Update from the NHOSC representative from the meeting held on 8 September 2022

Cawston Park

The Committee received a presentation from the independent chair of the Safeguarding board Heather Roach She highlighted the progress made implementing the recommendations of the review that was published by NSAB in September 2021 following the deaths of Joanna, Jon and Beth who were patients of Cawston Park with learning disabilities and or autism.

The committee agreed that the progress was accepted as being good, and that all patients removed from the hospital following the review had experienced good outcomes in their new places, with one resident moving into a self-contained flat.

The director of nursing Tricia D Orsi said that the recommendations from the review are a priority for her and for the ICG (integrated care board), she also said that the capacity for mental health services was a significant challenge particularly with regard to ensuring providers could meet the require standards. She also said that the situation was dire in terms of capacity in health and social care and work was underway to support the flow of patients through the system to make sure that people were given the right support at the right time. Also, work was also underway with acute hospital trusts and other system partners looking at how to facilitate more timely discharges into the community.

She also stated that racism is an issue throughout health and social care and that more work should be done in that area.

Also discharge for patients for appropriate housing was vital to ensure hospital stays are reduced and work was underway with district councils and others. Also, additional support for relatives was being investigated if they feel that their concerns regarding a patient's physical health are not being addressed.

The system currently had 13 adult patients and 2 child patients in a residential setting and robust weekly reviews of care plans were taking place to ensure that discharge into a community placement should happen over a period of time.

Examination of the Norfolk and Suffolk NHS Foundation Trust (NSFT) – Improvement plan following the Care Quality Commission inspection from November – December 2021.

Cath Byford NSFT Deputy Chief Executive advised the committee that the Trust had made significant progress and that changes implemented had been designed to ensure these were embedded and were sustainable to do. But there was still work to be done and the Trust needed to work on gaining and building trust amongst service users and the wider community.

Points from the report showed that there was a national shortage of consultant psychiatrists and recruitment was an issue. But it was being treated as a priority to ensure services and treatment could be improved and waiting lists reduced.

She also said that future reports will concentrate on how changes are making a difference and what will happen next to improve services further.

The improvement plan was being tackled.
The first was the 'Must dos'. The CQC asked the Trust to address immediately relating to quality and safety. Root cause issues which have been preventing improvement was also being addressed within the Trust and other partners. One key part of the plan was to ensure that changes were sustainable was to acknowledge how staff, service users and carers were feeling. The example that was given was at Queen Elizabeth Hospital in Kings Lynn which was to provide an independent check and challenge on how services were received and this has provided evidence that changes were having an effect.
Numerous changes had taken place within Dragonfly Ward in Lowestoft to improve safety which has included extensive training and webinars, in addition 120 safety reviews had been undertaken since December 2021. Also, a new psychiatrist had been recruited as well.
It said that the Trust is having problems retaining staff as 41%of new staff leave within two years of starting. The balance of recruiting the right leadership staff and clinical staff had been difficult for the Trust and this had made worse the void that had appeared for the leadership to support the frontline staff in their day-to-day activities. It was acknowledged the culture at NSFT had to change and this was being addressed by the board.
Both Norfolk and Suffolk ICBs had agreed to an independent review of the mortality data. The number of deaths were known although there was some confusion as to how this data had been collected and recorded. The findings of the review would it was hoped end the confusion. Members also asked whether bereaved families would be included in the discussions around mortality numbers. The Trust agreed to explore this.

NSFT will be returning to the Committee in November 2022 and that a precise list of questions would be provided prior to ensure detailed answers could be provided.

Second meeting held at 2pm on September 8th.

There was another meeting at 2pm with selected people from the NHOSC committee (not me) and they were discussing proposals for the redesignation of Psychiatric Intensive Care Units (PICUS) in Norfolk and Suffolk.

- After their discussion the chair concluded the discussion and the committee agreed that:
  Rollesby Ward (female PICU) should be allowed to open as soon as possible.
- A comprehensive communication exercise should be undertaken by NSFT to explain how these proposals would affect patients and their families.

Feedback should be encouraged so that NSFT can ascertain what issues would arise from the proposals and how these can be best overcome to make the changes successful. NSFT would return to the committee with the outcomes of this exercise of early 2023.

- It should be acknowledged that currently there was no provision for female patients in either county and these proposals did provide a more local service for women than out of area placements.
- NSFT would undertake a robust evaluation of the changes and report back to the committee after a period of six months from the opening of Rollesby Ward. It was anticipated that this meeting would take place in June/July 2023.