Assurance plan: June 2019

NHS Norfolk and Suffolk NHS Foundation Trust

Team	Standards of performance	Actions	Lead	Timeframe	Assurance
1 Care Planning					
	1. Service Users are involved and supported to make decisions about their care 2. Service User needs are recorded 3. Incidents are recorded in the care record 4. Care Plans are individualised 5. Risk Assessments and Care Plans are updated 6. Consultation with Service users and Carers is documented 7. Service Users (and Carers, where agreed) are offered a copy of the Risk Assessment and Care Plan 8. Carers assessments are stored in the care record				
2 Safety					
	1. Environmental risks are identified and mitigated 2. Environmental risks are identified in all locations and plans are in place to address them 3. Detailed ligature risk audits are in place and identified risks are mitigated 4. Risks to the health and safety of patients are assessed and everything possible is done to mitigate the risk, including ligature reduction work 5. Seclusion rooms are free from hazards 6. Risk associated with infection is assessed, prevented and reduced, including health care associated risks 7. Clinic rooms are cleaned regularly 8. Furniture used by patients is fit for purpose and doesn't pose an infection risk 9. Adequate toilet and bathing facilities are available 10. Reasonable adjustments are in place to ensure environments are suitable for people with a learning disability				
3 Medicines / Equipment					
	1. Standards of Medicines Management are maintained and evidenced 2. Medications and equipment is in date 3. Emergency equipment is in place and regularly checked 4. Controlled drugs keys are kept separately from other medicine keys				
4 Restrictive Interventions					
	1. Service Users privacy and dignity is protected at all times when Restrictive Interventions (RIs) are used 2. Records of Restrictive Interventions fully comply with the Seclusion Policy and Mental Health Act Code of Practice 3. Staff follow the Mental Health Act Code of Practice standards and record all incidents of seclusion 4. Service Users have detailed individualised Positive Behavioural Support Plans in place 5. "Best interest decisions" are documented 6. DoLS documentation is correctly completed				
5 Workforce					
	1. Suitably qualified, competent and experienced staff in place 2. Staff have the necessary skills to keep themselves safe and systems are in place to mitigate risks 3. Staff have the necessary training to keep themselves safe 4. Staff receive regular management and clinical supervision 5. Clear effective systems are in place to record and monitor clinical and management supervision				
6 Physical Health					
	1. Physical health needs are assessed, and plans are in place to meet needs 2. Physical health information is available 3. Physical health care is recorded in the care record				
7 Access					
	1. People will receive timely access to services 2. Systems are in place to reduce waiting lists 3. Systems are in place to monitor wait times, including for assessment, treatment and psychology 4. Systems are in place to consistently monitor waiting lists so people are helped to stay safe 5. Systems accurately reflect the nature of Service User contacts in order to monitor effectiveness 6. All services meet the 4 hour target for referral to emergency assessment 7. Out of Hours staffing levels are sufficient to meet Service Users needs 8. Services meet their responsibilities for assessing people in emergency departments 9. CFYP ADHD services are reviewed to reduce waiting lists				

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