an up to date appropriate care plan reported at 88.0%, which is 7.0% below target.
- In Suffolk the % of patients having a total time in the Emotional Wellbeing Hub (aged under 25) from point of referral to discharge within 10 working days reported at 66.1% for March 2020. This was a 19.6% improvement on February 2020, and reflects the progress in clearing the backlog, allowing more recent referrals to be discharged on a timely basis.
- In the Suffolk Youth Autism service none of the seven service users assessed received an assessment within 13 weeks of referral, there is ongoing capacity and demand work being undertaken with commissioners.
- In Norfolk and Waveney the % of DIST urgent referrals assessed within standard reported as 86.4% in Central and West areas and 83.3% in Great Yarmouth & Waveney, a 4.4% and 16.7% reduction from February 2020 respectively.
- Having been under significant focus, the Suffolk Eating Disorders service for under 19-year olds continues to show improvement in both one week urgent referrals and four week routine referrals, with 75.0% and 100.0% of cases respectively receiving NICE-approved treatment within target.

Finance Performance

- The position for the month was breakeven which was in line with annual plan.
- Out of Trust (OOT) placements expenditure was £0.4m in April.
- Secondary commissioned placements expenditure was £0.3m in April.
- The spending on agency staffing was over the NHS Improvement agency cap for the month.
- Cash held by the Trust at 30th April 2020 was £41.9m.
- The 2020/21 CIP target of £6.5m is forecast to be delivered in full.

The full performance and finance reports were discussed at the Finance and Business Investment Committee on 18th May 2020.
Section A (i): Operational Performance Indicators not achieved in the period
This section summarises the indicators which were not achieved in the period to the end of March 2020.

<table>
<thead>
<tr>
<th>Area</th>
<th>Indicator</th>
<th>Indicator Reference</th>
<th>Target</th>
<th>Actual</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>OF</td>
<td>Inappropriate out of area placements (bed days) for adult mental health services</td>
<td>OP09</td>
<td>273</td>
<td>869</td>
<td>293</td>
</tr>
<tr>
<td>WAITS</td>
<td>Emergency referrals assessed within 4 Hours</td>
<td>OP11</td>
<td>95%</td>
<td>81.23%</td>
<td>1.63%</td>
</tr>
<tr>
<td>WAITS</td>
<td>Routine referrals assessed within 28 days</td>
<td>OP12</td>
<td>95%</td>
<td>75.25%</td>
<td>2.73%</td>
</tr>
<tr>
<td>WAITS</td>
<td>Referrals treated within standard</td>
<td>OP13</td>
<td>95%</td>
<td>93.68%</td>
<td>1.22%</td>
</tr>
<tr>
<td>WAITS</td>
<td>Referrals awaiting treatment &gt;18 weeks</td>
<td>OP14</td>
<td>0</td>
<td>438</td>
<td>54</td>
</tr>
<tr>
<td>CPA</td>
<td>Service users allocated to either a CPA or Non CPA level</td>
<td>OP17</td>
<td>95%</td>
<td>93.31%</td>
<td>0.61%</td>
</tr>
<tr>
<td>CPA</td>
<td>CPA Service Users Completeness</td>
<td>OP18</td>
<td>95%</td>
<td>69.73%</td>
<td>1.63%</td>
</tr>
<tr>
<td>CPA</td>
<td>Non CPA Service Users Completeness</td>
<td>OP19</td>
<td>95%</td>
<td>49.87%</td>
<td>0.38%</td>
</tr>
<tr>
<td>INPAT</td>
<td>Inpatients whose transfer of care was delayed</td>
<td>OP20</td>
<td>7.5%</td>
<td>8.09%</td>
<td>0.63%</td>
</tr>
<tr>
<td>INPAT</td>
<td>Long-term inpatients that have received an annual Physical health check</td>
<td>OP21</td>
<td>100%</td>
<td>98.0%</td>
<td>0%</td>
</tr>
<tr>
<td>INPAT</td>
<td>Medium Secure Bed Occupancy Rate (including leave)</td>
<td>OP22</td>
<td>90%</td>
<td>80.96%</td>
<td>10.85%</td>
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<tr>
<td>INPAT</td>
<td>Low Secure Bed Occupancy Rate (including leave)</td>
<td>OP23</td>
<td>90%</td>
<td>89.87%</td>
<td>0.96%</td>
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<tr>
<td>INPAT</td>
<td>Women’s Secure Service Bed Occupancy Rate (Inc. leave)</td>
<td>OP24</td>
<td>95%</td>
<td>72.98%</td>
<td>2.51%</td>
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<tr>
<td>INPAT</td>
<td>No. of Adult Acute inpatients with Length of Stay &gt;117 days</td>
<td>OP25</td>
<td>0</td>
<td>16</td>
<td>1</td>
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<tr>
<td>INPAT</td>
<td>Patients requiring acute care who received a gatekeeping assessment</td>
<td>OP26</td>
<td>95%</td>
<td>93.98%</td>
<td>3.22%</td>
</tr>
<tr>
<td>LOCAL</td>
<td>Suffolk Under 19’s with an eating disorder receiving NICE-approved treatment within 1 week for urgent cases</td>
<td>OP15a</td>
<td>84%</td>
<td>75.00%</td>
<td>25.00%</td>
</tr>
<tr>
<td>LOCAL</td>
<td>Suffolk Psychiatric Liaison - Emergency referrals seen within 1 hour</td>
<td>OP28a</td>
<td>95%</td>
<td>82.00%</td>
<td>3.05%</td>
</tr>
<tr>
<td>LOCAL</td>
<td>Active Referrals with no activity recorded within 9 months</td>
<td>OP40a</td>
<td>4.0%</td>
<td>4.51%</td>
<td>0.66%</td>
</tr>
<tr>
<td>LOCAL</td>
<td>All patients admitted with a mental illness should receive a physical health check</td>
<td>OP41a</td>
<td>95%</td>
<td>70.49%</td>
<td>5.37%</td>
</tr>
<tr>
<td>LOCAL</td>
<td>Suffolk Learning Disability Service users have an up to date appropriate care plan</td>
<td>OP42a</td>
<td>95%</td>
<td>87.97%</td>
<td>0.35%</td>
</tr>
<tr>
<td>LOCAL</td>
<td>Suffolk CMAS Service - Time from referral to first assessment within 6 weeks</td>
<td>OP44a</td>
<td>95%</td>
<td>39.39%</td>
<td>5.08%</td>
</tr>
<tr>
<td>LOCAL</td>
<td>Suffolk CMAS Service - The diagnosis is given within 12 weeks of referral, unless any further specialist assessments or investigations are required</td>
<td>OP45a</td>
<td>95%</td>
<td>14.52%</td>
<td>4.53%</td>
</tr>
<tr>
<td>LOCAL</td>
<td>Suffolk EWH Patients will have a total time in the Hub from point of referral to discharge (encompassing Screening, triage and discharge) of 10 working days</td>
<td>OP51a</td>
<td>95%</td>
<td>66.11%</td>
<td>19.59%</td>
</tr>
<tr>
<td>LOCAL</td>
<td>Suffolk Youth Autism services (ages 0-18): 13 Weeks from Referral to Assessment in accordance with NICE guidance</td>
<td>OP52a</td>
<td>95%</td>
<td>0.0%</td>
<td>0.0%</td>
</tr>
<tr>
<td>LOCAL</td>
<td>Norfolk and Waveney IAPT: Proportion of people that enter treatment</td>
<td>OP10b</td>
<td>19%</td>
<td>16.10%</td>
<td>0.36%</td>
</tr>
<tr>
<td>LOCAL</td>
<td>Norfolk and Waveney Under 19’s with an eating disorder receiving NICE-approved treatment within 4 weeks for routine cases</td>
<td>OP16b</td>
<td>95%</td>
<td>90.0%</td>
<td>10.69%</td>
</tr>
<tr>
<td>LOCAL</td>
<td>Psychiatric Liaison - Emergency referrals seen within 1 hour (NNUH Psy Liaison only)</td>
<td>OP28</td>
<td>90%</td>
<td>86.81%</td>
<td>3.49%</td>
</tr>
<tr>
<td>LOCAL</td>
<td>DIST urgent referrals assessed within standard (120 hours Central &amp; West CCG’s Only)</td>
<td>OP31b(i)</td>
<td>95%</td>
<td>86.44%</td>
<td>4.38%</td>
</tr>
<tr>
<td>LOCAL</td>
<td>DIST urgent referrals assessed within standard (72 hour GY&amp;W Only)</td>
<td>OP31b(ii)</td>
<td>95%</td>
<td>83.33%</td>
<td>16.67%</td>
</tr>
</tbody>
</table>
Community Performance

Wait to Assessment Metric 4 hours and 28 days

Performance

The COVID situation has had an impact on the Trust in the reported period. March 2020 new secondary care external referrals (excluding IAPT) were 19% lower than March 2019. Chart 1 demonstrates this downward trend seen in 2020 to March which is not expected to continue indefinitely. In response to the situation services have reviewed the way in which they deliver assessments and treatments in order to protect service users and staff.

Chart 1

New Secondary Care External Referrals - 2020

Emergency referrals assessed within 4 hours are reported under target at 81.2%. This is a 1.6% reduction on the reported performance for February. As chart 2 demonstrates the system will be expected to consistently fail this target. Performance has fallen for the last two months after a period of improvement in special cause variation.

Chart 2

Routine (non-emergency) referrals assessed within 28 days reported under target at 75.3%, a 2.6% reduction on February’s reported performance.
Actions

In response to the COVID situation NSFT have introduced the following changes when delivering assessments and treatments in order to protect service users and staff:

- Minimised face-to-face contacts with service users to those in crisis and only where it is deemed necessary
- NSFT has set up a 24/7 helpline offering immediate support for people with mental health difficulties during the coronavirus pandemic. The Freephone number, which is staffed by mental health professionals from the Trust and is available to members of the public of any age, will provide reassurance, self-help advice, support and signposting designed to prevent people from going to the region’s emergency departments (EDs) during the COVID situation
- Introducing a new video consultation platform, Attend Anywhere (AA) across secondary care services. This provides a secure way to remotely triage, monitor and evaluate patients with the ability to add additional participants, such as another healthcare professional, as needed and agreed with the patient

These new ways of working will be reviewed and any learning will be carried forward after the COVID situation to inform how the Trust wishes to deliver assessments and treatments in the future.

Wait to Treatment Metric

Performance

The number of service users waiting for treatment greater than 18 weeks is reporting 438 incomplete waits, which equates to 10.6% of all incompletes. This is an increase of 54 when compared to February 2020. Of the 18 week waits c70% are attributable to two areas:

- 225 (51.4%) relate to CFYP services in Norfolk and Waveney, up 19 from 206 in February 2020
- 87 (19.9%) relate to ADHD services in Suffolk, up 15 from 72 in February 2020

Chart 4 demonstrates the system will be expected to consistently fail this target and that performance is now reporting as a cause for concern in special cause variation.
Chart 4

Referrals treated within standard reported under target at 93.7%, a 1.2% reduction on February’s reported performance. This is primarily attributable to referrals to under 18’s which reported at 85.0% compared to 95.2% for 18 and overs referrals in March 2020.

As chart 5 demonstrates the KPI is reporting a cause for concern in special cause variation.

Actions

Across the Trust the CFYP Rapid Improvement Groups for both counties will continue to work in partnership with each local system to improve services and implement the Quality Improvement Plan. These will focus on access and waiting times and will be supported by our newly appointed Improvement Director.

Demand for children, families and young people’s services has grown over the last few years both locally and nationally. The most recent CQC report highlighted the need to improve our services to children, families and young people across Norfolk and Suffolk. In response CFYP services in Norfolk and Waveney will be divided into two distinct Care Groups to reflect growing demand. One will focus on specialist services; early intervention, eating disorders, Kingfisher and Dragonfly wards and perinatal support, whilst the other will be responsible for core children and families and youth pathways, crisis and local authority commissioned services and ADHD support.

In Suffolk ADHD services waits are being impacted by the closure of schools and limitations of face to face consultations in response to the COVID situation. However this hoped to be mitigated by the use of video conferencing solutions like Attend Anywhere (AA) and Zoom. Additional consultant time is now available to the service which will utilise on reducing the numbers of service users waiting.
**CPA and Non CPA completeness**

**Performance**
The percentage of Service users allocated to either a CPA or Non CPA level was 93.3%, a 1.4% improvement on the reported performance 12 months previous but 1.7% under the 95% target. CPA (Care Programme Approach) completeness (all 5 items required are completed within the service user electronic record) was reported 69.7%, a 2.3% improvement on the reported performance 12 months previous. Of the 1,439 CPA service users across the Trust not meeting this standard 53.6% had 4 of the required CPA items present, therefore 86.0% of service users had four or more components present. Non CPA completeness was 49.0%, a 0.5% reduction on the reported performance 12 months previous. Of the 5,045 Non CPA service users across the Trust not meeting this standard 56.0% had 4 of the required Non CPA items present, therefore 77.5% of service users had four or more components present.

Charts 6 and 7 demonstrate the system will be consistently expected to fail this target unless significant actions are taken to address performance.

**Chart 6**

![Care Programme Approach (CPA): CPA Service Users Completeness](chart)

**Chart 7**

![Care Programme Approach (CPA): Non CPA Service Users Completeness](chart)

**Actions**
The rollout of Dialog+ safety planning has been paused until the autumn 2020 due to COVID. The early adopter sites will continue. The Trust has progressed an alternative measure for Care Planning using a toolkit as part of the Clinical Audit schedule. The measure is still to be finalised for the contracts in 2020/21 where negotiations have been delayed due to COVID but has previously been approved by Care Groups and Commissioners. The audit schedule will be reported outside of FBIC.
Inpatient Performance

In response to the COVID situation 16 beds on Blickling ward at the Julian Hospital in Norwich, with the potential of more, opened on Good Friday. A further six beds have been allocated on Eaton ward at Northside. Existing wards Yare, Avocet and Southgate have been allocated for nursing patients with coronavirus symptoms. These have been created or allocated to help manage care safely during the pandemic.

Inappropriate Out of Area Placements (OAP) bed days for adult mental health services

Performance

Chart 8 demonstrates inappropriate OAP bed days for adult mental health were 596 bed days above target for March 2020. OAPs in Norfolk and Waveney account for 99% of the 869 bed days reported in March 2020. No one factor has stood out to explain the increase seen since January 2020 however, increased length of inpatient stays on NSFT inpatient wards linked to increased delayed transfers of care and higher acuity in the community were contributing factors.

Chart 8

![Chart 8: Inappropriate out of area placements (bed days) for adult mental health services]

Actions

At the end of March 2020 an Integrated Discharge Team (IDT) was introduced; an NSFT, commissioners and Norfolk County Council partnership. The IDT will focus on prioritising discharge planning for patients who are safe to be discharged from NSFT inpatient wards. Provisional performance for April 2020 shows a 27% reduction to 632 OAP bed days for the month.

NSFT have directly commissioned 16 beds at Southern Hills Hospital in Norfolk to enable the opening of Yare Ward as a full COVID ward, supporting the safety of patients during the COVID incident. Both Yare Ward and Southern Hills have 16 beds. Being local and within Norfolk County, Southern Hills enables patients from Norfolk and Waveney to maintain contact with care teams and families and with the support from a Matron employed by NSFT 2 days per week. These beds are not considered as inappropriate out of area due to the close county links and the ability to maintain connection with local care teams and families.

Inpatients whose transfer of care was delayed

Performance

Chart 9 demonstrates that delayed transfers of care (DToC) across NSFT remain a cause for concern. Delayed Transfers of Care (DToC) are 0.6% above target for March 2020 after the target was met in February 2020. DToC’s in Norfolk and Waveney, largely driven by delays within older people services, account for 85.3% of DToC days reported in March 2020.
Chart 9

Inpatients whose transfer of care was delayed

Actions
The newly formed Integrated Discharge Team (IDT) are carrying out a range of actions to reduce DToCs including; daily IDT meetings to establish actions for the day and to offer a single joined up route of escalation, RAG rated patient progress list and a twice weekly virtual ward rounds of every ward within NSFT, focusing on discharge plans, actions, owners and adopting the "check and Challenge" ethos. Provisional performance for April 2020 shows performance at 6.42%; under the 7.5% target.

Number of Adult Acute inpatients with Length of Stay > 117 days

Performance
The number of Adult Acute inpatients with Length of Stay > 117 days decreased by 1 to 16 (11 in Norfolk & Waveney and 5 in Suffolk) as at the end of March 2020. These numbers are impacted by Delayed Transfers of Care (DToC) and more complex service users with challenging behaviours such as dual diagnosis, severe psychotic depression and ongoing psychosis.

Patients requiring acute care who received a gatekeeping assessment

Performance
The % of patients requiring acute care who received a gatekeeping assessment reported 1.0% (5 admissions) under target for March 2020. This is after 11 consecutive months of the target being met. Nationally this KPI is under consultation with a view to remove as NHS England and NHS Improvement believe that the gatekeeping measure is no longer reflective of modern practice. NHSE/I are to develop an alternative indicator to measure meaningful contacts with CRHTs prior to any admission.

Secure Service Bed Occupancy

Performance
The Low Secure inpatient unit reported 0.13% beneath its commissioned occupancy target of 90%, for the second consecutive month, equating to four unoccupied beds. The Medium Secure inpatient unit reported 9.0% beneath its commissioned occupancy target of 90%, after meeting the target in February, equating to nine unoccupied beds. The Women’s secure unit reported 73.0% occupancy equating to four unoccupied beds, this was 22.0% below and has not achieved target for the past 12 months.

Long-term inpatients that have received an annual physical health check

Performance
The 98.0% performance equated to one breach reported on Thurne ward which is being followed up by the service.

Local Commissioner Specific Metrics
**IAPT Access metric**

**Performance**

The Norfolk and Waveney Wellbeing service was 2.9% under the cumulative IAPT access target. The cumulative target is based on achieving the commissioned 19% annual target in Norfolk and Waveney by the end of the 2019/2020 financial year. Performance for March 2020 was 1.33%, which added to the 1.62% achieved in January 2020 and the 1.65% achieved in February 2020 meant the service was 0.15% (151 people) under the quarter 4 2019/20 trajectory target of 4.75%. The decrease in the numbers entering treatment in March is attributable to the impact of COVID. All IAPT services within East of England have noted a reduction in those entering treatment by at least 50% since the start of the COVID situation. Further analysis will focus on the impact and new ways of working have been explored.

**Actions**

In response to the current COVID situation NHS England has waived the requirement for IAPT services to be performance managed against this measure in Quarter 1 of 2020/21. In addition to the existing action plan, since the COVID outbreak, the service is now carrying out all of its one-to-one clinical work using video calls, the phone or instant messaging, depending on the service user’s preference. The service has been carrying out media publicity via radio and online outlets highlighting that the service remains open and the prioritisation of NHS workforce for assessment and treatment in the context of dealing with COVID.

**Eating Disorders Wait to Treatment Metric**

**Performance**

In Suffolk 75.0% of young people under 19 with an eating disorder received NICE-approved treatment within 1 week for urgent cases, which was 9.0% below the locally agreed 84.0% target. The expectation nationally was that CYP Eating Disorder services would have achieved the 95% target by Q4 2019/2020. In Norfolk and Waveney, the 90.0% of young people under 19 with an eating disorder received NICE-approved treatment within 4 weeks for routine cases, this is 5% below the national 95% target. This equates to 3 breaches out of 30. A clear action is in place which has been co-produced with NHS England and wider Suffolk stakeholders.

**Psychiatric Liaison Emergency Wait to Assessment**

**Performance**

In Suffolk the Psychiatric Liaison emergency referrals seen within 1 hour reported at 82%, 13% under the 95% target but a 3.1% improvement from February 2020. This target has not been met in the previous 12 months. In Central Norfolk Psychiatric Liaison emergency referrals seen within 1 hour reported at 86.8%, 3.2% under the 90% target and a 3.5% reduction from February 2020.

**Dementia Intensive Support Teams (DIST)**

**Performance**

In Norfolk and Waveney the % of DIST urgent referrals assessed within standard reported as 86.4% in Central and West areas and 83.3% in Great Yarmouth & Waveney, a 4.4% and 16.7% reduction from February 2020 respectively.

**Physical Health Checks at admission**

**Performance**

In Suffolk the % of inpatients admitted with a mental illness who received a physical health check was reported at 70.5%, a 5.4% reduction on February 2020, against a target of 95%

**Learning Disability (LD)**
Performance

In Suffolk the % of LD Service users who have an up to date appropriate care plan reported at 88.0%, a 5.4% reduction on February’s performance.

Community Memory Assessment Service (CMAS)

Performance

In East Suffolk the % of CMAS service users assessed within 6 weeks of referral and the % who had received a diagnosis within 12 weeks of referral reported at 39.4% (an increase of 5.1% from February) and 14.5% (a drop of 4.5% from February) respectively in March 2020. The Service reports that the majority of breaches relate to either service user’s choosing to have assessment outside of the 6 week timeframe or appointments being delayed to support the service user and carer needs. This is being further evaluated.

Emotional Wellbeing Hub (EWH)

Performance

In Suffolk the % of patients having a total time in the Emotional Wellbeing Hub (for service users aged under 25) from point of referral to discharge (encompassing Screening, triage and discharge) within 10 working days reported at 66.1% for March 2020. This was 19.6% improvement on February 2020.

Youth Autism Service

Performance

In Suffolk none of the service users out of seven cases aged 0-18 received an assessment within 13 weeks of referral due to focus on assessing those who have had the longest wait.

Active Referrals with no activity recorded within 9 months

Performance

In Suffolk the % of active referral with no activity recorded reported at 4.5%, 0.5% above target and a 0.66% increase from February 2020. This comes after the target has been met in the previous 8 months. This is being addressed via the current risk stratification process being undertaken to support service provision during the Covid pandemic.
Section B: Financial performance in the period – April 2020

Our financial position is as follows:

<table>
<thead>
<tr>
<th>STATEMENT OF COMPREHENSIVE INCOME (SOCCI)</th>
<th>YEAR TO DATE</th>
<th>FULL YEAR</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Annual Plan</td>
<td>Actual</td>
</tr>
<tr>
<td></td>
<td>£'000</td>
<td>£'000</td>
</tr>
<tr>
<td>Operating Income</td>
<td>(22,125)</td>
<td>(22,219)</td>
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<tr>
<td>Pay Costs (Substantive, Bank &amp; Overtime)</td>
<td>14,946</td>
<td>15,613</td>
</tr>
<tr>
<td>Agency &amp; Locum Costs</td>
<td>824</td>
<td>917</td>
</tr>
<tr>
<td>Drugs Costs</td>
<td>200</td>
<td>225</td>
</tr>
<tr>
<td>Other Costs</td>
<td>5,189</td>
<td>4,566</td>
</tr>
<tr>
<td>EBITDA</td>
<td>966</td>
<td>898</td>
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<tr>
<td>Depreciation</td>
<td>675</td>
<td>597</td>
</tr>
<tr>
<td>Non Operating Income</td>
<td>(13)</td>
<td>(6)</td>
</tr>
<tr>
<td>Non Operating Expenses</td>
<td>304</td>
<td>287</td>
</tr>
<tr>
<td>Net surplus / (deficit)</td>
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<td>20</td>
</tr>
<tr>
<td>EBITDA margin</td>
<td>4%</td>
<td>4%</td>
</tr>
</tbody>
</table>

OUT OF TRUST & SECONDARY COMMISSIONED PLACEMENTS
Total OOT bed days decreased from 757 in March to 614 in April. Total expenditure for the month was £0.4m.

Secondary commissioned placements spend was £0.3m.

TEMPORARY STAFFING
The NHS Improvement (NHSI) Trust agency spending cap has been set to the same limit as 2019/20 at £10.3m.

The following table provides a summary on overall temporary staffing spend.
The key booking reason for agency for qualified nursing and medical staff is unfilled vacancies.

<table>
<thead>
<tr>
<th>ACTUAL SPEND £'000s</th>
<th>APRIL</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Agency</td>
<td>Bank</td>
</tr>
<tr>
<td></td>
<td>Core</td>
<td>Covid</td>
</tr>
<tr>
<td>Medical</td>
<td>475</td>
<td>-</td>
</tr>
<tr>
<td>Qualified nursing</td>
<td>239</td>
<td>70</td>
</tr>
<tr>
<td>Unqualified nursing</td>
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<td>35</td>
</tr>
<tr>
<td>Clinical A&amp;C</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Scientific &amp; Therapeutic</td>
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<td>-</td>
</tr>
<tr>
<td>Corporate</td>
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<td>8</td>
</tr>
<tr>
<td>NSFT Annual Plan</td>
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<tr>
<td>NHSI Cap</td>
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</table>

CIP
The agreed CIP target for 2020/21 submitted in the revised Annual Plan is £6.5m, and this is expected to be achieved in full.
CASH FLOW
As at the end of April, the Trust held cash and cash equivalents of £41.9m, which was £24.9m ahead of annual plan, due to £21.3m of May block income received in April.

CAPITAL SPEND
The total capital spend YTD is £0.4m against the planned capital spend of £9.2m.

Risks / mitigation in relation to the Trust objective
In order to achieve the control total, the following areas need to be closely monitored and controlled.

(i) Agency and locum spend
(ii) Directorates managing their financial performance
(iii) Delivery of CIP programme
(iv) Impact of Covid-19 on costs incurred, including the availability of staffing
(v) OOT & Specialist Placements missing trajectory

There is still uncertainty regarding the national financial framework that will be implemented post July 2020, but the Trust is working with local and regional partners to ensure the interests and mental wellbeing of our communities are being fully considered.

Recommendations
The Board is asked to review and note the report.
## Appendix 1: Operational Performance Dashboard March 2020

### NHS Oversight Framework KPI's

<table>
<thead>
<tr>
<th>Indicator Description</th>
<th>Reference</th>
<th>Reporting Period</th>
<th>Target</th>
<th>Current Performance</th>
<th>Change</th>
<th>Performance Tracker</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>People with a first episode of psychosis begin treatment within 2 weeks of referral</td>
<td>OP01</td>
<td>Rolling 3 months</td>
<td>56%</td>
<td>72.22%</td>
<td>1.85%</td>
<td><a href="#">Tracker</a></td>
<td><strong><a href="#">Trend</a></strong></td>
</tr>
<tr>
<td>Ensure that cardio-metabolic assessment and treatment for people with psychosis is delivered routinely:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a) in inpatient wards</td>
<td>OP02</td>
<td>Annual</td>
<td>90%</td>
<td>20.83%</td>
<td></td>
<td><a href="#">Tracker</a></td>
<td><a href="#">Trend</a></td>
</tr>
<tr>
<td>b) early intervention in psychosis services</td>
<td>OP03</td>
<td>Annual</td>
<td>90%</td>
<td>43.59%</td>
<td></td>
<td><a href="#">Tracker</a></td>
<td><a href="#">Trend</a></td>
</tr>
<tr>
<td>c) community mental health services (people on Care Programme Approach)</td>
<td>OP04</td>
<td>Annual</td>
<td>65%</td>
<td>45.45%</td>
<td></td>
<td><a href="#">Tracker</a></td>
<td><a href="#">Trend</a></td>
</tr>
<tr>
<td>Data Quality Maturity Index (DQMI) – MHSDS dataset score</td>
<td>OP05</td>
<td>Quarterly</td>
<td>95%</td>
<td>97.03%</td>
<td>0.36%</td>
<td><a href="#">Tracker</a></td>
<td><strong><a href="#">Trend</a></strong></td>
</tr>
<tr>
<td>IAPT: Proportion of people completing treatment who move to recovery</td>
<td>OP06</td>
<td>Quarterly</td>
<td>50%</td>
<td>56.50%</td>
<td>1.84%</td>
<td><a href="#">Tracker</a></td>
<td><a href="#">Trend</a></td>
</tr>
<tr>
<td>IAPT: waiting time to begin treatment (from IAPT minimum data set) within 6 weeks</td>
<td>OP07</td>
<td>Rolling 3 months</td>
<td>75%</td>
<td>94.81%</td>
<td>0.54%</td>
<td><a href="#">Tracker</a></td>
<td><a href="#">Trend</a></td>
</tr>
<tr>
<td>IAPT: waiting time to begin treatment (from IAPT minimum data set) within 18 weeks</td>
<td>OP08</td>
<td>Rolling 3 months</td>
<td>95%</td>
<td>100.00%</td>
<td>0.03%</td>
<td><a href="#">Tracker</a></td>
<td><strong><a href="#">Trend</a></strong></td>
</tr>
<tr>
<td>Inappropriate out of area placements (bed days) for adult mental health services</td>
<td>OP09</td>
<td>Monthly</td>
<td>273</td>
<td>869</td>
<td>293</td>
<td><a href="#">Tracker</a></td>
<td><strong><a href="#">Trend</a></strong></td>
</tr>
</tbody>
</table>

### Waiting Times KPI's

<table>
<thead>
<tr>
<th>Indicator Description</th>
<th>Reference</th>
<th>Reporting Period</th>
<th>Target</th>
<th>Current Performance</th>
<th>Change</th>
<th>Performance Tracker</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency referrals assessed within 4 Hours</td>
<td>OP11</td>
<td>Rolling 3 months</td>
<td>95.0%</td>
<td>81.23%</td>
<td>1.63%</td>
<td><a href="#">Tracker</a></td>
<td><strong><a href="#">Trend</a></strong></td>
</tr>
<tr>
<td>Routine (Non-emergency) referrals assessed within 28 days</td>
<td>OP12</td>
<td>Monthly</td>
<td>95.0%</td>
<td>75.25%</td>
<td>2.73%</td>
<td><a href="#">Tracker</a></td>
<td><a href="#">Trend</a></td>
</tr>
<tr>
<td>Referrals treated within standard</td>
<td>OP13</td>
<td>Monthly</td>
<td>95.0%</td>
<td>93.68%</td>
<td>1.22%</td>
<td><a href="#">Tracker</a></td>
<td><a href="#">Trend</a></td>
</tr>
<tr>
<td>Referrals awaiting treatment &gt;18 weeks</td>
<td>OP14</td>
<td>Monthly</td>
<td>0</td>
<td>438</td>
<td></td>
<td><a href="#">Tracker</a></td>
<td><a href="#">Trend</a></td>
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### Care Programme Approach KPI's

<table>
<thead>
<tr>
<th>Indicator Description</th>
<th>Reference</th>
<th>Reporting Period</th>
<th>Target</th>
<th>Current Performance</th>
<th>Change</th>
<th>Performance Tracker</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service users allocated to either a CPA or Non CPA level</td>
<td>OP17</td>
<td>Monthly</td>
<td>95.0%</td>
<td>93.31%</td>
<td>0.61%</td>
<td><a href="#">Tracker</a></td>
<td><a href="#">Trend</a></td>
</tr>
<tr>
<td>Care Programme Approach (CPA): CPA Service Users Completeness</td>
<td>OP18</td>
<td>Monthly</td>
<td>95.0%</td>
<td>69.73%</td>
<td>1.63%</td>
<td><a href="#">Tracker</a></td>
<td><a href="#">Trend</a></td>
</tr>
<tr>
<td>Care Programme Approach (CPA): Non CPA Service Users Completeness</td>
<td>OP19</td>
<td>Monthly</td>
<td>95.0%</td>
<td>48.97%</td>
<td>0.38%</td>
<td><a href="#">Tracker</a></td>
<td><a href="#">Trend</a></td>
</tr>
</tbody>
</table>

### Inpatient KPI's

<table>
<thead>
<tr>
<th>Indicator Description</th>
<th>Reference</th>
<th>Reporting Period</th>
<th>Target</th>
<th>Current Performance</th>
<th>Change</th>
<th>Performance Tracker</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatients whose transfer of care was delayed</td>
<td>OP20</td>
<td>Monthly</td>
<td>7.5%</td>
<td>8.09%</td>
<td>0.63%</td>
<td><a href="#">Tracker</a></td>
<td><a href="#">Trend</a></td>
</tr>
<tr>
<td>Long-term inpatients that have received an annual Physical health check</td>
<td>OP21</td>
<td>Monthly</td>
<td>100.0%</td>
<td>98.00%</td>
<td>0.00%</td>
<td><a href="#">Tracker</a></td>
<td><a href="#">Trend</a></td>
</tr>
<tr>
<td>Medium Secure Bed Occupancy Rate (including leave)</td>
<td>OP22</td>
<td>Monthly</td>
<td>90.0%</td>
<td>80.96%</td>
<td>10.85%</td>
<td><a href="#">Tracker</a></td>
<td><a href="#">Trend</a></td>
</tr>
<tr>
<td>Low Secure Bed Occupancy Rate (including leave)</td>
<td>OP23</td>
<td>Monthly</td>
<td>95.0%</td>
<td>83.87%</td>
<td>0.96%</td>
<td><a href="#">Tracker</a></td>
<td><a href="#">Trend</a></td>
</tr>
<tr>
<td>Women’s Secure Service Bed Occupancy Rate (including leave)</td>
<td>OP24</td>
<td>Monthly</td>
<td>95.0%</td>
<td>72.98%</td>
<td>2.51%</td>
<td><a href="#">Tracker</a></td>
<td><a href="#">Trend</a></td>
</tr>
<tr>
<td>Number of Adult Acute inpatients with Length of Stay &gt; 117 days</td>
<td>OP25</td>
<td>Monthly</td>
<td>0</td>
<td>16</td>
<td>-1</td>
<td><a href="#">Tracker</a></td>
<td><a href="#">Trend</a></td>
</tr>
<tr>
<td>Patients requiring acute care who received a gatekeeping assessment</td>
<td>OP26</td>
<td>Rolling 3 months</td>
<td>95.0%</td>
<td>93.98%</td>
<td>3.22%</td>
<td><a href="#">Tracker</a></td>
<td><a href="#">Trend</a></td>
</tr>
<tr>
<td>Care programme approach (CPA) - proportion of discharges from hospital followed up within 7 days</td>
<td>OP27</td>
<td>Rolling 3 months</td>
<td>95.0%</td>
<td>97.17%</td>
<td>2.13%</td>
<td><a href="#">Tracker</a></td>
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### Outcomes KPI's

<table>
<thead>
<tr>
<th>Indicator Description</th>
<th>Reference</th>
<th>Reporting Period</th>
<th>Target</th>
<th>Current Performance</th>
<th>Change</th>
<th>Performance Tracker</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>IAPT Service users shall demonstrate reliable improvement</td>
<td>OP36</td>
<td>Monthly</td>
<td>60.0%</td>
<td>67.92%</td>
<td>0.66%</td>
<td><a href="#">Tracker</a></td>
<td><a href="#">Trend</a></td>
</tr>
</tbody>
</table>

**Notes:** 1) OP01 - Only reporting on referrals to existing (a) 14-35 year old early intervention services in Suffolk, and (b) 14-65 year old early intervention services in Norfolk & Waveney. No NSFT early intervention services currently commissioned to triage, assess and treat people with an at-risk mental state.
**Appendix 1: Operational Performance Dashboard March 2020 (cont.)**

**Local - Suffolk CCG Specific KPI's**

<table>
<thead>
<tr>
<th>Indicator Reference</th>
<th>Reporting Period</th>
<th>Target</th>
<th>Current Performance</th>
<th>Change</th>
<th>Performance Tracker</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>OP50a</td>
<td>Cumulative YTD</td>
<td>19.5%</td>
<td>21.85%</td>
<td>0.49%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>OP34a</td>
<td>Rolling 1 months</td>
<td>84.0%</td>
<td>75.10%</td>
<td>-8.90%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>OP19a</td>
<td>Rolling 1 months</td>
<td>75.0%</td>
<td>71.10%</td>
<td>-3.90%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>OP26a</td>
<td>Rolling 3 months</td>
<td>79.0%</td>
<td>100.00%</td>
<td>6.00%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>OP33a</td>
<td>Monthly</td>
<td>95.0%</td>
<td>95.89%</td>
<td>0.65%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>OP43a</td>
<td>Monthly</td>
<td>95.0%</td>
<td>98.40%</td>
<td>3.35%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>OP44a</td>
<td>Monthly</td>
<td>95.0%</td>
<td>87.97%</td>
<td>-0.9%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>OP45a</td>
<td>Monthly</td>
<td>95.0%</td>
<td>100.00%</td>
<td>5.08%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>OP46a</td>
<td>Monthly</td>
<td>95.0%</td>
<td>100.00%</td>
<td>5.08%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>OP50a</td>
<td>Monthly</td>
<td>95.0%</td>
<td>100.00%</td>
<td>5.08%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>OP51a</td>
<td>Monthly</td>
<td>95.0%</td>
<td>100.00%</td>
<td>5.08%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>OP52a</td>
<td>Monthly</td>
<td>95.0%</td>
<td>0.00%</td>
<td>-7.68%</td>
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<td></td>
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</table>

**Local - Norfolk and Waveney CCG Specific KPI's**

<table>
<thead>
<tr>
<th>Indicator Reference</th>
<th>Reporting Period</th>
<th>Target</th>
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<th>Change</th>
<th>Performance Tracker</th>
<th>Trend</th>
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</thead>
<tbody>
<tr>
<td>OP10b</td>
<td>Cumulative YTD</td>
<td>19.0%</td>
<td>16.10%</td>
<td>-0.5%</td>
<td></td>
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<tr>
<td>OP15b</td>
<td>Rolling 1 months</td>
<td>95.0%</td>
<td>100.00%</td>
<td>5.00%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>OP16b</td>
<td>Rolling 1 months</td>
<td>95.0%</td>
<td>90.00%</td>
<td>-10.0%</td>
<td></td>
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</tr>
<tr>
<td>OP28</td>
<td>Monthly</td>
<td>95.0%</td>
<td>86.81%</td>
<td>-8.19%</td>
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</tr>
<tr>
<td>OP29</td>
<td>Monthly</td>
<td>95.0%</td>
<td>100.00%</td>
<td>5.08%</td>
<td></td>
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</tr>
<tr>
<td>OP33b(i)</td>
<td>Monthly</td>
<td>95.0%</td>
<td>86.44%</td>
<td>-3.56%</td>
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<td></td>
</tr>
<tr>
<td>OP34b(i)</td>
<td>Monthly</td>
<td>95.0%</td>
<td>83.33%</td>
<td>-16.67%</td>
<td></td>
<td></td>
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<tr>
<td>OP35b</td>
<td>Monthly</td>
<td>95.0%</td>
<td>100.00%</td>
<td>5.08%</td>
<td></td>
<td></td>
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<tr>
<td>OP36b</td>
<td>Monthly</td>
<td>95.0%</td>
<td>100.00%</td>
<td>5.08%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>OP46b</td>
<td>Monthly</td>
<td>90.0%</td>
<td>100.00%</td>
<td>5.00%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>OP47a(i)</td>
<td>Monthly</td>
<td>95.0%</td>
<td>47.62%</td>
<td>-47.38%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>OP47a(ii)</td>
<td>Monthly</td>
<td>80.0%</td>
<td>92.86%</td>
<td>12.86%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>OP47b(i)</td>
<td>Monthly</td>
<td>80.0%</td>
<td>92.86%</td>
<td>12.86%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>OP48b</td>
<td>Monthly</td>
<td>95.0%</td>
<td>96.43%</td>
<td>1.43%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>OP49b</td>
<td>Monthly</td>
<td>TBC</td>
<td>25.00%</td>
<td>-7.79%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>OP50b</td>
<td>Monthly</td>
<td>TBC</td>
<td>50.00%</td>
<td>0.00%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**National**

<table>
<thead>
<tr>
<th>Indicator Reference</th>
<th>Reporting Period</th>
<th>Target</th>
<th>Current Performance</th>
<th>Change</th>
<th>Performance Tracker</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>NQR02</td>
<td>Monthly</td>
<td>99.0%</td>
<td>100.00%</td>
<td>0.00%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NQR03</td>
<td>Monthly</td>
<td>90.0%</td>
<td>99.24%</td>
<td>0.69%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Board of Directors - Public Session 21st May 2020**

**Integrated Performance Report**

**Version v1**

**Date produced: 13th May 2020**

**Retention period: 20 years**

**Author: Daryl Chapman**

**Department: Executive**

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### Strategic Objectives

<table>
<thead>
<tr>
<th>Risk Ref</th>
<th>Risk Description</th>
<th>Inherent Risk Rating (LxC)</th>
<th>Existing Controls (measures in place to reduce likelihood)</th>
<th>Assurances on controls</th>
<th>May 2020 Risk Rating LxC</th>
<th>Gaps in controls and/or assurance</th>
<th>Target Risk Rating (LxC)</th>
<th>Progress with actions to address gaps</th>
<th>Date for Review</th>
<th>Lead Assurance Committee</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1</td>
<td>Risk that lack of focus on staff engagement and development will adversely impact on leadership and staff morale, resulting in poor outcomes for patients and carers</td>
<td>H 3 x 4 = 12</td>
<td>Culture change programme. Medical Education Improvement Plan, working closely with Health Education England. Nursing education programme. People Before Process group jointly chaired with staff-side focusing on compassionate leadership and improvements in ERI. Increased focus on clinical supervision. Successful sessions held with band 3, band 6 nurses</td>
<td>Annual Staff Survey. Monthly Pulse Surveys. Regular HR reports to executive, Service Delivery Board and Quality Assurance Committee. Board. Quality Assurance Committee and Appts &amp; Remuneration Committee take assurance of effective staff engagement and development. Council of Governors - have set this as priority area and receive regular reports. Medical Education Survey. WRES data. FTSGU and Guardians of Safe Working reports to BoD</td>
<td>A 3 x 4 = 12</td>
<td>Staff Survey results and WRES data highlight improvements needed. Internal audit report on consultant job planning raised concerns on assurance. Clinical staff vacancies remain high. COVID-19 management impacts on staff wellbeing and delivery of culture work</td>
<td>A 2 x 4 = 8</td>
<td>1. People before Process Culture Change programme continues. Culture diagnostic undertaken. Expect Respect campaign. Report to May Board 2. Deputy Chief Nurse and AHP lead continuing with nursing and AHP development and Preceptorship programme. 3. Medical Director working in partnership with clinical leaders; training for junior doctors and consultant job planning. Working closely with HEE. 4. Medical Engagement survey completed 5. Care Groups implementing priority actions from Staff Survey results alongside culture work 6. Working closely with BAME Network colleagues for specific support during covid</td>
<td>Oct 2020</td>
<td>MG</td>
</tr>
<tr>
<td>1.2</td>
<td>Risk that failure to further develop clinical leadership and embed cultural change will adversely impact on improvement of clinical services and outcomes</td>
<td>H 3 x 4 = 12</td>
<td>Care Group Away Days - programme of support. Programme of NED and exec visits to teams. Phase 2 of the leadership restructure recruited to Governance framework of reporting and accountability. Corporate services more embedded in Care Groups. Part of culture work. Deputy Chief Nurse and AHP lead continuing with nursing and AHP development and Preceptorship programme.</td>
<td>Quality Performance Meetings. Monthly Pulse Surveys. Executive walkabouts and breakfast meetings. Workforce and Quality performance dashboards reviewed by BoD, Executive, FBIC, QAC. Governor visits and reports to CoG. FTSGU reports. Guardians of Safe Working reports</td>
<td>A 3 x 4 = 12</td>
<td>Staff Survey results highlight improvements needed. COVID-19 management may impact on clinical leadership progress</td>
<td>A 1 x 4 = 4</td>
<td>1. Proposals for leadership development with the Executive Team for approval; taking into account themes from culture diagnostics and triad managers’ induction, a Leading Confidence programme, Leadership Summits and coaching programmes. 2. People before Process culture change programme continues - report to May Board 3. Care Groups developing plans in response to staff survey; now part of COVID-19 recovery work, learning lessons from positive working practices 4. On-going support to Care Groups to develop local governance structures and changes to Care Group leadership</td>
<td>Oct 2020</td>
<td>Service Delivery Board Appointments &amp; Remuneration Committee</td>
</tr>
<tr>
<td>2.1</td>
<td>Risk that poor engagement with service users and carers and other stakeholders will mean that their views are not heard and responded to, and result in services that do not meet the needs of local communities.</td>
<td>A 3 x 4 = 12</td>
<td>People Participation Leads as part of Care Group leadership. BoD Patient Participation Committee overseeing PP Strategy. Triangle of Care. Working Together Hub. Carers Network. Service User Engagement Forums. Service Users, Carers and Governors trained in CI methodology and taking forward GI projects. Making Families Court conferences. Membership engagement events. Governor visits</td>
<td>Reports to BoD and People Participation Committee. Progress with Quality Improvement projects involving SUs reviewed by Quality Committee. COC inspection Reports. Progress reported in Quality Improvement Plan at CGC. Council of Governors have set this as priority focus. Healthwatch. MOISC</td>
<td>A 3 x 4 = 12</td>
<td>People Participation Strategy, implementation plan and resources Impact of COVID-19 on development of People participation strategy work</td>
<td>A 1 x 4 = 4</td>
<td>1. Draft People Participation Strategy - co-production and consultation underway; timeline delayed due to covid. 2. Service user and carer forums continuing to meet to inform and shape Trust services, led by PPLs 3. using feedback from Membership engagement events earlier in year to develop Trust’s Annual Plan. Further events planned later in year. 4. PPL development programme and rerouting to vacant PPL posts 5. PPL support for service users and carers during covid response; will be continued in recovery work. 6. covid has given new perspective on how we engage with service users and how best to use digital technology</td>
<td>Sept 2020</td>
<td>People Participation Committee</td>
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</table>

**Note:** The table above outlines key risks and strategies for the Norfolk & Suffolk Foundation Trust Board Assurance Framework (BAF) - May 2020. It details the risk descriptions, inherent risk ratings, existing controls, assurances on controls, May 2020 risk ratings, gaps in controls and assurance, target risk ratings, and progress with actions to address gaps. The table also includes the lead assurance committee, with dates for review and lead assurance committee.
<table>
<thead>
<tr>
<th>Strategic Objectives</th>
<th>Risk Ref</th>
<th>Risk Description</th>
<th>Inherent Risk Rating (LxC)</th>
<th>Existing Controls (measures in place to reduce likelihood)</th>
<th>Assurances on controls</th>
<th>May 2020 Risk Rating LxC</th>
<th>Gaps in controls and/or assurance</th>
<th>Target Risk Rating</th>
<th>Progress with actions to address gaps</th>
<th>Date for Review</th>
<th>Lead Assurance Committee</th>
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<tr>
<td>2. Cultural</td>
<td>2.2</td>
<td>2.2 Risk of not working in a collaborative way with all system partners will prevent the transformation and improved quality of services and better outcomes for the people we serve.</td>
<td>A 3 x 4 = 12</td>
<td>NSFT is active partner of Norfolk &amp; Waveney STP and Suffolk &amp; North East Essex ICS. NSFT CEO chairs the N&amp;W STP MH Programme Board. Key partner on Suffolk Alliance and N&amp;W CFYP Alliance - working to deliver adult MH and CFYP strategies. New Models of Care Work in collaboration with regional MH Trusts. Working with primary care colleagues to deliver care close to home. NSFT and NCH&amp;C signed MoU to work together to deliver better integrated services.</td>
<td>Feedback from STP/CPS partners, including commissioners, primary care, Healthwatch, HODSC, voluntary sector. Feedback from regulators. Feedback from governors and wider membership. OAG meetings open to all stakeholders. COC report. BoD and CoG receive regular updates on implementation of the strategies and implications for NSFT</td>
<td>A 2 x 5 = 10</td>
<td>Impact of COVID-19 on system transformation work. Impact on Alliance work on Trust's sustainability</td>
<td>A 2 x 4 = 8</td>
<td>March 2021</td>
<td>July 20</td>
<td>Service Delivery Board</td>
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<tr>
<td>3. Building Quality Improvement Skills</td>
<td>3.1</td>
<td>3.1 Risk of failure to embed quality improvement plans to address issues such as access, physical environments and medication management etc will adversely impact of quality and safety of services and clinical outcomes of service users</td>
<td>B 4 x 4 = 16</td>
<td>Quality Improvement Plan to address CQC actions, with workstreams for must do and should do actions. Care Groups developing local plans to address issues. Utilising QI methodology to continuously improve. Quality &amp; safety reviews promoting learning organisation. Culture change programme. Governance architecture to improve assurance reporting and flow of information word to board to ward.</td>
<td>OPMs with care groups to provide constructive challenge. Oversight &amp; Assurance Group meetings and OAG with NHSI CQC inspections. Quality Improvement Plan reported to each Board and scrutiny by Quality Committee and Quality Assurance Committee. Contract meetings with commissioners</td>
<td>A 2 x 4 = 8</td>
<td>CQC report - Requires Improvement. January 2020 - address CQC recommendations on quality and safety and to be a learning organisation Impact of COVID on Quality Improvement programme</td>
<td>Y 1 x 4 = 4</td>
<td>July 2020</td>
<td>June 20</td>
<td>Board of Directors Quality Assurance Committee</td>
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<td>3.2 Risk that failure to learn from complaints, incidents, Coroner’s recommendations and other information means that issues continue to occur, services do not improve and may result in harm to patients</td>
<td>3.2</td>
<td>3.2 Risk that failure to learn from complaints, incidents, Coroner’s recommendations and other information means that issues continue to occur, services do not improve and may result in harm to patients.</td>
<td>B 4 x 4 = 16</td>
<td>Serious incident (SI) policy and process - RCAs, liaising closely with families for each incident. Duty of Candour. SI Scrutiny panel. Family Liaison Officer in post. Suicide Prevention Lead. Patient Safety Manager. Patient Safety Alert process. Organised learning events. Complaints and PALs process. Quality and safety reviews. Care Groups addressing issues raised by complaints and incidents. New SI and Mortality Review Group. Patient Safety Alert process - reported to Quality Committee.</td>
<td>Quality Performance Meetings with Care Groups. Serious Incident and Mortality Review Group (SIMRG). Quality Improvement Plan monitored by Quality Committee and Quality Assurance Committee. SI reports to BoD each meeting. CQC reviews performance at contract meetings, OAG and OSM with NHSI. SI and Mortality Review Group. CQC inspections. Involve families and carers in each SI review</td>
<td>R 4 x 4 = 16</td>
<td>Address CQC recommendations on quality and safety, to be a learning organisation.</td>
<td>Y 1 x 4 = 4</td>
<td>Aug 2020</td>
<td>July 20</td>
<td>Quality Assurance Committee</td>
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<td>3.3</td>
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<td>Risk that an imbalance between the pace and scale of change required to address quality and safety issues, versus the need for long-term cultural change, will undermine change efforts and result in disengaged staff, patients and stakeholders</td>
<td>3 x 4 = 12</td>
<td>Cultural change programme - diagnostic undertaken. Regular reports to BoD. BoD reviews balance of financial sustainability and quality and safety requirements. Quality Impact Assessments. Apps &amp; Remuneration committee, QAG and FBIC provide deep dive scrutiny</td>
<td>BoD and committee oversight. Monthly Pulse reports Staff Survey Internal audit reports QAG and PRM Council of Governors CQC inspection NHSE - exec to exec meetings, QAG/OSM</td>
<td>A 3 x 4 = 12</td>
<td>Need for long-term cultural change Capacity to address quality and safety issues Impact of COVID-19 management on staff wellbeing</td>
<td>Y 4 x 4 = 16</td>
<td>1. Culture change programme - report to May Board 2. Building on positive changes of covid-19 and learning lessons as part of Recovery work, introducing enhanced wellbeing support 3. Continued focus on quality and safety during covid response, with continued governance and oversight and scrutiny by governors, NHSIE and other stakeholders</td>
<td>Apr 20</td>
<td>Quality Assurance Committee</td>
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<td>3.4</td>
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<td>Risk that not making progress in reducing waiting times impacts on service users, as well as breaches of contractual and regulatory standards.</td>
<td>4 x 4 = 16</td>
<td>Clinical harm review process reviewed. Service User tracker in place. Quality &amp; Safety Reviews. Access Improvement Team in place reporting to COO. Service users - safety is always maintained with visibility of those awaiting treatment &amp; system for clinical review. Access Improvement Director working with Care Groups re SU Tracker List and conducted deep dives into ADHD, Autism and ED pathways. Trust wide Access Policy from Jan 20.</td>
<td>High-level Performance Dashboard reports reviewed by Board, with regular deep dives on access and waiting times and processes for keeping people safe. Quality Assurance Committee provides scrutiny. Access Improvement Task Force receives escalations from SUTL. CQC Inspections QAG and OSM meetings with NHSIE &amp; system for clinical review. Access Improvement Task Force receives escalations from SUTL. CQC Inspections QAG and OSM meetings with NHSIE</td>
<td>N 4 x 4 = 16</td>
<td>CQC inspection reports Ensuring service user safety is maintained and visibility of those awaiting treatment Impact of COVID-19 on waiting times</td>
<td>N 4 x 4 = 16</td>
<td>1. Rapid Improvement Board reviewing CPYP waits and safety of service users. Audit of safety plans. Safeguarding practitioner supporting supervision. Reviews of case loads and increased recruitment. 2. Quality Summits to be held later in year to include feedback from the Quality Safety Reviews and Clinical harm Audits. 3. Care Groups finalising demand and capacity plans. 4. Significant work in collaboration with primary and community care and voluntary sector partners, during covid, to transform community services, and establish crisis helpline 5. Fast track of Attend Anytime video consultations 6. PPL co-producing care planning training</td>
<td>June 20</td>
<td>Service Delivery Board Quality Assurance Committee</td>
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<td>4.1</td>
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<td>Non-delivery of annual revenue and capital budgets impacts on ability to invest in improving services and increases risk of regulatory action</td>
<td>4 x 4 = 16</td>
<td>Standing financial instructions, financial controls, monthly finance review with budget managers. Regular Quality and Performance Meetings include financial scrutiny. Monthly scrutiny and challenge by Executive Group</td>
<td>Finance &amp; Business Investment Committee scrutiny Finance reports to Board. Internal and external audit reports, Annual Accounts approval Oversight and Support Meeting</td>
<td>N 4 x 4 = 16</td>
<td>High reliance on non-recurrent schemes; Historically budget management has been challenging within operational teams; Unknown future impact of Covid19; Lack of national guidance as to funding arrangements beyond July 20</td>
<td>Y 4 x 4 = 16</td>
<td>1. New CIP schemes are deferred until end of block contract funding phases, however this time will be used as opportunity to ensure plans are robust for implementation 2. Clear expectation that Service Leads will continue to be responsible for managing to budgets even during CV19 (CV19 costs can be reclaimed). This will be tested through QPMs and Exec review 3. Regular communication with national and regional Finance teams regarding interim processes, with updates to SOB and FBIC/Board</td>
<td>July 20</td>
<td>Finance, Business and Investment Committee</td>
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<td>4.2</td>
<td>H</td>
<td>Risk that transformation may lead to loss of services and impact on the long-term financial viability of the organisation.</td>
<td>4 x 5 = 20</td>
<td>Improving relationships within the systems the Trust operates within, particularly with commissioners; Dedicated Board Executive focusing on Strategic and Partnership working; Care Group leadership structure enables greater clinical and operational involvement in transformation discussions.</td>
<td>Finance &amp; Business Investment Committee scrutiny, Strategy reports to Service Delivery Board and Board. Council of Governors Significant Business Committee; NW NHS &amp; Mental Health Forum, Alliance Boards, and East of England New Care Models Collaborative.</td>
<td>H 4 x 5 = 20</td>
<td>Historical lack of structure to enable clinical and operational leadership in regional and local transformation and contractual discussions; Systems are maturing at different rates with different demands on the Trust; developing picture of what future services should look like and how they should be delivered, including what longer term impact of Covid-19</td>
<td>Y 4 x 4 = 16</td>
<td>1. CMD working with Clinical Directors to increase service leadership and engagement in strategic discussions; CCO developing Service Directors to partner with Clinical Directors in developing the future services 2. Trust starting to take the lead on what the future of services should look like 3. Recovery planning for next phase of covid-19 response</td>
<td>Sept 20</td>
<td>Finance, Business and Investment Committee</td>
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<td>Strategic Objectives</td>
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<td>4.3</td>
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<td>Risk of impact of the COVID-19 incident causing loss of life in service users, carers and staff; impact on quality of service delivery, staff wellbeing, mental health and wellbeing of the population during and post pandemic</td>
<td>H - 5 x 5 = 25</td>
<td>Tactical and Strategic command established Incident Management Team; Clinical Ethics committee; Daily sit reps monitoring staffing, PPE, impact on wellbeing and effectiveness of business continuity planning. Cohort wards established. Significant wellbeing support provided for staff, service users, other health and care colleagues and public, recognising impact on mental health. Covid-19 governance and risk registers.</td>
<td>Tactical and Strategic command with exec Strategic Advisory Forum receiving weekly reports. Daily sit reps from services reported to CCGs and NHSIE. System strategic command, LHRRP, Clinical and Ethics Group. Board and Board committees continue to provide oversight. Holding to account by CoG. Virtual OAG</td>
<td>H - 5 x 5 = 25</td>
<td>Unable to ascertain full impact on covid-19 currently. Impact on wellbeing will lead to demand for mental health services</td>
<td>A - 2 x 5 = 10</td>
<td>March 2021</td>
<td>June 20</td>
<td>Board of Directors</td>
</tr>
</tbody>
</table>

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**Sustainability & Transformation Partnership**

**Health Overview & Scrutiny Committee**

**Clinical Commissioning group**

**CCG**

**NHS England**

**NHSE**

**NHS Improvement**

**NHSI**

**Cost Improvement Plans**

**CIP**

**Business Continuity Plan**

**BCP**

**East London Foundation Trust**

**ELFT**

**Non executive Director**

**NED**

**Care Quality Commission**

**CQC**

**Likelihood x Consequence**

**LxC**

**Primary Care Network**

**PCN**

**Oversight and Assurance Group**

**OAG**

**Performance Review Meeting**

**PRM**

**Children & Young People**

**CYP**

**Service Users**

**SU**

**Remedial Action Plan**

**RAP**

**Access Improvement Team**

**AIT**

**Quality Improvement Plan**

**QIP**

---

**Memorandum of Understanding**

**MOU**

**Integrated Care System**

**ICS**

**Primary Care Networks**

**PCN**

**Workforce Race Equality Scheme**

**WRES**

**Workforce Disability Equality Scheme**

**WDES**

**Freedom to speak up Guardian**

**FTSUG**

**Care Programme Approach**

**CPA**

---

**Jonathan Warren**

JW

**Diane Hull**

DH

**Stuart Richardson**

SR

**Mark Gammage**

MG

**Dan Dalton**

DD

**Daryl Chapman**

DC

**Mason Fitzgerald**

MF

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**Board of Directors - Public Session 21st May 2020**

**Tab 18.1 Paper Mi BAF May 2020**

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**154 of 286**

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**18.1**
Executive Summary:

This report gives a summary of the year 2019/2020 period.

There were 170 cases in the year ranging from one off conversations to more detailed support and through to formal investigations and HR processes.

This report reflects the cases month on month through the year noting the move from locality to care group.

The report links to the risk 1.2, 3.2, 3.3 on the BAF.

1.0 Case activity

Activity fluctuation through the year has been roughly consistent over the three full years.

Points to note where there are spikes in activity:

- Sept/Oct in both 2018 and 2019 have been ‘Speak Up’ months which see the guardian out and about meeting staff in their working environments. This promotes awareness of the role and generate conversations with people who take the opportunity to discuss something there and then.

- The latest CQC report was published in January 2020. This may have contributed to the spike in case numbers compared to previous years.

- July, August and December look to be the quieter months which seems consistent with holiday activities during those periods

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Board of Directors - Public Session 21st May 2020-15/05/20

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As this is still a reasonably new role and the Trust is going through such a large amount of culture change, these year on year comparisons can only really be used to anticipate capacity.

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The following tables give a visual comparison of the case numbers by Locality/Care Group and by topic.

The greyed-out sections are where a Locality is effectively dissolved, or a Care Group area begins. It is difficult therefore, to compare those areas completely like for like.

A rough breakdown shows, 59 cases raised in Norfolk, 53 from Trust-wide teams and 29 each from Great Yarmouth and Waveney and the Suffolk teams, which looks like a wide variation. However, in terms of percentage of staff numbers, the reporting rate for the whole trust is 4%; Norfolk and Trust-wide teams are reporting just over 4% whereas GTY&W are reporting at a rate of 5.5% and Suffolk at 2.5%. 
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**Number of cases by Locality/Care Group**

Total 170
## Breakdown of theme by Locality/Care Group

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<th>Locality/Care Group</th>
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<th>Staffing Levels</th>
<th>Staff Safety</th>
<th>B &amp; H</th>
<th>System, procedure &amp; process</th>
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<th>Pt Experience</th>
<th>Service Change</th>
<th>Leadership &amp; mgt</th>
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Themes and trends

As noted in previous reports the majority of cases brought to the attention of the guardian centre around how colleagues work together. From these case discussions it appears that there is a body of work to be done to better support managers at all levels.

- to address matters of personality or style clashes
- to develop reflective teams who understand their impact on each other and teams around them.
- to ensure individuals understand their role, and their responsibilities to each other when working in a team.

A large number of cases are about our Systems and Procedures. Following the CQC’s findings, there has been work to streamline processes and cut out unnecessary procedures and there is a definite sense of change for the better and a feeling of optimism throughout the staffing. Whilst this isn’t the experience of everyone, managers have been most willing to hear and try to address the issues raised.

Regarding concerns around leadership and management; there is a will to address the issues raised around further developing managers. The current Coronavirus situation is delaying this.

2020 / 21 Activity and Coronavirus

Coronavirus has seemingly had a big effect on the number of people speaking up. Only 4 cases have been raised in April, none of which were directly related to the crisis. 1 appears to be a long-standing employment issue sitting alongside some behavioural issues. The others are about how people treat each other.

Upcoming Activity

Work has begun to look at the Freedom to Speak up service in NSFT. The Guardian is working with various stakeholders to assess the efficacy of the current format.

Looking at:

- the inter dependencies with other services such as the Culture group work, the People Before Process group, the Staff Experience and Equality and Diversity teams
- how best to interpret the issues raised, alongside SIs, complaints, staff sickness etc.
- clarifying the learning from cases and to share this across the organisation in a structured way.
• Learning from best practice in other Trusts
• the next steps needed to continually improve over time.

The Policy has been amended and is currently with the People before Process Group to ensure it works well with other policies around workforce.

2.0 Financial implications

Potential financial implications following current service assessment.

3.0 Quality implications

Continuously developing the service to meet the needs of the staff will enhance the organisation’s ability to improve. Also, crystallizing the learning from issues raised by staff and formalising how this is shared around the organisation can only help to improve quality and inform service delivery.

4.0 Equality implications

The Trust must ensure that minority groups within the staff cohort are supported and encouraged to raise concerns without discrimination.

Discussions are in place with the Equality Lead around specifically supporting BME staff during the Coronavirus pandemic given the growing awareness of their risk.

The FTSUG role is discussed and contact details shared, in Equality and Diversity training settings and the FTSUG is invited to BME, Equality Leads and Disability Group meetings.

5.0 Risks / mitigation in relation to the Trust objectives

Continued work to ensure staff feel able to speak up and are listened for when they do will assist the Trusts objective to be in the top quartile of trusts for safety and quality and staff engagement by 2023.

Liz Keay
Executive Summary:

This report provides information and assurance to the board on mental health law functions within the Trust.

The report consists of six parts

**Part One:** Executive Summary and Index

**Part Two:** Describes the structure of the Mental Health Law and Mental Health Act Administration departments.

**Part Three:** Provides a Key Summary on the use of the Mental Health Act 1983 and Deprivation of Liberty Safeguards followed by more in-depth analysis of the use of the Mental Health Act 1983 and a comparison to National trends.

**Part Four:** Associate Hospital Managers’ Committee report including structure of the committee and hearing data.

**Part Five:** The Mental Health Law team’s response to the COVID-19 crisis.

**Part Six:** Legislative changes including the Coronavirus Act 2020, Liberty Protection Safeguards and Revised Mental Health Act 1983 and the potential impact upon the Trust.

**Appendices:** Membership of the Associate Hospital Managers’ Committee Scheme of Delegation

COVID-19 Temporary Amendments to Scheme of Delegation

Mental Health Law and MHA Administration organisational chart

Inpatient Sites that have patients detained under the Mental Health Act 1983 or Deprivation of Liberty Safeguard authorisations.
<table>
<thead>
<tr>
<th>Index Mental Health Law Annual Report</th>
<th>Page</th>
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<tbody>
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<td>Part One: Executive Summary and Index</td>
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<td>Part Two: Mental Health Law and MHA Administration Departments</td>
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<td>2.2 Mental Health Act Administration Department</td>
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<td>2.3 Mental Health Act Administration Datix Report</td>
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<td>2.6 Training, Policies and Audit Schedule 2020/2021</td>
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<td>Part Three – NSFT use of the MHA and DoLS</td>
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<td>3.1 Mental Health Act 1983 Data</td>
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<td>3.2 NSFT MHA Data Compared with National Figures</td>
<td>14</td>
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<td>3.3 Deprivation of Liberty Safeguards Data</td>
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<td>3.4 Mental Health Act 1983 and Deprivation of Liberty Safeguards Snapshots</td>
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<td>Part Four– Associated Hospital Managers’ Committee Report</td>
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<td>4.2 Committees and Training</td>
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<td>4.3 Hospital Manager Hearing Data</td>
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<td>Part Five - Mental Health Law response to COVID-19</td>
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<td>5.1 Mental Health Law Guidance and Support during COVID-19</td>
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<td>5.2 Mental Health Act Administration during COVID-19</td>
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<td>Part Six – Legal Update</td>
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<td>6.1 Coronavirus Act 2020</td>
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<td>6.2 Impact for NSFT of Coronavirus Act 2020</td>
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<td>6.3 Mental Capacity (amendment) Act 2019 and Liberty Protection Safeguards</td>
<td>27</td>
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<td>6.4 Impact for NSFT of Liberty Protection Safeguards</td>
<td>28</td>
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<tr>
<td>6.5 Review of the Mental Health Act 1983</td>
<td>29</td>
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<td>6.6 Potential Impact for NSFT of Mental Health Act reform</td>
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<td>Appendices</td>
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<td>Appendix 1 - Associate Hospital Managers</td>
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<td>Appendix 3 - COVID-19 Temporary Amendments to Scheme of Delegation</td>
<td>35</td>
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<tr>
<td>Appendix 4 - Inpatient Sites</td>
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</table>
### Part One: Executive Summary

1. A priority for the Mental Health Law (MH Law) team and Mental Health Act (MHA) Administration team in 2020 is to further support Care Groups, wards and departments to improve compliance with mental health legislation and associated Codes of Practice, Regulations and Statutory Guidance.

2. NSFT detention rates for 2019/20 represent an increase on 2018/19 of 7%.

3. The black, Asian and minority ethnic (BAME) population is over-represented in detention and Community Treatment Order (CTO) figures both nationally and within the Trust.

4. The recording of ethnicity for detained patients and patients subject to CTOs is above 90%.

5. The MH Law team has provided an Ethnicity Report to Care Group leadership teams and Equality Diversity and Inclusion Lead to enable them to consider how best to monitor the over-representation of this group within detention and CTO figures, and to support them to improve ethnicity recording to 100%.

6. From May 2020 the MHA Administration team will provide details of Datix reports involving MHA errors or omissions to the relevant Care Group leadership team on a monthly basis.

7. The MHA audit schedule for 2020 includes auditing re-detention within one month of discharge from section, auditing the use of Section 2 vs Section 3, and auditing admissions to Section 136 suites across the Trust.

8. The MHA Administrators continue to provide regular training for ward staff on the correct procedures for receiving detention papers.

9. The MHA Administrator Manager, where requested, continues to support wards to inform their action plan responses following CQC MHA inspections.

10. The MHA Legal Practice Advisor continues to offer and deliver ad hoc training on legislation, process, procedures and practice where requested or where opportunities for improvement arise.

11. The MH Law team continue to advise clinicians and practitioners on legal and practice issues as requested.

12. The MH Law team will continue to review MH Law policies as per the review schedule and in collaboration with the Mental Health Act Committee (MHAC).

13. The MHA Administration team is in the process of a re-structure, to ensure there are sufficient resources in place to provide robust MHA administration in the Trust.

15. During the COVID-19 pandemic, the MH Law team receive updates from the Department of Health and Social Care, NHS England and NHS Improvement and other agencies, and consider and advise on how these apply to the Trust.

16. In consultation with the Chief Medical Officer, the Trust’s Scheme of Delegation has been temporarily amended as a result of the COVID-19 pandemic to allow additional staff to receive detention papers and to read Section 132 rights to patients.

17. In the event the MHA 1983 is modified by virtue of the Coronavirus Act 2020, and in consultation with the Chief Medical Officer and Local Authorities, the MH Law team will produce comprehensive guidance for the Trust on compliance with the new requirements.

18. In the event the MHA 1983 is modified by virtue of the Coronavirus Act 2002, the MH Law team will implement a robust system of Governance to provide accurate and up to date information about the efficiency and effectiveness of revised policies and guidance. The MH Law team will also implement a programme of audit to provide effective and accurate compliance recording.

19. The MH Law team and MHA Administration team remain committed to driving forward increasing compliance with mental health legislation.

20. The MH Law team and MHA Administration team will remain responsive to opportunities that arise where improvements to practice can be facilitated.

21. An external review of the MHA functions of the Trust has been completed by the Head of Mental Health Law at East London Foundation Trust. The review recommends the appointment of a Head of Mental Health Law.

### Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>BAME</td>
<td>black, Asian and minority ethnic</td>
</tr>
<tr>
<td>AC</td>
<td>Approved Clinician</td>
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<tr>
<td>AMHP</td>
<td>Approved Mental Health Professional</td>
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<tr>
<td>CCG</td>
<td>Clinical Commissioning Group</td>
</tr>
<tr>
<td>CEA</td>
<td>Clinical and Ethical Advisory Group</td>
</tr>
<tr>
<td>CEO</td>
<td>Chief Executive Officer</td>
</tr>
<tr>
<td>CMO</td>
<td>Chief Medical Officer</td>
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<td>CQC</td>
<td>Care Quality Commission</td>
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<tr>
<td>CTO</td>
<td>Community Treatment Order</td>
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<tr>
<td>DGH</td>
<td>District General Hospital</td>
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<tr>
<td>DHSC</td>
<td>Department of Health and Social Care</td>
</tr>
<tr>
<td>DoLS</td>
<td>Deprivation of Liberty Safeguards</td>
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<td>IMT</td>
<td>Incident Management Team</td>
</tr>
<tr>
<td>IPAC</td>
<td>Infection Prevention and Control</td>
</tr>
<tr>
<td>MCA</td>
<td>Mental Capacity Act 2005</td>
</tr>
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<td>MH</td>
<td>Mental Health</td>
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<td>Mental Health Act Committee</td>
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<td>Mental Health Tribunal</td>
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<td>NSFT</td>
<td>Norfolk and Suffolk NHS Trust</td>
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Part Two – Mental Health Law and MHA Administration Departments

2.1 Mental Health Law Department

The Legal Services Manager/Trust Solicitor has responsibility for legal advice, litigation, Court of Protection work, Inquest work, Coroner work and has overall responsibility in relation to the Mental Health Act 1983 (MHA), Mental Capacity Act 2005 (MCA), the MCA Deprivation of Liberty Safeguards (DoLS), and related legislation and case-law.

The Mental Health Law team (MH law team) is a corporate department and the executive lead is the Chief Medical Officer (CMO).

The MHA Legal Practice Advisor provides support to the Trust Solicitor and is responsible for MH Law policies, provides MH Law training and advice to NSFT staff, has responsibility for the Hospital Manager Committee and line manages the MHA Administration Manager.

The MH Law team maintains an up to date knowledge of relevant legislation and case law, as well as monitoring forthcoming amendments to legislation, as outlined in Part Five of this report.

The MHA Legal Practice Advisor attends a Section 135/136 interagency group in Norfolk. Membership includes police (including control room), District General Hospitals (DGH), Local Authority, Approved Mental Health Professional (AMHP) services, ambulance, fire, British Transport Police (BTP), Clinical Commissioning Groups (CCG) and NSFT senior operational staff. The Group is responsible for the Interagency Section 135/136 Policy. The Suffolk interagency group has been re-established using the Norfolk model although unfortunately the first meeting was suspended due to COVID-19.

The MCA Manager is the designated Trust lead for the MCA and DoLS and has recently been transferred to the management of the Trust Solicitor. Currently DoLS are administered by the MHA administration team but this responsibility will pass to the MCA Manager during 2020. The MCA Manager is involved in system wide discussions in respect of the implementation of Liberty protection Safeguards.

In September 2019 NSFT commissioned East London NHS Foundation Trust (ELFT) to carry out a review of MHA functions across NSFT. The interim report acknowledges the work of the Trust solicitor, MHA Legal Practice Advisor and MHA Administration Manager. It also acknowledges the requirement to improve assurance processes in relation to MCA and MHA at Board level and to enhance the MHA administration establishment.

The recommendation of the ELFT review is the appointment of a dedicated Head of Mental Health Law post that reports directly to the lead Executive Director for Mental Health.

2.2 MHA Administration

The MHA Administration Manager has operational management of the MHA Administrators within the Trust. There are three permanently staffed MHA offices at Norfolk, Bury St Edmunds and Ipswich with three additional hospital sites supported by administrators visiting on a regularly basis.

The team has 9.09 WTE MHA Administrators with the majority being part time members of staff. As set out in Part Two, MHA activity in the Trust continues to follow the national trend and is increasing year on year with the current establishment making every effort to maintain its service standards notwithstanding increased demand. To ensure robust MHA administration in the Trust, the team is in the process of a re-structure to ensure sufficient resource.
As part of the CQC improvement plan, MHA monitoring visits to each ward by MHA Administrators were increased from monthly to weekly in July 2019 to provide more regular reporting on compliance. This generates the MHA Run Chart Compliance reports which are provided to relevant Care Groups for action, and are reported by the MHA Administration Manager to the MHA Committee (MHAC see para 1.3). The MHAC is responsible for seeking assurance from the relevant Care Group via reporting or attendance at the MHAC.

2.3 Mental Health Act Administration Datix Report

Part of the role of a MHA Administrator is to scrutinise statutory MHA paperwork and, where it is permitted, arrange for rectification under Section 15 MHA.

Where the error relates to clinical services (and in addition to the submission of a Datix) the relevant ward or department is notified of the error and additional training is offered. From May 2020 the MHA Administration team will provide details of Datix reports to the relevant Care Group leadership team on a monthly basis. Where performance remains a concern, the MHA Legal Practice Advisor will provide a Datix Report to the relevant Quality Committee.

Detailed below are recorded Datix for the period 2018-19 and 2019-2020.

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<th>Episode</th>
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<td>Section 5(4) unlawfully applied as a Section 5(2) was already in place</td>
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<td>Section 5(2) unlawfully applied as a Section 5(2) was already in place</td>
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<td>S 5(2) unlawfully applied as patient was subject to a CTO</td>
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<td>S5(2) dates incorrect, received date predated implementation date</td>
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<tr>
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<tr>
<td>Medical Recommendations were dated outside permitted dates</td>
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<tr>
<td>Patient admitted to different hospital than detailed on the Med Recs</td>
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<tr>
<td>Medical recommendation unsigned/undated</td>
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<td>Section 3</td>
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<td>Consent certificate not completed for revoked CTO</td>
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<td>5(2) applied at James Paget hospital not received</td>
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<td>Section 3 formally received without patient attending the ward.</td>
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<tr>
<td>Section 3 unintentionally expired</td>
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<tr>
<td>Patient admitted to different hospital than detailed on the Med Recs</td>
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<tr>
<td>Renewal form dated after expiry of Section 3</td>
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<td>One medical recommendation missing from detention papers</td>
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</tr>
<tr>
<td><strong>Consent</strong></td>
<td></td>
</tr>
<tr>
<td>Consent certificate not completed for revoked CTO</td>
<td>1</td>
</tr>
<tr>
<td>Consent certificate not completed for CTO patient in community</td>
<td>3</td>
</tr>
<tr>
<td>Consent certificate not completed for Section 3 patient</td>
<td>3</td>
</tr>
<tr>
<td><strong>CTO</strong></td>
<td></td>
</tr>
<tr>
<td>AMHP consulted on CTO after the date of implementation by RC</td>
<td>1</td>
</tr>
<tr>
<td>Second consultee for CTO extension was another doctor</td>
<td>1</td>
</tr>
<tr>
<td>Revocation paperwork not formally received</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>41</td>
</tr>
</tbody>
</table>

### 2.3 Mental Health Assurance Committee (MHAC)

The Mental Health Law Forum was disbanded in May 2019 and replaced with the MHAC, which was established as a sub-committee of the Board of Directors. The purpose of the MHAC is to seek assurance that the Trust has discharged its responsibilities under relevant mental health legislation and where appropriate, to escalate concerns to the relevant Care Group, Quality Committee or Service Delivery Board. This will ensure that the appropriate senior operational staff remain accountable for operational management of relevant mental health law practices.

The inaugural meeting of the MHAC, chaired by Trust Chair was in September 2019. The second meeting, chaired by a Non-Executive Director (NED) took place in December 2019 and the third, chaired by the CMO in the absence of a NED took place in March 2020.

Standing agenda items are as follows:

- CQC Reports (see para 1.4)
- MHA Run Chart Assurance Report (see para 1.2)
- Interagency Update including Sections 135 and 136 (see para 1.1)
- Items to be reported by the Chair to the Executive Team/Board of Directors

Other agenda items may include:

- Mental Health Law Audit Reports (see para 1.5)
- Update from other agencies
2.4. CQC Monitoring: Reports, Action Plans and Progress

CQC MHA Inspection reports are received by the Quality and Safety Lead Nurse who supports the relevant clinical teams to produce action plans. The Quality and Safety Lead Nurse monitors compliance with the action plans and reports to Deputy Director for Patient Safety and Quality. Where appropriate, the MHA Administration Manager is requested to feed into action plans.

From June 2020, the Quality and Safety Lead Nurse will attend the MHAC to report on visits, to present CQC MHA action plans and to update on progress or outstanding actions. Where action plans remain outstanding MHAC will request assurance reports and attendance from the Lead Nurse of the relevant Care Group to ensure that appropriate senior operational staff remain accountable for the implementation of focused action plans and the resolution of outstanding actions.

The Trust will appoint a CQC liaison officer in the next six months within the Quality and Patient Safety directorate. The CQC liaison officer will take over from the Quality and Safety Lead Nurse.

The MHA Administration Manager continues to support wards (where requested) to inform their action plan responses following CQC MHA inspections.

2.5 Mental Health Law Training, Policies and Audit schedule 2020/2021

There is online MHA and MCA/DoLS training available via eLearning as mandated by staff competency requirements. The MHA Legal Practice Advisor, in consultation with Deputy Chief Nurse, E-learning Training Lead, and Education Lead updated the MHA eLearning in June 2019. This was evaluated by two Registered Mental Nurses (RMN) and two Practice Educators prior to being uploaded in July 2019.

As part of the CQC Improvement Plan, the MHA Legal Practice Advisor and MCA Lead offered ward-based MHA and MCA training to all 28 wards in the Trust with many wards accepting and receiving the training. MHA training was also offered to Trust Governors and all Duty Managers. The MHA Legal Practice Advisor is due to provide MHA training to the Board in June 2020.

Other ad hoc MHA and MCA training is provided as requested and during the past year has included junior doctors’ training, Approved Clinician training, ward away days, psychiatric liaison teams, DGHs and community teams.

MHA Administrators provide regular training of ward staff on the correct procedures for receiving detention papers.

The Mental Health Law team has responsibilities for the following policies:

- C92: Allocation and Transfer of Responsible Clinicians
- C91: Community Treatment Orders
- C71: Consent to Examination or Treatment
- C07: Mental Capacity Act
- C96 and C96b: Section 117 aftercare
- C05: Sections 135 and 36
These policies were previously overseen by the Mental Health Law Forum which was disbanded last year. Policies will now be overseen by the MHAC (para 1.3).

Pending MHAC approval (see para 1.3) the Mental Health Law audits for 2020 are below. The schedule has yet to be confirmed. However, audits will be completed and reported by the end of 2020. Other audits will be undertaken on an ad hoc basis in response to concerns, Datix or other relevant reasons.

1. Re-detention within one month of discharge from section.
2. The use of Section 2 vs Section 3.
3. Admission to Trust Section 136 suites to ensure process aligns with best practice.
Part Three – NSFT use of the MHA and DoLS

3.1 Mental Health Act Data

These figures have been internally generated by the Trust, based on currently available data, using the same rationale and criteria as that used by NHS Digital in the production of the annual MHA Statistics. This publication replaced the KP90 Data Collection in 2016 and it utilises data submitted throughout the year in the monthly Mental Health Service Data Set (MHSDS).

Key Summary Data 1 April 2019 to 31 March 2020:

- There were 1584 MHA detentions for period 2019/20 compared to 1478 MHA detentions in 2018/19.
- Detention rates in NSFT have risen by approximately 7% from the previous year. National Data is incomplete for the year 2019/20 but estimates 2-4% increase. However, NSFT had been an outlier in 2017/18 in reporting less detentions than the national average.
- Approximately 60% of Section 5 assessments result in Section 2 or Section 3.
- Approximately 19% of Sections 135(1)/136 result in Section 2 or Section 3.
- Nationally males account for just over half of all detention. Within NSFT females account for 50.8% of detentions.
- Within NSFT males make up approximately 68% of CTOs. This reflects the national picture.
- The highest age range for hospital detention was the 18-34 age range following by the 65+ age range. This reflects the National picture.
- The highest age range for CTOs was the 35-49 age range, which reflects the National picture.
- Although significantly lower than the nation average, the BAME population is over-represented within NSFT hospital detention and CTO figures.
- The recording of ethnicity within NSFT for detentions in 2018/19 and 2019/20 was 92.3% and 91.1% respectively. For CTOs the figures are 95.8% and 96.6% respectively.

<table>
<thead>
<tr>
<th>Description</th>
<th>2018/19</th>
<th>2019/20</th>
</tr>
</thead>
<tbody>
<tr>
<td>The number of detentions starting in the year, including both civil detentions under Part II and detentions via the Criminal Justice System under Part III of the MHA</td>
<td>1478</td>
<td>1584</td>
</tr>
<tr>
<td><strong>All detentions under Part II of the MHA that occurred on admission</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Section 2 Number of detentions under Section 2 of the MHA</td>
<td>554</td>
<td>613</td>
</tr>
<tr>
<td>Section 3 Number of detentions under Section 3 of the MHA</td>
<td>101</td>
<td>103</td>
</tr>
<tr>
<td><strong>All detentions under Part III of the MHA that occurred on admission</strong></td>
<td>39</td>
<td>43</td>
</tr>
<tr>
<td>Section 36 Number of detentions under Section 36 of the MHA</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Section 37/41 Number of detentions under Section 37/41 of the MHA</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Section 37 Number of detentions under Section 37 of the MHA</td>
<td>15</td>
<td>19</td>
</tr>
<tr>
<td>Section 47/49 Number of detentions under Section 47/49 of the MHA</td>
<td>10</td>
<td>14</td>
</tr>
<tr>
<td>Section 48/49 Number of detentions under Section 48/49 of the MHA</td>
<td>7</td>
<td>4</td>
</tr>
<tr>
<td>Sections 38, 44, 46 Number of detentions under Sections 38, 44, 46 MHA</td>
<td>3</td>
<td>2</td>
</tr>
</tbody>
</table>
Number of detentions that occurred following admission to hospital

<table>
<thead>
<tr>
<th>Section</th>
<th>Description</th>
<th>2020</th>
<th>2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>5(2) to 2</td>
<td>The number of detentions under section 2 following admission to hospital and preceded by Section 5(2)</td>
<td>102</td>
<td>98</td>
</tr>
<tr>
<td>5(2) to 3</td>
<td>The number of detentions under Section 3 following admission to hospital and preceded by Section 5(2)</td>
<td>67</td>
<td>59</td>
</tr>
<tr>
<td>5(4) to 2</td>
<td>The number of detentions under Section 2 following admission to hospital and preceded by Section 5(4)</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>5(4) to 3</td>
<td>The number of detentions under Section 3 following admission to hospital and preceded by Section 5(4)</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>4 to 2</td>
<td>The number of detentions under Section 2 following admission to hospital and preceded by Section 4</td>
<td>3</td>
<td>3</td>
</tr>
</tbody>
</table>

Detentions that followed the use of Section 135(1) or Section 136

<table>
<thead>
<tr>
<th>Section</th>
<th>Description</th>
<th>2020</th>
<th>2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>135(1) to 2</td>
<td>The number of detentions under Section 2 following the use of Section 135(1)</td>
<td>2</td>
<td>9</td>
</tr>
<tr>
<td>135(1) to 3</td>
<td>The number of detentions under Section 3 following the use of Section 135(1)</td>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td>136 to 2</td>
<td>The number of detentions under Section 2 following the use of Section 136</td>
<td>102</td>
<td>108</td>
</tr>
<tr>
<td>136 to 3</td>
<td>The number of detentions under Section 3 following the use of Section 136</td>
<td>26</td>
<td>36</td>
</tr>
</tbody>
</table>

In 2018/19 and 2019/20 there were 305 and 301 people respectively transferred in to an NSFT bed. This data is not reported in the Mental Health Service Data Set (MHSDS) as the detention originated elsewhere. The figures include out of area placements returning to NSFT.

Repeat Detentions

A repeat detention is where a patient is admitted to hospital under the MHA more than once within the same reporting period.

In 2019/20, 39 people had three detentions within the reporting period, 7 had four detentions, one had five detentions and two people had seven or more detentions within the reporting period.
Section 136

<table>
<thead>
<tr>
<th>The number of uses of Sections 135 and 136 in the year</th>
<th>2018-19</th>
<th>2019-20</th>
</tr>
</thead>
<tbody>
<tr>
<td>Section 135</td>
<td>5</td>
<td>19</td>
</tr>
<tr>
<td>Section 136</td>
<td>758</td>
<td>806</td>
</tr>
</tbody>
</table>

The criteria for detention under Section 135(1) or Section 136 are satisfied if, ‘...the person appears to be suffering from mental disorder and is in need of immediate care or control’. The threshold for Section 2 or Section 3 is significantly higher and as such the conversion rate is expected to be lower than that for Section 5. An audit of 508 people brought to the Norwich Section 136 suite in the period 2019/20 identified that 45.7% were discharged with community follow up.

<table>
<thead>
<tr>
<th>Outcome of Section 136s brought to Hellesdon Hospital for period 2019/2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discharged – No mental disorder</td>
</tr>
<tr>
<td>Discharged – Mental disorder, no follow-up</td>
</tr>
<tr>
<td>Discharged – Mental disorder with follow-up</td>
</tr>
<tr>
<td>Admitted/transferred on informal basis</td>
</tr>
<tr>
<td>Admitted under S2</td>
</tr>
<tr>
<td>Admitted under S3</td>
</tr>
</tbody>
</table>
### Section 5

<table>
<thead>
<tr>
<th>The number of uses of Section 5</th>
<th>2018-19</th>
<th>2019-20</th>
</tr>
</thead>
<tbody>
<tr>
<td>Section 5(2)</td>
<td>551</td>
<td>540</td>
</tr>
<tr>
<td>The number of uses of Section 5(2)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Section 5(4)</td>
<td>281</td>
<td>274</td>
</tr>
<tr>
<td>The number of uses of Section 5(4)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Conversion Rate from Section 5

![Conversion Rate from Section 5 graph](chart1.png)

- % Section 5(2) detained
- % Section 5 not detained

- 2018-19: 551
- 2019-20: 540

#### Section 2 and Section 3 detentions resulting from Section 5

![Section 2 and Section 3 detentions graph](chart2.png)

- Section 5(2) to 2
- Section 5(2) to 3

- 2018-19: 270
- 2019-20: 266

#### Community Treatment Orders

<table>
<thead>
<tr>
<th>Number of CTOs starting in the year</th>
<th>2018-19</th>
<th>2019-20</th>
</tr>
</thead>
<tbody>
<tr>
<td>Section 3 to CTO</td>
<td>73</td>
<td>90</td>
</tr>
<tr>
<td>CTOs following a detention under Section 3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Section 37 to CTO</td>
<td>68</td>
<td>85</td>
</tr>
<tr>
<td>CTOs following a detention under section 37</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CTO recalls</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Number of CTO which involved a recall</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CTO Revocations</td>
<td>34</td>
<td>21</td>
</tr>
<tr>
<td>Number of CTOs that ended with a revocation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CTO Discharges</td>
<td>18</td>
<td>11</td>
</tr>
<tr>
<td>CTOs that ended with the person being discharged</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Other Calculations

<table>
<thead>
<tr>
<th>% Section 5(2) detained</th>
<th>2018-19: 0.0%</th>
<th>2019-20: 10.0%</th>
</tr>
</thead>
<tbody>
<tr>
<td>% Section 5 not detained</td>
<td>2018-19: 100.0%</td>
<td>2019-20: 90.0%</td>
</tr>
</tbody>
</table>
3.2 NSFT MHA Data Compared with National Figures

Detention: Age, Gender and Ethnicity

Digital NHS Data for the year 2018/19 show that detention rates were higher for males (91.4 per 100,000 population) than females (83.2 per 100,000 population). This position is reversed in NSFT with females making up 51.4% of all detentions in 2018/19 and 50.8% in 2019/20.

Digital NHS Data for the year 2018/19 shows that in adults, detention rates tend to decline with age but rise again for the 65+ age group (98.1 per 100,000 population). Known detention rates for the 18 to 34 age group (128.9 detentions per 100,000 population) were around a third higher than for those aged 50 to 64 (89.0 per 100,000 population).

Within NSFT, the highest age range for detention was the 18-34 age range, followed by the 65+ age range. This reflects the national picture in both 2018-19 and 2019-20.

Digital NHS Data for the year 2018/19 shows that the detention rate was highest for those with 'Any Other Black Background', which forms part of the 'Black and Black British' group. At 728.1 detentions per 100,000 people, this was over ten times the rate for the White British group (70.1 detentions per 100,000).

Within NSFT, the BAME group make 4.1% of the local population (which is significantly lower than the national picture) however detention rates in this group are 6.4% (2018/19) and 8.4% (2019/2020). This demonstrates that the group are over-represented in detention figures, particularly so in 2019/20, although much less so that nationally.
CTOs: Gender, Age and Ethnicity

Digital NHS Data for the year 2018/19 shows known rates of CTO use for males (11.2 per 100,000 population) were higher than the rate for females (6.1 per 100,000 population). Across age groups, those aged 35 to 49 had the highest rate of CTO use (15.3 known uses per 100,000 population compared to 8.6 uses per 100,000 population for all age groups). The NSFT data reflects the national picture.

Digital NHS Data for the year 2018/19 shows that across age groups, those aged 35 to 49 had the highest rate of CTO use (15.3 known uses per 100,000 population compared to 8.6 uses per 100,000 population for all age groups). This is reflected within NSFT with the age group with the highest rate of CTOs being those aged 35-49.
Digital NHS Data for the year 2018/19 demonstrates that amongst broad ethnic groups, CTO use was highest for ‘Black or Black British’ people (53.8 uses per 100,000 population). Nationally, this is over eight times the rate for the White group (6.4 uses per 100,000 population).

Within NSFT the rate of CTOs for the ‘Black or Black British’ group is 2.9% (2018/19) and 3.5% (2019/20) despite the crude population being 0.7%. For the year 2019/20, this reflects a five times higher usage of CTOs in this group. Amongst broad ethnic groups, BAME groups make up 4.1% of the population but CTO use for BAME groups is at 10.4%.
Section 135(1) and Section 136 by ethnicity

The % BAME Section 135(1) and Section 136 rates within NSFT in 2018/19 demonstrated usage of 4.9% compared to a local population of 4.1%. The 2019/2020 rates show an under-representation of BAME groups within NSFT Section 135(1) and Section 136.

<table>
<thead>
<tr>
<th></th>
<th>2011 Census</th>
<th>2018-19</th>
<th>2019-20</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of population</td>
<td></td>
<td>% of detentions</td>
<td>% of detentions</td>
</tr>
<tr>
<td>BAME % of local population is 4.1%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2018/19</td>
<td>4.9%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2019/20</td>
<td>3.7%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The MHL team has provided an Ethnicity Report to Care Group leadership teams and Equality Diversity and Inclusion Lead to enable them to consider how best to monitor the over-representation of this group within detention and CTO figures, and to support them to improve ethnicity recording to 100%.

3.3. Deprivation of Liberty Safeguards Data

Where a person lacks capacity to consent to admission but is fully compliant with all elements of their care and treatment the appropriate legal regime for NSFT inpatients is DoLS. Although NSFT may self-authorise an urgent 7-day DoLS, only the relevant Local Authority may assess and subsequently decline or authorise a longer-term standard authorisation to cover the admission and treatment. A DoLS authorisation also covers admission to wards in general hospitals and residence in care homes; wherever a person lacks capacity to consent to the admission or residence.

For many years, the Local Authorities have faced significant workforce and financial restrictions which result in a significant backlog of work in relation to these assessments. As such, there is always a number of patients within NSFT wards who are awaiting a standard authorisation.

<table>
<thead>
<tr>
<th>Application of DoLS during the period</th>
<th>2017-18</th>
<th>2018-19</th>
<th>2019-20</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urgent DoLS applied and standard authorisations requested</td>
<td>164</td>
<td>158</td>
<td>166</td>
</tr>
<tr>
<td>Standard Authorisations approved</td>
<td>20</td>
<td>16</td>
<td>10</td>
</tr>
<tr>
<td>Outcomes of DoLS recorded during the period</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discharges from hospital</td>
<td>120</td>
<td>125</td>
<td>137</td>
</tr>
<tr>
<td>Deaths under DoLS</td>
<td>10</td>
<td>11</td>
<td>6</td>
</tr>
<tr>
<td>Conversions from DoLS to MHA</td>
<td>10</td>
<td>15</td>
<td>19</td>
</tr>
</tbody>
</table>
 Whilst the Local Authorities bear the responsibility for managing their backlog, NSFT have introduced a system by which a person who has been subject to DoLS for six months and is still awaiting a standard authorisation receives a review. The review is undertaken by a panel of specially trained Associate Hospital Managers.

There has only been one Associate Hospital Manager hearing to review the DoLS, as outlined above and there are no patients on NSFT wards who currently meet the criteria for a review.

The Mental Capacity (Amendment) Bill, which passed into law in May 2019 replaces the Deprivation of Liberty Safeguards (DoLS) with Liberty Protection Safeguards (LPS) although they are not yet implemented (see para 5.3). The implementation of the LPS will provide authority for NSFT to self authorise detention and will ensure that all inpatients within the Trust who lack capacity to consent their admission, care and treatment have a legislative framework unpinning their admission and treatment.

### 3.4 MHA and DoLS Snapshots

<table>
<thead>
<tr>
<th>Snapshot: People subject to MHA or DoLS as of 31 March 2020</th>
<th>2019</th>
<th>2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>DoLS People subject to DoLS (with or without standard authorisation)</td>
<td>31</td>
<td>39</td>
</tr>
<tr>
<td>The total number of people subject to the MHA</td>
<td>360</td>
<td>317</td>
</tr>
<tr>
<td>The number of people detained under Section 2 or 3, or Part III.</td>
<td>259</td>
<td>211</td>
</tr>
<tr>
<td>People with a CTO, CTO recall or Conditional Discharge</td>
<td>99</td>
<td>106</td>
</tr>
<tr>
<td>People subject to Sections 4, 5(2), 5(4), 135(1) or 136</td>
<td>2</td>
<td>0</td>
</tr>
</tbody>
</table>
Part Four – Associate Hospital Managers’ Committee Report

The Hospital Managers’ Committee report provides assurance on the work and function of the Committee.

4.1 The Role of the Hospital Manager

The Mental Health Act 1983 (MHA) and its Code of Practice defines the Hospital Managers in an NHS Foundation Trust as the Trust itself. In practice this means the Board of Directors of the Trust. It is the ‘Hospital Managers’ under the MHA who have the authority to detain patients. In practice, as the Code allows and as per the Trust’s Scheme of Delegation details, most of the functions of the Hospital Managers are delegated to and carried out by staff of the Trust (see Appendix Two).

The work of the Hospital Managers’ committee relates to the exercise of the hospital managers’ power to discharge patients from detention or CTOs, which may not be delegated. The specially appointed persons operate by virtue of delegated authority from the Board of Directors and only for the purpose of considering discharge from detention or community treatment orders; their role is specifically limited to this function and they do not perform the wider duties assigned to Hospital Managers by the Act and the Code of Practice.

The Handbook is a document that outlines the Terms of Reference and Code of Procedures as well as detailing the role description, appraisal procedures and protocol for renumeration.

The MHA Hospital Managers’ Committee is also attended by the Trust Solicitor, MHA Legal Practice Advisor and MHA Administration Manager. The Secretary to the Legal Services Department, is secretary to the Committee.

There are currently 46 Associate Hospital Managers. The membership of the Committee does demonstrate a level of diversity. A fee of £50 is paid for each panel member for each hearing attended regardless of whether or not the hearing is held on the papers or in person. There are three associate hospital managers on each panel, and occasionally a fourth member observing. The fees and travel expenses paid to Associate Hospital Managers in 2019 total £33,585

4.2 Hospital Manager Committees and training since March 2019

Associate Hospital Managers are required to attend three of the four Committees and associated training per year. This is to ensure they are competent and confident to fulfil their role.

<table>
<thead>
<tr>
<th>Committee Date</th>
<th>Subject</th>
<th>Speaker</th>
</tr>
</thead>
<tbody>
<tr>
<td>March 2019</td>
<td>Trust Visions and Values</td>
<td>Maeve Sykes</td>
</tr>
<tr>
<td></td>
<td>Decision Writing</td>
<td>Helen Dewson</td>
</tr>
<tr>
<td>June 2019</td>
<td>Safeguarding and Patient Safety</td>
<td>Saranna Burgess</td>
</tr>
<tr>
<td></td>
<td>Legal Update: Case law</td>
<td>Helen Dewson</td>
</tr>
<tr>
<td>September 2019</td>
<td>CAMHS Services within NSFT</td>
<td>Dr Sarah Maxwell</td>
</tr>
<tr>
<td></td>
<td>Review of Recent Decisions</td>
<td>Helen Dewson</td>
</tr>
<tr>
<td></td>
<td>Introduction and Question/Answer session</td>
<td>Marie Gabriel</td>
</tr>
<tr>
<td>December 2019</td>
<td>Psychopathology and Medical Terminology</td>
<td>Dr David Nelson</td>
</tr>
<tr>
<td></td>
<td>Case Update</td>
<td>Helen Dewson</td>
</tr>
<tr>
<td></td>
<td>Introduction and Question/Answer session</td>
<td>Jonathan Warren</td>
</tr>
<tr>
<td>March 2020</td>
<td>Cancelled due to COVID-19</td>
<td></td>
</tr>
</tbody>
</table>
Associate Hospital Managers are sent Trust Updates and Legal Updates received from external Solicitors.

### 4.3 Hospital Manager Hearings Data

<table>
<thead>
<tr>
<th>Type of Hearing</th>
<th>April 2018-March 2019</th>
<th>April 2019-March 2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>Section 2 Appeal</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Section 3 Appeal</td>
<td>13</td>
<td>6</td>
</tr>
<tr>
<td>Section 3 Contested Renewal</td>
<td>29</td>
<td>25</td>
</tr>
<tr>
<td>Section 3 Uncontested Renewal</td>
<td>9</td>
<td>21</td>
</tr>
<tr>
<td>Section 37 Appeal</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Section 37 Contested Renewal</td>
<td>5</td>
<td>9</td>
</tr>
<tr>
<td>Section 37 Uncontested Renewal</td>
<td>4</td>
<td>8</td>
</tr>
<tr>
<td>CTO Appeal</td>
<td>7</td>
<td>5</td>
</tr>
<tr>
<td>CTO Contested Extension</td>
<td>66</td>
<td>34</td>
</tr>
<tr>
<td>CTO Uncontested Extension</td>
<td>35</td>
<td>42</td>
</tr>
<tr>
<td>Section 26 NR Barring Hearing</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total Hearings</strong></td>
<td><strong>169</strong></td>
<td><strong>151</strong></td>
</tr>
</tbody>
</table>

As detailed in Part Two of this report, the number of detentions has increased, and this is shown in the total number of Section 3 renewal hearings taking place. The MHA Administration teams have been more proactive in seeking patient views on whether they wish to proceed with a full hearing when sections and CTOs are renewed which may account for the increase in uncontested renewals. There are safeguards built into the process to ensure that uncontested hearings only proceed in the event the patient’s RC or care coordinator has confirmed capacity is present.

<table>
<thead>
<tr>
<th>Attendees at Hearings</th>
<th>April 2018-March 2019</th>
<th>April 2019-March 2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient present</td>
<td>44</td>
<td>51</td>
</tr>
<tr>
<td>Solicitor Present</td>
<td>51</td>
<td>49</td>
</tr>
<tr>
<td>Advocate Present</td>
<td>11</td>
<td>5</td>
</tr>
</tbody>
</table>

There has been a very slight percentage reduction in advocates attending hearings but an 2% increase in Solicitors and 7% increase in patients attending.

<table>
<thead>
<tr>
<th>Cancellations and Adjournments</th>
<th>April 2018-March 2019</th>
<th>April 2019-March 2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hearing Cancelled</td>
<td>Not recorded</td>
<td>24</td>
</tr>
<tr>
<td>Hearing Adjourned</td>
<td>13</td>
<td>5</td>
</tr>
</tbody>
</table>

Cancelled hearings relate to hearings which have been arranged but do not take place due to the patient’s discharge. This has an impact on MHA Administration workload. In April 2019-March 2020, 175 hearings commenced, with 16% not taking place due to patient discharges.
Adjournments can be distressing for patients, and are expensive in terms of MHA Administration, Hospital Manager fees and expenses, and clinical staff attendance. The reduction in adjournments may be attributed to Associate Hospital Managers being encouraged to ask for additional information prior to convening to avoid adjournments due to insufficient information.

<table>
<thead>
<tr>
<th>Outcomes</th>
<th>April 2018-March 2019</th>
<th>April 2019-March 2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discharged</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>No discharge</td>
<td>154</td>
<td>150</td>
</tr>
</tbody>
</table>

It remains an exception for Associate Hospital Managers to discharge patients from section or CTO.
### Part Five - Mental Health Law response to COVID-19

During the pandemic, the MH Law team have continued to run critical services as usual and have provided guidance and support to the Trust as detailed below:

<table>
<thead>
<tr>
<th>Mental health Law Guidance and Support to Inpatient Services</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Scheme of Delegation</strong></td>
</tr>
<tr>
<td>Amended the Board of Directors Scheme of Delegation to include allowing additional staff to receive detention papers and to give patient’s Section 132 rights. Ratified by CMO. Communicated via resilience, comms and Care Groups (see Appendix Three).</td>
</tr>
<tr>
<td><strong>Giving of Rights</strong></td>
</tr>
<tr>
<td>Following the amended Scheme of Delegation, the provision of guidance for staff providing Section 132 rights. Communicated via resilience, comms and Care Groups.</td>
</tr>
<tr>
<td>Department of Health Rights leaflets uploaded to the intranet for easy reference along with links to leaflets in other languages.</td>
</tr>
<tr>
<td><strong>Receiving Papers</strong></td>
</tr>
<tr>
<td>Following the temporary amendment to the Scheme of Delegation, the provision of Guidance for staff receiving section papers. Communicated via resilience, comms and Care Groups.</td>
</tr>
<tr>
<td><strong>Medical Scrutiny</strong></td>
</tr>
<tr>
<td>Guidance completed for medical scrutineers. Communicated via resilience, comms, Care Groups and CMO.</td>
</tr>
<tr>
<td><strong>Section 17 leave</strong></td>
</tr>
<tr>
<td>Guidance provided in consultation with Clinical and Ethical Advisory Committee (CEAG) on restrictions on Section 17 leave. Guidance included advice on how patients could achieve one form of exercise a day without the use of off-site Section 17 leave. Communicated via resilience, comms and Care Groups.</td>
</tr>
<tr>
<td>Updated Guidance drafted on 30 April 2020 for consideration of CEAG in order to re-consider restrictions whilst balancing public health, safety, reduction of virus transmission, etc.</td>
</tr>
<tr>
<td><strong>Visitors</strong></td>
</tr>
<tr>
<td>At request of Incident Management Team (IMT), drafted letter to all inpatients including a green light version, to come from the Chief Executive Officer (CEO) communicating the decision to restrict visitors. Approved by CEO, Communicated via resilience, comms and Care Groups.</td>
</tr>
<tr>
<td>Updated guidance drafted on 30 April 2020 for consideration of CEAG in order to re-consider restrictions whilst balancing public health, safety, reduction of virus transmission etc. Decision to remain as per original guidance. Continue to review regularly, or as a result of Government advice or changes to restrictions.</td>
</tr>
<tr>
<td><strong>Advocates</strong></td>
</tr>
<tr>
<td>Liaison with Voiceability and Pohwer advocacy services to offer assistance in facilitating videoconferencing with patients. Provision of Guidance to wards on the importance of advocacy and provision of contact details. Communicated via resilience, comms and Care Groups.</td>
</tr>
<tr>
<td><strong>Medical Transfer</strong></td>
</tr>
<tr>
<td>At request of IMT, flow chart provided for legal basis for transfer to general hospitals. Communicated to all DGHs via resilience, comms and Care Groups.</td>
</tr>
<tr>
<td><strong>Guidance pts who refuse to self-isolate</strong></td>
</tr>
<tr>
<td>Written Guidance and flowchart detailing legal basis for isolating patients who refuse to self-isolate. Approved by CEAG, Infection Prevention and Control (IPAC) Lead and CMO. Communicated via resilience, comms and Care Groups.</td>
</tr>
</tbody>
</table>
Medical examination/assessment

Draft recommendations for remote Medical Examinations for MHA Assessments provided for CEAG to consider. Final version approved by CMO and communicated via resilience, comms and Care Groups. Continue to review regularly, or as a result of Government advice or changes to restrictions.

Exceptional Visitors

At request of IMT, drafted letter to family of critically ill patients to enable family to visit the ward safely to be with their loved one. Drafted in consultation with CEAG, IPAC, CMO, Deputy Nursing Director (DND) and Deputy CEO. Communicated via resilience, comms and Care Groups.

CEAG

Trust Solicitor and MHA Legal Practice Advisor membership of CEAG. Consideration of issues from legal practice perspective.

<table>
<thead>
<tr>
<th>MHA Administration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provision of Laptops to enable MHA Administration staff to work from home.</td>
</tr>
<tr>
<td>Duty MHAA rota for attendance at the three main sites across the Trust each day to process statutory papers, pick up post, send out hard copy letters, scan documents and continue with business ‘as is’.</td>
</tr>
<tr>
<td>Daily meeting via Google Teams and staff briefings</td>
</tr>
<tr>
<td>Retain uninterrupted MHA administration services. Ensure NSFT remains compliant with the MHA and Code of Practice despite extreme difficulties with self-isolation and sick leave of several members of staff at various points.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Monitoring</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ward monitoring was suspended on 17 March 2020, however virtual ward MHA monitoring recommenced week commencing 4 May 2020. Every detained patient in the Trust will receive virtual MHA monitoring two weekly to ensure MHA compliance.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Hospital Manager Hearings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Following Government Restrictions on movement, Associate Hospital Manager hearings were postponed due to visitors being restricted to hospital sites. All patients with forthcoming hearings were notified by letter.</td>
</tr>
<tr>
<td>Following a trial using Microsoft Teams, virtual hearings will proceed in May 2020 to review Section renewals and CTO extensions.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>MH Tribunals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conference call Mental Health Tribunals (MHT) facilitated followed by planning, testing and facilitation of MHTs via videoconferencing.</td>
</tr>
<tr>
<td>Guidance on facilitation of MHTs sent to all wards. Communicated via resilience, comms and Care Groups.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Electronic Forms</th>
</tr>
</thead>
<tbody>
<tr>
<td>The MH Law team, in consultation with Norfolk and Suffolk AMHP Leads, are developing a system by which electronic completion and electronic serving of statutory paperwork to wards and the MHA Administration team can be facilitated. The process will include a robust set of processes to ensure such potential deviations from the Code of Practice or diversion scan be recorded, monitored and audited for compliance by NSFT and/or CQC.</td>
</tr>
</tbody>
</table>
Part Six – Legal Update

6.1 Coronavirus Act 2020

As a result of the COVID-19 pandemic, the Government announced plans to pass an Act of Parliament to cover a wide range of powers relating to health, social care, public protection, education, Courts and Tribunals, elections, professional registrations, etc. The Bill proceeded rapidly through the House of Commons, the House of Lords and the Coronavirus Act 2020 received Royal Assent on 25 March 2020.

Section 10 of the Coronavirus Act 2020 allows for temporary modification of the MHA 1983. The temporary modifications are described in schedule 8 to the Act.

The Secretary of State will determine when the temporary amendments to the MHA will come into force. When, or if, the amendments come into force, the key change are detailed below:

Applications for admission to hospital

- An application made by an AMHP (not Nearest Relative applications) under Section 2 or Section 3 may be based upon a single medical recommendation if the AMHP considers it impractical or that it would involve undesirable delay to obtain two medical recommendations.

- If an application is based on a single medical recommendation the AMHP must record why they consider it impractical or that it would involve undesirable delay to obtain two medical recommendations.

- A single medical recommendation must be:
  - Signed on or before the date of the application, and
  - Made by a doctor who is approved under Section 12, and
  - Made by a doctor who has personally examined the patient (there is no requirement for the doctor to have had previous acquaintance.

- A single medical recommendation can be rectified or replaced under Section 15.

Applications for assessment in cases of emergency – Section 4

- Where an application under Section 4 is based upon a medical recommendation from a doctor who is not Section 12(2) approved it must still be followed up by a second medical recommendation (from a doctor who is Section 12(2) approved).

- One of these medical recommendations must still be made by a doctor who has previous acquaintance with the patient.

Use of holding powers – Section 5

- Any doctor (not just the nominated deputy) can put a patient on 5(2) if they consider that obtaining the attendance of the clinician in charge of treatment would be impractical or involve undesirable delay.

- Section 5(2) will last for 120 hours (up from 72 hours).

- Section 5(4) will last for 12 hours (up from 6 hours).

Periods of remand to hospital

- Section 35 and Section 36 will continue to run for 28 days at a time, but with no longer limited to a maximum of 12 weeks.
Court Orders

- Sections 36/37/38/45A and 51 – now only require evidence from one medical practitioner.
- For Section 45A the evidence must be provided orally to the Court.

Transfer Directions

- Sections 47 and 48 – transfer directions may be made based on a report from one medical practitioner.

Conveyance – Part III

- Section 35 – convey within 7 days, or as soon as practicable after that.
- Sections 37 and 38 – convey within 28 days, or as soon as practicable after that.
- Section 45A – convey within 28 days, or as soon as practicable after that.
- Section 47 – convey within 28 days (up from 14).

Part IV – Treatment

- The AC in charge of the treatment may certify medication under Section 58 for a patient who lacks capacity or is not consenting if they consider it would be impractical or involve undesirable delay to arrange for a SOAD to make the certificate.
- An AC completing form T3 can do so after consulting with just one other person, if the requirement to consult with two would be impractical or involve undesirable delay.
- If an AC completing form T3 consults with just one person, this person cannot be a nurse or doctor or another RC.

Detention in a place of safety

- Section 135(1) and Section 136 detention period extended from 24hrs to 36 hours (further extension of 12 hours still permitted).

Transitional provisions

- If a patient is subject to Section 5(2) or 5(4) at the time these amendments to the MHA cease to have effect, the Section 5(2) or 5(4) will continue to the maximum of 120hrs or 12hrs respectively.
- If a person is in hospital under Section 35 or 36 at the time the amendments to the MHA cease to have effect, the current period of detention will continue. However, the Court will not be able to further extend any period if it has already gone beyond 12 weeks.
- If a transfer direction has been issued during the period of temporary changes, the person can still be transferred within 28 days of the issue of the direction.

If a person subject to Sections 35, 37, 38, or 45A has not been admitted to hospital at the point the temporary amendments cease, they must be cannot be admitted later than one week after the period specified in the un-amended Act.

Updates can be accessed via this link: Coronavirus Act 2020
6.2 Potential Impact for NSFT of Coronavirus Act 2020

It is expected that prior to the Secretary of State implementing Section 10/Schedule 8 of the Coronavirus Act 2020, the DHSC will produce comprehensive guidance to assist mental health Trusts. The Mental Health Law team are closely monitoring the legal situation and are in constant contact with our AMHP colleagues.

The MHA Legal Practice Advisor has met via teams with NSFT Lorenzo Business Change Specialists, DXC colleagues and Mental Health Leads from other MH Trusts that use Lorenzo. The changes to Lorenzo required to reflect the revised Section 5 and Section 135(1)/136 timescales have been completed and will be facilitated immediately upon enactment.

In the event the MHA 1983 is modified, in consideration of the DHSC guidance and in consultation with the CMO and Local Authorities, the MH Law team will produce the following:

- Guidance for Section 12 doctors providing a single Medical Recommendation. This element of the modified MHA should only be used in exceptional circumstances and will need to be considered on a case by case basis.
- Guidance for medical scrutineers to ensure additional scrutiny is undertaken when only one medical recommendation is used to support an AMHP application.
- Potentially Joint NSFT/Local Authority Guidance for all MHA Assessing Team to include examples/vignettes of when it is proportionate to use only one MH medical assessor.
- Guidance for nursing and medical staff on the use of modified Section 5.
- Guidance for Section 136 suites on the use of modified Section 136.
- Implementation of a robust system of Governance to provide accurate and current information to the Board about the efficiency and effectiveness of revised policies and guidance. To include running a daily report from within the new functionality within Lorenzo.
- Implementation of a programme of audit to provide effective and accurate compliance recording where the Coronavirus Act 2020 is utilised.

6.3 Mental Capacity (Amendment) Act 2019 and Liberty Protection Safeguards

The Mental Capacity (Amendment) Bill, which passed into law in May 2019. It replaces the DoLS with Liberty Protection Safeguards (LPS) although they are not yet implemented.

Key features of the LPS include:

- LPS commence at 16 years old rather than the current 18 years old under DoLS.
- The LPS must be authorised in advance by the ‘Responsible Body’.
- For NHS hospitals, the Responsible Body will be the ‘hospital manager’.
• For arrangements under Continuing Health Care outside of a hospital, the ‘Responsible Body’ will be the CCG.
• In all other cases – such as in care homes, supported living schemes and private hospitals, the Responsible Body will be the Local Authority.

For the Responsible Body to authorise any deprivation of liberty, it needs to be clear that:

1. The person lacks the capacity to consent to the care arrangements, and
2. The person has a mental disorder, and
3. The arrangements are necessary to prevent harm to the cared-for person, and
4. The arrangements are proportionate to the likelihood and seriousness of that harm.

• In order to determine this, the responsible body must consult with the person and others, to understand what the person’s wishes and feelings about the arrangements are.
• An individual from the responsible body, but not someone directly involved in the care and support of the person subject to the care arrangements, must conclude if the arrangements meet the three criteria above (lack of capacity; mental disorder; necessity and proportionality).
• Where it is clear, or reasonably suspected, that the person objects to the care arrangements, then a more thorough review of the case must be carried out by an Approved Mental Capacity Professional.
• Safeguards once a deprivation is authorised include regular reviews by the Responsible Body and the right to an appropriate person or an Independent Mental Capacity Advocate (IMCA) to represent a person and protect their interests.
• As under DoLS, a deprivation can be for a maximum of one year initially. Under LPS, this can be renewed initially for one year, but subsequent to that for up to three years.
• As under DoLS, the Court of Protection will oversee any disputes or appeals.
• The new Act also broadens the scope to treat people, and deprive them of their liberty, in a medical emergency, without gaining prior authorisation.

The target date for implementation was October 2020 and prior to that, a revised MCA Code of Practice was in the process of being drafted, to be published in Spring 2020. The Code of Practice would clarify a number of outstanding questions about how LPS will work in practice. However, as a result of COVID-19, it is anticipated that this will be delayed.

On 29 April 2020 during a MCA & DoLS COVID-19 webinar, and in response to this specific query, a representative of the DHSC stated:

The Government is aware of the pressures that the pandemic is exerting on the health and social care sector. We are considering the implementation timetable for LPS in light of the pandemic. We are not asking the sector to prioritise LPS preparation and will make a national statement as soon as possible.

Updates can be accessed via this link LPS Updates.

6.4 Potential Impact for NSFT of Liberty Protection Safeguards

The Code of Practice will clarify processes and responsibilities. However, it is clear that the LPS regime will have an impact upon the Trust in terms of funding, training and development of processes and safeguards.

• As ‘Responsible Body’ NSFT will have the ability and responsibility of implementing LPS for deprivations of liberty within NSFT hospitals.
• A requirement for NSFT to review the LPS ‘passport’ of people admitted from the community with existing LPS.

• Where a person has an existing LPS, consideration of a revised LPS due to significant changes in care and treatment requirements for patients admitted from the community.

• Removal of the liability placed upon the trust as a result of Local Authority approval delays.

• Responsibility for arranging and undertaking LPS assessments within NSFT.

• Responsibility for arranging and undertaking ‘regular reviews’ for people with existing LPS within NSFT.

• Where it is clear, or reasonably suspected, that the person objects to the care arrangements within NSFT, requirement to refer to an Approved Mental Capacity Professional (provided by the Local Authority).

The MH Law team are monitoring regularly for updates. Once the Code of Practice has been published, the MHL team will be in a better position to advise on how to implement the changes and what the training, financial and workforce impact is likely to be.

6.5 Review of the Mental Health Act

On 4 October 2017, the government announced the launch of a review of the Mental Health Act 1983, to be led by Professor Sir Simon Wessely, a former President of the Royal College of Psychiatrists. The review was set up to look at how the legislation in the Mental Health Act 1983 is used and how practice can improve and particularly to understand the reasons for:

• rising rates of detention under the Act;
• the disproportionate number of people from black and minority ethnic groups detained under the Act;
• processes that are out of step with a modern mental health care system.

The full membership and terms of reference can be accessed via this link: Independent review of the MHA: Membership and ToR.

The Independent Review of the Mental Health Act 1983 report published in December 2018 set out recommendations for Government covering four principles:

• choice and autonomy – ensuring service users’ views and choices are respected
• least restriction – ensuring the Act’s powers are used in the least restrictive way
• therapeutic benefit – ensuring patients are supported to get better, so they can be discharged from the Act
• people as individuals – ensuring patients are viewed and treated as rounded individuals

The interim report was published in May 2018 and the final report in December 2018. The final report contained 154 separate recommendations of how the MHA and associated practice needed to change. A full copy of the Report can be access via this link: Final report of the Independent Review of the Mental Health Act 1983 published December 2018.
In a written statement in the House of Commons (HCWS1149) on 6 December 2018, the Secretary of State for Health and Social Care confirmed that the Government would consider the report and its recommendations in detail, and would respond in due course and stated the intention remained to reform mental health law. The statement confirmed that Government will develop and bring forward legislation when Parliamentary time allows. In the interim, the Department for Health and Social Care announced that two of the report’s recommendations which both highlight the Review’s focus on increasing the rights and autonomy of patients were accepted:

- The establishment of new statutory advance choice documents (ACDs) to enable people to express preferences on their care and treatment.
- The creation of a new role of Nominated Person, to be chosen by the patient, rather than allocated to them from a list of relatives. This person would have enhanced powers in their role; both to be informed about the person’s detention in hospital and to be involved in decisions made about their care.

On Monday 4 May 2020, representatives of the Department for Health and Social Care stated, via webinar:

_The response to the Review’s recommendations has been temporarily paused while the Department of health and Social Care (DHSC) and mental health sectors focus on responding to the pandemic. However, the Government remains committed to publishing a White Paper which will set out how the MHA will be reformed over the coming years. These reforms are centred on improving patient safeguards, experience and outcomes._

### 6.6 Potential Impact for NSFT of MHA reform

Reforms to the MHA are likely to take several years. In the interim the MHA Legal Practice Advisor and MHA Administration manager have attended several regional legal seminars in order to ensure the Trust is able to respond to consultations, and to maintain an overview on the progress of the Government’s response.

Once the Government’s response is published, the MHA Legal practice Advisor will identify priority themes and develop draft proposals for the Mental Health Executive Lead.
### Appendix 1 - Associate Hospital Managers

<table>
<thead>
<tr>
<th>Chairs</th>
<th>Panel Members</th>
</tr>
</thead>
<tbody>
<tr>
<td>Robert Bennett (Vice Chair)</td>
<td>Tracey Barker</td>
</tr>
<tr>
<td>Bob Billing</td>
<td>Pamela Bickley</td>
</tr>
<tr>
<td>John Brierley</td>
<td>Emma Bishton</td>
</tr>
<tr>
<td>Caroline Bunbury</td>
<td>Colin Boyd</td>
</tr>
<tr>
<td>Libby Cotton</td>
<td>Anne Browning</td>
</tr>
<tr>
<td>Graham Creelman</td>
<td>Joyce Cameron</td>
</tr>
<tr>
<td>Elizabeth Harlaar</td>
<td>Carl Coughlin</td>
</tr>
<tr>
<td>John Hume (Vice –Chair)</td>
<td>Penny Creasy</td>
</tr>
<tr>
<td>Tessa Innes</td>
<td>Sam Earl</td>
</tr>
<tr>
<td>Paula Kerr</td>
<td>Christopher Fielding</td>
</tr>
<tr>
<td>Guenever Pachent</td>
<td>Lady Kay Fisher</td>
</tr>
<tr>
<td>Brian Puplett</td>
<td>Moira Goodey</td>
</tr>
<tr>
<td>Janet Royce</td>
<td>Susan Harradine</td>
</tr>
<tr>
<td>Margaret Sparrow</td>
<td>Gregory Hayman</td>
</tr>
<tr>
<td></td>
<td>Judith Jones</td>
</tr>
<tr>
<td></td>
<td>Susan Whitaker</td>
</tr>
</tbody>
</table>
## Appendix Two: NSFT Scheme of Delegation

<table>
<thead>
<tr>
<th>Section/Reference</th>
<th>Form/Code</th>
<th>Description</th>
<th>Responsible Staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>Section 2, 3 and 4</td>
<td>H3 CoP Chapter 14</td>
<td>Record of Detention in Hospital</td>
<td>Mental Health Law staff band 4 and above and clinical staff at Band 5 or above (or equivalent) who have at least one year's experience at that level and have attended the relevant Trust training</td>
</tr>
<tr>
<td>Section 5(2)</td>
<td>H1 (part 2) CoP Chapter 18</td>
<td>Record of receipt of report on hospital in-patient</td>
<td>Duty doctor as per duty doctor rota or as otherwise set out in writing</td>
</tr>
<tr>
<td>Section 5(3)</td>
<td>CoP Chapter 37</td>
<td>Nominated deputy power under section 5(2)</td>
<td></td>
</tr>
<tr>
<td>Section 14</td>
<td>CoP Chapter 37</td>
<td>Request for social circumstances report following receipt of an application for detention made by Nearest Relative</td>
<td>Mental Health Law staff</td>
</tr>
<tr>
<td>Section 15</td>
<td>CoP Chapter 35</td>
<td>Arranging for rectification of recommendations and applications</td>
<td>Mental Health Law staff band 4 and above</td>
</tr>
<tr>
<td>MHA 15(2)</td>
<td>CoP Chapter 35</td>
<td>Scrutiny of Medical Grounds for Detention</td>
<td>Consultant Psychiatrist, other than the patient's RC or Dr who made a recommendation</td>
</tr>
<tr>
<td>MHA sections 17C or 19</td>
<td>Regs 11 and 12 CoP Chapter 17</td>
<td>Conveyance to Hospital on recall, transfer or other reasons</td>
<td>Any member of staff of the Trust or any person authorised in writing by the Hospital Managers</td>
</tr>
<tr>
<td>Section 17E</td>
<td>CTO4</td>
<td>Record of detention in hospital following recall</td>
<td>Mental Health Law staff band 4 and above and clinical staff at Band 5 or above (or equivalent) who have at least one year's experience at that level and have attended the relevant Trust training</td>
</tr>
<tr>
<td>Section 19, Section 19A, Section 17F</td>
<td>H4, CTO10 CTO5 CoP Chapter 37</td>
<td>Transfer of detained patient, community patient, recalled community patient</td>
<td>Mental Health Law staff band 4 and above and clinical staff at Band 5 or above (or equivalent) who have at least one year's experience at that level and have attended the relevant Trust training</td>
</tr>
<tr>
<td>Section 18</td>
<td>CoP Chapter 28</td>
<td>Return of patients who are absent without leave (AWOL)</td>
<td>Any member of staff of the Trust or any other person authorised in writing by the Hospital Managers</td>
</tr>
<tr>
<td>Sections 20, 20A, 21B</td>
<td>Regulation 13</td>
<td>Record of Renewal of compulsory powers</td>
<td>Mental Health Law staff</td>
</tr>
<tr>
<td>Section/Reference</td>
<td>Form/Code</td>
<td>Description</td>
<td>Responsible Staff</td>
</tr>
<tr>
<td>----------------------</td>
<td>-------------</td>
<td>-----------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Section 20 and</td>
<td>H5 CTO7</td>
<td>Receive report extending the detention or community treatment period</td>
<td>Mental Health Law staff band 4 and above and clinical staff at Band 5 or above (or equivalent) who have at least one year's experience at that level and have attended the relevant Trust training</td>
</tr>
<tr>
<td>Section 20A</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Section 23</td>
<td>CoP Chapter 32 &amp; 38</td>
<td>Power to discharge patient from detention or CTO. Power to discharge following renewal of detention of extension of CTO.</td>
<td>Associate Hospital Managers</td>
</tr>
<tr>
<td>MHA Sections</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>35(4) 36(3) 37(4)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>38(4) 44(2) 45A(5)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Section 23</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MHA sections 67, 68 and 71</td>
<td>CoP Chapters 12 &amp; 37</td>
<td>Evidence of admission arrangements</td>
<td>Evidence from the assigned AC or another person authorised by that Approved Clinician</td>
</tr>
<tr>
<td>Section 48</td>
<td>CoP Chapter 30</td>
<td>Duties in respect of victims of crime</td>
<td>Service Directors</td>
</tr>
<tr>
<td>MHA sections 67, 68 and 71</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Section 131A</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sections 132(1)</td>
<td>CoP Chapter 4</td>
<td>Informatin detained and community patients of their rights</td>
<td>Clinical staff at Band 4 or above (or equivalent) who have at least one year's experience at that level.</td>
</tr>
<tr>
<td>132(2) &amp; 132A(1)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sections 132(4)</td>
<td>CoP Chapter 4</td>
<td>Advising nearest relatives of rights</td>
<td>Mental Health Law staff</td>
</tr>
<tr>
<td>132A (3)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Section 133</td>
<td>CoP Chapter 4</td>
<td>Informing nearest relative of patient's discharge</td>
<td>Mental Health Law staff</td>
</tr>
<tr>
<td>Section 134</td>
<td>CoP Chapter 4 &amp; 37</td>
<td>Withholding outgoing post from restricted patients, recording same and notifying patient</td>
<td>Staff at Band 6 or above (or equivalent)</td>
</tr>
<tr>
<td>Reference</td>
<td>Description</td>
<td>Responsible Staff</td>
<td></td>
</tr>
<tr>
<td>-----------</td>
<td>-------------</td>
<td>-------------------</td>
<td></td>
</tr>
<tr>
<td>Code of Practice Chapter 35</td>
<td>Scrutinising admission documents</td>
<td>Mental Health Law staff band 4 and above</td>
<td></td>
</tr>
<tr>
<td>Mental Health Regulations 2008 Reg. 3 (9)</td>
<td>Making records or reports required by the regulations</td>
<td>Mental Health Law staff</td>
<td></td>
</tr>
<tr>
<td>Chapter 38</td>
<td>Deciding if a Hospital Managers Review should take place</td>
<td>Mental Health Law staff</td>
<td></td>
</tr>
<tr>
<td>MHA Part V1 Regulations 15 and 16</td>
<td>Record of detained patients moving within United Kingdom to England and Wales</td>
<td>Mental Health Law staff</td>
<td></td>
</tr>
<tr>
<td>Rule 32 of Tribunal Procedure (First-tier Tribunal) (Health, Education and Social Care Chamber) Rules 2008.</td>
<td>Sending reports to First Tier Tribunal (Mental Health)</td>
<td>Mental Health Law staff</td>
<td></td>
</tr>
<tr>
<td>First Tier Tribunal (Mental Health) Practice Direction 2012</td>
<td>Completion of Statement of Information for First Tier Tribunal (Mental Health)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Completion of Responsible Clinician Report for First Tier Tribunal (Mental Health)</td>
<td>Responsible Clinician or other clinician delegated by the Responsible Clinician</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Completion of Social Circumstances Report for First Tier Tribunal (Mental Health)</td>
<td>Care Co-ordinator, Social Worker or other practitioner delegated by the care co-ordinator or relevant Team Manager</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Completion of Nursing Report for First Tier Tribunal (Mental Health)</td>
<td>Registered Nurse (Mental Health or Learning Disability) as delegated by Team Manager</td>
<td></td>
</tr>
</tbody>
</table>
## Appendix Three: COVID-19 Temporary Amendments to NSFT Scheme of Delegation

<table>
<thead>
<tr>
<th>Section/Reference</th>
<th>Form/Code</th>
<th>Description</th>
<th>NSFT Business as Usual</th>
<th>NSFT COVID19 temporary proposal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Section 5(2)</td>
<td>H1 (part 2)</td>
<td>Record of receipt of report on hospital in-patient</td>
<td>Mental Health Law staff band 4 and above and clinical staff at Band 5 or above (or equivalent) who have at least one year’s experience at that level</td>
<td>Mental Health Law staff band 4 and above and clinical staff at Band 5 or above (or equivalent) who have at least one year’s experience at that level</td>
</tr>
<tr>
<td>Section 2, 3 and 4</td>
<td>H3</td>
<td>Record of Detention in Hospital</td>
<td>Mental Health Law staff band 4 and above and clinical staff at Band 5 or above (or equivalent) who have at least one year’s experience at that level</td>
<td>Mental Health Law team will ensure forms are scrutinised to pick up any errors</td>
</tr>
<tr>
<td>Section 19</td>
<td>H4</td>
<td>Transfer from one hospital to another</td>
<td>Mental Health Law staff band 4 and above and clinical staff at Band 5 or above (or equivalent) who have at least one year’s experience at that level</td>
<td>Mental Health Law team will ensure forms are scrutinised to pick up any errors</td>
</tr>
<tr>
<td>Section 20 and Section 20A</td>
<td>H5</td>
<td>Renewal of authority to detain</td>
<td>Mental Health Law staff band 4 and above and clinical staff at Band 5 or above (or equivalent) who have at least one year’s experience at that level</td>
<td>Mental Health Law team will ensure forms are scrutinised to pick up any errors</td>
</tr>
<tr>
<td>Section 17E</td>
<td>CTO4</td>
<td>Record of detention in hospital following recall</td>
<td>Mental Health Law staff band 4 and above and clinical staff at Band 5 or above (or equivalent) who have at least one year’s experience at that level</td>
<td>Mental Health Law team will ensure forms are scrutinised to pick up any errors</td>
</tr>
<tr>
<td>Section 20A</td>
<td>CTO7</td>
<td>Report extending the community treatment period</td>
<td>Mental Health Law staff band 4 and above and clinical staff at Band 5 or above (or equivalent) who have at least one year’s experience at that level</td>
<td>Mental Health Law team will ensure forms are scrutinised to pick up any errors</td>
</tr>
<tr>
<td>Sections 19, 19A, 17F</td>
<td></td>
<td>Transfer of detained patient, community patient, recalled community patient</td>
<td>Mental Health Law staff band 4 and above and clinical staff at Band 5 or above (or equivalent) who have at least one year’s experience at that level</td>
<td>Mental Health Law team will ensure forms are scrutinised to pick up any errors</td>
</tr>
<tr>
<td>Sections 132(1),132(2) &amp; 132A(1)</td>
<td>Code of Practice Chapter 4</td>
<td>Informing detained and community patients of their rights</td>
<td>Mental Health Law staff band 4 and above and clinical staff at Band 5 or above (or equivalent) who have at least one year’s experience at that level</td>
<td>Mental Health Law team will ensure forms are scrutinised to pick up any errors</td>
</tr>
</tbody>
</table>

Qualified staff Band 5 or above (or equivalent) with at least one year’s experience at that level. APs who have received Trust specific training. Written communication: Mental Health Law Staff

Oral Communication: CSW, APs, senior support workers and qualified clinical staff using crib sheet provided by Mental Health Law team

Written communication: Mental Health Law Staff
## Appendix Four: Inpatient Hospitals that have patients subject to the Mental Health Act 1983 and Deprivation of Liberty Safeguards

### Norfolk

<table>
<thead>
<tr>
<th>Hospital Name</th>
<th>Address</th>
<th>Tel.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hellesdon Hospital</td>
<td>Drayton High Road, Norwich, NR6 5BE</td>
<td>01603 421421</td>
</tr>
<tr>
<td>The Julian Hospital</td>
<td>Bowthorpe Road, Norwich, NR2 3TD</td>
<td>01603 421800</td>
</tr>
<tr>
<td>Northgate Hospital</td>
<td>Northgate Street, Gt Yarmouth, NR30 1BU</td>
<td>01493 337652</td>
</tr>
<tr>
<td>Carlton Court &amp; Dragon Fly</td>
<td>St Peters Road, Carlton Colville, Lowestoft, NR33 8AG</td>
<td>01502 527474</td>
</tr>
<tr>
<td>Samphire Ward</td>
<td>Chatterton House, Goodwins Road, Kings Lynn, PE30 5PD</td>
<td>01553 736318</td>
</tr>
<tr>
<td>Northside House</td>
<td>(formerly Norvic Clinic) St Andrews Business Park, Thorpe St Andrew, Norwich, NR7 0HT</td>
<td>01603 707500</td>
</tr>
</tbody>
</table>

### Suffolk

<table>
<thead>
<tr>
<th>Hospital Name</th>
<th>Address</th>
<th>Tel.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Woodlands Ipswich Hospital</td>
<td>Heath Road, Ipswich, IP4 5PD</td>
<td>01473 891700</td>
</tr>
<tr>
<td>Wedgwood House</td>
<td>West Suffolk Hospital, Hardwick Lane, Bury St Edmunds, Suffolk IP332QZ</td>
<td>01284 719700</td>
</tr>
<tr>
<td>Foxhall House</td>
<td>Foxhall Road, Ipswich, IP3 8LS</td>
<td>01473 322200</td>
</tr>
<tr>
<td>Walker Close off Pearson Road</td>
<td>Ipswich, IP3 8LY</td>
<td>01473 237003/4</td>
</tr>
<tr>
<td>SRRS</td>
<td>15 Ribbons Park Road, Ipswich, IP3 8XL</td>
<td>01473 322270</td>
</tr>
</tbody>
</table>
Report To: Board of Directors  
Meeting Date: 21st May 2020  
Title of Report: Scheme of Reservation and Delegation and Standing Financial Instructions  
Action Sought: For approval  
Estimated time: 5 minutes  
Author: Jean Clark, Trust Secretary  
Director: Daryl Chapman, Director of Finance  

Summary:  
The Scheme of Reservation and Delegation and Standing Financial Instructions have been reviewed.  
The SFI document includes tracked changes from the 2018 version.  
The Scheme of Reservation and Delegation is a new format highlighting:  
- Matters reserved to the Board of Directors and Council of Governors  
- Refresh of limits  
- Addition of delegations during an emergency response  
- The mental health act delegations  
The Finance, Business and Investment Committee (FBIC) are reviewing the documents on 18th May and their amendments will be shared with the board.  

Recommendation:  
The Board of Directors is asked to approve the Scheme of Reservation and Delegation and Standing Financial Instructions, subject to changes proposed by FBIC  
The report links to the risk 4.1, 4.2 on the BAF.
Norfolk & Suffolk NHS Foundation Trust
Scheme of Reservation and Delegation Draft V8.0

This document sets out the scheme of reservation and delegation of NSFT, arising from the Standing Orders and Standing Financial Instructions and Constitution.

Table 1 – Matters reserved to the Board of Directors and Council of Governors
Table 2 – Scheme of Delegation
Table 3 – Operational Scheme of Delegation
Table 4 – Authorisation Limits by Role - EPRR
<table>
<thead>
<tr>
<th>Title</th>
<th>Scheme of Reservation and Delegation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outcome Statement</td>
<td>To provide a schedule of reserved and delegated matters arising from the Standing Financial Instructions and Standing Orders so that the Trust’s decision making and financial transactions are carried out in accordance with the law and to achieve probity, accuracy, economy, efficiency and effectiveness</td>
</tr>
</tbody>
</table>
| Written by | Kathy Walsh, Deputy Director of Finance  
Jean Clark, Trust Secretary |
| Reviewed by | Finance, Business and Investment Committee (FBIC) |
| In consultation with | Executive Committee, Internal Audit |
| Approval by and date | Board of Directors |
| With reference to | NSFT Constitution  
The NHS Foundation Trust Code of Governance July 2014 |
| Associated Trust Policies | Standing Financial Instructions |
| Applicable to/ For use by | All employees, all Non Executive Directors |
| Reference Number | F005 |
| Version | 08 |
| Retention period | 20 years |
| Published Date | June 2020 |
| Review Date | March 2021 |
| Impact Assessment | |
| Reason for Development/revision | Annual review to ensure the Scheme of Reservation and Delegation reflects the most up to date procedures of the Trust |
| Monitoring and implementation of policy | CEO, Director of Finance  
FBIC  
All employees and the Board have a duty to disclose any non-compliance with the Scheme of Reservation and Delegation and Standing Financial Instructions to the CEO and Trust Secretary as soon as possible |
1. Introduction

1.1 The Foundation Trust Code of Governance states:
   A1.1 The Board of Directors should meet sufficiently regularly to discharge its duties effectively. There should be a schedule of matters specifically reserved for its decision. The schedule of matters reserved for the board of directors should include a clear statement detailing the roles and responsibilities of the council of governors. These arrangements should be kept under review at least annually.

1.2 The NSFT Constitution states:
   3.1 The powers of the Trust are set out in the 2006 Act
   3.2 The powers of the Trust shall be exercised by the Board of Directors on behalf of the Trust.
   3.3 Any of these powers may be delegated to a committee of Directors or to an Executive Director

1.3 The NSFT Standing Orders and Standing Financial Instructions state:
   1.3.1 The Standing Financial Instructions (SFIs)
   1.3.2 The Standing Orders (SOs)

1.4 The purpose of this document is to demonstrate how those powers are to be reserved to the Board while at the same time delegating to the appropriate level the detailed application.

1.5 The Board remains accountable for all of its functions including those delegated and would therefore expect to receive information about the exercise of delegated functions. Powers and decisions may only be exercised by the Board of Directors in formal session. Any non-compliance will be reported to the next formal meeting of the Board for action or ratification.

1.6 FTs can only delegate authority to a committee of directors or to an Executive director i.e. individual Non-executive directors cannot be delegated powers by the board and committees that have formal memberships other than directors cannot be delegated powers by the Board. Where committees are authorised to establish sub-committees they may not delegate executive powers to the sub-committee unless expressly authorised by the Board of Directors

1.7 All powers of the Trust which have not been retained as reserved by the Board or delegated to an individual or committee shall be exercised on behalf of the Board by the Chief Executive.

1.8 This Scheme of Delegation shows only the ‘top level’ of delegation and is to be used in conjunction with the system of budgetary control and other established procedures within the Trust.

1.9 In the absence of an officer to whom powers have been delegated, those powers shall be exercised by a designated deputy or by the responsible director.
### Table 1 – Matters Reserved to the Board of Directors and to the Council of Governors

<table>
<thead>
<tr>
<th>No.</th>
<th>Reserved Matter</th>
<th>Reserved to the Board of Directors</th>
<th>Reserved to Council of Governors</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Set the Trust’s strategic aims</td>
<td>✔</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Approval of standing orders and standing financial instructions</td>
<td>✔</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Disclose any non-compliance with these SFIs to the CEO and Trust Secretary as soon as possible</td>
<td>✔</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>The establishment, terms of reference and reporting arrangements of all committees and sub-committees of the Board; as a minimum Appointments and Remuneration Committee, Audit and Risk Committee, Charitable Funds Committee. The Board may establish such other committees as required to discharge the Trust’s responsibilities.</td>
<td>✔</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Approval and review of clinical governance arrangements</td>
<td>✔</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Approval and review of risk management arrangements, including emergency response, information governance</td>
<td>✔</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Approval of Standards of Business Conduct and Conflicts of Interest Policy</td>
<td>✔</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Expenditure in excess of approved budgets</td>
<td>✔</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Approval of doctors under Section 12 of Mental Health Act 1983</td>
<td>✔</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Use of Trust’s land, buildings, property or other resources, or staff other than for relevant health services or collaboration with local authorities</td>
<td>✔</td>
<td></td>
</tr>
<tr>
<td>No.</td>
<td>Reserved Matter</td>
<td>Reserved to the Board of Directors</td>
<td>Reserved to Council of Governors</td>
</tr>
<tr>
<td>-----</td>
<td>---------------------------------------------------------------------------------</td>
<td>-------------------------------------</td>
<td>---------------------------------</td>
</tr>
<tr>
<td>11</td>
<td>Acquisition and disposal of significant assets (value greater than £500,00)</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>Approval of Capital Programme as part of Annual Plan</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>Approval of PFI Capital Procurement</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>Approval of banking arrangements</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>Closure or change of use of health services premises or the commencement of related formal procedures</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>16</td>
<td>Authorisation of the CEO to enter into partnership arrangements with local authorities regarding the provision of health related local authority functions in accordance with S31 of the Health Act 1999</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>17</td>
<td>Approval and adoption of the Annual Report and Annual Accounts</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>18</td>
<td>Approve changes to the Trust’s Constitution</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>19</td>
<td><strong>General:</strong> To hold the Non-Executive Directors individually and collectively to account for the performance of the Board of Directors</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>20</td>
<td><strong>General:</strong> To represent the interests of the members of the Trust as a whole and the interests of the public</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>21</td>
<td><strong>Financial:</strong> Appointment and removal of external auditors following recommendations of the audit committee</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>22</td>
<td><strong>Financial:</strong> Receive the annual report, annual accounts and auditor’s report at the annual members meeting</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>No.</td>
<td>Reserved Matter</td>
<td>Reserved to the Board of Directors</td>
<td>Reserved to the Council of Governors</td>
</tr>
<tr>
<td>-----</td>
<td>---------------------------------------------------------------------------------</td>
<td>------------------------------------</td>
<td>-------------------------------------</td>
</tr>
<tr>
<td>23</td>
<td><strong>Appointments &amp; Remuneration</strong>: Appoint and remove the Chair of the Board of Directors</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>24</td>
<td><strong>Appointments &amp; Remuneration</strong>: Appoint and remove NEDs</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>25</td>
<td><strong>Appointments &amp; Remuneration</strong>: Approve remuneration and other allowances of the Chair and NEDs</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>26</td>
<td><strong>Appointments &amp; Remuneration</strong>: approval of process for evaluation of the Chair</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>27</td>
<td><strong>Appointments &amp; Remuneration</strong>: to agree skills, knowledge and competencies required by the board and the process for performance evaluation of the NEDs</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>28</td>
<td><strong>Appointments &amp; Remuneration</strong>: Approve the appointment of the CEO</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>29</td>
<td><strong>Appointments &amp; Remuneration</strong>: Appoint and remove the lead governors</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>30</td>
<td><strong>Strategy</strong>: to provide views on the forward plan and annual report</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>31</td>
<td><strong>Strategy</strong>: Approve ‘significant transactions’ as defined in the Constitution; mergers, acquisitions, separations or dissolutions; proposals to increase the proportion of the Trust’s income earned from non-NHS work by 5% a year or more, as proposed by the Board of Directors</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Ref</td>
<td>Delegated Area</td>
<td>Delegated Matter</td>
<td>Ref 1</td>
</tr>
<tr>
<td>-----</td>
<td>--------------------------------------</td>
<td>----------------------------------------------------------------------------------</td>
<td>-------</td>
</tr>
<tr>
<td></td>
<td><strong>STRATEGY AND PLANNING</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>PREPARATION &amp; APPROVAL OF ANNUAL PLAN</td>
<td>Approval of Capital programme as part of Annual Plan</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>AND BUDGETS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Compilation and submission to Board of Directors a Forward plan in respect of each financial year</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>3</td>
<td>Preparation and submission of budgets for approval by the Board of Directors prior to start of the financial year</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Budget holders to sign up to their allocated budgets at commencement of each financial year</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Determination of the level of delegation to Budget Holders</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>6</td>
<td>Approval of cost improvement and income generation activities in line with Annual</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Ref</td>
<td>HUMAN RESOURCES</td>
<td>APPOINTMENT AND REMUNERATION</td>
<td>REDUNDANCY AND EARLY RETIREMENT</td>
</tr>
<tr>
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</tr>
<tr>
<td>7</td>
<td>Appoint and remove the Chair and NEDs</td>
<td>Approve remuneration and other allowances of the Chair and NEDs</td>
<td>Decisions in respect of redundancy and severance payments to senior managers</td>
</tr>
<tr>
<td>8</td>
<td>Approve the appointment of the CEO</td>
<td>Approve remuneration and other allowances of Executive Directors including pension rights and any compensation payments</td>
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<td>9</td>
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<td>11</td>
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</tbody>
</table>

Delegated Matter
- Plan
- Approval of Significant transactions as defined in the Constitution
- Budget Manager
- Head of Service/Budget Manager

Delegated Area
- Finance
- Director of Finance
- Chief Medical Officer
- Chief Executive Officer
- Council of Governors
- Reserved to the Board of Directors
- Trustees
- Delegated to the Board of Directors

Other
- Delegated to
- QAC review
- Remuneration
- Reserve of QAC review
- Delegated to
- Delegated to
- Revised by

Tab 21.1 Paper Pi NSFT Scheme of Reservation and Delegation
Board of Directors - Public Session 21st May 2020-15/05/20
205 of 286
<table>
<thead>
<tr>
<th>Ref</th>
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<tr>
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<td>Delegated to Chief Medical Officer</td>
<td>Delegated to Audit &amp; Risk Committee</td>
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<td></td>
<td>Delegated to Finance Business &amp; Investment Committee</td>
<td>Delegated to Appts &amp; Remuneration Committee</td>
</tr>
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<td>Delegated to Trust Secretary</td>
<td>Delegated to Head of service/ Budget Manager</td>
</tr>
<tr>
<td></td>
<td>Delegated to Other</td>
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</table>

**PAYMENTS**

1. Authority to authorise temporary variations to pay rates within standard Agenda for Change Terms and Conditions.
2. Authority to grant discretionary increments to existing or newly appointed staff within budget and regulations.
3. Authority to vary terms and conditions of employment within budget and regulations.
4. Authority to authorise temporary variations to pay rates within standard Agenda for Change Terms and Conditions.
5. Authority to grant discretionary increments to existing or newly appointed staff within budget and regulations.
6. Authority to vary terms and conditions of employment within budget and regulations.
7. Authority to authorise temporary variations to pay rates within standard Agenda for Change Terms and Conditions.
8. Authority to grant discretionary increments to existing or newly appointed staff within budget and regulations.
9. Authority to vary terms and conditions of employment within budget and regulations.
10. Authority to authorise temporary variations to pay rates within standard Agenda for Change Terms and Conditions.
11. Authority to grant discretionary increments to existing or newly appointed staff within budget and regulations.
12. Authority to vary terms and conditions of employment within budget and regulations.

**TERMS AND CONDITIONS**

13. Authority to authorise temporary variations to pay rates within standard Agenda for Change Terms and Conditions.
14. Authority to grant discretionary increments to existing or newly appointed staff within budget and regulations.
15. Authority to vary terms and conditions of employment within budget and regulations.
16. Authority to authorise temporary variations to pay rates within standard Agenda for Change Terms and Conditions.
17. Authority to grant discretionary increments to existing or newly appointed staff within budget and regulations.
18. Authority to vary terms and conditions of employment within budget and regulations.
19. Authority to authorise temporary variations to pay rates within standard Agenda for Change Terms and Conditions.
20. Authority to grant discretionary increments to existing or newly appointed staff within budget and regulations.
21. Authority to vary terms and conditions of employment within budget and regulations.
<table>
<thead>
<tr>
<th>20</th>
<th>19</th>
<th>18</th>
<th>17</th>
<th>16</th>
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<tbody>
<tr>
<td><strong>CONTRACTS OF EMPLOYMENT</strong></td>
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<tr>
<td>Renewal of fixed term</td>
<td>Renewal of fixed term</td>
<td>Authority to vary terms and conditions of employment not within budget and regulations</td>
<td>Authority to vary terms and conditions of employment within budget and regulations</td>
<td>Authority to issue contract of employment in a form approved by the Board of Directors</td>
<td>Delegated Area</td>
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<tr>
<td><strong>Ref Delegated Area</strong></td>
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<tr>
<td>Renewal of fixed term Contract &gt;= 2 years</td>
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<tr>
<td>Authority to vary terms and conditions of employment not within budget and regulations</td>
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<tr>
<td>Authority to vary terms and conditions of employment within budget and regulations</td>
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<tr>
<td>Authority to issue contract of employment in a form approved by the Board of Directors</td>
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</table>

**Reserved to the Board of Directors**

**Reserved to Council of Governors**

**Delegated to Chief Executive Officer**

**Delegated to Director of Finance**

**Delegated to Chief Medical Officer**

**Delegated to Audit & Risk Committee**

**Delegated to Finance Business & Investment Committee**

**Delegated to Appts & Remuneration Committee**

**Delegated to Trust Secretary**

**Delegated to Head of service/ Budget Manager**

**Delegated to Other**
<table>
<thead>
<tr>
<th>Ref</th>
<th>Delegated Area</th>
<th>Delegated Matter</th>
</tr>
</thead>
<tbody>
<tr>
<td>21</td>
<td>Approve payroll forms, including standing data forms affecting pay, new starters, variations and leavers, overtime payments</td>
<td>Reserved to the Board of Directors</td>
</tr>
<tr>
<td>22</td>
<td>Approval to authorise travel and subsistence expenses</td>
<td>Delegated to Director of Finance</td>
</tr>
<tr>
<td>23</td>
<td>Agree workforce plans with annual budget</td>
<td>Delegated to Chief Medical Officer</td>
</tr>
<tr>
<td>24</td>
<td>Approve the workforce establishment in line with workforce plans</td>
<td>Delegated to Director of Finance Business &amp; Investment Committee</td>
</tr>
<tr>
<td>25</td>
<td>Authority to permanently appoint staff to posts above the formal budgeted establishment with NO income to offset</td>
<td>Delegated to Audit &amp; Risk Committee</td>
</tr>
<tr>
<td>26</td>
<td>Authority to change establishment within Board of Director’s agreed financial budget</td>
<td>Delegated to Trust Secretary</td>
</tr>
</tbody>
</table>

Note: Delegated to Other
<table>
<thead>
<tr>
<th>Ref</th>
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<th>Delegated to Finance Business &amp; Investment Committee</th>
<th>Delegated to Appointments &amp; Remuneration Committee</th>
<th>Delegated to Trust Secretary</th>
<th>Delegated to Head of Service/Budget Manager</th>
<th>Delegated to Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>27</td>
<td>Authority to fill funded posts on the establishment within area of operational/corporate responsibility</td>
<td></td>
<td></td>
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<td></td>
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<td></td>
<td>✓</td>
</tr>
<tr>
<td>28</td>
<td>Authority to add additional staff to the agreed establishment with specifically allocated finance</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>✓ via Establishment Control form</td>
<td></td>
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<tr>
<td>29</td>
<td>Authority to make changes to the establishment whether permanent or temporary including requests for re-grading within agreed budget</td>
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<td></td>
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<td>✓</td>
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<tr>
<td>30</td>
<td>Engagement of staff whether permanent or temporary within agreed budget</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
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<td>✓</td>
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<tr>
<td>31</td>
<td>Approval of Payroll provider (depending on value may go to Board as well)</td>
<td></td>
<td></td>
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<td></td>
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<td></td>
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<td></td>
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REGULATION AND CONTROL
<table>
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<th>Delegated to Chief Executive Officer</th>
<th>Delegated to Director of Finance</th>
<th>Delegated to Chief Medical Officer</th>
<th>Delegated to Director of Audit &amp; Risk Committee</th>
<th>Delegated to Finance Business &amp; Investment Committee</th>
<th>Delegated to Appointments &amp; Remuneration Committee</th>
<th>Delegated to Trust Secretary</th>
<th>Delegated to Head of Service/Budget Manager</th>
<th>Delegated to Other</th>
</tr>
</thead>
</table>
| 32  | POLICY        | Approval of policies:  
• Clinical policies  
• Operational policies |  
• Quality Committee  
• Service Delivery Board | | | | | | | | | | | |
| 33  |                | Approval of all financial policies | | | | | | | | | | | | |
| 34  |                | Maintaining systems of internal control | ✓ | | | | | | | | | | | |
| 35  | SYSTEM OF INTERNAL CONTROL | Overview and scrutiny of systems of internal control including risk management | | | | | | | | | | | | |
| 36  |                | Preparation and publication of Scheme of Delegation, Standing Financial Instructions and financial procedures | ✓ | | | | | | | | | | | |
| 37  |                | Maintenance of Risk Management framework | ✓ | | | | | | | | | | | |
| 38  |                | Maintenance and review of Emergency Preparedness resilience and response procedures and business continuity planning | ✓ | | | | | | | | | | | |

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<table>
<thead>
<tr>
<th>Ref</th>
<th>Delegated Area</th>
<th>Delegated Matter</th>
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</thead>
<tbody>
<tr>
<td>39</td>
<td>Maintenance and review of Information Governance, data protection and cyber security arrangements</td>
<td>✓</td>
</tr>
<tr>
<td>40</td>
<td>Review arrangements for Whistleblowing and Freedom to Speak Up</td>
<td>✓</td>
</tr>
<tr>
<td>41</td>
<td>Preparation and submission of financial reports in accordance with accounting policies, guidance and timetable prescribed and approved by the Department of Health</td>
<td>✓</td>
</tr>
<tr>
<td>42</td>
<td>Preparation and publication of annual report and audited accounts and presentation to the Board of Director and to the Annual Public meeting of the Trust</td>
<td>✓</td>
</tr>
<tr>
<td>43</td>
<td>Approval of Annual Report and Accounts</td>
<td>✓</td>
</tr>
<tr>
<td>Ref</td>
<td>Delegated Area</td>
<td>Delegated Matter</td>
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<tr>
<td>45</td>
<td>AUDITORS</td>
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<td>46</td>
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<tr>
<td>47</td>
<td>MANAGEMENT OF BUDGETS</td>
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<td>48</td>
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<tr>
<td>49</td>
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<tr>
<td>50</td>
<td>&quot;Ref Delegated Area Delegated...&quot;</td>
<td>&quot;Reserved to the Board of Directors&quot;</td>
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<tr>
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<td>Reserved to Council of Governors</td>
<td>&quot;Delegated to Chief Executive Officer&quot;</td>
</tr>
<tr>
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<td>Delegated to Chief Executive Officer</td>
<td>&quot;Delegated to Director of Finance&quot;</td>
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<tr>
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<td>&quot;Delegated to Chief Medical Officer&quot;</td>
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<td>&quot;Delegated to Audit &amp; Risk Committee&quot;</td>
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<td>&quot;Delegated to Finance Business &amp; Investment Committee&quot;</td>
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<td>&quot;Delegated to Appts &amp; Remuneration Committee&quot;</td>
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<td>Delegated to Appts &amp; Remuneration Committee</td>
<td>&quot;Delegated to Trust Secretary&quot;</td>
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<td></td>
<td>Delegated to Trust Secretary</td>
<td>&quot;Delegated to Head of service/Budget Manager&quot;</td>
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<td></td>
<td>Delegated to Head of service/Budget Manager</td>
<td>&quot;Delegated to Other&quot;</td>
</tr>
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</table>

- Receive the Annual Report and Accounts at the Annual General Meeting
- Auditors Appointment and removal of external auditors
- Approval of internal auditors and Local Counter Fraud Specialist
- Ensure adequate internal audit service and counter fraud service are provided
- Maintaining expenditure within budgets, in line with SFIs, at individual budget level
- Transfers (virement) of designated reserves budgets
- Transfers (virement) of budgets within same Department/Locality
- Transfers (virement) of designated reserves budgets within same Department/Locality
- Transfers (virement) of designated reserves budgets within same Department/Locality
- Transfers (virement) of designated reserves budgets within same Department/Locality
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<tr>
<td>51</td>
<td></td>
<td>Transfers (virement) of undesignated reserves/contingency</td>
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<tr>
<td>52</td>
<td><strong>BUDGETARY DELEGATION (REVENUE)</strong></td>
<td>Responsibility for delegation of the management of revenue budget to permit the performance of a defined range of activities</td>
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<td>53</td>
<td></td>
<td>(a) Designation of budget holder</td>
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<td>54</td>
<td></td>
<td>(b) Responsibility for management of revenue budget at individual budget level</td>
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<tr>
<td>55</td>
<td></td>
<td>(c) Responsibility for the totality of activities covered by each Corporate or Operational Directorate</td>
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<td>56</td>
<td></td>
<td>(d) Responsibility for all other revenue budgetary areas, e.g. reserves</td>
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*Executive Directors*
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<th>Council of Governors</th>
<th>Chief Executive Officer</th>
<th>Director of Finance</th>
<th>Chief Medical Officer</th>
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<tbody>
<tr>
<td>57</td>
<td>BUDGETARY DELEGATION (CAPITAL)</td>
<td>Responsibility for delegation of the management of capital budget in line with the approved Capital Programme</td>
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<tr>
<td>58</td>
<td>(a) Designation of budget holder</td>
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<td>✓</td>
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<tr>
<td>59</td>
<td>(b) Responsibility for management and monitoring of the capital budget</td>
<td></td>
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<td>✓</td>
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<tr>
<td>60</td>
<td>(c) Responsibility for the management of capital budget at individual level</td>
<td></td>
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<td></td>
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<td></td>
<td>✓</td>
<td></td>
<td></td>
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<tr>
<td>61</td>
<td>Overview and scrutiny of capital programme</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
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<td></td>
</tr>
<tr>
<td>62</td>
<td>SYSTEMS OF PAYMENT AND PAYMENT VERIFICATION</td>
<td>Responsibility for prompt payment of accounts, contract invoices and claims and that payments are only made once the goods and services are received and been appropriately certified</td>
<td></td>
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<td>✓</td>
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<td>Delegated to Finance Business &amp; Investment Committee</td>
<td>Delegated to Apps &amp; Remuneration Committee</td>
<td>Delegated to Trust Secretary</td>
<td>Delegated to Head of service/ Budget Manager</td>
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<tr>
<td>63</td>
<td></td>
<td>Agree and maintain a list of managers authorised to place requisition for the ordering and receipt of goods and services and authorisation of invoices</td>
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<td></td>
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<tr>
<td>64</td>
<td></td>
<td>Agree and maintain a register of employees (including specimens of their signatures) authorised to certify invoices</td>
<td></td>
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<td></td>
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<tr>
<td>65</td>
<td></td>
<td>Pre-payments (i.e. payments in advance) only permitted where exceptional circumstances apply</td>
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<tr>
<td>66</td>
<td>EXTERNAL BORROWING</td>
<td>Preparation of detailed procedural instructions concerning applications for loans and overdrafts</td>
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<td>INCOME, FEES AND CHARGES AND SECURITY OF CASH,</td>
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<td>PROCUREMENT AND CONTRACTS</td>
<td>PROCUREMENT OF IN-HOUSE SERVICES - Determination of in-house services to be subject to competitive tendering</td>
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Tab 21.1 Paper: NSFT Scheme of Reservation and Delegation
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--- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | ---
78 | PROCUREMENT OF IN-HOUSE SERVICES - Delegation of lead officer(s) to oversee and manage the process and contract on behalf of the Trust |  | ✓ |  |  |  |  |  |  |  |  |  |  
79 | APPROVED FIRMS | Maintenance of approved list of firms for tendering including financial standing, technical/medical competence |  |  | ✓ |  |  |  |  |  |  |  |  
80 | MANAGEMENT OF TENDERS | Issue of all tenders for goods, materials, services, building, engineering works with appropriate Terms and Conditions regulating the conduct of the tender and appropriate Terms and Conditions on which Contract to be awarded |  |  |  | ✓ |  |  |  |  | ✓ |  |  
81 | | Receipt and safe custody of all tenders |  |  |  |  |  |  |  |  |  | ✓ | ✓
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<td>Opening of Tenders via tender submission or via tender portal and Preparation and submission of formal written Tender Evaluation Report</td>
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<td>Review and sign off of formal written Tender Evaluation Report</td>
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<td>Approval of expenditure over agreed tender quotation/quotation budget</td>
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<td>Approval of Single Tender Waivers associated with Finance Directorate</td>
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<td>Scrutiny and oversight of Single Tender Waivers, Losses, compensations and special payments</td>
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- Written instructions for the collection, safe custody and recording of money and other...
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<td>personal property handed in by service users.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Operational management of service user property in accordance with procedures</td>
</tr>
<tr>
<td>103</td>
<td></td>
<td>MENTAL HEALTH ACT – further detail in Table 5</td>
</tr>
<tr>
<td>104</td>
<td>MENTAL HEALTH ACT</td>
<td>Discharge of patients under S23 of MHA 1983 (as amended) may be exercise by three or more “persons authorise by the Board of the Trust in that behalf each of whom is neither an Executive Director of the Board nor an employee of the Trust”</td>
</tr>
<tr>
<td>105</td>
<td></td>
<td>Approval of doctors under s12 of MHA 1983</td>
</tr>
</tbody>
</table>

MENTAL HEALTH ACT – further detail in Table 5

104 MENTAL HEALTH ACT

Discharge of patients under S23 of MHA 1983 (as amended) may be exercise by three or more “persons authorise by the Board of the Trust in that behalf each of whom is neither an Executive Director of the Board nor an employee of the Trust”

105 Approval of doctors under s12 of MHA 1983
Table 3 – NSFT Operational Scheme of Delegation

<table>
<thead>
<tr>
<th>Ref</th>
<th>Delegated Area</th>
<th>Delegated Matter</th>
<th>Limit (Excl VAT)</th>
<th>Delegated to</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>APPROVAL OF PURCHASE REQS/INVOICES FOR GOODS AND SERVICES</td>
<td>(a) All requisitions/invoices</td>
<td>&lt;£25,000</td>
<td>Budget Holder</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(b) All requisitions/invoices</td>
<td>&gt;=£25,000 and &lt;£100,000</td>
<td>Service Director/Head of Department</td>
</tr>
<tr>
<td>2</td>
<td></td>
<td>(c) All requisitions/invoices</td>
<td>&gt;=£100,000 and &lt;£200,000</td>
<td>Executive Director</td>
</tr>
<tr>
<td>3</td>
<td></td>
<td>(c) All requisitions/invoices</td>
<td>&gt;=£200,000</td>
<td>Director of Finance or Chief Executive Officer</td>
</tr>
<tr>
<td>4</td>
<td></td>
<td>Revenue Investment</td>
<td>&lt;£250,000</td>
<td>Director of Finance</td>
</tr>
<tr>
<td>5</td>
<td>REVENUE INVESTMENT (NOT BUDGETED)</td>
<td>Revenue Investment</td>
<td>&gt;=£250,000 and &lt;£1 million</td>
<td>Director of Finance following Exec. Approval</td>
</tr>
<tr>
<td>6</td>
<td></td>
<td>Revenue Investment</td>
<td>&gt;=£1 million and &lt;£2 million</td>
<td>Finance and Business Committee</td>
</tr>
<tr>
<td>7</td>
<td></td>
<td>Revenue Investment</td>
<td>&gt;=£2 million</td>
<td>Board of Directors (following discussion at FBIC)</td>
</tr>
<tr>
<td>8</td>
<td></td>
<td>Approval of Existing Business/Contract Rollover</td>
<td>&lt;£5 million (over life of the contract)</td>
<td>Director of Finance following Exec. Approval</td>
</tr>
<tr>
<td>9</td>
<td>INCOME CONTRACTS FOR PROVISION OF EXISTING SERVICES</td>
<td>Approval of Existing Business/Contract Rollover</td>
<td>&gt;=£5 million and &lt;£10 million (over life of the contract)</td>
<td>Finance and Business Committee</td>
</tr>
<tr>
<td>10</td>
<td></td>
<td>Approval of Existing Business/Contract Rollover</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ref</td>
<td>Delegated Area</td>
<td>Delegated Matter</td>
<td>Limit (Excl VAT)</td>
<td>Delegated to</td>
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</tr>
<tr>
<td>11</td>
<td></td>
<td>Approval of Existing Business/Contract Rollover</td>
<td>&gt;=£10 million (over life of the contract)</td>
<td>Board of Directors</td>
</tr>
<tr>
<td>12</td>
<td><strong>INCOME CONTRACTS FOR PROVISION OF SERVICES/NEW BUSINESS</strong></td>
<td>Approval of New Business or Diversification.</td>
<td>&lt;£2 million (over life of the contract)</td>
<td>Director of Finance following Exec. Approval</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Approval of New Business or Diversification.</td>
<td>&gt;=£2 million and &lt;£5 million (over life of the contract)</td>
<td>Finance and Business Committee</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Approval of New Business or Diversification.</td>
<td>&gt;=£5 million (over life of the contract)</td>
<td>Board of Directors</td>
</tr>
<tr>
<td>13</td>
<td></td>
<td>Minimum limit above which written competitive quotes are required</td>
<td>£10,000</td>
<td>Board of Directors</td>
</tr>
<tr>
<td>14</td>
<td></td>
<td>Minimum limit above which competitive local tender required</td>
<td>£50,000</td>
<td></td>
</tr>
<tr>
<td>15</td>
<td></td>
<td>Minimum limit above which OJEU tender required</td>
<td>£189,330</td>
<td></td>
</tr>
<tr>
<td>16</td>
<td></td>
<td>Minimum number of firms invited to quote competitively</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>17</td>
<td></td>
<td>Minimum number of firms invited to tender</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>18</td>
<td><strong>COMPETITIVE QUOTATION AND TENDERING REQUIREMENTS</strong></td>
<td>Contract Approvals and sign off</td>
<td>&lt;£500,000 (over life of the contract)</td>
<td>Director of Finance and Executive Director with budget responsibility</td>
</tr>
<tr>
<td>19</td>
<td></td>
<td>Contract Approvals and sign off</td>
<td>&gt;=£500,000 and &lt;£2 million (over life of the contract)</td>
<td>Chief Executive and Director of Finance</td>
</tr>
<tr>
<td>20</td>
<td></td>
<td>Contract Approvals and sign off</td>
<td>&gt;=£2 million (over life of the contract)</td>
<td>Board of Directors</td>
</tr>
<tr>
<td>Ref</td>
<td>Delegated Area</td>
<td>Delegated Matter</td>
<td>Limit (Excl VAT)</td>
<td>Delegated to</td>
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</tr>
<tr>
<td>21</td>
<td>LEASES, TENANCY AGREEMENTS AND LICENCES (NEW AND RENEWALS) AND EARLY TERMINATION CHARGES</td>
<td>Lifetime value of lease/or termination value</td>
<td>&lt;£500,000 over the term of the lease</td>
<td>Executive Director with Budget responsibility and Director of Finance</td>
</tr>
<tr>
<td>22</td>
<td></td>
<td>Lifetime value of lease/or termination value</td>
<td>£500,000 and &lt;£2 million over the term of the lease</td>
<td>Chief Executive and Director of Finance</td>
</tr>
<tr>
<td>23</td>
<td></td>
<td>Lifetime value of lease/or termination value</td>
<td>£2 million over the term of the lease</td>
<td>Board of Directors</td>
</tr>
<tr>
<td>24</td>
<td></td>
<td>Approval of individual Capital schemes</td>
<td>&lt;£500,000</td>
<td>Sponsoring Executive Director and Director of Finance</td>
</tr>
<tr>
<td>25</td>
<td>CAPITAL INVESTMENT</td>
<td>Approval of individual Capital schemes</td>
<td>£500,000 and £1 million</td>
<td>Director of Finance following Exec. Approval</td>
</tr>
<tr>
<td>26</td>
<td></td>
<td>Approval of individual Capital schemes</td>
<td>£1 million and &lt;£2 million</td>
<td>Finance and Business Committee</td>
</tr>
<tr>
<td>27</td>
<td></td>
<td>Approval of individual Capital schemes</td>
<td>£2 million</td>
<td>Board of Directors</td>
</tr>
<tr>
<td>28</td>
<td>CAPITAL DISPOSALS</td>
<td>Capital Disposals</td>
<td>&lt;£500,000 NBV</td>
<td>Chief Executive and Director of Finance</td>
</tr>
<tr>
<td>29</td>
<td></td>
<td>Capital Disposals</td>
<td>£500,000 and &lt;£1 million NBV</td>
<td>Finance and Business Committee</td>
</tr>
<tr>
<td>Ref</td>
<td>Delegated Area</td>
<td>Delegated Matter</td>
<td>Limit (Excl VAT)</td>
<td>Delegated to</td>
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</tr>
<tr>
<td>30</td>
<td></td>
<td>Capital Disposals</td>
<td>( \geq \text{£1 million NBV} )</td>
<td>Board of Directors</td>
</tr>
<tr>
<td>31</td>
<td></td>
<td>Losses governing: Cash, Fruitless Payments (including abandoned capital schemes, damage to buildings, equipment including loss)</td>
<td>( \text{&lt;£10,000} )</td>
<td>Director of Finance or his/her nominated Deputy</td>
</tr>
<tr>
<td>32</td>
<td>LOSSES &amp; SPECIAL PAYMENTS</td>
<td>Losses governing: Cash, Fruitless Payments (including abandoned capital schemes, damage to buildings, equipment including loss)</td>
<td>( \geq \text{£10,000 and &lt;£25,000} )</td>
<td>Chief Executive and Director of Finance</td>
</tr>
<tr>
<td>33</td>
<td></td>
<td>Losses governing: Cash, Fruitless Payments (including abandoned capital schemes, damage to buildings, equipment including loss)</td>
<td>( \geq \text{£25,000 and &lt;£100,000} )</td>
<td>Director of Finance following Exec. Approval</td>
</tr>
<tr>
<td>34</td>
<td></td>
<td>Losses governing: Cash, Fruitless Payments (including abandoned capital schemes, damage to buildings, equipment including loss)</td>
<td>( \geq \text{£100,000} )</td>
<td>Finance and Business Committee</td>
</tr>
<tr>
<td>35</td>
<td></td>
<td>Write-off of NHS and non-NHS debtors</td>
<td>( \text{&lt;£50,000} )</td>
<td>Director of Finance</td>
</tr>
<tr>
<td>36</td>
<td></td>
<td>Write-off of NHS and non-NHS debtors</td>
<td>( \geq \text{£50,000} )</td>
<td>Chief Executive and Director of Finance</td>
</tr>
<tr>
<td>37</td>
<td>BANKING &amp; CASH</td>
<td>Amount above which cheques and electronic transfers require two authorised signatories</td>
<td>( \text{£2,000} )</td>
<td></td>
</tr>
<tr>
<td>38</td>
<td>PETTY CASH</td>
<td>Maximum limit for petty cash holding (general)</td>
<td>( \text{£5,000} )</td>
<td></td>
</tr>
<tr>
<td>Ref</td>
<td>Delegated Area</td>
<td>Delegated Matter</td>
<td>Limit (Excl VAT)</td>
<td>Delegated to</td>
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</tr>
<tr>
<td>39</td>
<td></td>
<td>Maximum limit for petty cash holding (patient monies)</td>
<td>£5,000</td>
<td></td>
</tr>
<tr>
<td>40</td>
<td></td>
<td>Maximum value of an individual petty cash reimbursement</td>
<td>£200</td>
<td></td>
</tr>
<tr>
<td>41</td>
<td>REDUNDANCY AND EARLY RETIREMENT PAYMENTS</td>
<td>Redundancy payments</td>
<td>&lt;£75,000</td>
<td>Head of HR and Director of Finance</td>
</tr>
<tr>
<td>42</td>
<td></td>
<td>Redundancy payments</td>
<td>&gt;=£75,000 and &lt;£150,000</td>
<td>Chief Executive, Director of Finance and Head of HR</td>
</tr>
<tr>
<td>43</td>
<td></td>
<td>Redundancy payments</td>
<td>&gt;=£150,000</td>
<td>Board of Directors</td>
</tr>
<tr>
<td>44</td>
<td>CLAIMS/SETTLEMENTS AND COMPENSATION PAYMENTS ARISING FROM CONTRACTS OF EMPLOYMENT</td>
<td>Approvals of Claims/Settlements and Compensation Payments</td>
<td>&lt;£75,000</td>
<td>Head of HR and Director of Finance</td>
</tr>
<tr>
<td>45</td>
<td></td>
<td>Approvals of Claims/Settlements and Compensation Payments</td>
<td>&gt;=£75,000 and &lt;£150,000</td>
<td>Chief Executive, Director of Finance and Head of HR</td>
</tr>
<tr>
<td>46</td>
<td></td>
<td>Approvals of Claims/Settlements and Compensation Payments</td>
<td>&gt;=£150,000</td>
<td>Board of Directors</td>
</tr>
<tr>
<td>Ref</td>
<td>Delegated Area</td>
<td>Delegated Matter</td>
<td>Limit (Excl VAT)</td>
<td>Delegated to</td>
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</tr>
<tr>
<td>47</td>
<td></td>
<td>Approval of expenditure against Individual Funds</td>
<td>&lt; £1,000</td>
<td>Fund-Holder</td>
</tr>
<tr>
<td>48</td>
<td>CHARITABLE FUNDS</td>
<td>Approval of expenditure against Individual Funds</td>
<td>&gt; £1,000 and &lt; £5,000</td>
<td>Fund-holder and Service Director</td>
</tr>
<tr>
<td>49</td>
<td></td>
<td>Approval of expenditure against Individual Funds</td>
<td>&gt; £5,000 and &lt; £25,000</td>
<td>Above plus Director of Finance</td>
</tr>
<tr>
<td>50</td>
<td></td>
<td>Approval of expenditure against Individual Funds</td>
<td>&gt; £25,000 and &lt; £100,000</td>
<td>Charitable Funds Committee</td>
</tr>
<tr>
<td>51</td>
<td></td>
<td>Approval of expenditure against Individual Funds</td>
<td>&gt; £100,000</td>
<td>Board of Directors</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Role/Position</th>
<th>Delegated Approval Limit</th>
</tr>
</thead>
<tbody>
<tr>
<td>EPRR Strategic Command</td>
<td>&lt;£100,000 with single items in excess of this requiring approval of Director of Finance or Deputy Director of Finance (with escalation as per normal Scheme of Delegation)</td>
</tr>
<tr>
<td>EPRR Tactical Command</td>
<td>£25,000</td>
</tr>
<tr>
<td>EPRR Operational command</td>
<td>&lt;£10,000</td>
</tr>
</tbody>
</table>

In the event of emergency response, these delegations will be invoked by the CEO, in consultation with the Chair, during an emergency response. All decisions made under this scheme will be reported to the Strategic Advisory Forum (Executive)
<table>
<thead>
<tr>
<th>Title:</th>
<th>Standing Financial Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outcome Statement:</td>
<td>To provide detailed financial responsibilities, policies and procedures adopted by the Trust so that the trust's financial transactions are carried out in accordance with the law and to achieve probity accuracy, economy, efficiency and effectiveness.</td>
</tr>
</tbody>
</table>
| Written By: | Kathy Walsh – Deputy Director of Finance  
Jean Clark, Trust Secretary |
| Reviewed by: | Daryl Chapman, Director of Finance  
Finance, Business Investment Committee – May 2020 |
| In Consultation with: | Internal Audit  
External Audit |
| Approval By and Date: | Board of Directors – May 2020 |
| With Reference To: | NHS Improvement guidance |
| Associated Trust Policies: | Scheme of Reservation and Delegation |
| Applicable To: | All Executive and Non-Executive officers of the Trust  
All employees of the Trust |
| For Use By: | All Executive and Non-Executive officers of the Trust  
All employees of the Trust |
| Reference Number: | F004 |
| Version: | 08 |
| Retention period: | 20 years |
| Published Date: | June 2020 |
| Review Date: | March 2021 |
| Impact Assessment: | Completed. |
| Reason for Development / review: | Annual review to ensure SFIs reflect most up to date procedures of the Trust |
| Monitoring and Implementation of policy: | Chief Executive  
Director of Finance |
Norfolk and Suffolk
NHS Foundation Trust

Standing Financial Instructions

Board of Directors: June 2020
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STANDING FINANCIAL INSTRUCTIONS

1 INTRODUCTION

1.1 General

1.1.1 These Standing Financial Instructions (SFI’s) are issued for the regulation of the conduct of the Trust, its Directors, officers and agents in relation to all financial matters. They explain the financial responsibilities, policies and procedures adopted by the Trust. They are designed to ensure that the Trust’s financial transactions are carried out in accordance with the law and in order to achieve probity, accuracy, economy, efficiency and effectiveness. They should be used in conjunction with the Schedule of Decisions Reserved to the Board and the Scheme of Delegation adopted by the Trust.

1.1.2 These Standing Financial Instructions identify the financial responsibilities which apply to everyone working for the Trust and its constituent organisations including Trading Units. They do not provide detailed procedural advice and should be read in conjunction with the detailed departmental and financial procedure notes. All financial procedures must be approved by the Director of Finance.

1.1.3 Should any difficulties arise regarding the interpretation or application of any of the Standing Financial Instructions then the advice of the Director of Finance must be sought before acting. The user of these Standing Financial Instructions should also be familiar with and comply with the provisions of the Trust’s Scheme of Delegation.

1.1.4 The failure to comply with Standing Financial Instructions can be regarded as a disciplinary matter that could result in the application of the Trust’s disciplinary procedures, which may include dismissal.

1.1.5 Overriding Standing Financial Instructions: if for any reason these Standing Financial Instructions are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance shall be reported to the next formal meeting of the Audit and Risk Committee for referring action or ratification. All members of the Board of Directors and staff have a duty to disclose any non-compliance with these Standing Financial Instructions to the Director of Finance as soon as possible.

1.2 Terminology

1.2.1 The following terms shall be used within this document:

a) “Trust” means Norfolk and Suffolk NHS Foundation Trust.

b) “Board” means the Board of Directors of the Trust.

c) “Budget” means a resource, expressed in financial terms, proposed by the Board for the purpose of carrying out, for a specific period, any or all of the functions of the Trust.

d) “Budget Holder” means the director or employee with delegated authority to manage finances (Income and Expenditure) for a specific area of the organisation.

e) "Chief Executive" means the chief officer of the Trust.
f) “Director of Finance” means the chief financial officer of the Trust.

g) “Funds held on trust” shall mean those funds which the Trust holds at 1 April 1996 or date of incorporation, receives on distribution by statutory instrument or chooses subsequently to accept under powers derived under S.90 of the NHS Act 1977, as amended. Such funds may or may not be charitable.

h) “NHS Improvement” means NHS Improvement and NHS England

1.2.2 Wherever the title Chief Executive, , Director of Finance, or other nominated officer is used in these instructions, it shall be deemed to include such other director or employees who have been duly authorised to represent them.

1.2.3 Wherever the term “employee” is used and where the context permits it shall be deemed to include employees of third parties contracted to the Trust when acting on behalf of the Trust.

2 RESPONSIBILITIES AND DELEGATION

2.1 The Trust Board

2.1.1 The Board exercises financial supervision and control by:

a) formulating the financial strategy;

b) requiring the submission and approval of budgets within approved allocations/overall income;

c) defining and approving essential features in respect of important procedures and financial systems (including the need to obtain value for money);

d) defining specific responsibilities placed on members of the Board and employees indicated in the Scheme of Reservation and Delegation document;

e) The Board of Directors has resolved that certain powers and decisions may only be exercised by the Board in formal session. These are set out in the “Scheme of Reservation and Delegation” document. All other powers have been delegated to such other committees as the Trust has established.

2.2 Performance and Finance Committee

2.2.1 The Board shall establish a Finance, Business and Investment Committee composed of Non-Executive and Executive Directors.

2.2.2 The role and responsibilities of the Finance, Business and Investment Committee are set out in written terms of reference and include details of how it will:

a) Monitor the financial and healthcare contractual performance of the Trust;

b) Approve and recommend that the Board of Directors approve the annual revenue budget in addition to the longer term financial strategy and supporting financial plans;

c) Monitor the development and implementation of the cost improvement programme and relevant aspects of the quality improvement plan;

d) Approve and monitor the annual capital expenditure programme within agreed delegated limits, including investment proposals, business cases and disposal plans;
e) Monitor the development and implementation of the Estates and digital strategies;
f) Monitor service development and bid opportunities and to refer any significant opportunity/risk to the Board of Directors;
g) Review risks to the Trust’s performance in order to support Board assurance in the delivery of the Trust’s objectives;
h) Consider future opportunities/risks to financial performance that may impact on the achievement of the Trust’s strategic objectives.

2.2.3 The Chair of the Finance, Business and Investment Committee will prepare a written report, addressed to the Trust Board, summarising the key areas of discussion and outcomes.

2.3 **The Chief Executive and Director of Finance**

2.3.1 The Chief Executive and Director of Finance will, as far as possible, delegate their detailed responsibilities, but they remain accountable for their own defined areas of financial control.

2.3.2 Within the Standing Financial Instructions, it is acknowledged that the Chief Executive is ultimately accountable to the Board, and as Accounting Officer, to the Secretary of State, for ensuring that the Board meets its obligation to perform its functions within the available financial resources. The Chief Executive has overall executive responsibility for the Trust’s activities; is responsible to the Chair and the Board for ensuring that its financial obligations and targets are met and has overall responsibility for the Trust’s system of internal control.

2.3.3 It is a duty of the Chief Executive to ensure that Members of the Board and, employees and all new appointees are notified of, and put in a position to understand their responsibilities within these Standing Financial Instructions.

2.4 **The Director of Finance**

2.4.1 The Director of Finance is responsible for:

a) implementing the Trust’s financial policies and for co-ordinating any corrective action necessary to further these policies;

b) maintaining an effective system of internal financial control including ensuring that detailed financial procedures and systems incorporating the principles of separation of duties and internal checks are prepared, documented and maintained to supplement these instructions;

c) ensuring that sufficient records are maintained to show and explain the Trust’s transactions, in order to disclose, the financial position of the Trust at any time;

d) the provision of financial explanation to other members of the Board and employees;

e) the design, implementation and supervision of systems of internal financial control; and

f) the preparation and maintenance of such accounts, certificates, estimates, records and reports as the Trust may require for the purpose of carrying out its statutory duties.
2.5 Board Members and Employees

2.5.1 All members of the Board and employees, severally and collectively, are responsible for:

a) the security of the property of the Trust;

b) avoiding loss;

c) exercising economy and efficiency in the use of resources; and

d) conforming with the requirements of Standing Financial Instructions, Financial Procedures and the Scheme of Reservation and Delegation.

2.6 Contractors and their Employees

2.6.1 Any contractor or employee of a contractor who is empowered by the Trust to commit the Trust to expenditure or who is authorised to obtain income shall be covered by these instructions. It is the responsibility of the Chief Executive to ensure that such persons are made aware of this.

2.6.2 For all members of the Board of Directors and any employees who carry out a financial function, the form in which financial records are kept and the manner in which members of the Board of Directors and employees discharge their duties must be to the satisfaction of the Director of Finance.

3 AUDIT

3.1 Audit and Risk Committee

3.1.1 The Board shall establish an Audit and Risk Committee composed of Non-Executive Directors which should include at least three independent Non-Executive Directors. The Board shall satisfy itself that at least one member of the Audit and Risk Committee has recent and relevant financial experience.

3.1.2 The main role and responsibilities of the Audit and Risk Committee are set out in written terms of reference and include details of how it will:

a) monitor the integrity of the establishment and maintenance of an effective system of integrated governance, risk management and internal control across the whole of the organisation’s activities;

b) review the Trust’s Annual Report and Financial Statements before submission to the Board of Directors;

c) make recommendations to the Council of Governors in relation to the appointment, re-appointment and removal of the Trust’s external auditor;

d) gain assurance that there is an effective Internal Audit function which meets mandatory NHS Internal Audit Standards review all Internal and External audit reports including the annual report of the Head of Internal Audit and the Local Counter Fraud Specialist and agreement of the Annual Audit Letter before submission to the Board of Directors;
e) review and monitor management response and responsiveness to findings and recommendations contained within relevant Audit reports; and

f) report to the Council of Governors, identifying any matters in respect of which it considers that action or improvement is needed and making recommendations as to the steps to be taken.

3.1.3 Where the Audit and Risk Committee considers there is evidence of ultra vires transactions, evidence of improper act, or if there are other important matters that the Committee wishes to raise, the Chair of the Audit and Risk Committee should raise the matter at a full meeting of the Board of Directors. Exceptionally, the matter may need to be referred immediately to an appropriate higher authority, such as NHS Improvement, the Care Quality Commission, and the Department of Health etc. (to the Director of Finance in the first instance, if appropriate).

3.1.4 It is the responsibility of the Director of Finance to ensure an adequate Internal Audit service is provided and the Audit and Risk Committee shall be involved in the selection process when/if an Internal Audit service provider is changed.

3.2 Director of Finance

3.2.1 The Director of Finance is responsible for:

   a) ensuring there are arrangements to review, evaluate and report on the effectiveness of internal financial control including the establishment of an effective Internal Audit function;

   b) ensuring that the Internal Audit function is adequate and complies with the Public Sector Internal Audit Standards;

   c) deciding at what stage to involve the police in cases of misappropriation and other irregularities not involving fraud or corruption; and

   d) ensuring that an annual internal audit report is prepared for the consideration of the Audit and Risk Committee and the Board. The report must cover:

      • a clear opinion on the effectiveness of internal control in accordance with current assurance framework guidance issued including for example compliance with control criteria and standards;
      • major internal financial control weaknesses discovered;
      • progress on the implementation of internal audit recommendations;
      • progress against plan over the previous year;
      • strategic audit plan covering the coming three years; and
      • a detailed plan for the coming year.

3.2.2 The Director of Finance or designated auditors are entitled without necessarily giving prior notice to require and receive:

   a) access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature;

   b) access at all reasonable times to any land, premises, member of the Board of Directors or employee of the Trust;
c) the production of any cash, stores or other property of the Trust under a member of the Board of Directors and an employee’s control; and

d) explanations concerning any matter under investigation.

3.3 Role of Internal Audit

3.3.1 Internal Audit will review, appraise and report upon:

a) the extent of compliance with, and the financial effect of, relevant established policies, plans and procedures;

b) the adequacy and application of financial and other related management controls;

c) the suitability of financial and other related management data;

d) the extent to which the Trust’s assets and interests are accounted for and safeguarded from loss of any kind, arising from:
   - fraud and other offences;
   - waste, extravagance, inefficient administration; and
   - poor value for money or other causes.

3.3.2 Whenever any matter arises which involves, or is thought to involve, irregularities concerning cash, stores, or other property or any suspected irregularity in the exercise of any function of a pecuniary nature, the Director of Finance, or the Chief Executive if the irregularity involves or is thought to involve the Director of Finance, must be notified immediately.

3.3.3 The Chief Internal Auditor will normally attend Audit and Risk Committee meetings and has a right of access to all Audit and Risk Committee members, the Chair, and Chief Executive of the Trust.

3.3.4 The Chief Internal Auditor shall be accountable to the Director of Finance. The reporting system for internal audit shall be agreed between the Director of Finance, the Audit and Risk Committee and the Chief Internal Auditor. The agreement shall be in writing and shall comply with the NHS Foundation Trust Accounting Officer Memorandum and all other requirements of NHS Improvement and subject thereto, with the guidance on reporting contained in the Public Sector Internal Audit Standards or such other terms as the Director of Finance shall consider appropriate. The reporting system shall be reviewed at least every three years.

3.4 External Audit

3.4.1 External Auditors will be appointed in accordance with the National Health Service Act 2006 (as amended) and NHS Improvement’s Audit Code for NHS Foundation Trusts. The Audit and Risk Committee must ensure a cost-effective service in compliance with the NHS Foundation Trust Code of Governance.

3.4.2 The Council of Governors should take the lead in agreeing with the Audit and Risk Committee the criteria for appointing, reappointing and removing Auditors.

3.4.3 The Audit and Risk Committee should make recommendations to the Council of Governors in relation to the appointment, re-appointment and removal of the External Auditors and the
approval of the remuneration and terms of engagement of the External Auditor.

3.4.4 If the Council of Governors does not accept the Audit and Risk Committee’s recommendation, the Board of Directors should include in the Annual Report a statement from the Audit and Risk Committee explaining the recommendation and should set out the reasons why the Council of Governors has taken a different position.

3.4.5 When the Council of Governors ends an External Auditor’s appointment in disputed circumstances, the Chair should write to NHS Improvement informing it of the reasons behind the decision.

3.5 Fraud and Corruption

3.5.1 In line with their responsibilities, the Trust’s Chief Executive and Director of Finance shall put in place and maintain appropriate Counter Fraud arrangements, ensuring compliance with the NHS Standard Contract Service Conditions section SC24, which set out the Trust’s responsibilities with regards to ensuring that appropriate Counter Fraud arrangements are in place.

The Trust will co-operate with and participate in activities at the request of the NHS Counter Fraud Authority (NHSCFA), including the implementation of national anti-fraud and bribery measures. The Bribery Act 2010 introduced the offences of offering and/or receiving a bribe. It places specific responsibility on organisations to have in place sufficient and adequate procedures to prevent bribery and corruption taking place. Under the Act, Bribery is defined as “Inducement for an action which is illegal unethical or a breach of trust. Inducements can take the form of gifts, loans, fees, rewards or other privileges”. Corruption is broadly defined as the offering or the acceptance of inducements, gifts or favours, payments or benefit in kind which may influence the improper action of any person; corruption does not always result in a loss. The corrupt person may not benefit directly from their deeds; however, they may be unreasonably using their position to give some advantage to another. To demonstrate the organisation has sufficient and adequate procedures in place and to demonstrate openness and transparency all staff are required to comply with the requirements of Standing Financial Instructions and the Scheme of Reservation and Delegation.

For a more detailed explanation see the Trust’s Counter Fraud & Corruption Policy. Should members of staff wish to report any concerns or allegations they should contact the Trust’s Local Counter Fraud Specialist.

3.5.2 The Trust shall nominate a suitable person to carry out the duties of Local Counter Fraud Specialist (LCFS), as specified in the NHS Anti-Fraud Manual (July 2014).

3.5.3 The LCFS shall report to the Trust Director of Finance and shall work with the NHS Counter Fraud Authority in accordance with the relevant guidance issued.

3.5.4 The LCFS will provide an annual written report on the counter fraud work undertaken within the Trust.

3.6 Security Management

3.6.1 In line with their responsibilities, the Chief Executive will monitor and ensure compliance with the NHS Standard Contract Service Conditions section SC24, which set out the Trust’s
responsibilities with regard to ensuring that appropriate Security Management arrangements are in place.

3.6.2 The Trust shall nominate a suitable person to carry out the duties of the Local Security Management Specialist (LSMS) in accordance with the requirements of the NHS Counter Fraud Authority and the NHS Standard Contract Service Conditions section SC24.

3.6.3 The Chief Executive has overall responsibility for controlling and co-ordinating security. However, key tasks are delegated to the Director responsible for Security Management and the appointed Local Security Management Specialist (LSMS).

4 ALLOCATION, PLANNING, BUDGETS, BUDGETARY CONTROL AND MONITORING

4.1 Preparation and Approval of Plans and Budgets

4.1.1 The Chief Executive will compile and submit to the Board of Directors an Annual Plan, which takes into account financial targets and forecast limits of available resources and meets the requirement of the relevant regulatory bodies. The plan will contain:

   a) a statement of the significant assumptions on which the plan is based with detailed monthly projections; and

   b) details of major changes in workload, delivery of services or resources required to achieve the plan.

4.1.2 Prior to the start of the financial year the Director of Finance will, on behalf of the Chief Executive, prepare and submit budgets for approval by the Board. Such budgets will:

   a) be in accordance with the aims and objectives set out in the Plan;

   b) accord with workload and manpower plans;

   c) be produced following discussion with appropriate budget holders;

   d) be prepared within the limits of available funds; and

   e) identify potential risks.

4.1.3 The Director of Finance shall monitor financial performance against a budget and plan, periodically review them, and report to the Board.

4.1.4 In the event that the Annual Plan requires revision during the financial year, the Chief Executive will compile and submit to the Board of Directors a report which details proposed changes to the forecast financial performance of the Trust for the financial year. The report will contain:

   a) An explanation of why the original Annual Plan is no longer viable;

   b) A statement of the revised assumptions on which the changes are based;
c) Details of major changes in workload, delivery of services or resources required to achieve the revised financial forecast;

d) The potential risks to achieving the revised financial forecast.

4.1.5 All budget holders must provide information as required by the Director of Finance to enable budgets to be compiled.

4.1.6 All budget holders will receive their allocated budgets at the commencement of each financial year.

4.1.7 Where items are expected to be required in the budget but the amount and expected timing of the items are not known with sufficient information to allow budgets to be allocated to the relevant cost centre, for example a new development, a central reserve will be held, maintaining such items of income or expenditure.

4.1.8 Guidance provided by the Director of Finance is available on the Trust’s intranet and should be referred to when undertaking any budgetary role.

4.1.9 The Director of Finance has a responsibility to ensure that adequate training and support is delivered as required to budget holders to help achieve their financial management responsibility.

4.2 Budgetary Delegation

4.2.1 The Chief Executive may delegate the management of a budget to permit the performance of a defined range of activities. This delegation must be in writing using an authorised signatory form and be accompanied by a clear definition of:

   a) the amount of the budget;
   b) the purpose(s) of each budget heading;
   c) individual and group responsibilities;
   d) authority to exercise virement;
   e) achievement of planned levels of service; and
   f) the provision of regular reports.

4.2.2 The Chief Executive and delegated budget holders must not exceed the budgetary total or virement limits set by the Board. The virement limits are set out in the Scheme of Delegation.

4.2.3 Any budgeted funds not required for their designated purpose(s) revert to the immediate control of the Chief Executive, subject to any authorised use of the virement.

4.2.4 Non-recurrent budgets should not be used to finance recurring expenditure without the authority in writing of the Chief Executive, as advised by the Director of Finance.
4.3 **Budgetary Control and Reporting**

Monitoring of financial performance will be via the Board of Directors and in more detail through the Finance, Business and Investment Committee.

4.3.1 The Director of Finance will devise and maintain systems of budgetary control. These will include:

a) regular financial reports to the Board in a form approved by the Board containing:
   
   • income and expenditure to date showing trends and forecast year-end position.
   • the Trust’s Use of \\resources risk rating as defined by NHS Improvement for the period and forecast year-end position.
   • movements in working capital and cash balances.
   • capital project spend and projected outturn against plan.
   • explanations of any material variances from plan.

   details of any corrective action where necessary and the Chief Executive’s and/or Director of Finance’s view of whether such actions are sufficient to correct the situation.

b) the issue of timely, accurate and comprehensible advice and financial reports to each budget holder, covering the areas for which they are responsible;

c) investigation and reporting of variances from financial, workload and manpower budgets;

d) monitoring of management action to correct variances; and

   • arrangements for the authorisation of budget transfers.

4.3.2 Each Budget Holder is responsible for ensuring that:

a) any likely overspending or reduction of income which cannot be met by virement is not incurred without the prior consent of the Board of Directors;

b) the amount provided in the approved budget is not used in whole or in part for any purpose other than that specifically authorised subject to the rules of virement;

c) no permanent employees are appointed without the approval of the Director of Finance other than those provided for within the available resources and manpower establishment as approved by the Chief Executive;

d) they act in accordance with the guidance provided by the Director of Finance and work within their delegated financial limits; and.

e) where appropriate, budget holders can delegate responsibility for day to day budget management and transactional approval e.g. invoice authorisations and sign off of pay related documents. The budget holder remains ultimately responsible for these matters and accountable for the actions of delegates.

4.3.3 The Chief Executive is responsible for identifying and implementing cost improvements and income generation initiatives in accordance with the requirements of the Annual Plan and a balanced budget.
4.4 Capital Expenditure

4.4.1 The general rules applying to delegation and reporting shall also apply to capital expenditure. (The particular applications relating to capital are contained in SFI 12).

4.5 Monitoring Returns

4.5.1 The Chief Executive is responsible for ensuring that the appropriate monitoring forms submitted to the requisite monitoring organisation by the due date.

5 ANNUAL FINANCIAL STATEMENTS AND REPORTS

Preparation and Submission of Annual Financial Statements and Reports

5.1.1 The Director of Finance, on behalf of the Trust, will:

   a) prepare financial returns in accordance with NHS Improvement’s Audit Code for NHS Foundation Trust, the NHS Foundation Trust Financial Reporting Manual, all other binding guidance issued by NHS Improvement, the Trust’s accounting policies, and generally accepted accounting practice;

   b) prepare and submit financial reports to NHS Improvement in accordance with current guidelines;

   c) submit financial returns to NHS Improvement for each financial year in accordance with the timetable prescribed by NHS Improvement; and

   d) present to the Council of Governors the annual financial statements, the annual report and the report of the auditors on them.

5.1.2 The Trust’s annual accounts must be audited. The Trust’s audited annual financial statements must be presented to a public meeting and made available to the public.

5.1.3 The Trust will publish an annual report, in accordance with guidelines on local accountability, and present it at a public meeting. The document will comply with NHS Improvement regulations.

6 BANK AND GOVERNMENT BANKING SERVICE (GBS) ACCOUNTS

6.1 General

6.1.1 The Director of Finance is responsible for managing the Trust’s banking arrangements and for advising the Trust on the provision of banking services and operation of accounts. This advice will take into account guidance/Directions issued from time to time by NHS Improvement.
6.1.2  The Board shall approve the banking arrangements.

“The Director/Deputy Director of Finance are jointly authorised to sign documents in relation to electronic banking channels and to delegate to individuals the power to decide matters dealt with for electronic banking channels and to allow those individuals to sub-delegate the power to other individuals to make payments and give other instructions in respect of those electronic banking channels”

6.2  Bank and GBS Accounts

6.2.1  The Director of Finance is responsible for:

a)  Commercial bank accounts and Government Banking Service (GBS) accounts;

b)  establishing separate bank accounts for the Trust’s non-exchequer funds;

c)  ensuring payments made from commercial bank or GBS accounts do not exceed the amount credited to the account except where arrangements have been made; and

d)  reporting to the Board of Directors all arrangements made with the Trust’s bankers for accounts to be overdrawn.

6.3  Banking Procedures

6.3.1  The Director of Finance will prepare detailed instructions on the operation of commercial bank and GBS accounts which must include:

a)  the conditions under which each commercial bank and GBS accounts are to be operated; and

b)  those authorised to sign cheques or other orders drawn on the Trust’s accounts.

6.3.2  The Director of Finance must advise the Trust’s bankers in writing of the conditions under which each account will be operated.

6.3.3  Payments over a defined limit shall be supported by more than one authorised signature on the cheque or authority to pay as appropriate.

6.4  Tendering and Review

6.4.1  The Director of Finance will review the commercial banking arrangements of the Trust at regular intervals to ensure they reflect best practice and represent best value for money by periodically seeking competitive tenders for the Trust’s commercial banking business.

6.4.2  Competitive tenders should be sought at least every five years. The results of the tendering exercise should be reported to the Board of Directors. This review is not necessary for GBS accounts.
7 INCOME, FEES AND CHARGES AND SECURITY OF CASE, CHEQUES AND OTHER NEGOTIABLE INSTRUMENTS

7.1 Income Systems

7.1.1 The Director of Finance is responsible for designing, maintaining and ensuring compliance with systems for the proper recording, invoicing, collection and coding of all monies due.

7.1.2 The Director of Finance is also responsible for the prompt banking of all monies received.

7.2 Fees and Charges

7.2.1 The Director of Finance is responsible for approving and regularly reviewing the level of all fees and charges other than those determined by the Department of Health, by NHS Improvement or by Statute. Independent professional advice on matters of valuation shall be taken as necessary.

7.2.2 All employees must inform the Director of Finance promptly of money due arising from transactions which they initiate/deal with, including all contracts, leases, tenancy agreements, private patient undertakings and other transactions.

7.2.3 Payments in advance will not normally be made. Where a payment has been requested but is dependent upon the receipt of income from another entity, the payment must not be made until the income has been confirmed as received.

7.3 Debt Recovery

7.3.1 The Director of Finance is responsible for the appropriate recovery action on all outstanding debts.

7.3.2 Income not received should be dealt with in accordance with losses procedures.

7.3.3 Overpayments should be detected (or preferably prevented) and recovery initiated.

7.4 Security of Cash, Cheques and other Negotiable Instruments

7.4.1 The Director of Finance is responsible for:

a) approving the form of all receipt books, agreement forms, or other means of officially acknowledging or recording monies received or receivable;

b) ordering and securely controlling any such stationery;

c) the provision of adequate facilities and systems for employees whose duties include collecting and holding cash, including the provision of safes or lockable cash boxes, the procedures for keys, and for coin operated machines; and

d) prescribing systems and procedures for handling cash and negotiable securities on behalf of the Trust.
7.4.2 Official money shall not under any circumstances be used for the encashment of private cheques or IOUs.

7.4.3 All cheques, cash etc., shall be banked intact. Disbursements shall not be made from cash received, except under arrangements approved by the Director of Finance.

7.4.4 The holders of safe keys shall not accept unofficial funds for depositing in their safes unless such deposits are in special sealed envelopes or locked containers. It shall be made clear to the depositors that the Trust is not to be held liable for any loss, and written indemnities must be obtained from the organisation or individuals absolving the Trust from responsibility for any loss.

7.4.5 All cash, cheques, and other forms of payment received by an officer shall be entered immediately in an approved form of register. Every transfer of official money from one member of staff to another shall be evidenced in the records of the departments concerned by the signature of the receiving officer.

7.4.6 Wherever incoming post consistently contains remittances the opening of such posts must be undertaken by two officers. All cash, cheques, and any other methods of payment must be entered immediately in an approved form of register and be certified by both officers.

7.4.7 Incoming post not usually associated with remittances can be opened by an individual officer. If, however, a remittance is received a second officer must be involved immediately and the procedure outlined in SFI 7.4.6 followed.

7.4.8 The opening of coin operated machines (including telephones) and the counting and recording of the takings shall be undertaken by two officers together, except as may be authorised in writing by the Director of Finance.

7.4.9 The Director of Finance shall prescribe the system for the transporting of cash and uncrossed pre-signed cheques. During the absence (e.g. on holiday) of the holder of a safe or cash box key, the officer who acts in his/her place shall be subject to the same controls as the normal holder of the key. There shall be written discharge for the safe and/or cash box contents on the transfer of responsibilities and the discharge document must be retained for inspection.

7.4.10 All unused cheques and other orders shall be subject to the same security precautions as are applied to cash.

7.4.11 Staff shall be informed in writing on appointment of these responsibilities and duties for the collection, handling or disbursement of cash, cheques etc.

7.4.12 Any loss or shortfall of cash, cheques, or other negotiable instruments, however occasioned, shall be reported immediately in accordance with the agreed procedure for reporting losses.

7.4.13 Maximum limits for cash holdings shall be agreed with the Director of Finance and shall not be exceeded without his/her express permission in writing.

7.4.14 Reimbursement to members of staff for individual items of expenditure out of a petty cash float shall not exceed a defined limit as set out in the Scheme of Reservation and Delegation, which shall be updated from time-to-time.
8 TENDERING AND CONTRACTING PROCEDURES

8.1 Duty to Comply

8.1.1 The procedure for making all or entering into contracts by or on behalf of the Trust shall comply with the Regulatory Framework, the Constitution of the Trust, and the Standing Financial Instructions of the Trust.

8.1.2 The definition of contract is an agreement defining the provision of goods or services to be provided to the Trust. This should be approved in accordance with the Trust’s Standing Financial Instructions. A contract must contain the following:
   a) An offer that specifically details exactly what will be provided;
   b) Acceptance, which is the agreement by the other party to the offer presented;
   c) Consideration, money or something of interest being exchanged between the parties;
   d) Capacity of the parties in terms of age and mental ability;
   e) The intent of both parties to carry out their promise.

8.2 Procurement Principles

8.2.1 The aim of all procurement activity should be to obtain high quality supplies, works and services for the Trust that represent value for money.

8.2.2 All procurement activity should be carried out in compliance with the EU public procurement rules, as contained in The Public Contracts Regulations 2006 (the “Regulations”) and any subsequent regulations as well as the relevant EU Treaty principles of equality, transparency, non-discrimination and proportionality.

8.2.3 All procurement activity should be in compliance with the Trust’s Constitution, Scheme of Reservation and Delegation and financial and accounting disciplines, and all relevant NHS Improvement or guidance. The Trust’s Procurement Strategy sets out the Trust’s objectives for Procurement and should be followed at all times.

8.2.4 At all times procurement activity must be in accordance with recognised best practice.

8.2.5 In order to reduce procurement costs and facilitate procurement management, whenever established framework agreements exist they should, wherever possible be used for the purchase of supplies, works and services unless there is a robust business case for doing otherwise. Examples of relevant framework agreements include framework agreements established by Crown Commercial Services (CSS) and regional procurement. Revenue Business cases should be authorised at the appropriate level. Approval limits on revenue business cases are included in the Scheme of Reservation and Delegation.

8.2.6 Where these may deliver best value for money, the use of Electronic Auctions and Dynamic Purchasing Systems should be used for any purchase of supplies, works or services.

8.2.7 All procurement activity should consider sustainability and seek to promote the Trust’s environmental, social and economic objectives.

8.2.8 Equality and diversity issues should be considered as part of any procurement strategy.
including the use of Reserved Contracts.

8.2.9 The above principles should be complied with in a way that is proportionate to the supplies, works or services being procured and the relevant risk profile of the procurement.

8.2.10 Any use of single tender actions (regardless of the value) must first be submitted to the Head of Procurement for approval by the Chief Executive or a delegated officer. Such approval must be obtained as soon as it becomes apparent that this is a likely option and any request must be accompanied with reasons for the proposed use of this procedure.

8.2.11 The Trust’s chosen electronic procurement system should be used wherever possible, and will be the trust’s default form of raising requisitions, orders and receipting goods.

8.3 Capital Investment

8.3.1 The Trust shall comply with the following NHS Improvement requirements: “Supporting NHS providers: guidance on transactions for NHS Foundation Trusts”, and “Managing Operating Cash in NHS Foundation Trusts”.

8.4 Forms of Tendering

8.4.1 Following on from SFI 8.2.9 the nature of the tendering will vary with the application of the EU Regulations. Those matters
a) subject to the full application of the Regulations will be subject to Formal Competitive Tendering;

b) which constitute “light touch regime” under the Regulations will be subject to the relevant part of the Regulations and SFI 8.5;

c) which are below the Regulations Threshold but will be subject to SFI 8.4.2 ;which are sourced under SFI 8.2.5 , SFI 8.2.6 or from NHS Supply Chain and will not be subject to tendering unless the Regulations so require.

8.4.2 Where Formal Competitive Tendering does not apply the Trust shall ensure that there is fair and adequate competition so that competitive tenders are invited for all required purchases of £25,000 and above. Fair and adequate competition shall be deemed to have arisen when the Trust ensures that invitations to tender are sent to sufficient number of firms/individuals. In no case should this be less than three firms/individuals, having regard to their capacity to supply goods or materials or undertake services or works required.

8.4.3 When a procedure is adopted based on SFI 8.4.1 and SFI 8.4.2 and during the conduct of that procedure it becomes clear that the value of the resulting contract may result in it falling outside the requirements of that procedure, the tender shall continue in that procedure unless:

a) it appears that the choice of procedure has been used to avoid competition or for administrative convenience or to award further work to a consultant originally appointed through a competitive procedure; or

b) it could result in a breach of the Regulations leading to a legal challenge of the Trust’s contract award.

8.5 Tendering Procedure

8.5.1 The Trust shall ensure that invitations to tender are submitted via the chosen e-tendering system.
system and that this provides fair and adequate competition where possible as stated in SFI 8.4.1.

8.5.2 Invitation to Tender

8.5.1 All invitations to tender shall state the date and time as being the latest time for the receipt of tenders.

8.5.2 All invitations to tender shall state that no tender will be accepted unless it is submitted via the Trust’s e-tendering system. Paper documents will no longer be accepted.

8.5.3 Receipt and Safe Custody of Tenders

8.5.3.1 The Trust’s e-tendering system will provide a sufficient audit trail to ensure that tenders are tracked and confirmation obtained that they were received by the appointed time for their opening.

8.5.4 Register of Tenders

8.5.4.1 The e-tendering system will act as the register of tenders and the Director of Finance will be responsible for the integrity of the data held.

8.5.5 Admissibility

8.5.5.1 If for any reason the designated officers are of the opinion that the tenders received are not strictly competitive (for example, because their numbers are insufficient or any are amended, incomplete or qualified) no contract shall be awarded without the approval of the Chief Executive.

8.5.5.2 Where only one tender is sought and / or received, the Chief Executive and Director of Finance shall, as far as practicable, ensure that the price to be paid is fair and reasonable and will ensure value for money for the Trust.

8.5.6 Late Tenders

8.5.6.1 Tenders received after the due time and date, but prior to the opening of the other tenders, may be considered only if the Director of Finance or his / her nominated officer decides that there are exceptional circumstances; i.e. dispatched in good time but delayed through no fault of the tenderer.

8.5.6.2 Only in the most exceptional circumstances will a tender be considered which is received after the opening of the other tenders and only then if the process of evaluation and adjudication has not started.

8.5.6.3 While decisions as to the admissibility of late, incomplete or amended tenders are under consideration, the tender documents shall be kept strictly confidential, recorded, by the Director of Finance.

8.5.7 Acceptance of Formal Tenders

8.5.7.1 Any discussions with a tenderer which are deemed necessary to clarify technical aspects of his tender before the award of a contract will not disqualify the tender.

8.5.7.2 The most economically advantageous tender, if payment is to be made by the Trust, or if payment is to be received by the Trust, shall be accepted unless there are good and
sufficient reasons to accept the lowest offer.

8.5.7.3 Where factors other than price are taken into account in selecting a tenderer, these must be clearly recorded and documented in the contract file, and the reason(s) given.

8.5.7.4 No tender shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust or is not in accordance with these Standing Financial Instructions.

8.5.7.5 The use of these procedures must demonstrate that the award of the contract was:

   a) not in excess of the going market rate / price current at the time the contract was awarded; and

   b) the best value for money.

8.5.7.6 All tenders should be treated as confidential and should be retained for inspection.

8.6 Tender Reports to the Board of Directors

8.6.1 Reports to the Board of Directors will be made on an exceptional circumstance basis only but must be made where it is decided that competitive tendering is not applicable or where an application is made that a particular SFI should be waived. The fact of the waiver and the reasons should be documented and recorded in an appropriate Trust record and reported to the Audit and Risk Committee at each meeting.

8.7 Financial Standing and Technical Competence of Contractors

8.7.1 The Director of Finance may make or institute any enquiries he/she deems appropriate concerning the financial standing and financial suitability of approved contractors. The Director with lead responsibility for clinical governance will similarly make such enquiries as is felt appropriate to be satisfied as to their technical / medical competence.

8.8 Quotations: Competitive and Non-Competitive

8.8.1 General Position on quotations

8.8.1.1 Quotations are required where formal tendering procedures are not adopted and where the intended expenditure exceeds £10,000

8.8.2 Competitive Quotations

8.8.2.1 Quotations should be obtained from at least three firms/individuals based on specifications or terms of reference prepared by, or on behalf of, the Trust.

8.8.2.2 Competitive quotations shall not be required in the following instances:

   a) when the task is essential to complete the project, and arises as a consequence of a recently completed assignment and engaging different suppliers for the new task would be inappropriate;

   b) when there is a clear benefit to be gained from maintaining continuity with an earlier project or where the requirement is covered by an existing contract (However in such cases the benefits of such continuity must outweigh any potential financial advantage to be gained by competitive tendering);
c) where a consortium arrangement is in place and a lead organisation has been appointed to carry out tendering activity on behalf of the consortium members;

d) where specialist expertise is required and is available from only one source;

e) for the provision of legal advice and other professional services providing that any firm or partnership commissioned by the Trust is recognised as having sufficient expertise in the area of work for which they are commissioned, although it will be expected that quotes will be obtained for these services in the majority of occasions;

f) in the case of a specific clinical need, where the time frame required to tender impacts adversely on services users and/or the safety of services;

g) in the case where suppliers are externally determined e.g. a national project requires a particular provider.

All single tender waiver forms must also provide evidence that this solution offers best value for money.

A single tender waiver form must be completed in these circumstances and approved as evidence that one of these criteria has been met.

8.8.2.3 Quotations shall always be in writing.

8.8.2.4 All quotations should be treated as confidential and should be retained for inspection.

8.8.2.5 The Chief Executive or the Chief Executive’s nominated officer should evaluate the quotation and select the quote which gives the best value for money. If this is not the lowest quotation if payment to be made by the Trust, or the highest if payment is to be received by the Trust, then the choice made and the reasons why should be recorded in a permanent record.

8.8.3 Non-Competitive Quotations

8.8.3.1 Non-competitive quotations in writing may be obtained when there is only one provider or under the principles of proportionality, the potential contract is estimated value of £10,000

8.9 Authorisation of Tenders and Competitive Quotations

8.9.1 Providing all the conditions and circumstances set out in these Standing Financial Instructions have been fully complied with, formal authorisation and awarding of a contract may be decided by the following staff to the value of the contract as follows:

a) The Executive Director with budget responsibility and Director of Finance - below £500,000 (over the life of the contract).

b) Chief Executive and Director of Finance – equal or over £500,000 and below £2,000,000 (over the life of the contract).

c) Board of Directors equal or over £2,000,000 (over the life of the contract).

d) These levels of authorisation may be varied or changed and need to be read in conjunction with the Trust Board’s Scheme of Reservation and Delegation.

8.9.2 In connection with the granting or termination of leases formal authorisation may be decided by the following staff to the full term value of the lease as follows:

a) The Executive Director with budget responsibility and Director of Finance below £500,000 (over the term of the lease).

b) Chief Executive and Director of Finance equal or above £500,000 and up to £2,000,000
8.9.3 Formal authorisation must be put in writing and all contracts must be signed by the Director of Finance. In the case of authorisation by the Trust Board this shall be recorded in their minutes.

8.10 External Finance for Capital Procurement

8.10.1 When the Board proposes, or is required, to use finance provided by the private sector in addition to SFI 8.3.1 the following should apply:
   a) the Chief Executive shall demonstrate that the use of external finance represents best value for money.
   b) the proposal must be specifically agreed by the Board of Directors.
   c) the selection of a contractor / finance company must be on the basis of competitive tendering or quotations.

8.11 Compliance Requirements for all Contracts

8.11.1 The Board may only enter into contracts on behalf of the Trust in compliance with SFIs 8.1 and 8.2 and any relevant regulations issued by NHS Improvement.

8.11.2 Contracts shall be in or embody the same terms and conditions of contract as was the basis up on which tenders or quotations were invited.

8.11.3 In all contracts made by the Trust, the Board shall endeavour to obtain best value for money by use of all systems in place. The Chief Executive shall nominate an officer who shall oversee and manage each contract on behalf of the Trust.

8.12 Healthcare Services Agreements

8.12.1 Where the Trust is providing Healthcare Services:
   a) The Chief Executive, as the Accounting Officer, is responsible for ensuring the Trust enters into suitable service contracts with service commissioners for the provision of NHS services;
   b) Service agreements with NHS commissioners for the supply of healthcare services shall be drawn up as a legally binding contract based on templates (as they exist) agreed by NHS Improvement and the Department of Health;
   c) The Chief Executive, as Accounting Officer, will need to ensure that regular reports are provided to the Board detailing actual and forecast income from the service contracts;
   d) All contract documents must be authorised and signed by the Director of Finance.

8.12.2 Where the Trust is commissioning Healthcare Services:
   a) Service agreements with NHS providers for the supply of healthcare services shall be drawn up as a legally binding contract;
   b) The Chief Executive shall nominate officers to commission service agreements with providers of healthcare in line with the Annual plan approved by the Board;
   c) All contract documents must be authorised and signed by the Director of Finance.
8.13 Disposals (See overlap with SFI No. 14)

8.13.1 Competitive Tendering or Quotation procedures shall not apply to the disposal of:

a) any matter in respect of which a fair price can be obtained only by negotiation or sale by auction as determined (or pre-determined in a reserve) by the Chief Executive or his nominated officer;

b) obsolete or condemned articles and stores, which may be disposed of in accordance with the procurement policy of the Trust;

c) items to be disposed of with an estimated sale value of less than £2,500, (this figure to be reviewed annually);

d) items arising from works of construction, demolition or site clearance, which should be dealt with in accordance with the relevant contract; and

e) land or buildings concerning which Department of Health guidance has been issued but subject to compliance with such guidance.

8.14 In-House Services

8.14.1 The Chief Executive shall be responsible for ensuring that value for money can be demonstrated for all services provided on an in-house basis. The Board of Directors may also determine from time-to-time that in-house services should be market tested by competitive tendering.

8.14.2 The Chief Executive shall nominate an officer to oversee and manage the contract on behalf of the Trust.

8.15 Applicability of SFIs on Tendering and Contracting to Funds Held in Trust (See overlap with SFI No. 17)

8.15.1 These Standing Financial Instructions shall not only apply to expenditure from Exchequer funds but also to works, services and goods purchased from the Trust’s Charitable Funds and private resources.

8.15.2 Contracts involving funds held on trust shall comply with the requirements of the Charities Acts.

9 TERMS OF SERVICE, ALLOWANCES AND PAYMENTS OF MEMBERS OF THE TRUST BOARD AND EXECUTIVE COMMITTEES AND EMPLOYEES

9.1 Appointments and Remuneration Committee

9.1.1 In accordance with the Trust’s Scheme of Reservation and Delegation the Board shall establish a Appointments and Remuneration Committee, with clearly defined terms of reference, specifying which posts fall within its area of responsibility, its composition, and the arrangements for reporting.

9.1.2 The Committee will:

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a) establish a remuneration policy in respect of executive directors, and any senior managers on locally determined pay below board level and keep this under review. As part of this policy the committee will consult with the Chief Executive over proposals related to the remuneration of other executive directors;

b) keep the leadership needs of the Trust under review at executive level to ensure the continued ability of the Trust to operate effectively in the health and social care economy; and

c) be responsible for identifying and appointing candidates to fill posts within its remit.

The scope of the remuneration policy will include:

d) salary, including performance related pay or bonus payments if applicable;

e) provision for other benefits including pensions and cars;

f) allowances;

g) payable expenses; and

h) compensation payments.

9.1.3 An underlying principle of this policy will be to establish sufficient levels of remuneration so as to attract and motivate executive directors of the required quality to lead the Trust, without paying more than is necessary for this purpose, and at a level affordable for the organisation. In doing so, the committee will draw on national guidance and market benchmarking analysis in any determination of executive director (and any senior managers on locally determined pay). The committee will ensure that no director or senior manager on locally determined pay receives an increase in remuneration where the Trust or the individuals’ performance does not justify such an increase. The committee will also take into account and be sensitive to the pay and conditions of staff in the wider Trust in setting the remuneration policy and in making specific decisions based upon it.

9.1.4 The committee will monitor and assess the performance appraisal of individual directors and consider this information when reviewing changes to remuneration packages.

9.1.5 The committee will oversee contractual arrangement for executive directors (including termination payments) so as to avoid rewarding poor performance.

9.1.6 The Trust will pay allowances to the Chair and Non-Executive Directors of the Board in accordance with any directions issued by the Secretary of State for Health of by the Nominations and Conduct Committee of the Council of Governors.

9.2 Funded Establishment

9.2.1 The Workforce plans incorporated within the annual plan will form the funded establishment.

9.2.2 With the exception of skill mixing or funding from reserves with approval by the Director of Finance the funded establishment of any department may not be varied without formal approval as defined by the Board of Directors.
9.3 **Staff Appointments**

9.3.1 No officer or Member of the Board of Directors or employee may engage, re-engage, or re-grade employees, either on a permanent or temporary nature, or hire agency staff, or agree to changes in any aspect of remuneration:

a) unless authorised to do so by a process of arrangement agreed by the Board of Directors;

b) the Board of Directors will approve procedures presented by the Chief Executive for the determination of commencing pay rates, condition of service, etc. for employees.

9.4 **Processing Payroll**

9.4.1 The Director of Finance is responsible for:

a) specifying timetables for submission of properly authorised time records and other notifications;

b) the final determination of pay and allowances;

c) making payment on agreed dates; and

d) agreeing method of payment.

9.4.2 The Director of Finance will issue instructions regarding:

a) verification and documentation of data;

b) the timetable for receipt and preparation of payroll data and the payment of employees and allowances;

c) maintenance of subsidiary records for superannuation, income tax, social security and other authorised deductions from pay;

d) security and confidentiality of payroll information;

e) checks to be applied to completed payroll before and after payment;

f) authority to release payroll data under the provisions of the Data Protection Act 2018;

g) methods of payment available to various categories of employee and officers;

h) procedures for the recall of cheques and bank credits;

i) pay advances and their recovery in accordance with the Trust's salary overpayment policy;

j) maintenance of regular and independent reconciliation of pay control accounts;

k) separation of duties of preparing records and handling cash; and

l) a system to ensure the recovery from those leaving the employment of the Trust of sums of money and property due by them to the Trust.
9.4.3 Appropriately nominated managers have delegated responsibility for:

a) submitting time records, and other notifications in accordance with agreed timetables;

b) completing time records and other notifications in accordance with the Director of Finance’s instructions and in the form prescribed by the Director of Finance; and

c) submitting termination forms in the prescribed form immediately upon knowing the effective date of an employee’s or officer’s resignation, termination or retirement. Where an employee fails to report for duty or to fulfil obligations in circumstances that suggest they have left without notice the Director of Finance must be informed immediately.

9.4.4 Employees are responsible for ensuring:

a) Time records and expense claims are submitted accurately and in accordance with the Trust’s guidance and rejection policy;

b) Time records and expenses claims must be submitted on a timely basis or they will be rejected without a reasonable explanation and agreed by a member of the Senior Finance team;

c) Errors or inaccuracies in pay are reported as soon as they are identified to the relevant payroll officer or payroll service provider.

9.4.5 Regardless of the arrangements for providing the payroll service, the Director of Finance shall ensure that the chosen method is supported by appropriate (contracted) terms and conditions, adequate internal controls and audit review procedures and that suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies.

9.5 Contracts of Employment

9.5.1 The Board of Directors shall delegate responsibility to an officer for:

a) ensuring that all employees are issued with a Contract of Employment, including an up-to-date Job Description, in a form approved by the Board of Directors and which complies with employment legislation;

b) dealing with variations to, or termination of, contracts of employment;

c) dealing with claims, settlements, compensation, tribunal hearings and disputes generally, arising from contracts of employment; and

d) ensuring that where an off-payroll contractual arrangement is to be made, approval must be obtained from the relevant Director in advance of an agreement being reached. Where the engagement is likely to be over 6 months in duration, the required confirmation of compliance with HM Treasury requirements should be obtained and submitted to the relevant Trust officer.
10 NON-PAY EXPENDITURE

10.1 Delegation of Authority

10.1.1 The Board of Directors will approve the level of non-pay expenditure on an annual basis and the Chief Executive will determine the level of delegation to budget managers.

10.1.2 The Chief Executive will set out:

a) the list of managers who are authorised to place requisitions for the supply of goods and services; and

b) the maximum level of each requisition and the system for authorisation above that level.

10.1.3 The Chief Executive shall set out procedures on the seeking of professional advice regarding the supply of goods and services.

10.2 Requisitioning

10.2.1 As far as possible the Trust’s e-procurement system should be used for all relevant non-pay expenditure. Relevant expenditure is defined in the Procurement Policy.

10.2.2 The requisitioner, in choosing the item to be supplied (or the service to be performed) shall always obtain the best value for money for the Trust. In so doing, the advice of the Trust’s adviser on supply shall be sought and the Trust’s determined procedures followed. Where this advice is not acceptable to the requisitioner, the Director of Finance (and/or the Chief Executive) shall be consulted.

10.2.3 Other systems may be used for other types of expenditure where available and appropriate e.g. Backtraq for maintenance expenditure.

10.3 System of Payment and Payment Verification

10.3.1 The Director of Finance shall be responsible for the prompt payment of accounts and claims. Payment of contract invoices shall be in accordance with contract terms, or otherwise, in accordance with national guidance.

10.3.2 The Director of Finance will:

a) advise the Board of Directors regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained; and, once approved, the thresholds should be incorporated in the Scheme of Reservation and Delegation and Standing Financial Instructions and regularly reviewed;

b) prepare procedural instructions or guidance within the Scheme of Delegation on the obtaining of goods, works and services incorporating the thresholds;

c) be responsible for the prompt payment of all properly authorised accounts and claims;

d) be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable. The system shall provide for:
a list of employees authorised to certify invoices.

• certification that:
  o goods have been duly received examined and are in accordance with specification and the prices are correct;
  o work delegation;
  o services rendered have been satisfactorily carried out in accordance with the order, and, where applicable, the materials used are of the requisite standard and the charges are correct;
  o in the case of contracts based on the measurement of time, materials or expenses, the time charged is in accordance with the time sheets, the rates of labour are in accordance with the appropriate rates, the materials have been checked as regards quantity, quality, and price and the charges for the use of vehicles, plant and machinery have been examined;
  o where appropriate, the expenditure is in accordance with regulations and all necessary authorisations have been obtained;
  o the account is arithmetically correct;
  o the account is in order for payment;
  o a timetable and system for submission to the Director of Finance of accounts for payment; provision shall be made for the early submission of accounts subject to cash discounts or otherwise requiring early payment; and
  o instructions to employees regarding the handling and payment of accounts within the Finance Department.

e) be responsible for ensuring that payment for goods and services is only made once the goods and services are received. Invoices for relevant non pay expenditure as defined in the Procurement Policy will only be paid where they state a valid Purchase Order number.

10.4 Official Orders

10.4.1 Official orders must:

a) be consecutively numbered;
b) be in a form approved by the Director of Finance;
c) state the Trust’s terms and conditions of trade; and
d) only be issued to, and used by, those duly authorised by the Chief Executive.

10.5 Duties of Managers and other Employees

10.5.1 Managers and other employees must ensure that they comply fully with the guidance and limits specified by the Director of Finance and that:

a) all contracts (except as otherwise provided for in the Scheme of Reservation and Delegation), leases, tenancy agreements and other commitments which may result in a liability are notified to the Director of Finance in advance of any commitment being made, and subsequently lodged with the Head of Procurement;

b) contracts above specified thresholds are advertised and awarded in accordance with EU rules on public procurement;

c) where consultancy advice is being obtained, the procurement of such advice must be recognised as best practice and reflect guidance issued by an appropriate higher authority such as NHS Improvement, the Care Quality Commission, the Department of Health etc.;
d) no order shall be issued for any item or items to any firm which has made an offer of gifts, reward or benefit to directors or employees, other than:
   - isolated gifts of a trivial character or inexpensive seasonal gifts such as calendars;
   - conventional hospitality, such as lunches in the course of working visits;

e) no requisition/order is placed for any item or items for which there is no budget provision unless authorised by the Director of Finance on behalf of the Chief Executive;

f) all goods, services, or works are ordered on an official order except works and services executed in accordance with a contract and purchases from petty cash;

g) verbal orders must only be issued very exceptionally – by an employee designated by the Chief Executive and only in cases of emergency or urgent necessity. These must be confirmed by an official order and clearly marked “Confirmation Order”;

h) orders are not split or otherwise placed in a manner devised so as to avoid the financial thresholds;

i) goods are not taken on trial or loan in circumstances that could commit the trust to a future uncompetitive purchase;

j) changes to the list of employees and other employees authorised to certify invoices are notified to the Director of Finance;

k) purchases from petty cash are restricted in value (maximum of £200) and by type of purchase in accordance with instructions issued by the Director of Finance; and

l) petty cash records are maintained in a form as determined by the Director of Finance.

10.5.2 The Chief Executive and Director of Finance shall ensure that the arrangements for the financial audit of building and engineering contracts and property transactions comply with the guidance contained within Estatecode, making reference to the following guidance, HBN 00-08 Part A, HBN 00-08 Part B, HBN 00-08 Addendum 1 (a guide to Healthcare systems in England for Local Planning Authorities and HBN 00-08), Addendum 2 (a guide to Town Planning for Healthcare organisations).

11 EXTERNAL BORROWING AND INVESTMENT

11.1 Short-Term and Long-Term Borrowing

11.1.1 The Director of Finance will advise the Board concerning the Trust’s ability to pay dividend on, and repay Public Dividend Capital (PDC) and any proposed new borrowing. The Director of Finance is also responsible for reporting periodically to the Board concerning the PDC debt and all loans and overdrafts.

11.1.2 The Board of Directors will agree the list of employees (including specimens of their signatures) who are authorised to make short-term borrowings on behalf of the Trust. This must contain the Chief Executive and the Director of Finance.

11.1.3 The Director of Finance must follow the Trust’s Treasury Management Policy concerning applications for loans and overdrafts.
11.1.4 Any short-term borrowing must be with the authority of two members of an authorised panel, one of which must be the Chief Executive or the Director of Finance. The Board of Directors must be made aware of all short-term borrowings at the next Board meeting.

11.1.5 All long-term borrowing must be consistent with the plans outlined in the current Annual Plan and be approved by the Trust Board.

11.2 Investments

11.2.1 Temporary cash surpluses must be held only in such investments as required by the Trust’s Treasury Management policy.

11.2.2 The Director of Finance is responsible for advising the Board on investments and shall report periodically to the Finance, Business and Investment Committee concerning the performance of investments held.

11.2.3 The Director of Finance must follow the Trust’s Treasury Management policy on the operation of investment accounts and on the records to be maintained.

12 CAPITAL INVESTMENT, PRIVATE FINANCING, FIXED ASSET REGISTER AND SECURITY OF ASSETS

12.1 Capital Investment

12.1.1 The Board shall establish a Finance, Business and Investment Committee composed of Non-Executive and Executive Directors which will have oversight of the Trust’s capital investment.

12.1.2 The role and responsibilities of the Finance, Business and Investment Committee are set out in written terms of reference and include details of how it will:

a) ensure proposals are evaluated for new major business developments (capital and associated revenue consequences);

b) approve proposals within its delegated limits or make recommendations to the Board of Directors as appropriate; and

c) give advice on preliminary outline business cases or business opportunities where it is difficult to judge whether it is worth proceeding with a business venture.

12.1.3 For every capital expenditure proposal the Finance, Business and Investment Committee shall ensure:

a) that a business case is produced setting out:

   • an option appraisal of potential benefits compared with known costs to determine the option with the highest ratio of benefits to costs;
   • the involvement of appropriate Trust personnel and external agencies;
   • appropriate project management and control arrangements;

b) that the Director of Finance, or an employee designated by him/her, has certified professionally the costs and revenue consequences detailed in the business case.

12.1.4 For capital schemes where the contracts stipulate stage payments, the Chief Executive or Director of Finance will issue procedures for their management.
12.1.5 The Director of Finance shall issue procedures for the regular reporting of expenditure and commitment against authorised expenditure.

12.1.6 The approval of a capital programme shall not constitute approval for expenditure on any scheme.

12.1.7 The Chief Executive shall issue to the manager responsible for any scheme:

   a) specific authority to commit expenditure;
   b) authority to proceed to tender (see overlap with SFI No. 8.9); and
   c) approval to accept a successful tender (see overlap SFI No. 8.9).

12.1.8 The Director of Finance shall issue procedures governing the financial management, including variations to contract, of capital investment projects and valuation for accounting purposes.

12.2 Asset Registers

12.2.1 The Chief Executive is responsible for the maintenance of registers of assets, taking account of the advice of the Director of Finance and the Trust Secretary concerning the form of any register and the method of updating, and arranging for a physical check of assets against the asset register to be conducted once a year.

12.2.2 The Trust shall maintain an asset register recording fixed assets.

12.2.3 Additions to the fixed asset register must be clearly identified to an appropriate budget holder and be validated by reference to:

   a) properly authorised and approved agreements, architect’s certificates, supplier’s invoices and other documentary evidence in respect of purchases from third parties;
   b) stores, requisitions and wages records for own materials and labour including appropriate overheads; and
   c) lease agreements in respect of assets held under finance lease and capitalised.

12.2.4 Where capital assets are sold, scrapped, lost or otherwise disposed of, their value must be removed from the accounting records and each disposal must be validated by reference to authorisation documents and invoices (where appropriate).

12.2.5 The Director of Finance shall approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers.

12.3 Security of Assets

12.3.1 The overall control of fixed assets is the responsibility of the Chief Executive.

12.3.2 Asset control procedures (including fixed assets, cash, cheques and negotiable instruments, and also including donated assets) must be approved by the Director of Finance. This procedure shall make provision for:
a) recording managerial responsibility for each asset;

b) identification of additions and disposals;

c) identification of all repairs and maintenance expenses;

d) physical security of assets;

e) periodic verification of the existence of, condition of, and title to, assets recorded;

f) identification and reporting of all costs associated with the retention of an asset; and

g) reporting, recording and safekeeping of cash, cheques, and negotiable instruments.

12.3.3 All discrepancies revealed by verification of physical assets to fixed asset register shall be notified to the Director of Finance.

12.3.4 Whilst each employee has a responsibility for the security of property of the Trust, it is the responsibility of the Board of Directors and senior employees in all disciplines to apply such appropriate routine security practices in relation to NHS property as may be determined by the Board. Any breach of agreed security practices must be reported in accordance with agreed procedures.

12.3.5 Any damage to the Trust’s premises, vehicles and equipment, or any loss of equipment, stores or supplies must be reported by Board members and employees in accordance with the procedure for reporting losses.

12.3.6 Where practical, assets should be marked as Trust property.

13 **STORES AND RECEIPT OF GOODS**

13.1 General Position

13.1.1 Stores, defined in terms of controlled stores (pharmacy stores) and departmental stores (for immediate use) should be:

a) operationally necessary and kept to a minimum;

b) subjected to annual stock take; and

c) valued at the lower of cost and net realisable value.

13.2 Control of Stores, Stocktaking, Condemnations and Disposal

13.2.1 The overall responsibility for the control of stores shall be delegated to the Director of Finance by the Chief Executive. The day-to-day responsibility may further be delegated by the Director of Finance to departmental employees, subject to such delegation being entered in a record available to the Director of Finance. The control of any Pharmaceutical stocks shall be the responsibility of a designated Pharmaceutical Manager and the control...
of any fuel oil and coal of a designated Estates manager.

13.2.2 The responsibility for security arrangements and the custody of keys for any stores and locations shall be clearly defined in writing by the designated manager/Pharmaceutical Manager. Wherever practicable, stocks should be marked as health service property.

13.2.3 The Director of Finance shall set out procedures and systems to regulate the stores including records for receipt of goods, issues, and returns to stores, and losses.

13.2.4 Stocktaking arrangements shall be agreed with the Director of Finance and there shall be a physical check covering all items in store at least once a year.

13.2.5 Where a complete system of stores control is not justified, alternative arrangements shall require the approval of the Director of Finance.

13.2.6 The designated Manager/Pharmaceutical Manager shall be responsible for a system approved by the Director of Finance for a review of slow moving and obsolete items and for condemnation, disposal, and replacement of all unserviceable articles. The designated employee shall report to the Director of Finance any evidence of significant overstocking and of any negligence or malpractice (see also overlap with SFI No. 14 Disposals and Condemnations). Procedures for the disposal of obsolete stock shall follow the procedures set out for disposal of all surplus and obsolete goods.

14  **DISPOSALS AND CONDEMNATIONS AND SPECIAL PAYMENTS**

14.1 **Disposals and Condemnations**

14.1.1 The Director of Finance must prepare detailed procedures for the disposal of assets including condemnations, and ensure that these are notified to managers.

14.1.2 When it is decided to dispose of a Trust asset, the Head of Department or authorised deputy will determine and advise the Director of Finance of the estimated market value of the item, taking account of professional advice where appropriate.

14.1.3 The Finance, Business and Investment Committee shall ensure that all disposal and divestment proposals are evaluated and approved in accordance with the determined limits as set out in the Trust’s SFI’s.

14.1.4 All unserviceable articles shall be:

   a) condemned or otherwise disposed of by an employee (the Condemning Manager) authorised for that purpose by the Director of Finance;

   b) recorded by the Condemning manager (if the book value of the asset is in excess of £250), in a form approved by the Director of Finance which will indicate whether the articles are to be converted, destroyed or otherwise disposed of. All entries shall be confirmed by the countersignature of a second employee authorised for the purpose by the Director of Finance.

   c) The condemning Manager shall satisfy himself/herself as to whether or not there is evidence of negligence in use and shall report any such evidence to the Director of
Finance who will take the appropriate action.

14.1.5 Competitive Tendering Quotation procedures shall not apply to the disposal of:

- any matter in respect of which a fair price can be obtained only by negotiation or sale by auction as determined (or pre-determined in a reserve) by the Chief Executive or his/her nominated employee;
- obsolete or condemned articles and stores, which may be disposed of in accordance with the disposals policy of the Trust;
- items to be disposed of with an estimated sale value of less than £2,500 (this figure to be reviewed annually);
- items arising from works of construction, demolition or site clearance, which should be dealt with in accordance with the relevant contract; or
- land or buildings concerning which DoH guidance has been issued but subject to compliance with such guidance.

14.2 Losses and Special Payments

14.2.1 The Director of Finance must prepare procedural instructions on the recording of and accounting for condemnations, losses, and special payments.

14.2.2 Any employee discovering or suspecting a loss of any kind must either immediately inform their Head of Department, who must immediately inform the Chief Executive and the Director of Finance or inform an employee charged with responsibility for responding to concerns involving loss. In cases where fraud or corruption is suspected, the reporting process outlined in the Trust's Counter Fraud and Corruption Policy should be followed.

14.2.3 The Director of Finance must notify the NHS Counter Fraud Authority and the External Auditor of all instances of fraud and corruption.

14.2.4 For losses apparently caused by theft, arson, neglect of duty or gross carelessness, except if trivial, the Director of Finance must immediately notify:

- the Board of Directors; and
- the External Auditor.

14.2.5 The Director of Finance shall be authorised to take any necessary steps to safeguard the Trust's interests in bankruptcies and company liquidations.

14.2.6 For any loss, the Director of Finance should consider whether any insurance claim can be made.

14.2.7 The Director of Finance shall maintain a Losses and Special Payments Register in which write-off action is recorded.

14.2.8 All losses and special payments must be reported to the Audit and Risk Committee at every meeting.

15 INFORMATION TECHNOLOGY
15.1 Responsibilities and Duties of the Trust Senior Information Risk Owner (SIRO)

15.1.1 The Trust shall nominate a suitable individual to carry out the duties of Senior Information Risk Owner (SIRO) who is responsible for the accuracy and security of the computerised financial data of the Trust. He/she shall:

a) devise and implement any necessary procedures to ensure adequate (reasonable) protection of the Trust’s data, programs and computer hardware for which the appropriate Director is responsible from accidental or intentional disclosure to unauthorised persons, deletion or modification, theft or damage, having due regard for the Data Protection Act 2018 and General Data Protection Regulations

b) ensure that adequate (reasonable) controls exist over data entry, processing, storage, transmission and output to ensure security, privacy, accuracy, completeness, and timeliness of the data, as well as the efficient and effective operation of the system;

c) ensure that adequate controls exist such that the computer operation is separated from development, maintenance and amendment; and

d) ensure that an adequate management (audit) trail exists through the computerised system and that such computer audit reviews as the appropriate Director may consider necessary are being carried out.

15.1.2 The Trust SIRO in collaboration with the Deputy Director of Finance shall need to ensure that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation, assurances of adequacy must be obtained from them prior to implementation.

15.1.3 The Data Protection Officer shall publish and maintain a Freedom of Information (FoI) Publication Scheme, or adopt a model Publication Scheme approved by the information Commissioner. A Publication Scheme is a complete guide to the information routinely published by a public authority. It describes the classes or types of information about our Trust that we make publicly available.

15.2 Responsibilities and Duties of Directors and Employees in Relation to Computer Systems of a General Application

15.2.1 In the case of computer systems which are proposed General Applications (i.e. normally those applications which the majority of Trusts in the Region wish to sponsor jointly) all responsible directors and employees will send to the SIRO:

a) details of the outline design of the system; or

b) in the case of packages acquired either from a commercial organisation, from the NHS, or from another public sector organisation, the operational requirement.
15.3 **Contracts for Computer Services with other Health Bodies or Outside Agencies**

15.3.1 The Director of Finance shall ensure that contracts for computer services for financial applications with another health organisation or any other agency shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage. The contract should also ensure rights of access for audit purposes.

15.3.2 Where another health organisation or any other agency provides a computer service for financial applications, the Director of Finance shall periodically seek assurances that adequate controls are in operation.

15.4 **Risk Assessment**

15.4.1 The SIRO shall ensure that risks to the Trust arising from the use of IT are effectively identified and considered and appropriate action taken to mitigate or control risk. This shall include the preparation and testing of appropriate disaster recovery plans.

15.5 **Requirements for Computer Systems which have an impact on Corporate Financial Systems**

15.5.1 Where computer systems have an impact on corporate financial systems the Director of Finance shall need to be satisfied that:

a) systems acquisition, development and maintenance are in line with corporate policies such as an Information Technology Strategy;

b) data produced for use with financial systems is adequate, accurate, complete and timely, and that a management (audit) trail exists;

c) only appropriate staff have access to such data; and

d) such computer audit reviews as are considered necessary are being carried out.

16 **PATIENTS’ PROPERTY**

16.1 **Monies and other Personal Property**

16.1.1 The Trust has a responsibility to provide safe custody for money and other personal property (hereafter referred to as “property”) handed in by patients, in the possession of unconscious or confused patients, or found in the possession of patients dying in hospital.

16.1.2 The Chief Executive is responsible for ensuring that patients or their guardians, as appropriate, are informed before or at admission by:

a) notices and information booklets; (notices are subject to sensitivity guidance)

b) hospital admission documentation and property records; and

   c) the verbal advice of administrative and nursing staff responsible for admissions, that the Trust will not accept responsibility or liability for patients’ property brought into
Standing Financial Instructions June 2020

Health Service premises, unless it is handed in for safe custody and a copy of an official patients’ property record is obtained as a receipt.

16.1.3 The Director of Finance must provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patients’ property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all staff whose duty is to administer, in any way, the property of patients. Due care should be exercised in the management of a patient’s money in order to maximise the benefits to the patient.

16.1.4 Where there is a requirement for the opening of separate accounts for patients’ monies, these shall be opened and operated under arrangements agreed by the Director of Finance.

16.1.5 In all cases where property of a deceased patient is of total value in excess of £5,000 (or such other amount as may be prescribed by any amendment to the Administration of Estates, Small Payments Act 1965), the production of Probate or Letters of Administration shall be required before any of the property is released. Where the total value of the property is £5,000 or less, forms of indemnity shall be obtained.

16.1.6 Staff should be informed, on appointment, by the appropriate department or senior manager of their responsibilities and duties for the administration of the property of patients.

16.1.7 Where patients’ property or income is received for specific purposes and held for safekeeping the property or income shall be used only for that purpose, unless any variation is approved by the donor or patient in writing.

17 CHARITABLE FUNDS

17.1 Corporate Trustee

17.1.1 The discharge of the Trust’s corporate trustee responsibilities are distinct from its responsibilities for exchequer funds and may not necessarily be discharged in the same manner, but there must still be adherence to the overriding general principles of financial regularity, prudence and propriety. Trustee responsibilities cover both charitable and non-charitable purposes.

17.1.2 The Director of Finance shall ensure that each trust fund which the Trust is responsible for managing is managed appropriately with regard to its purpose and to its requirements.

17.2 Accountability to Charity Commission

17.2.1 The trustee responsibilities must be discharged separately and full recognition given to the Trust’s dual accountabilities to the Charity Commission for charitable funds held on trust.

17.2.2 The Scheme of Reservation and Delegation make clear where decisions regarding the exercise of discretion regarding the disposal and use of funds are to be taken and by whom. All Trust Board members and Trust employees must take account of that guidance before taking action.

17.3 Applicability of Standing Financial Instructions to Charitable Funds
17.3.1 In so far as it is possible to do so, most of the sections of these Standing Financial Instructions will apply to the management of funds held on trust.

17.3.2 The over-riding principle is that the integrity of each Trust must be maintained and statutory and Trust obligations met. Materiality must be assessed separately from Exchequer activities and funds.

18 ACCEPTANCE OF GIFTS BY STAFF

18.1 Awareness of the Trust Policy

18.1.1 The Director of Finance shall ensure that all staff are made aware of the Trust policy on acceptance of gifts and other benefits in kind by staff.

18.2 Gifts

18.2.1 Any gifts of cash or vouchers to individuals should be declined. Any gifts exceeding £25 in value from patients or third parties offered to Executive Directors, Non-Executive Directors, Governors or employees of the Trust shall be treated with caution and only be accepted on behalf of the organisation and not by the individual, in accordance with the guidance on business conduct and notified to the Trust Secretary. Any gifts of this value offered to a ward or department should also be notified to the Trust Secretary. Excluding cash or vouchers, Gifts accepted under £25 do not need to be declared.

19 RETENTION OF RECORDS

19.1 Records and Archives

19.1.1 The Chief Executive shall be responsible for maintaining archives for all records required to be retained in accordance with DoH guidelines.

19.1.2 The records held in archives shall be capable of retrieval by authorised persons.

19.1.3 Records held in accordance with latest DoH guidance shall only be destroyed at the express instigation of the Chief Executive. Detail shall be maintained of records so destroyed.

20 RISK MANAGEMENT AND INSURANCE

20.1 Programme of Risk Management

20.1.1 The Chief Executive shall ensure that the Trust has a programme of risk management, in accordance with current Department of Health assurance framework requirements, which must be approved and monitored by the Board of Directors.

20.1.2 The programme of risk management shall include:

a) a process for identifying and quantifying risks and potential liabilities;
b) engendering among all levels of staff a positive attitude towards the control of risk;

c) management processes to ensure all significant risks and potential liabilities are addressed including effective systems or internal control, cost effective insurance cover, and decisions on the acceptable level of retained risk;

d) contingency plans to offset the impact of adverse events;

e) audit arrangements including; internal audit, clinical audit, health and safety review;

f) a clear indication of which risks shall be insured; and

g) arrangements to review the Risk Management programme.

20.1.3 The existence, integration and evaluation of the above elements will assist in the production of the Annual Governance Statement within the Trust’s Annual Report and Accounts in accordance with the NHS Foundation Trust Reporting Manual.

20.2 Insurance: Risk Pooling Schemes Administered by NHS Resolution

20.2.1 The Board of Directors shall decide if the Trust will insure through the risk pooling schemes administered by the NHS Resolution or self-insure for some or all of the risks covered by the risk pooling schemes. If the Board of Directors decides not to use the risk pooling schemes for any of the risk areas (clinical, property and employers/third party liability) covered by the scheme this decision shall be reviewed annually.

20.3 Insurance Arrangements with Commercial Insurers

20.3.1 There are areas where Trusts’ risk pooling schemes administered by the NHS Resolution do not provide insurance cover and where the Trust will be expected to enter into other insurance arrangements with commercial insurers. These include:-

a) Trusts may enter commercial arrangements for insuring motor vehicles owned by the Trust including insuring third party liability arising from their use;

b) where the Trust is involved with a consortium in a Private Finance Initiative contract and the other consortium members require that commercial insurance arrangements are entered into; and

c) where income generation activities take place. Income generation activities should normally be insured against all risks using commercial insurance. If the income generation activity is also an activity normally carried out by the Trust for an NHS purpose the activity may be covered in the risk pool. Confirmation of coverage in the risk pool must be obtained from NHS Resolution. In any case of doubt concerning a Trust’s powers to enter into commercial insurance arrangements the Director of Finance should consult the Department of Health.

20.4 Arrangements to be followed by the Board in agreeing Insurance Cover

20.4.1 Where the Board of Directors decides to use the risk pooling schemes administered by NHS Resolution the Director of Finance shall ensure that arrangements entered into are appropriate and complementary to the risk management programme. The Director of Finance shall ensure that documented procedures cover these
arrangements.

20.4.2 Where the Board of Directors decides not to use the risk pooling schemes administered by NHS Resolution for one or other of the risks covered by the schemes, the Director of Finance shall ensure that the Board is informed of the nature and extent of the risks that are self-insured as a result of this decision. The Director of Finance will draw up formal documented procedures for the management of any claims arising from third parties and payments in respect of losses which will not be reimbursed.

20.4.3 All the risk-pooling schemes require Scheme members to make some contribution to the settlement of claims (the “deductible”). The Director of Finance should ensure documented procedures also cover the management of claims and payments below the deductible in each case.

21 MISCELLANEOUS

21.1 Signature of Documents

21.1.1 Where the signature of any document will be a necessary step in legal proceedings involving the Trust, it shall be signed by the Chief Executive unless any enactment otherwise requires or authorises, or the Trust shall have given the necessary authority to some other person for the purpose of such proceedings.

21.1.2 The Chief Executive or nominated employees shall be authorised, by resolution of the Trust, to sign on behalf of the Trust any agreement or other document not requested to be executed as a deed, the subject matter of which has been approved by the Trust or any committee, sub-committee or standing committee thereof where the Trust has delegated their powers on its behalf.

21.1.3 All signatures should also be dated and show the title of the person signing.

21.2 Scheme of Reservation and Delegation and SFIs to be given to Directors and Employees

21.2.1 It is the duty of the Chief Executive to ensure that existing directors and employees and all new appointees are notified of and understand their responsibilities within the Trust’s Scheme of Reservation and Delegation and Standing Financial Instructions. Updated copies shall be issued to staff designated by the Chief Executive. New designated employees shall be informed in writing and shall receive copies where appropriate.
Report to: Board of Directors
Meeting date: 21st May 2020
Title of report: Self-Certification to NHS Provider Licence Conditions
Action sought: For Approval
Estimated time: 5 minutes
Author: Jean Clark, Trust Secretary
Director: Mason Fitzgerald, Deputy CEO

Executive Summary:

The Trust has an NHS Provider Licence (no 120070) issued by Monitor (NHS Improvement) on 1 April 2013.

The annual self-certification provides assurance that NHS providers are compliant with the conditions of the NHS provider licence. Compliance is routinely monitored through the Single Oversight Framework (SOF) but, on an annual basis, the licence requires NHS providers to self-certify, after financial year end, as follows:

- Condition G6: The provider has taken all precautions necessary to comply with the Licence, NHS Acts and NHS Constitution (by 31 May 2020)
- Condition FT4: The provider has complied with required governance arrangements (by 30 June 2020)
- Condition CoS7: If providing commissioner requested services (CRS), the provider has a reasonable expectation that required resources will be available to deliver the designated services for the 12 months from the date of the statement (by 31 May 2020).

Trusts are not required to submit the self-certification statements to NHSI but must ensure that they are signed off by the Board of Directors and Condition G6 is published by 30 June 2020.

The completed self-certifications for NSFT are presented to the Board. This follows a review of whether process and systems were implemented in the previous financial year and were effective (G6) and to make a corporate governance statement under condition FT4 as to current and future compliance with FT4. The review involved assessing the effectiveness of board and committees, reporting lines and performance and risk management systems.

Recommendation

The Board is asked to approve the self-certification
1. **Purpose**

1.1. The purpose of this report is to seek the Board of Directors' approval of the Provider Licence self-certifications (condition FT4, G6 and CoS7) required by NHS Improvement (NHSI).

2. **Background**

1.1 Compliance is routinely monitored through the Single Oversight Framework (SOF) but, on an annual basis, the licence requires NHS providers to self-certify, after financial year end, as follows:

- **Condition G6:** The provider has taken all precautions necessary to comply with the Licence, NHS Acts and NHS Constitution (by 31 May 2020)
- **Condition FT4:** The provider has complied with required governance arrangements (by 30 June 2020)
- **Condition CoS7:** If providing commissioner requested services (CRS), the provider has a reasonable expectation that required resources will be available to deliver the designated services for the 12 months from the date of the statement (by 31 May 2020).

1.2 Trusts are not required to submit the self-certification statements to NHSI but must ensure that they are signed off by the Board of Directors and Condition G6 is published by 30 June 2020.

1.3 The self-certifications have been completed following a review of:

- whether process and systems were implemented in the previous financial year and were effective (G6); and
- effectiveness of board and committee structures, reporting lines and performance and risk management systems in order to make a corporate governance statement as to current and future compliance with FT4.

2.0 NHSI will undertake an annual audit on a small sample of Trusts to ensure compliance. If selected for an audit, Trusts will need to provide evidence that the self-certifications were signed off by the Board.

3.0 **Self-Certifications**

3.1 The questions in the self-certifications are shown in the appendices, along with the Trust's response, and risks and mitigating actions being taken.

3.2 Only FTs designated as providing commissioner requested services (CRS) must self-certify under Condition CoS7. The Trust is not designated as providing CRS.

3.3 Although the Trust remains in special measures, the CQC acknowledged the improvements in the governance structures when they inspected the Trust in October 2019. In their report published January 2020, The Trust received “Requires Improvement” for well-led as opposed to inadequate previously. The CQC noted: early signs of improvement in governance and management structures and shift in approach.

3.4 Improvements to the Trust’s governance were made throughout 2019/20 to address the issues, with the support of ELFT as buddy trust and with the new Board leadership in place. A Board development programme was introduced, the Board committees and governance architecture...
overhauled to improve flow of information, the way information is presented and used by the Board and its committees was improved. A new clinical leadership was established in Care Groups, with People Participation Leads playing a significant role, devolving more decision making to where care is provided and with robust scrutiny and challenge by Quality Performance Meetings. A governance improvement plan was co-produced with the Council of Governors to enable them to effectively fulfil their statutory duties.

3.5 Further to the PwC review, commissioned by NHSI, in May 2018 of the Trust’s governance arrangements, an action plan was put in place to address areas of weakness. Grant Thornton, the Trust’s internal auditor, provided an independent assessment of the implementation of this action plan and a Significant Assurance opinion was given.

3.6 Since the CQC inspection in October, work has continued to develop the clinical leadership, and address local governance and risk management processes. The Trust acknowledges there is more to do, particularly with developing consistent Care Group local governance structures to ensure effective ward to board to ward flow of information and ensure robust mechanisms for early warning and escalation of issues. This is reflected in the self-certification.

3.7 The Trust is carrying out an annual review of its governance arrangements, including work with the council of governors, and will commission an external, independent review later in the year. This will be verified at the next CQC inspection.

3.8 Details of licence conditions are included in Appendix 1 and the completed certificates are included in the Appendix 2.

4.0 Action being requested

4.1 The Board is asked to self-certify compliance with the NHS provider licence conditions and that these are signed by the Chair and Chief Executive, subject to the Board’s approval of the Annual Report and Accounts on 8th June 2020.

4.2 The Board is asked to RECEIVE and APPROVE the self-certification.
Additional Licence Condition 1 – Additional governance requirements

1. The Licensee must ensure that it has in place:
   a) an effectively functioning board and board committees;
   b) Sufficient and effective board, management and clinical leadership capacity and capability, and
   c) Appropriate governance systems and processes

To enable it to successfully meet the undertakings set out in paragraphs 1 to 6 of the Enforcement Undertakings agreed by the Licensee dated 17 February 2015 and varied on 2 November 2016.

Condition FT4: NHS Foundation Trust Governance Arrangements

1. This condition shall apply if the Licensee is an NHS foundation trust, without prejudice to the generality of the other conditions in this Licence.

2. The Licensee shall apply those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.

3. Without prejudice to the generality of paragraph 2 and to the generality of General Condition 5, the Licensee shall:
   a. have regard to such guidance on good corporate governance as may be issued by [Monitor] from time to time; and
   b. comply with the following paragraphs of this Condition.

4. The Licensee shall establish and implement:
   a. effective board and committee structures;
   b. clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and
   c. clear reporting lines and accountabilities throughout its organisation.

5. The Licensee shall establish and effectively implement systems and/or processes:
   a. to ensure compliance with the Licensee’s duty to operate efficiently, economically and effectively;
   b. for timely and effective scrutiny and oversight by the Board of the Licensee’s operations;
   c. to ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions;
   d. for effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee’s ability to continue as a going concern);
   e. to obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making;
   f. to identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence;
   g. to generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and
   h. to ensure compliance with all applicable legal requirements.

6. The systems and/or processes referred to in paragraph 5 should include but not be restricted to systems and/or processes to ensure:
   a. that there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided;
b. that the Board’s planning and decision-making processes take timely and appropriate account of quality of care considerations;

c. the collection of accurate, comprehensive, timely and up to date information on quality of care;

d. that the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care;

e. that the Licensee including its Board actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and

f. that there is clear accountability for quality of care throughout the Licensee’s organisation including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.

7 The Licensee shall ensure the existence and effective operation of systems to ensure that it has in place personnel on the Board, reporting to the Board and within the rest of the Licensee’s organisation who are sufficient in number and appropriately qualified to ensure compliance with the Conditions of this Licence.

8 The Licensee shall submit to [Monitor] within three months of the end of each financial year:

a. a corporate governance statement by and on behalf of its Board confirming compliance with this Condition as at the date of the statement and anticipated compliance with this Condition for the next financial year, specifying any risks to compliance with this Condition in the next financial year and any actions it proposes to take to manage such risks; and

b. if required in writing by [Monitor], a statement from its auditors either:
   (i) confirming that, in their view, after making reasonable enquiries, the Licensee has taken all the actions set out in its corporate governance statement applicable to the past financial year, or
   (ii) setting out the areas where, in their view, after making reasonable enquiries, the Licensee has failed to take the actions set out in its corporate governance statement applicable to the past financial year.

General Condition 6: Systems for compliance with licence conditions and related obligations

1 The Licensee shall take all reasonable precautions against the risk of failure to comply with:

a. The Conditions of this Licence;

b. Any requirements imposed on it under the NHS Acts; and

c. The requirement to have regard to the NHS Constitution in providing health care services for the purposes of the NHS.

2 Without prejudice to the generality of paragraph 1, the steps that the Licensee must take pursuant to that paragraph shall include:

a. The establishment and implementation of processes and systems to identify risks and guard against their occurrence; and

b. Regular review of whether those processes and systems have been implemented and of their effectiveness.

3 Not later than two months from the end of each financial year, the Licensee shall prepare and submit to [Monitor] a certificate to the effect that, following a review for the purpose of paragraph 2(b) the Directors of the Licensee are or are not satisfied, as the case may be that, in the financial year most recently ended, the Licensee took all such precautions as were necessary in order to comply with this Condition.

4 The Licensee shall public each certificate submitted for the purpose of this Condition within one month of its submission to [Monitor] in such a manner as is likely to bring to the attention of such persons who reasonably can be expected to have an interest in it.
Condition CoS7 - Continuity of Services 7: Availability of resources

1. The Licensee shall at all times act in a manner calculated to secure that it has, or has access to, the Required Resources.

2. The Licensee shall not enter into any agreement or undertake any activity which creates a material risk that the Required Resources will not be available to the Licensee.

3. The Licensee, not later than two months from the end of each Financial Year, shall submit to [Monitor] a certificate as to the availability of the Required Resources for the period of 12 months commencing on the date of the certificate, in one of the following forms:
   a. “After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate.”
   b. “After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors which may cast doubt on the ability of the Licensee to provide Commissioner Requested Services”.
   c. “In the opinion of the Directors of the Licensee, the Licensee will not have the Required Resources available to it for the period of 12 months referred to in this certificate”.

4. The Licensee shall submit to [Monitor] with that certificate a statement of the main factors which the Directors of the Licensee have taken into account in issuing that certificate.

5. The statement submitted to [Monitor] in accordance with paragraph 4 shall be approved by a resolution of the Board of Directors of the Licensee and signed by a Director of the Licensee pursuant to that resolution.

6. The Licensee shall inform [Monitor] immediately if the Directors of the Licensee become aware of any circumstance that causes them to no longer have the reasonable expectation referred to in the most recent certificate given under paragraph 3.

7. The Licensee shall publish each certificate provided for in paragraph 3 in such a manner as will enable any person having an interest in it to have ready access to it.

8. In this Condition:

   | “distribution” | includes the payment of dividends or similar payments on share capital and the payment of interest or similar payments on public dividend capital and the repayment of capital; |
   | “Financial Year” | means the period of twelve months over which the Licensee normally prepares its accounts; |
   | “Required Resources” | means such: (a) management resources, (b) financial resources and financial facilities, (c) personnel, (d) physical and other assets including rights, licences and consents relating to their use, and (e) working capital as reasonably would be regarded as sufficient to enable the Licensee at all times to provide the Commissioner Requested Services. |
### Corporate Governance Statement (FTs and NHS trusts)

The Board are required to respond "Confirmed" or "Not confirmed" to the following statements, setting out any risks and mitigating actions planned for each one.

<table>
<thead>
<tr>
<th>Corporate Governance Statement</th>
<th>Response</th>
<th>Risks and Mitigating actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. The Board is satisfied that the Licensee applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.</td>
<td><strong>Confirmed</strong></td>
<td>During 2019/20 the Trust reviewed its governance structure and critical leadership with new board committees, enhanced Board development recruitment of additional Directors and NEDs, new non-executive Care Group governance structure, better performance reporting and accountability to Board, and enhanced risk management. Work with the Council of Governors resulted in an improvement plan which has been fully adhered to. GGC inspection in October 2019 recognised improvements which at the time were beginning to embed. An independent audit of governance action plan gave significant assurance. Work continues to be undertaken in external, independent reviews.</td>
</tr>
<tr>
<td>2. The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time</td>
<td><strong>Confirmed</strong></td>
<td>The Board is fully briefed as and when guidance is published</td>
</tr>
<tr>
<td>3. The Board is satisfied that the Licensee has established and implements:</td>
<td><strong>Not confirmed</strong></td>
<td>As above, the Trust has reviewed its governance structure in year and continues to embed the new arrangements for performance and accountability. There is still work to be done with developing consistent Care Group local governance structure to ensure effective and robust board to ward flow of information and ensure robust mechanisms for early warning and escalation of issues. The Trust is carrying out an annual review of its governance arrangements and will commission an external, independent review.</td>
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**Board of Directors 21st May 2020**

**Self-Certification of Provider Licence**

**Version 1.0**

**Author:** Jean Clark  
**Department:** Trust Secretary

**Date produced:** 13/5/20  
**Retention period:** 20 years
4 The Board is satisfied that the Licensee has established and effectively implemented systems and/or processes:

(a) To ensure compliance with the Licensee's duty to operate efficiently, effectively and economically;
(b) For timely and accurate notification and oversight by the Board of the Licensee's operations;
(c) To ensure compliance with health and care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulations of health care professions;
(d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern);
(e) To obtain and disseminate accurate, comprehensive, timely and up-to-date information on the conditions of its Licence;
(f) To generate and monitor the development of business plans (including any changes to such plans) and to review internal and external appropriate external assurance on each plan and their delivery.

5 The Board is satisfied that the systems and/or processes referred to in paragraph 4 above should include but not be restricted to systems and/or processes to ensure:

(a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided;
(b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations;
(c) The collection of accurate, comprehensive, timely and up-to-date information on quality of care;
(d) That the Board receives and takes into account accurate, comprehensive, timely and up-to-date information on quality of care;
(e) That the Licensee, including the Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account appropriate views and information from these sources; and
(f) That there is clear accountability for quality of care throughout the Licensee including but not restricted to systems and/or processes referred to in paragraph 4 above.

6 The Board is satisfied that there are systems to ensure that the Licensee has in place personnel on the Board reporting to the Board and within the rest of the organisation who are suitably in number and appropriately qualified to ensure compliance with the requirements of the Licensee.

<table>
<thead>
<tr>
<th>Self-Certification of Provider Licence</th>
<th>Date produced: 13/5/20</th>
<th>Retention period: 20 years</th>
</tr>
</thead>
</table>

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Certification on training of governors (FTs only)

The Board are required to respond "Confirmed" or "Not confirmed" to the following statements. Explanatory information should be provided where required.

Training of Governors

1. The Board is satisfied that during the financial year most recently ended the Licensee has provided the necessary training to its Governors, as required in s15(9) of the Health and Social Care Act, to ensure they are equipped with the skills and knowledge they need to undertake their role.

Signed on behalf of the Board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Name: [Signature]

Name: [Signature]

Capacity: Chair

Capacity: CEO

Date: 

Date: 

Tab 22.63 Licence Self-Certification and review of FT Code
Executive Summary:

This report provides an update to the Board on the two meeting of the Quality Assurance Committee (QAC) held on the 24th April 2020.

Impact of Covid-19
The committee received a presentation from the Chief Medical Officer on the Trust’s response to covid-19, including feedback from clinicians, and any impact on quality. There had been a decrease in access and referrals, as seen nationally, and a decrease in staff incidents, potentially due to the intensive work underway to support specific teams. The committee discussed the use of restrictive interventions given the national directive on blanket interventions during covid response. This was being addressed by the newly formed clinical and ethics group. The committee was pleased to hear that the Trust had enough PPE but recognised staff anxiety.

Deep Dive on Waiting times
The Chief Operating Officer explained that the current situation had enabled opportunities to work closely with partners on innovative solutions and address some long-standing issues. This included the setup of the 24/7 phoneline which provides easy access to service users and the wider public and has proved successful, with a formal evaluation underway. Also, the work with MIND in Suffolk has been very positive. The committee asked for the learning to be picked up by the recovery workstream.

Quality Improvement Plan and CQC Reports
The committee discussed the two unannounced CQC visit reports and the actions in place to address the issues, including increased staffing, supervision, review of all the young people waiting, culture programme and new leadership. Rapid Improvement Boards (RIB) are taking these forward and will report progress regularly to the committee. The Wedgewood House RIB benefited from Healthwatch and Suffolk User Forum membership. The committee was concerned with the findings but recognised the work underway at pace to address them. An Improvement Director has been appointed with NHSI to support the trust and will focus initially on CFYP.

Internal Audit Reports
The committee received the Consultant Job Planning and Out of Area follow up audits and were provided with verbal updates on activity to address audit findings however they were concerned with the time taken and requested a further report in 3 months.

Quality Committee Chair’s Report
The Committee receives an assurance report from each meeting. The recent meetings had addressed psychology therapies, formulation and Dialog+ and the staff survey results.

Board Assurance framework (BAF) risks
The committee reviewed the relevant quality and safety risks which included the impact of covid-19.

**What is the impact on service users?**
The committee found that service users were put first and changes were improving the service delivered.

**Recommendation**
The Board is asked to note the report.
Report To: Board of Directors
Meeting Date: 21st May 2020
Title of Report: Chair’s report to BOD in respect of the Audit and Risk Committee meeting held on 5th May 2020
Action Sought: For Assurance
Estimated time: 5 minutes
Author: Adrian Matthews, Non-Executive Director; Jean Clark, Trust Secretary

Executive Summary:

This report provides an update to the Board on the meeting of the Audit and Risk Committee held on the 5th May 2020.

External Audit
There were no issues regarding year end audit to bring to the committee’s attention, even though this is being conducted remotely. The team are aiming to keep to the original timetable as much as possible. The accounts had been submitted on time. IFRS16 has been postponed to next year and the Quality Account is now to be shared with stakeholders in October and submitted in December. The Committee will meet on 1st June to review the full Annual Report and Accounts.

Internal Audit and Counter Fraud
The committee received a progress report and the draft annual report. There are some reports to finalise; some had been delayed due to the covid-19 outbreak. The Head of Internal Audit Opinion will be Partial Assurance again which reflects the number of high-risk recommendations outstanding. However the auditors noted the improvement over the last 6 months and a confidence that the opinion would improve next year. The Trust will ask internal audit to test the effectiveness of implementation of recommendations this year to demonstrate this improvement.

There were two finalised reports since the last meeting: Medium Term Financial Plan and Data Security and Protection Toolkit, both with Significant Assurance opinion.

The committee acknowledged the uncertainty with regard financial planning in 20/21 due to the covid-19 situation.

The recommendations tracker was improved, but there were still outstanding recommendations which officers were asked to urgently action.

The Committee received the counter fraud annual plan and the draft workplan for 2020/21, incorporating feedback from the fraud survey. The Local Counter Fraud Specialist was tasked with more promotional work with care groups, and to work more closely with the Freedom to Speak Up Guardian, to increase awareness; benchmarking data shows the Trust is an outlier in terms of the low levels of fraud referrals.

Risk Management
The Board Assurance Framework and Corporate Risk Register were reviewed. More challenge with Care Group risk reporting was required at the Quality Performance Meetings and development of local governance was needed. New BAF risks will be presented to the May Board following the board review in April.
Compliance
Reports were received on Information Governance, Losses, and single tender waivers. The DSP toolkit had been submitted on time with the significant assurance opinion as noted above.

Covid-19 Response
The Chief Medical Officer presented a report on the Trust's response to covid-19 and the work now underway in terms of recovery. The plans for the next phase will be reviewed by the Board.

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

This report provides an update to the Board on the meeting of the People Participation Committee held on the 21st April (held virtually by MS Teams).

The Committee noted the impact of covid-19 response on delaying the development of the People Participation Strategy. The People Participation Leads (PPLs) had planned a series of co-production events with service users and carers, staff and governors which have had to be postponed.

The Committee heard the range of engagement activity the PPLs were conducting in the midst of managing the outbreak. All PPLs had been active in calling and supporting service users and carers in the community during this difficult time. They had supported the roll out of Attend Anyway software for on-line consultation, the set up of the 24/7 response line, and had provided activity packs to inpatients and ipads so they can keep in touch with loved ones. Secure and Forensics have introduced inter-ward challenges. Feedback had been very positive.

Work has continued with carers leads, although the Triangle of Care submission has been postponed nationally, and the PPLs continue to review all complaints responses to ensure complaints are seen as an opportunity to listen and learn from service users and carers.

It was recognised there was a balance between managing covid-19 at pace and co-production, but PPLs continue to gather views on the changes that have been put in place and feeding this back to care groups.

The committee noted the PPLs and service users and carers will have a key role in the covid recovery work.

Recommendation

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

This report provides an update to the Board on the meeting of the Mental Health Act Committee held on 12th March 2020.

Terms of Reference
The terms of reference were amended, including membership changes and to allow reporting from the S136 Steering Group, and will be shared with Care Groups.

CQC Visits
Themes from recent CQC visits were reviewed including consent to treatment, S17 leave and Independent Mental Health Advocacy (IMHA) referrals. The S132 Rights Policy is nearing completion.

MHA Run Chart Assurance Report
The committee received the assurance report and requested the addition of assessment of capacity to future reports. The automation of tasks was considered, and the Committee agreed it would be beneficial to have the Chief Clinical Information Officer, attend a future meeting to discuss this.

Approved Mental Health Professional (AMHP) Update
The proposal to provide the same S12 service in Norfolk and Suffolk was discussed. In principle this has been agreed and being agreed with commissioners.

Inter-Agency Update including S136
The Inter-Agency Group is being re-established in Suffolk and has an initial meeting scheduled for April 2020. Membership includes Suffolk Police, NSFT Reducing Restrictive Interventions Lead and representatives from the Care Groups and the Liaison and Diversion Service has been invited to attend.

In regard S136, it was agreed that the Clinical Director should be the accountable person and the nurse in charge of the Suite should complete the Datix entry. DD agreed to arrange a deep dive in the Quality Committee following a review of the Getting It Right First Time (GIRFT) acute and crisis care data.

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

This report provides an update to the Board on the meeting of the Appointments and Remuneration Committee held on the 16th April 2020.

The Committee received an update on the culture change programme which underpins the Trust’s quality improvement agenda and aims to address the learning from the staff survey. The culture group is seeking more diversity representation and more service user involvement to develop the culture strategy and measures of success.

The committee reflected on the positive service changes during the covid-19 pandemic, particularly work with local partners and voluntary sector to mobilise services at pace. This had been well received by staff. Staff had also welcomed the daily covid briefings, as authentic and open. The committee saw these changes as a blueprint to the leadership we want going forward.

The committee commended the work of staff during the pandemic and recognised the impact on staff wellbeing. The wellbeing service had increased its offer and a new role in the HR team was in place to support staff experience and wellbeing. Work was underway to capture the learning from the Trust’s response in the recovery workstream.

The committee was pleased to receive the Freedom to Speak Up Guardian report and emphasised the importance of linking this work into the culture programme.

Risks to the delivery of the culture plan and to improving staff engagement and wellbeing were discussed.

Recommendation

The Board is asked to note the report.